COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO. 130 OF 1993)

REGULATIONS ON OCCUPATIONALLY ACQUIRED HIV/AIDS FORTHE COMPENSATION FUND MADE UNDER THE COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

The Minister of Employment and Labour, after consultation with the Compensation Board has, in terms of Section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993) made the Regulations in Schedule A. These regulations are published for public comments only.

Interested and affected parties are hereby invited to submit written representations on the proposed Regulations. The aforesaid representations must be marked for the attention of **Mr TH Maphologela** and sent by registered post or emailed or hand delivered within 60 days of publication of this notice to the following addresses:

Compensation Fund	OR	PO Box 955
167 Thabo Sehume Street		Pretoria
Pretoria		0001
0157		

Email addresses: Kimbly.Makgoba@labour.gov.za or Harry.Maphologela@labour.gov.za

Copies of the Regulations are herewith attached.

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 26/03/2020

SCHEDULE A

REGULATIONS ON OCCUPATIONALLY ACQUIRED HIV/AIDS FOR THE COMPENSATION FUND MADE UNDER COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

ARRANGEMENT OF REGULATIONS

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1. Definitions

In these Regulations, a word or expression to which a meaning has been assigned in the Act or these Regulations shall have that meaning, unless the context otherwise indicates

"AIDS" means Acquired Immune Deficiency Syndrome – a syndrome that results from infection with Human Immunodeficiency Virus;

"antibodies" means substances produced by cells of human body's immune system in response to foreign substances that have entered the body;

"Commissioner" means the Compensation Commissioner appointed under section 2 (1)*(a)* of the Act;

"confidentiality" means right of a person, or employee to have their medical information, including HIV status, kept private within the multi-disciplinary team;

"counselling" means confidential dialogue between a client and a trained counsellor aimed at enabling the client to cope with stress and take personal decisions related to an illness, e.g. HIV / AIDS;

"HIV" means Human Immunodeficiency Virus – the name of the virus that weakens the immune system and leads to AIDS;

"HIV infected source" means an HIV positive person or an object contaminated by HIV positive blood or body fluids that can expose another person to HIV infection;

"immune system" means a complex system of cells and cell substances that protects the body from infection and disease;

"informed consent to HIV testing" means the situation whereby the exposed employee has been provided with information, understands it, and based on that he or she agrees to undertake an HIV test;

"maximum medical improvement" means when the treating medical practitioner considers that no further improvement is anticipated on available medical treatment;

"occupational exposure" means exposure to blood and other body fluids, which may be infected with HIV during the course of carrying out working duties;

"opportunistic infections" means infections that occur because a person's immune system is weak that it cannot fight infections;

"occupationally acquired HIV infection" means an infection contracted as a result of exposure to an HIV infected source in a workplace, resulting in progressive weakening of the immune system of an individual leading to AIDS. The HIV infection must have arisen out of and in the course of employment;

"Post Exposure Prophylaxis (PEP)" means the antiretroviral medicine that can reduce the HIV seroconversion risk, which should be taken immediately after the exposure, (no later than 72hours);

"Regulations" means the Regulations on Occupationally Acquired HIV/AIDS made under the Compensation for Occupational Injuries and Diseases Act, 1993.

2. Diagnosis

(1) The diagnosis of occupationally acquired HIV shall be made by the medical practitioner.

(2) The diagnosis of occupationally acquired HIV infection must be confirmed by any test that is acceptable according to the Department of Health HIV Guidelines and the South African HIV Clinicians Society.

(3) For the purpose of diagnosing possible HIV infection at any given time, the following criteria must be met:

(a) an occupational exposure to a potential HIV infected source;

(b) documented (proof of a reported) work – related incident or accident involving a potential HIV infected source;

(c) laboratory blood test results (baseline HIV, hepatitis B and RPR test results) of the exposed employee done within 72hours of the incident or accident, confirming the absence of HIV antibodies and the absence of HIV antigen/virus (PCR) including viral load;

(d) confirmation that the source was HIV infected; and

(e) confirmatory laboratory blood test results of the exposed employee confirming HIV infection (seroconversion) at six and or twelve weeks or six months after the date of the work-related incident or accident.

