



Legis. Rel. Amer. Morf. Canada

INDEX

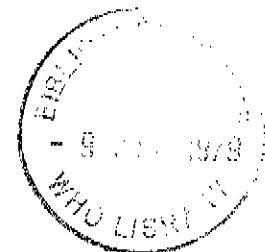
HEALTH LEGISLATION PROGRAMMES IN THE REGION OF THE AMERICAS:

de la santé

NATIONAL NEEDS, LEGISLATIVE TRENDS, AND STRENGTHENING
 OF REGIONAL ACTIVITIES IN HEALTH LEGISLATION

by

William J. Curran¹



CONTENTS

	<u>Page</u>
PART 1. REGIONAL FINDINGS AND RECOMMENDATIONS	3
Findings	3
Information exchange in health legislation	3
Technical cooperation in health legislation	6
Recommendations	7
Information exchange	7
Technical cooperation	8
PART 2. THE REGIONAL OFFICE FOR THE AMERICAS	10
Headquarters organization	10
Importance of health legislation	11
Recommendations in Ten-Year Plan	11
Update of regional planning	13
Information exchange in health legislation	13
PART 3. COUNTRY VISITS	14
Brazil	14
Federal structure	14
Health legislative trends	15
Information exchange	16

¹ Short-term Consultant, World Health Organization; Professor of Legal Medicine, Harvard University, Cambridge, Massachusetts, United States of America.

The issue of this document does not constitute formal publication. It should not be reviewed, abstracted or quoted without the agreement of the World Health Organization. Authors alone are responsible for views expressed in signed articles.

Ce document ne constitue pas une publication. Il ne doit faire l'objet d'aucun compte rendu ou résumé ni d'aucune citation sans l'autorisation de l'Organisation Mondiale de la Santé. Les opinions exprimées dans les articles signés n'engagent que leurs auteurs.

	<u>Page</u>
Health law education	18
Technical cooperation	18
Colombia	19
Legislative trends	19
Information exchange	20
Technical cooperation	21
Canada	21
Governmental health authority	22
Recent policy and legislative trends	22
Information exchange in health legislation	23
Technical cooperation in health legislation	25
Legislative developments for WHO's five-year report	25
PART 4. BRIEF NOTES ON OTHER COUNTRIES	27
Annex A. Persons interviewed in the Region of the Americas	29
Annex B. Proposed curriculum in public health law (in Portuguese)	32

PART 1

REGIONAL FINDINGS AND RECOMMENDATIONS

In accordance with the resolution on strengthening of the health legislation activities of WHO adopted in May 1977 by the Thirtieth World Health Assembly (WHA30.44), the Health and Biomedical Information Programme of WHO undertook an inquiry into the needs of the regional offices and of Member States with respect to health legislation and how WHO and its regional offices could meet these needs, particularly through information exchange and technical cooperation.

Planning of the inquiry was developed and conducted by the Health and Biomedical Information Programme in Geneva. Informal meetings were held on 18 November and 5 December 1977 to develop the scope of a worldwide review of health legislation activities. A questionnaire survey was designed and distributed to elicit data from all Member countries. For more detailed information and in order to provide a two-way discussion of health legislation needs, three short-term consultants with extensive backgrounds in international and national health legislation were retained and sent to visit the six regional offices of WHO, two regions for each consultant, and also to visit selected countries within the regions. The field visits were arranged after meetings of the six Regional Directors with the consultants during the Executive Board sessions, 23-27 January 1978.

The visit of Professor W. J. Curran, the consultant concerned with the Regional Office for the Americas, to the Regional Office in Washington DC and to selected countries in the Region took place over a period of months from the spring of 1978 to December of the same year. There were three visits to the Regional Office over this period and field trips to Brazil, Colombia, and Canada, as described later in these pages. Visits were also planned to countries in the Caribbean and Central America, but mutually convenient dates could not be arranged during the time allowed.

The consultant is indebted to Dr Héctor R. Acuña, Director, PAHO and the staff of the Regional Office for their cooperation in the interviews at the Washington headquarters and in arranging the country visits. Interviews and tours of facilities took place in each of the countries. Documents, reports, and copies of relevant legislation were collected during each visit. A list of persons interviewed and their agencies appears in Annex A to this report. The questionnaire responses from countries in the Region of the Americas were also examined and evaluated in preparing this report.

The primary stress in this report is placed upon matters of information exchange and technical cooperation of significance to the regional and worldwide role of WHO. Wherever possible, however, an assessment of views has been provided on legislative needs and legislative trends in the countries visited. The consultant bears full responsibility for the findings and recommendations made herein.

FINDINGS

Information exchange in health legislation

1. There was general support for continuation of the International Digest of Health Legislation at the Regional Office for the Americas and in the countries visited among officials familiar with the publication. It was also apparent that the Digest is highly useful to private subscribers from health-related industries and organizations located in the Region of the Americas.
2. Interest was expressed in exchange of information on important health legislation by Ministry of Health officials in every country visited and in virtually all questionnaire responses received from countries in the Region. Colombia, in its questionnaire response, indicated its need for "continuous information". Countries also expressed particular interest in the legislation of countries of similar types with similar health problems.

For example, in the questionnaire response from Haiti (Secrétairerie d'Etat de la Santé Publique et de la Population) it was said: "We would prefer a selection of legal texts emanating from countries where the general living conditions are similar to those of Haiti."

3. Knowledge of the Digest was relatively less frequent in countries of the Region of the Americas than in the European Region also visited by this consultant, both in developing and in industrialized countries. It seemed clear, however, that the country visits and the WHO questionnaire stimulated interest in use of the Digest and in seeking the aid of WHO in information exchange on international health legislation. This view was strengthened by the fact that none of the countries, even the most sophisticated industrialized countries, was aware of any other information exchange medium which has or could serve the purposes of the Digest in such a worldwide, comprehensive manner. It was readily admitted that the Digest is a unique resource in the world for information exchange on health legislation developments.

4. The cooperation of countries in the Americas in supplying copies of important new health legislation, ministerial decrees, regulations, etc., to the Digest leaves much to be desired. Prior to September 1977 and the dispatch of Circular Letter 29 to all Member States, only Mexico was consistently sending general legislation, while some documents were received from Canada (Food and Drugs Act and Food and Drug Regulations of the Federal Government only) and the United States of America (several states but not the Federal Government). Since the Circular Letter, some additional countries have sent health legislation or indicated their intention to do so, including Brazil, Colombia, Costa Rica, Nicaragua, St Vincent, and Venezuela in the Region of the Americas. As a result of the consultant visits to Brazil, Colombia, and Canada, further cooperation on sending legislation was promised. Support was also indicated from the Regional Office for the Americas to encourage more Member States to supply legislation and other legislative documents. In each of the countries visited, the Legal Departments did not seem to be aware of the agreement of their ministries to cooperate in sending important health legislation to the Digest, but they expressed their willingness to cooperate in the future.¹

5. The current format of the Digest was generally supported as against a movement to a simple newsletter. There was, however, strong support for an expanded publication with more laws and regulations from more countries under a plan of publication of titles only with very brief descriptions of content if the full text, translated if required, could be provided quickly on request by the Geneva office or by PAHO. Argentina, Brazil, Colombia, Guatemala, St Vincent, and others placed stress on this plan. The Dominican Republic supported such a plan as "an alternative approach" which could save time, finances, and material. Brazil suggested that a computer-based system for the Americas should give priority to titles of legislation, with advisory services and full texts available at PAHO and at WHO headquarters in Geneva.

