AN ANALYSIS OF PUBLIC POLICY IMPLEMENTATION WITH PARTICULAR REFERENCE TO PUBLIC HEALTH POLICY

by

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SUMMARY

This study investigates the role of public policy and the implementation of public policy with particular reference to public health policy in South Africa from 1910 to 1990.

The focus and locus of the public policy phenomenon within the political and administrative processes are also analysed. It is shown that the supposition that public policy is only part of the political process, is incorrect.

The public policy phenomenon is subsequently analysed. It is shown that the various levels of public policy impact upon the administrative process and that the policy implementation process is part of the public policy process.

In an analysis of the nature and scope of the public policy implementation process, it is argued that public policy implementation, as such, had been an underrated part of the policy process in South Africa up to the 1970's. It is also shown that internal and external variables impact upon the implementation of public policy, namely the generic administrative functions (as internal variables) and certain normative guidelines (as external variables).

The external variables that impact upon public policy implementation, namely legislative direction, public accountability, democratic requirements, reasonableness, and efficiency are analysed.

The external variables are used to establish their relevance, or not, to the implementation of public health policy in South Africa from 1910 to 1990. It was found that the external variables figured poorly in the implementation of health policy in the sense that the external variables were brought to bear in an **ad-hoc** fashion based on crises as it arose, in other words, not on pre-planned actions.

OPSOMMING

In hierdie studie word ondersoek gedoen na die rol van openbare beleid en die implementering van openbare beleid met spesifieke verwysing na openbare gesondheidsbeleid in Suid-Afrika vanaf 1910 tot 1990.

Die fokus en lokus van die openbare beleidverskynsel binne die politieke en administratiewe prosesse word ontleed. Daar word op gewys dat die veronderstelling dat openbare beleid slegs deel van die politieke proses is, verkeerd is. Daar word ook op gewys dat die verskillende vlakke van openbare beleid die administratiewe proses beïnvloed en dat die openbare beleidimplementeringproses deel van die openbare beleidsproses is.

In 'n ondersoek na die aard en omvang van die openbare beleidimplementeringproses word daarop gewys dat openbare beleidimplementering 'n onderskatte deel van die beleidproses in Suid-Afrika tot en met die 1970's was. Daar word op gewys dat interne en eksterne veranderlikes 'n invloed uitoefen op openbare beleidimplementering, te wete, die generiese administratiewe funksies (as interne veranderlikes) en bepaalde normatiewe riglyne (as eksterne veranderlikes).

Die eksterne veranderlikes vir openbare beleidimplementering, te wete, wetgewende rigtinggewing, openbare aanspreeklikheid, demokratiese vereistes, regverdigheid, en doeltreffendheid is vervolgens ontleed. Die eksterne veranderlikes word gebruik om hul toepaslikheid, al dan nie, by die implementering van openbare gesondheidsbeleid in Suid-Afrika vanaf 1910 tot 1990 te toets. Daar is bevind dat die eksterne veranderlikes swak, indien ooit, by die implementering van gesondheidsbeleid ter sprake was. Die rede daarvoor is dat die eksterne veranderlikes op 'n **ad-hoc** wyse ter sprake gebring is omdat die implementering van openbare gesondheidsbeleid toegepas is op die basis van krisisse soos dit ontstaan het en nie op beplande optredes nie.

CONTENTS

CHAPTER 1

INTRODUCTORY COMMENTS AND SUMMARY OF CHAPTERS

1.1 Aim and contents of study

This chapter explains, firstly, what the aim of the study is and why the study was undertaken. This is followed by an explanation of the approach adopted, an identification and explanation of key terms, the sources and reference technique and, lastly, a summary of the contents of each chapter.

1.2 Aim of study

From time to time in every scholarly discipline changes occur in what its scholars and practitioners consider to be the central focus. Consequently, scholars and practitioners ought to concern themselves from time to time with a compilation of an inventory and valuation of their study matter in order to ascertain what developments took place in its theory and practice, what the trends of developments are and what issues stand central to such development. P(p)ublic A(a)dministration and the topics that it represents for research is no exception to this rule.

The compilation of an inventory and evaluation of study matter presupposes, **inter alia** to look anew into the issues that the discipline has to offer. One of these issues is the nature and content of public policy. For example, although Thomas Woodrow Wilson is often credited, and

rightly so, with supporting the politics/administration-dichotomy viewpoint, it is seldom noted that the first object of the study of public administration is to discover what government can successfully do. Public policy is one of the components of the political and public administration processes that determines how successful government action is, and how government action can be properly conducted.

Concerning the scope and nature of this thesis, the need for such a study can be expressed in the words of Dwight Waldo (paraphrased), namely that it attempts to take a new look at an agenda of an old view of public policy (Waldo 1968:14-24). The central aim of this thesis, then, would be to provide an inventory and an evaluation of the theory and the practice of public policy implementation towards the rendering of public health services in the Union and the Republic of South Africa.

The importance of such a study is supported by a Human Sciences Research Council publication **Priorities for Research on the Development of Southern Africa** (H S R C 1985:2,13) in which the need for policy implementation studies is proposed. Such a need is also supported by a statement by the Deputy Director of the former Department of Constitutional Development and Planning during 1983, that the Government's proposals regarding constitutional development in the Republic of South Africa were widely publicised in the news media thus emphasising the political dispensation but dwarfing the attempts at administrative change that are continually brought about. What is more, administrative arrangements are often a precondition for change and may

even determine the degree of success achieved with constitutional reforms. This is borne out by the fact that officials often formulate the proposals conceived by the politicians and must interpret and give effect to resultant political decisions (Thornhill 1983:61). This giving effect to political decisions (or better known as the implementation thereof) affects mankind ubiquitously. Public health is no exception to this rule.

The reasons for the existence of governmental institutions in one or other form may appear self-evident because of a life-long association with them (Robbins 1980:4). When people live together as a group in a particular locality, it is self-evident that there must be persons and institutions that administer the affairs of public interest in an orderly fashion because humans are intent on associating themselves with collectivised patterns from time immemorial. Some of the reasons for organising into groups are found in the fundamental transitions that ultimately led to contemporary society, changing it, in part, from a rural culture to a culture based on technology, industry and city-life (Scott 1981:53). People living together in a group, develop group needs that cannot be satisfied by any one member of the group.

One cannot question the logic of the above oversimplified reduction of the rendering of public services, but the real question here is who are these persons and institutions referred to and by what means do they render public services? The point at issue is therefore the adoption and implementation of instruments by governments in order to facilitate the rendering of public services, **inter alia** the public policy process.

Cooperative action from the earliest times can be related to public administration and, in particular, to public policy as a means towards the attainment of the general welfare of the group (Hattingh 1986:10). Public administration and public policy are concerned with considerations of getting things done towards the realisation of what a particular group, the government, considers to be in the general interest of the public. Considerations of what ought to be in the interest of the public have their origin in the perception of the government of the values, needs, desires, fears, and demands of society or societal groups (Hanekom 1987:5).

Values, needs, desires, fears, and demands of society are never static. They continually move from past experiences to new challenges and will have to be continually reappraised by government as the providers of goods and services in order to meet the needs of the community. Garbers (1987:71) asserts that, similar to the rest of the world, the Republic of South Africa is also moving:

- towards an information era in which general technology is superseded by high technology;
- from relative short-term towards long-term orientation;
- from institutional aid to self-help;
- from a representative democracy toward a participatory democracy;
- from involvement within fixed hierarchies toward a system of coordinated networks; and
- from single to multiple options.

These societal trends stand central to the provision of goods and services by the government to the public. In fact, the government of the Republic of South Africa can ill-afford to ignore the general well-being of the community it governs (Hanekom 1986:25). The provision of goods and services to the public is made possible, **inter alia**, by a collection of administrative functions which must always and everywhere be undertaken where two or more people work towards the attainment of a common goal. One of these functions is the policy function (Cloete 1972:2).

An investigation into the policy process provides the background to the second aim of this thesis, namely, to investigate the framework within which the implementation of public policies in general, and public health policy in particular, is undertaken. Since public administration is continually putting its hands to new undertakings (Wilson 1887:6) and since what public office bearers do affect the lives of the inhabitants of the state (Robbins 1980:4), the necessity for probing the framework and how public policy is applied within such a framework, becomes evident.

The need for research about **inter alia** the implementation problems of health services had also been voiced from an international point of view (World Health Organization (WHO), **Public Health Papers** No. 67, 1977) as well as from a South African point of view (De Beer 1975:Foreword).

The importance of a contemporary study of the policy process is borne out by the statement that never before has the need been greater for insight

into the purposes of the state and the structure and functioning of public institutions dedicated to serving those purposes (Van Zyl 1983:preface).

Yet, aspects of P(p)ublic A(a)dministration are usually accorded a less prominent role in governmental affairs than that of politics because politics and what politicians do, or refrain from doing, are more spectacular and visible than the day-to-day activities of public officials (Gladden 1972:214). What is more, politicians concerned with securing action on public problems often lose interest therein or shift their attention elsewhere once they secure the enactment of a particular public policy (Anderson 1984:101).

The fact is, however, that the sustained existence of a country depends as much on the public administrative functions as on the political functions because the responsibilities of the public sector (notably that of the executive branch) are growing as rapidly as the demands of the society it serves. Both politics and public administration share many objectives, for example, public administration pursues, as much as politics, societal values and contribute to the development thereof, and both contribute to a science of the state and all its functions (Tötemeyer 1988:195,98).

The third reason why the study was undertaken, relates to the fact that a lack of research into the public policy function may lead to a lack of an appreciation of public administration and the role it has played, and will have to play through the policy process, in the rendering of public

services, in particular, public health services in the Republic of South Africa.

Broadly speaking, knowledge can be acquired either through accidental discovery or as a result of an intentional search for answers on questions that originate in the human mind. The latter refers to research. Research can be explained as an intentional, accurate and systematic search for new knowledge or the reinterpretation of existing knowledge (Cilliers 1973:17). The aim of research undertaken for this thesis is to reinterpret existing knowledge in order to provide answers to the following:

- Public policies are not self-executing. Legislatures in the Republic of South Africa (i.e. Parliament at the central government level, and local councils on the local government level) adopt policies to be implemented. And yet, little progress towards the accomplishment of these policies may occur. It is provisionally stated that questions concerning the role of the public policy process in the rendering of services will remain unanswered unless the importance, or not, of the policy implementation stage of the public policy process is also assessed.

  The link with the second aim of the study, namely, the role of the public policy process **vis-a-vis** the public policy implementation process is thus achieved.
- Research into the public policy arena, particularly the public policy implementation process, was prompted by the fact that the study of

public policy has traditionally favoured the policy-making process. This thesis was, therefore, motivated by the desire to assess and promote the prospects of the policy implementation process.

- In the past public policy studies had been dominated by the political process perspective and tended to concentrate on the authoritative allocation of values by political institutions. A re-evaluation of the role of executive institutions in the policy process, particularly the policy implementation process, is therefore deemed necessary.

The aim of science is to describe, to understand, and to explain (Duvenage 1983:25-6). Public Administration is regarded as a science (Botes 1987:29). Moreover, Public Administration is an applied science (Cloete 1972:46) and the answers to the questions posed can be of academic as well as of practical use.

In the search for answers to the problems posed, public policy-making and public policy implementation processes as constituent functions of the generic administrative process will be described and explained. Certain identified normative guidelines or external variables, namely, legislative direction, public accountability, tenets of democracy, reasonableness, and efficiency (Andrews 1985:28-9; De Beer 1988:107-15; Botes, Brynard, Fourie & Roux 1992:179-87). will also be explained with reference to the implementation of a specific public policy, namely health policy from 1910 up to 1990.

1.3 Approach to the study

The approach to the study is descriptive and analytical in nature, in other words, a description of the **locus** of public policy in both the political and administrative processes, a description of the policy process in its various manifestations, particularly the policy-making and policy implementation processes, together with an analysis of policy expressions within such descriptions. This is followed by a description of the normative guidelines of public administration to public policy expressions, referred to as external variables (**infra**, chapter 5). The approach is of an analytical nature in that the general is taken as a point of departure which, in turn, is narrowed down to the particular (Fowler 1983:280). For the purposes of this thesis, the relationship of the public policy process with the political and administrative processes is analysed. This is followed by a narrowing down of attention to the policy phenomenon, the policy implementation process, the external variables that impact upon the implementation process, namely, legislative direction, public accountability, tenets of democracy, reasonableness and efficiency. Lastly, the external variables are applied to public health policy implementation during the time of the Union and the Republic of South Africa.

The reason for the adoption of such an approach can be explained as follows. A study of implementation requires an understanding of a complex chain of reciprocal interaction between the component parts of the overall public policy process, particularly between the policy-making and policy implementation parts of such a process. Public policy

implementation **per se** does not refer to creating the initial conditions within which the implementation has to take place. In order to describe and analyse the public policy implementation process, cogniscance will have to be taken of the public policy-making process because, in a given governing situation, a policy has to be expressed through legislation that has to be passed and funds that has to be appropriated in terms of which implementation has to take place. The study of public policy implementation, therefore, requires an understanding that apparently simple sequences of events (namely the public policy-making and implementation parts of the comprehensive public policy process) consist of complex chains of reciprocal interaction. In the words of Pressman and Wildavsky: "The separation of policy design from implementation is fatal. It is no better than mindless implementation without a sense of direction." (Pressman & Wildavsky 1973:xvii). It is for these reasons that this study has to focus on the place of public policy in the political and administrative processes, as well as on the nature and contents of the public policy process itself, as part of the analysis of the policy implementation process and the variables that impact on a specific public policy implementation process, namely public health policy.

1.4 Sources

Both primary and secondary sources were used. Primary sources include standard academic works of acknowledged authors, **Debates** of the House of Assembly of the Union of South Africa and the Republic of South Africa, manifestos of political parties from 1910 to 1981, annual reports, acts,

ordinances, regulations, White Papers, and reports of commissions/committees of inquiry during this time. Primary sources were used throughout the thesis where applicable whilst those primary sources that specifically dealt with health policy and health policy implementation were used in the latter part of the manuscript.

Secondary sources were text books, articles in scientific journals and newspaper reports

Largely the same primary sources were used for the analysis of the relevance, or not, of the identified variables in the implementation of the public health policies in the Union and the Republic of South Africa. This procedure is deemed necessary in order to analyse the implementation of public health policies on what had been written authoritatively (such as in the **Debates** of Parliament and in government appointed commissions and committees of inquiry) on health matters. In other words, the primary sources that were consulted provided acknowledged and authoritative information on events in an **ex post facto** fashion on the implementation of public health policies from which the inadequacies, or otherwise, of the implementation process could be ascertained. Such a procedure involved that, where applicable, primary sources had to be used repetitively with the result that a degree of duplication was inevitable.

This thesis contains no end- or footnotes.

1.5 Terminology

Etymological explanations of certain English words were given in the text. The source consulted for such explanations is the **Twentieth Century Dictionary, New Edition**, London: W & R Chambers Ltd, 1974.

Sources consulted appear at the end of this manuscript.

Terms relevant to this study are explained in the text where they are used for the first time.

1.6 References

References to sources are done in accordance with a prescribed method, namely the Harvard method (Roux 1981:29).

1.7 Summary of chapters

Chapter 1 is an introductory chapter in which a description of the aim of the study, the approach to the topic of the study, the sources consulted, and the reference technique are given. It is concluded by a summary of the contents of the various chapters.

Chapter 2 contains a discussion of the developmental trends of the policy function as a constituent part of both the political and administrative processes. It is generally assumed that the public policy function is of a political nature only. In chapter 2 this general assumption is analysed

against the development of the nature and content of the political and administrative processes and the place (if any) of the public policy function in both. It is shown that public policy, as a declaration of intent, is indeed a component part of both the political and the administrative processes. It is also shown in chapter 2 that the development of administrative thought concerning public policy confirms it as a constituent function of the administrative process whose institutional abode is the executive branch of government.

Chapter 3 analyses the public policy phenomenon. Public policy is one of the means through which purposeful governmental action can be perceived and established. How this perceived and established action can be brought to bear is as much part of the policy-making phenomenon as it is of the policy implementation process (the latter forms the gist of chapter 4). Chapter 3 thus serves as a link to the analyses in chapter 4 since the public policy-making function impacts upon the public policy implementation process, and **vice versa**. It is shown in chapter 3 that the public policy phenomenon can be classified into various models, into classes of instruments, and into various levels.

Chapter 4 deals with the public policy implementation process. It is shown that a resurgence of policy implementation studies ocurred from the 1970's. It is shown that two major schools of thought exist in terms of which the implementation process can be analysed, namely the classical and the integrationist schools of thought. Factors that impact upon the policy implementation process in a South African setting are identified

under two headings, namely, the internal and external variables. Internal variables are identified as consisting of the generic administrative functions. These functions are not discussed for the purpose of this thesis. The external variables are identified as normative or guiding factors.

Chapter 5 contains an analysis of the external variables that influence the policy implementation process, namely legislative direction, public accountability, tenets of democracy, reasonableness, and efficiency.

Chapters 6 and 7 consist of an analysis of a particular public policy, namely public health policy, during the period 1910 up to 1990 in order to determine to what extent the external variables identified in chapter 5 are involved in its implementation. The study of the implementation process is, therefore, operationalised in a detail study of the rendering of South-African health services from 1910 to 1990.

Chapter 8 is an evaluation of the contents of the manuscript. It is shown that, in the case of the implementation of health policies from 1910 to 1990 in a South African context, that public health matters were accorded a low priority in the governing of the state by political parties and by the government-of-the-day. It is also shown that if measures to ameliorate the health problems of the country are tackled on an **ad hoc** basis, then little fruit will be borne from such measures. Rather, cogniscance will have to be taken of the external variables, singularly and combined, as

prerequisites for a more fruitful development and implementation of a public health policy.

CHAPTER 2

POLICY PROCESS AS PART OF THE POLITICAL AND ADMINISTRATIVE PROCESSES

2.1 Introduction

The analysis and comprehension of public policies is seen by many as central to an understanding and the control of political life. Public policy provides the framework within which governments seek to control, regulate or promote facets of society in the interests of the members of society. In the past public policy studies have been dominated by a political process perspective that have focussed on public policy as part of the political process only.

Whilst public policy emanates from the government-of-the-day in the form of acts, regulations, ordinances, by-laws and proclamations, they are more often than not designed and implemented through a variety of public executive institutions that are not directly involved in the party political process. This chapter attempts to indicate the place of the public policy process not only as part of the political process, but also forming part of the administrative process.

Such an attempt is considered necessary for the purpose of this thesis in as far as it describes the framework within which public policies and

therefore also public health policies are made and implemented by the government-of-the-day.

As a working approximation it is suggested that public policy, as a constituent function of the administrative process, fulfills as important a role in the administrative process as in the political process. In order to explain the hybrid nature of public policy (i.e. as a constituent function of both the political and administrative processes), an overview of the locus (i.e. the institutional abode) and the focus (i.e. the contents) of the public policy process is necessary. In so doing, the roles of the political and administrative processes in the adoption and implementation of public health policy will be clarified. Moreover, the administrative process is supposed to function within the ambit of the external variables of legislative direction, public accountability, tenets of democracy, reasonableness, and efficiency. An identification of the public policy process as part of the administrative process would therefore confirm the applicability, or otherwise, of the external variables to public policy-making and implementation, **inter alia**, in the South-African Department of Health.

2.2 Political process and public policy

In its broadest sense, politics include the decision-making and decision execution processes of any group that makes rules for its members and enforces it on them (Ranney 1990:26). At this stage the statement can therefore be made that public health policy is the product of the decisions

of a specific group (namely, the legislature) which is enforced by yet another specific group (the government-of-the-day) on the members (the inhabitants). Although political scientists have also studied these processes in non-governmental institutions, most of them have concentrated on decision-making and decision enforcing in governmental (i.e. public) institutions (Ranney 1990:26). It is in the latter sense that the generic term "policy process" assumes a specific character in as far as the policy output of governmental (public) institutions is known as a specific kind of policy, namely, public policy.

2.2.1 Political process

Definitions of politics and the political process abound in Political Science textbooks. Kotze and Van Wyk (1986:130) suggest that, notwithstanding the divergence of definitions politics can be summarised as consisting of those ideas, institutions and activities that give rise to and/or form part of the process by which rules and values are authoritatively allocated and enforced for a specific community.

In a governmental setting the political process can best be explained by referring to what is meant by the term process. A process can be described as a series of actions that form an identifiable pattern, occuring so regularly that the pattern repeats itself (Kotze & Van Wyk 1986:147).

It is generally held that the series of actions of a political process consist of:

- the formulation and expression (articulation) of demands by members of the society concerning rules that are made, or that are not made;
- the combination (aggregation) of different and sometimes diverse demands into consolidated demands;
- the conveyance or making known (communication) of the demands to the government so that the government can consider them;
- the making of rules;
- the execution of rules; and
- the settling of disputes (adjudication) that emerges as a result of the rules (Kotze & Van Wyk 1986:147-8).

It will be shown subsequently (**infra** chapters 3, 6 and 7) how the adoption and implementation of public health policy was kept in abeyance as well as how it came into being in the Union of South Africa as well as in the Republic of South Africa due to a lack of or as a result of the above series of actions by the successive governments-of-the-day.

Central to the above series of actions of the political process stand deliberations about policy and questions of justice (Kriek 1980:7); relevant not only in contemporary society but since ancient times.

2.2.1.1 Politics: an ancient legacy

The contemporary Western world received its legacy regarding its thought about the community - and therefore also about the political process -

from ancient Greek civilisation, particularly from Socrates (469-399 B.C.), Plato (427-347 B.C.) and Aristotle (384-323 B.C.) (Faure, **et. al.** 1981:11).

Aristotle, during classic Greek times, provided contemporary politics with one of the first in-depth divisions in the form and principles of the orderly human community in his writings about the ethical (including the religious) level of the community, the political level as instrument for the ethical, and the economical level as an instrument for the political function (Murray 1981:11).

Aristotle, for example, wrote in his **Politica** that "...deliberations whether about policy or about questions of justice are at the heart of and centre of the polis" (Kriek 1980:7).

The word politics derives from the root words **polis** and **politikos** which is from Greek, and in particular, Athenian origin. The root words refer to the early Greek cities or city-states, and the orderly arrangement of community life in the city-states respectively. Up to the present, the word politics retained its ancient Greek characteristics, influenced by various main streams of thought, **inter alia**, the Christian religion (Murray 1981:12; Vosloo 1977:12).

2.2.1.2 Politics: contemporary relevance

During the early twentieth century scholars of Political Science were inclined to focus on what they called the state. The subject of their research was concerned with governmental institutions, political parties,

and, later, interest groups. After the Second World War the political system came to replace the state as the central concept of the discipline Political Science. Attention was directed away from governmental and other political institutions towards aspects of political behaviour in a political system. Scholars became especially interested in the input side of the political system. As a result, research was done on subjects such as political culture, political socialisation, and the belief-systems of electorates (Gwyn & Edwards 1975:ix).

During the 1960's discontent with the emphasis associated with the systems concept of Political Science was accompanied by the emphasis on the public policy approach to Political Science which, by the early 1970's, appears to have supplanted the systems approach as the dominant emphasis of the discipline. By fixing their attention on the outputs of government, i.e. the public policy process, political scientists concerned themselves primarily with the purposive activities of government to achieve public objectives. Political Science has thus developed dialectically with the schism between the institutional and systems approaches being resolved by incorporating them into a synthesis in which both may play a part in explaining public policy and its social consequences (Gwyn & Edwards 1975:ix).

Thus, to contemporary sholars of politics, deliberations about decisions and policy form the core of Political Science. Roskin **et. al.** (1988:2) assert, for example, that contemporary Political Science focusses on the following two interrelated questions:

- why and how do leaders make decisions they do; and
- why do citizens obey some of these decisions, but some disobey others?

Since ancient Greek studies, public policy and public decisions were primarily under the jurisdiction of Political Science. The institutional and systems approaches are, in accordance with contemporary thinking, best understood by considering the operation of a political system in relation to its environment and by examining how such a system maintains itself and changes over time (Jenkins 1978:21), with particular emphasis on the output stage, i.e. public policy.

Thus, there exists at the centre of life in a community, **inter alia**, a demand for an understanding of the complexities of public policy, how policy is formed within political systems, and how it is received by different groups in society (Jenkins 1978:1).

Deliberations about public policy signifies that contemporary politics include decisions by a government concerning the goals for governance. These decisions ultimately culminate in the policy statements of the government-of-the-day in the form of policy decisions that are embodied in various authoritative actions (Hanekom & Thornhill 1986:16). Policies, as authoritative decisions and actions include legislation, judicial edicts, executive decrees and administrative decisions (Roskin **et. al.** 1988:40).

In the case of contemporary public health matters in South Africa an example of deliberations and decisions that ultimately culminated in a policy statement is that of the Health Act, 1977 (Act 63 of 1977) (**Debates**, 1977: Col.3088-3091).

2.2.2 Policy and politics

Modern governments, being involved in the complex business of making public policy, adopt and pursue different kinds of public policies to explain what they define as the public interest. The necessity for public policies have their origin in the public interest expressed in the form of values, needs, desires fears and demands of society or societal groups. Through the political process, these values, needs, desires and demands are transformed into policy decisions (Hanekom 1987:5). Policies as an output of the political process can range from the safegaurding of the integrity and the freedom of a country, to further the contentment and the spiritual and material welfare of all.

Two of the national goals of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983)), are the establishment and promotion of subordinate governmental services. In the latter case the policy of the government of the Republic of South Africa regarding, for example, regional governments, particularly Regional Services Councils, is contained in the Regional Services Councils Act, 1985 (Act 108 of 1985) subsumed under the following headings:

- the broadening of democracy to include all races in the Republic of South Africa;
- the elimination and prevention of domination by any one group over another;
- the elimination of discrimination on the grounds of race, colour or religion;
- the provision of local government services on an efficient and cost effective basis; and
- the development of financial resources to promote development and the provision of services in local government areas where the greatest need exists.

Policy decisions can range not only from government level to government level but range in a variety of forms corresponding to the particular goals a legislature may adopt through the political process. All policies, however, fall into, firstly, those that are material in nature and, secondly, those that are of a symbolic nature (Roskin **et. al.** 1988:41).

2.2.2.1 Material and symbolic policies

Material public policies refer to those policies of government that require the expenditure of scarce resources, **inter alia**, personnel and finances. Once material public policies are accepted the scarce resources have to be allocated through the political process for their attainment. Without the making available of scarce resources, policy outcomes may disappoint the intended beneficiaries and accomplish little towards goal attainment

(Roskin **et. al.**, 1988:41). Examples of material policies in the Republic of South Africa are public health policies and annual financial policies (in the form of budgets). It will be shown subsequently (**infra** chapters 6 and 7) how South African public health policies had been affected by scarce resources.

Symbolic public policies usually do not involve the allocation of personnel, money and other resources through the political process. Symbolic or non-material public policies are those acts of government that create and engender sentimental attachments (e.g. patriotism, loyalty and national pride) or that confer social status on key segments of society. Examples of symbolic policies in the Republic of South Africa are the provisions in Sections 2, 4 and 5 of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983) concerning the national flag and anthem. The English title of the national anthem, **Die Stem van Suid Afrika**, namely **The Call of South Africa** is also given official recognition in the constitution.

Symbolic policies can sometimes be more important than material policies, hence governments are careful to support and foster outward symbols of unity; symbols that are created and popularised to give people something they can identify with. Such symbols can also become a source of controversy. For example, the use , or not, of the national flag by all the inhabitants of the Republic of South Africa under the existing governmental system but in changing political and administrative environments evoked a debate in the South African press concerning the

feasability of the adaptation or not of the national flag to the changing political and administrative environments (Die Burger 1989: Editorial; The Sunday Star 1989:2; Sowetan 1989:14; The Star 1989:1; Beeld 1990:12; Potchefstroom Herald/Herout 1991:13).

The authoritative decisions, through the political process, of modern governments, are therefore contained in public policies which can be be of material as well as symbolic nature as explained immediately above. Public policies provide the framework within which public institutions operate in order to control, regulate and promote societal interests. The primary instrument of policy-making as part of the political process of contemporary Western governments is the legislature.

Public policy is, however, not only a component function of the political process but also of the administrative process (Marx 1959:337).

2.3 Administrative process and public policy

Early writers on public administration sought to make a distinction between politics and the process of administration. In doing so they attempted to keep public administration free from politics. Policy was regarded as synonymous with politics but in order to advance the concept of a neutral, non-policy-making executive branch of government, a distinction between politics and public administration was made (Nigro & Nigro 1984:6).

Certain contemporary writers, however, regard public policy as part of the administrative process. This contemporary view has its origin in the book **Policy and Administration** by P.H. Appleby who was one of the first scholars who indicated the relationship between administration and policy (Appleby 1957:170).

2.3.1 Administrative process

Public administration concerns the process of administration in the public (governmental) sector. The process of administration endeavours to explain why a country's administrative functions work as they do; it seeks to understand administrative systems. In this way the process of administration forms part, indeed the largest part, of the machinery of government as a subsystem in the larger system of politics (Ridley 1975:165). In order to understand the meaning of the administrative process the meaning of the adjective "administrative" need to be analysed. The term "process" described in item 2.2.1 **supra** applies **ipso facto** to this discussion.

2.3.1.1 Different usages of the term administration

The term administration can be used in its functional and organic senses. The functional sense designates a specific type of activity, a certain form of public action, namely the conduct of affairs to be performed for a social purpose by particular means. Social purpose refers to the aim pursued and means refer to the employment by a public institution of a group of

persons (public office bearers) and of material (public property) (Langrod 1968:13).

The organic sense of the term administration designates the personnel who collectively administer and who form for that purpose an institution. The usage of the term administration in its organic sense does not refer to a type of activity (as in the functional sense), but to a human group entrusted with a given task (Langrod 1968:13).

2.3.1.1.1 Functional nature of the term administration

Examples of the use of the term "administration" (or its inflections "administer" or "administrative") in its functional sense in South Africa are:

- by referring to administration as consisting of activities such as bookkeeping, general correspondence and office routine (Botes 1973:15), i.e. work with a low clerical credence or connotation (McKenzie 1983:35);
- by referring to the designations of incumbents as administration, for example, administrative assistant, administrative official and administrative manager (Adlem & Du Pisani 1982:88); and
- by referring to administration as a generic phenomenon consisting of certain generic functions (Adlem & Du Pisani 1982:88).

2.3.1.1.2 Organic nature of the term administration

Examples of the use of the term administration (or its inflections) in its organic sense in the Republic of South Africa are:

- by referring to administration as a public institution such as the Transvaal Provincial Administration and the Commission for Administration (Adlem & Du Pisani 1982:87); and
- by referring to administration as a certain section within any public institution, for example, the administrative section of a department (Adlem & Du Pisani 1982:87).

2.3.1.2 Etymology

Etymologically the term "administration" is derived from the Latin verb **administrare** (Latin: **-atum**, to, **ministrare**, minister) (Twentieth Century Dictionary 1974). According to Dunsire (1981:1,29) the Latin verb **administrare** appears for the first time in the works of Cicero, a Roman statesman and writer, dating back to the era before Christ. **Administrare** means "to serve" (Dunsire 1981:1,2) and "to serve", in turn, has two major significations:

- to perform duties or to do work; and
- to answer a purpose, to be of use (Chambers Twentieth Century Dictionary).

The meaning "to serve" subsequently aquired several diverse connotations. References to authors who outlined this diversity of meanings are:

Dunsire (1981:228-9) identifies fifteen different definitions of the term "administration". Nigro and Nigro (1984:11) identifies five characteristics of "administration". Bain (1986:11-2), referring to what can be termed political dictionaries as well as scholars writing on the subject of Public Administration, recapitulates twelve interpretations of the term.

The above is illustrative of the divergence of interpretation of the term "administration". In what sense the term will be used for the purposes of this thesis will be explained subsequently.

2.3.1.3 Administration as a process

As indicated under item 2.2.1 **supra**, a process can be described as "...the state of being in progress or carried on; a series of actions and events, a sequence of operations or changes undergone" (Twentieth Century Dictionary 1974); a series of actions forming a recognisable pattern ocurring so frequently that the pattern repeats itself (Kotze & Van Wyk 1980:147).

Administration as a process is present in various fields of activity and in a diversity of forms. It has been suggested that an analysis of the diversity of fields of activity and the interpretations thereof can be approached from a number of viewpoints (Gladden 1972:vii).

In the Republic of South Africa a number of viewpoints have been evolved by practitioners and academics, namely the:

- constitutional law view;
- institutional view;
- business economics view;
- implementation view;
- comprehensive view;
- conventional or narrow view;
- mangement view; and the
- generic view (**vide** Bain 1986:12).

In terms of the latter view (i.e. the generic view), administration can be regarded as consisting of certain components that are present and applicable in any group effort. Based on the assumption that the constituent parts of the administrative process are performed in all institutions, they are referred to as generic administrative functions (Hanekom & Thornhill 1986:17). The generic administrative functions can be classified into primary generic functions and secondary generic functions.

Primary generic functions as constituent parts of the administrative process in accordance to the generic view are:

- policy-making;
- financing;

- organising;
- staffing;
- determining and improving work procedures: and
- controlling (checking and rendering account) (Cloete 1981:43).

Secondary generic functions as constituent parts of the administrative process in accordance with the generic view are those functions that can be utilised in the execution of the primary generic functions, for example, planning, data collection, systems analysis and research (Cloete 1975:1-3).

With respect to the primary generic functions of the administrative process identified directly above, it should be noted that the generic nature i.e. the general applicability of the six component functions to any member of a group or class (Twentieth Century Dictionary, 1974) is implied by Cloete's statement that administration takes place in any situation where two or more individuals pursue, through collective action, a common purpose (Cloete 1972:1).

As an aside, it is significant to note that Cloete (1972:1) up to the publication of his book **Public Administration and Management** in 1991 (Cloete 1991:79) makes mention of only the policy-making function of administration and not to the other stages of the policy process, namely, policy implementation, policy analysis and policy evaluation (Hanekom 1987 : Chapters 3-9).

The classification of the administrative functions in terms of the generic view is an analytical model of administration. It identifies a specific relationship between the functions regarded by some contemporary writers on Public Administration as being its study object (focus) (Hanekom 1978:43).

The generic classification of the administrative functions gained appeal among some South African academics and higher educational institutions (i.e. universities and colleges for advanced technical training); with the Commission for Administration - the personnel agency of the central government level - and the Institute of Town Clerks of South Africa (Hanekom 1978:43). The generic administrative functions are also considered to have the most comprehensive application in the Republic of South Africa (Marais 1992:30). In the case of South African universities, for example, a survey (Rowland 1986:81) shows the acceptance of the generic administrative functions for teaching purposes at these institutions. Although this was still considered to be the position at the South African universities during 1990 (Müller 1990:63), it has also been indicated that the generic analytical model may have a number of shortcomings. Moreover, it is considered to be incomplete as far as the total content of public administration is concerned (Hanekom & Thornhill 1983:114). For example, the descriptive nature of the administrative functions - at least in the way in which it is reflected in articles on the subject - studies existing practices and institutions with the result that information becomes obsolete as soon as these practices and institutions

change. Instead, the focus ought to be on the values of people and not in accordance with scientific laws (Marais 1979:6,9). The view has also been expressed that the generic administrative model as the only valid one in the Republic of South Africa, is presently being discarded (Marais 1991:8).

Since public policy is one of the component parts of the administrative process, and since the locus (i.e. the institutional abode) of the administrative process is largely considered as the executive branch of government (Hanekom & Thornhill 1983:46), attention will have to be directed at the relationship between the policy process and administration.

2.3.2 Policy and administration

The policy function as a constituent part of the administrative process is of recent origin, i.e. from the 1950's with the publication of Appleby's book **Politics and Administration**. In references to the term "public policy" differing meanings may be given to or may be understood by the term (Hanekom 1987:7). This is, however, not alien to literature in public administration since the polimorphic nature of terminology in this field can be related to the complexity of the practice and of academic endeavour that make generalisations difficult (Greenwood & Wilson 1984:1). The differing meanings of, **inter alia**, public policy lies in a semantic problem that is not accidental and/or extraneous to the subject matter, but involved in its development (Waldo 1968:1).

Since the meaning of public policy can be coupled to the development of public administration, an interpretation of public policy as a function of the administrative process will therefore rest upon its development in public administration thought. The major thrust of public administrative thought can be related to the pre-1930 contributions of **inter alia**, Thomas Woodrow Wilson, Frank J Goodnow, Leonard Dupee White, Frederick Winslow Taylor, and Henri Fayol. An overview of the main emphases of these writers will be dealt with subsequently.

2.3.2.1 Thomas Woodrow Wilson (1856-1924)

Although steps were taken to establish Public Administration formally in European states, particularly Prussia (1729) and France (1808), it is generally held that Thomas Woodrow Wilson - an academic and lawyer who later became the 28th President of the United States of America (1913-1921) - paved the way in the English speaking world for the study of Public Administration as a discipline with the publication of an essay **The Study of Administration** published in the June 1887 issue of the **Political Science Quarterly**. This essay formed the backdrop to the development of public policy commensurate to the development of Public Administration as a discipline (Purcell 1955:1-2; Bain 1987:72-79).

The major attempts of the essay by Wilson were:

- to take an account of the history of the study of Public Administration;
- to establish the subject matter of Public Administration; and

- to determine the best methods by which to develop the discipline (Wilson 1887:1).

Wilson's fundamental proposition was that "It is getting harder to run a constitution than to frame one" (Wilson 1887:5). To run a constitution meant the administration (implementation) of a constitution, which, in turn, referred to the application of policies embodied in laws. According to Wilson the application of policies (the practice of public administration) and the study of the practice were lacking attention (Wilson 1887:3).

Wilson deplored the generally held belief that the who and the what of a law should be accorded the highest priority. Instead, the focus had to be on how a policy should be applied, and not that it should be "...put aside as practical detail which clerks could arrange after doctors had agreed on principles" (Wilson 1887:4).

Regarding the locus (institutional abode) of the policy function, some scholars maintained that Wilson was the inventor of the politics (policy) public administration (application) dichotomy. Other scholars opposed this view and maintained that he was aware of the fact that public administration was intrinsically part of the political, and consequenly, the policy process and that he made this clear in his essay (Henry 1975:5).

It had been shown that in the South African context the neat division between politics (policy) and public administration (application) attributed to Wilson does not hold in an analysis of the focus of public administration

but that, as far as the locus (institutional abode) is concerned that it still prevails (Bain 1987:79).

As a result of the emphasis on execution of public policy and the factual and assumed scientific nature of public administration, the subject Public Administration, and also the public policy function, was deprived of moving towards a value-integrated science; the move was rather to a value-free or a so-called exact science. The most notable contributions to the exact science literature were Frederick Winslow Taylor's **Shop Management** (1906) and **Principles of Scientific Management** and Henri Fayol's **Administration Industrielle et General** (General and Industrial Administration) (1916). Since these authors' contributions had an effect on public administration thinking, an overview of their major contributions is deemed appropriate.