3. Impairment

(1) Assessment of impairment shall be determined after maximum medical improvement (MMI) has been reached i.e. when the treating medical practitioner considers that no further improvement is anticipated on available medical treatment.

(2) Permanent functional impairment due to residual and permanent sequelae of an HIV / AIDS related condition(s) shall be assessed according to the system and organ(s) affected.

(3) For functional scale which is consequently a component of the ratings for HIV disease.

(4) The class ratings for some of the processes considered reflect factors that have an impact on the ability of the individual with that disease to

perform Activities of Daily Livings (ADLs). No separate functional scale is used for these.

(5) The functional class derived in the below tables.

(6) The latest AMA guides approach exposure to HIV and overt disease using four tables below:

Methodology for Determining the Grade in an Impairment Class

IMPAIRMENT CLASS	CLASS 0	CLASS 1					CLASS 2					CLASS 3					CLASS 4				
SEVERITY GRADE (%)		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
		(A	B	C	D	E)	(A	B	C	D	E)	(A	B	C	D	E)	(A	B	C	D	E)
				↑					↑					↑					↑		
		Class 1 Default					Class 2 Default					Class 3 Default					Class 4 Default				

(a) In order to consistently determine the appropriate impairment grade for a given class, the following procedure is recommended:

(i) determine the impairment class (IC) first, according to the "key factor" for that particular impairment grid;

(ii) default to the middle ("C") grade position for that IC;

(iii) for the first remaining (non-key) factor, determine the most appropriate IC position and record the number difference to the key factor IC;

(iv) repeat step 3 for each remaining (non-key) factor; and

(v) summate the IC column differences and add or subtract the final number from the default identified in step 1 to determine the final impairment grade.

Table9. 1: Karnofsky Performance Status Scale (KPSS) Definitions Rating (%) Criteria	
100	Normal ; no complaints; no evidence of disease
90	Able to carry on normal activity; minor signs or symptoms of disease.
80	Normal activity with effort; some signs or symptoms of disease
70	Cares for self; unable to carry on normal activity or to do active work
60	Requires occasional assistant; but is able to care for most of his personal needs.
50	Requires considerable assistance and frequent medical care
40	Disabled; requires special care and assistance
30	Severely disabled; hospital admission is indicated, although death not imminent
20	Very sick; hospital admission necessary; active supportive treatment necessary
10	Moribund; fatal processes progressing rapidly
0	Dead

Table 9.2: Eastern Cooperative Oncology group Performance Status Scale (ECOG-PSS)

Class 0(none)	Fully active; able to carry on all predisease performance without restriction (Karnofsky 90% to 100%)
Class 1 (mild)	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature e.g. Light housework, office work (Karnofsky 70% to 80%)
Class 2 (moderate)	Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours (Karnofsky 50% to 60%)
Class 3 (severe)	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours (Karnofsky 30% to 40%)
Class 4 (extreme)	Completely disabled; cannot carry out any self-care; totally confined to bed or chair (Karnofsky 10% to 20%)

*KPSS is widely used to describe the functional ramification of both oncology disease and AIDS

(7) In each class there are 5 different possible impairment grades.

(8) The median grade is the default rating for initial impairment determination and may be adjusted on either side of the median but only in the same impairment class, based on the non-key factors according to history and physical exam.

(9) The general steps for determining impairment class, and grade within class are outlined according to the example illustrated in table 9.8.

(10) The differences in clinical implications regarding movement from one class to another are large. The difference in the choices for ratings in class 3 & 4 as opposed to lower classes reflects the difference between having signs and symptoms that are generally controlled by treatment versus those that are uncontrolled by treatment.