6. There was support for commentary on important new health legislation, on how it came to be adopted, and on experience in implementation. The Canadian officials also stressed the need for information on experience under different types of legislative approaches in health programmes. In the publication of comparative legislative surveys, for example, it was felt by the Canadians that attention should be given to actual experience under the law and not merely to a comparison of the text language of the laws.

¹ The staff of the Digest does not rely solely on the contributed copies of health legislation from Member States. This source is supplemented by review of official legislative gazettes, bulletins, and registers received in the legal libraries available in Geneva. Also, various interested people and WHO staff alert the Digest to important legislative developments in countries they have visited. The combination of all of these sources provides the coverage in the Digest at present.

7. Some countries in Latin America suggested that a Spanish version of the Digest would be useful. The questionnaire responses from Bolivia, Brazil, Colombia, and Guatemala made such suggestions. As was said in the reply from Guatemala: "We consider it desirable that the Digest should also be published in Spanish. This language is used in an entire continent where there are few officials able to speak English or French. It is possible that this is one of the limitations on the use of the Digest." The English version of the Digest is currently more utilized in the Americas than the French version (except in the French-speaking countries of the Caribbean and in Quebec in Canada). A plan to make available various important health legislation texts through PAHO headquarters on request, and where practicable, translated into Spanish, could satisfy some of the need expressed for a Spanish version of the Digest.

8. As indicated earlier, there was an interest in the exchange of information concerning similar countries, but no interest was expressed in limiting the Digest to regional legislation.

9. The Digest is used directly and is referred to specifically in a number of countries when new health legislation is being considered by the legislative bodies. More of this type of response was found in the Americas than in the European Region. Argentina indicated that the Digest is frequently searched by the National Advisory Commission on Health Legislation. As an example, the Secretary of State for Public Health cited the use of the Digest for reference to French and EEC legislation on regulation of cosmetics. Brazil noted the fact that the Ministry of Health has used the Digest, most recently in examining the novel approaches of the French law in the field of organ transplantation. El Salvador noted the use of the Digest in its extensive recent revision of the Health Code.

10. A subject-matter grouping of materials was generally preferred to the current method of country grouping. The current broad coverage of fields was supported, including environmental health law, food and drug law, and health service law.

11. The comparative surveys of health legislation on a worldwide basis were found to be very popular, probably the most useful special feature in the Digest. Brazil and Canada stressed the usefulness of the surveys as did Grenada and a number of other countries. As noted earlier, the Canadian officials stressed the need for the surveys to include actual reference to evaluation of the legislation in practice and not merely on the books. The recently published survey of mental health laws was cited as a good example of the better approach, since it included evaluation and a questionnaire survey to the countries. (The Law and Mental Health: Harmonizing Objectives, International Digest of Health Legislation, 1977, 28, 725-885.)

12. There was no suggestion that responsibility for preparation or publication of the Digest or a similar periodical be decentralized to the regional offices or to collaborating centres.

13. There was, however, strong support in the countries visited for strengthening the support for health legislation programmes in the Regional Office for the Americas. In the Brazilian response, it was observed that Brazil would welcome PAHO assistance and would appreciate the establishment of "special legislative (advisory) units in PAHO and other Regional Offices".

14. There was practical interest and support for the development of collaborating centres in international health legislation. Such centres were thought to be feasible in all three major countries visited (Brazil, Colombia, and Canada) and in such other locations as the United States of America and the Caribbean. Such centres could be located in governmental agencies or in academic centres. Library resources at the University of São Paulo in Brazil could be a regional resource for all of Latin America in information exchange on health legislation, possibly with computer capability.

Technical cooperation in health legislation

1. There was enthusiastic interest in the development of technical cooperation in the field of international health legislation. Both Latin American countries visited urged establishment of an advisory unit in health legislation at PAHO headquarters. The Regional Office for the Americas does not currently have a legal staff unit or personnel working on health legislation in the interest of Member States. However, the programme of manpower training in health services management and training (with Mr Miguel A. Segovia) would be a resource for health law and policy training and information exchange.
2. Emphasis upon health legislation needs and technical cooperation in this area were found prominently displayed in the Ten-Year Health Plan for the Americas adopted at Santiago, Chile in 1972. In that plan, health is proclaimed a universal right, though it is admittedly not enjoyed by the majority of the people in the Region. Support is provided in the plan for legislation to carry out the objectives of operational programmes in public health in the Americas.
3. The Ten-Year Plan for the Americas has a special section recommending the strengthening of national systems of legal institutions to accomplish health programme objectives.
4. The Ten-Year Plan also contains a series of recommendations for research, training, and action in health legislation. These recommendations are described later in this report. Efforts are being made to accomplish many of the objectives of the recommendations, but more needs to be done. Among the recommendations which have been followed was one which urged the organization by PAHO/WHO of interdisciplinary seminars for lawyers who represent ministries of health throughout Latin America. A health legislation seminar was held in Washington in 1973. That seminar stimulated important efforts in health law, including the compilation of national health legislation in Brazil.
5. There are two quite different legal traditions in the Americas, the Civil Law (or Roman Law) tradition of Latin America, and the Common Law tradition of the English-speaking countries of North America and the Caribbean. There is a smaller segment with French legal traditions which are also based in Civil Law in the Caribbean and in the Province of Quebec in Canada. For some health legislation programmes, these different traditions need to be recognized.
6. Both of the Latin American countries visited by the consultant indicated that this was an opportune time for increased attention to health legislation in their countries. In Brazil, the health legislation of modern times is being compiled and important changes are being made. In Colombia, a new National Health Code is being considered by the legislature. In both countries, important programmes have been launched against tropical diseases and both are signatories to the Treaty for Amazonian Cooperation which is designed to deal with disease control, environmental health measures, and navigation and communications networks.
7. A number of other countries in the Americas indicated important current needs in health law and legislation. In its questionnaire response, Argentina indicated its need to recompile and reorganize its health legislation to create "a sound juridical base for its national health policy". In Dominica, it was indicated that the existing health laws were in need of updating and WHO's collaboration was requested all across the health legislation field and in drafting new codes. El Salvador indicated that there was "an urgent need" to update the health legislation of that country. Guatemala provided a similar response. The needs for new health legislation in the British Virgin Islands were described as ranging from environmental pollution control, to regulation of pharmaceutical drug sales, to mental health law. The health laws of Haiti, Guyana, and Honduras were also described as outdated and in need of revision. Guyana asked for technical assistance and cooperation in defining legislative needs and preparing plans for new health legislation. Honduras also asked for active cooperation from WHO in providing consultants when requested and for training the Ministry's legal advisers in courses and seminars in legal areas such as control of pharmaceuticals and foods, environmental health regulation, and protection against ionizing radiation.