2.3.2.2 Frederick Winslow Taylor (1856-1915)

Taylor (the originator of the modern-day organisation and method technique) concentrated on the field of industrial and business administration at a time when it was common to perceive of public administration, because it was underdeveloped, as a field of business administration (Garson & Overman 1983:47).

Taylor developed certain managerial principles from his engineering work at the Midvale and Bethlehem steel companies at the turn of the twentieth century. Being an entrepreneur attached to the private sector, Taylor was

interested in private sector employees and did not concern himself with the employees of the public sector, namely public officials. The four principles of management developed by him which at the time constituted a revolutionary approach to management, were:

- to develop a science for each element of work instead of a rule-of-thumb method;
- the scientific selection, training, teaching and development of workers;
- the cooperation of management and labour to accomplish work objectives by means of the scientific method; and
- a redivision of work and responsibility between managers (who were responsible for planning and supervision) and workers (who were responsible for execution) (Taylor 1934:36-7, 140; Robbins 1980:36).

The fourth principle concerns this thesis, particularly the work of managers as planning. Planning has been defined as: "...determining in advance **what** is to be done, **how** it is to be done, **when** it is to be done, and **who** is to do it" (Robbins 1980:128). Policy has been defined in a similar manner, namely **what** is envisaged, **how** action shall take place, **who** shall act, **when** action shall take place, and **what** shall be dealt **with** (Hanekon & Thornhill 1986:18).

Thus, the contribution by Taylor can be seen to be the allocation of the planning (policy) function beween the managerial and operational levels in the private sector. Based on the statement that public administrationists were "...courted by industry and government alike

during the 1930's and early 1940's for their managerial knowledge" (Henry 1986:82) and that, by definition, the principles of scientific management could be applied successfully anywhere, it can be inferred that the planning (policy) function was considered as a generic function that was also present within the ambit of the work of leading public officials.

2.3.2.3 Henri Fayol (1841-1925)

In France, Fayol sought to identify the principles of organisation and the functions of the manager, not only in the field of business management, but also related to the field of public administration (Fayol 1949:viii)

Fayol's contribution to administration as a generic phenomenon lies in his recommendation of his principles to public administration in a report entitled **La Reforme Administrative des Postes et Télégraphes** (1916, translated into English in 1949) on the French postal and telegraph services. He also addressed in 1924 the International Federation of Universities at the Assembly of the League of Nations in Geneva on the doctrine of the administration as a contribution to peace (Fayol 1949:viii).

The gist of his thesis propounded in his book **General and Industrial Administration** was that all operations that occur in business undertakings (also referred to as "government"), can be divided into six groups or "operations". One of these groups was known as the managerial group. The component parts of the managerial group consisted of the functions of planning, organising, commanding, coordinating and control. According to Fayol to plan is to study the future and to arrange the plans

of operations (Fayol 1949:3,43) i.e. actions similar to what is considered by contemporary writers as being the contents of the policy function.

Fayol also viewed administration as a separate body of knowledge that was generic in its applicability. As he put it: "Be the undertaking simple or complex, big or small, these ... essential functions are always present" (Fayol 1949:3). This is similar to the inferrence drawn from Taylor (**supra** 2.3.2.4), namely that administration had applicability to all forms of group activity. Fayol's description of the five functions of administration is regarded by Robbins (1980:38) as of importance to contemporary public administration in that the description of the functions of an administrator who plans, organises, leads, and controls is essentially unchanged.

The planning (policy) function as proposed by Fayol could be brought to bear by mangement in any group activity. Thus, political office bearers and public officials on the upper rungs of public institutions are also engaged in the planning (policy) function in the public sector (Ridley 1975:188).

2.3.2.4 Frank J Goodnow (1859-1939) and Leonard D White (1891-1958)

In his book **Politics and Administration** (1900) Goodnow contended that there were two distinct functions of government, namely politics and public administration. Politics concerned policies or expressions of the state will whereas public administration concerned the execution of these policies (Goodnow 1900:10-11). This distinction, according to Goodnow,

was based on the doctrine of the separation of powers. The legislative branch of government, assisted by the interpretive functions of the judicial branch, expressed the will of the state and thus formed public policy. The executive branch of government was expected to implement these policies in an impartial and apolitical way (Henry 1986:21).

Leonard D White's **Introduction to the Study of Public Administration** (1926), the first textbook devoted in its entirety to the field of public administration, had four major assumptions:

- "it assumes that administration is a single process, substantially uniform in its essential characteristics wherever observed;
- it assumes that the study of administration should start from the base of management rather than the foundation of law;
- it assumes that administration is still primarily an art but attaches importance to the significant tendency to transform it into a science; and
- it assumes that administration has become, and will continue to be the heart of the problem of modern government" (White 1929:2).

Thus the components of administration (such as: personal initiative, competence and integrity, responsibility, coordination, fiscal supervision, leadership and morale) represent themselves as generic components: "It seems important to insist that the administrative process is a unit, and to conceive it not as municipal administration, or state administration, or

federal administration, but as a process common to all levels of government" (White 1929:2).

According to White, the study of the will of the state and of policy were concerned with value aspects that fall solely within the ambit of the political process (Henry 1986:22).

The contributions by Wilson, Goodnow and White formed the basis for the explanation of public administration and the place of the policy function in governmental services. These writers made a distinction between policy and public administration because they were anxious to keep policy - which was regarded as part of the political process only - out of public administration. It was argued that the creation of a political-neutral, i.e. non-policy-making executive branch of government would sustain such a distinction. This distinction also emphasised the locus of public administration and, consequently, the locus of the public policy function (Nigro & Nigro 1984:6).

2.3.2.5 Other authors

The above scholars' contributions led to a spate of publications on the topic of the constituent functions of the management and administrative processes. The most prominent of these in the field of management were Henry L Gantt (1861-1919), Max Weber (1864-1920), Frank Gilbreth (1868-1924), Mary Parker Follett (1868-1933), G Elton Mayo (1880-1949), Chester I Barnard (1886-1961), and Kurt Lewin (1890-1947). Some were

influenced by Taylor and Fayol, others made independent contributions (Koontz, O'Donnel & Weirich 1980:42; Robbins 1980:37; Massie 1970:17).

Notable among the textbooks dealing with the public sector is L D White's **Public Administration** (1926) and F W Willoughby's **Principles of Public Administration** (1927). Both authors proceeded from the policy-making/administration dichotomy viewpoint. Policy-making was, therefore, not considered as falling within the ambit of the work of the administrators (Ridley 1975:183;185).

Luther H Gulick and Lyndall Urwick's **Papers on the Science of Administration** (1937) further contributed to the development of the policy function. The first function in their POSDCORB-anagram was planning. The planning function is explained as something similar to the policy function , namely "...to foretell the future and the methods for doing things that need to be done" (Gulick 1937:13).

In his article **The Proverbs of Administration** (1946) and in his book **Administrative Behavior: A Study of Decision-Making Processes in Administrative Organization** (1947), Simon proposed that in the decision-making processes that leads up to policy formulation, factual aspects, not ethical aspects, contend for pre-eminence in public institutions. Thus the factual aspects make up the real substance of administrative science (Simon 1976:249). In brief, the critique by Simon resulted in the reestablishment of public administration as a factual-laden

decision-making activity within the policy-making ambit of the political process.

In 1950, John Gaus stated that "A theory of public administration means in our time a theory of politics also" (Gaus 1950:168). A notable feature of the time after 1950 was the increasing importance of public administration as part of the value-laden policy arena in the political process (Garson & Overman 1983:48,54; Koontz **et al** 1980:50-1). Moreover, the emphasis was on public administration as policy formulation, not just policy implementation (Garson & Overman 1983:50-1).

Regarding the involvement of public officials in the policy process, it has been asserted that when public officials are called upon to take some course of action on a particular matter, they are always faced with a number of alternatives they might pursue. Since public officials cannot pursue all the alternatives simultaneously, they have to select from among the alternatives available the few that they intend to put into effect. This selection from among alternatives become government policies (Ranney 1990:337).

If the term politics refers, **inter alia**, to public policy-making, then public policy-making cannot be removed from present-day public administration since public officials use their discretion to interpret the laws they implement and decide on when, how and how much to enforce them. Even if it is desirable to prevent the exercise of discretion by public

officials, there exists no way to prevent them from being involved in discretion and, thus, in the policy process (Ranney 1990:337).

2.4 Administrative process and the public policy phenomenon

Having affirmed that the public policy phenomenon is not only part of the political process but also the administrative process, a description of the public policy phenomenon is deemed necessary in order to indicate its cause-and-effect relationship with the public policy implementation process.

When public policies are not realised, the assertion is usually that the activities that were supposed to be implemented were not implemented or were subject to excessive delays. The focus is thus on the public policy implementation process itself and such a focus seeks to understand the non-realisation of public policies by referring to the inadequacies of the implementation activities. However, another assertion, which is usually overlooked, is that the output of the political process, namely public policy, may be at fault. Thus, an analysis of the public policy implementation process not only requires an analysis of public policy implementation but, in the first place, the cause that gave rise to non-realisation, i.e. the public policy itself which sets the framework within which implementation will have to be undertaken. A study of the public policy phenomenon will therefore contribute to uncover the causes within the public policy process that are likely or unlikely to be met during the effect stage, namely the public policy implementation process (Pressman

& Wildavsky 1973:xvii). For these reasons chapter three will be devoted to a description of the public policy phenomenon.

2.5 *Conclusion*

Evidence suggests that since ancient Greek times up to the present, expressions of public policy and questions that are related to public policy form the basis of the political system.

Expressions of public policy include any declaration of intent, thus also declarations of intent concerning public health matters, behind which stands the enforcing power of the political system, i.e. the executive branch of the government. Public policy-making as a declaration of intent is therefore not only at the centre of the political process; it is also a constituent function of the administrative process whose institutional abode is the executive branch of government. The development of administrative thought concerning public policy confirms such a statement.

Public officials, as members of the executive branch of government, have to select from among alternatives to enable them to implement public policies. Being involved in the selection from alternatives, they become involved in the policy-making process. Public officials are also vested with discretionary authority and by exercising discretion they are similarly involved in the policy-making process.

Public policy implementation research cannot be undertaken in isolation. The public policy phenomenon is the cause in the cause-and-effect chain, i.e. it sets the parameters within which the public policy implementation process has to be undertaken.

CHAPTER 3

PUBLIC POLICY

3.1 Introduction

Basic to any discipline stands the development of a body of knowledge that can be applied in practice. Such knowledge is expressed in terms of concepts and theories. The concept "public policy" is used in different ways to refer to diverse sets of activities or decisions. In order to obtain clarity on the nature and contents of the theoretical constructs referred to as public policy implementation, and ultimately, public health policy implementation, an investigation into the nature and scope of the theoretical construct public policy is necessary. The diffuse field of policy studies also behoves an analysis of the constituent parts of the policy process expressed in terms of various models, levels and environments of public policy.

3.2 Public policy: concepts and theoretical constructs

All serious attempts to identify the ultimate elements of meaningful human conduct is oriented primarily in terms of concepts (Weber, tr. & ed. by Shils & Finch 1949:52).

Concepts are vehicles of thought that involve images. Concepts evolve from abstract notions, ideas and impressions received by the individual through his ability to reason and by sensing the environment. According

to Aristotle a human being is distinct from an animal in that he can gain insight into phenomena and can converse such insight to others through the formulation of principles whereas animals can only utter sound. The human being discovers through his insight that there are fixed relationships among things in nature, and among things in nature and his community, in other words, he discovers social systematicalness with the principles attached thereto (Murray 1981:11).

Since concepts create abstract images, and since concepts are influenced by previous learning experiences and fixed notions, concepts tend to have different meanings to different people and can lead to different interpretations (Torres 1985:2). The concept "public policy" is no exception to this rule. It is an amorphous and developing field that spans Political Science, Economics, Sociology, Psychology, Business Administration, Social Psychology, Anthropology and Public Administration (Henry 1975:230).

The public policy process, which is a complex of institutional decision-making processes, emanates from a policy-making process that determine the nature and scope of the concept public policy (Dror 1968:17).

The policy-making process has the following characteristics:

- it is complex and variegated;

- it is nondeterministic, i.e. a prediction of what most of the changes in the system will be, cannot be achieved with certainty;
- as a subsystem, it is interconnected with other subsystems, such as the economic-planning subsystem;
- it is of a normative nature (Dror 1968:20-2);
- a policy system is made up of actors, the sources of their authority, their interests, and their knowledge and objectives;
- the rules and practices governing the formal and informal relationships among actors; and
- the output of the process, i.e. the policy statement (Lynn 1980:10).

The complexity of the public policy process is compounded by certain limitations that influence the way in which the policy-making process comes into being, namely:

- it is not always possible to define policy needs in asolute terms;
- expectations of society by and large exceed the capabilities and the resources of the authorities;
- providing in the needs of a certain group may increase the needs of another group;
- a variety of community needs cannot be addressed by a policy focussing on one type of need only;
- it is often impossible to counteract certain movements in society, for example, increasing urbanisation;

- members of the public who do not support a particular policy tend to adapt their behaviour in such a manner that the aims of a that policy becomes ineffective;
- a negative effectiveness can be created by a policy in that the "cure" could prove to have an escalating effect on the problem; and
- complete rationality of public policy is non-existent (Dye 1978:30-32; Hanekom 1986:26-7).

The characteristics and limitations of public health policy and their effect on public health policy implementation in South-Africa are considered in chapters 6 and 7, by referring to **inter alia** party political manifestos, annual reports and commissions of inquiries.

From the above exposition of the characteristics and limitations of public policy can be inferred that complexity stands central to an analysis of the public policy process.

A number of reasons can be advanced for such complexity.

Firstly, the policy process takes place over time which leads to difficulty in explaining the process as a single unit. One such difficulty is that as the process proceeds over time a large number of tentative decisions are made and each of these tentative decisions might rightly be called public policy. These tentative decisions also tend to give finite direction to the process. Although these tentative decisions might be predictable by means of public policy theory, they can be constructed in such a way that

they merely act as "rubber-stamping" activities (Greenberg **et. al.** 1977:1533). Another difficulty is that the values of the predictors are likely to change as the policy process unfolds itself, with the result that prediction is nothing more than **post hoc** explanations (Greenberg **et.al.** 1977:1533).

Secondly, any given policy proposal is in itself complex, giving rise to difficulties to place it in any one of the sequential steps of the policy process, i.e. either the policy-making step, the policy implementation step, the policy evaluation step, or the policy analysis step (Greenberg **et. al.** 1977:1533).

Thirdly, public policy as a focus of analysis is complicated by the demands of many participants (Greenberg **et. al.** 1977:1533), for example, political parties, joint councils and interest groups of various orders and interests. On a macro scale, Pretorius (1982:2-30) lists 28 interest groups and 17 joint councils that are, together with public institutions, key role players in the formulation of the economic policy for the Republic of South Africa. Participants' interests in public policy might vary from subjectivity to objectivity (Greenberg **et. al.** 1977:1533).

Lastly, public policy is complex because the process cannot be described by simple additive models only, for example, the incremental model (Greenberg **et. al.** 1977:1533), but also by means of the elite, the group, the systems, the institutionalist, and the rationalist models (**infra** 3.2.3).

The complex nature of public health policies, the changing values of those who make (or intend to make, once having assumed authority through the electoral process) public health policy, the difficulties encountered with the implementation of public health policies, and the participants that are involved in the making and implementation of public health policies are analysed in chapters 5, 6 and 7.

3.2.1 Renewed interest in public policy studies

Notwithstanding the complexities associated with the policy process referred to above, the public policy process gained renewed interests in public policy studies since the 1970's (Nagel 1987:219).

Although policy studies reflect a long-term philosophical concern for public policy problems in the social sciences (Nagel 1987:219-20), the emergence of renewed interest was prompted by the problems faced by contemporary Western governments.

The growth in the number, variety, complexity and importance of policy issues confronting contemporary Western governments since the 1970's had made increased demands on political office bearers and public officials. Public policy issues such as nuclear safety, teenage pregnancies, urban decline, rising hospital costs, unemployment, violence towards spouses and children, and the disposal of toxic waste make demands on governments that they can ill-afford to ignore (Lynn 1980:1). Policy studies came to the fore as a result of these intense policy issues

in Western governments and the limited response to them by pre-1970 social sciences, particularly Political Science (Mead 1985:319).

For most political office bearers and public officials the complicated and controversial issues of public policy are on the periphery of the scope of their judgement and previous experience. Yet, political office bearers and public officials are expected to deal with them responsibly and effectively (Lynn 1980:1). This dilemma contributed to the development of public policy studies (Nagel 1987:219).

3.2.1.1 Public policy studies as a developing discipline

Public policy studies can be defined as studies into the nature, cause and effect of governmental decisions for dealing with societal issues (Nagel 1987:219). Since about 1970 the policy studies field has developed into a well-organised discipline hailed as being:

- both a new perspective on political and social phenomena, while at the same time retaining methodological principles that have been developed over time.
- both practical to societal issues (i.e. concerning the execution of policy by the civil service), while at the same time concerned with issues in political theory, social philosophy, and the philosophy of science;

- both an interdisciplinary perspective, while at the same time emphasising the importance of Political Science and Public Administration in policy formulation, implementation and evaluation;
- both a scientific field with a methodology akin to natural sciences (e.g. statistical analysis), while at the same time concerned with normative questions such as good society and ultimate values;
- both the concern of the institutions at the various levels of government, while at the same time being subjected to scrutiny by non-governmental institutions and the public; and
- both an instrument to be used by liberals as a form of socialist economic planning for relatively deprived groups in a society, while at the same time used by conservatives as an instrument of capitalism to bringing "good business sense" to government which favour relatively well-off groups in a society (Nagel 1987:231).

The term public policy can therefore be used in different ways to refer to diverse purposes, sets of activities or decisions. Different uses imply differences in the interpretation of the nature and contents of the term public policy. In an attempt to clarify the different uses and interpretations of public policy, one is, however, not assisted by turning from how the term is used in common parlance to how it is defined by social scientists (Jones 1977:4).

In order to devise a working approximation of the concept to serve as a basis from which public health policy implementation can be analysed, a number of theoretical constructs will be referred to. The aim of the

subsequent analysis is not to set down immutable formulations but is an attempt to introduce order and clarity in an area of investigation that represents a variety of interpretations.

3.2.2 Public policy: constructs and perceptions

Public policy does not seem to be a self-defining phenomenon because there is no unequivocal datum constituting policy that merely waits to be discovered in the world. Instead, a policy may usefully be considered as a course of action rather than specific decisions or actions (Heclo 1972:84-5).

Eullau and Prewitt (1973:465) describe policy as a theoretical construct inferred from the patterns of relevant choice behaviour; a theoretical construct that can be distinguished from policy goals, policy intentions, and policy choices.

The above descriptions by Heclo, and Eullau and Prewitt, direct attention towards an interpretation of public policy as courses of action or inaction and patterns of relevant choice behaviour. The following definitions of the term public policy can be regarded as examples of such interpretation:

- "...a kind of guide that delimits action" (Starling 1979:4);
- "...a mechanism employed to realise societal goals and to allocate resources" (Baker **et. al.**,1975:12-15);
- "...a declaration and implementation of intent" (Ranney 1968:7);

- the authoritative allocation through the political process of values to groups or individuals in society (Easton 1953:129);
- "...a framework and instrument for action" (Hanekom 1978:7);
- "...a comprehensive framework of and for interaction" (Dye 1978:4-5);
- "...whatever governments choose to do or not to do" (Dye 1978:5);
- "...a projected program of goals, values and practices" (Lasswell 1970:71); and
- "general rules to subsume future behavioural instances" (Greenberg **et al** 1977:1541).

The above definitions have two major significations in common, firstly, the open-endedness of public policies, and secondly, closely defined descriptions of public policy as an instrument to accomplish a specific purpose. The former relates to phrases such as "a kind of guide", "a framework", "a declaration of intent", "whatever governments choose to do", and "general rules". The latter refers to "a mechanism employed to realise", "instrument for action", "and projected program of goals, values and practices". Both these significations, however, are seen as authoritative choices of means to accomplish specific purposes. These means can be expressed in various models of public policy a well as in classes of means or classes of instruments. Regarding the former, the following models can be distinguished:

3.2.3 *Models of public policy*

The models of public policy can be approached from two main points of view, namely, from an input process point of view (prescriptive) and from an output or effect point of view (descriptive) (Henry 1975:230-240; Hanekom 1987:77,82).

3.2.3.1 *Models of public policy as an input process (prescriptive)*

Under this heading the following models can be classified:

- Elite model of public policy.

The elite model presupposes the existence of an elite group that shares common values; the members of which make policies that reflect elite values in governing a largely passive, ill-informed public that holds no power. The assumption underlying the elite model is that the elite reaches concensus of opinion on policy matters and that the elite system continues to operate as long as the elite maintains concensus. This assumption implies that the elite's values and interests have control over the values and interests of the masses in that the elite, who have larger incomes, better education, and more status, control the values and interest of the masses. The policies of the elite, therefore, uphold the value preferences of the elite group to the benefit of the elite group and to what is being considered as in the interest of the masses (Henry 1975:231; Hanekom 1987:78,79).

In the case of the Republic of South Africa the elite model can be seen to have manifested in the public policy, and therefore also in the public health policy scene since the coming into power of the government-of-the-day (**Debates** 1948: Col 225-28; 1951: Col 308; 1959: Col 6520; 1963: Col 239) up to the 1970's. The elite model was formalised at unification in that in terms of the South Africa Act, 1909 (adopted by the British Parliament), only European members of the community were eligible for membership of the Parliament of the Union of South Africa (section 34). The new state thus had legitimacy problems from the outset as the right to vote was limited to the European elite.

Moreover, the European elite was dominated by Afrikaner nationalism even prior to unification. An Afrikaner national consciousness which was based on a common historical experience, a common language, and a common religion, was an established fact by 1880. However, it took the second Anglo-Boer War (1899-1902) in which the Afrikaners fought a common enemy (the English), to unite the Afrikaner people, and another three decades before an ideology of Afrikaner nationalism was established with the establishment of the (Purified) National Party in 1934 (Worrall 1976:160).

Political elites in developing states usually accord preference to nation building programmes. This predominance of nation building then leads to the tendency of the centralisation of political power by the political elites in developing states (Joubert 1992:8).

It was in this sense, namely, as the political elite in South African White politics that the (Purified) National Party, and later, the National Party, sought to further the elite interests of the (mainly) Afrikaans speaking Whites. Along with institutions such as Nasionale Pers, the Afrikaner Broederbond, the Suid-Afrikaanse Nasionale Lewens Assuransie Maatskappy (Sanlam), the Voortrekkers, the Koöperatiewe Wynbouers Vereniging (KWV) and Volkskas, the National Party, which became the government-of-the-day in 1948 and remained the government-of-the-day ever since, became a growing Afrikaner elite group (Kotzé & Greyling 1991:144). It was natural that this elitism would also be reflected in how the government-of-the-day sought to deal with public health matters (**infra**, chapter 6).

The elite model was epitomised during Verwoerd's time as Prime Minister (1958-1966), during which time the White electorate held the National Party in sway who implemented its racial based public policies on all the inhabitants of the country (Schlemmer 1988:8-9; Schrire 1990:79). From 1978, however, a number of public policy reforms have been introduced which, taken together, indicated a departure from the elite model (Schlemmer 1988:8-9). These reforms that moved away from the elite model of public policy were, **inter alia**, the government's regional development policy that indicated economic and socio-demographic interdependence between traditionally White and Black areas (Department of Development Planning: Regional Development, 1988:**passim**), the Regional Services Councils that provided for multiracial metropolitan

authorities (Regional Services Councils Act, 1985 (Act 109 of 1985)), the the establishment of fully fledged Black local authorities (Black Local Authorities Act, 1982 (Act 102 of 1982) which (despite financial and legitimacy problems) reflected the government's departure from regarding Blacks as temporary citizens without any rights outside their homelands, and the abolishment, in 1986, of the influx control applicable to Black inhabitants which introduced, in principle, a common citizenship (Schlemmer 1988:9-12).

In 1990 the Group Areas Act, 1966 (Act 36 of 1966) and the Mixed Marriages Act, 1949 (Act 55 of 1949), the so-called "pillars of apartheid" which legally enshrined the White hegemony, were rescinded.

Also, the responsibility of the central government is increasingly limited to macro policy-making and coordination and the devolvement of public services to regional and local levels (Nieuwoudt 1988:41-4; Wessels 1991:11). This macro policy-making and coordination role of the central government can also be seen to have materialised since the inception of the Convention for a Democratic South Africa (CODESA) in 1991.

- Group model of public policy

The group model involves a variety of interest groups that exert pressure on the legislature to adopt policies favoured by individual groups. In the group model the polity is conceived as being a system of forces and

pressures acting and reacting to one another in the making of public policy (Henry 1975:231-32).

The group model of public policy played a minor role in the political life of the country from 1910 up to the 1980's because the exclusion of the majority of the inhabitants of the country from the political decision-making process had been a major characteristic of South Africa's political history (De Villiers 1949:511-33; Brookes 1949:27-40; Kotzé & Greyling 1991:24). The unfolding situation in South Africa from the 1980's is that of an increasing involvement by interest groups in public policy formation and the fact that interest groups will inevitably continue to play a central role within the policy-making environment. These interest groups include professional groups, private sector groups, agricultural boards, and joint councils (Pretorius 1982:2-27; Webster 1988:170; Seekings 1988:202).

The public health policy environment is no exception to the increasing involvement of interest groups as from the 1980's. For example, the role of the private sector institutions in the rendering of the health services of the Republic of South Africa, (such as the Federation of Private Hospitals) had been acknowledged by the Director-General for Health and Welfare (De Beer 1982: **passim**).

- Systems model of public policy

The systems model holds that in any given government area certain demands and supports exist among the inhabitants of a state. The demands and supports are the inputs into the policy-making system. These inputs are subsequently converted into outputs (i.e. policies) after which they are returned to the environment through the feedback stage (Henry 1975:232).

The systems model has been suggested as a model in terms of which, **inter alia**, the public policy process in the Republic of South Africa can be analysed. In an analysis of policy in terms of the systems model, aspects such as pluralism and public policy, public opinion and public policy, public opinion and the representative nature of policy-making authorities, and political variables and public policy can be considered (Kriek 1975:12).

The systems model has also been described as a methodological aid that can alleviate the shortcomings of traditional methodological tools for Public Administration (such as Cloete's six-function model) in the Republic of South Africa. In this sense the value of the systems model can be evaluated in terms of its practical applicability as well as the insights derived from such applications. A conceptual framework of the systems model could include the following conceptualisations:

- conceptualisation of complexity;
- conceptualisation of the whole;
- conceptualisation of interaction and interrelationships, and

- conceptualisation of the environment (Müller 1990:66-79).

To the extent that the administration of governmental institutions can be considered as a sub-system operating within a larger system, (Müller 1990:62), it can be argued that the public policy process can be interpreted in terms of the systems model.

Public health policy is increasingly adopting a pluralistic nature and a representative character in terms of the systems model since the establishment of, **inter alia**, the Regional Health Organisation of South Africa (RHOSA) in 1979. RHOSA serves as an agency through which the Department of National Health and Population Development of the Republic of South Africa jointly plan and take action attending to public health matters with the health ministries of the four independent states (Transkei, Bophuthatswana, Venda and Ciskei) and the six self-governing national states (Lebowa, Gazankulu, Qwaqwa, KwaZulu, KwaNdebele, and Kangwane). RHOSA has since 1979 established standing and expert committees to consider fields of mutual interest concerning public health matters (De Beer 1982:4).

- Institutionalist model of public policy

The institutionalist model focusses on a structural-functional description of the policy-making institutions of government, usually at the legislative and executive levels of government. The institutional model is depicted in the form of an organisational chart and describes the arrangements of

government levels, of departments within such levels, and of the official duties of office bearers attached to posts within such departments (Henry 1975:233; Hanekom 1987:82).

The Training Board for Local Government Bodies which was established in terms of section 2(1) of the Local Government Training Act, 1985 (Act 41 of 1985) is an example of the institutional model of public policy-making, particularly, training policy for the local government sector. In terms of a brochure (no number, no date) on the Training Board, an exposition is **inter alia** given of the structures and official duties of the Training Board, the National Co-ordinating Training Committee, and Regional and Sub-Regional Training Committees; the courses approved by the Training Board; the training methods; the funding of training in terms the Act; and key personnel such as Regional Training Co-ordinators.

In chapters 6 and 7 it will be shown that as far as public health policy and implementation are concerned, a particular kind of institutionalist model (the so-called reversed institutionalist model) existed for the first ten years after unification in 1910, and that the institutionalist model proper had been continued after 1920. It will also be shown that the institutionalist model proper had been closely linked to the elite model of policy-making and implementation.

3.2.3.2 Models of public policy as an output

The models of public policy as an output are the incrementalist and the rationalist models.

- Incrementalist model of public policy

The incrementalist model reflects that policies are only adapted incrementally among those who share common values i.e. only a limited selection of alternatives are provided to policy-makers, and that each of these alternatives represent only marginal change in the **status quo**. This model therefore posits a conservative way in which policies are made in that "new" policies are seen as being variations of the past (Henry 1975:235-36; 1986:254).

Annual budget proposals serve as the best known examples of incremental policy-making (Maynard-Moody 1989:140). However, the incremental model of public policy-making can be seen to be as entrenched in policy areas other than that of financing as a result of it being influenced by the political policy of the government-of-the-day. The adaptation of and variation in the political policy of the government-of-the-day since the coming into power of the ruling party in the Union of South Africa in 1948, can be regarded as a manifestation of the incrementalist model of policy-making within the elite model. For example, the reasons given by government itself for the present inefficiency of Black local authorities can be seen as a result of the

manner in which the policy of the government-of-the-day on the temporary nature of Black local authorities had been incrementally adapted (**Memorandum** 1991:1).

Central to the existence of Black local authorities stand the distinction between White and Black land ownership and occupation of land which became legally enshrined in the Black Land Act, 1913 (Act 27 of 1913). This policy of separate land tenure was incrementally perpetuated in the Development Trust and Land Act, 1936 (Act 78 of 1936). When more and more Blacks entered the economic sector and became urbanised, the Blacks (Urban Areas) Act, 1945 (Act 43 of 1945) incrementally ratified the most comprehensive division between land for Whites and Blacks. This policy of separate land ownership and occupation was at the same time incrementally consolidated in the Blacks (Urban Areas) Consolidation Act, 1945 (Act 25 of 1945) (**White Paper On Land Reform**, 1991:**passim**).

Within this incrementally adapted policy framework Black local authorities had to be managed. Prior to 1972 Black local authorities were managed by Bantu Advisory Committees who had no decision-making authority and could not be regarded as autonomous local authority councils. Since 1972/1973 Community Councils were established under the Development Boards system. The Community Councils were the perpetuation of the Advisory Committees under a new name because the Councils still had no autonomous authority over their own local areas. This incrementally adapted policy on Black local authorities continued up to 1986, when, with the termination of the Development Boards on 1 July 1986, all Community

Councils became autonomous local governments. Although the termination of the Development Boards led to autonomous Black local authorities, the effect of the policy in terms of which Black local authorities were regarded as of temporary nature had a spill-over effect in the sense that the newly created autonomous Black local authorities were not economically viable authorities (**Memorandum** 1991:1,2).

The incrementalist way of policy-making can also be seen to exist in the manner in which the incremental breakdown of racial legislation brought about an incremental introduction of the so-called "greying process" in South African cities (Urban Foundation: Report no. 6, no date:9).

This reversed incrementalism was brought about as a result of shared values and attitudes towards the **status quo**, of the step-by-step process of transition, and of the proposed nature of a future society for the Republic of South Africa. In this regard political parties and interest groups (such as those from the business community) can be regarded as being incrementalists (Bernstein & Godsell 1988:164-68) and the inference can be made that the proposals of such parties and groups to government can give rise to public policies being adapted incrementally by the governmental policy-making institutions.

It will be shown in chapter 7 that the incrementalist model also figured prominently in public health policy-making and, thus, public health policy implementation, particularly concerning, in certain cases, the piecemeal

adaption of health policies in terms of the recommendations of commissions/committees of inquiry since 1924.

- Rational-comprehensive model of policy-making

The rational-comprehensive model differs from the incrementalist model in that rationalists attempt to become familiar with all the value preferences in a society, to assign to each value a relative weight, to discover all the policy alternatives available, to know all the consequences of all the alternatives, to calculate how the selection of one alternative will affect the remaining alternatives in terms of opportunity costs, and lastly, to select the most efficient policy alternative in terms of the costs and benefits that can be derived from the social values embodied in the chosen policy (Henry 1986:254-55).

The rational model of public policy-making usually includes the following phases:

- the existence of a problem that can be separated from other problems or at least considered meaningfully in comparison to them;
- the goals, values and objectives that guide the policy-maker are clarified and prioritised;
- the various alternatives for dealing with the problem are examined;
- the consequences (in terms of costs and benefits, and advatages and disadvantages) that would follow from the selection of each alternative are investigated;

- each alternative and its attendant consequences can be compared with the other alternatives; and
- that alternatives, and their consequences, that maximises the attainment of goals, values and objectives, are selected (Anderson 1984:8).

The rational model of policy-making has had substantial criticism directed at it (Anderson 1984:8-9). If merely the second phase of the rational-comprehensive model (i.e. that goals and objectives of the policy-maker is clarified and prioritised) is analysed, then policy-making by the government of the Republic of South Africa does not resemble this model. It has, for example, been asserted by the Urban Foundation, based on its evaluation of the government's current housing policy (contained in **Circular Minute** No 1 of 1983, and the **White Paper on Urbanization**, 1986), that:

- no goals or objectives upon which to base a consistent and comprehensive housing strategy have been formulated;
- whilst government argues for a public-private sector partnership, there is no clear role definition; and
- the mobilisation of private initiative is constrained by:
    - the lack of the definition of the respective roles of the public and private sectors; and

- state involvement in direct housing provision in ways which undermine private sector participation (Urban Foundation: Report, no date:ii).

Public health policy in South-Africa also does not subscribe to the rational model of policy-making (**infra**, chapter 7)

3.2.4 Classes of instruments of public policy

Apart from the various models of public policy, a further understanding of the public policy process can be gleaned by referring to the classes of instruments of public policy.

Four major classes of instruments of public policy can be identified as means through which public policy can be made known, implemented, and evaluated (Elmore 1987:175), namely, mandates, inducements, capacity-building and system-changing. In the Republic of South Africa these instruments can be seen to exist in the following examples:

- mandates, i.e. rules governing the behaviour of individuals and institutions that are intended to elicit compliance, for example, the prescriptions of the Public Service Act, 1984, Act 111 of 1984), the Public Service Regulations, and the Public Service Staff Code. These mandates are, on the positive side, the sources of all the rights, privileges and legal expectations that guide the behaviour of civil servants. Mandates may, however, also contain negative overtones that lend themselves to the exploitation of civil service personnel, for

example, the reduction of the service benefits of officials (such as the service bonus), and the transfer of female employees to other posts when their existing posts are abolished. Should such a transfer be refused but the employee does not want to resign, she is regarded as having deserted and can be dishonourably dismissed with only a resignation benefit (Olivier 1991:22);

Written agreements between the departments of health of the independent and national states and the Department of Health and Welfare of the Republic of South Africa in terms of the assistence to be rendered by the latter to such states, can also be regarded as mandates.

- inducements, i.e. conditional transfers of, for example money, to individuals and institutions in return for the performance of certain actions, for example, the paying of subsidies by the central government to the local authority level in terms of the Health Act, (1972), Act 63 of 1972, for the rendering of preventative and curative health services. In terms of Section (26) (i)-(vi) of the Act, funding from the State Revenue Fund is payable to local governments after compliance with preventative and curative functions;
- capacity-building, i.e. the conditional transfer of money to individuals and institutions for the purposes of investment in future material, intellectual, or human resources, for example, the government's proposals in the **White Paper on Land Reform** (1991:2-12) concerning

inter alia future assistence to promote access to land rights, the utilisation of land, and rural development; and

- systems-changing, i.e. the transfer of authority among individuals and institutions in order to alter the system by which goods and services are rendered, for example, the institution of joint administrations between White and Black local authorities by way of joint agreement and subject to authorisation by the Administrator (File number GO 18/2/8/B) and thus also the joint rendering of public health services.

3.2.5 *Levels of policy*

Different levels are used to classify public policy. These levels which seek to establish order in the description of public policy are political policy, executive (government) policy, administrative policy, and operational policy (Gladden 1964:72-4; Cloete 1972:71-5; Hanekom 1987:10).

The different levels used to classify public policy seeks to establish order in the description of public policy. Although the public policy phenomenon can be distinguished by the four levels referred to, it cannot be separated into independent categories. The levels are inextricably related and interrelated, and an absolute dividing line is unrealistic in terms of the practical dynamics of the public policy process. Thus, although the four levels are distinct, their essential overlap cannot be denied (Maynard-Moody 1989:137).

3.2.5.1 Political policy level

The decisions of political office bearers concerning the direction into which community life will be directed by means of authoritative decisions are the decisive actions pertaining to this policy level (Riekert 1971:66). Political policy has its origin in the political life of a community as expressed formally by the various political parties, including the ruling political party. Thus, the political policy level is also referred to as the political party policy (Cloete 1972:71). The political policy is usually of a general nature and is often idealistic, i.e. it serves as general directives for executive policy. An example of a political policy in the Republic of South Africa is the statement by a spokesperson of the ruling political party (the National Party) concerning reform on the local government level. In terms of this statement the ruling political party supports the idealistic and general goal to move away from a paternalistic system of delegation to a system of consultation and negotiation with local authorities (**Debates** 1986: Col 816-18).

To what extent public health had been, and still is, part of the political policy level will be ascertained by referring to party political manifestos in chapter 6.

3.2.5.2 Executive policy level

Executive policy (also referred to as government policy) is the policy of the executive of the political party in power, i.e. the government-of-the-day. Executive policy is the translation into objectives of the political policy of

the party in power on how to govern the country and in what specific directions the society is to be steered. Executive policy is usually seen to be more specific than political policy (Hanekom 1987:10). Executive policy is applied to all the members of the community through the embodiment of such policy in legislation.

The task of the Department of Planning and Provincial Affairs is an indication of one of the executive policies of the government-of-the-day. In terms of its task the department formulates spatial-economic and socio-economic frameworks; it develops constitutional structures at provincial and local authority levels; and it coordinates and monitors the implementation of these tasks (Department of Planning and Provincial Affairs, **Annual Report**, 1989).

To what extent an executive public health policy (or lack thereof) can be seen to have existed within a political policy void will be explained in chapters 5 and 6.

Within the framework of the more specific executive policy, practical steps have to be alluded to which indicate in greater detail the aims of the executive institutions, i.e. the administrative policy level.

3.2.5.3 Administrative policy level

Administrative policy deals with matters such as personnel, finances, organisation and control, and the manner in which executive policy will be converted into practice.

