2012 Journal for Juridical Science 37(2):96-116

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Application of the international classification of functioning, disability and health with specific focus on disabling hearing impairment in legislation and policy in South Africa

Summary

Disability legislation faces two potentially contradictory perceptions. Persons with disabling hearing impairment (DHI) are committed to eradicating discriminatory attitudes and practices, and removing barriers to communication and integration. Legislation should be aimed at breaking down these barriers, and be designed to assist persons with DHI to overcome stereotyped assumptions about their disability and ability. To achieve these goals, a common framework for describing functional status information is needed in order to make this information comparable and of value. The World Health Organization's International Classification of Functioning, Disability and Health (ICF), which has been approved by all its member states, including South Africa, provides a common language and framework to be used in legislation. This article analyses disability legislation in South Africa, with specific focus on DHI, in order to determine the application and definition consistency. It finds that some legislation includes some elements of disability. This endeavour may have extensive implications for the development of law and public policy to supplement the ICF and the Constitution of South Africa.

Toepassing van die internasionale klassifikasie van funksionering, gestremdheid en gesondheid met spesifieke fokus op gehoorgestremdheid in wetgewing en beleid in Suid-Afrika

Gestremde wetgewing het dieselfde gesig, maar met potensiële teenstrydige persepsies. Mense met gehoorgestremdheid (GG) is vasbelote om diskriminerende gesindhede, praktyke, en hindernisse te verwyder om sodoende kommunikasie en integrasie te bewerkstellig. Wetgewing moet gerig wees om hierdie hindernisse af te breek, te stereotipeer, en aannames te maak rakende hul gestremdheid en vermoëns. Om hierdie doel te bereik, is 'n gemeenskaplike raamwerk vir die beskrywing van funksionele status nodig om inligting vergelykbaar en van waarde te maak. Die Wêreldgesondheidsorganisasie (WGO) se internasionale klassifikasie van funksionering, gestremdheid en gesondheid (FGG), wat deur al die lidlande, insluitend Suid-Afrika, goedgekeur is, bied 'n gemeenskaplike taal en 'n raamwerk om te gebruik in wetgewing. Die doel van hierdie artikel is om wetgewing rakende gestremdhede te ontleed, met spesifieke fokus op GG, en om die toepassing en konsekwentheid van die definisie te bepaal. Daar is ook gevind dat sommige wetgewing sekere elemente van gestremdheid insluit. 'n Nuwe benadering tot die komponente van 'n gestremdheid moet oorweeg word. Hierdie strewe kan uitgebreide implikasies vir die ontwikkeling van die reg en openbare beleid hê om die FGG en die Grondwet van Suid-Afrika aan te vul.

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1. Introduction and background

This article aims to present the results of a review on the application of the International Classification of Functioning, Disability and Health (ICF) with specific focus on disabling hearing impairment (DHI) in legislation and policy in South Africa (SA). In pursuance of this aim, relevant laws, regulations and policy statements issued in SA after 1994 are scrutinised. The term DHI is used to describe all individuals with hearing loss causing an impairment of functioning, regardless of their level of auditory impairment. The usage of terms such as deaf, socially deaf, and hard of hearing is subject to inconsistencies, and may embody a medical, psychological or social-cultural perspective.[1]

There is no separate disability legislation in SA. The World Health Organization (WHO) is advocating a paradigm shift in how the world perceives and defines disabilities.[2] An analysis of social protection and employment policies directed towards persons with disabilities first requires an answer to the question as to what constitutes a disability.

In 1980, an important breakthrough took place when the WHO developed the International Classification of Impairments, Disabilities and Handicaps (ICIDH), as the first conceptual framework of its kind to incorporate the influences of personal, social and environmental factors on persons with disabilities.[3] The ICIDH was the first framework for analysing disability issues compatible with the emerging understanding that medical rehabilitation, assistive devices and personal assistance can reduce the functional limitations of persons with disabilities, and thus increase their capacity to take advantage of social and economic opportunities, and that social and environmental policies can alter the societal contexts of disability.

Previously, "disability" was regarded as a medical issue of a severe abnormality of a body structure or a loss or deviation of physiological function. The ICF combined these concepts into a comprehensive whole of multiple dimensions of human functioning, synthesising biological, psychological, social and environmental aspects. The newly proposed model, called the biopsychosocial model, synthesises the best of both the medical and social models on which ICF is based. Therefore, the ICF, first published by the WHO in 2001, created a standard language and framework for describing health and health-related states.[4] In the case of the WHO, this is also in the acronym of the ICF, which replaces the acronym ICIDH, the International Classification of Impairments, Disabilities and Handicaps. Led by the WHO, the ICF is an attempt to improve our understanding of disability, and reflects the move from a static to a dynamic definition of disability. This has been underway for over twenty-five years. There are no published reports on the application of the ICF in SA.

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1 Calderon & Greenberg 1977:455-482.
2 World Health Organization 2001(a):4.
3 World Health Organization 1980:5.
4 World Health Organization 2002:3-23.

The right of persons with DHI to health and rehabilitation services has been grossly neglected. Necessary health care and support services are frequently unavailable or inaccessible, while human rights abuses are often pervasive within services where they do exist. Despite progress in developing appropriate services, additional policy and legislative initiatives are a prerequisite for persons with DHI to realise their right to health. A human rights approach, including participation, activities, environment, autonomy, dignity, inclusion, monitoring, and accountability should guide all relevant actions.