8. In the Canadian visit, stress was also placed on the role of WHO in arranging for special consultants in health legislation and in directing inquiries from one country to another to gather information and advice on different alternatives in legal regulation and policy implementation in the health sector.

9. Technical cooperation was seen as closely related to information exchange on health legislation developments. The need for an advisory health legislation unit at PAHO headquarters was mentioned frequently.

10. Collaborating centres were seen as useful for technical cooperation among nations of the Americas as well as for information exchange. A plan of cooperation between a centre in an industrialized country and one or more centres in developing countries seemed particularly suitable to the complex of countries in the Americas. Subject areas for cooperation of this type which were mentioned or suggested were mental health law, pharmaceutical and food regulation, and environmental pollution control. Further discussions would be needed, but resources do exist for efforts in each of these subject areas of health legislation.

RECOMMENDATIONS

Information exchange

1. The WHO programme in health legislation should be strengthened in the interest of improved public health all over the world. The area of highest priority should be the information exchange aspects of the programme.
2. The International Digest of Health Legislation should be the centrepiece of the efforts of WHO in information exchange in health law.
3. WHO should make preparation and publication of the Digest a more cooperative activity with the regional offices. The regional offices should aid the Geneva headquarters in obtaining the cooperation of Member States in furnishing copies of important new health legislation, ministerial decrees, regulations, etc.
4. The Regional Office for the Americas should establish an advisory unit in health legislation to aid Member States in the Region. This unit could cooperate with the Digest staff in obtaining (and supplying) health legislation to Member States on an exchange basis. The unit could contribute items for the Digest in the form of book reviews and other commentary on health law developments.
5. Coverage of health legislation subjects in the Digest should continue to be comprehensive. There was interest primarily in summaries or digests of laws and regulations, not as much in full texts of laws. There was also more support in the Americas than in Europe for a PAHO/WHO service of providing texts, preferably translated, after publication of titles (and brief summaries of coverage) in the Digest. There was support for a Spanish version of the Digest, but realizing financial and professional staff limitations this did not seem to require priority consideration at this time. The current Digest, with a new PAHO advisory unit in health legislation giving attention to Latin American developments, should be able to meet regional needs and increase utilization of the Digest throughout Latin America, as well as in other countries of the Region.
6. The format of the Digest should be changed to make the quarterly issues more useful as individual publications. The laws and regulations should be arranged by major subject-matter categories with a country-reference index in each quarterly issue. The Digest should continue to include book reviews and bibliographical notes, but could also include a newsletter section or commentary section calling attention to the most innovative and most significant legislation in each issue and making note of other important developments in the health law field and in the collaborating centres, if established, in the health law field.

7. A newsletter should not be adopted as a substitute for the Digest. There are currently available newsletters in the health law field, though none of the international scope and comprehensiveness of the Digest. The Digest serves a unique function in concentrating on texts and summaries of laws and regulations rather than more speculative and political aspects of legislative activity.
8. A network of collaborating centres in health legislation should be developed by WHO over a period of time. In the development period, responsibility should rest with an appropriate unit in Geneva since most of the collaborating centres would tend to serve an international legal purpose rather than have a regional focus. A small number of centres should be designated early on as pilot efforts. The centres could be of two types: general-purpose centres with comprehensive bibliographical-library resources and research staffs; and special-purpose centres with expertise and professional staff of the highest calibre and with concentrated bibliographical-library resources in the selected field. These centres should contribute to both the information exchange functions and the technical cooperation functions of WHO. It does not seem feasible that such centres could supplant the Digest on a decentralized basis. However, the centres could help in collecting important texts, providing summaries, and answering inquiries directed from WHO and the regional offices concerning evaluation of the effectiveness of laws in actual operation. (See the recommendations on technical cooperation for further discussion of collaborating centres.)
9. In order to improve the involvement of health law expertise in the Digest's future work, a board of editors should be added to the editorial staff of the periodical. The field of health law is now a specialty area throughout a substantial part of the world. Editorial experience in health law could be tapped by WHO to help in the general development of a comprehensive programme of information exchange.
10. If space permits, the Digest could publish short papers on international health law topics of wide general interest to Member States. These papers should be original contributions with priority given to subjects of significance to WHO's overall objectives and goals in health services and programmes, especially in the developing world. Papers could also provide comparative reviews of limited subjects, or practical instruction and advice on drafting and on principles of effective health legislation. All such papers offered for publication should be reviewed for suitability and quality by members of the editorial board.
11. An organized plan should be developed for assuring the continuation of international comparative surveys of health legislation as a regular feature of the Digest. The practice of cooperative preparation with other WHO units at the Geneva headquarters and in the regions should be strengthened and encouraged. The policy of having surveys as signed contributions by authors should be encouraged. Collaborating centres of the specialized-purpose type might take responsibility for preparing selected comparative reviews and for examining surveys in their fields. The comparative surveys should not be limited to reviews of the text of legislation but should, where practicable during the research, include actual experience under the various legislative approaches in the different countries surveyed.

Technical cooperation

1. WHO headquarters and the Regional Office for the Americas should respond to the World Health Assembly's emphasis in resolution WHA30.44 on Member States' needs for technical cooperation in health legislation. Desire for such cooperation was found to be very clear in many countries of the American Region. The great majority of all Ministry of Health responses to the WHO questionnaire on health legislation indicated that their health legislation was outdated and that technical cooperation from WHO would be welcomed.
2. The recommendations on health legislation programmes of research, training, and action in the Ten-Year Health Plan for the Americas adopted at Santiago in 1972 should be underscored and restated. They are the basis for an excellent programme of health legislation in the Americas and could serve as a model for other regions of WHO throughout the world.