Examples of administrative policies are the Public Service Act, Act 111 of 1984, the Public Service Regulations and the Public Service Staff Code. These policies cover the employment aspects of officials on the central and provincial government levels, and therefore also public health officials on these levels. For example, appointment to posts in the civil service is limited to persons with certain qualifications (section 11(1) Act 111 of 1984 and Civil Service Regulations B2 and B3), promotion in the civil service hierarchy is effected in accordance with the qualifications and merit of each incumbent (section 11(3), Act 111 of 1984), and the appointment of individuals to the Administrative Section from outside the civil service is subject to certain legal requirements (section 11(3)(b), Act 111 of 1984).

3.2.5.4 Operational policy level

Operational policies concern the daily routine activities followed by public officials based on the functional activities that have been decided upon at upper policy levels (Riekert 1971:67).

An example of an operational policy is the procedure for entering into agreements between White and Black local authorities in terms of the announced closer relationship between such local authorities. The procedures are available to any local authority and can be used and adapted in accordance to each local authority's own needs (**Memorandum**, Administrateur-in-Uitvoerende Komitee 1991:10).

3.2.6 Policy environment

The division of a policy into four levels of policy can be further explained by refering to the environment of the public policy process (Nakamura & Smallwood 1980:22-3).

In the making of policy a number of functional environments, namely the policy formation, the policy implementation and the policy evaluation environments can be distinguished (Nakamura & Smallwood 1980:22). The advantages of such a distinction are two-fold. Firstly, the use of environments minimises the tendency to characterise the implementation environment as a bounded and separate process when in fact all three environments are mutually inclusive in that the same actors can participate in different roles in different environments. For example, leading public officials are not only involved in the implementation of public policy but also in giving advice to their political superiors concerning the formulation of public policies, in the sense of drafting and revising of legislation (**Debates** 1972: Col.6629). Secondly, a variety of different actors who may attempt to influence the policy process are brought into play with the concept of environment. The concept of environment therefore minimises the dated view that only governmental actors have roles to play in the policy process (Nakamura & Smallwood 1980:22). For example, in the case of the Regional Development Advisory Committee for Development Region J (Western Transvaal and parts of Bophuthatswana) which falls under the aegis of the Department of Planning and Provincial Affairs the role players who are not governmental

actors are **inter alia** representatives of the Chamber of Mines, the Association of Chambers of Commerce, the Electricity Supply Commission, the South African Agricultural Union, the Agricultural Cooperative Movement, and the Afrikaanse Handelsinstituut (**Annual Report**, Regional Development Advisory Committee 1990).

3.2.6.1 Policy formulation environment

This environment views policy formulation primarily in terms of coming to a decision about a course of action by elected and appointed policy-making persons and institutions. The decision-makers are those persons in public policy-making positions and those who have claims on them (Nakamura 1987:146; Nakamura & Smallwood 1980:22).

From a South African perspective the persons and institutions in official policy-making positions are **inter alia**:

- the party caucus;
- Cabinet;
- Cabinet Committees;
- Select and Standing Committees;
- staff units (for example the training unit of a department); and
- departmental and interdepartmental committees (Cloete 1981:65-71).

Due to the nature of the three chamber Parliament of the Republic of South Africa with its checks and balances, Parliament also emerged as a policy-making institution, particularly policy-making by consensus

(Groenewald 1988:**passim**). In terms of section 30 of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983) the State President and Parliament are clothed with supreme legislative authority. Section 34(3) of Act 110 of 1983 re-inforces the legislative supremacy of Parliament by precluding judicial review of the validity of properly passed Acts of Parliament.

The functions of the legislative authority are to pass laws for peace, order and good government of the state and to approve budget proposals. The legislative authority plays a central role in public administration in that all authority, actions and authorisations are derived from the functions that are delegated to the executive institutions by Parliament.

In terms of the Republic of South Africa Constitution Act, 1961 (Act 32 of 1961), laws were made by the House of Assembly only (the abolished Senate was virtually an approval institution of the House of Assembly). The 1983 constitution demands that laws on general affairs be made by Parliament (i.e. all three Houses), and that the Houses have to pass the same version of a Bill before it can become a law of the Republic of South Africa (sections 30-36, Act 110 of 1983). The establishment of three Houses in terms of the 1983 constitution also rests on the presupposition that Whites, Coloureds and Indians have so many interests of their own that a separate chamber is needed for each of the groups (section 14), in other words a separate chamber for own affairs legislation. In addition, it rests on the assumption that there are common interests that need some form of joint decision making (section 14), in other words all three houses

become involved in the adoption of general affairs legislation. In the case of general affairs legislation, the constitution gives each House an effective mutual veto on matters common (section 32), and under such conditions there is a danger of legislative immobility. To prevent an **impasse** developing between the three Houses of Parliament, the constitution provides for mechanisms to facilitate consensus among the majority parties in each House, namely Joint Standing Committees (section 64), the Cabinet (sections 19, 20), and the President's Council (section 78).

By a system of Joint Standing Committees (section 64), for example, Bills must first be discussed and assented to by committee members. Such a system renders itself to two ways in which Parliament becomes involved in policy-making, namely, by way of summarised consensus by the chairman of a commitee, and consensus by means of concurrent majorities. The success of this mechanism of consensus was confirmed in that, during the first year of existence under the 1983 constitution, of 112 Bills introduced in Parliament, in only two cases consensus could not be reached (Groenewald 1988:vi,1).

The State President is the head of the Republic of South Africa. The State President forms part of the legislative and executive authority and as such has legislative and executive functions (sections 6 and 19 of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983). This means that the functions of the State President is combined with those of a Prime

Minister although the latter was abolished with the adoption of Act 110 of 1983.

Sections 19 to 29 of Act 110 of 1983, cover the executive authority. In terms of section 14 of Act 110 of 1983, a distinction is made between own affairs and general affairs. As far as own affairs is concerned, the State President shall act on the advice of the Ministers' Council concerned, whereas, as far as general affairs is concerned, the State President shall act in consultation with the members of the Cabinet (Secton 19, Act 110 of 1983). The terms "on the advice of" and "in consultation with" is an important distinction regarding the policy-making authority of the State President. From this distinction can be inferred that the State President's decisions as far as own affairs is concerned, are circumscribed or restrained by the advice of the Minister's Council concerned, whereas, in the case of general affairs, the State President only has to consult with the members of the Cabinet. Thus, the State President can exercise the executive powers vested in him (e.g. in terms of sections 6 and 20 of Act 110 of 1983) with or without the advice of his Ministers. He need not necessarily accept the advice of his Ministers, since disagreement with the Minister or Ministers concerned, could be resolved by replacing them with persons more amenable to his own line of thinking. Since Act 110 of 1983 determines that the conventions of the previous constitution will be followed (section 88), it can be said that the State President determines the policy-making environment of the Cabinet which will be in line with his own policy-making predispositions.

Non-governmental individuals and/or groups who have policy-making claims on official policy-makers are:

- a variety of interest and professional groups (Kotze & Greyling 1991:**passim**; Hanekom 1987:21), drawn, for example, from:
  - the business community, e.g. the Federated Chamber of Industries (FCI), Association of Chambers of Commerce and Industry (ASSOCOM), the Afrikaanse Handelsinstituut (AHI), National African Chamber of Commerce and Industry (NAFCOC), the Chamber of Mines (COM), the Steel and Engineering Industries Federation of South Africa (SEIFSA), the Building Industries Federation of South Africa (BIFSA) and the South African Agricultural Union (SAAU);
  - the organised economic community, e.g. trade unions such as the Trade Union Council of South Africa (Tucsa), the Congress of South African Trade Unions (Cosatu), the National Council of Trade Unions (Nactu), and the Azanian Congress of Trade Unions (Azactu). Notwithstanding their initial resistence to the Labour Relations Regulation Act, 1977, (Act 84 of 1977) that came about as a result of the recommendations of the Wiehahn Commission in 1977, a number of 212 trade unions with a membership that represents 20% of the total economic active population of the Republic of South Africa were registered under the Act in 1989 (Barker 1990:23-5);

- the church community, which, in current South African politico-church relationship, was particularly invited by the State President to consult with him concerning the South African constitutional future (Alberts 1990:14-21); and
- the voters.

The interest groups represented on the National Health Council responsible for policy-making on the central government level in terms of the Public Health Act, 1919 (Act 36 of 1919) are detailed in Addendum 2.

Although the so-called "text-book" view of public policy is that of a comprehensive policy process consisting of sequential steps starting with the policy-making environment and ending with the policy analysis environment, it has been asserted that the policy participants exist in a less bounded and more fluid world where events do not proceed neatly in typical text-book fashion. Policies can therefore also be formulated and reformulated in policy environments other than the policy-making environment (Nakamura & Smallwood 1980:22; Maynard-Moody 1989:137).

3.2.6.2 Policy implementation environment

Although, theoretically, the role players in this environment are guided by the mandates legitimised by the policy-makers (the legal imperative), they are also influenced by their own predispositions and/or attempts to gather support for their implementation attempts (the bureacratic and consensus imperatives). Hence the policy implementation environment

should not be regarded as a phenomenon that follows only after policies have been adopted (legalised) by the official policy-makers, but that the implementation environment can also be influenced by the composition, disposition and interaction of its role players, namely the elected members and public officials (Nakamura & Smallwood 1980:23).

The fact that the roles of elected members and public officials in policy-making and policy implementation do not subscribe to a categorical separation of powers is borne out by Langrod (1968:66) in that the executive branch of government always plays a part in the comprehensive policy process both through the elaboration of policy (by means of their reports, investigations, draft programmes, and the personal influence and advice of the leading civil servants) and, in particular cases, as regard its formation (either through the interpretation of decisions or by recourse to special tactics).

It can thus be stated that the advice of leading public officials can lead to public policy, and they can be asked to formulate policy on the grounds of their advice (Hanekom & Bain 1990:20). Policy-makers are therefore bound to be in the hands of leading public officials in the sense that policy plans are usually sketchily conceived by elected members and leading public officials have to deal with "...all sorts of problems connected with practicability, priorities, financial costs, the availability of material resources and essential human skills (that) crops up as soon as it is sought to bring the idealist's schemes down to earth" (Gladden 1972:60).

Technically, the implementation environment terminates when the policy is terminated by mandate of the elected members (Nakamura & Smallwood 1980:23).

3.2.6.3 Policy evaluation environment

The role players involved in evaluation of policy can include policy-makers from the policy-making environment, or policy implementers from the policy implementation environment as far as the official role players are concerned (Nakamura & Smallwood 1980:23). The unofficial role players, for example interest groups, can also make their presence felt through **inter alia**, negotiations, consultations and mass movements as a form of protest (Berger & Godsell 1988:95-98).

The process of evaluation usually has two objectives, namely to determine the success or failure of policies and/or to develop policy alternatives. New policies may therefore originate in the evaluation environment, which can ultimately be legitimised by the policy-making environment. If evaluation takes place on an **ex post facto** basis, the role players might include academics, public interest groups and the media, who had no prior connection with either formation or implementation (Nakamura & Smallwood 1980:23). This is particularly the case with commissions/committees of inquiry, also concerning public health matters (**infra**, chapter 7).

Drawing on the above the operation of the policy environments can be interpreted as an open and dynamic environment constellation - a term coined from Dror's "system constellation" (Dror 1968:21). In such a constellation different role players contribute to each functional environment but also to the environments combined.

3.2.7 Public policy and public policy implementation

This chapter has shown, **inter alia**, that although the public policy-making and the public policy implementation processes can be separated for the purpose of identifying certain stages in the overall public policy process, its interrelatedness concerning the rendering of governmental services cannot be denied. The possibility of a mismatch between public policy (as the output of the public policy-making process) and the implementation of a particular public policy calls not only for an analysis of the adequacy of the implementation of public policy but also the adequacy, or not, of the original policy design (Pressman & Wildavsky 1973:xvii). Thus, the analysis of the implementation stage of the overall public policy process is inextricably linked to taking cognisance of the public policy-making stage. This inextricability sets the scene within which the public policy implementation process will be analysed in chapter 4, after which an analysis of public health policy can be undertaken in chapter 5, 6 and 7.

3.2.8 Conclusion

Governmental activities should be purposeful. Public policies, and therefore also public health policies, is one of the means through which

purposeful governmental activities can be perceived and be established. The concept "public policy" is, however, subject to various interpretations. It is also subject to a diffuse field of studies. In this sense an understanding of the concept and of its manifestations can be beneficial to its utilisation as a means towards the accomplishment of purposeful governmental action.

A classification used by policy scholars is the classification of the policy process into various models. These models can be subsumed under two headings, namely models of public policy as a process, and models of public policy as an output. The former heading can be classified into the elite/mass, the group, the systems, and the institutionalist models. The latter can be classified into the incrementalist and the rationalist models. Although most of these models relate to the public policy process in general, and the public health policy process in particular, in the Republic of South Africa to a greater or lesser extent, the elite, incremental and institutional models were shown as the models that predominated the public policy scene since 1948 up to the late 1970's. This predominance also hold for public health policy.

Another way in which the concept public policy can be described as an instrument towards the attainment of governmental activities is to refer to the classes of instruments of public policy. The classes that were identified were mandates, inducements, capacity-building and systems-changing, all of which can be applied in the Republic of South Africa. For example, in the case of inducements, Section (26) (i)-(vi) of the

Health Act. 1972 (Act 63 of 1972) stipulates that the central government level funding of local authorities are effected after compliance with certain prescribed functions.

A further way in which to describe the comprehensive public policy process is to refer the levels of public policy. Four levels were identified namely the political policy level, the executive policy level, the administrative policy level, and the operational policy level. Once again, these levels can be applied in the Republic of South Africa. For example, in the case of the political policy level the political party in power (i.e. the government-of-the-day) presently supports the policy of moving away from a paternalistic system of policy-making to a system of the delegation of authority to local authorities combined with a system of consultation and negotiation.

In the making of public policy a number of functional environments can be distinguished, namely the policy formation environment, the policy implementation environment and the policy evaluation environment. Although these environments can be distinguished for analytical purposes, they cannot be completely separated in practice. In each of these environments certain individuals and institutions are role players that affect the nature and contents of each environment. The role players can be identified as official and non-official role players, all of whom contribute towards the formulation, execution and evaluation of public policy, either separately or in combination with one another.

The public policy process can therefore be regarded as an open and dynamic environment constellation of formulation, implementation and evaluation.

CHAPTER 4

POLICY IMPLEMENTATION PROCESS

4.1 Introduction

As indicated in chapter 3 the comprehensive public policy process consists of various successive stages or environments which repeat themselves and which are usually described as the policy-making, policy implementation, and policy evaluation (or analysis) stages. Attempts to deal with the public policy process would therefore also have to involve the policy implementation stage as one of its components. The transmission of policies into a series of consequential actions of implementation requires a comprehensive assessment of the kind, impact and implications of these implementation actions. Such an assessment is considered necessary for an analysis of public health policy implementation, since no such assessment had been made in South Africa.

While ideas and proposals of policy are legion, it becomes difficult to implement them after the ideals and proposals are formulated into policies. A study of implementation is a study of planned change. Planned change is inherent in any ordered society. As will be indicated, one of the reasons why public policies, particularly public health policy succeed or fail can be attributed to the policy implementation stage of the overall policy process.

4.2 Etymology

The word, implement, derives from the Late Latin **implementum** (Latin **in** in, **plere**, to fill) (Twentieth Century Dictionary 1974). The verb, implement, refers to a tool or instrument of labour as is used in Scottish Law. In the **Elements of English Composition** (11th edition, 1841) David Irving wrote: "To **implement**, signifying to fulfil, is ... derived from the barbarious jargon of the Scotish (sic) bar". As recently as 1933 the **Shorter Oxford English Dictionary** called the word chiefly Scottish. Since then it became a vogue word for politicians, public officials and the press in England. Synonyms are fulfil, carry out, keep, observe, and perform (Fowler 1983). Pressman and Wildavsky (1973 : xv) define implementation as a process of interaction between the setting of goals (the input) and the actions geared to achieve them (the output). Mazmanian and Sabatier (1983:4) refer to implementation as those events and activities that occur after the issueing of public policy, including the effort to apply it and the substantive impacts on people and events. Easton (1971: 130) asserts that when a government acts to implement a policy, then it enters the effective stage of the overall policy process. Effective stage in this sense refers to the tractability of a policy in the implementation stage. Evidence suggests that this effective stage of the public policy process has been accorded little thought by governments (Schrire 1990:xiii) and by the South African government (**infra** chapters 6, 7). This state of affairs can be blamed mainly on the emphasis placed on the input part of the public policy process, i.e. the policy-making stage.

4.3 Lack of emphasis on the policy implementation process

The study of public policy has traditionally been divided into the policy-making, policy implementation and policy evaluation stages of the comprehensive public policy process (Younis & Davidson 1990:3). The emphasis of policy studies has, however, traditionally favoured the process of policy-making by focussing on the participants and their interests, compromise through bargaining and negotiation, the role of analysis, and experts in policy-making (Frawley 1977:1). Policy implementation studies were relegated to a "black box" approach in that it was assumed that policy decisions were carried through the implementation system as intended and with the desired results (Younis & Davidson 1990:3).

The result was that studies focussed on the means of improving the quality of policy-making and providing prescriptive models whereby the probability of success was thought to be enhanced, but was not necessarily enhanced (Younis & Davidson 1990:4). The reasoning is therefore that the success of policy implementation is based on the basis of prescriptive policy-making models (i.e. models on which implementation will be effected precisely as prescribed) after which implementation would follow. The incorrect assumption was that once a policy has been formulated and officially adopted, the policy will be implemented and the results of the policy will be near those expected by the policy-makers (Nakamura & Smallwood 1980:8).

The making of policy and the role of policy analysis, notwithstanding the traditional emphasis of a focus on the input part can, thus, be seen as an incomplete overall policy process in instances where the implementation stage is overlooked or accorded little importance. The translation of policy into meaningful practice is therefore important and a government can ill-afford to ignore it (Hugo 1990:13). Nakamura and Smallwood (1980:3), for example, maintain that political life concerns not only those varieties of activities that influence the kind of authoritative policy adopted for society, but also the way it is put into practice, in other words, implemented.

The ways in which public policies are implemented by public officials behoves a consideration of factors that are usually ill-conceived or not conceived at all by political office bearers because what is intended by political office bearers in the form of public policies are not necessarily implemented by officials (Dror 1968:188).

4.4 Intention and implementation

In the sense that there exists planned action not to implement public policies, or to implement them incorrectly, or even to implement them on a selective basis, the following can be referred to. It has been argued, for example, that the failure of public policies in the post-Second World War era is at least partly responsible for the international, political and economic retreat from socialist structures and values. The reason advanced for this retreat is that service rendering government has been

regarded as having failed to implement comprehensive and ambitious public programmes, particularly those that required change in organisational or individual behaviour (Younis 1990:3).

Easton (1971:130) implicitly referred to the requirements of institutional and individual behaviour by referring to the intention of a public policy and the actual practice of putting it into effect: "Arriving at a decision is the formal phase of establishing a policy; it is not the whole policy in relation to a particular problem. A legislature can devise to punish monopolists; that is the intention. But an administrator can destroy or reformulate the decision by failing either to discover offenders or prosecute them vigorously. The failure is as much part of the policy with regard to monopoly as the formal law" (Easton 1971:130).

Thus, it can be seen that what is intended is not necessarily implemented (Dror 1968:188). In colloquial English this can be referred to as the **hiatus**, i.e. a break in continuity between "paper (i.e. the policy) and practice (i.e. implementation)". Taking into consideration that this break in continuity may be created by public officials in the stage after the making and during the implementation of public policy, it comes as no surprise that the implementation stage of the public policy process (and therefore also the implementation stage of the public health policy process), had been referred to as the "Achilles' heel of administrative reform" (Caiden 1976:142), and the "implementation gap" (Dunsire 1978:18) in public policy studies.

The failure to bring to bear a policy, however, lies not only in the fact that the implementation stage of the overall public policy process is overlooked, but it also lies in the fact that the failure to bring to bear a policy is as much a part of the policy-making process as the policy implementation process. For example, in the Republic of South Africa, former State President P.W. Botha's government policy that created the institutionalisation of a centralised and authoritarian state structure gave rise to a bureaucratic structure characterised by power struggles, secrecy and limited access to state authority (Schrire 1990:77). Another example concerns the tractability of the policy of the South African government contained in the Group Areas Act, 1966 (Act 36 of 1966). Regarding the implementation of this policy, the Transvaal Attorney General, Mr Klaus Von Lieres und Wilkau, stated in 1989 that it is impossible to implement the said Act in any area in which substantial greying (i.e. areas substantially inhabited by various races) has taken place (cited in Business Day 15/4/1989). Moreover, the acknowledgement by Deputy Minister of Constitutional Development and Planning, Mr Roelf Meyer, that the the Group Areas Act, 1966 (Act 36 of 1966) cannot be implemented because a large sector of the community finds it unacceptable (**Debates** 1988: Col 165), bears testimony to the statement that a particular policy which is the result of the policy-making stage is as much to blame for issues concerning its non-effectuation as is the implementation stage.

Public health policies and the successful implementation thereof in the Republic of South Africa, were similarly jeopardised by what the

policy-makers (legislators) did, and refrained from doing concerning the health issues the country had to cope with since 1910 (**infra**, chapters 5, 6 and 7).

Policy implementation as the effective stage of the comprehensive policy process gained new emphasis with the resurgence of policy implementation studies, particularly the book **Implementation** by Pressman and Wildavsky (Pressman & Wildavsky 1973) during the 1970's.

4.5. Resurgence of policy implementation studies

Implementation literature is regarded as of recent origin, having largely been neglected by policy theorists untill the 1970's (Younis & Davidson 1990:4). The reasons that studies of implementation were neglected until that time can be attributed to a combination of the following factors:

- the assumption that the implementation process was simple, even mundane, containing no issues that were worthy of the attention of scholars, i.e. merely the use of identified steps;
- the focus of attention on the Planning Programming Budgeting System (PPBS) with the emphasis on authoritative decision-making to the exclusion of subordinate ranks responsible for implementation, i.e. a top-down approach of the comprehensive public policy process;
- the difficulty of analysing policy implementation deterred scholars from entering into an analytical study of the implementation process; and

- the outlay of time and resources restricted such studies (Younis & Davidson 1990:4).

However, notwithstanding the above factors that played a combined role resulting in the neglect of policy implementation studies, a renewed interest arose in examining the scope and nature of the implementation stage of the comprehensive public policy process. This resurgent interest can be illustrated by referring to the developments in the United States of America, Britain, and the Republic of South Africa.

4.5.1 United States of America and Britain

From the early 1970's a resurgent interest developed in examining the functioning and the problems of the implementation stage of the comprehensive public policy process. In the United States of America authors such as Allison (1971), Destler (1974) and Halperin (1974) examined the implementation process from an international point of view. Williams (1971), Levine (1972), Derthick (1970, 1972), Pressman and Wildavsky (1973), Murphy (1974), Hargrove (1975), and Binstock & Levin (1976) (Frawley 1977:1) examined the implementation process and its failures in the domestic policy arena in the United States of America (Frawley 1977:1). In Britain studies on policy implementation are those of Dunsire (1978), Levitt (1980) (Bain 1986:36), Barret and Fudge (1981) and Younis and Davidson (1990).

In the United States of America the work of Pressman and Wildavsky is worth mentioning because, as a result of their book published in 1973, the implementation stage of the comprehensive public policy process was accorded a new emphasis with their study that reviewed the apparent failure of the United States Federal Government's job-creation scheme to meet its affirmative action objectives, essentially to provide employment for Blacks in Oakland, San Francisco (Pressmann & Wildavsky 1973 **passim**). Pressman & Wildavsky (1973:xiii) asserted that implementation has been much discussed but rarely studied and the case study of the Economic Development Agency (EDA) in the city of Oakland was an attempt to show why the provision of jobs for minorities through financial-aid schemes met with depressing outcomes. In essence, they showed that the apparent failures of providing jobs for minorities came about as a result of the non-agreement between a diverse group of participants with differing institutional objectives and that projects such as training programmes geared towards the implementation of the job-creation scheme required a long string of clearances by actors with differing perspectives (Pressman & Wildavsky 1973 **passim**). Thus, the simple (the Economic Development Agency's attempt was neither the product of any controversial issue, nor subject to circumstances such as political interference) became complex not because of any malign intent or bureaucratic sabotage, but because of institutional problems (Jenkins 1978:210-11).

Pressman and Wildavsky's (1973:167) review of traditional literature turns up a limited usage of the term implementation. The reasons Pressman and Wildavsky advanced for such a limited usage of this term are threefold:

- the literature does not use "implementation" at all; or
- the concept is undefined; or
- the word is mentioned only in passing.

These assertions are not surprising since terms other than implementation (such as administration, planning and programming) have been used to describe the implementation of policies (Henry 1975:160; Anderson 1984:38; Jones 1977:138).

For example, the planning function can be regarded as the oldest manifestation of government action. The earliest known city planner is Hippodamus of Miletus, who was responsible for the physical planning of several Greek cities in the 5th Century BC (Kling 1976:30). With regard to the United States in particular, early city plans (plans in the forms of architechtural blueprints for the development of almost virgin sites) include General Oglethorpe's plans for Savannah, William Penn's for Philadelphia and L'Enfant's for Washington. Later on, city plans also became associated with large-scale improvements to existing cities, for example, Burnham's plan for the development of Chicago in 1909 (Kling 1976:30).

A more recent example of planning and programming in the United States, is the advent of the so-called New Deal, as a means by which the effects of the Great Depression could be dealt with. The New Deal came to the fore during the presidential election in 1932 in the United States of America. The election of Franklin D Roosevelt as President (who originated the New Deal Programme), brought in its wake a flood of New Deal legislation which produced major implementation changes in government-economy relationships and in the role of government in the society in general (Anderson 1984:38). Concerning the government-economy relationships, the New Deal introduced the Performance Budgeting system (which was followed by the Programme Budgeting System) for the years 1935 to 1960. The general emphasis of the Performance Budgeting System was "Operations and Management" (O & M) In terms of O & M, executive institutions became increasingly involved with originating measures of work performance and performance standards (Henry 1975:160-61), i.e. they were concerned with implementation in the most cost-effective ways possible. The New Deal development, as far as budgeting was concerned, was reified in the Planning-Programming-Budgeting system for the years 1960 to 1970 (Henry 1975:162). Thus, as far as budgeting was concerned, the United States of America became involved in furthering efficient implementation even prior to the emerging emphasis of the term "implementation" in the 1970's. In this sense Jones (1977:138) regards implementation as a new term or a vogue word for an age-old activity, i.e. administration, planning and programming.

The point that emerges from the above is that the implementation of government programmes have continually received emphasis in the past although not under the term implementation. The same line of reasoning holds for the United Kingdom.

Barrett and Fudge (1981: 9) of the United Kingdom, referring to Dunsire (1978: chapter 2), note that the literature on the analysis of institutions recognises a distinct implementation process and that Dunsire asserts that many of the issues and ideas that are currently regarded as new by policy analists and practitioners, have actually been around for a long time. The history of public administration provides examples of implementation in the form of planning in England as early as 1500-1400 BC. A case in point is Stonehenge, a centre in south-west England whose standing stones and surrounding earthworks today still indicate the shape and nature of the original structure. Gladden (1972:10) maintains that it calls for no real stretch of imagination to visualise the existence of the proper planning of its structure.

The semantic debate referred to immediately above, points to the fact that the term implementation is known in many guises, e.g. administration, programming, and planning and that these emphases have been part of governmental activities from time immemorial. However, as far as **policy literature** is concerned, the term implementation has been favoured by policy scholars as from the 1970's.

4.5.2 Republic of South Africa

The situation in the United States of America and in Britain (i.e. a renewed emphasis on public policy under the term implementation) can also be seen to have materialised in the Republic of South Africa from the late 1970's early 1980's. The implementation stage of the comprehensive public policy process received particular emphasis from the 1980's (Van der Merwe 1990:2). The particular emphasis that implementation received during this time does not, however, negate previous implementation attempts in South Africa (which had been known, **inter alia**, as administration, planning and programming). Examples abound of such attempts throughout the history of South Africa. A study of Marais's **Constitutional Development of South Africa** (1985 **passim**) and **South Africa: Constitutional Development, A Multi-disciplinary Approach** (1990 **passim**) reveal the attempts, since 1652, of successive governing bodies to implement policies. These were, **inter alia**, the attempts to implement the monopolistic commercial policy under the Verenigde Oost Indiese Companje (VOC) (1652-1795), the autocratic public policies during the First British occupation (1795-1803), the attempts of policy implementation in accordance with De Mist's **Memorandum** during the Batavian period (1803-1806), the implementation of the Crown Colony's policies of centralisation, emigration and anglisation, the implementation of self governing policies of the Second British occupation, attempts to effectuate public policy in the Boer Republics, after unification in 1910, after

becoming a republic in 1961, and after the adoption of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983).

Although many examples can be cited of public policy implementation attempts over and above those mentioned by Marais (1985 **passim**), the following will suffice for the purpose of this thesis.

The Social and Economic Planning Council was established in 1942, abolished in 1952, and on the recommendations of the office of the Economic Advisor to the Prime Minister in 1962, the Economic Advisory Council of the Prime Minister was established (Du Plessis 1968:185). (Since the adoption of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983), the name Economic Advisory Council of the Prime Minister was changed to that of the Economic Advisory Council of the State President. The Central Economic Advisory Service attached to the Department of Constitutional Development and Planning acts in the capacity of Secretariat of the Economic Advisory Council.

The overall aims of the Economic Advisory Council of the Prime Minister were to coordinate co-operation between the public and private sectors; to serve as a coordinating instrument that promotes the flow of information essential for the efficient operation of the economic system; and to advise the government on current economic problems. The Council, during the time, consisted of representatives from ten national employers' and employees' institutions in the private sector, experts in economic and financial matters and heads of some government

institutions (**South Africa 1980/81** 1980:325-6). The office of the Economic Advisor in collaboration with the private sector, is responsible for the Economic Development Programme (EDP) which is also submitted to the Economic Advisory Council of the Prime Minister for review and for the formulation of recommendations to the government with regard to medium-term economic development policies (**South Africa 1980/81** 1980:326).

Public health policy implementation in the Republic of South Africa since 1910 also illustrates the omnipresence of such attempts. Whether or not they can be seen as successful attempts in view of the ways in which external variables such as legislative direction and public accountability were concerned, forms the gist of the analysis in chapters 5, 6 and 7.

Thus, although the term implementation became a salient and specific issue from the late 1970's, its emphasis in governmental activities prior to this date cannot be denied.

The resurgent interest in what happens in the implementation stage of the the overall policy process, opened up a field of practical and academic endeavour. Faure (1984:2-17), with his exposition of the ideas of Meehan on reasoned arguments, Hugo (1990:109-25) with his examination of the ways in which to implement a programme of equal opportunity and affirmative action in the South African public service, and Schrire (1990:77-89) with his exposition of the implementation of political policy by the South African bureaucracy, as academics , and Van der Merwe

(1990), as a representative of the public service involved in the day-to-day administration of public policy, are some of the authors who dealt with the policy implementation process as such or with aspects pertaining to public policy implementation.

For example, according to Faure's article on Meehan's reasoned argument in social science, the critical prerequisites for reasoned action, and thus, reasoned implementation, are that, firstly, those actions which are not yet conceivable, be anticipated or predicted. Such actions may be of the past or of the future and both of them are evolved in the same manner towards reacting on the environment, or to adapt to the environment, in the sense that the same considerations are valid in both cases. Secondly, the human situation requires a degree of control over some of the aspects of the environment. Without a belief in the ability of the human being to affect future conditions in an anticipated manner, human survival would be jeopardised. Lastly, a measure of control over future conditions results in the requirement of a selection amongst alternatives (Faure 1984:6)

A theory of knowledge that incorporates the above three main aspects, represents the minimum requirements in terms of which a satisfactory interaction with, and thus, implementation within the environment can be attained. Subsidiary aspects considered to be of importance in Faure's exposition of Meehan are the use of language, skill in mathematics and epistimology (Faure 1984:6).

Schrire (1990:xiii), posits that the ways in which the less glamorous but more important issues of how sensible public policy proposals (more particularly, political policy proposals) can be implemented are critical issues for the Republic of South Africa. He contends that although many thinkers have produced political policies in the form of "solutions", "constitutions" and "principles" for South Africa, the important issues of strategies and tactics of implementing public policies ought to be accorded the importance they are due (Schrire 1990:xiii).

Apart from the renewed academic interest in public policy implementation, various other factors gave rise to the emerging interest in the implementation stage of the comprehensive public policy process in the Republic of South Africa, namely:

- firstly, the publication of reports by commissions of inquiry, such as the reports of the **Wiehahn Commission** (1979-1981), the **Riekert Commision** concerning labour issues, and the report by the **De Lange Commision** on teaching (Van der Merwe 1990:2) (for an analysis of the reports of commissions/committees of inquiry pertaining to public health matters see **infra**, chapter 7)
- secondly, recommendations from advisory bodies such as the Economic Advisory Board of the State President, the National Manpower Commission and the President's Council pressed for the implementation of the recommendations of their respective commissions of inquiry (Van der Merwe 1990:2); and

- lastly, an increasing insistence on the curtailment of governmental expenditure and the decrease of the government's claim on scarce resources, particularly capital and medium and high level manpower, commercialisation, contracting out and privatisation (Van der Merwe 1990:2).

As the number of governmental strategies and White Papers increased as a result of the reports of the commissions of inquiry and other advisory bodies, scepticism was expressed by private business and the public on the likelihood of the effective implementation thereof. The perception was that the implementation of public policy was not regarded by the government as of a serious nature and that, measured against the degree of success obtained in implementing public policy, implementation was conducted commensurate with the ineffective allocation and utilisation of scarce resources (Van der Merwe 1990 :2).

Two reasons can be advanced for the perception described immediately above. Firstly, the large number of reports and White Papers and, secondly, the fact that strategies, reports and White Papers are made known to the public far better than the implementation, and the successes, or not, of implementation.

Concerning the former, the following examples are referred to:

- since 1980, 25 research reports of the President's Council, 17 reports of the National Manpower Commission on labour matters, and 27

research reports of the National Training Council were published. Since 1979 a total of 19 White Papers on policy and strategy were published compared to not even one during the preceding twenty years (Van der Merwe 1990:3); and

- regarding the second reason, the statement can be made that the perceptions exist that research investigations have become an end in themselves (Van Der Merwe 1990:3) and that researchers get paid handsomely for reports but not for their implementation. These perceptions are the result of the fact that the publication of strategies, research reports and White Papers were marketed better, i.e. were made known to the public at large, far better than the implementation thereof. Although cases do exist of successful implementation, for example, the consensus decision-making technique implemented in the three Houses of Parliament through the adoption of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983) (Groenewald 1988:1) and the implementation of the objectives of the Regional Services Council concept (Padayachy 1991:2-3; Woodroffe 1991:1; Bornman 1991:24), such cases are not marketed and such successes are, consequently, not generally known (Van der Merwe 1990:3).

External factors such as the influence of foreign countries, interest groups, pressure groups and political parties, that were not considered by public policy-makers resulted in the delay or obstruction of implementation attempts (Van der Merwe 1990:3).

Internal factors that influence the implementation of public policies derive from the inherently conservative nature of public executive institutions. They also derive from the weaknesses to which the conservative nature of the executive institutions give rise. For example, the existence of a focus on government control superimposed by the political system on the public executive institutions rather than a focus on development or welfare, resulted in an ethos and structure of public executive instititions through which control has been the driving force of the political system (Schrire 1990:86). In addition, the fragmentation of planning, execution and of management functions where coordinated and integrated action are **prima facie** more desirable, led to certain disadvantages in the rendering of services. For example, in the case of metropolitan areas in South Africa, fragmentation led to unnecessary prolifiration of functions, duplication of infrastructural services, under-utilisation of capital, equipment and wasteful use of manpower, especially at professional and skilled levels (President's Council, Joint Report, 1/1982). As will be shown in chapters 6 and 7, the fragmentation of policies and the prolifiration of public health functions led to the inefficient rendition of public health services.

The resurgence of implementation literature brought in its wake a renewed interest in the ways in which public policy implementation was, and is, conceptualised and practised. Such conceptualisations can be identified as various models of implementation which form the bases from which descriptions and analyses of implementation can be approached.

4.6 Models of public policy implementation

Various preconceptions about public policy-making helped to shape various models of public policy implementation. The two overriding models are the classic (hierarchical) and the integrationist (evolutionary) models of public policy implementation (Nakamura & Smallwood 1980:7-19; Barrett & Fudge 1981:9; Bain 1986:37; Van der Merwe 1990:6).

4.6.1 Classic model

The classic model derives from the machine metaphor of administration. The three concepts that are considered to be the major contributors to the machine metaphor of the administrative process are the organisational hierarchy of Weber (1864-1920), the separation of politics and administration of Wilson (1856-1924), and the Principles of Scientific Management of Taylor (1856-1915) (Nakamura & Smallwood 1980:7-8).

The concept of organisational hierarchy was advanced by Max Weber (1864-1920) in the form of an ideal-type bureaucracy. To Weber an ideal-type is formed by the one-sided accentuation of one or more points of view and by the synthesis of diffuse, separate, more or less present concrete individual phenomena, which are arranged in accordance with those one-sidedly emphasised viewpoints into a unified analytical mental construct or **Gedankenbild**. In its conceptual purity, this mental construct cannot be found empirically anywhere in reality and is, thus, a utopia (Weber, translated by Shils & Finch 1949:90).

Weber described the ideal bureaucracy as a rationalised legalistic and hierarchical organisational pyramid in which a large number of subordinates would dutifully implement the policies of a small number of superordinates in a prompt, automatic and unquestioning way. The superordinates in the act of policy-making choose the ends or goals of administrative action, and instruct the subordinates to implement them. In the Weberian model it is assumed that the discretion of subordinates involve only decisions on means, while the superordinates' decisions concern the determination of the ends (Blau 1963:1; Nakamura & Smallwood 1980:7-8).

Thomas Woodrow Wilson (1856-1924) contributed to this model of public policy in that administration can be considered a separate, neutral, professionalised, and non-political activity that could be carried out on the basis of objective principles of scientific rationality (Wilson introduced by Purcell 1955:1,2). Wilson, under the influence of his German trained lecturer, Herbert Baxter Adams, based this view of administration on the German Idealism prevailing in Germany at the time under the influence of prominent German political scientists, particularly Bluntschli (Thomas 1978:10-1) and Stein (Miewald 1984:18).

Frederick Winslow Taylor (1865-1915) who is the father of the scientific management movement, provided the rationale for the classic model in that he stressed the attainment of efficiency as the basic criterion against which to evaluate administrative performance (Taylor 1934:7; Massie 1970:22). In the attainment of efficiency "...the "initiative" of the workmen

(that is, their hard work, their good-will, and their ingenuity) is obtained with absolute uniformity..." (Taylor 1934:36) i.e. within a strong hierarchical framework.