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Table 9.8: Criteria for Rating Permanent Impairment due to HIV Disease

Class	Class 0	Class 1	Class 2	Class 3	Class 4
Whole person Impairment Rating (%)	0	3% - 15%	18% - 30%	35% - 55%	60% - 80%
Severity Grade (%)		3 6 9 12 15 (A B C D E)	18 21 24 27 30 (A B C D E)	35 40 45 50 55 (A B C D E)	60 65 70 75 80 (A B C D E)
History	Requires no treatment	Requires ARVs Therapy to control signs and symptoms Of disease.	Requires ARVs Therapy and Constant medical therapy to prevent opportunistic infections – history of prior Infections.	Requires constant ARVs therapy and chronic suppressive therapy with at least 1 active opportunistic infection.	Requires constant medical therapy and chronic suppressive therapy with at least opportunistic infections and/or opportunistic infections require hospitalization at least once per year.
Objective Findings	CD4 count of > 800 or HIV by polymerase chain reaction (PCR) < 50	CD4 count of 500 to < 800 or HIV by PCR > 50 000	CD4 count of > 200 but < 500	CD4 count of < 200 but > 100	CD4 count of < 100
Functional class	Class 0	Class 1	Class 2	Class 3	Class 4

(11) Initial score based on CD4 count is adjusted to 75% if patient meets a history criterion for class and to 80% if also meets functional criteria. Objective findings are key factors, and a key factor driving the impairment class assignment. The other factors determine at what grade (%) the ratings in a particular class.

(12) Impairment % may reflect severity of symptoms, physical and laboratory findings and estimated functional limitation resulting from Hematologic abnormality.

(13) The ratings of all classes, especially class 4, have been decreased as once one moves to higher levels of impairment, there is inevitably involvement of other organ systems or other hematologic process.

NB: These should be identified, rated and combined with the haematology oncology impairment ratings.

Table 9.3: Burden of Treatment Compliance

Intervention	% Impairment
Chronic anticoagulant therapy	5%
Chronic oral corticosteroids (discretionary)	**Up to 3%**
Chronic other immunosuppressant therapy (discretionary)	**Up to 3%**
Iron chelation or other systemic therapy	**Up to 3%**
Chronic oral chemotherapy (discretionary)	**Up to 5%**
Intravenous chemotherapy: per cycle given over the prior 6 months*	**1%**
Radiotherapy : per week given over the prior 6 months	**1%**
Transfusion per unit per month	**1%**
Phlebotomy : per treatment per month	**1%**
Aphorises: per treatment per month	**3%**
Bone marrow transplant	**10%**

4. Compensation Benefits

Compensation benefits will be payable according to the Act. Eligibility for benefits will lapse if there is no seroconversion after 6 months from the date of the incident.

(a) **Temporary total disablement**

Payment for reasonable temporary total or partial disablement shall be made for as long as such a disablement continues but not for a period exceeding 24 months.

(b) **Permanent disablement**

Permanent disablement will be assessed:

(i) once the treating doctor has furnished a comprehensive final medical report (W CI 5) to the Commissioner.

(ii) a confirmed diagnosis of occupationally acquired HIV infection shall be determined according to the latest edition of AMA Guide on permanent disablement.

(iii) permanent disablement due to impairment as a result of a permanent sequelae of an HIV/AIDS related condition(s) shall be assessed according to other relevant regulations or schedules to the Act.

(iv) a confirmed diagnosis with advanced AIDS and or treatment failure where all available HAART regimens have been exhausted shall be determined according to the latest AMA Guide for permanent disablement.

5. Medical Costs

(1) The medical costs shall cover the management of exposure, the diagnosis of HIV infection and any necessary treatment, including antiretroviral drugs (post exposure prophylaxis and chronic medication), provided by any health care provider. Medical costs for Post exposure prophylaxis will be covered until confirmation that the source is negative or after the 6 months' window period repeat test and the employee is negative.

(2) When a person has seroconverted, medical costs shall be provided for a period of not more than 24 months from the date of diagnosis or longer, if in the opinion of the Commissioner, further medical cost will reduce the extent of the disablement.

(3) Medical costs shall cover the costs of diagnosis of HIV/AIDS and any necessary treatment provided by any health care provider.

(4) The Commissioner shall decide on the need for, the nature and sufficiency of medical costs to be supplied.

(5) The management of HIV/AIDS related opportunistic infections will be covered under the Act for accepted claims.

(6) The Commissioner shall decide on the nature of and the sufficiency of the medical costs to be supplied.

(7) The employer should ensure that the employee has access to Post Exposure Prophylaxis (PEP) and on treatment within 72hours after exposure.

