



# The protection of privacy and confidentiality in the South African health care sector

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## DECLARATION

I, 25946382 declare that this dissertation which I hereby submit for the fulfilment of the requirements for the degree of Masters in Private Law at the North West University is my own work and has not been submitted by me for any other degree at any other University. I also declare that any secondary information used in this dissertation has been duly acknowledged and referenced in accordance with the requirements of the University.

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## ABSTRACT

This research focuses on privacy and confidentiality in the South African Health Care Sector (SAHCS). Through the *Constitution*<sup>1</sup> which brought about rights to its democratic state: constant educational developments, training, scrutiny, and understanding have been paramount to enforcing these rights in constitutional transformation.

In saying so, the right to privacy and confidentiality is consistently evolving with technological advancement.<sup>2</sup> This is indicated through recent developments as provided by the protection of privacy and confidentiality through the Protection of Personal Information Act<sup>3</sup> (POPIA) and the Promotion of Access to Information Act<sup>4</sup> (PAIA).

This study chose to investigate how the rights of privacy and confidentiality are catered for in the SAHCS. Furthermore – through *POPIA* and *PAIA* – significant protocols were introduced which aid with the promotion, protection, and enforcement of the rights to privacy and confidentiality and these do not exempt any sector from its legislative compliance. Therefore, this brings about a specific question in relation to the SAHCS which this study aims to answer. The research question is: how can the current health care legal framework in South Africa be enhanced to ensure sufficient protection of health care users' rights to privacy and confidentiality?

The study attempts to answer this question through a series of critical discussion, examination, comparison and analysis presented through a full literature review study of legislative and ethical frameworks, cultural influence, and analysis international standards.

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<sup>1</sup> The Constitution of the Republic of South Africa, 1996.

<sup>2</sup> Swales 2016 *SAMJ* 49. See also Burns and Burger-Smidt A commentary on POPIA 4.

<sup>3</sup> The Protection of Personal Information Act 4 of 2013.

<sup>4</sup> The Promotion of Access to Information Act 2 of 2000.

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## **DEDICATION**

To my late Nana and Nani (Mr & Mrs Harrinarian - my maternal grandparents) for the injustice done to your privacy and confidentiality in your last days.

Without you I would not be where I am today.

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## **LIST OF ABBREVIATIONS**

|        |                                                  |
|--------|--------------------------------------------------|
| AI     | Artificial Intelligence                          |
| BOR    | Bill of Rights                                   |
| CA     | Children's Act                                   |
| CPA    | Consumer Protection Act                          |
| CPD    | Continuing Professional Development              |
| ECAT   | Electronic Communications and Transactions Act   |
| EU     | European Union                                   |
| GDPR   | General Data Protection Regulation               |
| HCP    | Health Care Practitioners                        |
| HCS    | Health Care Sector                               |
| HPA    | Health Professionals Act                         |
| HPCSA  | Health Practitioners Council of South Africa     |
| ITHCPC | Interim Traditional Health Practitioners Council |
| MHCA   | Mental Health Care Act                           |
| NA     | Nursing Act                                      |
| NHA    | National Health Act                              |
| PAIA   | Promotion of Access to Information Act           |
| POPI   | Protection of Personal Information               |
| SADA   | South African Dentistry Association              |
| SAHCS  | South African Health Care Sector                 |
| SANC   | South African Nursing Council                    |

|      |                                      |
|------|--------------------------------------|
| SAPC | South African Pharmacy Council       |
| SLP  | Short Learning Program               |
| THPA | Traditional Health Practitioners Act |
| UN   | United Nations                       |
| US   | United States                        |

# CHAPTER 1 INTRODUCTION

## ***1.1 Problem Statement***

Whilst the world steadily transitions towards a fifth revolution, technological advanced lifestyle, the development/s of legal and statutory frameworks that, directly implicate individuals become questionable. Rights and regulations develop as the world transforms into different eras. Research indicates that, privacy is considered one of the oldest rights which is considered to originate since the existence of humankind.<sup>5</sup> It is noticeable that the right to privacy evolves with each era due to society, modern human interactions and evolution.<sup>6</sup> Before the discussion advances to key aspects of this study, one needs to comprehend the definitions of privacy and confidentiality.

### *1.1.1 Understanding privacy and confidentiality*

Due to continued technological developments and the age of digitalisation, privacy and confidentiality of personal information<sup>7</sup> have become a niche area.<sup>8</sup> As this study develops one would begin to understand that privacy and confidentiality in the health care sector are not interrelated. Privacy in the health care sector includes components of the health care environment that go beyond the health care practitioner and patient contract at a professional level.<sup>9</sup> Confidentiality often includes a normative framework applicable to a given profession.<sup>10</sup> For example, attorney-client confidentiality does not have the same limitations as privacy.<sup>11</sup> Similarly, confidentiality is extremely particular in its purposes which is governed by

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<sup>5</sup> Lukács 2016 *U-SZEGED* 256.

<sup>6</sup> Swales 2016 *SAMJ* 49 also see Lukács 2016 *U-SZEGED* 256.

<sup>7</sup> Swales 2016 *SAMJ* 49-51.

<sup>8</sup> Burger-Smidt A commentary on POPIA 4.

<sup>9</sup> Moodley K Introduction to medical ethics, law and human rights 106-176.

<sup>10</sup> We continuously see this through Section 14 and 15 of NHA and the same echoed in the ethical guidelines provided for by HPCSA 1- 12.

<sup>11</sup> As one would understand from section 1 of PAIA which defines personal information, and which will be discussed broadly in chapter 2.

legislative and ethical frameworks.<sup>12</sup> As a point of departure, the study investigates the definitions of privacy and confidentiality.<sup>13</sup>

Over several centuries of study, spread through the various eras, some scholars agree that privacy has no formal direct definition.<sup>14</sup> On the contrary, their opposes define privacy as 'society dependant'<sup>15</sup> based on several determining factors. Each society has its own differences, cultures and scientific development which can lead to developing what should be considered as private and the protection thereof.<sup>16</sup>

According to Alan Westin,<sup>17</sup> for a lengthy duration, scholars worldwide attempted to define privacy. He further added that privacy is affected by the political, socio-cultural, and personal spheres of society. In addition to this, according to Westin's research he extended the definition of privacy as:

The claim of individuals, groups or institutions to determine for themselves, when how and to what extent, information about them is shared or communicated to others.<sup>18</sup>

Daniel Solove<sup>19</sup> indicated that the scope concerning the definition of privacy was either too broad or narrow and all the definitions he encountered were problematic.

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<sup>12</sup> Both these frameworks will be discussed in detail via chapter 2 and 3 respectively.

<sup>13</sup> Perinan 2012 194.

<sup>14</sup> Lukács 2016 *U-SZEGED* 258.

<sup>15</sup> Fried 1968 *YLJ* 486.

<sup>16</sup> Each continent has their own unique set of privacy rules and regulations or else all privacy around the world would be aligned. As we see in Western Cultures through the development of Privacy bills, the United Nations the first mention of personal privacy dates back 1948; The United States of America the 4<sup>th</sup> Amendment refers to freedom from unreasonable searches and seizures; Africa through the African Charter of human and Peoples Rights adopted in 1981 to current section 14 of the Constitution of South Africa 1996 and to developments of privacy in 2000 through PAIA before POPIA was introduced in 2013; Read Olinger, Britz and Olivier 2007 *ULBR* 37.

<sup>17</sup> Alan F. Westin, the lawyer and political scientist, known as the most important scholar of privacy since, Louis Brandeis. Read further <https://www.theverge.com/2013/2/25/4027072/alan-westin-legal-scholar-privacy-law-obituary>.

<sup>18</sup> Westin 2003 431-453.

<sup>19</sup> One of the World's leading experts in privacy law, and the John Marshall Harlan Research Professor of Law at the George Washington University Law School. Read further <https://www.danielsolove.com/>.

Thus, in his attempt he defined privacy by creating six (6) categories of which privacy is (1) right to be let alone; (2) limited access to oneself; (3) secrecy; (4) control of personal information; (5) personhood and (6) intimacy.<sup>20</sup>

Confidentiality can be simply referred to as a secret<sup>21</sup> considered to award individuals limited access to personal information.<sup>22</sup> Traditionally, doctors, lawyers and priests all afforded their patients', clients and followers' professional confidentiality, regarding what these individuals confided in them.<sup>23</sup> Confidentiality affords client/s within professional spheres with a safe-haven that allows them to discuss private and highly confidential information.<sup>24</sup> Clients are able to seek relevant assistance by forming a trusting relationship between practitioner and user - therefore ensuring accurate transfer of important and relevant information in the treatment of a user in SAHCS. As a legal term, confidentiality refers to the duty of an individual to refrain from sharing confidential information with others, except with the express consent of the other party.<sup>25</sup>

From the above insight on how privacy and confidentiality are defined, one can conclude that these imperative aspects both echo anonymity. A brief historical overview is provided below on the origin privacy and confidentiality.

### *1.1.2 The origin of privacy and confidentiality*

Many<sup>26</sup> scholars that reigned during various eras researched the autonomy of privacy. The right to privacy is, considered one of the rights that is old as humankind.<sup>27</sup> It is considered that privacy stems even before the birth of Christ<sup>28</sup>

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<sup>20</sup> Solve 2011 4.

<sup>21</sup> Bok 1983 24.

<sup>22</sup> Yu 2008 161.

<sup>23</sup> Bok 1983 24.

<sup>24</sup> Bok 1983 24.

<sup>25</sup> Legaldictionary.net. <https://legaldictionary.net/confidentiality/> accessed 23 September 2021, 01:09am.

<sup>26</sup> Which are but not limited to the following scholars: Bloustein 1964; Fried 1968; Posner 1978; Warren and Brandeis 1980; Gavison 1980.

<sup>27</sup> Lukács 2016 *U-SZEGED* 256.

<sup>28</sup> Hereinafter referred to as BC.

and the beginning of the *Hippocratic Oath*<sup>29</sup> which established the concept of doctor-patient confidentiality. In 400, after the death of Christ,<sup>30</sup> most priests practiced medicine and practiced confidential communication due to the "*secret box*" which is a traditional Christian room. An individual consults a priest in the private room and attests to their sins, seek pastoral guidance and emotional support. As a result, the confidential practice was carried into the theatre room.<sup>31</sup>

The *Code of Hammurabi*<sup>32</sup> also included privacy. From a legal perspective, it contained a paragraph against the intention into someone's home whilst Roman law regulated the same question.<sup>33</sup> In ancient times, a society's and individual's private lives were influenced by the state and had limited possibility for self-determination.<sup>34</sup> During a Legal Philosophy module, legal graduates learn that Plato (a famous philosopher) echoes the same phenomenon of privacy in his famous dialogue, "*The Laws*",<sup>35</sup> in which a person's life was controlled and decided by the state, and did not allow any freedom.<sup>36</sup>

During the Medieval age, individuals existed as members of the community and their private lives were under surveillance by other members of the community, thus privacy was non-existent during this era.<sup>37</sup> In the 18<sup>th</sup> century, in the famous work of Brandeis' and Warren's "*The Right to Privacy and the Birth of the Right to Privacy*" in 1890, the authors argued that the law evolves with the generational transformation.

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<sup>29</sup> Hippocratic Oath can be, defined as, one of the oldest binding documents in history, the Oath written by Hippocrates is held sacred by physicians: to treat the ill to the best of one's ability, to preserve a patient's privacy, to teach the secrets of medicine to the next generation. [Medicinenet.com.https://www.medicinenet.com/hippocratic\\_oath/definition.htm](https://www.medicinenet.com/hippocratic_oath/definition.htm), reviewed 6 March 2021. Accessed 24 September 2021, 08h20.

<sup>30</sup> Hereinafter referred to as AD.

<sup>31</sup> Williams 2021 2.

<sup>32</sup> A set of code of laws that existed in ancient Babylon between 1755–1750 BC.

<sup>33</sup> Solve 2011 4.

<sup>34</sup> Lukács 2016 *U-SZEGED* 257.

<sup>35</sup> One of the most famous works of Plato published BC.

<sup>36</sup> Lukács 2016 *U-SZEGED* 257.

<sup>37</sup> Lukács 2016 *U-SZEGED* 257.

By the 19<sup>th</sup> century, societal and generational transformation drastically changed the way individuals conducted certain aspects of daily living.<sup>38</sup> Privacy and confidentiality thus evolved accordingly and people were awarded certain privileges of privacy as apposed their historic generations. Whilst the economy, society and individuals evolved with this era, more people followed urbanisation and moved away from traditional households in the village and countryside to the crowded cities.<sup>39</sup> The threat towards privacy began to spiral out of control rapidly. On the one hand, some people experienced a dose of privacy for the first time while others had to adopt into privacy regulations in order to learn how to protect their newly awarded right.<sup>40</sup> In doing so, urbanised individuals became vulnerable as technology and society transitioned into a rapid metamorphous of a more modern era.

As the protection of privacy became more vulnerable, this led to the start of legal and statutory developments across the globe.<sup>41</sup> Countries around the world were, influenced by the new transition and developments of privacy which required stringent legal regulations to consider the protection of privacy. The right for privacy influenced law across the world.<sup>42</sup> The United Nations (UN), was influenced from the famous Bradeis article, which led the Europe Union (EU) following in the footsteps of the UN. The EU commenced to examine the right to privacy and created their own protection of privacy.<sup>43</sup>

Some of these privacy regulations stem from the development of international human rights conventions, which included but are not limited to:

1948 – United Nations - Article 12 of the Universal Declaration of Human Rights  
1950 – Council of Europe – Article 8 – the European Convention of Human Rights  
1966 – United Nations – Article 17 of International Covenant on Civil and Political Rights;  
2000 - European Union – Article 7 of the Charter of Fundamental Rights.<sup>44</sup>

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<sup>38</sup> Lukács 2016 *U-SZEGED* 257.

<sup>39</sup> Bratman 2002 344.

<sup>40</sup> Bratman 2002 344.

<sup>41</sup> Lukács 2016 259.

<sup>42</sup> Lukács 2016 *U-SZEGED* 257.

<sup>43</sup> Lukács 2016 *U-SZEGED* 258.

<sup>44</sup> Lukács 2016 *U-SZEGED* 259.

When computers drastically underwent modification according to their demands of the new millennium, society and technology transitioned again to accommodate and evolve with the new way of life. With the new age of technology again came more attacks on the right to privacy and the protection thereof.<sup>45</sup> This influenced society,<sup>46</sup> individuals and the corporate world instantaneously as technology evolved drastically and is still consistently being developed. Thus, for the basis of this study, the statutory and legal framework of privacy and confidentiality will be analysed and discussed in Chapter Two (2) to understand efforts in the attempts of protecting privacy and confidentiality.

As discussed, privacy and confidentiality are both considered to originate from the initial existence of humankind. These terms have simultaneously developed in each era, whereby as the human population evolves into various stages so too do the concepts of privacy and confidentiality.<sup>47</sup>

### *1.1.3 A South African perspective on the right to privacy and confidentiality*

The *Constitution*<sup>48</sup> remains the supreme law<sup>49</sup> of South Africa and together with the Bill of Rights (BOR); it affords everyone a host of imperative rights with equal responsibilities. Privacy and confidentiality form part of these rights. Section 14 of the *Constitution* states:

Everyone has a right to privacy, which includes the right not to have – (a) their person or home searched, (b) their property searched, (c) their possessions seized, or (d) the privacy of their communications infringed.<sup>50</sup>

However, whilst the constitution reigns supremacy, it was due to the lack of clarity of the same constitution that it was necessary to introduce Patients' Rights Charter<sup>51</sup>

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<sup>45</sup> Refer to above footnotes 23 & 24.

<sup>46</sup> Refer to above footnotes 21-24.

<sup>47</sup> Lukács 2016 256-263.

<sup>48</sup> The Constitution of the Republic of South Africa, 1996.

<sup>49</sup> S1 of the Constitution of the Republic of South Africa, 1996.

<sup>50</sup> S14 (a-c) of the Constitution of the Republic of South Africa, 1996.

<sup>51</sup> Reg 2.7 of National Patients' Rights Charter.

and Rule 13 of Booklet 1 of HPCSA Generic Ethical Rules and guidelines<sup>52</sup>, which govern and guide health care sector.

In acknowledging such provisions, one cannot move away from the diverse concept of *Ubuntu*<sup>53</sup> that influences the South African democratic state. *Ubuntu* has influenced and developed transformation on the law and certain aspects within South Africa.<sup>54</sup> This democratic, transformative concept entails, "*A person is a person through other persons*,"<sup>55</sup> and is the humanness of people towards each other or a community-based mind-set.<sup>56</sup> According to Olinger and others, by understanding this concept, one can already determine the privacy and confidentiality challenges the concept brings with it as one can understand that the *Ubuntu* can infer directly on privacy and personal privacy.<sup>57</sup> The authors argued that the ideal of *Ubuntu* focuses on the welfare of a group or community, rather than individuals. Thus, implies individual rights will be considered and/or accepted if such serve the community.<sup>58</sup> As was initially alluded: privacy and confidentiality echo anonymity. According to authors Olinger, Britz and Olivier, *Ubuntu*, privacy, and confidentiality conflict as *Ubuntu* will not award privacy a role in its context.<sup>59</sup> However, whether or not such is the case will be discussed in detail through Chapter 3, as this will allude to influence of *Ubuntu*, the Constitution, the *Protection of Personal Information (POPI) Act*<sup>60</sup> on privacy and confidentiality.

There have been significant legislative developments that implicate, enforce, and protect the right to privacy and confidentiality these are, but not limited to, the

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<sup>52</sup> Rule 13 HPCSA Booklet 1, General ethical guidelines for health care professions.

<sup>53</sup> Revigilio and Alunge 2020 595-611.

<sup>54</sup> Olinger, Britz and Olivier 2007 *LBR* 33.

<sup>55</sup> A Nguni Language of Isi-Zulu and Xhosa which states, "*Umuntu ungumuntu ngabanye abantu*". Which will be addressed in full in chapter 3.

<sup>56</sup> Olinger 2007 33.

<sup>57</sup> Olinger 2007 35.

<sup>58</sup> Olinger 2007 35.

<sup>59</sup> Olinger 2007 36.

<sup>60</sup> Protection of Personal Information Act 4 of 2021.

POPIA, PAIA, the Consumer Protection Act (CPA)<sup>61</sup> and the Electronic Communications and Transactions Act (ECTA).<sup>62</sup>

With the vast development of the protection of privacy and confidentiality, fields of expertise across the spectrum will have to adhere to the stringent protocol that is coherent with the enforcement of the application of the POPIA.<sup>63</sup> Various, major employment sectors have commenced with stringent internal developments of handling clients (confidentiality) and further ensuring that privacy is maximally always protected.<sup>64</sup>

The health care sector is one of the sectors that has already been accustomed to practices of privacy and confidentiality (due to doctor-patient relationships) as discussed above. Therefore, according to a recent article by a prominent legal company in South Africa, the author echoes that the POPIA is not feared by this sector since POPIA reaffirms what the health care sector considers it already had in place.<sup>65</sup> The community at large share different views as statistics of medical negligence and malpractice surge.<sup>66</sup> Thus, these arguments provide for the key focal point of this study on privacy and confidentiality in the health care sector. Whilst privacy and confidentiality transform with each era, a pertinent contemporary question to be addressed by this study is, "How can the current health care legal framework in South Africa be enhanced to ensure sufficient protection of health care users' rights to privacy and confidentiality?"

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<sup>61</sup> Consumer Protection Act 68 of 2008.

<sup>62</sup> Electronic Communications and Transactions Act 25 of 2002.

<sup>63</sup> Protection of Personal Information Act 4 of 2021.

<sup>64</sup> Kande, Botha & Fitcher 2018 *SAJIM* 1.

<sup>65</sup> polity.org.za 2021 <https://www.polity.org.za/article/popii-reinforces-systems-already-in-place-in-the-healthcare-industry-2021-04-07> accessed 10 July 2021, 12:34am.; read with Webber Wentzel's publication on 7 April 2021 - <https://www.polity.org.za/article/popii-reinforces-systems-already-in-place-in-the-healthcare-industry-2021-04-07> accessed 3 November 2023, 10h45.