The machine metaphor of administration created and supported by the scholars referred to immediately above, forms the basis of the classic model of policy-making and policy implementation. The classic model rests on the following major preconceptions:

- policy-making and policy implementation are bounded, separate and sequential;.
- these boundaries exist because:
  - a clear division can be distinguished between policy-makers and policy implementers; the former set goals or ends, the latter carry out goals and ends;
  - policy-makers are capable of stating policies definitively because they can agree on a priority among different goals; and
  - policy implementers possess the technical capability, the obedience and the will to carry out these policies (Nakamura & Smallwood 1980:10).
- the process of implementation unfolds in a chronological and sequential fashion in which policy-making precedes policy implementation;
- decisions of implementers are percieved to be non-political and technical in nature (Nakamura & Smallwood 1980:10); and

- the legislature has primacy in the process of policy formation and the implementers ought to be an instrument rather than a brain (Long 1954:23).

4.6.1.1 Classic model as top-down model

The classic model of policy-making and policy implementation is also referred to as the top-down model. The top-down model regards policy as given and seeks to explain what is right or wrong with the implementation process and the institutions and actors responsible for implementation rather than the policy itself. Except for the belief that there exists a neat dichotomy between policy-making and policy implementation and that there are clear and explicit goals, the top-down model also assumes that it is a comparatively simple task to measure progress towards these goals (Hambleton 1983:405-6). Such a top-down or policy-making centered view of the public policy implementation process tends to play down issues such as power relations, conflicting interests and value systems among individuals responsible for making public policy and those responsible for implementation (Barret & Fudge 1981:3).

Reasons can be advanced why the distinction between policy-making and implementation in terms of the classic model should be maintained, the most important of which is that to view the comprehensive policy process as a nebulous web of interaction, obscures the normative and empirical foundations of the public policy process, namely, the division of authority

between elected office bearers (i.e. politicians) on the one hand, and the appointed public office bearers (i.e. officials) on the other (Mazmanian & Sabatier 1983:8).

However, reasons can also be advanced why the strict division between policy-making and implementation of the classic or top-down model should not be maintained, mainly because the adaptive or interactive approach to implementation emphasises the adjustments that take place between policy statements and implementation among various actors throughout the comprehensive policy process. It also advocates that, when officials act to implement a policy, they may increase or decrease the scope of the policy with the result that the distinction between policy-making and implementation become blurred (Mazmanian & Sabatier 1983:7-8).

An analysis of policy-making and implementation shows that the top-down model predominates in the Republic of South Africa (Van der Merwe 1990:6). The closed, hierarchical and authoritarian model of public policy-making and implementation predominates in the Republic of South Africa in that the government, as the ultimate role player in policy-making is a closely held monopoly enjoyed by political and administrative elites (Schrire 1990:79). As had been indicated earlier (**supra**, chapter 3) the top-down model also predominated as far as public health policy was concerned, on the basis of the government being regarded as an elite/mass, system-oriented, institutionalised and incrementally inclined policy making body.

In the South African case of an authoritarian model of public policy-making and implementation a dilemma can increasingly be created by a demand by the government to increase the democratisation process and at the same time to retain the neutrality of the civil service. The dilemma can thus be created that an increasing number of officials can, through the democratisation process, be brought into the policy-making arena, and thus in the governmental process, but at the same time not being under the direct control of the electorate. A contradiction in terms, namely undemocratic democracy can thus become a reality.

4.6.2 Integrationist (evolutionary) model

The emergence of the integrationist model moved away from the diverging trend of the classic model into a direction of a converging of interests between public policy-making and implementation. The major preconceptions of this model are:

- the clear distinction between public policy-making and implementation becomes blurred (Mazmanian & Sabatier 1983:8) and often disappears entirely (Frawley 1977:15). For example, legislation may have ambiguities or even contradictions and public officials must, in the process of interpreting, clarifying and programming the legislative intent, make some explicit choices about policy content (Frawley 1977:15). In the Republic of South Africa the emerging convergence of interests between public policy-making and implementation rests on the unspoken assumption that public officials are politicised

(Marais 1989:9,15). This assumption opens the door to the emergence of a bottoms-up approach which is further enhanced by the emergence of the approach that implementation is as important as the policy decision itself (Edwards & Sharkansky 1978:292) since during the implementation stage contending views of various actors, including public officials, are worked out. Subjects of dispute that could have been postponed during the initial stages of the policy-making process, must now be resolved (Frawley 1977:15); and

- an increasing emphasis is placed on the qualities of implementors in the policy process. These qualities are psychological factors, increased professional abilities and training of implementors, mutual adaptation between policy-makers and implementors, the roles that implementors can play to impede, frustrate and subvert policies, and political intrigue that can surround attempts to implement or suppress specific policies (Nakamura & Smallwood 1980:18).

4.6.2.1 Integrationist model as bottom-up model

The integrationist model of public policy-making and implementation is also referred to as the bottom-up model. As the name suggests, the bottom-up model accord prominence to what is actually done by role players during the implementation stage of the comprehensive public policy process, i.e. how and why groups and individuals act the way they do during implementation. Policy statements may be one of the variety of factors that may influence group and individual behaviour, but it cannot be assumed that this will always be so (Hambleton 1983:405).

Although the classic (top-down) model still prevails predominantly in the Republic of South Africa (Van der Merwe 1990:6), the bottom-up model of public policy-making and implementation emerges. This emerging trend can be seen to have taken place on the central government level in, for example, the underlying philosophy of the National Regional Development Programme (Department of Development Planning 1988:1). The underlying philosophy is that since the Good Hope Conference, 1981, a move away from the traditional approach in regional development, i.e. a rigid plan or blueprint drawn up by the government or the Department of Development Planning to force human actions in specific directions from the top down (Department of Development Planning 1988:1,2) occurred.

Also, the decentralisation of authority, the allocation of greater managerial independence and the granting of greater discretionary authority to executive departments serve as examples of the emerging trend. For example, in terms of Proclamation No 88 of 1983 (promulgated in terms of Section 5A(1)of the Public Service Act, 1957 (Act 54 of 1957) as amended) greater discretionary authority concerning matters involving the public service was assigned to Ministers and administrators.

The emerging concern of the central government in the Republic of South Africa with the bottom-up model is also illustrated by the confirmation of the government-of-the-day, on 22 August, 1990, of the basic rights of employees and employers attached to the governmental sector. On the said date the Commission for Administration was instructed by the Cabinet to establish effective arrangements in order to establish a sound

relationship between the state and its employees through the process of negotiation with all representative parties (Van der Merwe 1990:9).

The bottom-up model of policy implementation can be seen to have emerged even at an earlier stage in the system of Budgeting by Objectives in the Republic of South Africa. The Commission of Inquiry into the Fiscal and Monetary Policy in South Africa (the Franzsen Commision) recommended during 1970 that the Treasury investigate the possibility of introducing the so-called Programme Budgeting System that had been developed in the United States of America, in the South African public sector. As a result of the Franzsen Commission's recommendations the Treasury conducted an investigation into new budgeting techniques abroad. On approval by the Ministers concerned, a new budgeting technique (which later on became known as the Budgeting by Objectices System) was introduced on a trial basis in the Departments of Health and Agricultural Technical Services in 1973. In 1974 the Cabinet accepted the underlying principles of the new system and approved its implementation in the two departments with effect from the 1976-1977 book year and instructed its implementation in the remaining departments. Thus, as of the 1976-1977 book year, five departments partook in the new budgeting system, i.e. Health, Agricultural Technical Services, Defense, Finance, and Forestry (**Debates**, 1975: Col 377-384; Tesourie: Inleiding tot die doelwitbegrotingstelsel, 1976)

The reason why the Budgeting by Objectives System can be regarded as representative of a bottom-up model of public policy implementation (the

budget is ultimately a policy statement of the government-of-the-day expressed in terms of money), lies in the fact that the spirit of the system is a marriage between programme planning and budgeting, in other words, the planning of public programmes by public officials are suitably juxtaposed with the budget proposals by them. For example, one of the characteristics of the Budgeting by Objectives System is that the aims and objectives of the government is related to the activities at ground level (Thornhill 1972:151-64).

4.7 Variables important in public policy implementation

In order to explain the successes or failures of the policy implementation stage certain variables have to be identified against which the implementation process as one of the stages of the comprehensive public policy process can be evaluated. The fact that policies are sanctioned by legislators and promulgated in legislation of various kinds, does not necessarily lead to its implementation (Cruywagen 1984:94). Policies are not self-executing (Edwards 1984:ix) and attempts, therefore, will have to be made towards the successful implementation of sanctioned policies. Yet, notwithstanding these claims, a Kafkaesque aspect to the implementation area arose since implementation is a crucial area, yet people act as if it didn't exist. (Nakamura & Smallwood 1980:46).

Douglas Ray, referring to utilitarianism, the liberal theory of right and equality, sketches the background against which the search for variables has to be conducted: "Success comes to political ideas not when they are

justified in seminar and speech, but at the moment of their application to society by bureaucrats, economists, and prison wardens. The liberal theory of right finds success not in Locke and Mill, but in the promulgation and enforcement of the laws by which liberal societies are distinctively governed. And so it is with equality. Its success and importance lies not in its crystalline beauty among abstract conception, not in its wonderful symmetry, not even in its moral power, but in countless attempts to realise equality in polity, economy, and society" (Ray 1981:1).

The success and importance of public policies are therefore dependent upon the implementation stage of the comprehensive policy process, and the implementation stage, in turn, is dependent upon various variables that determine its success or not.

4.7.1 Identification of variables

The following paragraphs attempt to present the variables that are considered by writers on Public Administration and public policy as of major significance to the implementation of public policy.

Some of the major contributors to the variables that influence public policy implementation came as a result of the publication by Pressman and Wildavsky of their book **Implementation** in 1973. In their book Pressman and Wildavsky **inter alia** reviewed social science literature to establish how widespread the concern for implementation was. They concluded that such concern was virtually non-existent. Since the publication of the book by Pressman and Wildavsky there had been a spawning of

scholarships concerned with the topic (Bullock & Lamb 1984:vii) and consequenly the identification of variables. Scholars who have attempted to identify such variables are Hood (1976:6-7), Caiden (1976:145-74), Frawley (1977:22-7), Edwards and Sharkansky (1978:295-321), Mazmanian and Sabatier (1983: Chapter 2), Levitt (1980:200), Van Meter and Van Horn (1975 noted by Glynn (1977:81-2), and Bullock and Lamb (1984:4-15).

For the purpose of this thesis a classification of variables will be identified that can be used to explain why certain policies meet with greater success at one time rather than another. This selection of variables will be subsumed under the headings "internal variables" and "external variables".

For the remainder of this chapter these variables will be identified in order to provide a framework within which a critical analysis of the public health policy of the Union and Republic of South Africa can be undertaken.

4.7.1.1 Internal variables

In a South African context certain administrative functions have been identified as important modalities in the implementation of public policies (**supra** 2.3.1.3). These functions were identified as policy-making, organising, financing, staffing, determining and improving work methods and procedures, and controlling (checking and rendering account) (Cloete 1981:43).

One of the areas of research in which the administrative functions were used, concerns the implementation of public policies. The research was conducted by the Commission for Administration (Van der Merwe 1990 **passim**). Because these functions, as internal variables, have already been the subject for investigation of the implementation of public policies, (see Annexure 1) they are only alluded to in passing and do not form the gist for analysis for the purposes of this thesis. Instead, attention will be devoted to what can be considered as external variables.

4.7.1.2 External variables

The practice of public administration in the Republic of South Africa is characterised by certain foundations that serve as guidelines or from which guidelines can be derived that set the boundaries within which the activities of political office bearers and public officials take place (De Beer 1988:107-15; Cloete 1972:8). The foundations of public administration that serve as guidelines which direct the actions of public officials have been identified as legislative direction, public accountability, tenets of democracy, reasonableness, and effectiveness and efficiency (Andrews 1985:28-9; Botes, Brynard, Fourie & Roux 1992:179-87; De Beer 1988:107-15). These foundations are termed normative or guiding factors that influence governmental activities, and thus also public policy implementation. The external variables form the basis of the analysis of chapters 5, 6 and 7.

4.8 Conclusion

The public policy implementation stage of the comprehensive public policy process has been identified as one of the stages that determines the success or failure of public policy. The lack of emphasis on the public policy implementation process gave rise to the emergence of its importance as an instrument in the attainment of public policies.

The resurgence of public policy studies in the United States of America, Britain, and in the Republic of South Africa gave it the attention that was long overdue. The assumption that the implementation process was **inter alia** a simple and even mundane part of the comprehensive public policy process, was thus shown to be incorrect.

Views on the public policy implementation process were shaped by various models of public policy-making and implementation. The two overriding models are the classic and the integrationist models. Both these models apply to the situation in the Republic of South Africa. The classic model served as the predominant one up to the late 1970's. From this date the integrationist model emerged with a commensurate decrease of the importance of the classic model.

The fact that policies are sanctioned and promulgated in legislation of various kinds, does not neccessarily lead to its implementation because certain variables impact on the attainment or not of public policies during

the implementation process. These variables can be distinguished as internal and external variables.

In the Republic of South Africa certain administrative functions have been identified as internal variables that influence the public policy implementation process. These administrative functions are policy and policy-making, financing, organising, staffing, procedures and methods, and control. The administrative functions as internal variables have already been the subject for investigation and a summary of its findings is detailed in Annexure 1.

Concerning the external variables that impact on public policy implementation, the normative or guiding factors that set the boundaries within which political office bearers and public officials have to perform their official activities, and consequently also their policy implementation activities, were identified as deference to political supremacy, public accountability, tenets of democracy, fairness and reasonableness, and effectiveness and efficiency.

CHAPTER 5

EXTERNAL VARIABLES OF PUBLIC POLICY IMPLEMENTATION

5.1 Introduction

It is generally held in Western representative democracies, or in governments that aspire towards such democracy, that public administration ought to operate within democratic prescriptions that impact upon the implementation of public sector activities, thus also the implementation of public health policy. In other words, when a government claims to accept the prescriptions of democracy, then it has to accept that the selfsame prescriptions also apply to the way in which public health policies are implemented.

Prescriptions of democracy can be identified as guidelines, principles or external variables that serve as the ambit within which public health policy implementation ought to take place. The "ought to" nature of these external variables refers to their normative character i.e. they serve as maxims that guide the action of public functionaries and serve as a means towards understanding the complexities of public administration activities, and in particular of public policy implementation.

Various external variables can be identified. This chapter deals with the identification and a description of those variables that ought to guide the public health policy implementation process. Such an identification and

description can then serve as a means towards the critical analysis of the public health policy implementation process in chapters 6 and 7.

5.2 Ethical and value environments of P(p)ublic A(a)dministration

In representative democracies certain external variables have been identified which serve as a framework within which public sector activities and thus also public policy implementation have to take place (Gildenhuys 1989:52-4). The Republic of South Africa has a form of representative democracy. The statement that "The Republic of South Africa **is a democratic state**" (Cloete 1981:24- own emphasis) is, however, incorrect because democracy was limited only to the White electorate (Labuschagne 1988:251-66). Nevertheless, the fact remains that all administrative action on all levels of government ought to uphold the external variables (Cloete 1981:24) which characterise a system which aspire towards a representative democracy.

Public administration in the Republic of South Africa is characterised by certain foundations that serve as guidelines or from which guidelines can be derived that set the boundaries within which the activities of political office bearers and public officials ought to take place (Cloete 1972:8). The foundations of public administration are termed normative or guiding factors that influence governmental activities, and thus also public policy implementation. Normative refers to "what ought to be", in other words, as distinct from existential knowledge i.e. knowledge of what "is" (Weber 1949:51, tr. & ed. by Shils & Finch). Normative, therefore, refers to an

ideal type future situation, i.e. guidance by the expression of ultimate ends, goals, or purposes of social action (Inkeles 1964:74).

The normative guidelines that will be taken as external variables for the purpose of this thesis are:

- legislative direction;
- public accountability and responsibility;
- tenets of democracy;
- fairness and reasonableness; and
- effectiveness and efficiency (Cloete 1988:9-34; Coetzee 1988:146; De Beer 1988:110-14)

The external variables, above, are regarded as political values and norms of the government-of-the-day in accordance with which the activities of those in public employ ought to take place (Hanekom & Thornhill 1986:19; De Beer 1988:110; Coetzee 1988:146).

A consideration of the terms ethics, values and norms which is implicit in the normative character of the external variables is deemed appropriate because issues on public health policy implementation cannot be resolved merely on the basis of empirical considerations which assume already settled ends. In the case of public health the empirical considerations such as the infant mortality rate, albeit statistical indicative of the health status of the inhabitants of a country, cannot resolve the health dilemmas of a country unless the ethical and normative environment created by

economic and political processes are also taken into consideration (Savage & Benatar 1990:148). Moreover, the more general the public health policy issue becomes, and, thus, the broader its cultural significance, the less subject it becomes to empirical data and the greater the role played by ethical and value considerations (Weber 1949:56, tr. & ed. by Shils & Finch), for example, in the case of the overall aim with health services in 1977 as "...to promote the health of the population of the Republic of South Africa..." (Van der Merwe 1977:7).

5.2.1 Ethics

Ethics refers to morally correct action (Funk & Wagnalls, Dictionary), to rules of conduct (Fowler & Fowler 1952) and to the goodness or badness of the motives of particular actions (Chandler & Plano 1982:14). Ethics can be used in a specific sense to refer to the standards characteristic of a profession, or, more generally, "...any system of moral values held forth as meriting intrinsic obedience, and not on account of some purpose which obedience might incidentally serve" (Scruton 1982:156). Ethics, however, does not concern itself only with the behaviour and decisions of people but also with those things that they create such as institutions and policies which form part of the network of society. In this sense not only the ethical conduct of public officials and political office bearers have to be noted but also the importance of ethics for the institutions within which they act (Esterhuyse 1991:11).

Ethics can be explained by referring to its teleological and deontological implications. The former refers to concepts such as the good, the desirable, and happiness or well-being which concerns the ultimate and proper goals of human endeavour. The **telos**, in other words the goal or aim of government stands central to the attainment of such good and happiness. In Aristotle's **Politics** the **telos** of democracy is described as liberty, of oligarchy, wealth, of aristocracy, culture and right conduct, and of tyranny, self-preservation. Aristoteles rejected the dogma that changes and events occur in the world without any **telos** or overriding purpose although he did recognise that accidental events as a result of mechanistic causation could occur. All changes except accidents, therefore, were, according to Aristotle natural (Day & Chambers 1962:56,61). The latter (i.e. deontology) means that which is necessary and refers to concepts such as duty, correct conduct and moral responsibility which relate to the kinds of behaviour that may properly elicit moral approval (Scruton 1982:156).

Ethical teleologists regard the deontological concepts as subordinate concepts in that no behaviour may be considered right or worthy of moral approval unless it promotes the good or has desirable consequences. To justify a given act or behaviour on moral grounds it must be shown that it is conducive to the good or promotes human well-being. To the teleologists an act is only right when it is conducive to the good, because the terms "right conduct" means conduciveness to the good, in other words, the end must necessarily justify the means (Scruton 1982:157).

Ethical deontologists, on the other hand, hold that the concepts of correct conduct, duty and moral responsibility are logically independent of the teleological concepts. They maintain that an act or type of behaviour could be correct even if it were opposed to human well-being. The deontologists believe that most correct, moral conduct leads to the good, but admit that this is a generalisation to which there could be exceptions (Olsen 1967:92).

5.2.2 *Values and norms*

A political system is a system for achieving the authoritative allocation of values for a community (Easton 1967:21). The allocation of values has its foundation in political, cultural, demographic and welfare values and norms. According to Rip (1970:11-14) the culture anyone has as a member of a group he/she has acquired as a result of the process of socialisation. Values and norms are also part of this culture. As the person grows up in a specific society, certain values and norms that are institutionalised in that society, become internalised in that person i.e. they become part of his/her developing personality.

In modern Western societies there are certain general beliefs, for example, honesty, hard work, and the privacy and sanctity of the individual, i.e. imperatives dealing with what ought to be (Inkeles 1964:74; Rip 1970:11-14). When these general beliefs or imperatives (i.e. values) refer to specific situations with prescriptions and proscriptions as to how persons are expected to act, they become known as norms (Johnson

1960:8; Rip 1970:11-14). Thus: the value of honesty, when coupled with the specific situation of dealing with the property of others, becomes a norm that prescribes (ordains/order) that persons must care for it as if it were their own, and proscribe (forbids/prohibits) their stealing it (Rip 1970:11-12).

Public functionaries can never detach themselves from the value environment since they work within a society laden with values and norms. Decisions in the public sector requires not only facts but also values and norms, in fact, the existence and presence of values must be recognised in public administration (Marais 1979:6,7). When attempting to identify norms for public sector activities, it will be difficult to identify basic truths that will have the same relevance under all circumstances and in all political, economic, social, and even physical environments (Hanekom & Thornhill 1983:121).

Nevertheless, the point remains that in order to serve the dictates of a democracy, respect for community values and norms stand central to a consideration of guidelines within which public office bearers will have to operate.

5.3 External variables for public health policy implementation

The external variables referred to above are regarded as important in the accomplishment of policy implementation, thus also of public health policy implementation. The variables are, however, seldom regarded as

instrumental in the non-accomplishment, and even failure, of governmental functions and, consequently, also the public health policy implementation function. It is in both its positive and negative senses that the guidelines will be regarded as external variables for the purposes of this thesis.

5.3.1 Legislative direction

The guiding norm legislative direction lies in, and is set in motion, by the fact that administrative action is defined and authorised by the legislative institutions of a state, possessing authority to compel the members of the society, over which it has power, to act in certain ways. The ultimate ends that executive institutions pursue, for example, the promotion of the health standard of the inhabitants of the country are not of their own devising but are formed and expressed by the legislative institutions (Warner 1947:170).

The ends of all the actions of public institutions ultimately converge in the macro-objective known as the "general welfare". In democratic societies political office bearers attached to the legislative institutions at various levels of authority are the interpreters of the general welfare for the making and the implementation of public policy.

Public officials in a democratic state are, therefore, subordinate to the legislative institutions on the various government levels in a state (Roux 1971:179-80).

In the Union, and later, the Republic of South Africa, the legislative institutions can be identified at three government levels namely, Parliament at the central government level, provincial councils, up to 1986, on the provincial government level, and local councils on the local government level (South Africa Act, 1909; Republic of South Africa Constitution Act, 1961 (Act 32 of 1961); Republic of South Africa Constitution Act, 1983 (Act 110 of 1983); Provincial Government Act, 1986 (Act 69 of 1986))

The terms national, provincial and local refer to a geographical division of authority in the Union and the Republic of South Africa. Thus, legislative institutions within certain geographic areas are the sources of authority for action by political office bearers and public officials for the implementation of public policies.

For example, during the time of the Union of South Africa (1910-1961) the legislative authority at the central government level was vested in Parliament which consisted of the (British) sovereign, a Senate, and a House of Assembly. The legislative authority at the provincial government level consisted of a provincial council in each province consisting of the same number of members as were elected in the province for the House of Assembly, and municipal councils and divisional councils on the local government level (South Africa Act, 1909, Parts IV and V).

From the establishment of a Republic in 1961 in South Africa, the legislative authority at the central government level was vested in

Parliament consisting of the State President, a Senate and a House of Assembly. Apart from the introduction of a State President to replace the (British) sovereign, the composition of Parliament was a perpetuation of the position during the time of union. The provincial councils at regional government levels, as well as local authority councils at the local government level also continued to exist under the 1961 constitution (Republic of South Africa Constitution Act, 1961 (Act 32 of 1961), Parts V and VI).

At the time of the Republic of South Africa from 1983 the variable of legislative direction at the central government level was confirmed by Sections 30 and 34 of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983). Section 30 determines that the legislative authority of the Republic is vested in the State President and Parliament, which, as the sovereign legislative authority, shall have full power to make laws for peace, order and good government. Section 34 refers to the testing rights of the courts and the validity of acts of Parliament. In terms of section 34(2)(a) the Supreme Court shall be competent to inquire into and announce upon the question as to whether the procedures of the Constitution were complied with in connection with any law which was made by the State President and Parliament or by the State President and any House of Parliament. However, save for the testing right referred to immediately above, no court of law shall be competent to inquire into or pronounce upon the validity of an Act of Parliament (Section 34(3)).

At the provincial government level the 1983 Constitution made no separate entry for the provincial government level and referred to provincial councils only in passing (sections 95, 98). Provincial councils were abolished in 1986 in terms of the Provincial Government Act, 1986 (Act 69 of 1986). In terms of the said Act the Administrator can amend, repeal or substitute any provision of an ordinance on provincial affairs (section 14 (2)(a)(i-ii) Provincial Government Act, 1986 (Act 69 of 1986)) with the proviso that such a proclamation be issued only after it has been approved by a standing committee of Parliament described in section 64 of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983). The Administrator is therefore vested with a kind of legislative authority subject to the approval thereof by a standing committee, of the highest legislative authority.

Section 64 of the 1983 constitution defines a standing committee as a joint committee of the three Houses of Parliament which is established for the duration of a Parliament and is competent to perform its functions during the recess of Parliament as well. The section further provides that, apart from any other rules relating to Parliamentary committees made by each House internally, the joint rules and orders of the Houses must provide for at least one joint standing committee on general affairs. The joint rules and orders may also provide for political parties, including opposition parties, to be presented in such committees, and for the chairmanship, powers, decision-making, and other procedures of such committees.

Since Parliament (through the said standing committee) has the final say in proposals of the Administrator, such an Administrator is therefore vested with indirect legislative functions only.

At the local government level, local councils are **inter alia** responsible to adopt local by-laws on matters that are entrusted to them in terms of Acts of Parliament and Provincial Ordinances. An example of an Act of Parliament in terms of which local authorities can make by-laws is the Black Local Authorities Act, 1982 (Act 102 of 1982). This Act which has largely been based on local government principles for White local authorities espoused in the Local Government Ordinance, 1939 (Ordinance 17 of 1939) (**Debates** 1982: Cols 9610, 9619), makes provision for a variety of matters on which Black local authorities can legislate and thus provide legislative direction to its executive departments. Such matters are, **inter alia**, electricity (Government Notice R.2231 of 12 October 1984), public swimming pools (Government Notice R.1449 of 13 July 1984), recreation (Government Notice R.1450 of 13 July 1984), prevention of slums (Government Notice R.1253 of 22 June 1984), and provision of water (Government Notice R.1107 of 30 May 1984).

Being subordinate to the legislative institutions presupposes that political office bearers and public officials have to abide by legislation (which are the instruments of public policy - **supra**, item 2.2.2) of the legislative institution concerned.

The intentions of public policies may, however, differ markedly from the way in which policies are implemented and the social processes to which they give rise. In this way what has been a **de jure** policy statement, may not be realised **de facto**.

This state of affairs arises when compliance by the excecutive institutions with the policy decisions of the legislative institutions are compounded by the nature and contents of such policy, for example, changes in the needs and the actions of members of the community could make the existing decisions of the legislatures and implementation activities inappropriate (Cruywagen 1984:92-4). Kane-Berman (1990:371-79) illustrates this point by referring to what he terms the erosion of the policies of sport, social segregation, industry, property, residential segregation, and education. The policy of social segregation is a case in point. The Group Areas Act, 1966 (Act 36 of 1966) as one of the major apartheid policy laws prior to it being rescinded in 1991 had been eroded by means of a **de facto** residential desegregation which has been under way for ten to twelve years (Kane-Berman 1990:375). During 1987 and 1988 the said Act came under constant scrutiny because of existence of so-called "grey areas", i.e. White suburbs into which Black people had moved despite the prohibition contained in the Group Areas Act, 1966 (Act 36 of 1966). In fact, the "grey areas" became an issue in the general election among Whites in 1987. During this election the Conservative Party blamed the government for not evicting African, Coloured and Indian people who were unlawfully resident in White suburbs. The governments' reply was that in some such

areas, at least, evictions were not a practical possibility (**Race Relations Survey** 1987/88:478). The result was that the Free Settlement Areas Act, 1988 (Act 102 of 1988) was designed to provide for the proclamation of certain **de facto** racially mixed areas as official mixed areas (Kane-Berman 1990:375).

Thus, the legislative direction through the legislative institutions on whatever level of government is set in motion through various authoritative policy decisions in the form of legislation. Such legislation may, however, be **ex post facto** instruments that came about as a result of the needs and actions of the community.

Policy decisions become the legal imperative for executive purposes as soon as legislation is adopted in terms of such policy decisions (Cloete 1972:58). To what extent legislative direction influences the implementation of the health policy at the times of the Union and the Republic of South Africa, will be analysed in chapter 6.

5.3.2 Public accountabilty

The guiding norm public accountability is an essential and distinctive philosophy of democracies or in governments that strive towards democracy. In cases where governments gave little concern to this guiding factor, the control over political office bearers and public officials on behalf and in the interests of the citizens was seldom regarded as necessary. Governments must be accountable to someone besides

themselves because a government responsible only to its own conscience is not for long tolerable. (Hodgson 1969.242).

Public accountability is deemed an important guiding norm for public administration even to the extent that it is considered to be the main distinction between the public and private sectors (Greenwood & Wilson 1984:8; Keeling 1972:153). In other words, public institutions ought to be subject to external control and supervision, for example, ministers of state ought to be accountable to Parliament for their actions and the actions of the executive officials by the convention of collective and individual ministerial accountability from which private companies are relatively immune (Greenwood & Wilson 1984:8, 227-9).

It can be argued that, in a South African context, the tradition of public accountability had manifested itself because of the occurrence of actions of political office bearers and public officials that were contrary to government policy and legislation and the resultant appointments of commissions of inquiries to investigate such actions, for example the report of the **Kommissie van Ondersoek na Beweerde Onreëlmatighede in die Voormalige Departement van Inligting**, 1978, on the so-called "information affair". By the same token it can be argued that the acceptance of the tradition of public accountability by the South African government lies in and sets in motion actions that will uncover behaviour inconsistent with policy and legislation. The latter is taken to exist in the South African context since the non-compliance with policies and legislation does not nullify the existence of this tradition. Also, since 1914

political parties, in particular the National Party in all aspects of its organisation and its day-to-day activities undoubtedly came nearest to being a model of how responsible parties in a system of responsible party government ought to behave. The elected representative's accounting to the party organisation in regard to the implementation of the election mandate and also to Cabinet after coming into power as the government-of-the-day illustrates the existence of accountability as an external variable in a South African context (Kleynhans 1987:16).

The external variable, public accountability, is not of recent origin. During the times of Plato (427-347 BC), for example, the inhabitants of city-states assembled in a given place from time to time to decide on issues to be implemented by the persons authorised to do so (usually public officials selected by lot). The inhabitant's "...sharp interest in daily business..." was particularly evident in financial matters because Athenians were least prepared to trust "...aloof and unscrutinized bureaucrats" (Day & Mortimer 1962:182). The implementation of government policy in ancient Athens was coupled to the responsibilities of public officials for the strict application of the various rules, for example, public money had to be used in strict accordance with the annual financial appropriations. Non-compliance with budgetary prescriptions brought the guiding norm of public accountability into play. In Aristotle's study of the constitution of Athens public accountability is alluded to in Chapter 54 of the constitution in terms of the embezzlement of money, bribery, the misappropriation of money, and the penalties for such misdemeanors.

(**Aristotle's Constitution of Athens and Related Texts**, tr. and intro. by Von Fritz and Kapp 1950:128-29). In Aristotle's **Politics** (Book III, Chapter 11) reference is also made to the calling to account of the magistrates (**Aristotle's Politics**, tr. and intro. by Jowett and Lerner 1943:147).

The above approach to accountability required that rules had to be adhered to judiciously (**Aristotle's Constitution of Athens and Related Texts**, tr. and intro. by Von Fritz and Kapp 1950:128-29) and it implied that the measures introduced focussed mainly on regularity without considering the merits of a transaction (Hanekom & Thornhill 1983:185).

The requirement that political office bearers and public officials have to account for their actions and inactions when involved with public matters (for example public money) also re-appeared in contemporary government and administration (**Aristotle's Politics** tr. and intro. by Jowett and Lerner, 1943:16-7).

The principle of public accountability appeared in the development of contemporary democratic states. In a democratic state a government is a creation of the public that exists for and on behalf of the public. Those who govern are required to be accountable or responsible to those whom they govern. In the United Kingdom, for example, parliamentary supremacy emerged by the end of the seventeenth century, but it was not until the Reform Act of 1832 that the principle of the responsibility of the executive to Parliament was established. This meant, amongst other things, that the Reform Act of 1832 introduced the principle that

appointments to the civil service could no longer be determined by influence and patronage (Farnham & Mc Vicar 1982:24).

Although the principle of the responsibility of the executive to Parliament was introduced in 1832 in England, it did little to increase the representative character of Parliament. It was only in 1918 that general franchise, i.e. for all males over 21 and all women over 30 was granted in Britain (Mackintosh 1977:23).

South Africa inherited its political system from Britain. The principle of public accountability in South Africa has its origin in the establishment of a rudimentary form of public administration during the first British occupation (1795-1803) at the Cape. The first British occupation was, however, characterised as an autocratic form of government and to become truly public, the civil service and those that govern, had to be responsible to the people of the country. Responsibility to the people of the country, particularly regarding public finance came to the fore during the Batavian period (1803-1806) that followed on the first British occupation (Marais 1989:36,42; Marais 1985:11). During the Batavian period (1803-1806) Commissioner De Mist applied the principle of public responsibility in the administration of public finance at the Cape in that public officials were trained to work responsibly with public finances (Marais 1985:11).

It has been shown that the intrinsic correlation between government philosophy (in the form of public accountability) introduced by De Mist,

endured long after the formal institutions of the Batavian Period had been abolished and also appears in contemporary South African government and administration (Marais 1989:46. **passim**). Thus the principle of public accountability remains a valid principle in contemporary Republic of South Africa.

The reasons for existence of a government lies in the fact that it must **inter alia**, act in the interests of those that it serves. During the rendering of public services through the implementation of public health policies, the guiding norm public accountabilty will therefore also have to be considered (De Beer 1988:110). This consideration will be done in chapter 6.

5.3.3 Tenets of democracy

It had been shown that a reasonably responsive democracy (thus a democracy also responsive to public policy implementation) can exist only if at least eight guarantees are present, namely:

- freedom to form and join institutions;
- freedom of expression;
- right to vote;
- eligibility for public office;
- right of political leaders to compete for support and votes;
- alternative sources of information;
- free and fair elections; and

- institutions responsible for making public policies depend on votes and other expressions of preference (Dahl in Lijphart 1984:2)

In South African terms the most recent expression of the tenets of democracy is detailed in the State Presidents' manifesto for the new South Africa (**Manifesto** 1991). Manifestos serve as important vehicles through which political parties in South Africa formulate and, in the case of their being the government-of-the-day, implement their party policy (in the latter case as the policy of the government-of-the-day) (Kleynhans 1987:16). At this stage it is not the intention to elaborate upon the manifestos of South African governing political parties since 1910, but merely to illustrate what the contents of the tenets of democracy ought to be.

In terms of the 1991 manifesto the above gaurantees are contained in what can be referred to as the four P's, namely:

- participation: A free and democratic political system;
- progress: An equitable social system;
- prosperity: A Free and equitable economic system; and
- peace: Freedom and security for all (**Manifesto** 1991)

Such a proposed framework raises the question as to the tenets that were upheld for the implementation of public health policies prior to the the publication of the 1991 **Manifesto**.

The claim that public administration in the Republic of South Africa has always been conducted on the basis of the tenets of democracy (Cloete 1991:68) is, of course, incorrect and should rather be seen as having been conducted on the basis of a White (particularly Afrikaner) hegemony (Faure, Kriek, Labuschagne, Du P Louw & Venter 1988:ix; Esterhuyse no date:573), i.e. the governing process under a leader that takes account of secondary issues without sacrificing essential interests which serve the fundamental long-run interests of the (White) dominant group (Jessop 1982:148).

It has been stated that, for democratic tenets to be respected for public administrative purposes three requirements have to be met. Firstly, the activities of public authorities should be capable of being observed, investigated and judged. Secondly, those who have been involved in the observation, investigation and judgement of the activities of public authorities should have the right and freedom to express their views on the matter. Lastly, democracy allows the individual to obtain freedom of association (Cloete 1991:68). Thus, the statement that public administration in the Republic of South Africa has always been conducted on the basis of the tenets of democracy will therefore have to be reassessed in terms of the implementation of public health policy. Such a reassessment will be done in Chapter 6 by referring to **inter alia** party manifestos.

To ensure that the tenets of democracy will prevail, both the political office bearers and public officials will have to adhere to the rule of law (Cloete 1991:71).

Aristotle, in his **Politics**, was perhaps the first person to recognise that individual human judgement on cases of social conflict that came before decision-makers was not likely to produce equity and thus recommended that decision-makers should be no more than implementers of previously fixed rules to factual cases (Robertson 1987:180). In his **Politics** Aristotle wrote, for example, that "...laws, when good, should be supreme...true forms of government will of necessity have just laws, and perverted forms of government will have unjust laws" (**Politics**, Book III, Chapter 11). Following the idea of the supremacy of the law, the rule of law has come to be seen as a major contribution to equality and liberty (Robertson 1987:180).

The majority of contemporary jurists agree that the classic definition of the rule of law was formalised by Dicey (Faure **et.al.** 1988:77). Dicey's description of the **Rule of Law** in his **Introduction to the Study of the Law of the Constitution** (8th ed. 1915), posists:

- firstly, that "...no man is punishable or can be lawfully made to suffer in body or goods exept for a distinct breach of law established in the ordinary legal manner before the ordinary courts of the land";
- secondly, that "...no man is above the law, but (what is a different thing) that here every man, whatever be his rank or condition, is

subject to the ordinary law of the realm and amenable to the jurisdiction of the ordinary tribunals"; and

- Lastly, that "...the constitution is pervaded by the rule of law on the ground that the general principles of the constitution (as for example the right to personal liberty, or the right to public meeting) are as a result of judicial decisions determining the rights of private persons in particular cases brought before the courts..." (Dicey 1915, in Wiechers & Verloren van Themaat, 1967:122-3).

Although jurists have shown inconsistent practices in Britain where Dicey's rules on the rule of law were formulated (Wiechers & Verloren Van Themaat 1967:123), it is generally accepted that the main objective of the rule of law is to curb arbitrary governmental actions (Faure **et. al.** 1988:77).

For contemporary administrative purposes it can be accepted that the rule of law means that:

- executive institutions shall not be vested with such authority as would enable them to act arbitrarily and with unlimited personal discretion;
- the citizens shall enjoy equal treatment before the law and in the courts; and
- judgement shall be dispensed by impartial courts of law presided over by independent judges (Cloete 1991:70).

5.3.4 Fairness and Reasonableness

The legal principles **ubi eadem ratio ibi idem ius** (Like reason makes like law) and **cessante ratione legis cessat ipsa lex** (Reason is the soul of law and when the reason for any particular law ceases so does the law itself) (Warner 1947:15) concerns the making and upkeep of law within the boundaries of reason. To be reasonable (referring to a disposition), is to be endowed with reason (referring to a source of knowledge) or acting according to reason (**Chambers Twentieth Century Dictionary**). Thus, in a country where reason prevails in the making and implementation of public policy, the prevailing policies in a country ought to reflect the reason and reasonability that exist in its policy formulators (the political office bearers and high ranking public officials).