6. Death Benefits

Death benefits payable are-

(a) the reasonable burial expenses payable in terms of the Burial Expenses Policy; and

(b) the widow's and dependant's pensions payable, where applicable, if the employee dies as a result of occupationally acquired HIV/AIDS.

7. Reporting

(1) The following documents must be submitted to the Office of the Compensation Fund immediately after the incident or accident:

(a) initial report of occupational exposure to blood or other body fluid-borne pathogens (W CL 306). Annexure A, and a copy of certified identity document;

(b) further documents as may be required to be submitted to the Office of the Compensation Commissioner or the employer individually liable or licensee after seroconversion are listed below, and confidentiality should be respected at all times;

(c) Employer's Report of an Accident (W CL 2);

(d) Notice of Accident and Claim for Compensation (W CL 3);

(e) First Medical Report (W CL 4);

(f) Laboratory blood test results (baseline HIV test results) of the exposed employee done within 72 hours of the incident/ accident, confirming the absence of HIV antibodies and the absence of HIV antigen/virus (PCR);

(g) confirmation that the source was HIV infected. Laboratory blood test of HIV test results of the source;

(h) confirmatory laboratory blood test results of the exposed employee confirming HIV infection (seroconversion) at six and or

twelve weeks or six months, after the date of the work-related incident or accident;

(i) Progress Medical Report to be submitted monthly to the Compensation Commissioner (W CL 5P);

(j) all other reports that may be relevant to the diagnosis and treatment of the condition;

(k) Final Medical report (W CL 5F); and

(l) in case of death, a death certificate and a BI1663 (notification of death) must be submitted, alternatively, a death certificate accompanied by a detailed medical report on a practice letterhead on the cause of death must be submitted.;

(2) The following principles must be adhered to when reporting:

(a) the employer or employer-provided health services may subject the exposed employee to HIV testing without Labour Court authorization if the testing is voluntary and confidential;

(b) where the source of possible infection is known, testing is compulsory;

(c) informed consent must be obtained from the source if HIV testing is contemplated; and

(d) during HIV testing for compensation purposes, it must be noted that "permissible" testing as defined in accordance with the Department of Health's policy on testing for HIV together with the HPCSA guidelines on good ethical practice must be adhered to.

8. Claims Processing

(1) The Commissioner will consider and adjudicate upon the liability of all claims.

(2) The medical officers employed by the Compensation Fund are responsible for the medical assessment of a claim and for the confirmation of the acceptance or rejection of the claim.

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 26/03/2020

the doj & cd

Department:
Justice and Constitutional Development
REPUBLIC OF SOUTH AFRICA

OFFICE OF THE CHIEF STATE LAW ADVISER
P/bag X9069, Cape Town, 8000
12th Floor, Atterbury House, 9 Riebeeck Street, Cape Town, 8001
Tel (021) 441-4900 Fax (021) 421-7923

Ref: 8/7/Labour/2019/20/156A+B
Enq: B Tolse
Tel: (021) 441 4948
e-mail: BTolse@justice.gov.za
website: http://www.doj.gov.za
Date: 6th December 2019

Mr T Lamati
Director-General
Department of Employment and Labour
Private Bag X117
PRETORIA
0001

For Attention: Mr H Maphologela
Per e-mail: Harry.Maphologela@labour.gov.za

Dear Mr T Lamati

REGULATIONS ON OCCUPATIONALLY ACQUIRED HIV/AIDS FOR THE COMPENSATION FUND MADE BY THE MINISTER UNDER THE COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO. 130 OF 1993)

INTRODUCTION

1. We have been requested by the Department of Employment and Labour ("the Department") to scrutinise, and provide it with a legal opinion on the Regulations on HIV/AIDS for the Compensation Fund made by the Minister under the Compensation for Occupational Injuries and Diseases Act, 1993 ("the Regulations") in terms of section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993) ("the Act").

2. We have scrutinised the Regulations and have, where we found errors, made suggested amendments directly in the text of the Regulations for the

Department's consideration. For the purpose of this legal opinion, we provide hereunder an overview of the provisions of the Regulations.