3. The recommendation in the Ten-Year Plan for seminars in health legislation was adopted by the Regional Office. The Regional Office should now move to hold an interdisciplinary conference on health law for the Americas in 1979. For best results, the conference or conferences should be in two parts, one for the Civil Law tradition countries of Latin America, and one for the Common Law tradition countries of the Caribbean and North America. Indicated areas of technical cooperation could be placed together for both legal traditions. The focus of the conferences (as far as subject matter is concerned) should be the same: the importance of health legislation for carrying out national objectives and policies in health. The outline provided in the Ten-Year Plan could be used to prepare the agenda. First consideration should be given to comprehensive updating of national health codes. Next, consideration should be given to the operational and administrative structure of the Ministry of Health and to issues of delegation of authority to other levels of government. Special areas of concentration for the conferences (identified by country visits and the WHO questionnaire responses) could include pharmaceutical regulation, food law, illicit drug traffic and abuse of dangerous drugs, health manpower regulation, immunization programmes, environmental health, industrial health and safety, and death-related issues such as care of the dying patient, definition of brain death, and donation of vital organs for transplantation. The conferences should also deal with matters of research and special training in health law.
4. In action programmes, priority should be given to updating the national health codes in those countries of the American Region where the national legal codes in the health sector are greatly out of date. PAHO should make a complete inventory of the status of the national health codes of Member States in the Region and report on progress periodically. Consultation and technical cooperation should be arranged for countries seeking help in revising and updating their national health codes or significant parts thereof.
5. All the WHO regional offices should adopt a programme of encouraging the development of health law courses (covering national and international aspects of the subject) in schools of public health in their regions. Advanced training in comparative health law should be encouraged also for legal specialists in the field of health law. To help develop specialization, the ministries and departments of public health at the national and state-provincial levels in the regions should be encouraged to establish full-time legal units where these are not currently in operation.
6. To aid in technical cooperation, WHO should organize an expert committee on health legislation. This committee should prepare reports and provide advice similar to other expert committees utilized with great success by WHO in other fields. The committee could overlap with or also serve as an editorial board for the Digest.
7. At the regional level, if PAHO seeks to establish a health legislation advisory service, it may be desirable to set up an expert committee or some similar group to aid in planning and developing the service. An excellent group could be formed of influential and experienced health lawyers from all parts of the Region of the Americas.
8. As a part of a Regional Office advisory service in health legislation, the unit should seek to establish regular contact and liaison with a health-lawyer counterpart in each Member country in the Region. Such a counterpart could be found in the full-time legal department of the Ministry of Health or Ministry of Justice or in another governmental agency. The plan of this type now being implemented in the European Region could be a model for such a counterpart system in other regional offices, with whatever variations are needed or desirable to fit regional differences.
9. The development of collaborating centres in health law was recommended earlier. These centres could perform their primary role in providing technical cooperation and advice. The special-purpose centres would be most useful to answer specific area requests. The general-purpose centres could be most useful in preparing comprehensive reviews of national health codes covering all or a large part of the health services of a Member State, or in government reorganizations or decentralization programmes. Country collaboration could be provided by

a team composed of an experienced health lawyer and a technical expert as noted in the section on findings, or by an experienced health lawyer alone. The health lawyers selected should be trained in international health law, not merely their own national law, and preferably should have interdisciplinary education in public health services and science, and should be able to work closely with health personnel of different backgrounds.

10. A plan for meeting the needs of developing countries in the field of health legislation services should be prepared and implemented by WHO. The earlier recommendation of an inventory of the status of national health codes should help in achieving this plan. The collaborating centres could be integrated into this plan by selecting a centre in an industrial country (where the resources in terms of a law library and professional expertise would be available) but uniting that centre with other collaborating centres in selected developing countries. Such a system of use of collaborating centres in health legislations is particularly appropriate to the Region of the Americas, both for functioning within the Region and to work with centres in other regions.

PART 2

THE REGIONAL OFFICE FOR THE AMERICAS

The Region of the Americas is different from the other five regions of WHO in operational structure. The Regional Office is conducted functionally by the Pan American Health Organization (PAHO), an independent inter-American organization which existed prior to the establishment of the United Nations and the World Health Organization. PAHO was joined with WHO at the time of WHO's creation after the Second World War. The governing body of PAHO is the Pan American Sanitary Conference, which meets every four years to set the policy of the Organization. There are currently 32 Member governments and participating governments, in the Region. The budget of PAHO/WHO in 1978 was approximately US\$ 66.8 million.

My report on the Regional Office is based upon a number of contacts with the Office and with Dr Héctor R. Acuña, the Regional Director, since 1975. I first met with Dr Acuña in Geneva on 23 January 1978 along with Dr Manuila and Dr Cooper. The mission was explained and Dr Acuña gave his full cooperation in planning the country visits. Since that time three visits have been made to the PAHO headquarters in Washington. The most comprehensive, with interviews with various divisional chiefs, was on 6 March 1978. I am particularly indebted to Mr Miguel A. Segovia and his secretary, Ms M. T. Carillo, for helping with the arrangements for my interviews at the Regional Office and for my country visits to Brazil, Colombia, and Canada.

Headquarters organization

Unlike the Regional Office for Europe, the Regional Office for the Americas does not have a legal staff member working on programmes or services in international health law or legislation.

At our first meeting in Geneva, Dr Acuña suggested that my liaison at the Regional Office would be Mr Segovia, mentioned earlier, who is legally trained. Mr Segovia's activities relating to management training in health services administration include many elements significant to health legislation. Dr Acuña also indicated that responsibility for health legislation matters in the Regional Office was assigned to the Division of Health Services, under Dr A. J. de Villiers.

My interviews with staff members at PAHO in Health Services, Disease Control, Environmental Health, and Family Health indicated that health legislation receives considerable attention in PAHO programme planning and health services development.

Importance of health legislation

The significant place of health legislation and law generally in the programmes of PAHO and its Member States are best illustrated by reference to the major policy document of the Organization, the Ten-Year Health Plan for the Americas adopted in Santiago in October 1972.¹

The document's theme is set by its first section called: "The Universal Concept of Health." A broad and comprehensive definition is provided. Opening the fourth paragraph is the statement:

It is for these reasons that health is today proclaimed a universal right, and not a privilege to be enjoyed by the few.
(emphasis supplied)

The universal recognition of a right to health is essentially a constitutional and legal function. The document goes on to point out that it is the responsibility of governments to ensure that the right is "enjoyed equally by all". The establishment of an effective right to health for all people is the underlying aim of the entire Ten-Year Plan.

A few pages along in the document, the first substantive area concerns ecology, which is defined as the study of the continuous relationships between living beings and the environment of which they are a part. Priority is accorded to people living in villages and on the outskirts of major cities. Among the objectives of operational programmes in environmental health is said (on page 7) to be:

enactment of laws and issuance of regulations
to render the established policies and rules
viable.

In these two sections it is made clear that PAHO has recognized the fundamental importance of health law in national and international health programmes. By citing the universal right to health, the Organization understands the legal significance of human rights or civil rights in formulating public health policy. In the second section, PAHO recognizes the role of law (especially of legislation and regulations) as a means of implementation. The national legislation breathes life into health policy (as the document puts it, the law renders the policy "viable").

Recommendations in Ten-Year Plan

The second section of the Ten-Year Plan contains the recommendations in health programme areas. There are 29 categories of recommendations. These are followed by a last section which I believe is unique in international health documents. It is a summarizing section which relates effective utilization of national systems of legal institutions to accomplishing health programme objectives.