Public officials have to act within the dictates of reasonableness when implementing laws, including public health laws, of the public authorities (De Beer 1988:113). Thus, they are required to implement the laws formulated by the legislators in a reasonable fashion although their inclination concerning certain public issues may not be the same as those of the law-makers. A dilemma can thus be created in that public officials have to implement public policies to which they are not favourably inclined.

The guideline of fairness and reasonableness presupposes that public officials ought to go about their duties without discriminination, that they should act within the scope of their lawful authority and that, in exercising

their discretion, they should be balanced, honest and objective (De Beer 1988:113). These presuppositions attempt to gaurantee due process of law (procedural human rights).

Preservation of due process of law obliges political office bearers and public officials to afford people affected by governmental action a fair opportunity to get their views on official decisions and actions registered so that their interests are not overlooked or arbitrarily overridden by those in authority.

An analysis of the provisions of due process of law as it concerned the states of emergency in South Africa had shown that a great number of basic substantial and procedural rights had been abrogated, in that **inter alia**:

- the emergency regulations have limited the inherent powers of review of the South African courts; and
- the principle of parliamentary sovereignty has had the result that emergency legislation and administrative powers could not be tested (Olivier 1989:623).

The conclusion in the above mentioned analysis was that the emergency regulations had not been in accordance with the specific provisions as well as the general tenor of certain internationally accepted norms of due process and basic human rights documents, namely the **Leuven Declaration on Human Rights Relating to the Legal Process** and the

United Nations Draft Universal Declaration on the Independence of Justice (Olivier 1989:623). To what extent the variable of reasonableness was brought to bear in the implementation of public health policy will be analysed in chapter 6.

5.3.5 *Promotion of efficiency*

Efficiency also serves as an important maxim in governmental activities and therefore also public policy implementation (Gulick & Urwick 1937:191; Cloete 1987:83). Although effficiency as a technical term in the social sciences is regarded as of recent, i.e. twentieth century origin (Meyer 1957:69), it should be noted that the use of the term dates back to the time of ancient Greek city states. Aristotle, for example, noted that there exist four causes for the existence of any given thing, thus also governmental institutions, and explained these causes by referring to marble and the work of a sculptor, namely:

- the material cause of a statue, namely the marble;
- the formal cause of the statue, namely the pattern in the mind of the sculptor;
- the efficient cause, namely the sculptor who works with the marble; and
- the final cause, namely the finished statue as it was intended to be (Day and Chambers 1962:51).

The efficient cause has been described as the basic good in the science of Administration (Gulick & Urwick 1937:191-5). The elevation of the

efficiency criterion as the only guideline in public administration activities - the so-called "gospel of efficiency", can be attributed to the contributions of classical theorists such as Henri Fayol, Frederick Winslow Taylor, Luther Gulick and Lyndall Urwick, and J. D. Mooney (Gross 1964:119-48).

In Taylorian terms the notion of efficiency is that there is one best way to do a job and that such a best way could be measured accurately in the private sector by means of measurable standardised activities, particularly against monetary gains or losses (Henry 1986:112). The classical theorists proposed to rationalise institutional behaviour from the "bottom up" by creating and introducing changes in the performance of individual tasks in order to increase the performance of the larger structure (Scott 1981:64).

The fundamental aim of the private sector institutions, namely profit-making, renders such institutions to the measurement of efficiency in terms of losses and gains far greater than the measurement of efficiency in the public sector. The measurement of efficiency in the public sector is compounded by the fact that the ultimate aim of the public sector is the promotion of the relatively undefined general welfare and that in public institutions there are no criterion of efficiency other than the debatable directives of the political office bearers and the variable assessment of public opinion (Roux 1971:180). Political office bearers and public officials could, therefore, stray from stated public policies and in so doing forfeit the attainment of the objectives contained in such a policy.

Whenever efficiency in the public sector is examined, the focus invariably turns to the social responsibility of a government and the ways in which such a government's social responsibility programmes do indeed attain efficiency. The following examples illustrate the concern over social responsibilities and efficiency. During the period 1964-1986 the federal government of the United States of America expanded its role in the field of social policy (e.g. the combating of poverty and crime). This expansion was followed by a reaction based on the fact that poverty seemed as pervasive, and crime even seemed to have become more acute notwithstanding the federal government's commitment. The resulting mood of scepticism that followed (termed "new conservatism"- i.e. the rejection of the belief that government can improve social problems), led to an unwillingness to let the government spend public money without evidence that it would indeed improve social problems (Robertson 1987:97).

Concern with the effectiveness of governmental institutions in the United Kingdom, as was the case in the United States of America, has also sought to maintain a proper balance between the spending of public money and the welfare functions of the state (Robertson 1987:97).

Developments in the Netherlands since the 1970's showed a similarity with what happened in the United States of America and in the United Kingdom. During this time it became clear that government action did not increase in effectiveness in proportion to the growth of the civil service. The civil service had grown so large that it was increasingly preoccupied

with solving its own problems instead of those for which the various departmens were created (Breunese 1991:26). This led to an increasing awareness of "value for money" and "less but better" i.e. that the spending of public money be used in the most effective and efficient ways in terms of the functions that are supposed to be rendered by the civil service (Breunese, Interview: 1991).

The endeavour for a smaller and more effective civil service has also not escaped the South African situation. Ever since the Dutch East India Company came up with the idea in 1790, successive governments attempted to reduce the civil service and to make it more efficient. The British tried it in the Cape in 1820, and again in 1885, all to no avail. It was tried unsuccessfully at the formation of the Union of South Africa in 1910 (Marais 1991:87).

In the case of the Republic of South Africa, attempts were also made to make the civil service smaller and more efficient by means of the government's rationalisation programme. For example, on 28 August 1979, the then Cabinet approved a programme for the reform of the central public service which became known as the rationalisation programme (**White Paper** 1980). After his election on 28 September 1979, the then Prime Minister announced that the public administration during his term of office would be improved. Shortly thereafter a programme of organisational restructuring was finalised under the then Office of the Civil Service Commission (since 1 April 1980 this Office was renamed the Office of the Commission for Administration) (**White Paper** 1980:2). The objective

of the Programme of Rationalisation was to place the administrative system on a basis that would ensure that it would be able to function efficiently in any set of circumstances and would at all times be manned by an adequate and competent body of staff. This objective was subsequently followed by the implementation of three phases. The first phase dealt with the creation, abolition, transfer, changing of name, and the re-linking of certain departments and semi-state institutions. The second phase entailed the amalgamation of existing departments and the addition of an additional managerial level. The last phase involved the systematic transfer of functions and associated semi-state institutions between departments until each department had the functional content and link-up with semi-state institutions as approved by the Cabinet on 3 December 1979 (**White Paper** 1980).

Notwithstanding the rationalisation attempts since 1979, the scheme had failed. The duplications that came about as a result of the government's own and general affairs division of the rendering of public services, as well as the increased staff establishments involved, and increased inefficiency, were part of the reasons why it failed (Business Day, 20 May 1988). Also, the introduction of the Tricameral Parliamentary system adopted in terms of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983), practically dissolved the attempts towards rationalisation with the prolifiration of civil service departments with concommitant [sic! concomitant] coordination and organisational problems that ultimately led to inefficiency. Although the Republic of South Africa Constitution Act,

1983 (Act 110 of 1983) introduced changes in the political and governing systems, it did not change the statutory arrangement of group relationships, with the result that provision had to be made to render public services for the different race groups. There are presently (1991) for example 14 departments, TBVC States and homelands included, involved with agricultural matters of one or other kind (Van Niekerk, SABC, 23/10/1991).

The concepts of own and general affairs led to, apart from the Cabinet which covered the services that were previously rendered and that were regarded as general affairs, the creation of three Ministers' Councils each with its own administration. The Cabinet and each Ministers' Council were allocated certain functions in terms of what was listed (schedule 1 of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983)) as its own affairs in terms of section 14, and general affairs in terms of section 16 of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983).

Efficiency remains a much sought-after objective notwithstanding its failures in previous attempts. In a recent congress addressed by spokespersons of the major political parties all of them called for an efficient public service to deal with the requirements of a so-called "new South Africa" (Marais, Van Wyk & Ströh 1991:**passim**).

Efficiency in the public sector is difficult to quantify and qualify in terms of the accomplishment of aims, since the public sector mainly work with

such intangible aims as the promotion of the general welfare of the public, or the promotion of the health of the public. Moreover, efficiency in the public sector, in contrast to the private sector, cannot as easily be measured by material profit. The measurement is rather by public utility. Such limitations, however, do not absolve the public sector from the obligation to make a purposeful attempt to achieve efficiency (Gross 1964: Chapter 6, **passim**).

In attempting to establish instruments by which to determine the effective implementation of public health policy in the Union and the Republic of South Africa the following modalities can be identified, namely:

- coordination;
- specificity of standards of evaluation; and
- resources.

These modalities will be explained subsequently.

5.3.5.1 Coordination

Coordination is an administrative function aimed at the well-ordered combination and integration of individual or group activities in order to ensure the efficient achievement of the objectives of an institution (Cloete 1991:120; Fayol 1949:103; White 1929:69-73).

One of the dilemmas of public institutions is the coordination of actions of a variety of specialities that are involved in the rendering of a particular

service. The following problems to the efficient implementation of a public policy may arise when specialisation is allowed to continue without corrective steps being taken through the coordination function:

- a horizontal prolifiration of departments and functions;
- a vertical shift of specialised functions from lower to higher levels of government, or, conversely, an increase in the range of services provided by central departments; and
- a creation of parastatal agencies or boards to carry out particular tasks of the department concerned (Self 1977:80).

The analysis in chapter 7 attempts to determine whether the implementation of the public health policies in South Africa reflected these problems, i.e. whether a lack of coordination prevailed and led to inefficiency.

5.3.5.2 *Specificity of standards of evaluation*

Specificity of standards to be used in evaluating compliance to policies by the executive institutions is a second variable that need to be considered in public policy implementation attempts. A statement of intent, i.e. a goal or policy statement will accomplish little even if the clarity requirement is adhered to unless a measure against which to mark progress is also specified (Bullock & Lamb 1984:6).

For example if quantative standards for judging the adequacy of air pollution control are lacking merely by an admonition to "improve" air

quality, air quality can indeed be improved marginally and yet the air might remain hazardous to human health. The point is, to contribute towards effective implementation, evaluation ought to be replicable, i.e. policy outcomes ought to be affirmed or denied through pre-set measurable evaluation standards (Clifton & Dahms 1980:50).

5.3.5.3 Resources

Lack of resources not only hinders policy-making, it also limits the effective implementation of a policy in that if the personnel who are responsible for the implementation of policies lack the resources, policy-makers will be disappointed in the results (Edwards & Sharkansky 1978:12, 303).

Lack of resources is therefore no less important in the implementation stage than in the policy-making stage, a fact underscored during 1983 at a conference on the "Administrative realisation of political reform in the Republic of South Africa" during which the following topics were dealt with:

- personnel and the realisation of political reform;
- finance and the realisation of political reform; and
- control and the realisation of political reform (SAIPA 1983:Contents).

The importance of resources were also underscored by the Administrator of Transvaal during 1984 in an article in which he referred to what was

required for effective implementation after a policy has been made a law. They are:

- money may need to be made available through the annual estimates of expenditure;
- staff may need to be recruited and trained;
- work methods and procedures may have to be devised;
- organisational arrangements could be neccessary; and
- control measures may have to be instituted so as to see that the policy objectives are indeed being pursued (Cruywagen 1984:94).

Since the contribution of resources to the effective implementation of public policies has already been subject to scientific investigation by the Commision for Administration (see **Addendum 1**), it will not be repeated in this thesis.

5.4 Conclusion

Public policy implementation does not occur in an environment devoid of external influences. Certain external variables determine the success, or not, of public policy implementation. In the Republic of South Africa certain maxims or normative guidelines can be identified that can serve as external variables which influence the public policy implementation process. They are the guidelines of legislative direction, of public accountability, of tenets of democracy, of reasonableness and fairness, and of efficiency.

The first guideline, namely, legislative direction, holds that the executive actions of a government are defined and authorised by the legislative process in a state, in other words, executive action is the result of the policies adopted through the legislative process. The adoption of public policies is institutionalised in legislative forums. In the Republic of South Africa, this institutionalisation is formalised in the legislative institutions on the three government levels, namely, central, provincial, and local authority levels.

The second external variable, namely, public accountability holds that political office bearers and public officials are accountable to the legislatures who possess authority on behalf of the electorate. For administrative purposes, public accountability can be upheld:

- by legislatures;
- through organisational arrangements; and
- through work procedures.

The third external variable in the implementation of public policies is known as the tenets of democracy. The upholding of the tenets of democracy can be measured against the following:

- actions of public authorities should be capable of being observed;
- the right and freedom of the public to express their views on public matters; and
- freedom of association.

The penultimate external variable covers the dictum of reasonableness. The guideline of reasonableness presupposes that public officials ought to go about their duties without discrimination, that they should act within the scope of their lawful authority and that, in exercising their discretion they should be balanced, honest and objective.

These presuppositions would afford people affected by governmental action a fair opportunity and guard against their interests not being overlooked or arbitrarily overridden by those in authority.

The fifth, and last, external variable is the requirement of efficiency. Efficiency can be enhanced by referring to communication, specificity of standards of evaluation, and resources.

The variables espoused in this chapter are commonly regarded as of importance in public administration and, consequently, in public policy implementation. To what extent, if any, they can be seen to have been applied, will be analysed in Chapters 6 and 7 by referring to the South African public health policy.

CHAPTER 6

LEGISLATIVE DIRECTION, PUBLIC ACCOUNTABILITY, TENETS OF DEMOCRACY AND REASONABLENESS IN THE IMPLEMENTATION OF HEALTH POLICY

6.1 Introduction

An analysis of the application of the external variables identified in Chapter 5 can be effected in two ways for the purpose of this chapter. Firstly, the implementation of a particular public policy or policies can be described and in the process of such a description the particular external variable or variables that become salient as a result of the unfolding description of such a policy or policies can be identified and analised. Thus, the implementation of the public policy concerned becomes the frame of reference for the identification and analysis of the external variables implied in such a policy. Secondly, each external variable as identified in chapter 5 can be used separately to serve as a frame of reference to analyse the implementation of a particular public policy or policies.

For the sake of an overall analysis of public health policy implementation and for the purpose of predicting the shortcomings of such implementation activities in terms of the applicability of external variables, the latter mode of analysis will be used. The external variables that were

identified, are legislative direction, public accountability, tenets of democracy, reasonableness, and efficiency.

For the purpose of this chapter, the variables legislative direction, public accountability, tenets of democracy, and reasonableness, can be grouped together. Such a grouping is made possible by the fact that legislative direction is the result of the political ideology pursued by the ruling political party(ies). In the case of a democratic ideology, legislative direction ought to be based on the tenets of democracy. Public accountability is one of the characteristics of a democratic form of government (Cloete 1991:57-70). Reasonableness is one of the variables emanating from community values and derives from the premise that public institutions and officials should promote the welfare of the community (Cloete 1991:70).

Since the ways in which public health policy had been implemented in South-Africa depends on the time-frame within which it took place, this chapter commences with a statement of the time scale covered by this thesis. In order to analyse the external variables, the functional organisation adopted for the making and implementation of public health policies will also be stated.

6.2 Time-scale covered by the South African health policy

As will be gleaned from the analysis, the time scale commences with the constitutional position of South Africa as from unification in 1910 and then

continues with the constitutional dispensations of 1961 and 1983 and up to 1990.

6.3 Functional organisation attending to public health matters

The functional organisation for the making and implementation of public health policies at the central, provincial and local government levels can be described in terms of the two main Acts that dealt with public health matters from 1919 to 1992, namely, the Public Health Act, 1919 (Act 36 of 1919) (and amendments to it) and the Health Act, 1977 (Act 63 of 1977) (and amendments to it).

6.3.1 Functional organisation: Public Health Act, 1919 (Act 36 of 1919)

The Public Health Act, 1919 (Act 36 of 1919), or to give it its full provenance, Act to Make Provision for the Public Health, 1919, made provision for the division of functions attending to public health matters at the central, provincial, and local government levels.

6.3.1.1 Central government level

The public health functions at central government level in terms of the Public Health Act, 1919 (Act 36 of 1919) were allocated to a Department of Health and a Council of Public Health which became the National Health Council in 1946 in terms of the Public Health Amendment Act, 1946 (Act 51 of 1946). The said Public Health Amendment Act also created a Central Health Services and Hospitals Coordinating Council in 1946.

6.3.1.1.1 Department of Health

In terms of section 2 of the Public Health Act, 1919 (Act 36 of 1919) a Department of Health had to be established which had to be under the control of a Minister and in respect of which there had to be a portfolio of health.

In terms of section 3 of the said Act, the functions of the Union Department of Health were defined as follows:

- to prevent or guard against the introduction of infectious disease into the union from outside;
- to promote public health and to prevent, limit or suppress infectious or preventable disease within the union;
- to advise and assist provincial administrations and local authorities in regard to public health matters;
- to promote and carry out research in regard to the prevention and treatment of human diseases;
- to publish reports and statistical matters relating to public health;
- to assist the National Health Council in collecting reports, statistics and other information it may require; and
- to publish information regarding health matters in the union and epidemic disease in other countries as the interests of the country may require.

In addition to these duties, the Department of Health had from time to time been assigned, or has adopted, more comprehensive functions in regard to public health. These functions included: the control of district surgeons and port health; the control of mental illness, leprosy, tuberculosis, venereal disease, and formidable epidemic disease hospitals; field work against plague, typhus and malaria; the establishment of laboratories; and, the establishment of health centres (sections 3 (1) and 3 (2); Cluver 1949:318-9)

6.3.1.1.2 Council of Public Health/National Health Council

The Council of Public Health consisted of the minister (as chairman), the chief health officer, and seven persons (not being officers in the public service) who were appointed by the Governor-General. The functions of the Council of Public Health were to advise the minister and the Department of Public Health on the functions of the department (**supra** 6.3.1.1.1). Up to the adoption of the Public Health Amendment Act, 1946 (Act 51 of 1946) no provision was made in the original Act, or amendments thereto, of a race classification concerning its membership.

Section 4 of the Public Health Act, 1919 (Act 36 of 1919) as amended by the Public Health Amendment Act, 1946 (Act 51 of 1946) described the constitution and functions of the National Health Council which replaced the Council of Public Health. The amendment Act of 1946 specifically determined that the members of the National Health Council had to consist of European members only (section 4.5).

In terms of the policy-making and implementation models described earlier (**supra** chapters 3 and 4), the National Health Council can be regarded as having subscribed to the elite policy-making model (only European members - a White hegemone elite - had the authority to make public health policy) and the top-down model of public policy implementation (the authority for the implementation of public health policy rested with Parliament within a unitary state which traditionally favours a top-down approach to public policy implementation).

Apart from eight **ex officio** and thirteen elected members, the Council also consisted of members of professional associations (See Addendum 2) and European representatives for the Native, Coloured and Indian populations of the country (section 4(d), Act 51 of 1946). The said Act also made provision for the establishment of committees of the National Health Council, and in respect of these committees there existed no colour bar (Brookes 1947:4).

It must be mentioned that section 35 of the South Africa Act, 1909, determined that the names of Coloured voters in the Cape were placed on the same voter's role as the Whites. The composition of the National Health Council in terms of section 4(d) of Act 51 of 1946 as it pertained to a European representative for the Coloured population of South Africa was, however, not determined by an election in terms of the constitution.

Provision was also made for one representative of the executive committee of each provincial council (section 4(e), Act 51 of 1946). In

terms of the South Africa Act, 1909 (sections 34, 44, 71, and 78) members of the provincial council's executive committee had to consist of British subjects of European descent.

These arrangements perpetuated the elite model of public policy-making in that the authority of the white elite (with the exception of the franchise for the Coloured voters in the Cape) was enshrined in the South Africa Act, 1909, and the Public Health Amendment Act, 1946 (Act 51 of 1946). The fact that the National Health Council also consisted of members of professional associations subscribed to the group model of public policy-making but within the dominant elite/mass model.

The functions of the National Health Council had been to advise and assist the Minister and the Administrator of each Province in the planning and direction of health services and, accordingly, had to:

- examine reports concerning health matters published from time to time by the Department of Health, provincial Administrations, local authorities or other public authorities;
- call for and examine reports and statistics relating to any aspect of the functions of the Department of Health: and
- require the submission to it by the Department of Health either verbally or in writing of such supplementary information as it may require from time to time (section 10(a)-(c), Act 36 of 1919).

6.3.1.1.3 Central Health Services and Hospitals Coordinating Council

A Central Health Services and Hospitals Coordinating Council which had since 1920 been established administratively (Cluver 1949:319) was given statutory recognition in terms of section 4 of the Public Health Amendment Act, 1946 (Act 51 of 1946).

The Central Health Services and Hospitals Coordinating Council had to be established simultaneously with the National Health Council established in terms of section 4 of the Public Health Amendment Act, 1948 (Act 51 of 1946) and had to consist of eight members, namely:

- the Minister as chairman;
- the Chief Health Officer or his nominee;
- two members appointed by the Governor-General at least one of whom had to be a member of the medical, dental or nursing profession; and
- one member appointed by the executive committee of each province.

The Central Health Services and Hospitals Coordinating Council, similar to the National Health Council, reflected the elite/mass policy-making model and the top-down policy implementation model.

The establishment of the Coordinating Council, as its name suggested, was to achieve the establishment of sound coordination through effective correlation and coordination of hospital and all other personal health in the union, and to facilitate and expedite the collaboration between the union government and the provincial Administrations to the general

benefit of the community (section 4bis (2), Act 36 of 1919). It will be indicated subsequently (**infra** chapter 7) that, notwithstanding these laudable objectives, the coordination of health services for the country remained a problem up to the 1970's and even continued after that.

6.3.1.2 Provincial government level

Since unification the provincial councils were vested with the authority to establish, maintain, and manage hospitals and charitable institutions in terms of the South Africa Act, 1909, (section 85 (v))

Section 8 (1) to (3) of the Public Health Act, 1919 (Act 36 of 1919) (as amended) provided that the Administrator of any province may, by proclamation, be declared the local authority in respect of any area in the province not being within the district of any existing local authority and to exercise all or any of the functions conferred on local authorities. Thus, public health functions could be added to the functions prescribed in the South Africa Act, 1909.

6.3.1.3 Local government level

Section 7 of the Public Health Act, 1919 (Act 36 of 1919) (as amended), which defined local authorities, required that, unless otherwise provided, the Act shall be implemented by local authorities. Section 10 defined the duties of local authorities. In terms of this section they were required to take all lawful, necessary and reasonably practical measures for dealing with or preventing the outbreak of preventable disease, and to promote

the public health. In cases of failure or refusal by a local authority to exercise the powers or perform the duties devolved upon it under any act, thus endangering the public health, the administrator of the province, in consultation with the Chief Health Officer may call upon such a local authority to perform its duties. Should the local authority fail to comply, the administrator had the authority to exercise the authority or perform the duties necessary to remedy any matter endangering the public health, and recover the cost from the defaulting local authority.

6.3.2 Functional organisation: Health Act, 1977 (Act 63 of 1977)

The Health Act, 1977 (Act 63 of 1977) also made provision for the division of functions attending public health matters at the central, provincial and local government levels.

6.3.2.1 Central government level

The chief officer of the Department of Health is the Secretary for Health (renamed the Director-General for Health in terms of the Health Amendment Act, 1984 (Act 2 of 1984), who is a registered medical practitioner. The Director-General is also the chief accounting officer of the Department and accountable to the Select Committee on Public Accounts of the House of Assembly (The Health of the People, 1977:20). In terms of section 14 of the Health Act, 1977 (Act 63 of 1977), the Department of Health (in turn renamed the Department of Health, Welfare and Pensions in terms of the Health Amendment Act, 1981 (Act 33 of 1981), Department of Health and Welfare in terms of the Health Amendment Act,

1984 (Act 2 of 1984), and Department of National Health and Population Development in terms of the National Policy for Health Act, 1990 (Act 116 of 1990) is responsible for the coordination of the health services of the Republic of South Africa; to take steps to establish a national health laboratory service; to take steps for the promotion of a safe and healthy environment; to promote family planning; to provide facilities for, and to undertake, research in connection with health matters; to provide services in connection with the procurement or evaluation of evidence of a medical nature with a view to legal proceedings; and to perform such other functions as may be asigned to it by the Minister.

In terms of section 2 of the Act, a Health Matters Advisory Committee was established. Its functions (section 3) were to investigate, consider and make recommendations to the Minister in regard to the functions of the National Health Policy Council. The National Health Policy Council was established in term of section 10 of the Act with functions to formulate a national policy for the rendering of health services by the central, provincial and local government levels (section 12). The National Health Policy Council was also responsible for particular coordination functions, namely coordination of the functions rendered by the health authorities on the three government levels as well as the coordination of the training of health services personnel (section 12). It will be shown subsequently (**infra** chapter 7) that notwithstanding these particular coordination functions, serious coordination problems were brought to light by the

various commissions and committees who conducted investigations into the rendering of health services for South Africa from 1924 up to 1986.

In terms of section 20 (1) of the National Policy for Health Act, 1990 (Act 116 of 1990, sections 4 and 14), the National Health Matters Advisory Committee was replaced by the Health Matters Committee, and the National Health Policy Council became the Health Policy Council.

6.3.2.2 Provincial government level

The functions of provincial administrations in terms of section 16 of the Health Act, 1977 (Act 63 of 1977) were to provide hospital facilities and services; to provide ambulance services; to provide facilities for the treatment of patients suffering from acute mental illness; to provide facilities for the teatment of out-patients; to provide and maintain maternity homes and services; to provide personal health services; to coordinate the aforementioned services; and to perform any other function assigned to it by the Minister.

6.3.2.3 Local government level

In terms of section 20 (a)-(d) of the Health Act, 1977 (Act 63 of 1977) local authorities were to take all lawful, necessary and reasonably practical measures to maintain the hygiene of its district; to prevent the pollution of water; to render services for the prevention of communicable diseases; to promote the health of persons; the rehabilitation in the community of persons cured of any medical condition; and to coordinate such services

with due regard to similar services rendered by health institutions on the central and provincial government levels.

6.4 Legislative direction and health policy implementation 1910-1961

Although all the governments since the **Verenigde Oost Indiese Companje** (1652-1795) had had health policies of one or other kind, the first signs of a national health policy in a South African context came into existence with the adoption of the Public Health Act, 1919, (Act 36 of 1919). For this reason the subsequent analysis will commence with the reasons that led up to the adoption, by the union government, of a health policy in the form of the Public Health Act 1919 (36 of 1919) and subsequent health policies up to 1990.

6.4.1 Unification and health policy implementation

With the bringing together into unification of the four British colonial governments in South Africa, namely the Cape of Good Hope, the Orange River Colony, the Transvaal, and Natal in 1910 an ommission in the unification attempt becomes evident. This ommission concerns the unification of a health policy for the Union of South Africa. In order to explain the circumstances under which this ommission ocurred, reference will be made to the National Convention (1908-1909) that led to the establishment of the four colonial governments into a single political entity, namely, the Union of South Africa, and the way in which legislative

direction, public accountability, the tenets of democracy and reasonableness influenced the implementation of public health policy.

6.4.2 National Convention and the South Africa Act, 1909 and health policy implementation

The National Convention who proposed unification, gave only incidental reference to the health of the inhabitants of the country whose political future it was deciding (Cluver 1949:317).

In the Minutes of Proceedings of the Convention the only reference to health was the motion, as amended, put and agreed to, namely "...the establishment, maintenance and management of hospitals and charitable institutions" (**Minutes of Proceedings**, 1911:81). This agreed to motion was later adopted in the South Africa Act, 1909, as one of the functions of the to be established provincial councils.

Not even the diary of a member of the Convention, Sir Edgar Walton, **The Inner History of the National Convention of South Africa**, together with a Memorandum by Mr Gys R. Hofmeyer, one of the Secretaries to the Convention, made mention of matters concerning public health that were raised during the deliberations of the Convention (Walton 1912: **passim**). This hiatus regarding health matters was also reflected in the Act that brought unification. The cases of incidental references in the South Africa Act, 1909, were those of assigning to the provincial councils the administration of all local government matters (section 85(vi)) and of

hospitals and charitable institutions (section 85(v)). Elementary education (i.e. education other than higher education) (section 84(iii)), was also assigned to the provincial councils, which had been interpreted as school medical inspection and hygiene (**Official Year Book, No. 7-1924**, 1925:184).

The term "public health" was not mentioned in the South Africa Act, 1909. It was merely considered to be a matter under the control of the union government in the sense that after the constitution of the union, the implementation of public health matters was carried on by the Department of the Interior, with an Advisory Medical Officer of Health for the union at Pretoria, and three Assistant Health Officers, with headquarters at Cape Town, Durban, and Bloemfontein respectively (**Official Year Book, No. 4-1921** 1921:232).

Nine years since unification no steps had been taken by the legislature towards the creation of a central Department of Health. Also, the functions of the Department of Health that came into being in 1920 had never been properly defined by the legislature (**Report: Influenza Epidemic Commission**, 1919:12).

In terms of section 19 of the South Africa Act, 1909, the legislative authority of the Union was vested in the Parliament of the union, which consisted of the (British) sovereign, a Senate, and a House of Assembly. Up to the date of the first general election on 15 September 1910 (three and a half months after becoming a union on 31 May 1910), no legislature as envisaged in the South Africa Act, 1909 existed in the union. During

this time the governing of the country was vested in the sovereign and was administered by a Governor-General appointed by the sovereign as his representative (sections 8,9). The Governor-General had to exercise in the union such authority and functions assigned to him by the sovereign (Section 9). Thus, in practice, the legislative authority of the Union of South Africa was vested in the sovereign only.

The Governor-General's first task was to appoint a Prime Minister to govern the union. The British government was of the opinion that Louis Botha, at the time the head of the Transvaal government, was to be appointed as Prime Minister of the union. After his appointment as Prime Minister by the Governor-General, Louis Botha selected his cabinet from the ruling parties in the four colonial governments.

6.4.3 Public health policy implementation and party political manifestos

The manifestos of the political parties that took part in general elections from 1910 to 1961 reflected a lack of concern for as well as piecemeal references to public health matters.

6.4.3.1 Lack of concern for public health

An analysis of the manifestos of three of the political parties that took part in the 15 September, 1910 general election gives an indication of the importance or not of the future state of the health of the people and the way in which each party sought to deal with it after becoming the ruling party of the proposed legislature on winning the general election.

The De Zuid-Afrikaanse Nationale Partij (ZAP) that won the election with sixty seven seats, undertook in its election manifesto eleven objectives and principles which the party desired to implement in the Union of South Africa. None of these objectives and principles dealt with how the party envisaged its involvement in the health issues of the country. The objectives dealt with aspects such as the native question (in the terms of the manifesto: "...the fair and sympathetic treatment of the coloured races in a broad and liberal spirit") immigration, education, labour, national defence, and the development and implementation of railway, mining and agricultural policies (**Manifesto** 1910). As far as railway, mining, and agricultural policies were concerned, this was indeed what happened when the party formed a government after the first general election in 1910 (**Debates**, 1910: **passim**).

The programme of the contesting Unionist Party of South Africa and the manifesto of the South African Labour Party, similarly made no mention of how they proposed to deal with the health problems of the country should they become the ruling party in the legislature. For example, matters that were of concern to them dealt, in the case of the Unionist Party of South Africa, with an impartial public service, education, native policy (in the terms of the programme: "...the treatment of questions relating to natives in accordance with the degree of civilization attained by them"), excise, agriculture, and industrial development (**Programme**, 1910). In the case of the South African Labour Party, proposals were made attending to education, labour, women rights, defence, mining,

agriculture, native policy (e.g. the separate representation of Blacks in a separate Advisory Council), and asiatics (namely, the prohibition of Asiatic immigration combined with state aided Asiatic emigration (**Manifesto**, 1910).

Thus, matters attending to public health implementation and the state of health of the people of the newly formed union, received no attention by the parties that contested the general election and it was seemingly not a priority for the parties referred to. The situation of how to deal with the health issues of the country was therefore in a state of limbo as far as the political parties sought to deal with the problems of the country once having gained the majority and having become the government-of-the-day in the legislature. The only inference that can be made from the above observation is that the union legislature, once constituted, did not envisage to deal with health matters as a priority and that it would continue with the implementation of pre-union health policies that was suited for the individual colonial governments and not for a Union.

This indeed materialised as can be gleaned from the proceedings of the First Session of the First Parliament of the Union of South Africa. In the Governor-General's opening speech to both Houses of Parliament on Friday, November 4, 1910, he stressed that the policies of the pre-Union colonies differed materially in many important respects and that, sooner or later, it would be necessary, by alteration and consolidation, to substitute uniform policies that had to be implemented in the whole union. Among the measures that were to be submitted to the Houses of

Parliament for the continuation of the implementation of services in the union, were Bills dealing with Estimates of Revenue and Expenditure, the Audit, Naturalisation, Railways and Harbours, Posts and Telegraphs, Immigration, and Stock and Plant Diseases (**Debates**, 1910: Col. 11,12).

Public health was conspicuous in its absence when the newly appointed Prime Minister, at the same date, gave notice to the House of Assembly of a number of Bills of priority to carry unification into practice. Amongst these measures, but excluding public health, were those dealing with what the Governor-General had referred to in his opening speech, namely Bills dealing with Estimates of Revenue and expenditure, the Audit, Naturalisation, Railways and Harbours, Posts and Telegraphs, immigration, and Stock and Plant Diseases (**Debates**, 1910: Col. 19,20).

The creation of a separate portfolio of Public Health for the implementation of health policies was not considered a priority. On being asked in the House of Assembly whether, in consideration of the importance of the health of the people of the union, the government will advise the appointment of a Minister holding the Portfolio of Public Health, the Minister of Interior replied that an appointment was not necessary because matters of public health could be dealt with adequately in the Department of Interior. The Minister's reply elicited laughter from the members of the house (**Debates**, 1910: Col.30).

The reversed institutionalised model of public policy-making and implementation processes referred to earlier (**supra**, chapter 3) is evident

in this case. Public health for the union according to the Minister had been institutionalised in the Department of Interior and no need existed to establish a department solely for the purpose of rendering a national health service. Such a service could be rendered as effectively by the existing Department of Interior.

During the years 1910-1911 the month of March 1911 (twelve months after the formal opening of Parliament by Proclamation on October 31, 1910), can be considered an important point in the development of a national health service because it was the first attempt by the union legislature to embark upon the adoption of a Public Health Acts Amendment Bill, 1911 to serve the interests of the Union (**Debates**, 1910: Cols. 1511, 1724).

On the Minister of Interior's moving of the Second Reading of the Public Health Acts Amendment Bill, 1911, he stated that it was a very short and simple Bill which contained only two provisions, namely, one providing for the appointment of an Officer of Health for the union, and the other making provision for certain measures which may become necessary in the case of a large outbreak of an epidemic in the country. No mention was made by the Minister of the establishement of a separate portfolio for public health. This motivation by the Minister of Interior also elicited laughter from the members of the House of Assembly (**Debates**, 1910: Col. 1724).

On the grounds of various objections to the Bill, **inter alia** that it was not a well thought out piece of legislation, that it was an apology for a Health Bill, that animal diseases were catered for more extensively in Acts that

were already adopted than that of human beings in the proposed Bill, and that the introduction of the Bill was crude and superfluous and had not taken proper cognisance of the health circumstances at the time, the Bill was negatived at the Second Reading and was not reached at the Committee stage (**Debates**, 1910: Cols. 1725, 1726, 1729, 1731, 2942).

The situation of a reversed institutionalist policy model thus remained.

During the years 1911-1913 the most important enactments dealt with were agriculture (**Debates**, 1910-1911: Cols. 968, 989, 995) defence (**Debates** 1912: Cols. 619, 659, 741, 755), railways (**Debates** 1910-1911: Cols.2831, 2843, 2845) and Black land ownership (**Debates**, 1913: Cols. 2270, 2439, 4482, 2530, 2825).

A comprehensive consolidating and amending Public Health Bill, 1913, designed to replace the separate public health legislation of the provinces was drafted in 1913. The draft Bill was submitted to local authorities for their information and comments in the following year (1914), but owing to the First World War (1914-1919), it was not proceeded with. Owing to the indefiniteness of the South Africa Act, 1909 concerning public health matters, the different provincial administrations proceeded on lines in the rendition of health services that were divergent in certain respects (**Official Year Book, No. 7-1924** 1925 :184). For example, concerning the registration of births and deaths a different series of laws were in force in each of the provinces. It was recognised at the time of the Influenza epidemic (1918) that it was desirable to introduce a uniform system of

registration throughout the union, but it was not accomplished at the time. Although the registration of births and deaths of Europeans could have been regarded as reliable throughout the union, the situation amongst Blacks was "...a matter of great difficulty" (**Official Year Book, No. 4-1921** 1921:175).

During the October, 1915 general election which was contested by De Zuid-Afrikaanse Nationale Partij (54 seats won), the Unionist Party (40 seats won), the National Party (27 seats won), the South African Labour Party (4 seats won), and the Independents (5 seats won), no mention was made by the contesting political parties of whom manifestos could be traced, of public health matters as a priority on which the particular party sought to govern the country after having won the election. In fact, public health was not even mentioned by any one of the parties. The objectives of the various parties focussed on aspects such as amnesty of political detainees, defence, agriculture, industries, the poor-White issue, martial law, education, Black labour issues, language issues, financing, provincial councils and local authorities (**Redevoeringen**, Speciale Kongres van de ZAP; **Manifest en programma van Aktie**, Nationale Partij van de Kaap Provincie; **Volledig Verslag** van het Kongres van de Nationale Partij van Transvaal; **Die Hertzogtoesprake** Deel 3; **Manifes**, van die Suid-Afrikaanse Arbeids Partij; **Speeches** delivered by General L Botha and Ministers at the Zuid-Afrikaanse Partij Special Congress at Bloemfontein; **Manifesto**, The National Party of the Cape Province; and **Manifesto**, S A Labour Party).

6.4.3.2 Piecemeal references to public health

The manifestos of the parties that contested the 1920 general election gave no direct indication as to how the party sought to deal with the health problems of the inhabitants of the country. Only the Unionist Party referred in passing to the Public Health Act, 1919 (Act 36 of 1919) as being an instrument that its members helped to place on the statute book (**Manifesto**, Unionist Party of South Africa, 1920). Similarly, public health did not figure as a priority during the 1921 elections that came about as a result of the indecisiveness of the 1920 election (i.e. the 1920 election failed to give any party a parliamentary majority). The adoption of the Public Health Act, 1919, as a result of the influenza epidemic of 1918 was seemingly regarded as a one-off issue that would meet the needs of the inhabitants of the country.