<sup>66</sup> Malpractice claims in South Africa: Opening the door for compensation in kind 5.

Section 2 of the POPIA <sup>67</sup> provides the purposes of the act which gives effect to the right of privacy. Part A of the act<sup>68</sup> sets out eight (8) conditions that must be adhered to when processing personal information. Upon remaining cognisant of the POPIA, when one looks at the health care sector one cannot deny there are millions of data sources consisting of personal information shared every second. Patient records are being shared to a host of the data controllers, from hospital porters, medical aids, administration, hospital legal teams, a host of health care practitioners and one must treat the patient as a 'client' according to CPA.<sup>69</sup>

The challenges rise when the current protocol that is set out within the health care sector is due to the unprecedented challenges of the Covid-19 pandemic.<sup>70</sup> Prior to the pandemic of COVID-19 being announced in South Africa when an individual or a group went to visit an admitted patient there was no form of stringent adherence. There was not any hospital protocol of verification and or identification - a whole group of people could visit one patient without any trouble. Often the patient was sharing common space (resting rooms or communal wards) with other patients; their files kept alongside their hospital beds and their medical practitioners' details – and other credentials – were displayed. Patients' wards/rooms and bed numbers were displayed at the entrance of visiting wards,<sup>71</sup>visually visible to the public.<sup>72</sup>

Health care practitioners are guided by Section 14 of the National Health Act (NHA), which states that, "No one is entitled to disclose any information on a health user's health status, treatment or stay in a hospital unless the user has consented thereto

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<sup>67</sup> S2 of Protection of Personal Information Act 4 of 2021.

<sup>68</sup> Part A of Protection of Personal Information Act 4 of 2021.

<sup>69</sup> Rowe & Moodley Medical Ethics 2013 *BMC* 14.

<sup>70</sup> Mediclinic.co.za 2021 <https://www.mediclinic.co.za/en/corporate/stay-and-visit/visitor-information.html> accessed 12 August 2021.

<sup>71</sup> The writer is of the opinion that this process of allowing visitors without any verification protocol in place is not in the best interest of the patients. This is something that can be, further investigated. This is due to disparities between public and private and private health care facilities.

<sup>72</sup> (for the basis of this study 'public' refers to the non-patients, inclusive but not limited to, relatives and external services providers in the health care sector).

in writing”.<sup>73</sup> The NHA further states in *Section 15*<sup>74</sup> specific instances during which a health care practitioner can disclose information on transmissible diseases without consent by law, court order, or due to a duty to protect public health at large.<sup>75</sup> The issue of when to disclose or how to share and limit information is somehow neglected to an extent, especially when there is sharing of information from one practitioner to another. Additionally, due to the data processing and access to personal information there has been a surge in cybercrimes, and specifically the SAHCS took strain due to increase in crime.<sup>76</sup>

The compliance of the NHA remains a challenge since health care employees are neither familiar with the scope and extent of the POPIA nor fully cognisant of its dire repercussions. Issues are further compounded because generally healthcare practitioners are medical experts and not considered legal experts. Therefore, the aforementioned specific challenge, amongst others, supports further discussion during the development of the study in Chapters Two (2) and Three (3). These chapters will allude on a comprehensive approach before providing insight into whether a constitutional transformation of the health care sector is required and if the development thereof, through Continuous Professional Development (CPD),<sup>77</sup> processes will pave the way for new legal paradigm/s provided by Chapters Three (3) and Four (4).

Summarily, as privacy and confidentiality are constantly developed and so are their protection enforced, even until today.<sup>78</sup> Due to the drastic move and transformation

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<sup>73</sup> S14 of Nation Health Care Act 61 of 2003.

<sup>74</sup> Nation Health Care Act 61 of 2003.

<sup>75</sup> S14 (2) (a-c) of Nation Health Care Act 61 of 2003.

<sup>76</sup> Life Healthcare Group 2020 1-3. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.lifehealthcare.co.za/media/3177/20200609\_life-healthcare-cyber-incident\_web-q-and-a-final.pdf. see also Katuu SA Managing records in South African public health care institutions- a critical analysis2015. Further read Mungadse S Life Health Care reveals damage caused by data breach <http://www.itweb.co.za/content/rW1xLv59YPGvRk6m> accessed 6 June 2022 at 13h55.

<sup>77</sup> CPD plays an educational role in the Health Care Sector. All Health Care Practitioners are subject to it and must re-register annually as well as, prove that they are compliant with their CPD requirements.

<sup>78</sup> Burger-Smidt *A commentary on POPIA* 4.

with each generational and societal evolution, it is imperative for South Africa to follow foot with international standards<sup>79</sup> ensuring effective and efficient change in privacy protection and the enforcement of these regulations.

Privacy and confidentiality, require ongoing development and evaluation as seen from each era and this is something that the SAHCS cannot be exempted.<sup>80</sup> This gives rise to the points of departure which echo the main aim of this study. Thus, will contextualise this study guided by the study's objective set out in, point 1.3.2 below.

## ***1.2 Research question***

How can the current health care legal framework in South Africa be enhanced to ensure sufficient protection of health care users' rights to privacy and confidentiality?

## ***1.3 Aim and objectives***

### ***1.3.1 Aims***

The aim of this study is to examine, discuss and then provide suggestions and/or recommendations on the pre and post historic dispositions in the South African HCS had/has and should desirably have in place to enhance, promote, and effectively protect privacy and confidentiality within its health care sector.

### ***1.3.2 Objectives***

The ancillary objectives of the study are:

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<sup>79</sup> International boards are there for standardisation. The idea of this study is not a comparative in nature but to ensure that South Africa is adherent to international standards that has been, derived in different systems.

<sup>80</sup> Burns -Smidt *A commentary on POPIA* 4. See also Swales 2016 *SAMJ* 49-50.

- to create an analysis of the existent legal and statutory frameworks that govern and promote the protection of a patient's rights to privacy and confidentiality within the health care sector;
- to promote the development and transformation of Health Care Law and application when dealing with rights of privacy and confidentiality; and
- to elucidate on the probability of a unified strategy to protect a patient's privacy and confidentiality for all health care practitioners to stringently adhere to.

The objectives will thus create emphasis justifying the practical implementation and enforcement of protecting a patient's privacy and confidentiality in the health care sector.

#### ***1.4 Research Methodology***

A literature review will be conducted to achieve the desired understanding towards interpreting of context, finding complexities, challenges, and/or any limitations that adversely affect the study. This form of research will be conducted using primary sources (Constitution, BOR, case law, legislation, rule, and regulations) and secondary sources (books, e-books, textbooks, theses, journals, study guides, and credible acknowledged articles). Furthermore, through chapter 4 subsection 4.4 a comparative analysis will be discussed briefly.

#### ***1.5 Assumptions and hypothesis***

##### ***1.5.1 Assumptions***

Health care practitioners are not adequately trained in understanding and complying with the law and statutory guidelines because they are not part of the legal sector.<sup>81</sup>

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<sup>81</sup> Singh and Mathuray 2018 *DEJURE* 122-139.

Patients' privacy and confidentiality is not necessarily considered a priority amongst health care practitioners.<sup>82</sup>

The legal implications for health care practitioners are vague and ambiguous for the breach of privacy and confidentiality since they are protected by their "supreme" white coat.<sup>83</sup>

The legal frameworks that govern privacy and confidentiality are not uniformly applied across the health care sector.<sup>84</sup>

### *1.5.2 Hypothesis*

The development of health care ethics within training regimes, will allow stringent adherence to the protection of the patients' privacy and confidentiality. This will place an onus and obligation on health care practitioners to act per the prescribed legal requirements stipulated in their medical ethical guidelines, within their job profiles.

This will further pave the way to develop a uniform application of the protection of privacy and confidentiality of patients in any medical facility. Thus, limiting the medical sector from being ramified creating scope for a paradigm shift.

### **1.6 Significance of the study**

As indicated in the motivation above, the current stringent adherence to the privacy and correct processing of personal information<sup>85</sup> is well amongst us; one cannot deny that this act has already influenced our lifestyles in some way or the other. We have seen major social media privacy transformations<sup>86</sup> and other stringent

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<sup>82</sup> In *S v Makwanyane* 1, O'Regan J stated that: "the right to human dignity and the right to life are 'entwined'." Read further *S v Makwanyane and Another* 1995 (3) SA 391. However, this is the case as research as indicated that medical negligence is still spiked. Refer to footnote 66 and 76.

<sup>83</sup> Refer to chapters 2 and 3 of the study.

<sup>84</sup> Refer to footnote 83.

<sup>85</sup> Protection of Personal Information Act 4 of 2021.

<sup>86</sup> Wijoyo, Limakrisna & Suryanti 2021 *IMJ* 22.

developments all of which promote, educate and transform the protection of privacy and confidentiality within its jurisdiction and various sectors.

Thus, this study which majorly revolves around privacy and confidentiality examines current legal framework developments. Based on these developments, the relevance of this study is current and still evolving since privacy and confidentiality in the health care sector affect everyone at some stage in life. This topic of study is prevalent in the designated research unit, which fits within the sub-projects group of *Justice in Practice*.

### **1.7 Framework**

This study has been divided into five (5) chapters. Chapter 2: Legislative framework of privacy and confidentiality; this chapter will investigate the definitions of privacy and confidentiality and how they relate to the health care sector. The definition will advance to those provided by *the Constitution*<sup>87</sup> which will link to sections of the National Health Act<sup>88</sup> and the definition enshrined in the *POPI Act*.<sup>89</sup> This research will reference specific legal instruments such as the National Patients' Rights Charter<sup>90</sup> and which will create provision for the discussion of Chapter 3 to follow.

Chapter 3 titled: Ethical framework and statutory bodies of privacy and confidentiality in the South African Health Care Sector will commence with an overview of all health care practitioners and the specific general principles that guide privacy and confidentiality. It progresses to a discussion of the Health Professions council South Africa, booklets 1, 3, 4, and 5, 6, 8 and 9 and the framework develops this chapter, which then discusses the theoretical and practical perspectives. This chapter emphasises the legislative and statutory provisions linking Chapter 1 to Chapter 2, which gives indicative perspectives of being part of the law and thus provisions enforceable to providing a guided reading linking ethics to the legislature.

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<sup>87</sup> Everyone has a right to privacy, which includes the right not to have – (a) their person or home searched; (b) their property searched; (c) their possessions seized; or (d) the privacy of their communications infringed

<sup>88</sup> S14 & 15 of National Health Act 61 of 2003.

<sup>89</sup> S1 of Protection of Personal Information Act 4 of 2021.

<sup>90</sup> Reg 2.7 of National Patients' Rights Charter.

The study alludes to the South African concept of *Ubuntu* and its influence on privacy and confidentiality, which thereafter creates a basis for Chapter 4.

The focal point of the study is Chapter 4 titled: "Access to health records and data, influential instruments and international standards, within the employment of the health care sector" This chapter provides what must be conducted within the South African health care sector/s when handling and dealing and/or sharing patients/users/clients data<sup>91</sup> together with the management of their files and records. This creates emphasis on record management that allows the study to tap into virtual management since technology is transforming daily and evolving mundane tasks. The chapter then makes specific reference to a patient who becomes a client and how the Consumer Protection Act (CPA)<sup>92</sup> becomes prevalent in medical practices due to the protocol thereof. Before a summary to the chapter is accomplished, the study draws a minor comparison to international standards. In summary, this chapter brings into reality the focus of developing governing pre-historic and current data within a medical practice; how privacy and confidentiality should be dealt with hereon and going forward; and why it is prudent that the guidelines provided to health care practitioners are uniform and bound with medical ethics.

Chapter 5 gives the conclusion and recommendations. This chapter draws a distinct conclusion which discusses and elaborates on the challenges that are encountered within medical practices, and the protection of privacy and confidentiality. This chapter provides for the study outcome which is the possible ways to limit and/or omit the infringement or breach of privacy and confidentiality in the medical sector.

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<sup>91</sup> For basis of the study, the writer will refer to a person that seeks services from the health care sector as a patient. Unless, and/or otherwise specified in relation to context of discussion (a patient will be referred to a **client** during contractual discussions and a **user** of services rendered when at a health care facility) these identifications will be used inter-changeably.

<sup>92</sup> Consumer Protection Act 68 of 2008.

## **CHAPTER 2      LEGISLATIVE FRAMEWORKS OF PRIVACY AND CONFIDENTIALITY IN THE SAHCS**

### ***2.1 Introduction***

This chapter investigates the relevance and promotion of privacy and confidentiality through legal instruments which serve as legislative frameworks in the SAHCS. The discussion will advance to create an emphasis on how privacy and confidentiality are promoted, discussed, adhered to and if there are any limitations thereof.

In doing so, this chapter aims to provide a broad overview on the legislative frameworks that directly impact the SAHCS. Furthermore, the discussion will create an understanding around how the country's health care sector functions within and around these framework/s and/or legal instruments.

### ***2.2 Legislative framework***

#### ***2.2.1 The Constitution***

##### **2.2.1.1 The Constitution and the right to privacy**

The following discussion aims to provide an overall comprehensive understanding of the constitutional provisions and impact surrounding privacy and confidentiality.

Chapter 2 of the *Constitution*, the BOR,<sup>93</sup> is an integral part of the *Constitution* which enshrines all fundamental rights. This includes the right of privacy, which is encapsulated in Section 14 of the *Constitution*.<sup>94</sup>

However, privacy is not an absolute right and may be subjected to limitations by law of general application and must be balanced with other rights and values

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<sup>93</sup> Section 7 (1) of the *Constitution of the Republic of South Africa*, 1996 which provides that: "The Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom."

<sup>94</sup> Section 14 of the *Constitution of the Republic of South Africa*, 1996. See also Burns & Burger-Smidt A commentary on POPIA 4.

enshrined in the *Constitution*.<sup>95</sup> The word "may" here implies that there can be possible limitations and therefore confirms that privacy is not an absolute right. Consequently, privacy is recognised and protected in relation to an individual in terms of personality, interest, physical integrity/ liberty, good name, dignity, privacy, and identity.<sup>96</sup> This is noted and provided for in Section 10 of the *Constitution*, an associated right to privacy and confidentiality which states:

Everyone has inherent dignity and the right to have their dignity respected and protected.<sup>97</sup>

Additionally, through the word "includes" we are able to see that the right of privacy extends to various other areas and not restricted to those enshrined by its provision as per Section 14 of the *Constitution*.<sup>98</sup> Although *the Constitution* does not explicitly make reference to the protection of privacy of health care information it states that, "A person has the right to privacy of their communication,"<sup>99</sup> which therefore implies and extends to the protection of such information and data.<sup>100</sup>

Furthermore, the word communication is not defined by the *Constitution*, it can therefore extend to the definition provided by personal information which can be classified as special information as provided for by POPIA. Thus, this can be in line with the value of privacy in maintaining autonomy and dignity<sup>101</sup> as provided through Section 10 of *the Constitution*.<sup>102</sup>

Consequently, it guarantees individuals the right to control and limit access to their personal health information and protects them from illicit intrusions.<sup>103</sup>

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<sup>95</sup> Privacy and Data Protection South African Law Commission 2005 4. See also Taylor and Cronjé 101 Questions and Answers about the Protection of Personal Information Act 2.

<sup>96</sup> Dala Compliance of Section 7 of the POPI Act 50.

<sup>97</sup> Section 10 of the *Constitution of the Republic of South Africa*, 1996.

<sup>98</sup> Burns & Burger-Smidt A commentary on POPIA 4. See also Heyink 2013 Law Society of SA 5; Swales 2016 *SAMJ* 50.

<sup>99</sup> Section 14 (d) of the *Constitution of the Republic of South Africa*, 1996.

<sup>100</sup> Swales 2016 *SAMJ* 50. See also footnote 138 and Section 32 of POPIA.

<sup>101</sup> Section 10 of the *Constitution of the Republic of South Africa*, 1996.

<sup>102</sup> Refer to footnote 97 above.

<sup>103</sup> Section 14 of the *Constitution of the Republic of South Africa*, 1996 read with section 14 and 15 of the NHA. See also Swales 2016 *SAMJ* 50.

As a result, in certain circumstances, privacy rights can be reduced but only for defensible and reasonable reasons. Except as stipulated in paragraph (1) of Section 36 of the Constitution, or in any other provision of the Constitution, no law may limit any right enshrined in the BOR.<sup>104</sup> Should any individual in South Africa feel that their rights provided for in the BOR have been infringed and/or threatened in anyway, they could approach the courts for an appropriate relief, including declaration of rights.<sup>105</sup>

However, one must be cognisant of the fact that whilst the Constitution confers rights to an individual it similarly places explicit duty on the side of the state as the government of South Africa with the same.<sup>106</sup> Therefore, the government of South Africa is obligated to constitute fit and proper practices and correct stringent enforcement of rights: a duty to perform under compliance of the constitution.<sup>107</sup>

Thus, from the BOR there is an understanding that these rights apply both vertically (in relation to the state) <sup>108</sup>and horizontally (in relation to private persons)<sup>109</sup>such that both state and private person can be charged for being inconsistent with the BOR.

#### 2.2.1.2 The Constitution and the right to privacy in the SAHCS

This sub-section focuses on how the right to privacy is envisaged and protected by the *Constitution* within the SAHCS. From the discussion provided in 2.1.1.1 there is an understanding that in order of effective health care systems, the health care sector must prioritize rights outlined in the BOR because this practice safeguards the rights and dignity of those seeking medical care from the health care sector.<sup>110</sup>

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<sup>104</sup> s 36 (2) of the *Constitution of the Republic of South Africa*, 1996.

<sup>105</sup> s 38 of the *Constitution of the Republic of South Africa*, 1996.

<sup>106</sup> Vertical and Horizontal application of law.

<sup>107</sup> s 8 (1) and (2) of the *Constitution of the Republic of South Africa*, 1996.

<sup>108</sup> s 8 (1) of the *Constitution of the Republic of South Africa*, 1996.

<sup>109</sup> s 8 (2) of the *Constitution of the Republic of South Africa*, 1996.

<sup>110</sup> Section 10 of *Constitution of the Republic of South Africa*, 1996 read with footnote 97 and 98.

### 2.2.2 *The Constitution and Patients' Rights Charter (PRC)*

The PRC was originally published by the Minister of Health under Section 234 of the Constitution. The PRC is an extension of the Constitution. One should keep in mind that the PRC was not necessarily innovated to do fundamental rights. It clarified existing rights in the SAHCS context such as privacy and confidentiality in the HCS.

Since healthcare rights and the interpretation of fundamental rights in the SAHCS were not specifically dealt with in the Constitution a decision was taken to promulgate the PRC to extend the interpretation and assist laypersons understand their rights.

Section 234 of the Constitution gives legal force, whilst the NHA, might provide statutory force to the contents of the 1999 Patients' Rights Charter (PRC) which discusses the right of patients to "have medical records kept confidential."<sup>111</sup>

Furthermore, Section 7 of the same charter also states:

Information concerning one's health, including information concerning treatment may be disclosed on with informed consent except, when required in terms of any law or any court of order.<sup>112</sup>

The above can be interpreted as: without a patient's permission after being duly informed of their diagnosis and prognosis their health status and treatment cannot be disclosed to any third party. The exception<sup>113</sup> of such is due to exceptional circumstances which is when the information is requested by a court order.

Thus, through 2.2.1.1 and 2.2.1.2 above it can be concluded that, the Constitution provides for privacy within its ambit through Chapter 2.<sup>114</sup>A limitation might come into effect due to privacy not being an absolute right. However, this will be the case

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<sup>111</sup> Section 7 of the Patients' Rights Charter read with s 2.7 of HPCSA Booklet 3.

<sup>112</sup> Section 7 of the Patients' Rights Charter read with s 2.7 of HPCSA Booklet 3.

<sup>113</sup> This is not the only exception there are more provided through section 14 (2) (a-e) of the NHA.

<sup>114</sup> The Bill of Rights, section 10, 14, 32, 36 and s38 of *the Constitution of the Republic of South Africa*, 1996.

only if it is reasonable and justifiable<sup>115</sup> taking into full consideration Section 10 of the Constitution which provides for human dignity, equality, and freedom.