In the section it is pointed out that the traditional relationship of the health sector to legal systems has been "superficial". Law has been little considered in planning or evaluation except as a source of blame for being a barrier to achieving health goals. It has not been realized that in many instances the law has been substantively quite adequate; it has been administrative failure that should have received the blame. Conversely, the writers of the section also point out that some areas have been overregulated rather than

¹ PAHO Official Document No. 118, January 1973.

underregulated. The critical failure has been a lack of sophistication about legal systems and their total functions in an organized form of government. As it is put in the document (pages 95-96):

Public health administrators need to have a better understanding of the different components and levels that make up the legal framework, of the functions of each, and of the nature, weight, and extent of their influence on action in the health sector.

In a very important observation, the writers call attention to the fact that the knowledge, beliefs, and attitudes of health professions in the health sector often do not correspond to the attitudes and values of those lawyers and policy-makers in the legislatures who are called upon to draft, amend, apply, and interpret the pertinent health legislation of the country.

A series of recommendations are made in the document in regard to research, training, and action in the field of health legislation. I would summarize them as follows:

1. Research. To carry out research which will provide full understanding of the legal system and assess the effectiveness of the system in serving the purposes of the health sector in different countries.
2. Action at law. To promote the development of complete health codes and regulations in the countries of the region.
3. Publication. To promote systematic updating of publications containing all existing health legislation in the countries of the region.
4. Defining health problems. To define the national health problems of each country where health legislation is needed and to develop a plan for framing new laws and specific rules and regulations to deal directly with these problems.
5. Interdisciplinary seminars. To organize and present a series of interdisciplinary seminars involving participation by health professionals and technical personnel along with lawyers, judges, and legislative draftsmen to exchange views on the functions of the legal system and its relation to the health sector and health programme goals.
6. Teaching health legislation. To improve the teaching of the basic ideas and principles of administrative law and health legislation in schools of public health and in university courses on preventive medicine.
7. Training lawyers in comparative health legislation. To provide training for practising lawyers in the subject of comparative health law in order to develop the legal specialty area of international health law.
8. Full-time legal units in health ministries. As a further result of training specialists in health law, the document recommends establishment of full-time legal units or departments in ministries of health in Member countries. These units should have responsibility for proposing and drafting new laws and regulations and for updating and systematizing the existing health codes of the countries.

This set of recommendations is admirable. In my interviews at PAHO headquarters I found many of the staff highly knowledgeable about the importance of health law. These provisions of the Ten-Year Plan were called to my attention by more than one staff member.

There has been important progress in carrying out some of these recommendations on health legislation. As a direct consequence of these recommendations, a seminar on health legislation and health law was convened by PAHO in Washington in 1973 gathering together the legal counsels (or heads of law departments) in the ministries of health in Latin American countries. The Regional Office has also been involved in other efforts in health legislation including the preparation of a model law for national therapeutic drug regulation. In 1969 the Office prepared a comparative survey of mental health hospitalization laws in Latin America. This survey was found to be very helpful in the preparation of the WHO worldwide survey of mental health legislation conducted in 1975-1976.

Update of regional planning

The latest published expression of the views of the Health Ministers of the Member States of PAHO in regard to the above matters can be found in the Report of the IV Special Meeting of the Ministers held on 26-27 September 1977. In the conclusions of the meeting, the Ministers first affirm their belief in the concept that:

Health is a basic human right and man is
both the means and the end of socioeconomic
development.¹ (emphasis supplied)

The Ministers concluded that the bulk of the population in most of the countries of the Region still lacked the most basic health services. In order to accomplish improvement in the health status of the people, two strategies were stressed: (1) strengthening of primary health care; and (2) promotion of more community participation in the planning and operation of health services for the people.

Information exchange in health legislation

There was support for the International Digest of Health Legislation at the Regional Office. It was felt, however, that many of the countries should support the Digest more effectively by supplying copies of new legislation to the Geneva editorial offices.²

The most frequently used sections of the Digest were believed to be those related to the more technical fields of environmental health, food law, and therapeutic drug control law. Most of those interviewed indicated they thought organization of contents by subject matter would be preferable to the current system of classification by country. The comparative surveys were said to be the most valued special features in the Digest.

I did not find approval of the idea of substituting a newsletter for the current Digest. However, it was believed that the WHO Chronicle might take more note of legislative developments in Member countries, movements toward international legislative cooperation, and the preparation of model legislation in health fields.

There was considerable enthusiasm for promoting more exchange of information and viewpoints on health legislation. The seminar in health legislation held in Mexico some five years ago had led to continuing contact among some of the lawyers on the staff of health ministries in the countries of Central and South America. The Regional Office was

¹ PAHO document REMSA4/FR, 27 September 1977.

² Prior to September 1977, not a single nation south of Mexico in Central or South America regularly sent new laws to the Digest. Mexico regularly sent its laws. In the United States of America, a few states sent laws, but no regular supply came from the Federal Government. In Canada, only the food and drug laws and regulations of the Federal Government were sent; no provincial laws were received. After the Circular Letter, laws have been received or been promised from Brazil, Colombia, Costa Rica, Nicaragua, St Vincent, and Venezuela.

specifically interested in encouraging further seminars in health legislation. It was reported that Brazil might be the host for such a seminar. Later discussions suggested that separate seminars (or seminars in two parts) might best be held for (a) the English-speaking, Common Law tradition countries of the Region in North America and the Caribbean; and (b) the Spanish- or Portuguese-speaking, Roman Law tradition countries of Latin America.

PART 3

COUNTRY VISITS

BRAZIL

The site visit to Brazil was conducted from 27 March 1978 through 2 April 1978. The first part of the visit was to Brasília, the federal capital of Brazil since 1960, located inland in the central, western part of this vast country. The second part was to Rio de Janeiro, the former capital, a large metropolitan centre where many health service agencies and academic centres are located. The large industrial concentration around São Paulo could not be included in this trip, but information was gathered concerning this area. My reception throughout Brazil was warm and enthusiastic. As indicated later, it was felt by many people I interviewed that I had come at an opportune time in the reorganization of health programmes and public health law in Brazil. There was a clear and spontaneous interest in international cooperation and exchange of information on health legislation. An expanded role for PAHO and WHO in information exchange and technical cooperation in health legislation was welcomed.

Federal structure

Brazil has been called a continent within a continent. It is larger than the continental United States of America. It includes the largest part of the massive Amazon River Basin at the Equator, a subtropical central-western region of vast size, and a temperate-climate mountainous area in the south. With the establishment of Brasília as the capital, efforts have been concentrated on development of the vast country as a whole. Since 1964, when a change of government occurred, many reforms have been instituted to control inflation, to develop export trade, and to make the country more self-sufficient in many vital areas ranging from oil to foodstuffs. Public health programmes have been vigorously pursued in recent years in the vast jungle areas and in the shanty towns around the coastal metropolitan population centres.

On an international level, the Treaty for Amazonian Cooperation recently signed by the nations along the Amazon River Basin (an area of over 7 million km², double the size of any other river system in the world) is designed to provide for cooperation in disease control, environmental health measures, navigational systems, and communications networks.