From 1921, general elections were held on 17 June 1924, 17 June 1929, 17 May 1933, 18 May 1938, 7 July 1943, 26 May 1948, 15 April 1953, 16 April 1958, and 18 October 1961 (Kleynhans 1987:ix). A perusal of the manifestos that had been available for the parties that took part in the elections provide the following facts concerning the parties that undertook to focus **inter alia** on the implementation of a public health policy once they won the majority of seats in Parliament. From 1921 to 1938, the Labour Party proposed a national cost-free system of state health services during the 1938 elections with particular emphasis on a national feeding system and a state medical service for all the inhabitants of the country. This proposal was contained under the heading "Public Health"

(**Manifesto**, 1938:3). Also, the election manifesto of the National Party for the same year (1938) for the first time since its inception, referred to health matters in that the party undertook to bring about an enlarged and better coordinated medical service for the nation (the word "nation" was not qualified in the manifesto), including district-nursing, the training of sufficient number of nurses, the prevention of malnutrition, and insurance against illness and physical disability. These undertakings were not entered under a separate public health heading but hidden under the heading: "The Party Will Take Steps To Bring About" (**Manifesto**, 1938:2).

During the 1948 and the 1953 general election only the Labour Party refered to public health matters in a Manifesto. In the 1953 Manifesto of the Labour Party the implementation of the recommendations of the Gluckman commission was propagated (**Manifesto** 1953:1). In a Report on the Colour issue of the Herenigde Nasionale Party mention was made of the betterment of the state of health of the Coloured people during the 1948 election (**Verslag, circa** 1984:5) The Colour Policy of the National Party also referred, in passing, to rendition of health and welfare services (**National Party's Colour Policy, Circa** 1948:2).

From 1953 to 1961 public health matters were referred to only scantily by the United Party (**Manifestos, Circa** 1953), and not at all by the National Party (**Manifestos, Circa** 1953, 1958, 1961 **passim**), who, since 1948, was the party with the majority in Parliament, and therefore also the government-of-the-day. Clearly, public health was not a priority at the time for the National Party, notwithstanding the fact that in its election

Manifesto of 1953 the statement was unequivocally made that "For the people it has therefore become a choice between policy and lack of policy, direction or lack of direction..." (**Manifesto**, 1953:3).

This lack of policy and lack of direction was particularly illustrated in the case of public health policy. The fact that the political parties referred to sought to gain the majority in Parliament on issues other than public health, also had to precipitate in the legislative direction forthcoming from Parliament. This, in turn, determine the manner in which health policy is implemented under circumstances where it is needed. In other words, prior to the implementation of a public health policy it may already have been compromised (i.e. exposed to risk of failure) due to a lack of legislative direction. In the case of public health policy this was no better illustrated than during the outbreak of the Influenza epidemic in 1918.

6.4.4 Health policy implementation and the Influenza epidemic, 1918

The fact that the state of health of the inhabitants of a country can be as important to the future of the country as is the state of political development was brought forcibly home to the legislators of the union by the single, most important phenomenon, namely, the influenza epidemic of 1918.

To the inhabitants of the Union of South Africa of all colours and creeds (infectious diseases show no respect whatsoever for constitutional boundaries and/or racial and cultural differences), the result of the lack

of legislative direction to deal with public health matters, was devastating. To the inhabitants of a country who were still in a recovery phase after the Anglo-Boer War (1899-1902), the 1913 miners' strikes and riots at the Witwatersrand which continued into 1914 and as a result of which martial law was proclaimed, the First World War (1914-1919) for the purposes of which the defence of South Africa was undertaken by the union government, and the outbreak and the suppression of the Rebellion in 1914 (**Official Year Book, No.4-1921** 1921:232), the influenza epidemic could not have come at a more inopportune time.

6.4.4.1 Emphasis on public health legislation

As a result of the ravages of the epidemic (the official total death rate per 1000 of the population was 22.80 (**Report: Influenza Epidemic Commission** 1919:23), there met in Bloemfontein during 1918 under the chairmanship of the then Minister of Interior, representatives of the central and the four provincial governments, of the four municipal associations, of the Cape Divisional Council's Association, and of medical and welfare institutions. This is an indication of the importance of interest groups to the governmental policy-making and implementation institutions referred to earlier (**supra**, chapter 3) albeit of an **ad hoc** nature induced by the Influenza epidemic. During that occassion, namely the Public Health Conference, the representatives considered and made recommendations on steps that had to be taken to remedy the defects in the existing legislation and to place the implementation of public health on a sound footing (Cluver 1949:317). These recommendations admitted of the lack

of legislative direction attending a national health policy for the Union of South Africa since unification. The result was the adoption of the Public Health Act, 1919 (Act 36 of 1919).

6.4.4.2 Expeditious legislative direction

The legislative direction was unusual with the adoption of the Act in the sense that the Public Health Bill, 1919 was passed expeditiously through all the stages by the legislature in 1919 when compared with subsequent attempts at passing health legislation. The First Reading was on 22 January, the Second Reading on 5 February, the Committee Stage on 25, 28 and 29 April, and on 2, 5, 7 and 8 May, Amendments Considered on 12 May, the Third Reading on 19 May, Amended by Senate on 9 June, Amendments Considered on 10 June, and assented to on 20 June, 1919 (**Debates**, 1919:xiv). For an example of the tedious legislative process that usually accompanies the adoption of health legislation, the following can be referred to: attempts to consolidate laws relating to medical practitioners and related professions were before Parliament for more than ten years before the Medical Dental and Pharmacy Act, 1928 (Act 13 of 1928) became law in 1928 (Cluver 1949:3, 317). The state of health of the people of the Union was clearly not an insignificant matter anymore and what was previously not regarded as a priority, became one after the ravages of the influenza epidemic (also referred to as "Spanish Flu", "Black October' and "South Africa's worst demographic disaster").

The number of one hundred and thirty nine thousand, four hundred and seventy one (139 471) deaths (**Report**, Influenza Epidemic Commission, 1919: par.49) was, however, not regarded as a reliable expression of the number of deaths and it had been proposed that "perhaps a figure of some 300 000 would be a reasonable estimate (Philips 1988:63).

The Public Health Act, 1919 can thus be considered a watershed in legislative direction attending public health matters in that, for the first time, after nine years of unification had lapsed, a consolidating health policy for the inhabitants of the union was combined in a single Act.

Louis Botha, who was the leader of the government of the union since its creation, could not see the result of his government's work (a consolidated public health policy) being implemented because he died in the same year in which the Public Health Act, 1919 (Act 36 of 1919) came into existence. On his death on 7 August 1919 (merely two months after the Public Health Act, 1919 (Act 36 of 1919) was assented to), Botha was hailed as being the Father of a new South Africa (**Debates**, September 6, 1919:3). Public health had at last become part of the development of South Africa in a consolidating and national sense.

During the Second Reading debate on the Public Health Bill, 1919, the then Minister of Interior stated that the new and salient features of the Bill were the creation of a Portfolio of Public Health and the creation of a central health administration to control and coordinate all health duties in the union (**Debates**, 1919:23). Although it was necessary to amend the

Public Health Act, 1919 (Act 36 of 1919) on no less than twenty-one occasions because it was an Act which was born out of emergency and disaster (**Debates**, 1977: Col. 3137), it had to serve the needs of the inhabitants of the country from 1919 to 1977 (**Gids tot die Wet op Gesondheid, 1977**, 1978:3).

During the Second Reading Debate of the Health Bill, 1977 the Minister of Health reported that in its attempts to effect changes to the principles to the Public Health Act, 1919 the state, since 1924, had appointed commissions/committees to inquire into and to make recommendations on the subject (**infra**, Chapter 7). It was also reported by the Minister that the reason why the attempts had been less successful or even in vain, could be attributed to the principle reason that "...previously it had not been possible to succeed in reconciling the different standpoints with one another" (**Debates**, 1977: Col.3137). The Minister elaborated no further on this statement, and it can only be inferred from what has already been analysed, that the legislative direction was not conducive to the reconciliation of such standpoints save for situations of utmost importance such as an epidemic.

6.4.5 Legislative direction and public health policy implementation 1961-1990

The adoption of the Republic of South Africa Constitution Act, 1961 (Act 32 of 1961) brought no change to the legislative direction attending public health matters. Save for the fact that the establishment of the Republic of

South Africa came about as a result of the Afrikaners's striving for constitutional independence, the 1961 constitution embodied the 1909 constitution in its entirety, with the exception that the position of Governor-General became that of the State President (Marais 1985:33). The Public Health Act, 1919 (Act 36 of 1919) (as amended) continued to exist and had to serve the needs of the country up to 1977 with the adoption of the Health Act, 1977 (Act 63 of 1977). The Health Act, 1977 served as the principle policy expression in terms of which health services had to be rendered up to 1990. (To what extent the implementation of the former can be said to have been efficient will be analysed in Chapter 7).

6.4.5.1 Manifestos of political parties

Of the political parties who took part in the elections of 1966, 1970, 1974 and 1981, only the 1970 and 1974 manifestos of the National Party referred to public health. In the 1970 manifesto, the statement was made "The National Party had already achieved great success in the task of building up a healthy and vigorous population in our country. With this object in view it has introduced various services and schemes" (**Manifesto**, 1970:5). These services and schemes were not detailed in the manifesto. For the purpose of the 1974 election, a similar entry appeared in the National Party's Manifesto (**Manifesto**, 1974:2). Whether the National Party as government-of-the-day had indeed succeeded in achieving "great success in the task of building up a healthy and vigorous population" prior to 1970 will be analysed in Chapter 7.

6.4.5.2 Health Act, 1977 (Act 63 of 1977) and thereafter

A major legislative direction concerning the implementation of a public health policy was made with the adoption of the Health Act, 1977.

The underlying philosophy of the Health Act, 1977, was to create a blueprint for the three government levels to render a public health service and to control the implementation of kindred functions (**Gids tot die Wet op Gesondheid, 1977**, 1978:19). The underlying problem, however, still prevailed in that the republic which embodied the principles of a unitary state had to contend with an increasing emphasis being placed on the decentralisation and prolifiration of institutions responsible for the implementation of health services. This decentralisation and prolifiration of institutions were particularly amplified with the adoption of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983) in terms of which legislative direction for own affairs was vested in three institutions on the central government level, namely, the House of Assembly (for Whites), the House of Delegates (for Indians), and the House Representative (for Coloureds). Own affairs in terms of the constitution also included certain health services (such as hospital, clinic, and nutritional services) (section 14 and schedule 1, Republic of South Africa Constitution Act, 1983 (Act 110 of 1983)) with the result that apart from the existing Department of Health and Welfare, a Department of Health Services and Welfare was established for the House of Representatives and the House of Delegates respectively.

Although PW Botha (at the time Prime Minister) won an election, **inter alia** on the basis of making the civil service smaller, the size of the civil service increased at an alarming rate under his rule (Marais, van Wyk & Ströh 1991:87). Speaking in Parliament in May 1984 (i.e. after the adoption of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983)), the Minister of Health and Welfare said that he could not give an accurate picture of the structure of health services under the 1983 constitution because the position of provincial and local authorities were stil uncertain but that he did not see that health services would be divided and separated (**Debates**, No. 15, 1984 : Cols 6390-6392). A year later (1985) with the separate own affairs departments of health already established, the Health Amendment Act, 1985 (Act 70 of 1985) was adopted to provide for the representation of an officer of each of the Administrations of the House of Delegates, the House of Representatives and the House of Assembly on the Health Matters Advisory Committee (section 4) and for the representation of the Ministers' Councils of the said Houses on the National Health Policy Council. These measures were to enhance the cooperation between the various health ministries towards the formulation of a national health policy. This illustrates the lack of anticipation by the Minister on the possibility of the proliferation of health services in terms of the 1983 constitution. The fact that health services implementation would indeed proliferate under the 1983 constitutional environment as a result of the lack of a central policy direction to curb it was also aptly illustrated by the **Commission of Inquiry into Health Services**, 1980 (the Browne commission).

The Browne commission recorded in its **Final Report** in 1986 that the implementation of the public health policy was inadequate in as much as the excessive fragmentation of implementation of health services was the result of a lack of legislative policy direction. This led to a misallocation of resources and to wasteful duplication of services. Moreover, largely as a result of this lack of legislative direction, there had been an under-emphasis on preventative and primary health care and an over-emphasis on expensive secondary and tertiary health services which were inappropriate to the needs of the South African community (**Final Report** 1986:18).

The government argued in a White Paper on the Browne commission that it was already implementing many of the recommendations of the Brown commission and that recommendations relating to the non-independent homelands would be negotiated with them as soon as they gained autonomy in respect of health services (**White Paper**, 1986:1). Barnard, a Progressive Federal Party spokesman on health matters said, however, that the White Paper was a non-event since, as pointed out by the White Paper, most of its major recommendations had already been implemented, while other important aspects had been ignored. Furthermore, it did not address itself to the division of health services along racial lines (**Race Relations Survey**, Part 2, 1968:771).

The Browne commission confirmed that the lack of political direction to remedy the duplication and overlapping that arose as a result of the 1983 constitutional environment was still prevelant in 1986 and would continue.

The commission in its report of 1986 recorded, for example, that "...there are too many uncertainties: uncertainties regarding the future constitutional framework into which the State health services must be fitted, and uncertainties regarding the nature, composition and distribution of the community which the health care system must serve" (**Final Report**, 1986:20).

All indications are that this situation still existed up to 1990 (**Race Relations Survey**, 1986:767; 1990:835). For example, in 1989 and 1990 eighteen separate health departments were responsible for the implementation of public health policy in South Africa (including the TBVC States).

6.5 Public accountability and public health policy

Similar to the previous rubric (heading 6.4) the analysis of the public accountability variable will also be undertaken for the periods 1910-1961 and 1961 to 1990.

6.5.1 Public accountability and public health policy 1910-1961

The executive government of the union was vested in the King and had to be administered by the King in person or by the Governor-General as his representative (South Africa Act, 1909, Section 8). The Governor-General was accountable to the King for the way in which he exercised his functions as assigned to him by the King (Section 9). An Executive Council appointed by the Governor-General and collectively known as the

Governor-General-in-Council, was responsible for the governing process of the union. The members of the Executive Council, the number of which had not to exceed ten, would hold office during the pleasure of the Governor-General as the King's Ministers of State (Sections 13 and 14).

With the proclamation of the union the new state took over all the assets and liabilities of the different colonies. The public debt for which it assumed responsibility amounted to 116 million pounds Sterling. Against this, all assets, including Crown lands, public works and the movable and immovable property of the four colonies, the right in and to mines, minerals and precious stones were vested in the union government. All ports and harbours and the railway system also became the property of the union government (Krüger 1969:46).

From the appointment of his Cabinet, the Prime Minister (Louis Botha) had difficulty in applying the principle of collective Cabinet responsibility. There was little solidarity in a Cabinet formed from different (albeit kindred) political parties during moments of enthusiasm for union (Krüger 1969:63). For example, in the Hertzog speeches of De Zuid-Afrikaanse Nationale Partij of the Orange Free State (this was prior to the Party being constituted as a federal-organised party during which time each province of the Party issued its own manifesto), the point was made that ministers of state had to accept real and not nominal accountability and that they had to act not contrary to what has been prescribed in an Act of the government (**Die Hertzogtoesprake**, Deel 3, April 1913-April 1918).

6.5.2 *Central and provincial government accountability*

Prior to union each colonial government had its own health laws. The responsibility for the provision of hospitals and for dealing with outbreaks of infectious diseases at first rested only with the Colonial governments. Since the adoption of legislation in terms of which local authorities could have been established, they were endowed with authority in regard to sanitation and health control in their respective areas of jurisdiction. However, the rendition of services that were not of a local character, such as the establishment and administration of hospitals, and health control at the ports, remained the responsibility of the colonial legislatures (**Report** 1959:10; **The Health of the People**, 1977:14).

Section 135 of the South Africa Act, 1909 determined that all laws in force in the colonies at the establishment of the Union shall continue in force in the respective provinces until repealed or amended by the Parliament of the union.

The responsibilities of the colonial legislatures concerning public health were therefore transferred to the provincial administrations by the South Africa Act, 1909.

In terms of Section 85(v) of the South Africa Act, 1909, the provincial councils had authority over the establishment, maintenance and management of hospitals and charitable institutions. Thus, the health legislation of the colonial legislatures were transfered to the newly

established provinces but remained, in essence, legislation adopted by the colonial legislatures for the particular needs of the various colonies and not for the purposes of a unified state. The situation was thus created that the newly adopted constitution formed a unitary state in which the piecemeal legislation of dealing with health matters in the former colonies was perpetuated to serve the needs of a union.

These opposing forces, namely the need for centralised accountability **versus** a piecemeal means of dealing with health matters became even more evident as more thought was focussed on the problem of providing adequate health services for all the inhabitants of the country (**Debates**, 1913: Col. 3293-4). It was realised by government that the uncoordinated system resulting from pre-union attempts to implement health policies with each health problem as it arose, or rather when it became acute, could not be allowed to continue. As a member of the House of Assembly expressed it: "Every investigation into public health showed that it was in a more deplorable state than even the members of the House thought of" (**Debates**, 1913: Col. 3294). Unfortunately, however, the tendency to institute **ad hoc** enquiries and piecemeal legislation persisted (**Debates**, 1913: Col.3293; **Report**, U.G. No. 30-1944).

At the central government level public health matters were dealt with by the Department of Interior up to 1920, and this Department accepted responsibility for all public health matters (**Debates**, 1910-1911: Col. 30). There was, however, no consolidating legislation concerning public health for the union of South Africa during the first nine years of its existence and

the responsibilities for the implementation activities were similarly dealt with in a piecemeal fashion.

The Public Health Act, 1919, was drafted with regard to the constitutional position of unification on the one hand, which made the attainment of the ideal of a comprehensive health service under the direct responsibility of the government impracticable, and on the other hand, to the desirability of decentralisation and the encouragement of local interest and responsibility (Roux 1977:38).

The government was called upon to account for its action (actually its inaction) during the 1910-1911 Parliamentary session concerning the implementation of public health services. The call to account referred to the health state of miners on the Witwatersrand. The Minister of Interior's reply was that the government was fully aware that the health conditions under which miners worked on the Witwatersrand were capable of improvement. The steps that the government proposed to take to ameliorate the poor conditions were the promulgation of improved regulations and an adaption in the way in which the regulations had to be implemented (**Debates**, 1910-1911: Col. 29).

With the development of health services since union to meet the needs of the times it became desirable to devise means towards a better demarcation of traceable localities of accountability by preventing overlapping and duplication of health services provided by the central government on the one hand and the provinces on the other. Accordingly,

in 1940, Parliament enacted the Finance Act, 1940 (Act 27 of 1940). Section 16 of this Act sought to indicate more specifically which matters entrusted to the provinces might, with the consent of the executive committees concerned, be transferred to the central government and which should remain with the provinces.

The provisions of section 16 of the Finance Act, 1940 (Act 27 of 1940), were subsequently repealed and re-enacted in terms of section 16 of the Financial Relations Consolidation and Amendment Act, 1945 (Act 38 of 1945). The provisions of section 16 of Act 38 of 1945 had an important bearing upon the demarcation of responsibilities between the provincial Administrations and the central government in relation to personal health services in that, save for the province of Natal, the matters entrusted to them under the South Africa Act, 1909, no longer fell within their purview and that the transfer of further functions and responsibilities from any province to the central government may be effected by Proclamations which had to be made by the Governor- General in terms of the provisions of section 16 of Act 38 of 1945.

6.5.3 Central, provincial and local government accountability

All four colonial governments had established systems of local government when the Union of South Africa was created in 1910. Section 93 of the South Africa Act, 1909, provided that all the then existing local authorities should continue to function. This provision was reaffirmed in

section 92 of the Republic of South Africa Constitution Act, 1961 (Act 32 of 1961).

Thus, throughout South Africa as the law stood, the responsibility for environmental health (in other words excluding hospitals and charitable institutions) was placed upon local authorities. Local authorities consisted at the time of municipalities, village management boards, and divisional councils (the latter only in the Cape Province (**Debates**, 1919:23).

Although provincial councils were allocated the functions of the establishment, maintenance, and management of hospitals and charitable institutions in terms of the South Africa Act, 1909, they were not endowed with specific health functions in terms of the Public Health Act, 1919 (Act 36 of 1919). The only secondary functions they could fulfill in terms of the latter Act were that they could be proclaimed a local authority for a defined area (Section 8(1)-(3)) and that the Administrator of the province had certain powers in the case of defaulting local authorities. In terms of section 10(1) of the Public Health Act, 1919 (Act 36 of 1919), preventative health services were specifically the primary responsibility of local authorities. The other functions of local authorities (i.e. those excluding preventative health services), and particularly, the finances of local authorities were under the control of the provincial Administration concerned who, as indicated immediately above, were not entrusted with specific health functions.

The position thus created was that a local authority which defaults in respect of its health duties could not be coerced by the central health authority without prior reference to the provincial authority. This cumbersome arrangement was an essential weakness not only in the implementation of preventative health services in the country, but also stood in the way of proper boundaries of public accountability (Gale 1949:393).

The attempts to deal with public health responsibilities had been in stark contradiction to public financing and railways. It had been stated, for example, that the unitary principle found its most complete fulfilment in Part VII of the South Africa Act, 1909. Part VII of the Act dealt with finance and railways. Revenues, from whatever source, over which the colonial governments had authority of appropriation at the establishment of the Union, and all the railways, ports, and harbours belonging to the colonies, were vested in the central government during unification (De Kock 1922:3). Thus, the establishment of the Union of South Africa was prompted, in no slight degree, by the realisation of the substantial economies likely to be effected by their unification. In fact, the development of the railways system, for example, was a priority objective to be attained by the political parties that took part in the first general election in the union (**Manifestos**, 1910). Little were the union legislature to know that the effective implementation of the railway development programme, coupled with the uncoordinated state of affairs concerning public health policy responsibilities, were to jeopardise the lives of all the inhabitants of the

union eight years after Unification (**Report: Influenza Epidemic Commission**, 1919:16).

After the outbreak of the influenza epidemic during 1918 the government-of-the-day was vehemently critisised for the way in which it lacked anticipatory measures as well as the way in which it dealt with combating the illness. The influenza epidemic was seen by a member of Parliament as a disease that had been sent down from the Almighty for sins that the people had committed; that the scourge had swept through South Africa like a fire; that it was Providence that fanned the fire; and that the government had to heed the warning given them (**Debates**, 1919:35).

The government stood accountable of being guilty of grave neglect of duty in, firstly, not taking proper steps to prevent its introduction into the country; secondly, not taking precautionary measures to prevent it spreading throughout the union; and, lastly, in not assisting the public in combating the disease. Moreover, the medicine recommended and used by the government had been critisized as being useless, and had it not been for inocculations with the old cure, namely, linseed and turpentine, thousands of other people would have died (**Debates**, 1919:35).

The Minister of Interior's reply to the allegations was that in all the cases that were brought to the Union by ship, the disease was in a "very mild form" and that no deaths had occurred on board ship (**Debates**, 1919:35).

The mild form of the disease was also confirmed by an investigation into the circumstances attending the commencement of the illness into the union (**Report: Influenza Epidemic Commission**, 1919: par. 29,31).

The introduction of the Public Health Act, 1919 (Act 36 of 1919), although seen as an important step to deal with the health issues of the country, complicated the accountability variable. The main emphasis of the Public Health Act, 1919 was decentralisation by placing the primary responsibility for the control over infectious diseases and environmental health in the hands of local authorities (**Gids tot die Wet op Gesondheid, 1977**, 1978:3). The philosophy of centralised accountability implied by constitutional unification was therefore effectively eroded by the Public Health Act, 1919 and it remained as such up to 1990.

Although the **Committee of Inquiry Re Public Hospitals and Kindred Institutions**, 1924 (the Vos committee) did not deal directly with the accountability variable in its report, it stressed the point raised immediately above in that the recommendations of the committee pinpointed the necessity for the location of responsibities between the health institutions on the various government levels (**Report**, 1924:46-7).

The dissipation of responsibilities concerning the rendition of public health functions were also reflected in the union Health Department's annual reports from 1927-1944 as well as in the reports of the commissions of inquiry ever since the 1924-report (**infra** Chap. 7). For example, the most recent Commission of Inquiry into Health Services

which published its final report in 1986, reported on the lack of adequate communication between the higher and lower tiers responsible for the rendering of health services (**Final Report**, 1986:19).

In 1944 the Prime Minister, General Smuts, made a statement in regard to the demarcation of responsibilities between the government and the provincial governments with regard to health matters. The provincial governments would provide general hospital services, including out-patient services directly connected with such services while health centres (the so-called extra-institutional services) would be the responsibility of the central government. The central government, however, accepted financial responsibility for out-patient services provided by the provincial governments. Mainly due to the shortage of trained personnel arising out of the increased need for health services after the Second World War (1939-1945), the government was unable to proceed with its proposal for developing a coordinated system of responsibilities of the various government levels (Roux 1977:40).

At an Administrators Conference in Cape Town in 1954 the issue of the division of responsibilities was, once again, raised in that the conference proposed to the Minister that the central government had to accept full responsibility for infectious diseases while the provincial governments would assume responsibility for the provision of district nursing and out-patient services. These proposals were accepted in principle by the Minister of Health at a conference in Cape Town in 1955. However, no

change had been made in regard to the responsibilities of local authorities in respect of personal (i.e. curative) health services (Roux 1977:39).

6.5.4 Public accountability and public health policy 1961-1990

The feature of the 1961 constitution was its similarity with the 1909 constitution (i.e. unification) and lacked fundamental changes (Marais 1985:33). The Public Health Act, 1919 was implemented from 1919 up to 1977 when the Health Act, 1977 was adopted. The decentralisation of health services and accountability within a unified (albeit republican) constitutional framework was therefore perpetuated by the 1961 constitution. The Public Health Act, 1919, thus placed varying degrees of responsibility on three levels of authority, namely the central government, the provincial administrations and local authorities up to 1977 with the adoption of the Health Act, 1977 (Roux 1977:37).

An important development since 1970 was the acceptance of financial and executive responsibility for their own health services by the emergent Black homelands. Proclamation R.96 of 1970 provided **inter alia**, that the Minister of Bantu Administration and Development would be responsible for all functions and duties that affected the administration of health matters, including hospitalisation for Blacks in Black areas. The Department of Health was, however, entrusted with the task of rendering health services. To complicate the divided responsibilities thus created even further, section 6 of Proclamation R.96 of 1970 determined that the provision of any Ordinance of a provincial Council, or any other law

relating to the establishment, maintenance and management of hospitals had to remain in force in so far as they related to any hospital in a Black area. The Annual Report of the Department of Health for the year 1971 reported that it had been necessary to incorporate section 6 of Proclamation R.96 because there was not sufficient time to draft all the necessary legislation (**Annual Report**, 1971:58).

For the purpose of establishing liaison between the Department of Health and the Department of Bantu Administration in health matters, an Interdepartmental Health Services Committee had been formed. The Committee had to serve as a forum in which the Department of Health had to advise the Committee on medical and technical matters, whilst the Department of Bantu Administration and Development had to ensure that such medical and technical advice had to be implemented within the framework of the policy laid down for the development of the so-called Homelands (**Annual Report**, 1971:60).

The extent to which divided health responsibilities were created between the Republic of South Africa and the development of independent territories had been illustrated by the matters which the Committee had to investigate, the most prominent of which had been the placing of responsibilities of capital and running costs. The then Department of Bantu Administration and Development was responsible for the administration of capital funds for health services, whilst the Department of Health was responsible for running costs for such services. This divided responsibilities led to difficulties being created in the functioning

of hospitals in the territories by the fact that items for the running of hospitals could be purchased only by capital funds controlled by the Department of Bantu Administration and Development whereas such items had to be purchased by funds controlled by the Department of Health. Such an invidious situation had been ultimately overcome by a committee decision to transfer certain capital items to maintenance items to ensure that urgent and essential equipment needed by hospitals could be purchased either out of funds provided for maintenance purposes or out of savings (**Annual Report**, 1971:60). Thus, the rendering of health services in the territories, although under responsibility of the territories was ultimately controlled by the two South African departments mentioned and in so doing created a prolifiration of checks and balances particularly with regard to financial responsibility (**Annual Report**,1971:58).

To return to the situation in the Republic of South Africa. The Health Act, 1977 (Act 63 of 1977) attempted to replace the rigidity of the accountability relationships between the various government levels in the Republic by envisaging a more flexible pattern in which the authority, functions and duties of the different levels were reflected. The central theme of the legislation was the coordination of services in the making and implementation of health policy directed from a national level (Health Act, 1977, Preamble).

In the Second Reading Debate of the Health Bill, 1977, the Minister of Health reported that the first attempts to deal with the overlapping of responsibilities between the various government levels during the 1970's

was the Health Bill of 1972. The Commission that was appointed to investigate the 1972 Bill made its recommendations when there were a "...heated state of the discordant relations which prevailed" (**Debates**, 1977: Col.3138). These discordant relations, as can be gathered from the Second Reading, concerned the number of members who had to participate in the Health Matters Advisory Committee.

The creation of self-governing territories also had an effect on the scope and responsibilities of such governing institutions (**Debates**, 1977: Col.3138).

As was the case with legislative direction, the divided responsibilities between the three levels of government and the resultant lack of establishing clearly demarcated accountability levels, continued up to 1990. For example, health services in 1989 and 1990 continued to be rendered by eighteen separate health departments (including the TBVC States). Health services for Blacks in the White designated areas were rendered by the provincial health departments of the Cape province, Natal, the Orange Free State and the Transvaal. Health services in the ten homelands were rendered by health or health and welfare departments of the homeland governments. White, Coloured, and Indian health services were rendered by the own affairs departments of health services and welfare of the House of Assembly, the House of Representatives and the House of Delegates. The Department of National Health and Population Development was reponsible for national health policy in the White-designated areas and the six non-independent homelands. And

yet, its ultimate goals under these circumstances were, **inter alia**, to secure the optimal utilisation of all resources for health and welfare services, and to ensure the success of the population development programme (**Race Relations Survey**, 1989:1990; **Annual Report**, 1989).

Although the principle of collective Cabinet responsibility was in vogue during the time of the 1961 constitution, the position changed after the adoption of the Republic of South Africa Constitution Act, 1983. The redistribution of legislative and executive authority by means of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983) brought about a state of flux in the responsibility of the government in the rendering of health services.

In terms of the 1983 constitution health services are both a "general" and "own" affairs. This means that overall policy is laid down in legislation passed by all three Houses of Parliament which results in a divided responsibility.

Firstly, the responsibility for the implementation of "general" affairs health policy is that of the Department of National Health and Population Development which is accountable to Parliament for the health of the nation in the final resort. The four provincial governments are also vested with responsibilities of "general" affairs, namely, the retention of responsibilities of providing and managing curative institutions which was vested in them by the Health Act, 1919 (Act 36 of 1919) and the Health Act, 1977 (Act 63 of 1977) (**South Africa 1987-1988** 1988:524).

Secondly, as regards the implementation of "own" affairs health services the division of responsibilities is manifested as follows. There exist the departments of Health Services and Welfare of the three Houses of Parliament (House of Assembly for Whites, House of Representatives for Coloureds and House of Delegates for Indians), which are responsible for the implementation of health and welfare services for each of these three population groups.

Thirdly, since local authorities in the Republic of South Africa were instituted on the basis of race, health services as an extention of the constitutional dispensation are rendered on an "own" affairs basis.

Lastly, departments of Health of the Black national states - the independent TBVC countries (Transkei, Bophuthatswana, Venda and Ciskei) and the six self-governing national states (Lebowa, Gazankulu, Qwaqwa, KwaZulu, KwaNdebele and Kangwane), the latter which are still part of the Republic of South Africa, are responsible for the implementation of health services. (**South Africa 1987-1988** 1987:524). From 1973 to 1984 the responsibility for all health services was handed over to the Ministries of Health of these territories. This was accomplished on the following dates of transfer:

- Transkei 1 April 1973, Bophuthatswana 1 April 1975, Ciskei 1 November 1975, Lebowa 1 April 1976, Venda 1 September 1976, Gazankulu 1 September 1976, Qwaqwa 1 April 1977, Kwazulu 1 October 1977, KwaNdebele 1 April 1984, and Kangwane 1 July 1984).

Assistence was, and still is, given by the Department of National Health and Population Development to the health ministries of these ten territories (**South Africa 1987-1988** 1987:524-5). Also, consultation and cooperation between the Department of National Health and Population Development and the ministries mentioned immediately above on common health problems in the respective regions had been institutionalised in a Regional Health Organisation for South Africa (RHOSA) in 1979 as an agency for joint planning and implementation in terms of the 1961 and 1983 constitutions (**South Africa 1987-1988** 1987:524-5).

On 21 November 1984 (a year after the adoption of the 1983 constitution) the State President at the time, Mr P W Botha, announced that the principle of collective Cabinet responsibility would not be applied as strictly as before in order to provide for differences of principle among the Cabinet members and to avoid conflict with ministers who disagreed with Cabinet decisions (**The Star**, 21 November 1984).

6.6 Tenets of democracy and public health policy implementation 1910-1990

Unification in South Africa could have created the background for the development of democracy in South Africa. It could have prompted the opportunity to broaden the democracy substantially. Ultimately, however, the striving towards unification was considered to be more important than the broadening of democracy (Labuschagne 1988:258). These facts cannot

be understood without some reference to the appropriate historical background of the Union.

6.6.1 Democracy prior to unification

When the four colonies entered into Union in 1910, there were brought together two different traditions of governing. In the Cape Colony, the tradition of government was based on the refusal to recognise race or colour as a qualification or disqualification for political office. Thus, the franchise was open to all men who complied with certain qualifications and, theoretically speaking, any post in the Cape Colony might have been held by any such qualified voter (Brookes 1949:27).

The (mostly Afrikaans speaking) Whites who objected to the autocratic Cape colonial rule continuously attempted to bring about a democracy in which they could govern themselves. These attempts ultimately led to the formation of democratic systems of government for Whites in the Transvaal and Orange Free State Boer Republics (Labuschagne 1988:258). In the Transvaal and Orange Free State (the Boer Republics), there was an absolute exclusion from the franchise and from every public office of every man who was not a European. This exclusion was a matter, not of custom, but of law. While this exclusion was not so absolute in Natal, the tendency was to approximate more closely to the Transvaal and the Orange Free State than to the Cape (Brookes 1949:27; Labuschagne 1988:258).

In terms of the Cape of Good Hope Constitition Ordinance, 1852, which made provision for the granting of Representative Government to the Cape Colony, the franchise was given to all male persons, European and non-European, who possessed the required qualifications. Representative Government was granted to Natal in terms of the Charter of Natal, 1856. As in the Cape Colony, all males who possessed the required qualifications were entitled to the franchise in Natal.

In the Transvaal Republic the principles of no equality and the limiting of the franchise to Europeans were repeatedly embodied in legislation, for example in the 33 Articles (Art 6); Sections 9 and 31 of the Grondwet van de Zuid-Afrikaansche Republiek, 1885; and the Volksraad Resolution, of 11 June 1873. In the Republic of the Orange Free State, as in the Transvaal, political rights were confined to the European population in terms of Chapters I and II of the Constitutie van den Oranjevrijstaat (**Report** 1955:31)

On the introduction of Responsible Government in the Transvaal in 1906 and in the Orange River Colony in 1907, the franchise was limited to male Europeans (**Report**, 1955:31).

6.6.2 Democracy after unification

The South Africa Act, 1909, compromise as it was between Afrikaans and English speaking South Africans and between Cape colonial liberalism and northern republican conservatism, recognised the principle of

inequality between White and Black (Krüger 1969:44). The representatives of the National Convention who sought to achieve the compromise consisted of Whites notwithstanding the call from the organised non-White interest groups to also participate in the Conference. Thus the ultimate product of the Convention, namely the South Africa Act, was the result of White political thought, convictions and expectations (Labuschagne 1988:257) and was a manifestation of the top-down model of policy-making and implementation (**supra**, chapter 4) reserved for the elitist White population only.

This top-down model of policy-making and implementation was formalised in the 1909 constitution which provided that only European (i.e. White) men were eligible for membership of Parliament (section 26) and that the quota of membership of the union had to be obtained by dividing the total number of European male adults in the union as ascertained at the census of 1904, by the total number of members of the House of Assembly as constituted at the establishment of the Union of South Africa (section 34(1)). As from 1911, and every five years thereafter, a census of the European men had to be taken for the purposes of the South Africa Act, 1909 (secion 34(2)).

The protection of the right to franchise of Cape non-Whites who were eligible for membership of the provincial Council were embodied in section 35 of the constitution in terms of which they became eligible to vote for representation in Parliament.

In practice this meant that the non-White franchise as it existed in the pre-union Cape colony would be retained in the union (South Africa Act, 1909, section 35). Although the Cape non-White franchise was retained in the constitution, non-Whites were constitutionally not allowed to sit in either of the Houses of Parliament, but had to be represented by Whites (sections 24, 34).

This White hegemony was also seen to be instituted in institutions that were responsible for the making and implementation of public health policy. Section 4 of the Public Health Act, 1919 (Act 36 of 1919) described the constitution and functions of the National Health Council. In terms of section 4(5) of the said Act, every member of the National Health Council had to be a European. The National Health Council, apart from eight **ex officio** and thirteen elected members, also consisted of members of professional institutions (see Addendum 2). Furthermore, the Governor-General could appoint as members, after consultation with such persons or institutions as he deemed necessary:

- two persons having special knowledge of the Natives of the union;
- one person having special knowledge of the health needs of the Coloured population of the union;
- one person having special knowledge of the health needs of the Indian population of the union; and
- not more than five persons to represent such interests as the Minister may recommend.

No mention was made in the Public Health Act Amendment Act, 1946 (Act 51 of 1946) that the eight members of the Central Health Services and Hospitals Coordinating Council (that had to be established simiitaneously with the National Health Council) had to be Europeans (sections 4bis (1)-(3)). The Minister (as one of the members), however, had to be European in terms of section 34(2) of the South Africa Act, 1909. The members of the executive committee of each provincial council would for all intents and purposes, also had to qualifify with this constitutional requirement (**South Africa 1987-1988** 1987:136).

Thus, the division, on racial lines, of representation of the non-European population on the National Health Council was confirmed by the provision of section 4 of the Public Health Amendment Act, and was partly implied in section 4bis of the said Act.

Drawing on the above the statement by George W Gale, Secretary for Health and Chief Health Officer for the Union of South Africa in 1949, that "While it is true that the different racial groups in the Union do not receive medical and health services in proportion to their needs, this fact is the consequence of their differing economic status and even of their cultural differences, and is an outgrowth of the country's social and economic structure, rather of deliberate legislative and administrative discrimination" (Gale 1949:387) is debateable. In fact, it is nowadays commonly accepted that deliberate legislative discrimination became formally entrenched in the principles of the National Party since 1948. In fact, the National Party's Colour Policy of 1948, unambiguously stated that

the principle of separation would be implemented so far as it is practically possible (**Manifesto, Circa** 1948:2). Moreover, in order to implement separate development, registration would determine who belonged to a particular race group (**Rassevrede langs die weg van apartheid, Circa** 1948:1). Examples abound of the fact that government applied deliberate legislative and administrative discrimination. For example, in Janse Van Rensburg's monograph "Die Wet het van my 'n Kleurling gemaak" (translated: "The Law made me a Coloured person") an exposition is given how discrimination was applied through the laws of the country with regard to the Coloured race group.