In addition to the above, the Constitution does not explicitly address and/or make any provision for confidentiality, one can argue that due the perception that privacy and confidentiality are interrelated, the Constitution can be interpreted to include elements directly related to confidentiality. Furthermore, the Constitution itself does not explicitly reference privacy or confidentiality in the health care sector. However, privacy and confidentiality are crucial components of the SAHCS. Whilst these terms might not be specifically referenced by the Constitution rights are vital for constitutional promotion, adherence, obligation, and transformation.

In addition to the Constitution, the discussions that follow expand onto additional contributing legislative frameworks such as NHA, PAIA and POPIA which aid in the research aim and objective.

### *2.2.3 The National Health Act (NHA)*

The NHA provides a legal framework for the protection and regulation of the health care sector in South Africa. The opening directive of the act states that it serves as:

a framework for a structure uniform health care system within the Republic, considering the obligations imposed by the Constitution and other law on the national, provincial, and local governments about health services; and to provide for matters connected therewith.<sup>116</sup>

One can thus understand from the above paragraph that the NHA provides guidelines through all spheres of the health care sector. This act guides both public and private health care with specific aspects pertaining to the SAHCS, this also ties in with constitutional obligations and responsibilities.<sup>117</sup>

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<sup>115</sup> S 36 of the *Constitution of the Republic of South Africa*, 1996.

<sup>116</sup> The National Health Act 61 of 2003.

<sup>117</sup> The objectives of the NHA read with s 23 a (i and vii).

Furthermore, as provided for in the Constitution, the NHA is also indicative of three tiers and/or levels<sup>118</sup> namely: (1) national, (2) provincial and (3) local which set out functions provided for in Chapters 3<sup>119</sup>, 4<sup>120</sup> and 5<sup>121</sup> of the NHA.

#### 2.2.3.1 Privacy, Confidentiality and the NHA

The NHA does not specifically reference privacy in relation to the SAHCS. However, the discussion below will provide how it indirectly promotes and protects patients' right to privacy through patient confidentiality,<sup>122</sup> informs consent,<sup>123</sup> promotes ethical guidelines<sup>124</sup> and processing of patient health information<sup>125</sup> and systems<sup>126</sup> which will be discussed through

The NHA refers to confidentiality through Section 14(1) and (2a-c) which provide the following:

- (1) All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.
- (2) Subject to section 15, no person may disclose any information contemplated in subsection (1) unless—
  - (a) the user consents to that disclosure in writing.
  - (b) a court order or any law requires that disclosure; or
  - (c) non-disclosure of the information represents a serious threat to public health.<sup>127</sup>

From interpreting Section 14 itself one can begin to understand that "user"<sup>128</sup> confidentiality extends to the health status, treatment, health facility or organisation which have limitations in conjunction with Section 15(1) of the NHA. Section 15(1) provides a clear indication on the handling of a user's personal information which

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<sup>118</sup> This is also based on Schedule 4 and 5 of the Constitution as part of the exclusive and concurrent functional areas of the different spheres.

<sup>119</sup> Section 21 of NHA.

<sup>120</sup> Section 25 of NHA.

<sup>121</sup> Section 29 of NHA.

<sup>122</sup> Section 14 (1) and (2a -c) of NHA.

<sup>123</sup> Sections 7 and 8 of NHA.

<sup>124</sup> The establishment of HPCSA.

<sup>125</sup> Section 14 -17 of NHA

<sup>126</sup> Section 74 (1) – (2) of the NHA.

<sup>127</sup> Section 14 (1) and (2a -c) of NHA.

<sup>128</sup> A **user** in this context is a patient of the health care sector can additionally be referred to as a patient/user/client which will be used inter-changeably.

remain privy to the health care sector unless legitimate purpose, access or disclosure is in the interest of the user.<sup>129</sup>

Furthermore section 15(2) states that the definition of "personal information" remains as provided for in Section 1 of the PAIA.<sup>130</sup> Sections 16 and 17 provide guidance on the access, handling, and the protection of healthcare records and information (which will be discussed fully in Chapter 4). These sections clearly provide that the above indicated instances are exceptional circumstances and may not be breached negligently.<sup>131</sup>

#### 2.2.3.2 Informed Consent<sup>132</sup>

In South Africa, a patient must provide consent for all medical treatment and procedures (diagnostic or therapeutic) performed on him or her.<sup>133</sup> The word must indicates that the healthcare practitioner has an obligation to obtain informed consent from the patient. Furthermore, a patient has a right to sufficient understanding, knowledge, consent<sup>134</sup> and intelligible consent.<sup>135</sup> This is an integral

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<sup>129</sup> A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user.

<sup>130</sup> Act 2 of 2002.

<sup>131</sup> Section 15 to 16 of NHA.

<sup>132</sup> Informed consent is discussed since it is regarded as an integral part of a patient building contractual and procedural relationships which are the foundation to a patient being treated (triage will be established and section 27 of the constitutions starts to unfold). Thus, it is imperative to discuss informed consent to understand how it can contribute to privacy and confidentiality of a patient.

<sup>133</sup> *Stoffberg v Elliot* 1912 CPD.

<sup>134</sup> Section 8 of NHA which states: (1) A user has the right to participate in any decision affecting his or her personal health and treatment. (2) (a) If the informed consent required by section 7 is given by a person other than the user, such person must, if possible, consult the user before giving the required consent. (b) A user who is capable of understanding must be informed as contemplated in section 6 even if he or she lacks the legal capacity to give the informed consent required by section 7. (3) If a user is unable to participate in a decision affecting his or her personal health and treatment, he or she must be informed as contemplated in section 6 after the provision of the health service in question unless the disclosure of such information would be contrary to the user's best interest.

<sup>135</sup> *Castell v De Greeff* 1994 (4) SA 408 (C) A.

part of a patient building relationships (contractual and procedural) with their health care practitioners. In addition, informed consent relates to the patients' rights to human dignity, privacy and confidentiality as well as the autonomy shared decision-making, which is related to Section 12 of the Constitution.<sup>136</sup>

The process of informed consent is about obtaining permission to perform professional health care services in order to respect the autonomy of the user and becomes relevant to confidentiality if it is required to divulge information to pass onto the next health care official.<sup>137</sup> This information must not be given to others unless the patient consents, or the health care practitioner can justify the disclosure.<sup>138</sup> Section 9 (1) to (3) of the NHA makes provisions where informed consent cannot be obtained.<sup>139</sup> In all cases informed consent is of paramount importance for medical treatment and procedures to occur.

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<sup>136</sup> Read with section 10 and 12 of the Constitution of the Republic of South Africa, 1996.

<sup>137</sup> Section 7 of the NHA states: (1) Subject to section 8, a health service may not be provided to a user without the user's informed consent, unless- (a) the user is unable to give informed consent and such consent is given by a person- (i) mandated by the user in writing to grant consent on his or her behalf; or (ii) authorised to give such consent in terms of any law or court order; (b) the user is unable to give informed consent and no person is mandated or authorised to give such consent, and the consent is given by the spouse or partner of the user or, in the absence of such spouse or partner, a parent, grandparent, an adult child or a brother or a sister of the user, in the specific order as listed; (c) the provision of a health service without informed consent is authorised in terms of any law or a court order; (d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or (e) any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service. (2) A health care provider must take all reasonable steps to obtain the user's informed consent.

<sup>138</sup> Sections 6 to 9 of NHA.

<sup>139</sup> Section 8 of *NHA* which states: (1) Subject to any applicable law, where a user is admitted to a health establishment without his or her consent, the health establishment must notify the head of the provincial department in the province in which that health establishment is situated within 48 hours after the user was admitted of the user's admission and must submit such other information as may be prescribed. (2) If the 48-hour-period contemplated in subsection (1) expires on a Saturday, Sunday or public holiday, the health establishment must notify the head of the provincial department of the user's admission and must submit the other information contemplated in subsection (1) at any time before noon of the next day that is not a Saturday, Sunday or public holiday. (3) Subsection (1) does not apply if the user consents to the provision of any health service in that health establishment within 24 hours of admission.

### 2.2.3.3 Health information and systems

Various sections<sup>140</sup> of the NHA provide guidance on health care information and systems which include collection, storage, procession, and sharing health information. Through these sections the act also promotes and makes provisions for security and handling of sensitive (confidential) information by managing these information practices.

The above-mentioned legislation indicated that a person's privacy and confidentiality is not taken lightly. It is actioned and protected by the health care sector but becomes limited during specific instances as provided for by the NHA Section 15. The NHA may not address privacy individually like it does with confidentiality in the SAHCS. However, indirectly does so through various sections in the act as indicated in this discussion.<sup>141</sup>

### 2.2.4 *The Protection of Personal Information Act (POPIA)*

In South Africa, the POPIA was promulgated on 19 November 2013. POPIA has become one of South Africa's most discussed topics.<sup>142</sup> POPIA endeavours to strengthen the protection of privacy already provided by Section 14 of the Constitution.<sup>143</sup> In doing so, this creates a balance between rights. The right of access to information and the right to privacy then regulate the way personal information is processed lawfully<sup>144</sup> thus protecting confidentiality.

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<sup>140</sup> Sections 14 to 17.

<sup>141</sup> Refer to footnote 126 to 140.

<sup>142</sup> Moore Protection of Personal Information: Understanding the essentials 2021.

<sup>143</sup> Dala Compliance of Section 7 of the POPI Act 51. See also Swales 2016 SAMLJ 49.

<sup>144</sup> Moore Protection of Personal Information: Understanding the essentials 2021 1. See also Taylor and Cronje 101 Questions and Answers about the POPIA 2.

POPIA regulates the legitimate processing of personal information<sup>145</sup> through conditions which are aligned and in accordance with international norms.<sup>146</sup> It further provides a person with rights and remedies that protect their personal information which assists them with any unlawful processing of their personal information.<sup>147</sup> In addition, POPIA also establishes measures like the Information Regulator<sup>148</sup> which ensures these rights according to POPIA are respected, promoted, enforced, and fulfilled.<sup>149</sup>

#### 2.2.4.1 Four (4) main persons that process lawful personal information

POPIA consists of four (4) main role-players that become involved during the processing, handling, collecting, and updating of personal information. They differ as per their roles when certain POPIA rights and obligations become applicable.

These four (4) are classified as follows:

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<sup>145</sup> Personal Information is defined as: With reference to POPIA this means information relating to an identifiable, living, natural person, and where it is applicable, an identifiable, existing juristic person, including, but not limited to: (a) information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and birth of the person; (b) information relating to the education or the medical, financial, criminal or employment history of the person; (c) any identifying number, symbol, e-mail address, physical address, telephone number, location information, online identifier or other particular assignment to the person; (d) the biometric information of the person; (e) the personal opinions, views or preferences of the person; (f) correspondence sent by the person that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence; (g) the views or opinions of another individual about the person; and (h) the name of the person if it appears with other personal information relating to the person or if the disclosure of the name itself would reveal information about the person;

<sup>146</sup> Department of Justice 2006 <https://www.justice.gov.za/salrc/dpapers/dp109.pdf>. Considering that the European Union (UN) has been the driving force regarding the protection of personal information protection, which is also why SA legislative frameworks relied on European legislative guidelines and directives regarding data protection. See also Burns & Burger Smidt A commentary on the Protection of Personal Information Act 5.

<sup>147</sup> Kandeh, Botha and Futchter 2018 *SAJIM* 3.

<sup>148</sup> herein after IR; Also see Swale 2016 *SAMLJ* 82.

<sup>149</sup> Moore Protection of Personal Information: Understanding the essentials 2021 1.

(a) Data subjects

These consists of any living, natural, identifiable juristic persons which the personal information relates to.<sup>150</sup> These persons are awarded specific rights to control access to their personal information,<sup>151</sup> (this could be a patient at a health care sector).

(b) Responsible party

A responsible party according to POPIA can be any person in South Africa or a state entity or can be a group of these persons.<sup>152</sup> This may consist of any public/private body who decides to process, how to process and what the personal information will be used for.<sup>153</sup> The responsible party is accountable for lawful processing of personal information,<sup>154</sup>(in this research a responsible party will be the management of health care sector). Through, POPIA there are obligations, duties and responsibilities imposed on such persons.<sup>155</sup> A responsible party may delegate certain powers to assist with processing personal information which are known to be operators but cannot outsource their own due to the ultimate accountability vested upon them through POPIA.<sup>156</sup> Thus, written contracts<sup>157</sup> are a stringent requirement between responsible parties and operators which ensure that operators process personal information in a lawful manner, in accordance with POPIA.

(c) Operator

These are persons who processes<sup>158</sup> personal information on behalf of responsible parties. These parties are merely service providers who do not use

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<sup>150</sup> Section 1 of POPIA.

<sup>151</sup> Chapter 2 s5 of POPIA.

<sup>152</sup> Chapter 1 ss1 of POPIA.

<sup>153</sup> Chapter 1 ss1 of POPIA.

<sup>154</sup> Chapter 3 s8 of POPIA.

<sup>155</sup> These are provided for consistently through the various chapters in POPIA.

<sup>156</sup> This is through Section 8 Condition 1: Accountability of POPIA.

<sup>157</sup> Section 21 of POPIA.

<sup>158</sup> Chapter 1 read with section 20 of POPIA.

personal information for their own use (for purpose of this research these parties can be health care practitioner within the health care sector). Thus, it is of importance that a written contract is in place to ensure that personal information is generated and processed in a lawful manner, which must respect and establish measures to safeguard personal information. Operators must ensure that they treat personal information as confidential and may not disclose it unless required by order of the law or to properly perform their duties.<sup>159</sup> These parties should inform responsible parties immediately if they suspect any unauthorised activity and access of personal information.<sup>160</sup>

#### (d) User

These persons are anyone who may process personal information on behalf of the responsible party and operator/s.<sup>161</sup> The user must process personal information with authorisation of responsible parties and operator<sup>162</sup> and always treat personal information as confidential unless required by order of the law.<sup>163</sup>

#### 2.2.4.2 Eight (8) conditions for processing lawful personal information <sup>164</sup>

From the above, one should understand the parties involved in processing personal information. It is also important to note that to process lawful personal information there are eight (8) requirements laid out in Chapter Three (3) of POPIA. These conditions are made up of specific obligations and duties as prescribed by the act. These conditions are pertinent when processing personal information.

#### (a) Accountability

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<sup>159</sup> Section 20 (b) of POPIA.

<sup>160</sup> Section 21 (2) of POPIA.

<sup>161</sup> Section 20 of POPIA; for purpose of this study these persons can be but not limited to administrative staff and/or nurses within the SAHCS.

<sup>162</sup> Section 20 (a) of POPIA.

<sup>163</sup> Section 20 (b) of POPIA.

<sup>164</sup> Relates to the lawfulness of the information.

Accountability is an obligation to the responsible party who are persons accountable for the compliance to the POPIA entirely.<sup>165</sup> These obligations cannot be contracted to any other person to outsource the processing of personal information.<sup>166</sup>

(b) Process limitation

Personal information must be processed in a lawful,<sup>167</sup> fair and reasonable manner with the consent<sup>168</sup> of the data subject and must not infringe the privacy<sup>169</sup> of the data subject. Responsible parties bear the onus of proof for the consent and a data subject may withdraw such consent at any given time.<sup>170</sup>

(c) Purpose specification

Personal information may be processed for legitimate, explicit, and specific reasons only.<sup>171</sup> The data subject should be aware of the reasons for collecting any data which must be clear and concise.<sup>172</sup> Records must be retained only for a specific stipulated period as prescribed by the law and a contract of which the data subject has consented to.<sup>173</sup> Records holding personal information must be destroyed, de-identified as earliest as possible once the use is completed. This should be done by ensuring that re-construction in an intangible form cannot be achieved.<sup>174</sup>

(d) Further process limitation

Further processing of personal information must be in line with the original purpose.<sup>175</sup> Personal information cannot be processed for a secondary purpose. There should be clear contractual rights and obligations surrounding the processing

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<sup>165</sup> Section 8 of POPIA.

<sup>166</sup> Refer to reasonable party above.

<sup>167</sup> Section 9 (a) and (b) of POPIA.

<sup>168</sup> Section 11 of POPIA.

<sup>169</sup> Section 9 (b) of POPIA.

<sup>170</sup> Section 11 (2) read with s(3) of POPIA.

<sup>171</sup> Section 13(1) of POPIA.

<sup>172</sup> Section 13(2) read with s18 (1 and 4) of POPIA.

<sup>173</sup> Section 14 of POPIA.

<sup>174</sup> Section 14(4) of POPIA.

<sup>175</sup> Section 15 (1) of POPIA.

of personal information. In addition, there should be preventative steps for further processing of data.<sup>176</sup> Data mining and record retention should not exceed the original purpose of processing the personal information, and any unlawful processing must be immediately terminated and reported.

(e) Information quality

The responsible party should ensure reasonable measures are taken to provide accuracy, complete, non-misleading, up-to-date personal information.<sup>177</sup> The impact of the personal information integrity in terms of the collection of the personal information and date.

(f) Openness

The responsible party must ensure transparency of personal information on the data subject is always maintained. The data subject should be aware of what personal information is being processed, being collected and any purpose that the personal information will be used for.<sup>178</sup> Data subjects should also have knowledge of the Information Regulators address and location.<sup>179</sup>

(g) Security safeguards

The responsible party should ensure and maintain confidentiality, the integrity of the data subject and personal information at all times of processing, relaying, retaining the security and access of the personal information from any risk of loss, unlawful access, interference, modification, unauthorised destruction/processing, and disclosure.<sup>180</sup> These safety measures must include physical, technical, and organisational safeguards.<sup>181</sup>

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<sup>176</sup> Section 15 (2) of POPIA.

<sup>177</sup> Section 16 of POPIA.

<sup>178</sup> Section 18 of POPIA.

<sup>179</sup> Section 18 of POPIA.

<sup>180</sup> Section 19 (1) of POPIA.

<sup>181</sup> Section 20-22 of POPIA.

(h) Data subject participation.

Data subjects are entitled to request the responsible party to confirm (free of charge) if the personal information is held correctly and personal information deleted.<sup>182</sup> Data subjects have a measure of influence over their personal information and the processing thereof.<sup>183</sup>

Through these conditions, practical compliance comes down to good business practices that will improve the controls and processes of businesses<sup>184</sup> or in this case the health care sector. These eight (8) conditions provide for a stringent flow of adherence and compliance, it also provides that non-compliance of the act comes with dire legal ramifications.<sup>185</sup> It is advisable that personal information be consistently processed in a lawful way as prescribed by the act. It is also critical that all parties are aware of these minimum threshold requirements as breach and non-compliance carry heavy penalties.<sup>186</sup> A person or entity can be liable for a fine up to R10 million or 10 years in jail. Remember that “or” includes “and” and could face both penalties.<sup>187</sup>

It is therefore prudent to note that in the health care sector, a patient becomes a data subject (which will be explored in subsequent chapters) owing to the application of POPIA. Due to personal information always being such a confidential and sensitive practice in the health care sector long before POPIA, therefore certain elements of POPIA have already been in practice. However, due to POPIA introducing various additional factors to practice the lawful processing of personal information, the writer suggests that education and comprehension of POPIA are crucial for the health care industry to remain compliant.<sup>188</sup> Through discussion as

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<sup>182</sup> Section 23 of POPIA.

<sup>183</sup> Section 24 of POPIA.

<sup>184</sup> Moore Protection of Personal Information: Understanding the essentials 2021 9.

<sup>185</sup> Sections 59, 100, 101, 102 103, 104, 105 and 106, 107 of the POPIA 2020.

<sup>186</sup> Moore Protection of Personal Information: Understanding the essentials 2021 9.

<sup>187</sup> Chapter 11 Section 7 of POPIA 2021.

<sup>188</sup> Webber Wentzel’s publication on 7 April 2021 - <https://www.polity.org.za/article/popii-reinforces-systems-already-in-place-in-the-healthcare-industry-2021-04-07> accessed 3 November 2023, 10h45.

this study unfolds privacy and confidentiality via POPIA is enforced, encouraged, and consistent in the SAHCS. One can thus understand that POPIA provides for a further enforcement of protecting privacy and confidentiality and that the SAHCS cannot be exempted from this, even though privacy and confidentiality have been a common practice.<sup>189</sup> Through the explicit discussion presented by this section an understanding of processing personal information is provided. Therefore, a person needs to understand how to access information in accordance with the prescribed act of *Promotion of Access to Information* as per 2.2.5 below.