In an effort to improve the collection of disability data in developing countries, the United Nations Statistical Division formed the Washington Group on Disability Statistics consisting of representatives from member states and statistical agencies. The World Bank has provided support for this group to help arrange regional meetings, subsidise the attendance of developing country representatives, and conduct field tests. First, in order to facilitate the gathering of basic disability information throughout the world, the group is guiding the process of developing a small set of general disability measures for use in censuses and sample-based national surveys. Secondly, the group is preparing recommendations for extended sets of survey items related to general measures that can be used as components of population surveys or supplements to speciality surveys. The ICF framework will be used to develop the measures.

In 2001, the 191 member states of the WHO, including SA, agreed to adopt the ICF as the basis for scientific standardisation of data on health and disability worldwide.[5] As a result, the ICF serves as a powerful tool to address disability issues from clinical management to multidisciplinary research, legislation, policy development, and economic impact. The SA government sent a delegation of representatives to participate in the revision process.

2. Method

An analytic-comparative study of disability legislation with a descriptive focus was conducted, and an attempt was made to accurately portray the application of the ICF principles in disability legislation.[6] The approach to this study is deductive in that legislation will be utilised and applied to the definitions in disability legislation by means of the biopsychosocial model in the context of the ICF.[7] Definitions of hearing impairment in legislation were analysed according to the framework provided by the WHO. The discussion is exploratory in the sense that it explores the application of the ICF to the SA context with the aim of developing new insights into, and understandings of the topic. The method of investigation relied mostly on a comprehensive literature review on the application of the ICF to

5 World Health Organization 2002:5.
6 Heywood 2002:12-15.
7 World Health Organization 2001(b):9.

SA legislation and consisted of books, journals, newspaper articles and internet sources. The study focused primarily on SA legislation by studying the relevant laws, regulations and policy statements issued after 1994 to illustrate the application of the ICF in SA disability legislation, with specific emphasis on DHI in the SA context.

3. Legal frameworks in support of disability legislation in South Africa

Legal definitions of disability have been an issue of much international debate. Despite the efforts of the ICF, there is no universal international legal definition of disability. A study of the definitions of disability in various European Union (EU) countries has shown variations not only from country to country, but also within each country.[8] While there are similarities among the definitions of disability in some areas of social policy, definitions of legal disability in each country differ with respect to income maintenance, employment measures or social assistance with daily life activities. ICF combined these concepts into a comprehensive whole of multiple dimensions of human functioning, synthesising biological, psychological, social and environmental aspects. Therefore, ICF presents health and disability in a single spectrum. Traditionally, these areas were considered separately and at times polarised. However, a detailed analysis of the domains that make up health and disability shows that these two basic constructs are, in fact, different manifestations of the same domains of functioning such as vision, cognitive, hearing and many others. Despite the WHO's efforts, there is no universal international legal definition of disability, nor is there one in South Africa.

In international law, a number of international agreements refer to rules of a non-legal nature, respect for which is made obligatory by such references. Governments frequently wish to record, in writing, the terms of an understanding or arrangement between them without creating obligations that would be binding under international law.[9] While not binding under international law, a non-binding instrument may carry significant moral or political weight. Non-legally enforceable instruments are referred to as "soft law", and such instruments are often used in international relations to establish political commitments.[10]

It is suggested that the ICF be regarded as a treaty, since it is a basic principle of international law that a state which is party to an international treaty must ensure that its own domestic laws and practices are consistent with what is required by the treaty.[11] In this instance, the ICF gives specific stipulations and general guidance on the measures to be taken.[12]

8 Employment & Social Affairs 2002:65.
9 Mörth 2004:11.
10 Goldmann 2012:335.
11 Brownlie 2008:282.
12 World Health Organization 2002:19.

The United Nations Convention on the Rights of Persons with Disabilities (UNC) is an example of a treaty which entered into force on 3 May 2008.[13] Although the UNC does not explicitly define disability, it considers that disability arises from a health condition in interaction with the environment. Parliament thus has a critical role in ensuring that the legislative measures required by the WHO and the UNC are adopted.

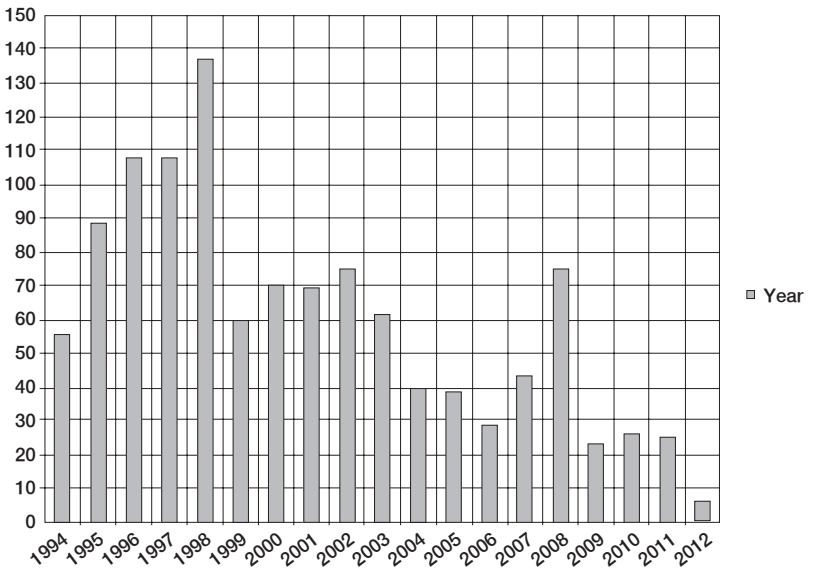
It is arguable that SA definitions of disability in legislation are closely aligned with the medical model. Definitions of disability in the SA context vary in relation to different legal purposes. The *Social Assistance Act*, 2004 (Act no. 13 of 2004) provides personal assistance benefits; for example, it may have a different target group of disabled persons than in discrimination law.