Considerable leadership in health matters is provided from the federal level. The health law of Brazil is made at the federal level with opportunity for the states to supplement it concerning local matters. The Ministry of Health has broad responsibility across the health sector in preventive medicine, regulatory programmes in disease control, sanitary conditions, pure food and drugs, health manpower training and licensing, etc. Other federal ministries also have important health functions, including particularly the Ministries of Social Security and Welfare (which provides from 60% to 70% of the medical care in the country), Labour, the Interior, and Education and Culture. The Ministry of Health functions with a National Council of Health. In addition to its internal departments and units, the Ministry has associated with it four autonomous health organizations: the Public Health Service Foundation (FSESP), the Oswaldo Cruz Foundation (FIOCRUZ), the Foundation of Social Pioneers (FPS), and the National Institute of Food and Nutrition (INAN). In Rio de Janeiro, I visited the first two of these organizations.

Health legislative trends

The Legal Department (Consultoria Jurídica) of the Ministry of Health is under the very able direction of Dr Hélio Pereira Dias, the Legal Counsel to the Minister of Health. Dr Dias has had a quarter of a century of experience in his post. He is a scholar of health law, a conceptualizer of health-law principles, and a compiler of the health law and legislation of Brazil. Dr Dias' Department has a staff of over 10, with three lawyers working closely with the Minister.

During the past five years the Minister of Health, Dr Paulo de Almeida Machado, has worked to reorganize the structure of health programmes in Brazil. The reorganization has been accomplished through important new laws and decrees. The primary piece of legislation has been Law No. 6.229 of 17 July 1975, which organizes the National Health System. The law deals with the complex of health services in the private and public sectors in the country. Responsibilities are described not only for the Ministry of Health but for the Ministry of Social Security and Welfare, the Ministry of Education and Culture, the Ministry of the Interior, and the Ministry of Labour. The responsibility of the States, Federal Districts, Territories, and Municipalities are also described in the law.¹

Dr Dias has accomplished a great task in compiling the federal legislation and decrees in the health field in a three-volume set first published in 1973. A second edition was published in 1977. The volumes contain all important laws, Presidential decree-laws, decrees, ministerial orders, interministerial orders, and other legal instruments. The editorial reviser for the 1977 volumes was Dr João Coelho de Souza e Oliveira Filho, Assistant Legal Counsel of the Ministry of Health.

The basic public health law of modern times in Brazil can be traced in this collection, the earliest law in the compilation being Law No. 1.261 of 31 October 1904, which dealt with vaccinations and revaccinations.

In his Introduction to Volume I of the compilation, Dr Dias credits the 1973 Seminar organized by PAHO for the Legal Counsel of Ministries of Health in Latin America as an important influence on the development of health law and this compilation of laws for Brazil.

In terms of programme priorities, the most important recent laws and decree-laws in Brazil have been the following:

- (1) Presidential Decree No. 70.986 of 21 October 1969, which establishes a comprehensive regulatory system under the Ministry of Health for control and basic standards for foodstuffs from production to consumption.
- (2) Law No. 5.726 of 29 October 1971, which sets up control measures and preventive programmes against traffic in and use of narcotics and dependence-producing substances, educational efforts, and treatment and rehabilitation programmes for drug-dependent persons.
- (3) Law No. 5.991 of 17 December 1973, which sets up a nationwide regulatory system for commercial (over-the-counter) pharmaceutical drugs. This law was followed by important regulations in Decree No. 74.170 of 10 June 1974.
- (4) Law No. 6.150 of 3 December 1974, which controls the manufacture and sale of iodized salt used for human consumption. This law was followed by regulations in Decree No. 75.697 of 6 May 1975.
- (5) Law No. 6.050 of 24 May 1974, which orders fluoridation of all public water supplies. The programmes must be in place in the States by the end of 1979. Implementing regulations were adopted by decree and ministerial order in 1975.

¹ The law is published in Volume I, pp. 149-153, of Federal Legislation in the Health Sector, Brasília, 2nd Edition, 1977 (Portuguese only).

- (6) Law No. 6.229 of 17 July 1975, which reorganized the National Health System, mentioned earlier.
- (7) Presidential Decree No. 76.078 of 4 August 1975, which alters the name and programme of the component of the Ministry of Health dealing with the field of leprosy. The former name of the Division concerned was the National Division of Leprosy and the National Campaign against Leprosy. The new name is National Division of Dermatological Health and the National Campaign against Hansen's disease.
- (8) Law No. 6.259 of 30 October 1975, which reorganizes the entire immunization programme for preventable diseases, establishes new priorities, implements programmes of obligatory immunizations, etc. (This was one of the most important new programmes installed after the establishment of the National Health System.) Implementing regulations were issued in Decree No. 78.231 of 12 August 1976. Later ministerial orders provided for compulsory notification of diseases throughout the country.
- (9) Presidential Decree No. 76.973 of 31 December 1975, which sets up norms and standards for facilities for health services throughout the states, federal districts, territories, and municipalities.
- (10) Presidential Decree No. 77.052 of 19 January 1976, which concerns the work conditions and regulation of health professionals and technicians and auxiliaries related directly to health.
- (11) Presidential Decree No. 78.171 of 2 August 1976, which controls and regulates the production and bottling of mineral water intended for human consumption.
- (12) Law No. 6.360 of 23 September 1976, which further regulates production, marketing, sales, and consumption of medicaments, drugs, cosmetics, vitamins, perfumes, insecticides, etc., covered by Law No. 5.991, mentioned earlier. (An extensive law in 17 titles.)
- (13) Law No. 6.368 of 21 October 1976, which further regulates and imposes criminal penalties concerning prevention and control of illicit traffic in and use of narcotics and dependency-producing drugs. (Updates controls in areas indicated in Law No. 5.726, mentioned earlier.)
- (14) Law No. 6.437 of 13 November 1976, which establishes a graduated series of penalties (warnings, fines, confiscations, etc.) for violation of public health laws, regulations, etc. (The fines have a built-in factor of increase to take account of monetary inflation.) The earlier law in this field was Decree-Law No. 785 of 25 August 1969.
- (15) Presidential Decree No. 79.367 of 9 March 1977, which further regulates drinking-water quality from source to consumer.

The above list was compiled as a result of visits to the Ministry of Health headquarters in Brasília in interviews with high officials of the Ministry, including Dr Humberto Torloni, the National Secretary for Special Programmes, Dr Sergio Franco, National Secretary for Basic Actions, and Dr Dias, mentioned earlier, as well as interviews at the highest levels in the Public Health Service Foundation (FSESP), which is concerned particularly with environmental health. In the latter organization, I met with Dr Aldo Vilas Bôas, President of FSESP, and a number of sanitary engineers on the staff.