#### *2.2.5 Promotion of Access to Information Act (PAIA)*

The PAIA<sup>190</sup> is a legal framework that governs access to and processing of information in public and private organisations. As a result, the health care sector is not an exception, as all South African organisations are required to comply with this act.<sup>191</sup> While this act implements Section 32<sup>192</sup> of the Constitution, its aim is to balance the interests and rights of the record requester and the public or private body<sup>193</sup> that holds the record. Thus, the act promotes the right of access to information, to cultivate a culture of transparency and accountability in South Africa, as well as to promote an open democracy in which people from all levels of society are empowered to engage with government and participate in decisions that affect their lives.<sup>194</sup>

This act prioritises information access and how it is processed, distributed, and/or requested.<sup>195</sup> As a result, it is pertinent to the health care sector, which is constantly

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<sup>189</sup> Through standard practice of doctor-patient confidentiality as per the Hippocratic Oath and Health Care Practitioners ethical oath.

<sup>190</sup> Act 2 of 2000.

<sup>191</sup> Michalsons Promotion of Access to information Act (PAIA), 2022.

<sup>192</sup> (1) Everyone has the right of access to— (a) any information held by the state; and (b) any information that is held by another person and that is required for the exercise or protection of any rights.

<sup>193</sup> Refer to section 1(8) Of PAIA.

<sup>194</sup> South African Human Rights Commission Guide on How to Use the Promotion of Access to Information Act 2014 14. <https://www.sahrc.org.za/home/21/files/Section%2010%20guide%202014.pdf>

<sup>195</sup> Section 3-5 Promotion of Access to Information Act 2 of 2000.

processing, distributing, and requesting data/information.<sup>196</sup> The act via a PAIA manual by the information regulator, provides a clear overview on the objectives and aims of the act. The act further provides reasonable protection of privacy, commercial confidentiality, and effective, efficient, and good governance. Furthermore, the legislation balances that right with any other right, including those in the BOR, and provides for state constitutional requirements. The act, as implemented through a PAIA handbook by the information regulator, gives a comprehensive summary of the legislation's objectives and goals. Personal privacy is one of PAIA's 19 exclusions, which ensures the preservation of such right as indicated in Chapter 5 of PAIA, which reinforces the required protection of a third party's private. It is critical to remember that effective adherence and compliance to the POPIA is granted under Section 11 of the PAIA.

The writer is of the opinion that the right to access information enforces and empowers POPIA since failing to comply with PAIA might result in a violation of POPIA rules.<sup>197</sup> Thus, it is of the best interest of the health care sector to be compliant of both since the breach of one (1) or the other might impact the other. This will then adversely impact on the legal outcome in such instances.

#### *2.2.6 Health Professions Act (HPA)*

This act was created to promote and implement the South African Health Professions Council (*HPCSA* - which will be discussed more specifically in Chapter 3, respectively.) and professional boards; to oversee the education, training, registration, and practise of health professions registered under this act; and to provide for issues ancillary thereto.

Even though the act's goal is explicitly stated, it makes no reference of maintaining privacy and/or confidentiality, as well as protecting and/or promoting it. As a result,

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<sup>196</sup> Section 14-15 of NHA.

<sup>197</sup> Section 11 of PAIA read with section 23 of POPIA.

this raises concerns about the act, as it serves as a guiding legislative framework for its statutory body HPCSA, which would not exist otherwise.

### 2.2.7 *The Children's Act (CA)*

Privacy and confidentiality are rights awarded to all persons<sup>198</sup> of South Africa thus, including children. In South African law you are regarded as minor (child), until the age of 18 years old.<sup>199</sup>

Every child has a right to basic health care<sup>200</sup> and like majors in South African law, children have the same rights as their majors (adults). Therefore, it is prudent to acknowledge the below pertinent aspects when discussing privacy and confidentiality of a child and how it is promoted in the SAHCS.

#### 2.2.7.1 Privacy, confidentiality and the CA

Section 13 of the Children's Act provides specific protective details when handling of children's information, which states:

Every child has a right to – confidentiality regarding their health status, and health status of parent, care-giver, family member, except when maintaining such confidentiality will not be in the best interest of the child.<sup>201</sup>

The children's act thus, caters for minors in South Africa and in doing so is indicative of a minor's equal right of confidentiality with specific mention of exceptions.

#### 2.2.7.2 Informed consent and the CA

The South African Health Care sector provides that informed consent should be determined for all persons which includes children. According to Section 10 of the Children's Act it states that,

every child that is of such an age, maturity and stage of development must be able to participate in any matter concerning that child, has a right to participate in an

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<sup>198</sup> Section 14 of the *Constitution of the Republic of South Africa*, 1996.

<sup>199</sup> Section 28 of the Bill of Rights.

<sup>200</sup> Section 28 of the *Constitution of the Republic of South Africa*, 1996.

<sup>201</sup> Section 13 of Children's Act 2005.

appropriate way and views expressed by the child must be given due consideration.<sup>202</sup>

Therefore, one can confirm that a child should be provided with considerable amount of information as per their level of understanding and mental capacity to understand and acknowledge the medical condition, process/s, treatment and/or services offered. However, should it be known and/or due to any unforeseen circumstance presented the child's informed consent can be given by a parent or guardian or by necessary attempts in compliance with the laws – as the consent should be in the best interest of the person - in this case a child.

#### 2.2.7.2.1 Consent of a parent and guardian

In the best interest of the child the parents and/or a guardian of the child, can provide consent on behalf of the child. Section 129 of the act states that, if a child is under the age of 12 or over the age of 12 but is insufficiently mature or unable to understand the benefits, risks, and social implications of the medical treatment or surgical operation, the following people may consent to the child's medical treatment or surgical operation:

the parent or guardian; in an emergency, the superintendent of a hospital (or the person in charge of the hospital if the superintendent is unavailable); If a parent or guardian refuses to grant consent or assist, is unable to do so, cannot be found, or is deceased, the Minister of Social Development; and in all instances where another person who may give consent refuses or is unable to give such consent, a High Court or a Children's Court.<sup>203</sup>

#### 2.2.7.3 Access to health information and the CA

Section 13 of the same act includes information of health care which states that every child should have access to their health information regarding their diagnosis, prognosis, health status, cause of treatment and confidentiality of against the same, unless the confidentiality will not be in the best interest of the child.<sup>204</sup>

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<sup>202</sup> Section 10 of Children's Act 2005.

<sup>203</sup> Section 129 of Childrens Act.

<sup>204</sup> Section 13 (a – d) of Childrens Act.

Through the above discussion, one can understand that the health care sector will only disclose information if it is in the child's best interest and none of the child's information poses a threat to the child. With making such provision it can be considered that a child's privacy will be indirectly protected as well, since these rights fit in together.

### *2.2.8 Mental Health Care Act (MHCA)*

The purpose of this act is to provide care, rehabilitation and treatment to persons who are mentally unfit or ill.

Chapter 3 subsection 8 (1) much like that of Section 10 of the Constitution refers to respecting human dignity and privacy states, "The persons, human dignity and privacy of every mental health care user must be respected."

In Chapter 5, section 27 (8) the act further mentions that the head of the health establishment may only approve assisted care, treatment, and rehabilitation of a prospective user as an inpatient if they are:

satisfied that the restrictions and intrusions on the rights of the mental health care user to movement, privacy and dignity are proportionate to the care, treatment and rehabilitation services required.<sup>205</sup>

The above act clearly promotes privacy and indirect confidentiality with specific references to the constitution and in doing so making provision for exceptions. Thus, such facilities cannot overlook or selectively practice guidelines provided by this act. The writer is of the opinion that Section 27(8) provides as indirect promotion of confidentiality whilst serving as a catalyst in answering the research question of this study.

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<sup>205</sup> Section 27 (8) (b) of Mental Health Care Act.

## **2.3 Summary of chapter**

This chapter looked at the legislative frameworks that govern the SAHCS through a series of discussions and has identified the following:

The Constitution does not explicitly address privacy and confidentiality in the SAHCS. However, through section 234 of the Constitution the PRC was formed to assist people understand their rights in the HCS and provides the right to privacy in the HCS.<sup>206</sup> The NHA, addresses privacy through promotion of protecting personal information and maintaining confidentiality.<sup>207</sup> It also provided certain limitations which confirmed that privacy is not an absolute right.<sup>208</sup>

Additionally, POPIA clearly establishes guidelines and requirements for the health care sector to protect a person's personal information (which includes personal health information which is classified as special personal information)<sup>209</sup> and this act also provides that data and personal information is handled securely and confidentially.<sup>210</sup> PAIA indirectly contributes to the protection of privacy by establishing a framework which promotes the importance of privacy which incorporates safeguards to balance transparency with the need for privacy protection. In HPA there is no reference to privacy and confidentiality. The CA and MHCA makes provisions for the indirect promotion of privacy and confidentiality.<sup>211</sup>

Evidence from this chapter indicates that whilst there are sufficient frameworks in place to assist other legislative operating frameworks, these frameworks are not unitary. Each either differ with the interpretation of compliance of privacy and confidentiality or they omit privacy or confidentiality whilst addressing the other, or they do not explicitly address the promotion of enforcing, maintaining, and guiding

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<sup>206</sup> Section 234 of the *Constitution of the Republics of South Africa*, 1996 read with section 7 of the PRC and section 2.7 of HPCSA Booklet 3.

<sup>207</sup> Section 14 of NHA.

<sup>208</sup> Section 15 to 17 of NHA.

<sup>209</sup> Section 1 of POPIA read with s32 of POPIA.

<sup>210</sup> Section 19 to 22 of POPIA read also footnote 168.

<sup>211</sup> Section 13 and 10 of CA and Section 27 (8) MHCA.

of privacy and confidentiality. None of them explicitly addresses the need to enforce, promote and comply with privacy and confidentiality within the SAHCS.

## **CHAPTER 3      THE ETHICAL FRAMEWORK AND STATUTORY BODIES AND PRIVACY AND CONFIDENTIALITY IN THE SAHCS**

### ***3.1 Introduction***

This chapter begins with an overview of all health care practitioners and the basic principles that regulate privacy and confidentiality in the SAHCS followed by an explanation of the ethical framework and statutory bodies that govern privacy and confidentiality. It then discusses the Health Care Practitioner Act booklet 1, 2, 4, 5 and 9. This chapter is developed by the framework which then examines the theoretical and practical views. The chapter continually underlines the legislative and statutory provisions presented in the preceding chapter, which provides suggestive viewpoints of being part of the law and therefore provisions enforceable, as well as a guided reading tying ethics to the legislature. The researcher refers to the South African concept of *Ubuntu* and its impact on privacy and confidentiality.

### ***3.2 South African Statutory bodies of the Health care sector***

This discussion will focus on the following statutory bodies in the SAHCS these are (but not limited to): HPCSA, SANC, SAPC, AHPCSA and ITHPCSA.

Statutory bodies are established as an act of parliament which govern, guide and ensure compliance to legislation which develops ethical standards and/or considerations that these professions in South Africa are obliged.<sup>212</sup>

Furthermore, according to Cohn, Salmon and Stobo, to be recognised as a practitioner within the SAHCS, "Such professionals are subject to legal and voluntary requirements or guidelines related to ensuring the competence of practising professionals, practice standards, and professional and patient protection."<sup>213</sup>

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<sup>212</sup> Curriculum Development Unisa 1.

<sup>213</sup> Cohn Salmon and Stobo *Confronting chronic neglect* 45.

### *3.2.1 Health Professions Council South African (HPCSA)*

Made up of 12 professional boards the HPCSA in its jurisdiction, is designed to provide oversight of education, training, and registration for health professions registered under the Health Professions Act.<sup>214</sup> The council further provides that it has duty to safeguard, uphold and maintain professional, ethical standards within the health profession as well as, disciplinary action will be taken against practitioners that do not adhere to this.<sup>215</sup> The HPCSA is a statutory body with only the powers and functions specified in the act.<sup>216</sup> Section 2 of the Health Professions Act creates the HPCSA as a legal entity. The HPCSA takes the initiative through various<sup>217</sup> guiding documents promoting interpretation and understanding of pertinent obligations of their registered practitioners. This will be discussed in 3.2.1.1 to 3.2.1.4.

#### **3.2.1.1 HPCSA Booklet 1 – General ethical guidelines for healthcare professions**

The HPCSA booklet one (1) entitled, 'General ethical guidelines for the health care professions' opens with a preface which states that the spirit of professional guidelines for being a good HCP requires a lifelong commitment to sound profession and ethical practices overriding dedication to the interest and well-being of one's fellow human beings and society<sup>218</sup> which makes the practice a moral enterprise. From this we already understand the ethical expectations from registered practitioners under this statutory body.

These ethical expectations and obligations are again echoed in the Introduction 1.1 of this HPCSA booklet which states that:

Being registered as a health care professional with the HPCSA confers onto the registered practitioners the right and privilege to practise their professions.

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<sup>214</sup> Health Professions Act 1974.

<sup>215</sup> HPCSA Ethical guidelines for good practice in the health care professions 1-13.

<sup>216</sup> Refer to footnote 194.

<sup>217</sup> HPCSA Booklet 1 to 10.

<sup>218</sup> HPCSA Booklet 1 2021 1.

Correspondingly, practitioners have moral or ethical duties to others and society. These duties are generally in keeping with the principles of the South African Constitution and the obligations imposed on health care practitioners by law.<sup>219</sup>

To gain a greater understanding of the ethical requirements enforced on health care practitioners regulated under the HPCSA, one will examine several points that emphasise these obligations throughout booklet 1.

Under 2.3.2 this captures the best interest and well-being of patients whilst 2.3.3 makes mention that human rights of all individuals must be recognised. Throughout this research indication of human dignity and integrity is a pertinent aspect of ethical obligations in the SAHCS. Healthcare practitioners should ensure integrity and all these core ethical values are the foundation of their character and practice.<sup>220</sup> Healthcare practitioners should ensure that truth and truthfulness are the core of their relationships with their patients.<sup>221</sup> In saying so, all personal or private information should be treated as confidential, unless there is a dual legal or ethical obligation to disclose.<sup>222</sup> Healthcare practitioners should be showcasing sensitivity and empathy with their patients to create mechanisms that provide comfort and support where appropriate and possible.<sup>223</sup>

Booklet 4: Chapter 3 discusses ethical debates through the guidelines mentioned in 3.3.1 to 3.3.7 which derived from the medical ethics manual and can assist practitioners holistically.<sup>224</sup>

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<sup>219</sup> HPCSA Booklet 1 2021 1.

<sup>220</sup> 2.3.5 HPCSA Booklet 1 2021 2.

<sup>221</sup> 2.3.6 HPCSA Booklet 1 2021 2.

<sup>222</sup> 2.3.7 HPCSA Booklet 1 2021 2.

<sup>223</sup> 2.3.8 HPCSA Booklet 1 2021 2

<sup>224</sup> Read HPCSA Booklet 4 which states,

"3.3.1 Formulating the problem: Determine whether the issue at hand is an ethical one once this has been done it must be decided whether there is a better way of understanding it. 3.3.2 Gathering information: All the relevant information must be collected - such as clinical, personal, and social data. Consult authoritative sources such as these guidelines, practitioner associations, respected colleagues and see how practitioners generally deal with such matters. 3.3.3 Considering options: Consider alternative solutions considering the principles and values they uphold. 3.3.4 Making a moral assessment: The ethical content of each option should be weighed by asking the following questions: 3.3.4.1 What are the likely consequences of each option?

4.1 to 4.2 captures ethical legal obligations where 4.6.4 states that legal duties are obligations imposed by statutes and common law which for example are: the NHA<sup>225</sup> or the HPA<sup>226</sup> on healthcare practitioners that require them to follow certain procedures and to use skill and care when dealing with patients.

In Chapter five and specifically paragraph 5.2.1 Healthcare practitioners should respect the privacy, confidentiality, and dignity of patients.<sup>227</sup> Similarly in 5.2.5 it is stated that a healthcare practitioner should always be on guard towards patient human rights misconduct.<sup>228</sup> In paragraph 5.4 HCPs are briefly guided on confidentiality of patients<sup>229</sup> which specifically makes mention of Section 14 and 15 of NHA,<sup>230</sup> before referred to booklet 5<sup>231</sup> for a more extensive discussion around confidentiality.

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3.3.4.2What are the most important values, duties, and rights? Which weighs the heaviest? 3.3.4.3What are the weaknesses of the health care practitioner's individual view concerning the correct option? 3.3.4.4How would the health care practitioner himself or herself want to be treated under similar circumstances. – 3.3.4.5How does the health care practitioner think that the patient would want to be treated in the circumstances? 3.3.5Discuss your proposed solution with those whom it will affect? 3.3.6Act on your decision with sensitivity to others affected 3.3.7 Evaluate your decision and be prepared to act differently in the future."

<sup>225</sup> Act 61 of 2003.

<sup>226</sup> Act 56 of 1974.

<sup>227</sup> 5.2.1 HPCSA Booklet 1 2021 8.

<sup>228</sup> 5.2.5 HPCSA Booklet 1 2021 8.

<sup>229</sup> 5.4.1 Recognise the right of patients to expect that health care practitioners will not disclose any personal and confidential information they acquire in the course of their professional duties unless the disclosure thereof is: made in accordance with patient's consent; 5.4.1.1. made in accordance with the court order to that effect; required by law; or in the interest of the patient. Section 14 and 15 of the NHA. 5.4.2 Not breach confidentiality without sound reason and without the knowledge of their patients 5.4.3 When claiming from medical schemes explain to patients the significance of ICD-10 coding and get the permission of patients to breach confidentiality when making a medical scheme claim.

<sup>230</sup> Section 14 of the National Health Act, which states that, "no one is entitled to disclose any information on a health user's health status, treatment or stay in a hospital unless the user has consented thereto in writing. It further states, which is subject to section 15 provides for, specific instances during, which a health care practitioner can disclose without consent, by law due to transmissible diseases, by court order, or a duty to protect public health at large.

<sup>231</sup> HPCSA Booklet 5 2016.

Additionally, in Chapter 8 of the same booklet 1, health practitioners are guided with maintaining a professional practice. In 8.2.5 particularly it states that health practitioners should ensure that employees are trained to respect patients' rights and in particular the right to confidentiality <sup>232</sup>

### 3.2.1.2 HPCSA Booklet 2: Ethical and professional rules of the HPCSA

This handbook explicitly advises HCPs on professionalism, and Section 13 of this booklet refers to professional confidentiality, which states that HCPs, shall divulge verbally or in writing information regarding a patient which he or she ought to divulge only: (a) in terms of a statutory provision; (b) at the instruction of a court of law; or (c) where justified in the public interest. (2) Any information other than the information referred to in subrule (1) shall be divulged by a practitioner only – (a) with the express consent of the patient; (b) in the case of a minor under the age of 12 years, with the written consent of his or her parent or guardian; or (c) in the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient's estate. <sup>233</sup>

From this it is again clear that the HPCSA provides the same application to its registered practitioners as provided for in the legal framework of the South African health care sector, which is that of the NHA section 14 (2) (a-c) subject to section 15<sup>234</sup> no person may disclose any information contemplated in subsection (1) unless:

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<sup>232</sup> 8.2.5 HPCSA Booklet 1 2021 12.

<sup>233</sup> HPCSA Booklet 2 2016 13.

<sup>234</sup> Section 15 of NHA states: (1) A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user.(2) For the purpose of this section, "personal information" means personal information as defined in section 1 of the PAIA Act 2 of 2000.

(a) the user consents to that disclosure in writing. (b) a court order or any law requires that disclosure; or (c) non-disclosure of the information represents a serious threat to public health.<sup>235</sup>

Thus Booklet 2 provides adequate information for a healthcare practitioner and their professional conduct.