Therefore, eligibility criteria to classify impairment are based mainly on a person's medical status, with secondary attention paid to environmental dysfunctions as incorporated, among others, in the *Social Assistance Act*, 2004 (Act no. 13 of 2004), the *Compensation for Occupational Injuries and Diseases Act*, 1993 (Act no. 130 of 1993), the *Blind Persons Act*, 1968 (Act no. 26 of 1968), the *Income Tax Act*, 1962 (Act no. 58 of 1962), the *Income Tax Act*, 1997 (Act no. 28 of 1997), the *Medical Schemes Act*, 1998 (Act no. 131 of 1998), *Government Gazette* (No. 2284 of 2001), *Government Gazette*, 2002(a) (No. 22209 of 2002), and *Government Gazette*, 2002(b) (No. 23718 of 2002). Since April 1994, 1.135 Acts of Parliament have been issued, as illustrated in Figure 1. As a result, 17 pieces of the 1.135 Acts contain words such as disability, disabled, deaf, Deaf, deafness, hearing impairment, and hearing impaired. Six pieces of this legislation are analysed according to the framework of the ICF, as illustrated in Figure 2:

- Impairments of body function;
- Activities, and
- Participation.

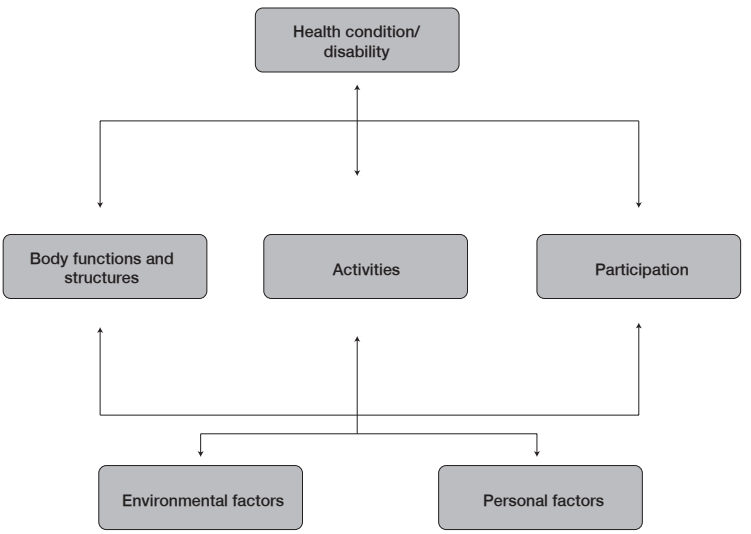
13 United Nations 2008:1-3.

Figure 1: Total Acts of Parliament issued after 1994



Source: South African Government Information 2012

Figure 2: ICF framework and components



Source: ICF (WHO 2001)

4. Results and discussion

This section critically analyses disability legislation with the application of the ICF and with specific reference to DHI. As a result of the concentrated lobbying activities of persons with disabilities and their advocates, key findings drawn from the analysis are briefly discussed. SA passed several laws aimed at protecting persons with disabilities.

4.1 *Income Tax Act* 58 of 1962

Expenditure prescribed by the *Income Tax Act* (*ITA*) of 1962, which is necessarily incurred and paid for by the taxpayer in consequence of a physical impairment or disability, is deductible in terms of Section 18 of the *Act*, subject to certain limitations. This *Act* came into effect on 1 March 2009.

Previously, persons with disabilities could only claim their total medical expenses not covered by their medical aid if they were 65 years and older, or if the *ITA* regarded them as handicapped. Prior to the recent changes, Section 18(3) referred to a "handicapped person" and was defined to the extent that some persons with a disability were excluded from being "handicapped". Disabled but not "handicapped" persons are afforded lesser tax benefit than "handicapped persons". These limitations in the *ITA* were restricted to persons with a disability who were not "handicapped".

The term "handicapped person" was narrowly defined, and covered five categories of persons, namely a blind person; a deaf person; a permanently disabled person requiring a wheelchair, calliper or crutch to move from one place to another; a person requiring an artificial limb, and a person suffering from a mental illness, as defined in Section 1 of the *Mental Health Care Act* of 2002. This meant that a person would have to have DHI to the point that s/he relied on sign language to claim all expenses, whereas a person requiring a hearing aid could not claim the expenses incurred in full.

In recognition of this, the *ITA* was amended in 2008 so that persons with disabilities can claim all expenses, medical or otherwise, to enable them to function more fully in their daily lives. These new deductions apply if the taxpayer concerned, the taxpayer's child or spouse has a disability. The *ITA* was amended to broadly replace the terms "physical disability" and "handicapped" by "physical impairment" and "disability", respectively, with effect from 1 March 2009. In addition, the word "impairment" is based on the definition of "disability" in Section 18(3) of the *ITA* and this is used in respect of all disabilities. Accordingly, the terms "hard of hearing", "Deaf", and "deaf" cannot be used.