Information exchange

All of the health agencies visited in Brazil were interested in improved exchange of information in the health legislation field on an international basis. In fact, the establishment of permanent methods of international exchange of information and experience

between qualified persons in health law in order to promote new legislative approaches was the first-ranked area of "country's needs" in the health legislation field in the questionnaire response to Question 1 by the Ministry of Health. In response to Question 2 concerning cooperation with WHO/PAHO, the Ministry replied that it would welcome the Organization's assistance in developing health legislation information exchange in sponsoring periodic seminars on health law. These seminars should be in specific areas, not generalized discussions, with priority given to such areas as food and drug laws and environmental health, including industrial health. In Brazil, the highest priority in the latter areas is the prevention and control of serious public health diseases such as Chagas' disease and schistosomiasis. The Ministry recommended that all WHO regional offices should establish units concerned with international health legislation.

The interest of the Ministry of Health in international health legislation is also displayed by the fact that the Legal Department under Dr Hélio Pereira Dias has compiled all of the important international legal instruments, decrees, and conventions in the health field in Brazil.¹ The organizer of the legal texts was Dr João Coelho de Souza e Oliveira Filho, mentioned earlier.

In view of Brazil's great size and its federal structure, it is not surprising that the Digest is received in 64 different locations in many health agencies, organizations, and libraries in the country. The Digest can be found in the Ministry of Health in different departments as well as in the Ministry library in Brasília. It is also to be found in the library of the Chamber of Deputies in the Federal Legislature and in the excellent building housing the PAHO/WHO Country Representative in Brazil.

The health agencies visited were very sophisticated concerning health legislation and were interested in comparative international studies. There were numerous suggestions for computerizing the health law of Brazil and other Latin American countries in a source accessible to Brazilian agencies and universities. The most likely place for such computerization seemed to be the Regional Library of Medicine and the Health Sciences at the University of São Paulo, which is already supported by WHO. This library is currently an international resource for all of South America.

Many of the agencies indicated that the Digest was known and utilized, though the most frequently examined foreign legislation in the health field for Brazil is usually that of the United States of America, especially in technical areas such as drug control, food laws, environmental health, drinking-water standards, etc. Many important Brazilian laws have been published in the Digest during the 1970s although until recently Brazil was not systematically sending its significant health legislation to the Geneva editorial offices of the Digest. I spoke to Dr Dias and Dr Torloni about instituting a regular service of transmitting new health laws and decree-laws to Geneva for publication and notification.

In the Digest, the Ministry officials preferred full texts or good summaries of important legislation, but if computerization can be adopted with ready access, then titles could be given first priority in creating a data bank. The full texts could be made available in health legislation advisory service units set up at PAHO (and in the offices of its country representatives) and at WHO headquarters in Geneva.

When asked about publication of special international comparative surveys of health legislation, the Ministry officials were very enthusiastic and considered such surveys one of the most important parts of the Digest. The Ministry also thought important international conventions in health areas should be covered in the Digest.

The officials and staff members interviewed in Brazil were satisfied with the current format of the Digest. The current broad coverage was favoured and it was felt that no fields should be eliminated. The Brazilians currently use the English version of the Digest and are satisfied with it. However, a Spanish version was thought to be desirable for more effective utilization of the periodical throughout the rest of Latin America.

¹ Atos Internacionais Pertinentes ao Sector Saúde, Brasília, in two volumes, 1977 (Portuguese only).

Health law education

There is a strong tradition in Brazilian medical schools of medico-legal education and service, but currently the concentration in these departments is on forensic pathology and investigation of death. Only limited attention is given to health law (or public health legislation) in the public health schools, medical schools, and law schools of Brazil. There are few specialist lawyers in health fields, though some are retained by private industry in the food and drug and environmental fields. Dr Dias has had an interest in health law training, particularly in the schools of public health. He has constructed a 12-point outline of the content of a course in public health law which could be taught in schools of public health and perhaps in other professional health programmes.¹ It begins with instruction in health law (including administrative law) and continues with public law and private law. The third section describes the hierarchy of laws in the national system of law in Brazil. Next is a description of the jurisdiction of the federal, state, and municipal governments. Fifth is a description of "the concept of sanitary police", or health control. The next six points are more detailed descriptions of areas of public health law. It should be noted that the stress in this outline is upon the general structure and character of health law in Brazil, not upon the specific, technical content of preventive medical provisions or sanitary regulations which would be outdated within a few years.

I visited the National School of Public Health (ENSP) in Rio de Janeiro. The School is a unit of FIOCRUZ, the independent research and training foundation. I had meetings with the School's Director, Dr Luis Fernando Ferreira, and with two key faculty members whose courses include attention to public health law, Professor Elsa Ramos Paim, who teaches health services administration, and Professor S. E. Cynamon, who teaches sanitary engineering. There is no course in public health law and no lawyer on the regular faculty. In Professor Paim's courses, there are general lectures which deal with health law and the legal system in Brazil. In the advanced specialization course in administration, there are about 12 hours of lectures related to law and government in a total of 120 hours. Professor Paim indicated that there was a strong and growing interest in public health legal concepts and topics and a public lawyer might well be a valuable addition to the faculty. Professor Cynamon indicated that legal enforcement of sanitary and environmental standards receives considerable attention in the courses given in his department of the School. Emphasis is on practical matters of operational significance, not only in the enforcement areas but also in legal aspects of contracts, specifications, and public bidding in the construction and housing fields.

It was not indicated that the academic centres in Brazil are engaged in research in health law, or in compiling or redrafting the country's health laws. This type of activity was widely acknowledged to be concentrated in the Federal Government's Legal Department in the Ministry of Health.

Technical cooperation

There was considerable enthusiasm for improved efforts by PAHO and WHO in providing a health legislation "advisory service" or technical cooperation programme. A number of interviewees supported the establishment at PAHO of a health legislation unit with trained, interdisciplinary health lawyers. This unit was seen as working on both information exchange (supplying copies of important legislation, coordinating health law seminars, arranging training and fellowships in health law) and technical cooperation (furnishing health law experts as consultants, arranging for evaluations of health legislation, helping to establish computerized access to health legislation and standards). It was felt that PAHO and other regional offices of WHO would, however, need leadership and guidance from a legal unit and/or an expert committee on health legislation formed and operated at the Geneva WHO headquarters.

¹ I was given a copy of the course outline by Dr Dias (Portuguese only). The outline is reproduced with this report as Annex B.

There was frequent reference to the current period in the development of health legislation and national health programmes as very favourable for international cooperation. As Dr Carlos André Salles of FIOCRUZ said, "You have come at an opportune time in Brazil for developing health legislation". He pointed to the new national laws and the compilation of the entire federal laws in the field. At the National School of Public Health, the Director, Dr Ferreira, spoke of this as a "key moment, a propitious period" for progress in health programmes in cooperation with WHO, especially in dealing with the tropical diseases in Brazil and the need for more effective food and drug regulation.