#### 3.2.1.3 HPCSA Booklet 4: Seeking patients informed consent – The ethical considerations

Through Booklet 4 HCPs are made aware specifically the various processes guiding a patient's informed consent and ethical considerations. Point 5.2.1 specifically states that a patient's health status remains confidential except in circumstances where there is substantial evidence that the disclosure would be a risk to the best interests of the patients wellbeing.<sup>236</sup> Therefore, this booklet navigates the pertinent aspects of a practitioner around informed consent.

#### 3.2.1.4 HPCSA Booklet 5: Confidentiality – Protecting and providing information

One would assume that because confidentiality is covered in the health care sector through various processes and booklets, a health practitioner will be able to digest the necessary information required of him/her regarding confidentiality in the South Africa. This is not the case, as the HPCSA's handbook 5 is completely focused on instructing registered practitioners on confidentiality, practice, and information provision.

At the commencement of this booklet, through point 1.2 it states that HCPs are required to withhold information that is private and sensitive about patients. This section also refers to the NHA which points out provisions on when the information can be disclosed.<sup>237</sup> In saying so, it also further holds practitioners responsible for

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<sup>235</sup> Section 14 (1) and (2a -c) of NHA.

<sup>236</sup> HPCSA Booklet 4 2021 6.

<sup>237</sup> Section 1.2 HPCSA Booklet 5 2021 1; Section 14 of NHA (1) and (2) (a-c).

ensuring all staff respect confidentiality in their duties.<sup>238</sup> If staff are negligent and breach confidentiality, the employer (HCP) can be held, vicariously liable. Point 1.3 is in line with Section 14 and can be read with Section 15 of the NHA.<sup>239</sup>

Point 1.5 provides for privacy – friendly relationships<sup>240</sup> between practitioners and patients and assists HCP with their compliance of their ethical and legal obligations. On one hand, loyalty to a patient should come first but on the other hand a health practitioner has a simultaneous obligation to a third party (such as the broader South African community especially when faced with a daunting pandemic similar to Covid-19 pandemic).<sup>241</sup>

In Point 2.6 personal information is defined as means of information about people that health care practitioner learn about in a professional capacity and from which individuals can be identified this isn't limited to patients of the practitioner.<sup>242</sup> An assumption would be any person who shares personal information with the health practitioner.

Point 3 addresses a patient's right to confidentiality<sup>243</sup>. Though there is no express right to confidentiality in the Constitution, as stated in Chapter 2, the principle of privacy includes components of confidentiality, and so both terms are used interchangeably.

Through 3.1. of the HPCSA the NHA is immediately encapsulated and this section confirms that without justification that all patients have a right to confidentiality, and this is consistent with the right to privacy in the Constitution.<sup>244</sup>

In 3.2 rule 13 of the HPCSA's booklet two provides stringent guidance on when a practitioner should divulge information regarding a patient which states:

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<sup>238</sup> Section 1.2 HPCSA Booklet 5 2021 1.

<sup>239</sup> Refer to footnote 201.

<sup>240</sup> Section 1.5 HPCSA Booklet 5 2021 1.

<sup>241</sup> Carstens PA Introduction to medical ethics, law, and human rights 107

<sup>242</sup> Section 2.6 HPCSA Booklet 5 2021 2.

<sup>243</sup> Section 3 HPCSA Booklet 5 2021 2.

<sup>244</sup> The *Constitution of the Republic of South Africa* 1996.

- 3.2.1 In terms of a statutory provision,
- 3.2.2 At the instruction of a court
- 3.2.3 In the public interest
- 3.2.4 With the express consent of the patient,
- 3.2.5 With the written consent of a parent or guardian of a minor under the age of 12 years,
- 3.2.6 In the case of a deceased patient with the written consent of the next of kin or the executor of the deceased's estate.<sup>245</sup>

3.3. speaks to the public and patient interest as that in NHA Section 15.<sup>246</sup>

From the above one can distinguish that through the constant referral to Section 14 and 15 of the NHA <sup>247</sup> the HPCSA tries to create an emphasis of how paramount these sections are when it comes to patient confidentiality.

Further to the aforementioned in point 4 of booklet 5, patients have the right to expect that information about them will be held in confidence by their HCP.<sup>248</sup> This is paramount between HCP and patient which relationship is considered a privileged relationship.<sup>249</sup> However, it must be observed that ethical requirements of patient privacy and confidentiality are not absolute rights but a relative privilege.<sup>250</sup> This is because a particular and unique situation might require an HCP to disclose certain information even if it is contrary to the patient's wishes and rights. This is due to dual loyalty of the HCP<sup>251</sup> as the HCP may have to breach the patient's right to confidentiality at a certain point to a simultaneous 3<sup>rd</sup> party obligation and/or the risk to the community.<sup>252</sup>

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<sup>245</sup> Refer to footnote 200.

<sup>246</sup> Refer to footnote 201.

<sup>247</sup> Act 61 of 2003.

<sup>248</sup> Section 4.1 HPCSA Booklet 5 2021 3.

<sup>249</sup> Carstens PA Introduction to medical ethics, law and human rights 131.

<sup>250</sup> Carstens PA Introduction to medical ethics, law and human rights 131 read with Carstens P and Pearmain D Foundational Principles of South African Medical Law 948.

<sup>251</sup> Carstens PA Introduction to medical ethics, law and human rights 106.

<sup>252</sup> Carstens PA Introduction to medical ethics, law and human rights 106; read with section 14 and 15 of the NHA.

With regards to POPIA and PAIA in the HPCSA, via the HPCSA, registered practitioners are guided through a 15-page document focusing on PAIA and POPIA, which through clear guidelines indicate stringent adherence of what personal information entails and the processing and disseminating of personal information.<sup>253</sup> This is apart from the consistent mention of Section 1 of PAIA<sup>254</sup> and its definition of personal information.

From the said document it is evident that the aim of the HPCSA is to create emphasis on promoting both these acts <sup>255</sup> which enforce and promote the protection of privacy and confidentiality within the South African health care sector. However, if one were to read the document without prior knowledge of these acts, one would be unaware of the impact that these acts have on the promotion of privacy and confidentiality. One should not assume that because the health care sector is made up of highly intellectual beings (health care practitioners) that they are able to understand and interpret the law and legalities correctly, consistently, and objectively.

The HPCSA has taken the initiative to provide guidance to its practitioners registered within their professional body. It must also be noted that there is a considerable mention of the legal frameworks such as Sections 14 and 15 of the NHA. This provides a constant reminder to practitioners on how to deal with patient confidentiality and personal information. One can therefore look into other statutory bodies and how they promote (if at all), enforce and enhance a patients right to privacy and confidentiality in the South African Health Care Sector.

### *3.2.2 South African Nursing Council (SANC)*

The SANC is tasked with establishing and maintaining nursing education and practise standards in the Republic of South Africa. It is a self-governing, financially

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<sup>253</sup> HPCSA PAIA and POPIA Manual 5-14.

<sup>254</sup> 2 of 2000.

<sup>255</sup> HPCSA PAIA and POPIA Manual 1.

independent statutory body that was formed by the 1944 Nursing Act and now governed by the 2005 Nursing Act.<sup>256</sup>

The council highlights the procedures it will follow, as quoted by a published circular, and cited on the SANC webpage, while urging strict conformity with the POPI Act. This expressly states that:

To ensure compliance with these provisions, the SANC is taking the necessary steps to ensure its clients' Personal Information remains protected. To that purpose, the SANC will no longer release any Personal Information in its possession to any third party unless the necessary procedure is followed, as evidenced by a filled and signed Consent Form. Only consented-to information will be distributed to properly authorised parties. This may have an impact on certain SANC services, particularly those when a person attempts to solicit services from the SANC on behalf of a Nurse.<sup>257</sup>

Thus, this council is indicative of the guidelines to follow whilst processing personal information and as a result, promotes privacy and confidentiality within its discipline and inter-disciplines. However, on the contrary, research indicates that the practice of promoting privacy and confidentiality amongst the nursing profession is still a challenge.<sup>258</sup>

### *3.2.3 South African Pharmacy Council (SAPC)*

The SAPC is the regulator established in terms of the Pharmacy Act, to regulate pharmacists, pharmacy support personnel and pharmacy premises in South Africa.<sup>259</sup>

The council's mandate and mission are: to protect the rights and safety of the public; promote universal health coverage; support the health, safety and wellbeing of their patients and the public which is to ensure accessible quality pharmaceutical service

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<sup>256</sup> *Act No 45 of 1944* read with *Act No 33 of 2005*.

<sup>257</sup> <https://www.sanc.co.za/2021/10/12/circular-6-2021-implementation-of-popi-act-2013-2/> accessed 24 August 2022, 17h00.

<sup>258</sup> Singh and Mathuray 2018 *DEJURE* 122-139.

<sup>259</sup> *Act 53 of 1974*.

for all South Africans. Consequently, developing, enhancing, and upholding acceptable norms and standards in all disciplines of pharmacy.<sup>260</sup>

Though the webpage makes specific reference to a privacy notice, there is no direct mention or guiding documents informing the members of privacy and confidentiality of their patients'.

However, the writer is of the opinion that when the council makes mention of their specification of achieving goals following their mission to, "protecting the rights and the safety of the public," this broad ambiguous statement could be interpreted as the council's sole interpretation of privacy and confidentiality protection. When one investigates the policy presented via the webpage it dawns upon the reader that privacy and confidentiality are of paramount importance, which is strictly practiced, emphasised, echoed, and promoted by this council.

#### *3.2.4 Allied Health Professions Council of South Africa (AHPCSA)*

The AHPCSA is a statutory health body established under the Allied Health Professions Act<sup>261</sup> to regulate all allied or complementary health professions as provided for in the act.

This council is made of four (4) representative boards all of who are guided by the NHA Section 14 and 15, as this council in their guiding document specifically references access to information of patients in conjunction with code of ethics as a professional registered under this council.<sup>262</sup> In addition, this council has developed a guiding document<sup>263</sup> for their members, to follow when accessing and processing information. With an increasing<sup>264</sup> number of patients/clients among these allies, this document outlines a clear procedure for adhering to PAIA. There is, however, no mention of the POPIA and/or its requirements, adherence, or non-adherence.

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<sup>260</sup> <https://www.pharmcouncil.co.za/> accessed 22 September 2022 at 21h00.

<sup>261</sup> *63 of 1973.*

<sup>262</sup> AHPCSA Promotion of Access to information manual 3.

<sup>263</sup> AHPCSA Promotion of Access to information manual 1.

<sup>264</sup> Leisegangs 2010 *SAJNM* 1.

Whilst different disciplinaries may argue that the PAIA document is sufficient in educating these members about processing and protecting personal information because it makes indirect references<sup>265</sup> to the matter. The writer is of the opinion that this loophole (ambiguous indirect reference) could pose as a risk amongst the AHPCSA when it comes to promotion, protecting and enforcing the POPI act with reference to privacy and confidentiality among their patients/clients. This will be due to the lack of communication from the AHPCSA in educating their members about the act's<sup>266</sup> stringent adherence and legal ramifications.

### *3.2.5 Interim Traditional Health Practitioners Council of South African (ITHPCSA)*

Through the Traditional Health Practitioners Act (THPA) South Africa recognises traditional practitioners.<sup>267</sup> The THPA's aim is to provide legislative frameworks to ensure efficacy, promote safety, quality of traditional health services and in doing so establish a council to promote, enforce and regulate its registered members and practitioners.<sup>268</sup> The act alone cannot administer and regulate its practitioners and according to Louw and Duvenhage this has been a challenging task to administer 200000 unregulated healers.<sup>269</sup>

Section 1 of the act prescribes to its practitioners' clear legal guidelines for the registration of traditional healers and added merits.<sup>270</sup> Due to challenges presented at the legislated enforcement of the act since 2007, practitioners and practices needed to be regulated and therefore a dire need for a Traditional Health Practitioner Council (THPCSA) was sought. However, due to unknown delays thereof, in 2013 an Interim Traditional Health Practitioners Council (ITHPC) was established and inaugurated.<sup>271</sup> To date this council remains an interim council, reasons of which are not pursued in this research. It should be noted that according

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<sup>265</sup> Sections 4.1 (a, b, d); 4.5 (a, c, e, g); 10.2-3 Promotion of Access to information manual 6-9.

<sup>266</sup> Protection of Personal Information Act 13, 2013/2021.

<sup>267</sup> The Traditional Health Practitioners Act 22 of 2007.

<sup>268</sup> Department of health 2013 SABINET 1.

<sup>269</sup> Louw and Duvenhage 2016 *AMJ* 445.

<sup>270</sup> Section 1 of the Traditional Health Practitioners Act 22 of 2007.

<sup>271</sup> Tshehla 2015 *SAMJ* 279.

to Louw and Duvenhage the registration process of these practitioners still has not gained momentum.<sup>272</sup> Due to impact of the ITHPC provided through the act and the interim council, one could distinguish the focus of the council was to regulate its registered practitioners through the establishment of the ITHPC.

Through the THPA a few purposes of the ITHPC are:

Promote and maintain appropriate ethical and professional standards required from traditional health practitioners. Promote and develop interest in traditional health practice by encouraging research education and training. Compile and maintain a professional code of conduct for traditional health practice. Ensure that traditional health practice complies with universally accepted health care norms and values.<sup>273</sup>

This council also guides and promotes the Bill of Rights and the NHA.<sup>274</sup> So even though the council might remain in the interim phase of its existence, guiding documents have elements which promote compliance of the legal and ethical frameworks that govern the health care sector of South Africa. The council is compiled by twenty (20) members which consists of a legal expert, a member of the HPCSA, a member of the SAPC, academics, researchers and the department of health.<sup>275</sup>

From this indication, it can be assumed that due to broad expertise (made up with inter-disciplinary representatives) constituting this ITHPC, its registered practitioners and members should promote, enforce, maintain, and adhere to privacy and confidentiality within this discipline. However, this remains an assumption as the council is in an interim phase. With the identified challenges presented by the interim council very limited information around this focused discipline of practitioners are available. Therefore, this has posed as a limitation that directly impacted this discussion, as the information regarding this council and research around its registered practitioners that form part of it, are limited to scarce.

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<sup>272</sup> Louw and Duvenhage 2016 *AMJ* 445.

<sup>273</sup> Department of health 2013 SABINET 1.

<sup>274</sup> The National Health Act 61 of 2003.

<sup>275</sup> Department of health 2013 SABINET 1.

However, through the limited information provided it can be understood that this interim council is cognisant of maintaining ethical standards within the South African health care sector but there wasn't enough information to determine whether there is sufficient protection offered to a traditional health patient and their right to privacy and confidentiality.

### ***3.3 Ubuntu: The ethical impact on privacy and confidentiality in the SAHCS***

According to the discussion in 3.2, traditional medicine is recognised as part of the SAHCS, even though information presented is limited. In keeping to the spirit of traditional and cultural practices, the South African post- apartheid transition has given birth to the concept of *Ubuntu*<sup>276</sup>. Through a common African aphorism "*umuntu ngumuntu ngabantu* – which translates *a person is through a person*"<sup>277</sup>

The purpose of this discussion is to determine if *Ubuntu* practises and beliefs have any influence or impact on promoting, enforcing, and adhering to privacy and confidentiality in the South African health care sector. To determine such effect (if any) and/or impact on the South African health care sector, one needs to first understand how *Ubuntu* is defined and what its core fundamental components are. It would thus become indicative of the extent to which *Ubuntu* could impact and influence privacy and confidentiality in the South African health care sector.

According to various authors <sup>278</sup> *Ubuntu* is defined as follows:

According to Nziwake, *Ubuntu* cannot not be easily definable. He, further states that, "*Ubuntu* is an old African term for humanness which promotes cooperation

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<sup>276</sup> Ubuntu is discussed as this is an African term that South African's resonate with as compared to other foreign ethical concepts (utilitarianism, virtual theory or individualism), this is due to the history of South Africa and the vast majority of the rural individuals do not have access to education to understand this terminology. Thus, the writer has decided to make use of Ubuntu.

<sup>277</sup> Gade 2012 *SAJP* 484-503.

<sup>278</sup> Nziwake; Brichhill and others; Murithi; Fox; Hano and others.

between individuals.<sup>279</sup> Nziwake further went on by saying, "*Ubuntu* is not limited to the African continent and is described has a world view in African societies."

Brack, Hill, Edward, Grootboom and Lassiter describe *Ubuntu* as, "a fundamental sense which represents personhood, humanity, humanness and morality."<sup>280</sup> *Ubuntu* tries to capture the essence of what it means to be human.<sup>281</sup> In South Africa, the Nguni<sup>282</sup> tribe describe *Ubuntu* as a practice that addresses our interconnectedness, our common humanity, and the responsibility to each other.<sup>283</sup>

*Ubuntu* deals with many feelings of compassion, related to making life more humane for others.<sup>284</sup> In Fox's description of *Ubuntu* he states, "That one of the recipes that stood out was the equality and dignity of human personality."<sup>285</sup> Respect and dignity together with survival solidarity spirit and compassion, constitute the African value system of *Ubuntu*.<sup>286</sup> Kamawangamulu mentioned that *Ubuntu* is defined, "As both and ideology and a philosophy, a multidimensional concept representation core values of African ontologies: respect for all humans, dignity, sharing, obedience, humility, solidarity, caring, hospitality, interdependence and communalism."<sup>287</sup>

In essence, *Ubuntu* can be defined as an African ethical practice: a practice of solidarity, humanness, morality, dignity and equality. Additionally, all definitions of *Ubuntu*, the philosophy, is characterised by values, beliefs and customs that tie personhood, humanity, humanness, and morality to the survival of communities and position community of well-being and interpersonal responsibility.<sup>288</sup>

Some of the core values of *Ubuntu* are, truthfulness, humanness (dignity, respect), openness, communalism, independence as presented by the above authors in their

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<sup>279</sup> Nziwake 2014 *AJPA* 30.

<sup>280</sup> Nziwake 2014 *AJPA* 31.

<sup>281</sup> Murithi "Practical peace-making wisdom from Africa: Reflections of *Ubuntu*" 221-223.

<sup>282</sup> Refers to a particular tribe of people found in South Africa.

<sup>283</sup> Nziwake 2014 *AJPA* 31.

<sup>284</sup> Nziwake 2014 *AJPA* 32.

<sup>285</sup> Fox *A guide to Public Ethics* 123.

<sup>286</sup> Poovan, D Toit, and Engelbrecht 2006 *SAJBM* 17-27.

<sup>287</sup> Kamwangamalu 1999 *CAOJ* 24-41.

<sup>288</sup> Nkhata *The relevance and viability of trust-based governance and constitutionalism in Malawi* 32-37.

definitions. Now that there is a better overview on the concept of *Ubuntu* one can proceed to discuss if such a concept will have any ethical impact or obligations in respect of the SAHCS.

### *3.3.1 The ethical impact of Ubuntu in the SAHCS*

The researcher commences this discussion with a paper dated back to 2007 to indicate to the reader the developments on the ethical impact of *Ubuntu* in South Africa. Additionally, several<sup>289</sup> South African authors suggested that within the *Ubuntu* culture, privacy has been relegated to position of lower importance than in western culture.<sup>290</sup>

These authors argued that *Ubuntu*:

Is not mentioned anywhere explicitly in the South African Constitution's preamble or articles. Due to the development of privacy legislation in South Africa, the influence of *Ubuntu* will be less significant than originally suggested in the interim Constitution of South Africa. There are no *Ubuntu*-specific references of privacy in the Constitution of the Republic of South Africa, 1996 neither in the current legislation of South Africa. The *Ubuntu* influence in privacy jurisprudence will be weaker.<sup>291</sup>

Furthermore, the authors of the article concluded that *Ubuntu* does not possess an advanced concept of privacy and model of privacy in accordance and opposed to international standards.

From the above arguments presented by these authors one would assume that *Ubuntu* would adversely impact on the practice of privacy and confidentiality in the SAHCS. However, recent<sup>292</sup> research developments have indicated that the contrast has occurred. In 2019, Euwoso argued that *Ubuntu* can assist with addressing the conflict between partner notification and patient confidentiality in serodiscordant relationships which concluded that through *Ubuntu* (which can be considered as an

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<sup>289</sup> Hanno N Olinger, Johannes J. Britz and Martin S. Olivier.