The *ITA* defines a "person with a disability", as a person living with a "disability" as defined by the new legislation. This is a more widely accepted term and generally used in lieu of the term "handicapped person". The qualifying expenditure under section 18 of the *Act* is not subject to a

limitation if a taxpayer, his/her spouse or child is a person with a disability. "Moderate to severe limitation" is defined as a significant restriction on a person's ability to function or perform one or more basic daily activities after maximum medical correction.

The prescribed list of qualifying expenses relating to physical impairment or disability and the diagnostic criteria for disability were published on 20 April 2010 (South African Revenue Services 2010).

The amendment clarified which expenses the South African Revenue Services (SARS) would allow as a deduction; it also provides the list and the diagnostic criteria. The extensive but not comprehensive list of qualifying expenses identifies broad categories of qualifying expenses and provides examples of expenditure that can be claimed.

With respect to the diagnostic criteria, disability is viewed as an impairment to the body or mind that results in a moderate to severe limitation on a person's ability to perform daily functions. A person might be diagnosed with a permanent or temporary disability. In the case of a permanent disability, the diagnosis will be valid for five years and must be confirmed by a registered health practitioner at the end of that period, whereas a temporary disability diagnosis is valid for one year.

"Physical impairment" is interpreted as a disability that is less restraining than a disability defined as the restriction on the person's ability to function or perform daily activities after medical correction is below a "moderate to severe limitation". Qualifying expenses paid by a taxpayer in respect of a person with a physical impairment will still be deductible under section 18(1)(d) of the *ITA*, but the quantum of the deduction will be limited to amounts in excess of 7.5 per cent of the taxpayer's taxable income in the case where the taxpayer is below the age of 65. To claim the deductions, the person with a disability must be diagnosed and obtain a confirmation of his/her disability from a registered health practitioner in accordance with the criteria prescribed by SARS. To determine eligibility under section 18(2)(b) of the *ITA* (as amended), the information required in order to comply with the document, ITR-DD: "Confirmation of Diagnosis of Disability" is prescribed. The diagnoses as defined by the *ITA* are divided into six categories, namely vision; communication; physical; mental; hearing, and intellectual.

The *ITA* refers to a "hearing disability" which is defined as the functional limitations resulting from a hearing impairment (HI). HI is a sensory impairment that will influence verbal communication between speaker and listener. It is an abnormal or reduced function in hearing resulting from an auditory disorder.

The list is structured in such a way that it broadly defines the category of allowable expenses and then provides examples of expenses that will be allowed under a specific category.

The definition given implies that impairment is a less severe disability than the one defined in the document. However, in the context of health,

impairment is not defined in the same way as disability. WHO defines impairment as "any loss or abnormality of a psychological, physiological or anatomical structure or function", and as "problems in body function or structure such as a significant deviation or loss".[14]

To the extent that alterations or modifications to assets are made to enable the person with disability to function or perform daily activities in both an efficient and safe (reducing the risk of personal injury) manner, the expenses incurred will be regarded "as necessarily incurred as a consequence of disability" and, therefore, allowable. The ICF provides a common language for describing the experiences of persons with DHI, as well as those experiencing a variety of other conditions, in terms of the impairment in body structure or function and the resulting limitations in the individual's ability to perform daily activities or participate in life. The ICF presents a clear framework which specifically incorporates contextual factors (environmental and personal) and demonstrates the potential impact of these factors on a person's overall experience of health.

4.2 *National Health Act* 61 of 2003

The *National Health Act* (NHA) of 2003 states that a

> review of research proposals and protocols in order to ensure that research conducted by the relevant institution, agency or establishment will promote health, contribute to the prevention of communicable or non-communicable diseases or disability or result in cures for communicable or non-communicable diseases.[15]

Moreover, the *NHA* states that the head of a provincial health department must, in accordance with national health policy and the relevant provincial health policy in respect of, or within the relevant province, "provide services for the management, prevention and control of communicable and non-communicable diseases".[16]

Regulations relating to certificates of need "must ensure the equitable distribution and rationalisation of health, with special regard to vulnerable groups such as women, older persons, children and persons with disabilities" and (d) "must ensure and promote access to health services and the optimal utilisation of health care resources, with special regard to vulnerable groups such as women, older persons, children and people with disabilities", (e) "must ensure compliance with the provisions of this Act and national operational norms and standards for the delivery of health services".[17]

The ICF is based on two important principles that have significant implications for how health services are conceptualised and structured.

14 World Health Organization 2001a:10.
15 *National Health Act* 61/2003:section 73(2)(a).
16 *National Health Act* 61/2003:section 25(2)(w).
17 *National Health Act* 61/2003:section 39(2)(a).

The first principle is universality, that is, the view that disability is a typical phenomenon of the human condition, affecting all individuals in some way and at some time in their lives. This is in contrast to the view of disability as a defining characteristic of specific minority groups. The second underlying principle of the ICF is continuity, or the view that disability in any area exists along a continuum, based on the interaction of the person, the health state, and the environment. This is in contrast to a view of disability as a categorical phenomenon, that is, something intrinsic to the person that s/he either does or does not have. The values that underlie the ICF include the dignity and worth of all individuals, the inclusion of persons with disabilities in society to the fullest extent possible, and the need for advocacy to provide persons with disabilities with the best opportunity to maximise their independent functioning.