6.6.3 Democracy and the National Party government

Democracy meant the following to the National Party during 1948 and continued to be its model up to 1961. Firstly, that the policy of separation had grown from the experience of the established European population of the country and that it was based on Christian principles of justice. Secondly, that a permanent advisory body of experts on non European affairs would be established. Thirdly, the unhealthy system which allowed Coloureds in the Cape to be registered on the same voters role as the Europeans, and to vote for the same candidates as Europeans, would be abolished. Fourthly, that the Native reserves had to become the true fatherland of the Native. Fifthly, that the number of detribalised Natives had to be "frozen" whereafter their influx into the urban areas and their regular departure would be taken under control by the government on a country-wide basis in cooperation with urban local authorities. Sixthly,

that the interests and opportunities for employment of the European worker in European areas would be safeguarded and protected. Penultimately, that the representation of Natives in the House of Assembly and the provincial councils would be abolished, and, lastly, that the National Party accepted as a basis of its policy, the repatriation of as many Indians as possible (**Manifesto, Circa 1948, passim**).

The adoption of the Republic of South Africa Constitution Act, 1961 (Act 32 of 1961), brought no change in the broadening of the democracy for non-Whites. Consequently, the continued implementation of the Public Health Act, 1919, which was formulated under a White hegemony during the time of union, was perpetuated by the Republic of South Africa Constitution Act, 1961.

The adoption of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983) saw the introduction of a three-chamber Parliament and the extension of the democracy to Coloureds and Indians. As a corollary to this constitutional dispensation the three Houses were vested with the authority to decide on health matters that were regarded as their own affairs. In terms of section 14 of the 1983 constitution, health was also included as an own affairs function. In accordance with **Schedule 1** of the 1983 constitution the following health matters pertaining only to a specific population group are that group's own affairs, subject to general affairs legislation:

- hospitals, clinics and similar or related institutions;

- medical services at schools and for indigent persons;
- health and nutritional guidance; and
- the registration and control of private hospitals.

If these matters do not pertain solely to a specific group but affect more than one group, they were regarded as general affairs (**Explanatory Memorandum**, 1983:62). The democratisation of the making and implementation of a public health policy was, however, not completed since the Blacks were not represented in the highest decision-making and governing bodies in the Republic of South Africa. This was still the case regarding public health policy in 1990.

6.7 Reasonableness and public health policy implementation 1910-1990

A former Director of Hospital Services in the Orange Free State, former Secretary for Health (presently known as the Director-General of Health and Welfare), and former member and Chairman of the Commission for Administration, Dr J De Beer remarked as follows concerning the variable of reasonableness in the book: **South African Public Administration: Past Present and Future**: "In the day to day execution of public activities, this principle probably stands out more prominently than the others. This implies that the public official should go about his duties without discrimination, that he should act within the scope of his lawful powers and that, in exercising his discretion, he should be balanced, honest and objective. As a practitioner of **personnel administration**, I have found that the average public official is very sensitive to this principle...The mere fact

that there is an autonomous statutory body like the Commission for Administration, which guides personnel administration in the Public Service according to statutes, is a formal manifestation of this principle within our system of government" (De Beer 1988:113)(Author emphasised).

The legislative direction and tenets of democracy that characterised the system of government from 1910 to 1990 was described earlier in this chapter (**supra** 6.3; 6.7). In this earlier description it was shown that the democracy that prevailed for most of the time from 1910 to 1990, was one that could be described as a White hegemony. It had also been shown that certain institutions that were established in terms of the Health Act, 1919 (as amended) which were responsible for the making and implementation of health policies first consisted of only, and later, largely White representatives. In fact, the colour policy of the National Party when it came into power in 1948, was, as had been shown in the sub-title to one of their manifestos, **Separation on Christian Principles of Justice and Reasonableness** (**Manifesto, Circa** 1948). This policy was regarded by the National Party government as a positive step towards attaining peace between races by way of separate development (**Manifesto, Circa** 1948). Dr W.W.M. Eiselen (Secretary for Native Affairs) commented, for example, as follows concerning the reasonable implementation of government policy during the Sixth Annual Conference of the Institute of Administrators of Non-European Affairs in 1957: "Can the Department of Native Affairs be accused of being frivolous and of drafting its laws in so

unreasonable a manner that a well intentioned Native finds it difficult or unduly irksome to comply? I have no hesitation in denying this most emphatically. I have already indicated the positive and constructive nature of our legislation. Obviously there must be sanctions for dealing with people who refuse to comply with the rules laid down for the sake of maintaining law, order and control".

6.7.1 Reasonableness within an unreasonable democratic system

Although the statement made by De Beer can be regarded as being valid for public officials attached to the Department of Health, the fact remains that they had to implement health policies reasonably within what is presently regarded as having been an unreasonable democratic system. The variables of legislative direction and tenets of democracy as applied in the case of public health policy implementation can therefore be regarded as being in conflict with the variable of reasonableness. To illustrate this conflict the following public health policy implementation deficiencies can be referred to from the 1920's through the 1970's in the Union and the Republic of South Africa.

The Secretary for Health and Chief Health Officer of the Union of South Africa in 1949 (G W Gale) in a review of the public health since 1919, referred to the fact that the policy of racial segregation tended towards the acceptance of dual standards by local authorities which could be observed in public health policy implementation. In section 130 of the Public Health Act, 1919, (Act 36 of 1919), permission was granted for the

lowering, in respect of Black housing only, of the ratio of window area to floor space from one-twelfth (the general standard) to one-fourteenth. Also, in terms of section 2 of the Slums Act, 1934 (Act 53 of 1934) a medical officer of health of a local authority could report to his local authority a housing nuisance, where it was deemed to be injurious or dangerous to the health of the inhabitants. In terms of section 11 of the said Act, the local authority then had to proceed to eliminate the slum condition (i.e. demolish the dwelling) and had to ensure that suitable housing be made available for those whose dwelling had been demolished (Cluver 1949:693). In terms of section 1 of the Slums Act, 1934 (Act 53 of 1934), however, Native compounds (erected under the Native Labour Regulations Act, 1911 (Act 15 of 1911)) and Native locations (established by White local authorities in terms of the Natives (Urban Areas) Act, 1923 (Act 21 of 1923) were expressly excluded from the purview of the said Act and thus also of the reasonable implementation of measures to ameliorate health hazards that might have arisen as a result of the existence of slums.

The Natives (Urban Areas) Act, 1923 (Act 21 of 1923), required of every local authority conducting a location or hostel or supplying Native beer, to open a Native Revenue Account. The principle of a self-balancing Native Revenue Account, adopted by the vast majority of local authorities, meant in practice that no more could be spent on **inter alia** the health services of the Black townships than could be raised from the residents therof. In 1949 the Secretary for Health for the Union of South Africa

stated that the municipal monopoly of the brewing and sale of native beer meant that health services in the Black townships were rendered in accordance with the capacity of the Native Revenue Account instead of the rendering of such services in accordance with the health needs of the inhabitants of the Black townships (Gale 1949:394). In 1954 the Manager of non-European Affairs at Brakpan City Council, Dr F J Language, confirmed at the Third Annual Conference of the Institute of Administrators of Non-European Affairs, that the Natives (Urban Areas) Amendment Act, 1944 (Act 36 of 1934), did not allow the profits from the Native Revenue Fund "...to be utilised on the erection of houses for Natives. Local Authorities accumulated considerable amounts of money which they did not know how to spend while State money was not available for Native housing" (Language 1954:182).

In the Proposals for an Adequate Health Service by the **Commission for the Development of the Bantu Areas Within the Union of South Africa**, 1955 (the Tomlinson commission) it was stated that the district of a magistrate, or a divisional council in the Cape Province, constituted the district of a rural health authority. For health implementation purposes the Bantu areas falling within the boundaries of such a district, formed an integral part of that district (**Report**, 1955:60, 160). Most of the rural local authorities have done little or nothing towards development of their health services, their activities in this regard often being limited to the outbreaks of infectious disease (**Report**, 1955:160). On the other hand there existed the so-called Native areas which had been generally regarded as

connoting rural Native reserves under the control of Native Commissioners (**Report**, 1955:42, 160). Native Commissioners did not provide health facilities and the multiplicity of agencies providing health services in the Native reserves (i.e. the central government Department of Health, provincial governments, local authorities, and services provided by so-called non-statutory health institutions such as the South African National Tuberculosis Association (SANTA), missionary societies, charitable institutions, and voluntary institutions such as the South African Red Cross Society), led to the maldistribution of health functions.

The report of the **Commission of Inquiry into Matters Concerning the Coloured Population Group**, 1976, (the Erika Theron commission) illustrated, for example, the mostly unsatisfactory health conditions attending the Coloured people as a result of unreasonable implementation of health services within the parameters of the legislative direction and the tenets of democracy prevailing at the time.

Although the Theron commission indicated that medical services were rendered to most inhabitants of the country virtually free of cost or at a nominal cost, the commission also indicated discriminatory practices in the rendering of public health services to the Coloured people (**Report**, 1976:227-56). These included as part of the racial segregation policy of the government-of-the-day **inter alia**, separate treatment and separate health facilities (for example, public hospitals and ambulances), salary disparities beween White and Coloured nurses, absence of proper hostel facilities for Coloured nurses, Coloured doctors who were not allowed to

give instructions to White health personnel, Coloured doctors who were allowed to render sessions in non-White out-patient sections of a public hospital provided that such a doctor is accompanied by a non-White nursing sister, and the disparity in salaries of paramedical personnel when, in fact, the training and the professional responsibilities of such personnel was equal to that of their White counterparts (**Report**, 1976:229-40).

In 1986 the government announced its National Health Plan which attempted to enhance the mental, physical and social well-being of all the inhabitants of the country with the emphasis on the prevention rather than the cure of illness. In order to implement its National Health Plan, the Primary Health Care Plan was adopted in 1989. One of the main aims of the Primary Health Care Plan was the aim to render a primary health care service to all the inhabitants of the country that would be reasonable and acceptable. In fact, the government committed itself that the rendering of an affordable health service in South Africa would only be possible if a reasonable and acceptable health service would be provided (**Konsepstrategie**, 1989:2-6).

However, the implementation of health policies in terms of the race segregation policy of the government-of-the-day referred to above were largely perpetuated up to 1990. The most prominent statement regarding the implementation of health services **vis-a-vis** that of the segregation policy of the government was when, on 16 May 1990, the Minister of National Health and Population Development (Dr Rina Venter), announced

at a press conference in Cape Town that, owing to a surplus of beds in white hospitals and a shortage of beds in Black hospitals, empty beds had to be made available to all races provided that funds being available (Race Relations Survey, 1989/90:387). This change in policy, which would ultimately impact upon the implementation of public health policies were regarded by a National Party spokesman as one of the most important announcements since the guidelines laid down for political and constitutional reform, and for the redress of socio-economic problems on 2 February 1990 (Race Relations Survey, 1989/90:388).

6.8 Conclusion

In terms of the National Convention the political direction was that of unification and a drafting of a constitution that would embody the political aspirations of the Whites as well as the amalgamation of the economies (particularly that of mining, customs, agriculture and railways). Public health matters were not considered a priority of unification, in fact, no consolidating health measures were taken and a separate portfolio for public health did not exist up to 1920.

Although the institution of a union as expressed in the South Africa Act, 1909, created one state out of four colonies, it was an uneasy compromise concerning health matters which were essentially of a fragmentary nature. Legislative direction concerning health matters from 1910 to 1919 were nigh-on non-existent. Save for an incidental reference to health in the South Africa Act, 1909, the newly established provinces had to cope with

health matters in terms of fragmented legislation that had been created for and had been implemented in the previously existing colonial governments. The manifestos of the contesting political parties to the 1910 and the 1915 general elections also gave no indication of how the political party with the majority of seats intended to implement health legislation for the purposes of a unified country once having been elected.

The unimportance of public health was also reflected in the debates of the House of Assembly from where legislative direction was formalised. Objections to the poor state of health in the union by members of the House of Assembly as a result of the implementation of piecemeal health legislation did little to ameliorate the health situation.

The lack of a health policy for the Union of South Africa from 1910 to 1919 became evident as a result of the influenza epidemic of 1918. As a result of this scourge the health of the inhabitants of the union became a priority and the Public Health Act, 1919 (Act 36 of 1919) was passed expeditiously by Parliament compared to subsequent attempts of dealing with health legislation.

Drawing on the analysis of this chapter, the following concluding remarks can be made. Firstly, up to 1919 legislative direction was lacking concerning the adoption and implementation of a coordinated health policy for the whole of the union. It is clear that the union Parliament regarded the implementation of colonial health policies as a satisfactory

means of dealing with the health problems of a union which, of course, it was not.

After the influenza epidemic, legislative direction was elicited on an **ex post facto** basis. It differed from the legislative direction that was elicited for **inter alia**, agriculture, railways, land issues, and defence which received attention from the very first meeting of the House of Assembly after unification.

Legislative direction was also ill-prioritised after the adoption of the Public Health Act, 1919. Although this Act was amended on no less than 21 occasions it continued to exist up to 1977 notwithstanding problems experienced with the implementation of it, particularly the demarcation of responsibilities of the various government levels.

The situation created by the legislative direction perpetuated the duplication and overlapping of the responsibilities of the various levels of authority and their institutions responsible for public health services. This resulted in the duplication and overlapping of the accountability variable in the rendering of public health sevices. This situation existed up to 1990 notwithstanding attempts by the central government to curb it through a National Health Plan.

The variable of democracy pertained to the needs of a white hegemony from 1910 up to 1983. The implementation of successive health policies reflected the needs and requirements of a minority group (in terms of

numbers) but at the same time a ruling group (in terms of legislative supremacy) to the exclusion of full participation in the democratic legislative processes. It was only natural that the democratic culture for Whites would be reflected in democratic structures for Whites. The 1983 constitution brought, for the first time the Coloured and Indian population groups into the position of becoming part of legislative institutions at the central government level and therefore also in the making and implementation of health policies. The 1983 constitution was, however, an uneasy compromise between the granting of democratic rights to the Coloured and Indian Groups and the implementation of the health policy of the country since the policy of separate development was perpetuated in the 1983 Constitution. The 1983 constitution created own and general affairs for Whites, Coloureds and Indians. The implementation of public health policy was also based on the basis of this division.

Regarding the variable of reasonableness, the implementors of public health policies were put in an invidious position in that they had to implement policies attending health matters that were based on the racial segregation policy of the government-of-the-day that had been regarded as a reasonable policy at the time of the National Party gaining authority in 1948 up to 1983 but, which had been rejected by the National Party as being unreasonable and, in essence, a discriminatory policy in 1990. The variable of reasonableness in the implementation of public health policies could therefore not to be upheld from 1910 to 1990 notwithstanding the government's National Health Plan (1986) and Primary Health Care

Programme (1988) that specifically referred to a primary health care service to all the inhabitants of the country that had to be reasonable. A contradiction in the relevance of the variables of legislative direction and reasonableness can therefore be seen to have existed from 1910 to 1990 in the implementation of public health policies, in fact, they worked at cross-purposes as far as the rendition of public health services were concerned.

CHAPTER 7

EFFICIENCY AND PUBLIC HEALTH POLICY IMPLEMENTATION

7.1 Introduction

The general rule that governmental institutions and public office bearers have to increase the general welfare of the public that they are supposed to serve implies that they have to act in an efficient manner in the implementation of public policies. Public health policy is no exception to this general rule.

Efficiency implies that those services that are to be rendered must be rendered with due regard to the needs of the inhabitants of a state for a particular policy area coupled with sound coordination, specificity of standards and effective use of resources.

Against these factors the efficiency, or not, in the rendition of public health services will be analysed by referring to the annual reports of the Department of Health and reports of commissions/committees of inquiry into the functioning of such institutions in the rendition of health services.

7.2 Efficiency and public health policy implementation

As already pointed out in the previous chapter there existed, from unification up to the adoption of the Public Health Act, 1919 (Act 36 of 1919), no separate central Department of Public Health. The health

services that were rendered during this time at the central level were implemented by the Department of Interior. As a result of the piecemeal nature of health legislation (i.e. legislation adopted for the particular needs of each colonial government) that had to serve for the needs of a unified state, inefficiency in health matters became the order of the day.

Until nine years after unification no steps had been taken by the union parliament towards the creation of central Department of Health through which coordination, setting of standards and use of resources could have been dealt with in a coordinated way.

During the influenza epidemic of 1918 the inadequacy and the inefficiency of the implementation of piecemeal legislation in order to deal with an illness of a national nature was confirmed from the second half of 1918 to 1919. That inefficiency had to result from the implementation of different rules concerning the control of the same problem (the epidemic), was only natural. Particularly the lack of standards of measurement of the health status of the inhabitants of the country and a lack of a coordinated health policy that could be implemented throughout the union, exacerbated the combatting of the disease.

7.3 Lack of specificity of standards

From unification up to the influenza epidemic the statistical data concerning the whole population was inadequate. The two main sources of statistical information at the time were the periodical censusses and the

official records of births, marriages, deaths and migrations. As far as the periodic censuses were concerned, the first simultaneous count of the population of the four territories later incorporated in the Union took place in 1904 (Sonnabend 1949:4).

The South Africa Act, 1909, required a census of the European population from 1911 and every five years thereafter (Section 34(2)). The Census Act, 1910 (Act 2 of 1910) created the first census office of the union which became operational on 1 July 1910 (**South Africa 1987-1988** 1987:83).

The Census Act, 1910 (Act 2 of 1910) gave the Governor-General the right to decide whether a given census should include non-Europeans. Of the seven censuses since union, three (1918, 1921, and 1931) were restricted to the European population, and four (1911, 1921, 1936, and 1946) included non-Europeans (Sonnabend 1949:5).

The Births, Marriages and Deaths Registration Act, 1923 (Act 17 of 1923) provided for compulsory registration for all races in urban areas only. In rural areas non-Europeans were not required to register, but may have done so voluntary (Sonnabend 1949:5).

Thus, as far as the non-Europeans of the country were concerned, statistical data was either inadequate or non-existent and, this lack of information greatly vitiated conclusions drawn from it, also concerning public health matters. In addition, the absence nine years since unification, of health authorities in rural areas in the four provinces, can

also be seen to have exacerbated the problem (**Report**, 1919: par.77). It was recognised at the time of the influenza epidemic (1918) that it was desirable to introduce a uniform system of registration throughout the union, but it was not accomplished at the time (**Official Year Book, No. 4-1921** 1921:175).

The situation of the absence of vital statistics for Blacks in the rural areas was perpetuated up to 1952 when such registration was made compulsory. However, it was reported that it would still take several years before registration could be regarded as complete (**Annual Report**, 1959:8-9). The annual report of the Department of Health of the union for 1959, reflects, for example, only the vital statistics for Whites, Asiatics and Coloureds (**Annual Report**, 1959:8-9). So did the Annual Reports of the Department for 1965, 1966, 1967, and the combined one for 1969-70. From 1971 up to the present the statistics on the registration of births and deaths were not reflected in the Annual Reports of the Department of Health. The combined annual report for the years 1965, 1966 and 1967 merely stated under the heading "Demography" that details of population and vital statistics were available in the relevant Statistical Year Books of the Bureau of Statistics (**Annual Report**, 1965-67:11).

7.4 Lack of coordination

That inefficiency resulted from a lack of coordination in the implementation of health policies as a result of the piecemeal, and sometimes conflicting legislation was acknowledged by the government

(**Jaarverslag**, 1927:3; **Official Year Book, No.4-1921** 1921:175). For example, the Annual Report of the Department of Public Health (the first publication of an annual report by the Department of Public Health appeared in 1927 in Afrikaans only) reported this state of affairs as follows: "Gedurende die ag of nege jare wat gevolg het op die voltrekking van unifikasie in Suidafrika, was daar heel weinig vooruitgang in volksgesondheidsaangeleenthede, daar was inderdaad in sommige opsigte bepaalde agteruitgang. Volksgesondheid word nie eers in die Uniewet genoem nie, en of dit 'n Uniale of Prowinsiale aangeleentheid sou wees, kon slegs deur vermoeding en 'n stilswygende verstandhouding tussen Regering en Provinsies uitgemaak word. In een van die Provinsies was daar feitlik geen volksgesondheidswette nie; in een ander werd dergelike wetgewing net vir 'n sekere tyd uitgevoer om daarna in onbruik te raak; in al die Provinsies was daar twyfel en verwarring ten opsigte van die omvang en die funksies van die Unieregering en die Prowinsiale Administrasies, waardeur onvermydelik 'n verdubbeling van werksaamhede, versuim en onbevoegdheid onstaan het" (**Jaarverslag**, 1927:3).

Although the selfsame annual report stated that this poor state of affairs was changed for the better by the adoption of the Public Health Act, 1919 (Act 36 of 1919) (**Jaarverslag**, 1927:3), the annual report of the following year (1928) stressed that urgent attention had to be given to a simpler and better organised institution in the union for the implementation of a public health policy (**Jaarverslag**, 1928:5).

During the Second Reading debate on the Public Health Bill, 1918, in the House of Assembly on 30 January, 1919, the then Minister of the Interior, Sir Thomas Watt, stated that the new and salient features of the Bill were the creation of a new Portfolio of Public Health and the creation of one central health administration to effectively control and coordinate all health duties in the union.

The newly created Department of Health (1919) was to guard against the introduction of infectious diseases into the union, to advise and assist provincial Administrations and local authorities, and to take central supervision of all health matters (**Debates**, 1919:23). An analysis of the inefficiency, or not, of public health policy implementation brought to light by annual reports of the Department of Health and commissions/committees of inquiry will subsequently be considered. Such an approach is deemed necessary for two reasons. Firstly, the Public Health Act, 1919 (Act 36 of 1919) remained on the statute book for fifty eight years (from 1919 to 1977) and, secondly, it had been necessary, on no less than twenty one occasions, to amend the Act and effect essential changes as brought to light by various commissions of inquiry (**Debates**, 1977: Col. 3137).

7.5 Commissions/committees of inquiry into health matters

Commissions/committees of inquiry are instruments through which the adequacies or inadequacies of the implementation of public policies are analysed on an **ex post facto** basis.

In its attempts to effect changes to the provisions of the Public Health Act, 1919 (Act 36 of 1919) the Government, since 1924, had appointed various commissions and committees to inquire into and make recommendations on the nature and contents of the public health policy and the ways in which it had been implemented in the past and how it had to be implemented in future. On each occassion the reports of the commissions/committees of inquiry made representations to the government for fundamental changes to be effected to the Act, precisely because it was an Act that had been born out of emergency and disaster (**Debates** 1977: Col.3137) and yet, the government heeded little of these represention with the result that the public health policy continued to be largely ineffective in nature and contents. This will be shown by an analysis of the following committees and commissions of inquiry which conducted investigations into public health matters:

- **Report of the Committee of Inquiry Re Public Hospitals and Kindred Institutions 1924** (hereinafter referred to as the Vos committee);
- **Report of the National Health Services Commission on the Provision of an Organised National Health Service for all sections of the People of the Union of South Africa 1944** (hereinafter referred to as the Gluckman commission);
- **Intergovernmental Committee of Inquiry into Health Matters** (hereinafter referred to as the Havenga committee (1949);
- **Committee of Inquiry on the Financial Relationships between the Central Government, the Provinces and Local Authorities 1956: First**

Interim Report, Introduction and Report on the re-allocation and Financing of Health Services (hereinafter referred to as the Borckenhagen committee);

- **Commission of Inquiry into the Financial Relations Between the Central Government and the Provinces 1964** (hereinafter referred to as the Schumann commission); and
- **Commission of Inquiry into Health Services 1986** (hereinafter referred to as the Brown commission).

7.5.1 Vos committee (1924)

The committee was constituted by Government Notice No. 1706, dated 15th October 1924, and Government Notice No. 1873, dated 5th November 1924. Its chairman was retired Chief Local Government Inspector Mr Michael Christiaan Vos. The six members included two Members of Parliament - Dr A.J. Stals and Mr G Reyburn - and two members of the medical profession - Dr A.H. Louw and Sir Edward Thornton (**Report**, 1924:6; **Report**, 1964:62).

The Vos committee's field of investigation included four aspects, that is:

- accommodation, facilities and apparatus of public hospitals and related institutions;
- establishment, financing, administration, management and working of the abovementioned institutions;

- hospital facilities used for the training of medical and dental students, nurses and midwifes; and
- public medical, dental, nursing and midwifery-nursing services in general; and
- the coordination of the various institutions involved with illnesses and with the promotion or safeguarding of public health (**Report**, 1924:6).

Although the Vos committee was directed to undertake its investigation with regard to public hospitals and kindred institutions, its main findings also concerned the efficient rendering of public health matters generally (**Report**, 1924:Par's 639, 640, 641, 647, and 648).

The Vos committee concluded in its report that the implementation of health services with regard to ill persons, and the relationship between the central government, the provincial administrations and the local authorities inevitably led to extravagance in the sense that the rendering of the services was uncoordinated between the various government levels.

The recommendations of the committee pinpointed the necessity for the coordination of public institutionalised treatment of patients and the coordination of the relationship between the health institutions on the various government levels (**Report**, 1924:46-7).

The main recommendations were, however, never implemented probably owing to the circumstances that prevailed during the change of

government which occurred on June 1924 during which time the Labour and National parties combined (the "pact"), won the general election (**Report** 1964:63).

In 1923 Hertzog formed his pact with the Labour Party which consisted mostly of English speaking members. It was part of the pact compromise that Hertzog and his National party would not urge an alteration in the status of the union. The mid-twenties were also years of dour political debate and bitter controversy between Afrikaners on **inter alia** the national flag issue that became an acrimonious wrangle over a design that would please both Afrikaner and English sentiments (**Report**, 1964:63; De Kock 1971:34). It is not surprising that in this crucible of political debate and issues of sentiment as well as that of the status of the union, and therefore also its division of responsibilities among the various government levels in terms of the South Africa Act, 1909, public health was accorded little prominence.

The non-implementation of the principle recommendations of the Vos committee left the three government levels free to develop health and hospital services with available funds and without consulting one another. The results of the non-implementation of the recommendations were that:

- the union Department of Health was responsible for infectious and epidemic diseases. Indirect control was exercised in this regard over urban and rural local authorities by way of subsidies;

- the Department of Internal Affairs exercised control over mental hospitals;
- provincial Administrations were in control of general hospitals; and
- isolation hospitals, controlled by the larger local authorities were prolifirating under the stimulus of the subsidies provided by the union Department of Health (**Report**, 1964:63).

The result of the above was that as the divided responsibilities developed independently as the years passed, administrative and financial difficulties began to multiply. Cross claims by the union Health Department on the provincial Administrations and local authorities, and by the latter two on the union Health Department, were in vogue at the time as a result of the fact that the dissipation of responsibilities for patients was a fruitful ground for argument amongst public officials as to which government level was responsible for patients suffering from more than one disease or infirmity (**Report**, 1964:63). The dissipation of functions and responsibilities and the inefficiency that resulted from different government levels working at cross purposes with each other was also on an increasing scale reflected in the union Health Department's annual reports as from 1927.

In the first published annual report of the Union Department of Health in 1927 (two years after the publication of the Vos commission report in 1925, and eight years after the creation of the Department of Health in 1919), the Chief Union Health Official, Dr J. Alexander Mitchell reflected little concern over the duplication, inefficiency and general problems that were

covered by the Vos committee report. It was only referred to in passing and then mainly in comparison with the situation that existed prior to the adoption of the Public Health Act, 1919 (Act 36 of 1919): "Ten spyte van verskil van mening ten opsigte van enige geskilpunte, en 'n seker mate van onvermydelike verdubbeling van werksaamhede tussen die Departement en die Prowinsiale Administrasies, het die gedragslyn van mede-toesig en beheer van plaaslike outoriteite oor die algemeen vlot gewerk (alhoewel dit in onbevredigende mate afhanklik is van onderlinge verstandhouding, en 'n aanleg vir vriendskaplike samewerking van die betrokke beamptes), en is 'n ontsaglike vooruitgang op die wanordelike administrasietoestande wat vanaf die totstandkoming van die Unie tot op die aanname van die Volksgezondheidswet geheers het" (**Jaarverslag**, 1927:5).

However, in the following year's annual report of the Department (1928), Dr Mitchell expressed, in stark contradiction to the above, grave concern about the immediate and most pressing needs that had to be met with regard to public health, **inter alia**, that a less complicated and better organised system for the control and inspection of local authorities, public health and related matters be instituted; that a closer relationship be established between the union Department of Health and local authorities as regards both preventative and curative health services (**Jaarverslag**, 1928: 5).

The 1929 annual report was almost a verbatim copy of the aspects mentioned immediately above (**Jaarverslag**, 1929:5) and thus underscored

the need for the establishment of a better organisation, coordination and control of health services throughout the union.

The 1930 annual report continued in the same vein by stating that: "Die vorige Jaarrapport het 'n opsomming bevat van die vernaamste en dringendste vereistes van die Unie op die gebied van volksgesondheid en -welsyn. Dit is tans nog van toepassing..." (**Jaarverslag**, 1930). During 1929, 1930, 1931 and 1932, the annual reports reflected, for the first time, the decisions of the National Health Council (Raad van Volksgesondheid). The decisions covered **inter alia**, the plea for the centralisation of public health under one central institution (**Jaarverslae**, 1929, 1930, 1931, 1932). Since the Public Health Act, 1919 (Act 36 of 1919) was based on the principle of decentralisation by allocating the primary responsibility of public health on decentralised local authorities (**Gids tot die Wet op Gesondheid, 1977**, 1987:3), an uneasy compromise between centralisation and decentralisation persisted.

7.5.2 Gluckman commission (1942-1944)

The inefficient way in which public health services were rendered at the time, was the major factor that led to the acceptance by the Union government in February, 1942, of a motion by a private member for the appointment of a commission of inquiry. The result was that the The Gluckman commission was instituted on 28 August, 1942.

The Gluckman commission's terms of reference were to inquire into, and to report and advise upon:

- the provision of an organised National Health Service in conformity with the modern conception of "Health" which would ensure adequate medical, dental, nursing and hospital services for **all** (emphasis in report of commission) sections of the people of the Union of South Africa; and
- the administrative, legislative and financial measures which would be necessary in order to provide the Union of South Africa with such a National Health Service (**Report** 1944:1).

The Second World War of 1939-1945 led to an upsurge of idealism and the desire to improve the lot of man, including the provision for the care of his own and his family's health. There existed worldwide a growing dissatisfaction with the lack of a comprehensive approach to national health needs and an appreciation of the importance to the national well-being of effecting such an approach. These world-wide socialistic overtones concerning public health were also alluded to as follows by the Gluckman commission: "These trends of thought, which would in any case have developed in response to our own indigenous problems, were stimulated and encouraged by the descriptive literature issued regarding national health services in Denmark, Norway, Sweden, Yugoslavia, New Zealand, Chili, and, above all, in Russia. This literature abounds in references to the claim that health services should be available to every citizen, that the preventive aspect should be in the foreground of all health

activities, and that medicine, like education, must be a function of the State" (**Report**, 1944:2).

The Gluckman commisson issued its report in May 1944. The document of 219 pages was the most comprehensive report covering the field of public health during the time of the Union of South Africa and its recommendations were considered to be of a revolutionary nature for the time (**Report** 1944: **passim**; **Report** 1964:64).

The Gluckman commission reported that the level of health of the people was far below what it should be and what it could be and that the country was not making effective use of the scientific knowledge available to it nor even of its own resources of medical and medical auxiliary manpower. It also reported that health services in the union were not organised on a national basis and were not available to all sections of the people (**Report**, 1944:13).

The commission recommended the introduction of a National Health Service that would ensure the free provision of adequate medical, dental, nursing and hospital services for all sections of the people of the union in which the state had to assume ultimate legislative and financial responsibility for the provision of health services for all, on a basis of need instead of means (**Report** 1944:13, 181).

The report of the Gluckman commission was valuable for the contribution it made towards gaining recognition of a more sound and scientific basis

of classification of the health services of the union. It also had socialistic overtones. The commission recommended:

- that the health services of the union be classified into non-personal (environmental) and personal (preventive, curative and rehabilitative) health services;
- that the Central Government had to assume executive and financial responsibility for all personal health services;
- that the provision of non-personal health services should be the responsibility of local authorities, except that in areas where there are no local authority, the provincial administration had to assume responsibility for such services; and
- that the provincial administrations had to retain control over local authorities (**Report**, 1944:181-2).

Most of the subsequent inquiries into and legislation on health matters had since adopted this classification of the Gluckman commission (**Report**, 1964:64).

The recommendations of the Gluckman commission aimed at ensuring three objectives, namely:

- administrative efficiency through a national health policy to be implemented on a decentralised basis with decentralised responsibilities;

- the protection of democratic interests through the establishment of a National Health Council, and, through representation and the right of appeal, for each region a Regional Health Council, for each health centre a Health Centre Council, and for each hospital a Hospital Advisory Board;
- the protection of the professional interests of the technical personnel employed in the service through a system of technical committees with right of appeal from their decisions in matters to be defined and with the right to elect representatives to the Hospital Advisory Board and the Regional Health Conference (**Report**, 1944:181).

The recommendations of the Gluckman-commission were, however, not acceptable to the government at the time inasfar as their adoption would have divested the provincial administrations of the powers conferred upon them under the South Africa Act, 1909, to establish, manage and maintain hospitals. The implementation of the commission's recommendations would therefore have had the effect of not recognising the constitutional rights of all tiers of government (**Report**, 1959:24).

The Prime Minister at the time, General Smuts, in announcing the government's decision of non-implememtation of the recommendations in October, 1944, made a statement in regard to the demarcation of functions between the Central Government and the Provinces in the sphere of health. This statement laid down that it was the governments policy that the provincial administrations would continue to be responsible for hospital services including out-patient services directly connected with

hospitals, but that the government would develop a system of health centres for those patients not directly connected with hospitals i.e. patients that could be accommodated in the extra-institutional field. This policy was reaffirmed by a sub-committee of the Inter-Provincial Consultative Committee at a meeting at Cape Town in February 1945, under the chairmanship of the Minister of Health (**Report**, 1959:16-7) and found legislative expression in the Public Health Amendment Act, 1946 (Act 51 of 1946).

It did not take long before this policy of Smuts, which maintained the organisational **status quo** in the health functions rendered by the various government levels, led to friction between the provincial Administrations and the Department of Health (**Report**, 1964:64).

A perusal of the annual reports of the Department of Health during and after the time of the Gluckman commission's investigation (1942-1944) reveals little about the inefficient ways in which the health policy of the union government was found implemented and brought to light by the Gluckman commission. The annual reports reflected, incorrectly, that the health policy was generally a sound one, and, incorrectly, that progress was made with its implementation. This statement will be substantiated by the subsequent analysis.

In accordance with the general policy of the government dictated by war conditions (i.e. to keep expenditures as low as possible), a full annual report for the Department of Health was not printed in 1942 (**Annual**

Report, 1942:1). In the brief report of 1942 mention was made that in spite of the war conditions prevailing at the time the Department made steady progress with the implementation of the health policy. To substantiate this statement, the Report stated: "That the policy of the Department is a sound one is shown by the vital statistics returns" (**Annual Report**, 1942:1)

Vital statistics had always been the "barometer" of the health status of a country in that it reflect the level of health of the community of a country (**Report**, 1955:59). To what extent the statement in the **Annual Report** can be accepted as a true reflection of the state of health of the people in the union becomes evident by the fact that statistics were available only for the European section of the population and that it was considered in the selfsame report that it was most unfortunate that statistics for other sections of the population were not available (**Annual Report**, 1942:1). Thus, to what extent the health policy could have been described as a sound one when the instrument (vital statistics) to measure this "soundness" had not been available for all the inhabitants of the country at the time, illustrates the contradiction in terms of the annual report and also the inefficiency of the rendition of health services to all the inhabitants of the country. This lack of legally requiring for the registration of births and deaths for all the inhabitants of the country, was rectified when such registrations became compulsory for all with the extension of registration of Blacks to the rural areas on 1 July 1952. The statistics for all inhabitants of the country could, however, not be regarded as complete. For example, the Department of Health reflected in its

Annual Reports of 1959, 1965, 1966 and 1967 the births and deaths registration of only the Whites, Asiatics and Coloureds (**Annual Report** 1959:8-9; **Annual Report**, 1965-67:38-9).

The 1943 annual report, once again, mentioned the inadequacies as a result of a lack of vital statistics for the population as a whole and reported that the registration of the births and deaths for all sections of the population is one post-war inadequacy that needed urgent attention of the government. Although the annual report acknowledged considerable and increasing difficulties, namely the lack of coordination in the implementation of health policies, it also acknowledged that the work of the Department of Health had been carried out and expanded and that the Secretary for Public Health had been a member of various committees, all with the object of coordinating present and post-war health activities (**Annual Report**, 1943:1.)

The 1943 annual report also referred, for the first time, to the report of the Gluckman commission that would become available early in 1944, the next year (**Annual Report**,1943:1). This is an interesting point since no mention was made to the report of the Gluckman commission in annual reports of the following years as will be indicated subsequently.

The 1944 annual report was introduced by the expression "The strength of a chain lies in its weakest link" (**Annual Report**, 1944:1) and then continued by referring to the ill-health of the non-European section of the population as an ever-present menace to the general well-being of the

country, in other words, the weakest link. Peculiar to an annual report of a "non-political" department such as the Department of Health (departments such as the Departments of Foreign Affairs and Internal Affairs can be considered as "political" departments), the 1944 report described the ill-health of the non-European section in political and racial terms. It had been stated, for example, that the European section, as a result of "the survival of the fittest"., had, through the process of evolution, acquired a way of life capable of standing up to the stresses and strains of present times. In accordance with the report, this was not the case with the non-European who, generally speaking, had not even reached the medieval standards of the European civilisations. It was true, the report stated, that certain sections of the Bantu population had attained to the European standards, but the Holism of Field-Marshall Smuts still holds and until such time as the mass of the Bantu population had sufficiently progressed, difficulties will exist in keeping the country free from epidemics. By referring to the incidence of Tuberculoses and Syphilis amongst non-Europeans in the United States of America, of which the proportion had "...been somewhat similar...(**Annual Report**, 1944:1) to that of the union, the annual report reached the conclusion that the crux of the problem, then, lied not in the Department of Health providing increased facilities for treatment when large numbers of the non-European community carried on a life of gross immorality unheeded and unchecked - a life which could only lead to physical, moral and spiritual degeneracy (**Annual Report**, 1944:1).