LEGISLATION

3. Section 65 (1) of the Act deals with compensation for occupational diseases and states as follows:

> *"**65. Compensation for occupational diseases.**—(1) Subject to the provisions of this Chapter, an employee shall be entitled to the compensation provided for and prescribed in this Act if it is proved to the satisfaction of the Director-General—*
>
> *(a) that the employee has contracted a disease mentioned in the first column of Schedule 3 and that such disease has arisen out of and in the course of his or her employment; or*
>
> *(b) that the employee has contracted a disease other than a disease contemplated in paragraph (a) and that such disease has arisen out of and in the course of his or her employment."*

4. In terms of section 97 of the Act, the Minister is empowered to make regulations in respect of the matters tabulated in subsection (1) (*a*) to (*h*).

> *"**97. Regulations.**—(1) The Minister may make regulations, after consultation with the Board, regarding—*
>
> *(a) the place of meeting and the procedure to be followed at any meeting of the Director-General and assessors or at any proceedings in terms of this Act with which the assessors are concerned, or at any investigation in terms of this Act;*
>
> *(b) subject to section 76, the fees payable to medical practitioners or chiropractors in respect of services rendered in terms of this Act;*
>
> *(c) the procedure to be followed in paying assessments and fines to the Director-General;*
>
> *(d) the persons to whom, the places where and the manner in which payment of assessments in terms of this Act shall be made;*
>
> *(e) the determination of the amount and the conditions and manner of payment of benefits to assessors or classes of assessors;*
>
> *(f) the disposal of moneys payable in terms of this Act to any person other than the Director-General and not claimed within the prescribed period by the person entitled thereto;*
>
> *(g) any matter which shall or may be prescribed by regulation in terms of this Act;*

(h) any other matter, whether or not connected with any matter mentioned in paragraphs (a) to (g), which he may deem necessary or expedient to prescribe in order to further the objects and purposes of this Act.

(2) Different regulations may be made under subsection (1) in respect of different classes of employers and employees and of different areas, and the Minister may, after consultation with the Board, in respect thereof differentiate in such manner as he or she may deem expedient.

(3) Any person who contravenes or fails to comply with any regulation made under subsection (1) shall be guilty of an offence and liable on conviction to a fine, or imprisonment for a period not exceeding six months."

DISCUSSION

Minister's powers to make Regulations

5.1 The Minister's power to make the regulations is a public power that must be exercised subject to the Constitution and the law. The exercise of all public power is subject to the provisions of the Constitution which is the supreme law of the Republic[1]. The Constitution regulates the exercise of public power in different ways, which include the application of the Bill of Rights and other specific provisions of the Constitution, which regulate and control the exercise of particular powers. Another source of constraint on the exercise of public power is the rule of law which is one of the foundational values of our constitutional democracy[2]. The role of the rule of law as a form of constitutional control on the exercise of public power was sketched out in the **Affordable Medicines Trust and Others v Minister of Health and Others** 2006 (3) SA 247 (CC), where the Constitutional Court stated the following in this regard:

> "[48] Our constitutional democracy is founded on, among other values, the '(s)upremacy of the Constitution and the rule of law'. The very next provision of the Constitution declares that the 'Constitution is the supreme law of the Republic; law or conduct inconsistent with it is invalid'. And to give effect to the supremacy of the Constitution, courts 'must declare that any law or conduct that is inconsistent with the Constitution is invalid to the extent of its

[1] Section 1(c) of the Constitution of the Republic of South Africa, 1996 reads as follows:
"The Republic of South Africa is one, sovereign, democratic state founded on the following values:
(a) ...
(b) ...
(c) Supremacy of the Constitution and the rule of law."

[2] Masethla v President of the Republic of South Africa and Another 2008 (1) SA 566 (CC) at paragraph [172].

inconsistency'. This commitment to the supremacy of the Constitution and the rule of law means that **the exercise of all public power is now subject to the constitutional control.**

[49] The exercise of public power must therefore comply with the Constitution, which is the supreme law, and the doctrine of legality, which is part of that law. The doctrine of legality, which is an incident of the rule of law, is one of the constitutional controls through which the exercise of public power is regulated by the Constitution. It entails that both the Legislature and the **Executive are constrained by the principle that they may exercise no power and perform no function beyond that conferred upon them by law.** In this sense the Constitution entrenches the principle of legality and provides the foundation for the control of public power.