Assistive devices form part of health services "the development of an essential drugs list and medical and other assistive devices list".[18] The *NHA* provides regulations regarding (j) communicable diseases, (k) notifiable medical disease, (l) rehabilitation, (q) non-communicable diseases, and (r) health technology. Municipal health services include the (e) "surveillance and prevention of communicable diseases, excluding immunisations".[19]

The *NHA* focuses strongly on local authorities adopting an enabling role, in partnership with the voluntary and private sectors. It also focuses on a more imaginative response to needs, rather than assessing people for services. This *Act* should be viewed, in conjunction with the ICF and other legislation, as managing or providing a range of services including hearing devices, interpreters and environmental aid provisions.

Rehabilitation is an important aspect of health and is defined by the *NHA* as "a goal-orientated and time-limited process aimed at enabling impaired persons to reach an optimum mental, physical or social functional level". ICIDH-2 was developed for application to various aspects of health. Furthermore, the ICF provides a framework to code a wide range of information about health such as diagnosis, functioning and disability, and reasons for contact with health services. It uses a standardised common language permitting communication about health and health care across a country in various disciplines and sciences. In a sense, it is a retrograde step and perhaps bodes badly for anti-discrimination legislation. The *NHA* has no joint plans on DHI services.

Furthermore, the ICF is particularly relevant to DHI, because it focuses on more than merely the observable characteristics of disorders. For DHI, the ICF supplements information on observable characteristics such as repetitions, prolongations, and misunderstandings that may characterise DHI with information about the overall impact of disorder, including negative communication attitudes, shame, embarrassment, and limitations in an individual's ability to participate in society. In addition, the ICF allows the description of both impeding factors such as negative responses to

18 *National Health Act* 61/2003:section 90(1)(d).
19 *National Health Act* 61/2003:section 25(j)(k)(l)(q)(r)(j).

a person's DHI and facilitating factors such as speech therapy, support groups, and an accepting environment. The application of the ICF in this *Act* will firmly enforce the notion of local authorities acting as enablers rather than providers, and will contribute to a mixed economy of social services and partnerships.

4.3 *Medical Schemes Act* 131 of 1998

The *Medical Schemes Act* of 1998 was amended by the *Medical Schemes Amendment Act* (*MSAA*) of 2001.[20] The *MSAA* promotes the right to equal treatment by stating that "the medical scheme does not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds including race, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health".[21] The *MSAA* is, in fact, human rights legislation. One of the objectives of the Council for Medical Schemes in creating the *Act* was to protect and enhance the rights of the members, referred to as "beneficiaries", "at all times".[22]

These rights may be championed or protected in two ways. First, by the registrar of medical schemes, who is empowered to conduct an inspection of a medical scheme "if he or she is of the opinion that such an inspection will provide evidence of any irregularity or of non-compliance with [the] Act by any person" or "for purposes of routine monitoring of compliance with [the] Act by a medical scheme or any other person".[23] As amended, the *MSAA* also entitles the registrar to address to a medical scheme any inquiries related to "any matter connected with the business or transactions of the medical scheme".[24]

The second is by the members themselves. In this regard, the *MSAA* affords the members the right to lodge a complaint with the registrar against a truant medical scheme. If the member is not satisfied with the outcome of the complaint, s/he may appeal to the Council for Medical Schemes.[25] The *MSAA* also provides the member with a procedure that does not require the beneficiary to incur legal costs or formal litigation.

The rules of a medical scheme, which form the contract between the scheme and its members, are also regulated by the *MSAA*. What the rules may and may not contain is specified. These specifications are designed to protect members against discrimination. In addition, a medical scheme in SA operates as a "non-profit organisation (NPO)", also known as "Section 21 Companies" in accordance with the *Non-Profitable Organisations Act* of 1997. According to section 31(a), an application for registration is R5.000.

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20 *Medical Schemes Amendment Act* 55/2001.
21 *Medical Schemes Amendment Act*:section 24, substitution (2)(e).
22 *Medical Schemes Amendment Act* 55/2001.
23 *Medical Schemes Amendment Act* 55/2001.
24 *Medical Schemes Amendment Act*:section 43.
25 *Medical Schemes Amendment Act*:section 47.

Prescribed minimum benefits are defined as benefits contemplated in terms of the *MSAA*, and consist of the provision of the diagnosis, treatment and covering of the health care costs of diagnoses and treatment pairs subject to limitations in Annexure A (AA), and any emergency medical condition.[26]

An emergency medical condition means the sudden and, at times, unexpected onset of a health condition that requires immediate medical and/or surgical treatment. If the treatment is not available, the emergency could result in serious impairment to bodily functions, serious and lasting dysfunction to organs, limbs or other body parts, or even death.

Code 905A in AA states that the diagnosis of acute and sub-acute meningitis requires "medical and surgical management". This means that a medical scheme may not refuse to pay for a cochlear implant if needed.