The Gluckman commission's findings and recommendations were not mentioned in the 1944 annual report (they were mentioned in the 1943 report), nor were they mentioned in the 1945 annual report. This is significant since the Gluckman commission's findings and recommendations were published in 1944. The reasons for such an ommission could not be ascertained; it can be inferred, however, that the commission's recommendations which were couched in socialistic overtones, were not acceptable to the union government at the time and that the less was reported about it in annual reports, the better. Moreover, the "paving the way" for the rejection of the Gluckman commission's report by referring to the bad state of health of the union as a result of the gross immorality of the non-European inhabitants reported in the 1944 annual report, becomes evident.

The Gluckman commission's recommendations were not implemented, and the non-reflection of its recommendations in the annual reports of the Department of Health at the time can be interpreted as the government's unwillingness to proceed with the recommendations that were based on socialism.

7.5.3 Havenga committee (1949)

After the change of government in 1948, local authorities pressed for the review of the provision and financing of health services as part of the whole question of the financial relations between the central government, the provincial Administrations and local authorities. The matter formed

the subject of discussions at a conference during 1949 under the chairmanship of the Minister of Finance, when it was decided, **inter alia**, to appoint a committee (the Havenga committee), representative of the three levels of government, and under the chairmanship of the Secretary for Health, to investigate the question of the demarcation of health functions and the financial relationships between the various authorities concerned (**Report**, 1959:19-20).

The Havenga committee recommended as a long-term policy, the gradual assumption by the central Government and/or provincial Administrations of full financial responsibility for personal health services (**Report** 1964:64). The recommendations of the Havenga committee were accepted by the Government and given legislative effect through the Public Health Amendment Act, 1952 (Act 44 of 1952). This amending Act gave the Minister of Health control over the rates of salaries paid by the provincial Administrations to persons employed on nursing and midwifery services. It also empowered him to compel the provincial Administrations to establish district nursing and outpatients departments and limited the central government Health Department's liability for refund on such services to those established at the Minister's request. The amending Act did not deprive the provincial Administrations of the right to establish and maintain these services at their own cost, provided that the minister was first consulted (**Report**, 1964:65).

These arrangements were far from satisfactory, because for various reasons, mainly the inability to obtain trained personnel, the Department

of Health was unable to implement the policy of developing a nation-wide system of health centres into which district nursing and out-patient services could be integrated (**Report**, 1964:65).

By 1954 it had become recognised that measures would have to be taken to curb the ineffective financial relationships between the institutions on the various government levels responsible for the rendering of health services. The United Municipal Executive as well as the Cape Divisional Councils Association also continued to press for an investigation into the relationships between local authorities and central and provincial governments. These representations led, on 17 August 1956, to the appointment of a committee to inquire into the financial relations between the various authorities under the chairmanship of Mr C.L.F. Borckenhagen (**Report**, 1964:65).

7.5.4 Borckenhagen committee (1959-1962).

The Borckenhagen committee was appointed to inquire into and to report on:

- the existing functions of all types of local authorities in the Republic of South Africa;
- the question of whether there was any justification for the exercise of such functions by local authorities and whether it would be advisable to abolish or curtail certain of these functions, or transfer them to other suitable institutions;

- the revenue resources of local authorities;
- the adequacy of such revenue resources in view of the functions that local authorities perform or are required to perform;
- any changes in the revenue resources of local governments considered necessary;
- the implications of such changes for the central government, for those of the four provincial Administrations and for those of other public institutions; and
- the legal provision that would be required for the implementation of any changes proposed (**First Interim Report**, 1959:1,2).

It will be noted that no mention was made under the second point above of the possible transfer **to** (own emphasis) local authorities of any functions that were at the time performed by other authorities. The committee, at its first meeting, decided, however, that it would in any case make recommendations in this respect in order to give a complete picture in its report (**First Interim Report**, 1959:2).

The Borckenhagen committee started off by investigating the reappropriation and financing of health services. In its **First Interim Report on Health Services** of 1959 the committee described in detail the history of the existing health system in the union and its state at the time. It reported that the medical and health services were financed by a central Health Department, four provincial authorities with important health functions, local authorities of varying kinds and status's and numerous

other institutions both official, semi-official and private (**First Interim Report**, 1959:10-20).

A thorough study of the **First Interim Report** reveals that it is difficult to imagine a greater degree of divided responsibility and inefficiency in a single service than those that existed in public health - not only in regard to the particular services physically provided for, but also in regard to the distribution of the regulating powers that relate to health and the financing of health services (**Interim Report**, 1959: **passim**).

The Borckenhagen committee divided health services into three general groups that corresponded in broad terms to the division recommended by the Schumann commission in 1944, namely, environmental health services, curative services, and promotional health services.

In accordance with the **Interim Report** environmental health would normally include the provision of pure water supplies, sanitation, inspection of trading and residential premises, food hygiene, the reduction of nuisances, the regulation of vexatious trades, the extermination and/or neutralisation of vectors, the provision of public conveniences, cemeteries and crematoria, health aspects of housing and town planning, slum clearance and the control of air pollution (**Interim Report**, 1959:30-1)

The above activities had to be carried out and financed by local authorities, but the Department of Health had to have a formal and central

advisory bureau dealing with matters on which the smaller local authorities may turn to it for assistence (**Interim Report**,1959:31).

The Borckenhagen commission found that most of the environmental functions mentioned were at the time carried out by local authorities. Legislation on these matters were scattered, and financing was done in an haphazard fashion (by different subsidy formulas). The implementation of enactments had been controlled in a tedious way, control being divided between the central and provincial authorities in an unsatisfactory manner. The coordination of standards and interchange of information were purely accidental. Appreciable differences existed between local authorities of like kind and status in the different provinces. None of the three authorities (central, provincial and local) was apparently satisfied with the state of affairs at the time (**Interim Report**, 1959:6,32,).

By curative services the Borckenhagen committee meant the combating of contagious diseases and the treatment and hospitalisation of patients suffering from communicable diseases. This would also include the treatment of common illnesses (**Interim Report**, 1959:33-41).

Curative services, both as regards the policy laid down and the physical and financial provisions made, were divided in a complicated, confusing and overlapping manner between the central provincial and local authorities. The committee mentioned the fact, for example, that all three authorities control and maintain hospitals. These were admittedly different kinds of hospitals, but the committee pointed out that

specialisation was expensive, and it had in this case been taken to the extreme which resulted in uncoordination in the implementation of health policies (**Interim Report**, 1959:34-6).

According to the Borckenhagen committee promotional health services were services meant for persons suffering from no disease or indisposition. These services were aimed at raising the general standard of health, at sounding timely warning against conditions likely to lead to a break-down in a person's health and at facilitating the early discovery of signs of disease or illness. Examples of promotional services would include services in respect of personal and domestic hygiene, diet, child-welfare and physical education. These types of services had been rendered only on a limited scale at the time in the sense that all three authorities had taken over certain aspects of it on an **ad hoc** basis. Financial relations were out of the question in this case since the services were not formalised and were provided for only on a small scale. This the Borckenhagen committee deplored and part of its report was devoted to an argument for the formalised institution for such services. In this sense the time had arrived to move from the negative conception of health, as being synonymous with the absence of disease, to the positive conception of the promotion of good health in the individual (**Interim Report**, 1959:51-59).

In the analysis of the Borckenhagen committee's recommendations above the lack of formal machinery for the coordination of health services becomes evident. Although the central Government Department of Health

was supposed to coordinate such services, its efforts in this direction were thwarted by the confusing legislation. The Borckenhagen committee found the position in connection with the provision and financing of health services in the Union of South Africa unsatisfactory in the extreme. Coordination and cooperation were conspicious only by its absence.

One cannot avoid the conclusion that the union governments were chiefly to blame for the development and perpetuation of the unsatisfactory state of affairs at the time. As indicated previously (**supra**, chapters 5 and 6) the fact that the final responsibility and accountability rested with the supreme legislative authority, indicated that the government was trying to apply successful secondary measures regarding the implementation of public health policy on a foundation that was faulty or ineffective. No satisfactory relationships between the three tiers in the South African hierarchy of authorities regarding health matters could have been established because the constitutional framework (especially the reasons why authorities exist) had not been surveyed realistically. Yet, this was deliberately avoided by the Borckenhagen committee. The committee, for example, stated that it could not express itself on this issue, and that the central government had rejected certain recommendations by the earlier Gluckman commission because it had tampered with the "constitutional rights" of the provinces (**Report**, 1959:34).

The Borckenhagen committee's recommendations had certain defects. The proposed way in which health services had to be rendered sounded laudable, yet certain defects in these recommendations can be pointed

out. The committee recommended that the three government levels had to carry out one function, but conveniently avoided specific recommendations about the nettlesome question of policy determination and implementation. The Committee also commented extensively on cooperation and coordination, yet no explanation had been forthcoming on how this had to be achieved.

The most paradoxical of all the committee's recommendations had been the one in which it had proposed, without going into detail, that certain local authority services be provided by central and provincial authorities. If they were regarded as local authority services then the question arises why the higher authorities ought to provide them. The implementation of such a recommendation would lead to inefficiency as a result of three government levels becoming responsible for the implementation of health services on one government level only. Perhaps the committee cannot be blamed for such an oversight because the terms of reference of the committee were to inquire into and to report on, **inter alia**, whether there was any justification for the exercise of functions by local authorities and whether it would be advisable to abolish or curtail certain of these functions, or transfer them to other suitable institutions. Perhaps, also, the fact that the Borckenhagen committee had to inquire into the financial relationships between the various authorities, and not public health matters **per se**, led to such a recommendation.

7.5.5 Schumann commission (1960)

The Schumann commission was appointed in terms of Government Notice, No. 520 of 8 April 1960. The commission's terms of reference were to inquire into and to report on the financial relations between the central government and the provincial governments with particular reference to a variety of aspects. Concerning health matters, the commission had to investigate and report on the following:

- the efficacy of the division of functions between the central government and the provincial governments and the desirability, or otherwise, of a reallocation of functions;
- the elimination of overlapping of provincial and central government functions and services, particularly in the fields of health, education and roads (**Report**, 1964:5).

The Schumann commission itself, interpreted the terms of reference to embrace mainly three mutually interdependent aspects of the financial relations between the central government and the provincial governments, namely:

- the division of functions between the institutions concerned and the expenditure involved for each;
- the sources of taxation and the resultant revenue of the different bodies; and

- provincial deficits and the question of subsidies and monetary grants by the central government (**Report**, 1964:5).

It becomes clear from the terms of reference of the Schumann commission that local authorities were not included to be investigated which is to be regretted. How any commission can investigate fully the financial relations involved between the central government and the provincial governments without also including the local authority level in such an investigation, is not clear.

In its summary of the historical development of health services in South Africa, the commission alluded to the fact that it was apparent from the reports of the various committees and commissions appointed up to that time to inquire into health services of the country, that they had been unanimous in finding that the division of health functions between the various authorities was unsatisfactory and should be rationalised in the interest of the sick, and that a more economical and efficient implementation of such functions were necessary (**Report**, 1964:65).

The Schumann commission also pointed out that it was a striking fact that as far back as 1924 the then forgotten Vos committee anticipated the report of the Gluckman commission in stressing the urgent need for a national health policy and the creation of a central health authority to control it (**Report**, 1964:65).

The main findings and recommendations of the Schumann commission attending public health in the Republic of South Africa were that:

- the division of health functions at the time of the investigation between the central government, the provincial governments and local authorities had been artificial and caused overlapping, wastage and inefficiency;
- there was a lack of unified policy in respect of health and hospital services in the country, and that the formulation of a national health policy had to rest with the central government, preferably in consultation with the authorities on provincial and local government levels;
- the policy had to include all forms of health services, namely, non-personal, promotive, preventive, curative and rehabilitative; and
- as far as the implementation of the policy is concerned, it ought to be in conjunction with measures of decentralisation of services, particularly in respect of non-personal or environmental services (**Report**, 1964:78-9).

In order to give effect to the recommendations of a unified health service (which had still been lacking more than fifty years after unification), the Schumann commission recommended the creation of a National Health Advisory Council that would be responsible for the proposal of a national health policy.

The commission's recommendations led to the drafting of a Health Bill in 1972. Because of the prevailing discordant relations between the various government levels as well as the progressive constitutional measures of transferring health functions to self-governing territories (Transkei in 1973, Bophuthatswana and Ciskei in 1975), the 1972 Health Bill was never passed as an act by Parliament (**Debates**, 1977: Col.3138).

This was also the time of the investigations of the **Commission of Inquiry into Matters Relating to the Coloured Population Group** (the Theron commission) which was appointed on 23 March, 1973 to inquire into all the matters pertaining to the Coloured population, including their political position. The Theron commission's proposals led to the appointment of a Cabinet Committee to investigate the ways and means of taking the political and constitutional development of Coloureds and Indians "...a step further" (Introductory note to the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983)).

As a result of the abovementioned factors the Health Bill, 1972 was investigated by a parliamentary commission under the chairmanship of Dr. C V Van Der Merwe, Member of Parliament for Fauresmith (**Debates**, 1977: Col.3138-9).

These investigations led to the formulation of a Health Bill, 1977. During the Second Reading debate of the latter, the point was specifically made by the Minister of Health that the Bill was to replace the rigid health legislation that existed at the time with a more flexible pattern in which the

authority, functions and duties of all the institutions would be reflected. Provision was also made for the coordination of services and the determining of a health policy on a national basis so that the functions and the duties of the different institutions could be adapted to utilize available resources to the maximum, making the most effective health service available to the public (**Debates**, 1977: Col.3140).

As an aside, Second Reading Debates of the House of Assembly provide ample **ex post facto** disclosures by the government-of-the-day of policy implementation problems that were encountered as a result of which the policies have had to be rescinded or adapted and substituted by better formulated policies. The Second Reading Debate on the Health Bill, 1977 was no exeption to this peculiarity.

The Public Health Act, 1977 (Act 63 of 1977) attempted to remedy the lack of efficient coordination of health services brought about by previous legislation. The health institutions up to that time functioned in an unrelated way with almost no involvement of the community in the policy-making as well as the evaluation of the implementation thereof. The main aim of the Health Act, 1977 (Act 63 of 1977) was therefore to establish a coordinated and comprehensive health service in the Republic of South Africa. It also envisaged to ensure that every individual, irrespective of community status or population group has the assurance that Parliament has taken every possible precaution in the interest of his/her health and that of the public at large (Preamble, Health Act, 1977 (Act 63 of 1977); **Debates**, 1977: Col. 3140; Roux 1977:48).

In summarising the main objective of the Health Act, 1977 (Act 63 of 1977), Dr S W Van Der Merwe, Minister of Health at the time, stated that "The respective authorities are required, within the scope of their respective jurisdiction and functions, to endeavour to provide and maintain all the measures as may be necessary to promote the health of the population of the Republic of South Africa to enable every individual person to attain and maintain a state of complete physical, mental and social well-being" (Van Der Merwe 1977:7).

This objective (i.e. the attainment of a state of complete physical, mental and social well-being) which was, and still is, the World Health Organisation (WHO) definition of health (WHO-Technical Report Series, No 528, 1973) might have echoed the ideal, but that it was unattainable became clear on three points. Firstly, the attainment of this objective was an ideal state beyond the recognition and capabilities of man, and up to this day remains so. Secondly, the lack of specificity of standards against which progress towards the objective could be measured were lacking (how does one measure "complete physical, mental and social well-being"?) (Caiden 1976:150-1). Thirdly, and relating to the second point, legal advisors were of the opinion that such a goal, if included as a provision in the Act would have little legal standing, as any contravention thereof did not make provision for a specific contravention indicating a crime with resultant penalties attached thereto (**Debates**, 1977: Col.3140). Although this ideal was removed from the statute book for the latter reason, it still appears in an international publication of the Department

of Health, "The Health of the Nation", which was issued after the adoption of the Health Act, 1977 (Act 63 of 1977). (The Health of the People 1977:7). Lastly, the unattainability of this ideal was illustrated by yet another commission of inquiry (the Browne commission) which was appointed in 1980 (merely three years after the adoption of the Health Act, 1977 (Act 63 of 1977) with its main aim to coordinate health services in the Republic of South Africa), to inquire, once again, into the implementation of health services in the Republic.

7.5.6 Browne commission (1980)

In terms of Government Notice No. R902 of 2 May 1980, a commission of inquiry (the Browne commission) was appointed by the State President of the Republic of South Africa to inquire into the rendering of health services in the Republic. The commission's terms of reference were published in Government Gazette 6969 dated 2 May 1980. With a view to the rationalisation of health services, the promotion of more effective services and the placing of the costs of the services on a sound and firm basis, the commission had to inquire into, consider and report and make recommendations on the range and cost structure of health services in the public and private sectors in the Republic with **inter alia**, particular reference to:

- health services and facilities supplied and provided by the state, provincial administrations, and local authorities;

- the range and cost of health services provided by local authorities; and
- any related matters (**Final Report**, 1986:3-4).

The Browne commission published eight interim reports - one during 1984, six during 1985, and one (the final report) during 1986. The final report was not to summarise the interim reports already submitted but aimed to assess the effectiveness of the whole spectrum of health services in relation to the present and future community to be served, to identify problem areas and to make recommendations on how health services ough to be developed (**Final Report**, 1986:9).

The principle shortcomings in the implementation of health services identified by the Browne Commission were **inter alia**:

- excessive fragmentation of control over health services which has led to a misallocation of resources and to wasteful duplication of services;
- an under-emphasis on preventive health services and an over-emphasis on expensive curative health services which were inappropriate to the needs of the South African community;
- insufficiency of Asian, Black and Coloured doctors, dentists, nurses and other health personnel to serve their respective needs
- a lack of adequate communication between the higher and lower tiers of health administration;
- the practice of health education was largely underdeveloped, uncoordinated, sporadic, financially limited and poorly staffed; and

- statistical information on health matters was generally inadequate in both quality and quantity (**Final Report**, 1986:18-20).

For example, in a Research Report on overlapping and/or conflicting statutory provisions pertaining to the manufacture, distribution, usage and control of medicine to the Browne commission by the writer of this thesis and a colleague, the inefficiency in the implementation of the policies dealing with medicine control as a result of overlapping and/or conflicting of statutory provisions was confirmed (Hanekom & Bain 1982: **passim**).

The government responded to the recommendations of the Final Report in a White Paper (a statement, printed on white paper, issued by government for the information of Parliament). In the White Paper the government agreed with the finding of the commission on the need for a comprehensive statement of a health policy. It was also reported in the White Paper that the government believed that the way in which the various health authorities were financed was one of the causes of the fragmentation of health services and the lack of central policy direction. The government had therefore decided that all budgets of health authorities would be channelled through the Health Matters Advisory Committee to the National Health Policy Council for consideration. The government had also decided to follow a standard procedure for obtaining funds to finance all government services in South Africa whereby all government health authorities (including those in the non-independent homelands) would negotiate funds for specific objectives on the basis of the national health policy and priorities. The White Paper warned,

however, that because of the economic realities of South Africa and the increasing size of the population, the gap between funds available for health matters and the needs of the population might widen (**White Paper**, 1986:2-4).

The government also stated in the White Paper that the National Health Policy Council, acting on the Health Matters Advisory Committee's advice, would be responsible for determining national health policy, planning national health services, and monitoring and coordinating the national health system. The Department of National Health and Population Development would provide the structure for planning and coordinating the national health. The central government would also create a full-time secretariat within the Department for the Health Matters Advisory Committee and the National Health Policy Council. This secretariat would undertake secretarial services, coordinate all advice received by the National Health Policy Council, furnish the latter with health data, conduct investigations on behalf of the Council, ensure that all concerned were advised of decisions affecting them, and ensure that policy decisions were implemented (**White Paper,** 1986:3).

The Browne commission was the most recent commission of inquiry that reported on the implementation of health services in the Republic of South Africa. The adoption of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983) brought about the division of health services for Whites, Coloureds and Indians on an own and general affairs basis (**supra**, Chap 6). That the constitutional arrangements of 1983 would impact negatively

on the coordinated and efficient rendering of health services became evident from 1983 up to 1990 (**Race Relations Survey** 1983:482-3, 1989/90:385). The government did, however, make concerted attempts to render an efficient health service for all the inhabitants of the country during this time, the first of which was the announcement of a National Health Plan in 1986 with the emphasis on preventive health services through the medium of community centred health services - in other words, a primary health care service. The idea of a primary health care service was also precipitated in a policy decision of the National Health Council to the effect that, **inter alia**, the only way in which an affordable health service could be rendered for all the inhabitants of the country was a service that had to be based on the National Health Facility Plan with the emphasis on primary health care. Secondly, a concept strategy for the development of primary health care was adopted in 1989 in terms of which a geographical, financial, cultural and functional accessible health service was propagated (**Konsepstrategie**, 1989:2,6)

The fact that the negative impact of the 1983 constitution persisted up to 1990 notwithstanding the laudable attempts is best illustrated by a statement by Dr Rina Venter, Minister of National Health and Population Development in 1990, and a statement by the Health Ministerial Representative of the region: Northern and Western Transvaal (Dr M H Veldman) in 1992.

Opening the Parliament debate on the Budget Vote for her department on 16 May 1990, Dr Rina Venter proposed a plan aimed at the reconstruction

of South Africa's health services which would revolve around five principles, namely, the accessibility of health services, their affordability, the effectiveness of health care programmes, equity in the provision of health services, and the acceptability of services to all people of the Republic of South Africa (**Debates**, May 1990: Cols 9383-9394). The fact that the plan was proposed in 1990, illustrates that the government had not yet fulfilled its plans adopted in 1988 and 1989 referred to earlier.

In 1992 the Ministerial Representative for the portfolio National Health and Population Development confirmed that the excessive fragmentation in the delivering of health services enhances inefficiency and that the time had arrived that the actions that are necessary to establish health policy in practice would be that such policy had to be implemented actively and aggressively (Veldman 1992:2-3).

7.6 Main impediments to the efficient implementation of health policy

Firstly, during and for a considerable time after unification in 1910 the health policies of the then defunct colonies had to serve the needs of a union. This piecemeal way of dealing with the health position of the country led to inefficiency in the implementation of these policies.

Secondly the non-existence of a separate portfolio for public health at unification up to 1919 coupled with the lack of a health policy for a national state contributed to an uncoordinated way of dealing with the health problems of society.

Thirdly, the ocurrence of the influenza epidemic in 1918 through 1919 brought the inefficiency and the redundancy of the public health policies forcibly home to the legislators of the union.

Fourthly, commission after commission of inquiry into health and financial matters in the Union of South Africa, and later on in the Republic (a total of six: 1924, 1942-44, 1949, 1956, 1964, and 1986) confirmed the inefficienct ways in which the government programmes had been implemented, and yet, little progress was made by the government-of-the-day at the particular times to ameliorate such inefficiency. The way in which the problems of the inefficient implementation of the public health policies were investigated can also be considered to be at fault. No enduring solutions to the problems identified could possibly be offered by commissions/committees of inquiry with a limited frame of reference of investigation that, as a result, had to break up the field of investigation into fragments and inquire into only one functional aspect.

Lastly, the information in annual reports of the Department of Health from 1926 to 1946 concerning the rendition of health services corresponded little with the information given in the reports of commissions of inquiry for the same periods and it therefore did not reflect correctly the status of health of the union at the time. If one assumes that annual reports mentioned in this thesis are the only official reports of the activities of the Health Department of the government-of-the-day for a particular year, then the results of the lack of correct information becomes apparent.

7.7. Conclusion

The efficiency variable in the implementation of the health policy of the Republic of South Africa was analysed in this chapter. The analysis focussed chiefly on the prominence, or not, of efficiency with regard to health policy implementation by referring to the main public health Acts, Annual Reports of the Department of Health since 1927 when it first appeared, and the reports of commissions/ committees of inquiry pertaining to public health

Drawing on the analysis of this chapter, the following concluding remarks can be made.

The constitutional dispensation created by unification has not unified and coordinated the piecemeal health policies of the then defunct colonial governments which became provinces. For all intents and purposes the implementation of colonial health policies in a union could not have been efficient. Unification created a centralised government structure for which the piecemeal policies of the defunct colonial governments had to serve.

In the absence of vital statistics for all the inhabitants of the country during the beginning years of the Union of South Africa the state of health of the country could not be measured and thus, whether the implementation of the health policies was efficient, could not be be ascertained by the health authorities.

Although commission after commission of inquiry focussed the attention of the government on the inefficient ways in which health policies were implemented, only limited steps, and in certain cases, no steps at all were taken by the government to ameliorate the duplication, uncoordination and working at cross-puposes in the implementation of public health policies.

The final responsibility for the amelioration of the inefficient ways in which public health policies were implemented rested with the supreme legislator, Parliament. The supreme legislator attempted to apply some of the secondary measures which had been recommended by some of the commissions/committees of inquiry, on primary foundations (the successive 1909, 1961 and 1983 constitutions) that were faulty for the purposes of the rendition of an efficient public health policy. The result was that **ad hoc** and piecemeal steps were taken with the result that inefficiency was perpetuated on a broader scale.

CHAPTER 8

Evaluation

This study concerned itself with an analysis of the public policy process, particularly the impact of the variables of legislative direction, public accountability, democratic requirements, reasonableness, and efficiency on the public policy implementation process as a means towards the accomplishment of governmental activities.

Governmental activities ought to be purposeful. In order to understand the purposefulness of governmental activities the relationship of the public policy function in the political and administrative processes as well as the focus and locus of the policy process and the policy implementation functions were described.

Certain variables must **inter alia**, also be taken into account in order to implement public policies purposefully. For the purposes of this study certain external variables such as legislative direction, public accountability, tenets of democracy, reasonableness, and efficiency were identified as a framework within which the implementation of public policies, particularly public health policy in South Africa was analysed from 1910 to 1990.

The study indicates first and foremost that to consider the public policy process as part of only the political process is incorrect and ought to be dispelled. The public policy process is as much a function of the

administrative process as it is of the political process. For government action to be purposeful, behoves a recognition of the nature and contents of the public policy process (consisting of various models, instruments and levels) as a constituent part of both the political and administrative processes. It cannot be otherwise since the political process cannot do without the advice, research and planning that evolves from the administrative process.

The fact that the public policy process is also a constituent part of the administrative process can be linked to the importance of the implementation part of the public policy process since the place of abode of the administrative process is usually considered to be the executive arm of government. A point emerges here that can serve as a topic for future research, namely, to what extent the executive arm of government is becoming a political policy-making body without being subject to the checks and balances of the political process. Together with the increased emphasis on the democratisation of the public service (particularly as from February 1990) and therefore also an increased delegated policy-making authority to public officials, ought to come an increased emphasis on how public services can be democratised without it becoming undemocratic. To put it in different terms: what is the break-even point of democratisation of the public service without it becoming so involved in policy-making that the much emphasised neutrality and a-political nature of the public service become eroded?

This study has indicated that the implementation of public policies in general, and the health policy in particular, leaves much to be desired. The main causes for such a state of affairs are that the external variables, namely, legislative direction, public accountability, democratic requirements, reasonableness, and efficiency were generally ill considered by the legislatures and the Department of Health in the Union of South Africa (1910-1961) and the Republic of South Africa under the 1961 constitution, and ultimately, under the 1983 constitution. This ill consideration impacted on the effectiveness of public policy implementation by being essentially fragmented.

The unification of South Africa in 1910 was that of a constitutional union, but it was, with a few exceptions far removed from a unification in the rendering of public health services through the implementation of the successive health policies.

The South Africa Act, 1909 was an act of the British Parliament. The Act was a top-down approach to the policy process and therefore also the policy implementation function. This top-down approach was carried over into the Republic of South Africa Constitution Act, 1961 (Act 32 of 1961) and the problematics of having public health policies effectively implemented remained. This approach was also carried over into the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983).

It had been shown that the constitutional fact of unification which can also be seen to have been formalised in the Republic's motto - **Ex Unitate Vires**

(Unity through strength) was not realised in the case of the implementation of public health policies.

It was inevitable that the top-down approach to public policy implementation would also be reflected in the implementation of public policies, particularly the successive health policies during the time of union, after becoming a Republic in 1961, and after the adoption of the 1983 constitution up to 1990.

It had been shown that the external variable of legislative direction concerning the amelioration of the implementation difficulties brought to light by questions in Parliament, by annual reports of the Department of Health, and by commissions/committees of inquiry were of an **ad hoc** and piecemeal nature and that it did not succeed in addressing attendant health problems successfully. Particularly during the initial years of unification (1910-1919) the piecemeal policies of the then defunct colonial governments had to serve the needs of a unified state.

It was not until, and because of, the influenza epidemic of 1918 that the legislature at the time considered for the first time to attempt to consolidate the ex-colonial health policies into one health policy for the Union of South Africa. The result was the speedy adoption of the Public Health Act, 1919 (Act 36 of 1919). Up to that time and even thereafter health policy implementation was fragmented.

The Public Health Act, 1919 (Act 36 of 1919) essentially enshrined the principle of decentralisation whilst the the constitutional principle embodied in the South Africa Act, 1909, was one of centralised rule by a White hegemony. These two diametrically opposed principles were perpetuated in the 1961 constitutional dispensation. The Public Health Act, 1919 was still on the statute book and implemented up to 1977.

Although the main emphasis of the Health Act, 1977 (Act 63 of 1977) was to render a coordinated health service for all the peoples of the Republic of South Africa, the fragmentation of such services was perpetuated up to 1990. The constitutional principle of separation on the basis of race, and the coordination of health services for all the peoples of South Africa worked at cross purposes in the implementation of health services in the country.

Annual Reports of the Department of Health and commissions/committees of inquiry into health matters (of which the first was appointed in 1924 and the last in 1983) confirmed such a fragmentation of health services. For example, both the first commission of inquiry (the Vos committee, 1924) and the last one (the Browne commission, 1983), confirmed the lack of centralised health policy direction as one of the major difficuties that thwarted the implementation of public health policy.

A point that emerged from the research for this thesis is that information contained in the Annual Reports of the Department of Health during the time of union did not at all times correspond to the information contained

in the reports of the commission/committees of inquiry at the time. Annual Reports as official reports of the activities of the Department of Health ought to reflect the reality and it should not be veiled in hidden terms.

Concerning the external variable of public accountability the members of the first Cabinet of the Union of South Africa appointed by Genl. Louis Botha had little solidarity because the members hailed from different (albeit kindred) political parties. The first general election on 15 September, 1910 formed the basis of the principle of Cabinet (and party) responsibility which became the hallmark of South African politics up to the introduction of the Republic of South Africa Constitution Act, 1983 (Act 110 of 1983). The fact that the Department of Interior was responsible for the rendition of health services from 1910 to 1919 also resulted in the dissipation of responsibility between the various government levels in that no consolidating measures were taken during this time to curb the fragmentation of health policies.

The Public Health Act, 1919, (Act 36 of 1919) did not envisage or create a national health service, but was born out of an emergency situation created by the influenza epidemic of 1918. The principle behind the Act was decentralisation. All that the Act tried to facilitate was to create the administrative machinery and make the financial provisions to cope with a variety of health services. The difficulties that have since arisen, arose out of the **ad hoc** attempts to deal with a national health system for which the Act did not provide.

Little, or no action at all, was taken by the government on the recommendations of the reports of the most important committees and commissions appointed by the selfsame government to inquire into the rendering of a health service for the country. The only direct result of all the attempts that were put into these inquiries had been comparatively minor and piecemeal changes from time to time on the basis of which the central government subsidised those health services for which it was constitutionally responsible but whose execution it delegated to local authorities. The result was that the accountability variable was complicated by the numerous institutions that were responsible for the implementation of health policies. Responsibility was dispersed and resulted in cross-references between various health institutions concerning the **locus** of responsibility. Working at cross-purposes followed inevitably.

Democratic government and governmental institutions in accordance with the 1909 and 1961 constitutions were developed by the White electorate for the purposes of a White hegemony. This White hegemony was also perpetuated in the the first consolidating health policy for the Union of South Africa namely the Public Health Act, 1919 (Act 36 of 1919) in terms of which non-Whites were excluded from the National Health Council whose function it was to advise and assist the Minister of Health and the Administrator of each province in the planning and implementation of health services. Although the 1983 constitution broadened the democracy to include Coloureds and Indians through the institution of a three

chamber Parliament, the Blacks were excluded from participating in this highest law-making institution. The 1961 and 1983 constitutional dispensations were also reflected in the way in which health services were structured and implemented. The independent Transkei, Bophuthatswana, Venda, and Ciskei states and the six self-governing national states (Lebowa, Gazankulu, Qwaqwa, Kwazulu, KwaNdebele, and Kangwane) received, from 1973 to 1984 full responsibilities for all health services in their respective areas.

The applicability of the variable democratic requirements was inferrred from the constitutional dispensations of the 1909, 1961 and 1983 constitutions. In terms of the 1909 constitution only Europeans had direct representation in Parliament and were subject to censusses for these purposes. For other censusses the Governor-General could decide on the inclusion or not of non-Europeans. The expression of democracy by the governing party (the National Party) from 1948 up to February 1990 was one that was based on the Christian basis that the party undertook to protect the White race properly and effectively against any policy, doctrine or attack that might have undermined its continued existence. This policy of the National Party was also reflected in the way in which health policies were adopted and implemented.

The analysis of the variable of reasonableness showed that it was inextricably linked, and incongruent to the variables of legislative direction and democratic requirements. It was shown that public health policies, and policies related to public health, were supposed to be

implemented in a reasonable fashion within an unreasonable government policy framework. The unreasonable government policy framework also precipitated in the unreasonable implementation of public health legislation, and other legislation concerned with public health.

It was shown that the lack of the variable of efficiency in the rendition of health services became the major force for the government to appoint various commissions/committees of inquiry to deal with the inefficient implementation of health services. Six commissions/committees were analysed for the purposes of this thesis. Commission/committee after commission/committee of inquiry confirmed the inefficient ways in which health services were rendered in the Union of South Africa, and later on in the Republic of South Africa. The main impediment of the efficient implementation of health policy was that the first consolidating health policy for the union, namely, the Health Act, 1919 (Act 36 of 1919), was based on the principle of decentralisation while the constitutional dispensation was one of centralisation. These opposing principles resulted in the dissipation of functions, energy and skills. Seen against this background, measures to ameliorate the inefficient implementation of health policies were of **ad hoc** and piecemeal nature and did little (as was exemplified by the reports of the commissions/committees of inquiry) to rectify the matter.

The evidence of this thesis brings one main conclusion and recommendation to the fore, namely, that unless and until public health matters and the problems associated with the implementation thereof are

placed on a party political and a constitutional agenda, little headway will be made. The aphorism "public health creates public wealth" is perhaps not out of place here. Through the years since unification in 1910 up to the 1983 constitution, little was done to place public health on a constitutional agenda. It also did not figure prominently, or did not figure at all, in the manifestos of the political parties that partook in general elections through the years. The actions of governments that resulted in certain steps that were taken during these years were based on experiences, (i.e. reaction), as was shown in the case of the sudden outbreak of the influenza epidemic in 1918 which prompted the speedy adoption of the first consolidating health policy for the union in the form of the Public Health Act, 1919 (Act 36 of 1919) nine years after unification. This Act was adopted in a time of crisis and had to serve the needs of the country up to 1977 (i.e. for fifty nine years) by being amended on no less than 21 occasions. Although the Act endured for fifty nine years, it was shown by the research that the much alluded to external variables of Public Administration in South Africa, namely, legislative direction, public accountability, democratic requirements, reasonableness, and efficiency were largely not heeded in the case of health policy implemention.

The fact that the Republic of South Africa is to undergo constitutional changes in the near future, makes the reconsideration of **inter alia** the external variables, singularly and in combination, of the utmost importance if the rendering of future health services for the country is to

be conducted in a planned fashion that will work towards meeting the requirements of all the inhabitants of the country.

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Addendum 1

Administrative functions that influence the policy implementation process

Policy

- Heads of departments do not partake collectively in the formulation of public policy that influence state administration.
- Public policy statements are vague.
- Public policies are not always practically implementable.
- Arbitrary deviation from and inconsistent implementation of stated public policies.
- Uncertainty over the future political and governmental dispensation.
- Contradictory policy statements.

Organising

- Continuous allocation and division of functions create problems such as negativism among personnel, insufficient personnel provision and funds, and duplication of functions.
- Excessive influence and control over the determination of organisational structures and departments by the Commission for Administration.
- Unclear demarcation of areas of responsibility, for example, the Department of Planning and Provincial Affairs and the provincial Administrations, and various institutions responsible for health services and transport.
- Inefficiency and the duplication of administrative structures linked with political structures.
- Obvious inability to adapt internal organisational structures to changing circumstances.
- Uncertainty over future governmental structures.
- Rapid changes necessitate the creation of **ad hoc** and alternative structures that obstruct the harmonious functioning of such structures with the existing structures.
- Regulating legislation that requires additional administrative structures.
- Unmanageable administrative structures, for example, within provincial Administrations.

Financing

- Lack of funds for the implementation of public policy.
- Excessive influence and control exercised by the Department of Finance over the utilisation of funds.
- Existing financial prescriptions are too detailed, wordy, time consuming, and too restricting and do not comply with the individual departments' unique needs.
- **Ad hoc** adaptations to the budget complicate long term planning towards the satisfying of needs.
- Lack of proper prioritising and long-term strategies.

Personnel provision and utilisation

- Excessive influence and control over personnel provision and utilisation by the Commission for Administration.
- Personnel prescriptions are too detailed, wordy, time consuming and too restricting and do not comply with the individual departments' needs.
- Existing prescriptions have no leeway for discretion.
- Apparent lack of confidence of personnel in management.
- Shortage of suitably trained manpower, particularly on management level .

Procedures and methods

- Procedures are frequently written into legislation with the result that the adaptation thereof are impossible.
- Rigid control measures that dictate circumlocutory procedures.
- Decisions of management frequently focus on the symptoms of a problem instead of the causes, namely faulty procedures and methods.

Control

- Control measures that are centrally prescribed are unnecessarily rigid and detailed.
- Lack of clear and quantifiable goals limit effective control.
- Existing control measures limit the establishment of accountability with responsible managers.

Source: Van der Merwe 1990.

Addendum 2

Organizations that nominated one member to represent them on the National Health Council

- Municipal Association of each province;
- Association of Divisional Councils of the Cape Province;
- Health Officials Association of Southern Africa;
- South African Veterinary Medical Association;
- South African Trades and Labour Council;
- Chamber of Mines;
- Federated Chamber of Industries and Association of Chambers of Commerce jointly;
- South African Red Cross Society;
- St John Ambulance Association and the Noodhulpliga jointly;
- South African Women's Agricultural Union;
- National Council of Women of South Africa;
- South African National Council for Child Welfare;
- South African National Council for the Deaf;
- SouthAfrican National Council for the Blind;
- South African National Council for Mental Hygiene;
- National Council for the Care of Cripples in South Africa;
- Each university in the Union possessing a medical or dental faculty;
- Two persons to represent the Federale Vroueraad;
- Not more than three persons to represent three other organisations as the Governor-General may specify in the the Gazette.

Source: **Public Health Act**, 1919 (Act 36 of 1919), Section 4(1)(c).