<sup>290</sup> Olinger, Britz and Olivier 2007 *LBR* 31-43.

<sup>291</sup> Olinger, Britz and Olivier 2007 *LBR* 31-43.

<sup>292</sup> 2019 to date (that is 2023).

African ethical stance) a health care practitioner is obliged to facilitate harmonious relationships where individuals are subjects and objects of relationships.<sup>293</sup>

This author further argued that *Ubuntu* will do a better job at ensuring that partner notification (within the context of HIV transmission and care) receives more emphasis.<sup>294</sup> He also provided that there is a need to shift in emphasis from patient confidentiality to partner notification in medical ethical guidelines, because concealing important life-saving and relevant information from those who ought to care for a patient is not the appropriate way and not in line with principles of *Ubuntu*.<sup>295</sup>

Furthermore, according to authors Sambala, Cooper and Manderson, *Ubuntu* – as a moral philosophy – is an adequate tool for those with responsibility for decision-making during epidemics. They argued that *Ubuntu* establishes a unique normative benchmark for social responsibility relevant to the prevention of conflicts and infection and provides a way to analyse ethical problems that might emerge in these contexts.<sup>296</sup> Furthermore, they proposed that *Ubuntu* can be used as an ethical decision-making framework to resolve ethical conflicts between individuals and the public health. Their reasoning was twofold, *Ubuntu* goes beyond the traditional ethical reasoning of balancing potential harm and maximizes potential benefits in public health. *Ubuntu* builds on the idea that individuals should act to protect others' health but also that individuals should not be disadvantaged.<sup>297</sup>

Ngondo and Klyueva suggested that on a broader spectrum *Ubuntu* can be useful in Western settings because notions of community exist even in individualistic societies which exemplified how communities come together during epidemics (like COVID-19) and natural disasters.<sup>298</sup> Inclusiveness in *Ubuntu* implies human dignity

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<sup>293</sup> Ewuoso 2019 *DWBIJ* 84.

<sup>294</sup> Ewuoso 2019 *DWBIJ* 84.

<sup>295</sup> Ewuoso 2019 *DWBIJ* 84.

<sup>296</sup> Sambala, Cooper and Manderson 2019 *EBJ* 7.

<sup>297</sup> Sambala, Cooper and Manderson 2019 *EBJ* 10.

<sup>298</sup> Ngondo and Klyueva 2022 *ROCJ* 36.

and respect of all humans. The authors provided that *Ubuntu* is about balancing the good of the community whilst still allowing individualism.<sup>299</sup>

Nicolaides stated that, "In healthcare ethics interactive relationships are crucial for moral agency."<sup>300</sup> In addition to this he further stated that, "*Ubuntu* aligns well with what is expected in the healthcare sector, it places great value on caring, kindness, tolerance, empathy, compassion respect for others and transparent consensus building."<sup>301</sup> The author further stated that, "Health care practitioners must be part of the community and view themselves as being a person through their relationships with others in the community and sustain their community the best they can, act ethically at all times, genuinely care and seek peace, healing and justice, as well as communal and individual well-being for their patients."<sup>302</sup>

From each of the above discussion contrary to the that of Oblinger and others one can see that *Ubuntu* has contributed significantly to the South African health care sector through its core values<sup>303</sup>. In addition to this, one can see that each author specifically alluded to best practices for balancing individualism and the community, and in doing so making specific references to human dignity, truthfulness, and people well-being. Furthermore, Nzimakwe referred that, "The ethics of true community does not ask a person to sacrifice their own good, in order to promote the good of others, but instead to recognise that they can attain their own good by promoting the good of others."<sup>304</sup>

Therefore, understanding the core values presented by *Ubuntu*, dignity, humanness and cognisant of the arguments presented by other authors mentioned above, it can be noted that *Ubuntu*, though it might not be directly referenced in the South African Constitution,<sup>305</sup> consistently promotes, encapsulates, and enforces Section

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<sup>299</sup> Ngondo and Klyueva 2022 *ROCJ* 34;37.

<sup>300</sup> Nicoladis 2023 *JMLSTA* 75.

<sup>301</sup> Nicoladis 2023 *JMLSTA* 75.

<sup>302</sup> Nicoladis 2023 *JMLSTA* 75.

<sup>303</sup> Refer to footnote 259 -266.

<sup>304</sup> Nzimakwe 2014 *AJPA* 36.

<sup>305</sup> The *Constitution of the Republic of South Africa*, 1996.

10 of the constitution which caters for the right of dignity.<sup>306</sup> Therefore, the writer is of the view that *Ubuntu* may not be in conflict of privacy as human dignity interrelates with privacy. As well as, taking note that privacy and confidentiality are not absolute they may be ethically breached.<sup>307</sup> Through Section 14 of NHA the patients' rights of privacy and confidentiality will be breached to protect the broader community. It is the same with *ubuntu* practice of taking everyone's rights into account as one would their own. This notion places an ethical duty from a person to the broader community/public as it could poses as risk as witnesses during the COVID-19 epidemic.

The core values of *ubuntu*, are compliant with privacy and confidentiality as they promote the right to human dignity (through humanness, respect and dignity). *Ubuntu*, whilst it might seem directly silent on promoting privacy and fostering confidentiality, directly promotes healthy, ethically inclined relationships. As provided by arguments above it should not infringe on the practice of privacy and confidentiality in the South African Health Care Sector.

### **3.4 Summary of Chapter**

This chapter provided an in-depth discussion on the ethical framework and statutory bodies in context related to the SAHCS. It commenced with the frameworks that govern statutory bodies such as HPCSA, SANC, SAPC, AHPCSA and the ITHPCSA which emanate from the previous chapter and its legal frameworks before it addressed the ethical implication of *Ubuntu* practices in the SAHCS. Each statutory body was indicative of the ethical processing of patient information which assists in maintaining confidentiality in the HCS.

The discussion commenced with HPCSA which was provided an in-depth guideline process which is divided into 12 booklets and guides their registered practitioners under this statutory body through various processes of patient confidentiality,

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<sup>306</sup> Section 10 of the Constitution state that, everyone has inherent dignity and the right to have their dignity respected and protected.

<sup>307</sup> Section 14 read with section 15 of the NHA.

promoting privacy at the health care practices, enforcing privacy and confidentiality through PAIA and POPIA and even data management (which will be discussed in detail through the next chapter). This statutory body, throughout its 12 guidelines in some ways have echoed the sentiments provided for by its legal framework – the NHA.<sup>308</sup>

The SANC though makes up many employees in the health care sector, provided very brief guidance on confidentiality and privacy in the SAHCS. The writer is of the opinion that this could be the reason why research has indicated that the practice of promoting privacy and confidentiality amongst the nursing profession is still a challenge.<sup>309</sup>

The SAPC and AHPCSA provided a very vague overview on privacy and confidentiality which the writer is of the opinion that was done to comply of PAIA and POPIA. This could pose as a compliance risk to their registered members and practitioners.

The ITHPCSA provided an assumption that due to its conformity of board members (that is made up on a member of HPCSA, SAPC) it ought to promote, enforce and enhance within its framework privacy and confidentiality.

Lastly, this chapter indicated a comparison between HPCSA and *Ubuntu*

This study has identified the following core values of *Ubuntu* enshrined in booklet 1 of the HPCSA's core ethical values and standards for good practice:

The HPCSA promoted respect of a persons, human rights and integrity<sup>310</sup> which tie in with *Ubuntu's* humanness and dignity.<sup>311</sup>

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<sup>308</sup> Specifically, section 14 (1); 14 (2) (a-e) read with section 15.

<sup>309</sup> Refer to footnote 224.

<sup>310</sup> Section 2.3.1; 2.3.3;2.3.5 HPCSA Booklet 1 2021 2.

<sup>311</sup> Refer to footnote 261-262.

The HPCSA promoted truthfulness<sup>312</sup> which reverberates *Ubuntu's* trustworthiness and honesty.<sup>313</sup>

The HPCSA echoed compassion<sup>314</sup> which is in conjunction with *Ubuntu's* compassion towards the community.<sup>315</sup>

HPCSA advises its practitioners on tolerance<sup>316</sup> and reverberates *Ubuntu's* promotion of tolerance within the community.<sup>317</sup>

Therefore, *Ubuntu* is ethically compliant within the SAHCS since it is indirectly promoted in through the guidelines of this statutory body.

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<sup>312</sup> Section 2.3.6 HPCSA Booklet 1 2021 2.

<sup>313</sup> Refer to footnote 268 and 279.

<sup>314</sup> Section 2.3.8 HPCSA Booklet 1 2021 2.

<sup>315</sup> Refer to footnote 255 to 279.

<sup>316</sup> Section 2.3.9 HPCSA Booklet 1 2021 2.

<sup>317</sup> Throughout the discussion and in addition to this, see also footnotes 258,268,270,271.

## **CHAPTER 4      ACCESS TO HEALTH RECORDS AND DATA, INFLUENTIAL INSTRUMENTS AND INTERNATIONAL STANDARDS**

### ***4.1 Introduction***

According to Marutha,

Medical records management, like any other field has to be guided by a sound legislative framework. Furthermore, the application of legislation in the management of medical records can help safeguard privacy and confidentiality and assist with the loss, modification, alteration, damage and misfiling of records.<sup>318</sup>

This chapter will be divided into three (3) main themes. (1) Access to health records: which will provide a discussion on the legislative and statutory frameworks governing such access in the SAHCS. (2) Influential instruments: which through this sub-section the reader will gain an insight to the indirect influence of the CPA and ECTA in the South African health care sector. (3) International standards: which will conclude this chapter by drawing a brief comparative discussion between international standards that govern patient privacy and confidentiality in their respective jurisdictions and the South African health care sector.

### ***4.2 Access to health records in the SAHCS***

For basis of consistency and ease of reference the discussion in 4.2.1 follows the chronological sequence as presented through Chapter 2.<sup>319</sup>

#### ***4.2.1 Provisions provided by legislative frameworks regarding access to health records in South Africa***

Through section 14 (b), (c), (d) of the Constitution everyone has the right of privacy not to have their property searched, possession seized and communications

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<sup>318</sup> Matura N 2019 Information Development 551.

<sup>319</sup> The discussion commences with legislative frameworks as presented in chapter 2 and follows the following order of discussion: the Constitution of the Republic of South Africa, 1996, NHA, POPIA, PAIA, CA and MHA.

infringed.<sup>320</sup> This can be broadly interpreted as any property and/or possession of any form (electronic /hardcopy). This will then imply that a health record (indirectly this can be argued as a patient's property which is safeguarded by the health care establishment), the health information and communication within this record (health recordings: x-rays/pictures and/or but not limited to health prognosis and treatment)) are all the patient's property, a personal possession and communication of the patient. Therefore, the handling, processing, sharing, tracking, controlling of this kind of data and record should be managed correctly with the utter most sensitivity, diligence, and integrity, as they consist of very important and personal information (gender/sex, medical diagnosis etc) regarding a patient.<sup>321</sup>

Furthermore, Section 33 of the Constitution addresses the right of access to information which provides that everyone has the right to access any information that is held by the state; as well as any information that is held by another person that is required for the protection of any rights.<sup>322</sup>

Additionally, the NHA makes provision for the access to health records and disclosure (sharing of personal information) through Section 15,<sup>323</sup> and Sections 16 and 17.<sup>324</sup> For basis of consistency, since Section 15 was discussed earlier in Chapter 2, Sections 16 and 17 of the NHA will be discussed herein.

Section 16 (1) provides two instances where a health practitioner can examine a user's health record for purposes of (a) treatment with the authorisation from the user and (b) study, teaching, or research with the authorisation of the user, head of health establishment concerned and the relevant health research ethics committee.<sup>325</sup>

However, Section 16 (2) provides that if the study, teaching, or research contemplated in subsection (1) (b) reflects or obtains no information as to the

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<sup>320</sup> S14 (b)(c)(d) of the Constitution of the Republic of South Africa, 1996.

<sup>321</sup> S10 of the Constitution of the Republic South Africa, 1996.

<sup>322</sup> S33 of the Constitution of the Republic South Africa, 1996.

<sup>323</sup> Refer to chapter 2 which this section is discussed fully.

<sup>324</sup> Sections 16 and 17 of the NHA 61 of 2003.

<sup>325</sup> s16 (1) of the NHA 61 of 2003.

identity of the user concerned, it is not necessary to obtain the authorisations contemplated in that subsection.<sup>326</sup>

In addition to the above, Section 17 of the NHA makes the following provisions for the protection of health records:

(1) The person in charge of a health establishment in possession of a user's health records must set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept.<sup>327</sup>

Section 17 makes it an offence to access or reproduce patient information without authorisation and is punishable by a fine, imprisonment, or both.<sup>328</sup>

In addition, the access to health records is also governed by POPIA and PAIA where part A<sup>329</sup> of POPIA governs the processing of personal information (as discussed in detail through Chapter 2 of this study). POPIA also provides that a data subjects

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<sup>326</sup> s16 (2) of the NHA 61 of 2003.

<sup>327</sup> s17 of the NHA 61 of 2003.

<sup>328</sup> s17 of the NHA, (2) Any person who fails: (a) to perform a duty imposed on them in terms of subsection (1); (b) falsifies any record by adding to or deleting or changing any information contained in that record; (c) creates, changes or destroys a record without authority to do so; (d) fails to create or change a record when properly required to do so; (e) provides false information with the intent that it be included in a record; (f) without authority, copies any part of a record; (g) without authority connects the personal identification elements of a user's record with any element of that record that concerns the user's condition, treatment or history; (h) gains unauthorised access to a record or record-keeping system, including intercepting information being transmitted from one person, or one part of a record-keeping system, to another; (i) without authority, connects any part of a computer or other electronic system on which records are kept to: (i) any other computer or other electronic system; or (ii) any terminal or other installation connected to or forming part of any other computer or other electronic system; or (j) without authority, modifies or impairs the operation of: any part of the operating system of a computer or other electronic system on which a user's records are kept; or (ii) any part of the programme used to record, store, retrieve or display information on a computer or other electronic system on which a user's records are kept, commits an offence and is liable on conviction to a fine or to imprisonment for a period not exceeding one year or to both a fine and such imprisonment.

<sup>329</sup> The eight (8) conditions of POPIA refer to chapter 2 for a full discussion.

health information or data is considered, special information<sup>330</sup> and the processing of such information is prohibited by limitations provided by Section 32<sup>331</sup> of the POPIA. Therefore, it can be considered that POPIA does indeed provide legislative guidelines on the protection of health information which is classified as special personal information.

In addition to POPIA, "PAIA was introduced to give effect to Section 32 of the Constitution of South Africa."<sup>332</sup> Section 11 (1) to (3) of PAIA is about right of access to records of public bodies which state that an information requester<sup>333</sup> must not be denied access to information as long as they have properly followed the information as provided for by PAIA.<sup>334</sup> In addition to this, Sections 29 and 30 of PAIA govern access to health records.

According to Moodley,<sup>335</sup>

Section 30 of PAIA states that,

The information officer may allow access to a health record unless s/he is of the opinion that – disclosure of the record to the relevant person might cause serious harm to his or her physical or mental health<sup>336</sup> and in terms of section 29 <sup>337</sup>may liaise with the relevant health practitioner who...has been nominated by the relevant person.

As per section 30 (2),

If the relevant person is under the age of 16 years, a person having parental responsibilities for the relevant person must make the nomination contemplated in subsection (1); or (b) incapable of managing his or her affairs, a person appointed by the court to manage those affairs must make that nomination.<sup>338</sup>

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<sup>330</sup> Section 26 of POPIA states: A responsible party may, subject to section 27, not process personal information concerning (1) the religious or philosophical beliefs, race or ethnic origin, trade union membership, political persuasion, health or sex life or biometric information of a data subject.

<sup>331</sup> Section 32 of POPIA 4 of 2013.

<sup>332</sup> Katuu SA Managing records in South African public health care institutions- a critical analysis 2015.

<sup>333</sup> Moodley K Introduction to medical ethics, law and human rights 131-132.

<sup>334</sup> Matura N 2019 Information Development 555.

<sup>335</sup> Moodley K Introduction to medical ethics, law and human rights 131-132.

<sup>336</sup> Section 30 (1) of PAIA.

<sup>337</sup> Section 29 of PAIA.

<sup>338</sup> Section 30 (2) of PAIA.

In terms of section 30 (3) (a):

if, the health practitioner consulted in terms of subsection (1) is of the opinion that the disclosure of the record to the relevant person would be likely to cause serious harm to his or her physical or mental health, or well-being, after access to the record was granted. Then the information officer may only give access to the record if the requester proves to the satisfaction said officer that, adequate provisions are made, and which are but not limited to counselling and/or other arrangements of rehabilitation.<sup>339</sup>

In terms of section 30 (3) (b):

The record should be given to said rehabilitator identified in (b) above before the access is granted to the requester.<sup>340</sup>

In addition to the protocol mentioned above, the CA states that, "A child of the age 12 or older will be provided with a copy, abstract or direct access to their own records regarding medical treatment on request."<sup>341</sup>

Furthermore section 13 (3) the MHA in line with Section 30 (2) of PAIA provide that,

A mental healthcare practitioner can temporarily deny a mental health care user access to their information if the practitioner can foresee the possible harm, prejudice, or if the users conduct will prejudice him/her and/or other people, that will be caused due to the disclosure of information to the user.<sup>342</sup>

Therefore, one is able to acknowledge that there is sufficient enforceable legislative context to support and protect a patient or users' personal information. These are controlled by specific processes and stringent protocols that must be adhered to.

#### *4.2.2 Provisions provided by statutory bodies regarding access to health records in South Africa*

Through provisions published in form of guidelines from the HPCSA this study was able to identify the following guidelines which specifically deals with record and data management in the SAHCS.

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<sup>339</sup> Section 30 (3) (a) of PAIA.

<sup>340</sup> Section 30 (3) (b) of PAIA.

<sup>341</sup> Section 41 of the CA 38 of 2005.

<sup>342</sup> Section 13 (3) of MA 17 of 2002.

According to the HPCSA

a patient health record is defined as the longitudinal collection of an individual's personal and health information, recorded by a healthcare practitioner or at the directive of the healthcare practitioner, regardless of the form or medium used to make such record.<sup>343</sup>

Therefore, it can be assumed that electronic communication/consultations and data/records are included in this definition due to the last sentence of this definition.

According to Section 4 it states that, "In terms of Section 27A (ethical rule) a practitioner shall at all times act in the best interests of their patients, respect patient confidentiality, privacy, choices and dignity, maintain the highest standards of personal conduct and integrity."<sup>344</sup>

Here one can see again that ethical principles are emphasised to a practitioner as encapsulated through various booklets<sup>345</sup> and guidelines.

Additionally, Section 6 of the same booklet<sup>346</sup> refers to Section 17 of the NHA<sup>347</sup> which states that:

the person in charge of the health establishment in possession of a user's health records, must set up control measures to prevent any unauthorised access to the records or storage facility, or system which the records are kept. This is irrespective of the format, either hard copy or electronic. Health records should always be secure and safe and should be protected against improper access or disclosure. All electronic data must be managed stored, back up using internationally accepted standards and the protection of patient confidentiality during electronic data transmission and when documents are transferred between facilities and/or healthcare practitioners.<sup>348</sup>

Section 6 states that a healthcare establishment should ensure everything that is required to ensure privacy (which includes patient confidentiality) and security of health information, data and records which should be irrespective of their format. Now that there is guidance on the stance of privacy and confidentiality of records

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<sup>343</sup> HPCSA Booklet 9 2021 1.

<sup>344</sup> HPCSA Booklet 9 2021 3.

<sup>345</sup> Through the HPCSA Booklets 1 to 17.

<sup>346</sup> Section 6 of HPCSA Booklet 9 2021 4-5.

<sup>347</sup> 61 of 2003.

<sup>348</sup> Section 6 of HPCSA Booklet 9 2021 4-5.

and information, further discussion the access to health information and patient health records can be explored.

Sections 9.2 to 9.5<sup>349</sup> contain legislative guidance. Section 9.4 focuses on the provisions of Sections 15 to 17 of the NHA.<sup>350</sup> In terms of Section 9, this section contains the provisions of NHA, POPIA, PAIA and the CA which have been discussed fully in 4.2.1 above.