In 2003, the Board of Healthcare Funders wrote to its members to suggest that medical schemes volunteer to initiate a separate, shared fund to cater for specific rare conditions that usually create significant financial risk. Included on the proposed list of diseases was Gaucher disease, an inherited enzyme deficiency disorder, haemophilia, cystic fibrosis, cochlear implants, interferon-treated multiple sclerosis and chronic myeloid leukaemia. Gaucher disease was included as a prescribed minimum benefit and could cost between R600.000 and R700.000 to treat one individual. However, no discussion has taken place on the treatment and rehabilitation programmes for persons with DHI.

It was recommended that the concept be developed and that it would only be successful with the buy-in from the majority of the medical schemes. Shaun Matisonn, principal of Discovery Health, was of the opinion that such a fund might protect individual schemes from "adverse selection fallout". He mentioned that schemes are prevented from offering best practice care unless other schemes buy in, because if only a limited number of schemes offered treatment for particular expensive conditions, then all the sufferers of those diseases "flocked to that limited number of firms".[27] It is observed that inappropriate terms are used for cochlear implants such as "a rare disease"; moreover, it is astonishing that reference has been made to a technology device and not DHI. According to the WHO, "hearing loss, visual impairment and mental disorders are the most common causes of disability worldwide".[28]

Moreover, it has become the norm not to exclude all impairments from the benefits of a medical scheme. However, medical scheme product designers are cautious about what they include and about the amount in the insured benefit portion of their scheme. Hearing devices, including cochlear implant devices and assistive listening equipment, whether introduced internally or not, as well as the maintenance of these devices,

26 *Medical Schemes Amendment Act*:section 47.
27 Board of Healthcare Funders 2003.
28 World Health Organization 2006:35.

usually do not qualify for payment from insured benefits. The majority of medical aids pay between R4.000 and R15.800 for hearing aids per family annually. A limited number of medical schemes pay for cochlear implants, with benefits ranging between R55.000 and R140.000 per family annually, subject to prior approval.

The Council for Medical Schemes' 2010-2011 annual report revealed that the Council dealt with 863 more complaints last year (total 5.351) than it did in 2009, when 4.488 people complained about schemes.[29] The highest number of complaints the Council received in 2010 were related to the prescribed minimum benefits (1.749), followed by refusal to authorise treatment (272), and exclusion of conditions or benefits (87).[30]

The *MSAA* refers explicitly to diagnostic groups without the framework of the ICF. The ICF definition clearly expresses the essential structure of the concept of disability as a result of an interaction between features of an individual with a health condition and features of the physical and attitudinal environment. In addition, the *MSAA* is restricted to specific groups, but is not flexible so that, as resources become available, the threshold of disability can be adjusted so that more individuals can benefit from these resources.

The relationship of health and functional status information from the ICF codes for activities, participation, and the environment to ICD codes in predicting health-care expenditures for persons with DHI is ignored. In addition, the analysis revealed that activities and participation within the context of the environment moderate the effect of physically disabling conditions on total health-care expenditures for persons with DHI. The analysis used in an internationally recognised procedure for linking ICF classification codes and health-care expenditures describes the relationship between total health expenditures and treats physically disabling conditions and function within the context of the environment.

The author argues that differences in conditions mean that expenditures are provided for all total, in-patient, ambulatory care, prescription medication, as well as dental and other medical care expenditures. The environment component of the ICF will contribute and ensure equality towards total health expenditure for persons with DHI.

An already complex industry has only now begun to embrace its newfound flexibility. The onslaught of managed care concepts and technology will raise the levels of complexity to new heights. Players will become more sophisticated, offering ever greater levels of service in order to survive. Furthermore, as the industry matures, an overall definition must be maximally inclusive and conceptually valid. The ICF adopts neutral language and does not distinguish between the type and the cause of disability – for instance, between "physical" and "mental" "health". "Health conditions" are diseases, injuries, and disorders, whereas "impairments"

29 Council for Medical Schemes' 2010-2011 annual report.
30 Council for Medical Schemes' 2010-2011 annual report.

are specific deviations in body functions and structures, often identified as symptoms or signs of health conditions.[31]

4.4 *Criminal Law (Sexual Offences and Related Matters) Act* 32 of 2007

The *Criminal Law (Sexual Offences and Related Matters) Act* (*CLA*) defines a "person who is mentally disabled" as "a person affected by any mental disability, including any disorder or disability of the mind, to the extent that he or she, at the time of the alleged commission of the offence in question, (d) is unable to communicate his or her unwillingness to participate in any such act".[32]

No provisions are made for persons with DHI and the provisions made apply explicitly to persons with mental disabilities. Legislation designed to protect persons with DHI from injury, ill-treatment or abuse refers to persons, in the main not themselves HI, who might be in a position, or who might take advantage of the condition of the HI, to cause them harm. Legislation which may be termed discriminatory in respect of the HI, though possibly for their protection as well, has been limited.

The ICF could play a vital role if used as an advocacy tool for the promotion of an inclusive and participatory approach in the fight against victimised persons with DHI, with a well-defined objective towards scaling down the *Act* to all vulnerable groups which will include all persons with different disabilities, whether visible or invisible.

Currently, there is no consistent data-gathering system in SA to document longitudinally the prevalence of childhood sexual abuse among children who are HI. If the prevalence of sexual abuse among this population is to be truly understood, additional steps must be taken to elicit consistent and widespread data-collection techniques from national organisations, and from the Departments of Social Welfare and Health. Understanding the prevalence of abuse is important to intervention and treatment. However, a problem with the system is the classifications used to identify children with disabilities and, in particular, those with DHI.