[50] In **exercising the power to make regulations, the Minister had to comply with the Constitution, which is the supreme law, and the empowering provisions** of the Medicines Act. If, in making regulations the Minister exceeds the powers conferred by the empowering provisions of the Medicines Act, the **Minister acts ultra vires** (beyond the powers) and in breach of the doctrine of legality. The finding that the Minister acted ultra vires is in effect a finding that the Minister acted in a manner that is inconsistent with the Constitution and his or her conduct is invalid. What would have been ultra vires under common law by reason of a functionary exceeding his or her powers is now invalid under the Constitution as an infringement of the principle of legality. The question, therefore, is whether the Minister acted ultra vires in making regulations that link a licence to compound and dispense medicines to specific premises. The answer to this question must be sought **in the empowering provisions.**"(Our emphasis.)

5.2 **In Voster and Another v Department of Economic Development, Environment and Tourism, Limpopo Province, and Others** 2006 (5) SA 291 (T) the court stated the following in this regard:

"[18] Lawfulness is relevant to the exercise of all public power, whether or not the exercise of such power constitutes administrative action. Lawfulness **depends on the terms of the empowering statute.** If the exercise of public power **is not sanctioned by the relevant empowering statute,** it will be **unlawful and invalid."**(Our emphasis.)

5.3 The Act permits the Minister to enact secondary legislation, namely, the regulations. The power to make the regulations is vested in the Minister in terms of section 97 of the Act. Section 97 (1) of the Act sets out various matters that the Minister is authorised to regulate on and in terms of section 97 (1) of the Act, the Minister may make regulations, after consultation with the Board regarding to various matters listed in that section.

5.4 From section 97(1) of the Act, it is clear that the Minister does not have the express authority to make regulations dealing with occupationally acquired HIV/AIDS. Therefore, in order to make the draft Regulations, the Minister must be so authorised by paragraph *(g)* or *(h)* of subsection (1) of section 97 of the Act. We would in this regard like to expand slightly on this provision.

Minister's power to make the draft Regulations in terms of section 97(1)*(g)* of the Act

5.5.1 The Minister is authorised to make regulations in terms of section 97(1)*(g)* of the Act if another section in the Act authorises him to make regulations relating to the subject matter dealt with in that section. There are many sections in the Act which, when read with section 97(1) *(g)* of the Act, authorise the Minister to make regulations. However, there are none that authorise him or her to make regulations regarding occupational diseases. Therefore, we are of the opinion that the Minister cannot make the draft Regulations in terms of section 97(1) *(g)* of the Act, should he continue to do so would render the regulations invalid and *ultra vires*.

Minister's power to make the draft Regulations in terms of section 97(1) *(h)* of the Act

5.5.2 In view of our conclusion in paragraph 5.5.1 above it must be determined whether the Minister is authorised to make the draft Regulations in terms of section 97(1) *(h)* of the Act. This section makes it clear that the "objects and purposes" of the Act must be determined before the question whether the Minister has the power in terms of section 97(1)*(h)* of the Act to

make the draft Regulations can be addressed. In **Road Accident Fund v Makwetlane** 2005 (4) SA 51 (SCA), (hereinafter referred to as "the **Makwetlane** case") the Court discussed the power of the Minister of Transport to make regulations to "achieve or promote the objects" of the Road Accident Fund Act, 1996 (Act No. 56 of 1996) and remarked as follows at pp. 58-59:

> "Section 26 empowers the Minister to make regulations in order to achieve or promote the objects of the Act. It does not confer authority on him to traverse terrain outside that limited scope and ambit. All regulations promulgated by the Minister must thus be reasonably necessary to achieve those objects and goals. It is indeed so that the possibility of fraud is greater in cases where the identity of the driver or owner of the vehicle in question has not been established, as it would usually be difficult for the RAF to secure evidence to dispute a claim (see *Mbatha* at 718H). Stricter requirements would thus be justified in unidentified vehicle cases. It follows that regulations designed to eliminate fraud and facilitate proof of legitimate claims, falling as it does within the Minister's power to regulate, would be permissible. No other reason has been suggested for such a requirement and I can think of none. That legitimate end, may not, however, be achieved by means that sweep too broadly. ...
>
> The Constitution places significant restraints upon the exercise of public power. It is a requirement of the rule of law that the exercise of public power should not be arbitrary. It follows that the exercise by the Minister of the regulatory power conferred upon him had to be rationally related to the purpose for which the power was granted - rationality being the minimum threshold requirement. (See *Pharmaceutical Manufacturers* paras [85] and [86].) Conduct that fails to pass that threshold requirement would fall below the standards set by our Constitution and would therefore be unlawful." (Our underlining.)

5.5.3 We have analysed the Makwetlane case, the subject matter of the

regulations, and the rationality principle which must be considered to enable the Minister to achieve the objects and purposes of the act. We are in this regard of the view that sections 97(1)(*h*) read with 65 (1) of the Act are the appropriate provisions in so far as the Minister's powers to make the regulations are concerned.

6. We now turn to deal with the regulations as set out in the Schedule. We have suggested tracked changes with regards to the drafting style and form of the Regulations. This is done in order to align the Regulations with common drafting principles.

***Ad* Regulation 1: Definitions**

7. Regulation 1 provides for the definition of some of the words used in the Regulations. We have made some suggested amendments in regulation 1 for the Department's consideration.

***Ad* Regulation 2: Diagnosis**

8. Regulation 2 provides for the diagnosis of occupationally acquired HIV by a medical practitioner and further for various ways in which such a diagnosis can be made. Minor amendments were made to this regulation.

***Ad* Regulation 3: Impairment**

9. Regulation 3 provides that assessment of impairment shall be determined after maximum medical improvement (MMI) has been reached, i.e. when the treating medical practitioner considers that no further improvement is anticipated on available medical treatment. Minor amendments were made to this regulation.

***Ad* Regulation 4: Compensation benefits**

10. Regulation 4 provides for the compensation benefits payable according

to the Act after assessment of the total impairment score. Minor amendments were made to this regulation.

***Ad* Regulation 5: Medical costs**

11. Regulation 5 provides that medical costs shall cover the management of exposure, the diagnosis of HIV infection and any necessary treatment, including antiretroviral drugs, provided by any health care provider. It further provides for the period of such assistance. Minor amendments were made to this regulation.

***Ad* Regulation 6: Death benefits**

12. Regulation 6 provides for death benefits payable in terms of the Burial Expenses Policy and where the employee dies as a result of occupationally acquired HIV/AIDS, widow's and dependent's pensions will be payable. Minor amendments were made to this regulation.

***Ad* Regulation 7: Reporting**

13. Regulation 7 lists the documentation that must be submitted to the Office of the Compensation Fund, immediately after the incident or accident. Minor amendments were made to this regulation.

***Ad* Regulation 8: Claims processing**

14. Regulation 8 provides for the consideration and adjudication of all claims by the Commissioner and that the medical officers employed by the Compensation Fund are responsible for medical assessments of claims and for the confirmation of acceptance or rejection of the claims. Minor amendments were made to this regulation.

***Ad* Regulation 9: Short title and commencement**

15. Regulation 9 provides for the date of commencement.

16. The Department's attention is drawn to the fact that, in terms of section 6 (3) of the Constitution of the Republic of South Africa, 1996, the Regulations must be published in at least two official languages and non-compliance with this requirement may render the Regulations to be unconstitutional.

CONCLUSION

17. In light of the exposition above, we are of the view that the Minister has the requisite authority to make the regulations under consideration. Subject to our suggested amendments made directly in the text of the regulations, we are of the view that the regulations are in order and conform to the form and style of legislative drafting.

18. A copy of the Regulations with track changes incorporating our suggested amendments, is hereto attached, for your kind attention.

Yours sincerely

FOR THE OFFICE OF THE CHIEF STATE LAW ADVISER
B TOISE / X MDLUDLU / S MASAPU