Section 9.5. makes a broad reference of POPIA and its provision on special information which again has been discussed in 4.2.1 above. However, through 9.5 a healthcare practitioner is guided to read booklets 4 and 5 in conjunction with POPIA. The difficulty here is that a healthcare practitioner is not legal trained to grasp the appropriately interpret pertinent information provided by POPIA. These have been confirmed by research where Marutha confirmed that most officials in the healthcare institutions have not mastered the contents of the legislative frameworks and do not understand them.<sup>351</sup> His research further revealed record management officials did not under the content or stipulations of the legislative frameworks relate to record management.<sup>352</sup>

Additionally, this is where gaps around, understanding, interpretation and ambiguity of legislative context could influence the promotion of enforcing provisions stipulated in the POPIA.

In the absence of the SANC, SAPC, APHCSA, ITHCPC not providing any specific guidelines to the registered practitioners regarding patients and/or users personal information, one can argue that they are governed by legislation as provided for in Chapter 2 and from this discussion POPIA and PAIA which will bind them to comply with these two stringent privacy and confidentiality legislative frameworks.

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<sup>349</sup> Section 9 of *HPCSA Booklet 9* 2021 8-9.

<sup>350</sup> Refer to footnotes 69; 133; 215; 294-296.

<sup>351</sup> Matura N 2019 *Information Development* 557-558.

<sup>352</sup> Matura N 2019 *Information Development* 557-558.

However, in the absence of such guidance it can be further argued that the disciplines are not unified as opposed to those registered under HPCSA. Furthermore, it is evident that there are gaps between the various statutory bodies, and these can cause uncertainties amongst practitioners and patients alike.

### **4.3 Influential Instruments**

This section addresses a particular situation<sup>353</sup> that affects the SAHCS majorly as a patient and/or user of the health care establishment becomes a consumer and how their electronic communications can become infringed in the SAHCS will be discussed below through 4.3.1 and 4.3.2.

#### *4.3.1 Consumer Protection Act (CPA)<sup>354</sup>*

Although this legislation may play a minimal role in all the contexts of the SAHCS, it influences the patient and healthcare practitioners' rights. Calling a recipient of a health care sector a consumer as opposed to a patient had distinct connotations and may result in differential behaviour.<sup>355</sup> Therefore, this discussion will investigate the definition of a consumer within the healthcare sector and identify how the CPA relates to and influences the SAHCS as well as, differentiate the context in which the CPA will apply and how it will apply.

Furthermore, it can be assumed that the CPA might not have a lot of impact on the public sector of the SAHCS, due to the limitations presented by the state healthcare facilities, as well as the differential contractual approach in the public sphere compared to private health care providers. However, there are constitutional rights at play and necessarily so, also consumer rights.

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<sup>353</sup> The reason for addressing these legislative provisions herein and not in the chapter 2 above is due to their indirect affect and application on the SAHCS. However, these topics are prevalent in context due to the vast developments around protection of personal information and consumer rights in conjunction with electronic communication of records and personal information.

<sup>354</sup> Act 68 of 2008.

<sup>355</sup> Rowe K and Moodley K Medical Ethics 2013 *BMC* 1-9.

The CPA came into existence in April 2008 since unethical business practices were on a . CPA was created to assist consumers in SA with their purchases and award the consumer with securities and rights of their purchases via legislative context. This applies to all transactions with SA involving the supply of goods and/or services in exchange for consideration unless the transaction is exempted from the application of the act.

Furthermore, the act came into being to promote fair, responsible consumer and behaviour. Establish national norms and standards to ensure consumer protection; make provision for improved standards of a consumer's information and prohibit certain unfair marketing and business practices.<sup>356</sup> One can understand that the act is in line with PAIA and POPIA in protecting consumer information.

In addition, the act further provides consumer additional rights, of which all South African' should be aware of and these are: Right to Equality in the Consumer Market and Protection Against Discriminatory Marketing Practices; Right to Privacy; Right to Choose; Right to Disclosure of Information; Right to Fair and Responsible Marketing; Right to Fair and Honest Dealing; Right to Fair, Just and Reasonable Terms and Conditions; Right to Fair Value, Good Quality and Safety; and the Right to Accountability by Suppliers.<sup>357</sup>

Again, we see that the CPA in conjunction with POPIA and PAIA enforces consumers right to privacy and confidentiality and furthermore ensure legitimate processing of personal information by service providers.

A consumer is defined by Section 1 of CPA as,

a person to whom goods or services are marketed to or, a person who has entered into transactions with suppliers and/or users of particular goods or recipients/beneficiaries of services.<sup>358</sup>

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<sup>356</sup> CPA act 68 of 2008.

<sup>357</sup> These are considered fundamental consumer right provided by chapter 2-part A-C and sections 8 to 21 of the CPA act 68 of 2008.

<sup>358</sup> Section 1 of CPA 2008.

Additionally, from the above definition according to Moodley a patient is defined as,

a person receiving medical treatment whilst the term consumer under CPA is defined as a person whom goods or services are promoted or supplied in the ordinary course of the supplier's business.<sup>359</sup>

From the broad definition of Section 1 of the act read together with Moodley and her definition of a patient a distinction can be drawn that a patient is indeed a consumer.<sup>360</sup> For purposes of understanding the CPA in the context of the SAHCS, several researchers identified the patient is a consumer and the healthcare sector and/or the healthcare practitioner is the service provider whilst the goods received and/or services is the medical treatment and/or procedures and/or advice. Therefore, the CPA is prevalent to the SAHCS and may indirectly influence the privacy and confidentiality in the SAHCS as a patient becomes a consumer which presents additional liability and obligation to the SAHCS but specifically to the private healthcare sector since patients pay for their services (medical treatment/s) as opposed to public healthcare sector which is governed by the state and it is subject to limitations.

In understanding this patient-consumer context and from the provision of the additional right to privacy by the CPA one can confirm that privacy and confidentiality is indeed enforced by the CPA and the same will be in the context of the CPA in the healthcare sector as these terms are used inter-changeably.

Additionally, medical researchers confirm that CPA poses many challenges to the SACHS due to various liabilities, which need to be considered between services providers.<sup>361</sup> However, for basis of consistency this will not be discussed herein but may be considered for future research developments.

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<sup>359</sup> Rowe and Moodley Medical Ethics 2013 *BMC* 1-9.

<sup>360</sup> Refer to footnote 331.

<sup>361</sup> Refer to footnote 330.

#### 4.3.2 *Electronic Communications and Transactions Act (ECTA)*

This discussion will consider the influence that the ECTA has on the SAHCS and how it assists in the developing technological era to enforce and protect privacy and confidentiality in the SAHCS.

In addition to the CPA, the ECTA cannot be ignored in the HC sector since the technological age is drastically moving towards digitalization and electronic communications.<sup>362</sup> Additionally the use of modern communication measures and electronic communication is often used in the healthcare sector. According to Prahladh, awareness of current legislature governing record keeping and electronic documentation, especially in modern medicine and forensic medicine, has not been sufficiently explored.<sup>363</sup>

The Electronic Communications and Transactions Act or better known as ECTA came into operation in August 2002. According to Mashaba, it was the first time in South Africa that legal recognition of data messages as way of concluding valid agreements.<sup>364</sup> The acts objectives are provided through Section 2 of the act and for basis of consistency focus will be on the necessary objectives in relation to this study namely:

to create awareness and understanding of electronic transactions in South Africa,<sup>365</sup> to remove and prevent barriers to electronic communication and transactions;<sup>366</sup> to promote legal certainty and confidence in respect of electronic communications and transactions;<sup>367</sup> to ensure that electronic transactions conform to the highest international standards<sup>368</sup> and to develop a safe and secure environment for the consumer, business, and government to conduct and use electronic transactions.<sup>369</sup>

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<sup>362</sup> Mashabela MAN The protection of South African Consumers transacting in the electronic space 2018 1.

<sup>363</sup> Prahladh S and Van Vyck J South African and international legislature with relevance to the application of electronic documentation in medicolegal autopsies for practice and research purposes *EJFS* 2022 1.

<sup>364</sup> Mashabela MAN The protection of South African Consumers transacting in the electronic space 2018 9.

<sup>365</sup> Section 2(1)(c) of the ECTA.

<sup>366</sup> Section 2 (1) (d) of the ECTA.

<sup>367</sup> Section 2 (1) (e) of the ECTA.

<sup>368</sup> Section 2 (1) (h) of the ECTA.

<sup>369</sup> Section 2 (1) (j) of the ECTA.

Additionally, the act came into existence to facilitate and regulate communication; transact of an electronic format and mediums, to simplify implementation of the national electronic service delivery strategy, inter alia. According to Marutha the act through part one deals with issues of legal requirements for data messages. From Sections 11 to 17 the act<sup>370</sup> provides directives on issues pertaining to: legal recognition for data messages; written information; electronic signatures; originality of information or record, admissibility and evidential weight of data; and retention and production of documents and information.<sup>371</sup>

Furthermore, Prahladh and Van Vyck argued that the ECTA was developed to prevent abuse of information systems which strengthening the support for the use of electronic communications and transactions. They further emphasised the importance of business to integrate technology and electronic communication due to the technological development and demand.<sup>372</sup> Cognisant of the development and provisions in addition to the objectives of ECTA the possible assumption would be the provision provided by PAIA to safeguard, data and information, records of any form as discussed in 4.1.1 above will take prevalence and supersedes ECTA even during communication and transaction of any kind.

Due to vast developments of technology, even the healthcare sector had to move into the technological modification and enhancement as electronical communication via social media and the next era of AI devices come into play it poses risk to the safeguarding of personal information.<sup>373</sup>

However, at the time this research commenced two critical data and personal information breach cases occurred which indicated that the objectives set out by ECTA were not effective enough. These cases were the cybersecurity attacks in June 2020 with one of South Africa's leading private health care operators Life Healthcare

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<sup>370</sup> 25 of 2002.

<sup>371</sup> Matura N 2019 Information Development 555.

<sup>372</sup> Prahladh S and Van Vyck J *EJFS* 2022 3.

<sup>373</sup> Prahladh S and Van Vyck J *EJFS* 2022 6

Group which manages 66 hospitals in South Africa<sup>374</sup> and Experion a consumer, business and credit information services agency announced a breach of data and personal information of approximately 24 million South Africans and just under 800000 business entities.<sup>375</sup>

In addition to this fast forward to 2022, research by Prahladh and Vykhant concluded that despite having the ECTA the healthcare, and safeguarding of data, the main obstructive issues with the healthcare sector implementing computerised systems are security, privacy and confidentiality.<sup>376</sup>

#### ***4.4 International Standards maintaining privacy and confidentiality in health care: Record and data management***

This sub-paragraph will discuss how South Africa compares with international standards in terms of the study theme of privacy and confidentiality in the HCS. The two focus areas of this discussion are divided into countries outside Africa and the countries within Africa by the countries outside Africa which will include, the United States (US) and Sweden. The countries that form part of Africa will include Egypt and Nigeria.<sup>377</sup>

The rationale for selecting the above countries is because the countries mentioned are considered data heavy countries and which Sweden forms part of the European Union (EU). According to research South African privacy legislation favours the European concept to protect personal information.<sup>378</sup> Additionally, the rationale

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<sup>374</sup> Life Healthcare Group 2020 1-3.

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<sup>375</sup> Mungadse S Life Health Care reveals damage caused by data breach <http://www.itweb.co.za/content/rW1xLv59YPGvRk6m> accessed 6 June 2022 at 13h55.

<sup>376</sup> Prahladh S and Van Vykhant J *EJFS* 2022 5.

<sup>377</sup> The reason for choosing these countries to compare in this section is because they are policy and protocol burdened countries. According to Anas Baig of *Technopedia* Sweden (who forms part of the EU), Nigeria and Egypt are all part of the ten (10) countries with the strictest privacy laws as at 2022.

<sup>378</sup> Data Compliance of Section 7 of the POPI Act 62.

behind the African countries selected is Egypt is considered to be one of the privacy strict countries in Africa apart from South Africa, whilst Nigeria is playing catch up with privacy laws.<sup>379</sup>

#### *4.4.1 Countries outside Africa*

##### *4.4.1.1 US*

The US legal framework is complex and ambiguous. This discussion will focus on legislation and or any ethical frameworks that govern privacy and confidentiality in the US health care sector.

The following legislation make provision for privacy and confidentiality:

- (a) California Consumer Privacy Act (CCPA) this act has been amended accordingly and provides requirements and restrictions on the collection, use, disclosure of personal information.
- (b) California Privacy Rights Act (CPRA) regulations had not been finalised by the completion of this study.
- (c) A statutory body named the US Federal Trade Commission (FTC) protects consumers against unfair business practices and institutes legal action against business that breach privacy and infringe data security.

The CCPA and FTC have similar provisions to South Africa's CPA and its Ombudsman in terms of compliance with CPA.

The legislative frameworks that provide for privacy and confidentiality in the HCS will be discussed herein:

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<sup>379</sup> Olyaniyi Data Protection in the Nigerian Health Care Sector 1.  
<https://www.linkedin.com/pulse/data-protection-nigerian-health-sector-adetunji-oluwadamilareolaniyi#:~:text=The%20Constitution%20guarantees%20the%20right,sectors%2C%20including%20the%20health%20sector>. Accessed 14 December 2023 20h00.

(a) the Health Insurance Portability and Accountability Act of 1996 (*HIPAA*)  
and

(b) Health Information Technology for Economic and Clinical Health Act of  
2009 (*HITECH*)

According to McGraw and Kenneth both this cited legislation promulgates privacy, security, and breach notifications which provide a comprehensive set of protections but only for data within the health care system.<sup>380</sup> Furthermore, they also confirmed that there is a lot of uncertainties in relation to current privacy and data regulations with the US health care sector.

#### 4.4.1.2 Sweden

Due to its membership with the European Union (EU)<sup>381</sup> Sweden is directly influenced by the data legislation provided by the General Data Protection Regulation (GDPR).<sup>382</sup> This is because (Regulation (EU) 2016/679 (*GDPR*) being enforced by the EU. The GDPR is the main governing act regarding the processing of personal data in all forms (which includes medical data in any form).

However, prior to being governed by the *GDPR*, Sweden had its own existing statutes in place for the protection of personal data within the health and pharmaceutical sectors. Additionally, this was reviewed and amended by the GDPR accordingly. This is merely because the GDPR governs data protection within the healthcare sector.

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<sup>380</sup> McGraw D and Kenneth D Privacy protections to encourage use of health-relevant digital data in a learning health system 2021 *NPJ digital medicine* 2.

<sup>381</sup> For understanding purposes, the EU is an organization that consists of 26 countries in Europe that make decision around the governance in Europe and thus protects the economy and peace of Europe amongst other things.

<sup>382</sup> According to Shankar, and Aryal the General Data Protection Regulation (GDPR) is the world's most stringent privacy and security law. Even though it was designed and passed by the European Union (EU), it imposes duties on organisations anywhere that target or collect data about EU citizens. Read further B S Shankar, and S K Aryal The right to privacy and an implication of the EU General Data Protection Regulation (GDPR) in Europe: Challenges to the companies *JOCES* 2023 1391-1402.

Therefore, we look at the extensive measures Sweden had in place before being compliant and adhering to the GDPR. These are as follows:

- (a) Data Protection Act which governed the general aspects of data protection.<sup>383</sup>
- (b) The Patient Data Act which together with the Patient Data Ordinance provides healthcare practitioners and establishments on the protocol for the processing of personal data.<sup>384</sup> This is similar to sections 32 of PAIA read with POPIA sections 7 and 8.
- (c) Electronic Communications Act and the Electronic Communications Ordinance provides protocol on the lawful processing of personal data.<sup>385</sup> This is similar to that of South Africa's ECTA and PAIA.<sup>386</sup>

#### *4.4.2 Countries within Africa*

##### *4.4.2.1 Egypt*

The Personal Data Protection Law<sup>387</sup> (DPL) which is referred to as the law in Egypt serves as a legislative framework which promotes the protection of privacy. Furthermore, this piece of legislation is similar to South Africa's POPIA in the sense that the DPL provides definitions through article 1 for Personal Data and Sensitive Personal Data whilst POPIA defines Personal Information and Special Personal Information which are provided for by Sections 1 and 26,<sup>388</sup> respectively. In addition, the law provides conditions for collection and processing of data which provides guidelines for processing (article 6), rights of the data subjects (article 2) obligations or controllers and the processor (article 3) this is indicative of similar provisions to that of *POPIA* Part 2 and the 8 conditions provided for legitimate processing of

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<sup>383</sup> Data Protection Act (2018:218) and Data Protection Ordinance (2018:219).

<sup>384</sup> The Patient Data Act (2002:355) and the Patient Data Ordinance (2008:360).

<sup>385</sup> The Electronic Communication Act (2022:482) and the Electronic Communications Ordinance (2022:511).

<sup>386</sup> Refer to footnotes 331 to 340.

<sup>387</sup> Personal Data Protection Law No 151 of (2020).

<sup>388</sup> Sections 1 and 26 of POPIA.

personal information.<sup>389</sup> In addition to the protection of privacy through the Law, Egypt has additional legislation that deals with privacy and data protection in the healthcare sector. These are identified as follows:

- (a) Penal Code: which through article 310 provides that healthcare providers and pharmacist who breach patient confidentiality (which is Egypt refers to as secrets) may be sentenced to imprisonment or a fined.<sup>390</sup>
- (b) Blood Operations Law<sup>391</sup> which states that all employees working in the field of blood operation and plasma collection are under the obligation to preserve the confidentiality of the data. This can only be disclosed with that of a court order. We able to distinguish that this is like section 14 read with section 15 of the NHA and provisions of HPCSA.
- (c) Psychiatry Law which through article 4 provides that the institution in which the patient is at should prepare a record and maintain confidentiality. Access to the said record should be only provided to those that are permitted to such as the medical council and secrecy (confidentiality) should be maintained in terms of the contents presented in the record. <sup>392</sup>This can be noted as like the provisions provided for by the MHA read with PAIA.<sup>393</sup>
- (d) Medical charter as per article 30 provides that healthcare practitioners may not disclosure information to their patients unless permitted by the law.<sup>394</sup> This is like sections provided for by section 14 of NHA read with HPSCA guidelines 1.2 of booklet 5.<sup>395</sup>

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<sup>389</sup> Refer to chapter 2 above read in conjunction with footnotes 148 to 172.

<sup>390</sup> Egyptian Penal Code of (1937).

<sup>391</sup> Blood Operations Law No 8 of (2021).

<sup>392</sup> *Psychiatry Law No 71* of (2009).

<sup>393</sup> Section 13 of MHA; Section 30 of PAIA.

<sup>394</sup> Medical Charter issued by Decree of the Minister of Health and Population No 238 of (2003).

<sup>395</sup> Refer to footnote 213 to 214.

South Africa and Egypt share similar legislative frameworks that govern their HCS in terms of processing personal information and medical information that impact privacy and confidentiality in the HCS.<sup>396</sup>

#### 4.4.2.2 Nigeria

The right to privacy is enshrined in Constitution of the Federal Republic of Nigeria 1999.<sup>397</sup>

At the commencement of this study Nigeria did not have legislation that protect general data. June 2023 Nigeria introduced the Data Protection Act, which promotes data processing in a responsible manner and provides a legal framework which protects personal information and the privacy of data subjects. From this one can see that this new piece of legislation is similar to South Africa's POPIA and PAIA provisions<sup>398</sup>

In addition to this Nigeria has specific frameworks that govern their HCS and which promote privacy and confidentiality protection. The frameworks are as follows:

- (a) The National Health Act of Nigeria:<sup>399</sup> this legal framework of Nigeria provides for patient privacy and confidentiality through section 26 it states that all information concerning the patient's use of a medical establishment which includes all information relating to his or her health status, treatment or stay in a health establishment is confidential. Furthermore, section 27 of the act provides for when a health record can be shared and accessed by various stakeholders of the healthcare establishment. In terms of section 28 (1) states that a healthcare provider can access the health record of a patient with the consent of the patient. Section 29 states that a healthcare head of facility should put into place control measures to prevent unauthorised access

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<sup>396</sup> Refer to footnote 362 to 367 above.