The *CLA* requires the registration of any person convicted of a sexual offence against a child or a mentally disabled person.[33] Section 43 states that the register seeks to "protect" children and mentally disabled persons by "maintaining a record" of convicted offenders. Section 49(b)(i-iii) requires a limited amount of information concerning an offender. The register only requires the offender's name, address, identification number, passport number, and driver's license number. The register will outline the nature of the crime, including the date of the offence, the place of conviction, the case number and the court in which the trial took place. The provisions

31 World Health Organization 2002:3-5.
32 *Criminal Law (Sexual Offences and Related Matters) Act*:section 1.
33 *Criminal Law (Sexual Offences and Related Matters) Act*:section 43(a)(i).

in section 51(1)(a)(i) are lenient and the duration of the registration period is linked to the length (or potential length) of the offender's sentence. The *CLA* states that persons sentenced to imprisonment or correctional supervision for between six to eighteen months are to be removed from the register after a period of ten years. Persons with sentences of six months or less may be removed after seven years. The level of confidentiality of the contents of the register is stipulated in Section 52(1), and will not be available to the public, but only those entitled to apply for a certificate will have access to the information contained in the register. Furthermore, the *CLA* makes it a criminal offence for anyone to wilfully disclose or publish information contained in the register, except as when necessary to give effect to the provisions of the *CLA* or when ordered to do so by a court (section 52(3)(a-b)).

Government needs to consider the possibility that the register could violate the Constitution of the Republic of South Africa, 1996 (Constitution). Perhaps by curtailing the register's scope, Government hopes to avoid possible legal challenges. Chapter 2 of the Constitution is loaded with explicit and substantive rights. Several sections might form the basis for a substantive attack on SA's sex offender register. Section 9(1) states that: "[e]veryone is equal before the law and has the right to equal protection and benefit of the law". Section 10 states that: "[e]veryone has inherent dignity and the right to have their dignity respected and protected". Section 12 states that: "[e]veryone has the right to freedom and security of the person, which includes the right not to be treated or punished in a cruel, inhuman or degrading way". Section 14 states that: "[e]veryone has the right to privacy".

In addition, the *CLA* does not prescribe penalties for at least 29 sexual crimes described in the legislation. The crimes include consensual sex acts with children and sexual offences against persons with mental disabilities. The Constitution states that the rights contained in the Bill of Rights "may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors". The factors to be considered include "the nature of the right, the importance of the purpose of the limitation, the nature and extent of the limitation, the relation between the limitation and its purpose; and less restrictive means to achieve the purpose". In other words, South African courts will conduct a balancing test when faced with a law that infringes upon any of the rights contained in the Bill of Rights.

Individuals who need support services are usually more vulnerable than those who do not. Persons with mental health conditions and intellectual impairments are often subjected to arbitrary detention in long-stay institutions without right of appeal, in contravention of the CRPD (98, 99). Vulnerability – both in institutions and in community settings – can range from the risk of isolation, boredom, and lack of stimulation, to the risk of physical and sexual abuse. Evidence suggests that persons with DHI are

at higher risk of abuse, for various reasons, including dependence on a large number of caregivers and barriers to communication.[34]

Contextual factors include environmental and personal factors that may have an impact on the individual with any disability. In addition, environmental factors make up the physical, social and attitudinal environments in which people live and conduct their lives, and are external to individuals and can have a positive or negative influence on the individual's performance as a member of society, on his/her capacity or on his/her body function or structure. Environmental factors focus on two different levels, namely:

- Personal, including settings such as home, workplace and school. This level includes the physical and material features of the environment which an individual faces, as well as direct contact with others such as family, acquaintances, peers and strangers.
- Services and legal systems, referring to formal and informal social structures, services and overarching approaches or systems in the community or a culture, have an impact on individuals. This level includes components such as laws, regulations, formal and informal rules, attitudes and ideologies.

According to the ICF, environmental factors interact with the components of body functions, structures, activities and participation. One could almost assume that DHI and other disabilities are not a key factor in terms of child abuse, and that this *Act* does not represent the contextual factors of the ICF with the complete background of an individual's life and living.

4.5 *Mines Health and Safety Act* 29 of 1996

The *Mines Health and Safety Act* (*MHSA*) for noise regulation was introduced to increase eligibility for DHI according to specific measurements and classifications as required by the *MHSA*.[35] In industries such as gold mining, in which the equipment generates noise greater than 85 decibels (dB), noise can cause irreversible hearing loss.[36] The *MHSA* requires mines to implement hearing conservation programmes and to provide personal protective equipment to individuals exposed to such noise. The *MHSA* is based on the WHO's severity-level definitions for adult-onset hearing loss.[37]

There is an increasing need to accurately identify sound sources that may be dangerous, and to quantify the hazard or risk they potentially present. To date, research has primarily been directed at examining noise

34 Goodstein 2010; South African Government Information 2002; Berke 2011.
35 *Government Gazette* No. 2284 of 2001; *Mines Health and Safety Act* 29/1996.
36 Kahan & Ross 1994:37-47; Franz *et al.* 1988:3; Crandell *et al.* 2004:176-186.
37 World Health Organization 2001a:8.

exposure in workplace environments.[38] As a consequence, both Neitzel *et al.* and Monley *et al.* addressed the problem; the focus has generally been on documenting the amount and level of sound received throughout an individual's working years, often with a specific focus on designated industries such as manufacturing, mining, transport and defence.[39]

According to the ICF, these environmental factors comprise five different components: products and technology; natural environment; man-made changes to the environment; systems, and security policies.[40] A WHO steering committee is in the process of developing an internationally accepted, evidence-based, reliable, comprehensive and valid ICF Core Sets for Hearing Loss.[41]

4.6 *Electronic Communications Act* 36 of 2005

Regulations in respect of meeting the needs of persons with disabilities are stipulated in terms of section 4(1) of the *Electronic Communications Act* (*ECA*) of 2005, and section 2(h) of the *Postal Services Act* of 1998. The *Act* defines "persons with disabilities" as individuals who are limited in one or more functional activities. This may be seeing, hearing, communicating, moving, learning or other intellectual and emotional activities. The impairment may be permanent, recurring or transitory. It may be sensory, physical, cognitive or psychological.

Section 5(2)(e) of the *ECA* states that subtitles and sign language need to be provided to persons with DHI in television programmes. Section 10(1)(a) sets out the guidelines concerning specialised equipment for persons with DHI at no extra cost such as text phones. Two individuals with text phones can type directly to each other. Some text phones also have printers so that a physical record of a conversation could be on record to avoid misunderstandings. Landline phones are equipped with amplifiers, sms equipment and additional volume ringers.

The *ECA* goes beyond the medical model to take a much broader view of disability. These requirements are based on the ICF framework, namely body structure, function, individual activities and social participation, to make use of electronic technology in order to maximise communications to a full extent.

5. Conclusion

In the field of disability legislation in SA, the various terms used can be confusing and elicit controversy. Legislation without the framework of the

38 World Health Organization 2006; Neitzel *et al.* 2004:463-473; Monley *et al.* 1994:22.
39 Neitzel *et al.* 2004:463-473; Monley *et al.* 1994:23.
40 World Health Organization 2001:8.
41 Danermark *et al.* 2010:256-262.

ICF has become a pivotal issue, especially for persons with DHI. In most instances, with the exception of the tax domain, persons with disabilities have obtained little relief when seeking to utilise constitutional means to redress discriminatory conduct, in several contexts. This article serves as a cursory analysis to a very complex area of the law. It is not meant to be utilised for comprehensive analysis. This study proceeds from the assumption that disability law should be designed in such a way as to enable policymakers to address the definition, activity, participation, as well as environmental and personal factors associated with disabilities. There is no doubt that this assumption requires further clarification, particularly since research reports and different definitions in SA legislation do not agree on any single definition for disability.

After 1994, interest in disability increased, but many new problems associated with disability emerged. Although conceptually simple, disability became quite complex when attempts were made to define it on all the different dimensions of disability, including DHI. SA legislation has a heavy, unbalanced and biased focus on persons with mental disabilities. This article thus promotes the opinion that DHI is a simplistic view of the medical model that implies the presence of the pathology in a person with DHI, which a few physicians have the knowledge and skills to identify and refer the patient for appropriate rehabilitation.

There are clear benefits to using the ICF within the DHI context, although one should also recognise the challenge ahead, namely the direct and precise application of the ICF in specific settings. A critical appraisal of the ICF may emphasise three strengths. First, the involvement of consumers, institutions, organisations and government. All role players have an important role in the revision process. Secondly, universalism as a way to fight stigma and segregation. It is a powerful approach for understanding what persons without DHI and those with DHI think. Thirdly, the purpose of changing the environment, which is a very important component of the ICF. Environment is a separate list of items, to be coded in conjunction with the other components. In addition, environment is also a central part of the causal model underlying the coding guidelines. Moreover, the operationalisation of environmental factors could be challenging, especially considering the breadth of these factors in health care, education, and the workplace and the HI person.

It is suggested that the ICF and DHI interface be explored further, using empirical and qualitative studies and encouraging stakeholders' participation. The lack of classification of personal factors of the ICF in South Africa legislation may point to efforts to be undertaken in the future in order to further understand their impact on participation.

Hence, it is suggested that the role of contextual factors (personal and environment) in capturing important aspects of functioning be carefully investigated. Different perspectives can shape the understanding and practice of DHI. Therefore, an ideal definition in legislation should be an ''overarching'' of these perspectives. It is recognised that these differences

in terms depend on the perspective. For example, DHI as a term may not fit well in the broad area of economic development. An inclusive conceptual definition will serve as a powerful organising force that could help unite the diverse stakeholders in the field of DHI.

It is for this reason that the ICF strongly and rightly critiqued this model and is currently regarded as a human rights violation of understanding and responding to the health and needs of the person with DHI. Furthermore, the medical model alone is clearly an unhelpful and potentially devaluing way of thinking about a person with DHI at either the individual or population level. Grant *et al.* (2005:48) argue that the medical profession has long been aware of the complex interaction of biological, psychological and social factors in the conditions they been treating and this has now been made explicit in what is termed the "bio-psycho-social" model of the WHO.[42]

It is within the framework of the ICF that the process of diagnosis and assessment of the health needs of an individual with DHI and the planning of rehabilitation services to meet their needs should take place. There is currently no medical school that teaches this model at any level of discipline in the medical field in South Africa.

42 Grant *et al.* 2005:10.

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