<sup>397</sup> The Constitution of the Federal Republic of Nigeria (1999).

<sup>398</sup> Refer to footnote 134 to 145.

<sup>399</sup> National Health Act (2014).

to health records or system which health inform, and records are kept.” This section is identical to that of South Africa’s section 14 to 17 of NHA.<sup>400</sup>

- (b) National Health Insurance Scheme Act<sup>401</sup> through section 38 provides secrecy (which is again confidentiality) obligation binding all officials and employees of the scheme to treat all information obtained by their powers or in ordinary of duty as confidential – unless information is required by order of court as per section 38 (2) of the act. This is similar to *NHA* section 14 to 17 in South Africa although there are talks of South Africa of having a similar legislative framework called the National Health Insurance Bill.
- (c) Patient Bill of Rights<sup>402</sup> is aimed at ensuring easy access to quality healthcare services in Nigeria and recognises patients right to privacy and confidentiality of medical records. This we can relate to *POPIA* and *PAIA* as well as the *PRC* of South Africa.

This discussion provided that Nigerian and South African legislative frameworks are similar. However, it should also be noted that South Africa has been in a better position with legislative frameworks regarding data and privacy protection which safeguard systems records, data and personal information as compared to Nigeria who only recently confirmed such legislation and this discussion.

#### **4.5 Summary of Chapter**

This chapter looked at three pertinent themes influencing the SAHCS. The themes included: the access to data and record management in the SAHCS, instruments that influenced privacy and confidentiality in the SAHCS and International standards.

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<sup>400</sup> Refer to footnote 68 and section 14 of NHA.

<sup>401</sup> National Health Insurance Scheme Act (2021).

<sup>402</sup> Patients Bill of Rights (2018).

It identified that access to health information can be provided as long as stringent adherence to the provisions of legislative frameworks are maintained throughout the request, processing and sharing of such information, data and/or record.<sup>403</sup>

The chapter provided that through the CPA a patient becomes a consumer once they enter a contract with a healthcare provider and/or establishment.<sup>404</sup> Furthermore, CPA and ECTA did influence the SAHCS due to societal demands or electronic communication, social media and the evolution of technology.<sup>405</sup> Reports indicated severe data breaches since the SAHCS is lagging with the enhancement of technology and aspects of AI. The aforementioned indicate that the ECTA objectives have not been met in anyway and need to be relooked and reworked.<sup>406</sup>

It is of paramount importance that the SACHS must keep up with these demands and remain consistent with enhancing technology, ethical provision and review of legislative frameworks should the need present itself and bridge these gaps.<sup>407</sup> This will ensure that SAHCS is committed to promoting, enhancing, and enforcing privacy and confidentiality whilst remaining compliant with legal and ethical frameworks.<sup>408</sup>

When one compares South African legislative and ethical frameworks regarding privacy and confidentiality in the HCS as compared to international standards, South Africa remains in a better position. This also indicates that South Africa has sufficient legal frameworks that promotes a patients' rights to privacy and confidentiality.

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<sup>403</sup> Section 32 of the Constitution of the Republic of South Africa, 1996; read also section 15 to 17 of NHA; Section 26 and 32 of POPIA also see footnotes 293-235.

<sup>404</sup> Refer to footnote 327 read with 328 to 331.

<sup>405</sup> Refer to footnote 347 and 348.

<sup>406</sup> Refer to footnote 332 read with 344 to 346.

<sup>407</sup> Refer to footnote 349.

<sup>408</sup> Prahladh S and Van Vyck J *EJFS* 2022 5.

## CHAPTER 5 CONCLUSION

### 5.1 Introduction

At the onset the study aimed to examine, discuss, and then provide suggestions and/or recommendations on the pre, post and future dispositions that the SAHCS had, has, and should desirably achieve to enhance, promote, and effectively protect privacy and confidentiality within its sector.<sup>409</sup>

Privacy and confidentiality are consistently developing through each era.<sup>410</sup> This is due to societal demands and modern human actions which are impacted by consistent technological development.<sup>411</sup>

Furthermore, despite having stringent protocol and procedures that require adherence for the protection, processing and safeguard of personal information (as mentioned above) the SAHCS experienced a surge in data and privacy breaches which remains a challenge.<sup>412</sup>

Additionally, due to healthcare law, ethics of healthcare and human rights being interwoven, it is of paramount importance that practitioners across the SAHCS be well trained on both ethical and legislative frameworks.<sup>413</sup> Knowledge on legal implications and possible outcomes needs to be simplified and non-ambiguous so it can be interpreted by both HCP's and patients from the onset which will limit or/may reduce data and privacy breaches from occurring.

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<sup>409</sup> Refer to the aim of this study in 1.3.1.

<sup>410</sup> From the Hippocratic Oath to Warren and Brandeis "The right to Privacy and the Birth of the Right to Privacy" 1890 193; the *Constitution of the Republic of South Africa*, 1996 to current POPIA and other legislative frameworks.

<sup>411</sup> Swales 2016 *SAMJ* 49.

<sup>412</sup> Refer to footnote 76,93 and 387.

<sup>413</sup> Oosthuizen H and Verschoor T Ethical principles becoming statutory requirements 2008 *SAFPJ* 40.

## **5.2 Summary of findings**

The *Constitution* provides for the right to privacy and confidentiality but does not directly provide for the right to privacy and confidentiality in the SAHCS which indicates the development for the PRC which is an extension of the Constitution. In addition, the PRC was used to clarify existing rights in the SAHCS context as it elaborated on the patients' rights in addition to constitutional rights.

The NHA specifically addresses privacy and confidentiality in the SAHCS and provides limitations to when it may be breached through stringent protocol.

In terms of POPIA it indicates specific definitions of information which is distinguished by personal and special information. These terms are consistently provided for and provided by legislation that follow the discussion. Furthermore, POPIA indicates stringent protocol that must be adhered to protect personal information, and this is provided for throughout the chapter and discussion/s that followed.

Additionally, PAIA provides specific protocol for the access to information and records which assisted and guided the discussion in the context of the SAHCS as well as, in chapter 4 of the study on how privacy and confidentiality is protected, promoted, and enforced regarding data and record management in the SAHCS.

Furthermore, it is evident through the CA and MHA that these group of persons are also catered for with rights to privacy and confidentiality in the SACHS and there are specific limitations provided as to when privacy and confidentiality can be breached.

Chapter 3 indicated that the HPCSA provided their registered practitioners with the guidance and reiterated the importance of adhering to ethical guidelines as healthcare practitioners and referred to the importance of patient confidentiality and adherence to POPIA and protocol provided by PAIA.

This chapter also indicated that whilst most statutory bodies made mention of privacy and/or confidentiality they did not necessarily cater for both but one of the two aspects.

In terms of the SANS, AHPCSA, presented very vague overviews on privacy and confidentiality. As mentioned above, due to POPIA compliance this was addressed with the bodies so as to have an educative stance through CPD as well as to grasp understanding of legal complexities that may have presented as a breach of privacy and confidentiality, negligence, and/or non-compliance.

The ITPCSA is expected to first expediate their consolation and confirm their statutory body, it has been 10 years or more since their formation and existence. This in itself poses a risk to compliance as one relies heavily on the ethical morale of its board members to guide its practitioners. Furthermore, little to no information on the ITPCSA also indirectly posed as a limitation to the study.

From the onset one would assume due to a brief understanding of traditional practices such as *Ubuntu*, there is a lack compliance in terms of adhering, promoting and enforcing privacy and confidentiality due to its simple translation.<sup>414</sup> However, this study has provided the contrary through an in-depth definition guiding the reader to adequately understand *Ubuntu* and how it can be used to promote and enhance the understanding of privacy and confidentiality in the SAHCS.<sup>415</sup> In terms of *Ubuntu* chapter 3 presented that it could be an ideal change<sup>416</sup> in the SAHCS which could assist cultural challenges that are present in the SAHCS, as it helped in the post-apartheid days with achieving democracy. The discussion was also indicative of the fact that *Ubuntu* also reflected through the ethical framework of the SAHCS more specifically so, in captured in the HPCSA as presented in booklet one (1)<sup>417</sup> the core values <sup>418</sup>of *Ubuntu* are enshrined in the ethical principles of the SAHCS and

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<sup>414</sup> Refer to 3.3 above.

<sup>415</sup> Refer to 3.3 above.

<sup>416</sup> Refer to footnote 268 to 272.

<sup>417</sup> HPCSA Booklet 1 2021.

<sup>418</sup> Section 2.3.1; 2.3.3; 2.3.5; 2.3.6; 2.3.8; 2.39 HPCSA Booklet 1 2021 2.

*Ubuntu* doesn't conflict with privacy as confirmed through the discussion by research.<sup>419</sup>

In addition to the above discussion as a whole, the following gaps were identified through this chapter:

- (a) Non-unified procedures presented by each statutory body in relation to POPIA and PAIA interpretation and where some had guideline provisions and others not, which indirectly impacts the protection of privacy and confidentiality in the SACHS since each body conduct themselves differently as opposed to a uniformed compliance regime;
- (b) Consistent training through CPD for pressing issues such as POPIA and PAIA compliance and the dire impact of non-adherence.

Suggestions are provided for through section 5.5 below.

Chapter 4 followed three pertinent themes influencing the SAHCS were discussed. These were the access to data and record management in the SAHCS, instruments that influenced privacy and confidentiality in the SAHCS and International standards.

The first discussion identified that legislative frameworks such as the *Constitution*, NHA, POPIA, PAIA, CA and MHA provided stringent protocol for the access of data, system information and healthcare records. In relation to this, it is guidance through statutory bodies that echoes provisions provided for through legislative and ethical frameworks alike.

It is, however, evident that there are gaps between the statutory bodies such as the SANC, AHPCSA, ITHCPSA, SAPC to that of the HPCSA in providing guidance on the adherence of access to healthcare records, data, and system information. Once again registered practitioners under the HPCSA are in a better position in understanding access to information and records management than those of SANC, AHPCSA, ITHCPSA, SAPC. This is evident in the fact that the HPCSA provides clear

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<sup>419</sup> Refer to footnote 281-282

and proper guidelines which their practitioners can refer to on a regular basis as apposed the rest of the statutory bodies mentioned herein.

This poses as a risk to the breach of privacy, confidentiality and processing data, system information and healthcare records.

The second discussion identified two (2) additional pieces of legislation that indirectly influences the SAHCS which are CPA and ECTA. Whilst there is minimal research around how these pieces of legislation have an influence on the SAHCS, it is evident that they do. The CPA provides that a patient becomes a consumer as per the broad definition of a consumer provided for in section 1 of the act. Due to this transition of patient to consumer, the CPA becomes pertinent in the space of the SAHCS. Furthermore, through the CPA a patient as a consumer is provided with additional rights that is referred to as fundamental consumer rights which emphasizes the consumers right to privacy.<sup>420</sup>

In addition to this, the ECTA indicates desirable objectives it set out since its existence. The ECTA was developed to prevent abuse of information systems which strengthening the support for the use of electronic communications and transactions. However, the act failed with its objectives set out as business (including the SAHCS) integrated technology and electronic communication due to the rise in technological development and demand.<sup>421</sup> An assumption presented that the provision provided by PAIA to safeguard, data and information, records of any form as discussed in 4.1.1 would take prevalence and supersede ECTA even during communication and transaction of any kind.

Even the healthcare sector had to move into the technological movement. As electronical communication via social media and the next era of AI devices came into play it posed as a risk to the safeguarding of personal information.<sup>422</sup> Research confirmed that despite having the ECTA the healthcare and safeguarding of data,

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<sup>420</sup> Refer to footnote 326.

<sup>421</sup> Prahladh S and Van Vyck J *EJFS* 2022 3.

<sup>422</sup> Prahladh S and Van Vyck J *EJFS* 2022 6

the main obstructive issues with the healthcare sector implementing computerised systems are security, privacy, and confidentiality.<sup>423</sup>

This discussion presented that the SAHCS is in a better position in protecting privacy and confidentiality. The only vast difference apart from other countries having additional regulations around privacy and confidentiality is that South Africa does not have a specific piece of legislation that focuses on privacy and confidentiality in the HCS. Furthermore, this section noted that various researchers have indicated that, even though policy development and vast literature on benefits of electronic health records exist, security and privacy issues are difficult to overcome in resource rich countries such as Switzerland which is part of the *EU* and hence governed by the *GDPR*.<sup>424</sup>

With all of the above taken into account one can conclude that SA has done a lot to ensure sufficient mechanisms for the protection of privacy and confidentiality, that it is viewed in a serious light, but that there remains several hurdles ranging from individual's lack of understanding knowledge, or even negligence in this regard, as well as the enforcement mechanisms that are not always as stringent as it should be.

### **5.3 Recommendations and/or Suggestions**

- (a) The Department of Health should investigate the possible development of simplified and clear documents which can assist both patients and HCPs alike on privacy and confidentiality which educate them on their responsibility, obligations, and inform them of possible limitations.<sup>425</sup>
- (b) Annual policy monitoring, evaluation and development meetings should be encouraged and incorporated into the SAHCS's strategic planning and quality

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<sup>423</sup> Prahladh S and Van Vyck J *EJFS* 2022 5.

<sup>424</sup> De Pietro C and Francetic I E-health in Switzerland 2018 69-74; Prahladh S and Van Vyck J *EJFS* 2022 7.

<sup>425</sup> Research Analyst or Data Administrators could be deployed by the department to evaluate the need of simplified needs, conduct surveys with the old, frail, mental and needy and paediatric departments.

enhancement preparation. This meeting should consist of all registered practitioners belonging to the statutory body.

- (c) Further training: host annual SLP's and CPD compulsory courses for purposes of registration of practitioner and annual compliance coursework for hospital management (who might be non-practitioners), which should be conducted in a unified educative stance with all statutory bodies and affiliations of the SACHS should be executed urgently to address the importance of POPIA and PAIA compliance which will possibly reduce data and system information breaches.<sup>426</sup> Annual compliance certificates can be issued to practitioners for training and development and healthcare establishments for remaining compliant.<sup>427</sup>
- (d) In addition to point (c) above, upon completion of the educative stance, these statutory bodies and affiliations should draft out a unified guideline on the practice promoting the protection of privacy and confidentiality in the SAHCS. This can ultimately be aligned across the SAHCS. An ideal will be a full guideline on privacy and confidentiality in addition to *POPIA* and *PAIA* guidelines.<sup>428</sup>
- (e) There is a need to have medi-legal offices stationed within the Ombudsman's office at each healthcare establishment and/or cluster. This person can be liable for advocacy and awareness in the SAHCS and take the lead in coordinating and organising points a – d mentioned above. Furthermore, the same person can provide quick guidance on the legal implications such as *POPIA* and *PAIA*. This will provide for optimal compliance with privacy and confidentiality and orchestrate possible reviews of legislation as feedback will be provided to relevant authorities to investigate.

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<sup>426</sup> Form a group of representatives as POPIA Champions who can assist with disseminating data inquiries and provide additional assistance or guidance regarding such matters.

<sup>427</sup> This has been confirmed by research of Marutha, Prahladh and others. Refer to footnotes, 330 -332 and 340-341.

<sup>428</sup> As presented through international standards such as Sweden, US, Nigeria and Egypt.

## **5.4 Future research opportunities**

This study has identified that full empirical research of a similar study and a comparison be done between private and public SACHS which could be in the form of a doctoral research which will have outcome articles presented at various conferences for awareness and educative purposes.

Furthermore, during this study AI drastically commenced to influence and infiltrate through various sectors given the present development of a fourth industry revolution. Therefore, the possibility of the impact of AI and its influence on privacy and confidentiality in the SAHCS can be looked at. Additionally, the ethical impact of AI the SAHCS can be additionally perused.

## **5.5 Final Considerations**

With the current vast developments regarding the processing of personal information<sup>429</sup> around the world<sup>430</sup> the protection of privacy is labelled as a necessity,<sup>431</sup> and the South African health care sector are not exempt from taking the necessary steps to ensure compliance, adherence, enforcement, education, enhancement, and consistency.

The right of privacy and confidentiality in the South African healthcare sector is provided for through various<sup>432</sup> legislative and ethical frameworks as well as, instruments. The study provided an interpretation and discussions which indicated that the current South African healthcare legal framework provides sufficient protection of the healthcare users' right to privacy and confidentiality.

However, the study also found that there is an urgent need to unify guidelines on the interpretation of existing frameworks which will assist with the enforcement of

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<sup>429</sup> As defined by section of POPIA and referenced throughout this study. See also Burns & Burger Smidt A commentary on POPIA 4.

<sup>430</sup> As per the discussion of GDPR discussed above. Refer to footnote 376 and 412.

<sup>431</sup> Swales 2016 *SAMJ* 49.

<sup>432</sup> The Constitution of the Republic of South Africa, 1996, NHA, POPIA, PAIA, CA, MHA, HPCSA, SANS, SAPC, AHPCSA, THPCSA, CPA, ECTA and influenced by international instruments.

these legal frameworks and further assist with the consistent application of the same. In doing so and confirmed by various authors<sup>433</sup> this must be done in conjunction with the demands of technological development and its influence on a patient right to privacy and confidentiality in the South African Healthcare Sector. This will then allow for the maximum protection and enforcement of a healthcare users' privacy and confidentiality.

In reaching an answer to the research question posed, as to how the current health care legal framework in South Africa be enhanced to ensure sufficient protection of health care users' rights to privacy and confidentiality, one can conclude that the extensive existing legal framework provides encompassing protection to the rights of the health care user, whilst also providing sufficient guidance as to how these protections should be employed. What is however lacking is the implementation and oversight regarding these principles and provisions, in all spheres of public and private health care, that ultimately undermines the standing, well-rounded legal framework.

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<sup>433</sup> Prahladh S and Van Vyck J *EJFS* 2022 1-8; Matura N 2019 Information Development 555-558; Rowe K and Moodley K 2013 *BMC Medical Ethics* 1-9.

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## SOLEMN DECLARATION AND PERMISSION TO SUBMIT

### 1. Solemn declaration by student

I, **Mr Ujeet Maharaj**

declare herewith that the thesis/dissertation/mini-dissertation/article entitled (exactly as registered/approved title),

The right to privacy and confidentiality in the South African health care sector.

which I herewith submit to the North-West University is in compliance/partial compliance with the requirements set for the degree:

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is my own work, has been text-edited in accordance with the requirements and has not already been submitted to any other university.

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Signature of Student

**Ujeet  
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Signed on this **12** day of **March** of 20**24**

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Faculty of Humanities  
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19 March 2024

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To whom it may concern

Editorial Assistance for Magister Legum in Private and Public Law at the North-West University Dissertation

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Editorial intervention was restricted to: Language and Illustrations as well as Completeness and consistency as defined by the current South African standards for Editing Practice. Where the editor provided advice on structure, they gave examples only and did not undertake a structural re-write themselves. Material for editing or proofreading was submitted in electronic copy to the editor and a markup was done using tracking Changes. The decision to accept and implement changes suggested rests solely on the candidate.

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Candidate's Name: Mr Ujeet Maharaj

Dissertation Title: The protection of privacy and confidentiality in the South African health care sector

Editor's Name: Prof Lighwa P. Siziba

I declare that I have edited /proofread the thesis in compliance with the above conditions, as instructed when engaged by the candidate.

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A handwritten signature in black ink, appearing to read 'L. P. Siziba', with a stylized flourish underneath.

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Based on approval by the **Law Higher Degrees Committee (HDC)** on 10/08/2023, the Law Research Ethics Committee hereby **approves** your study as indicated below. This implies that the North-West University Senate Committee for Research Ethics (NWU-SCRE) grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

**Study title:** The protection of privacy and confidentiality in the South African health care sector

**Promotor:** Dr AF van den Berg (12533726)

**Student:** Mr U Maharaj (25946382)

**Ethics number:**

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Institution Study Number Year Status  
Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

**Application Type:** Single Study

**Commencement date:** 10/08/2023

**Expiry date:** 10/08/2024

**Risk Category:**

**No Risk**

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