The Oswaldo Cruz Foundation (FIOCRUZ) is a focal point for research and planning in public health in Brazil. I met with Dr Aldo Villas Bôas, President of FIOCRUZ, Dr Guilardo Martins Alves, Vice President, and Dr Carlos André Salles, mentioned above. The entire programme of the Foundation was described and priorities were indicated. Among the priorities is the establishment of a national computerized reference library for food and drug programme information, including the laws, decrees, and other legal regulations in these fields. Dr Alves and Dr Salles indicated that the development of FIOCRUZ as a WHO collaborating centre in health legislation could well be considered. The Foundation has 77 years of experience in public health in Brazil. It is a national resource for advanced professional and technical education and research as well as for the production of vaccines for the people of the country. Along with the Ministry of Health, the Foundation engages in the development of national health policy for Brazil.

In addition to this Foundation, the most frequently mentioned potential collaborating centre, especially in information exchange and legal research, was the Regional Library of Medicine and the Health Sciences at the University of São Paulo in São Paulo. Other library resources in health areas and law that were mentioned were in Rio de Janeiro (best law library collection), Brasília, Recife, and the University of Bahia, Salvador.

COLOMBIA

The field visit to Colombia took place from 2 to 6 April 1978. Interviews were arranged with the office of the PAHO/WHO Country Representative, and with the Ministry of Health, the Colombian Institute of Family Health, and the Medical Institute of Social Security, all in the capital city of Bogotá. Most of the visits were with the Offices of Law (legal departments) in each of these national agencies. However, other medical and health planning personnel were also involved in the visits.

Colombia is one of the most important and larger countries in Latin America, situated on the north-west coast bordering both the Pacific Ocean and the Atlantic (or Caribbean). It has a population of approximately 28 million people, with 4.5 million in Bogotá. Growth and development have been substantial since the Second World War. The country is perhaps best known for its largest export crop, high-quality Colombian coffee. There are serious health problems, especially in the Amazon River Basin, which is shared with Brazil and six other nations. Colombia is a signatory to the Treaty for Amazonian Cooperation, to which reference has already been made. Colombia has also a serious problem of illicit drug traffic along its coasts, probably the most serious in Latin America at the present time. Vigorous government efforts are being directed at controlling and eliminating this international trade and its effects on the people of Colombia.

Legislative trends

Leadership in health matters is provided in the Ministry of Health. The most recent reorganization of the Ministry took place in 1976 under Ministerial Decree No. 121 (made under Law No. 28 of 1974), which replaced an earlier organization of 1968. The Decree and the Law establish a national health system. The country is divided into regions and sectors for the health programme. The Decree establishes the staff and line divisions of the Ministry in very modern fashion covering all major fields of public health as well as health manpower and hospital construction and maintenance.

Considerable attention has been given to health planning and health legislation in recent years. It was indicated that this study by WHO in the health legislation field was most welcome at this time because of these developments. A new National Health Code is currently being considered. It has been passed by the Senate and is now being examined in the Chamber. There have also been important changes in health service coverage in the Social Security system, including a new investigational programme under the Ministry of Health. I was able to interview the Director of this programme, Dr Ricardo Galan Morera. I was also provided with a copy of a proposed new law in the field of organ transplantation.

Among the most important new Ministerial Decrees in recent years have been the following:

- (1) Decree No. 1061 of 6 June 1973, concerning assignment of functions for the licensing of manufacture of food and non-alcoholic beverages.
- (2) Decree No. 281 of 21 February 1975, concerning the regulation and registration of drugs, foods, cosmetics, domestic cleaning fluids, detergents, and other such products.
- (3) Decree No. 0522 of 18 March 1976, concerning regulation of the pharmaceutical drug industry.
- (4) Decree No. 056 of 15 January 1975, which replaces the structure for local sectors of the National Health System provided under Decree-Law No. 654 of 1974. This structure concerns community health and aspects of promotion, protection, recuperation, and rehabilitation services for the people.
- (5) Decree No. 350 of 4 March 1975, establishing the organization and functions of the sectional health services of the Regions of Colombia. This Decree provides a detailed organizational structure for the sectional health services.

Information exchange

Twelve copies of the Digest are currently being received in Colombia. Two copies go to the Ministry of Health (the Secretary-General and the Head of the Office of International Relations) and one goes to the PAHO/WHO Country Representative, whose office is located in the same building as the Ministry in Bogotá. Most of the other subscriptions are held by libraries in Bogotá, Barranquilla, Medellín, and Manizales. Up to the time of the WHA resolution adopted in 1977, Colombia was not regularly providing copies of health legislation and decrees to the Digest. After that time, Colombia is listed as regularly sending or planning to send legislation.

The Head of the Legal Office at the Ministry of Health, Dr Gustavo Combatt Lacharme, who has been in that position for some nine years, was not familiar with the Digest. He was also not familiar with any practice of sending health legislation to the Digest offices in Geneva. He did, however, promise his cooperation in sending such documents to the Digest in the future. He did not know of any custom of examining the Digest or other sources for examples of health legislation in other countries prior to enactments in Colombia. The most frequent foreign law examined is that of the United States, particularly at the federal level.

Dr Combatt did not have the health legislation questionnaire, but he filled it out while I was there and answered it on behalf of the Ministry. He indicated on Questions 1 and 2 that Colombia would welcome more decisive WHO collaboration in the health legislation field, particularly through supplying texts and authoritative commentaries on health law and experience in enforcing health law programmes. Particular fields of importance currently for Colombia were food and drug regulation, environmental health, organ transplantation, and regulation of health facilities.

Dr Combatt indicated he would like to have full texts of important laws, although good summaries were just as valuable. He would be quite satisfied to have texts or summaries supplied by the PAHO/WHO Office in Washington through the Country Representative. He would prefer Spanish translations. He also indicated that he would find a Spanish-language version of the Digest most helpful.

Other health officials interviewed in Colombia were not familiar with the Digest.

Technical cooperation

There was a clear interest expressed in cooperation with PAHO/WHO a health legislation unit in Washington, if such were established. Several officials interviewed thought such a unit should be organized. Dr Combatt, mentioned above, had attended the Seminar on Health Legislation for Latin American Countries which was held at PAHO headquarters in 1973. He expressed an interest in further cooperation of this type. For collaborating centres, the library efforts at São Paulo in Brazil were mentioned, especially if Latin American laws and regulations could be placed on a computerized system. The mental health programme in Cali, which is cooperating with the Division of Mental Health in Geneva, was also mentioned. (Dr Sartorius, Director of that Division in Geneva, was visiting the programme in Cali while I was in Bogotá. I also discussed the potentials at Cali with officials at the office of the Country Representative in Bogotá.)

CANADA

The field visit to Canada took place from 10 to 12 December 1978. Arrangements for the visit were made through the PAHO/WHO Office and were planned with Mr R. S. G. Thompson, Director for Legal Services, Department of National Health and Welfare, and Mr Saul Tunis, Legal Advisor, Department of National Health and Welfare. From the Department of National Health and Welfare, I am particularly indebted to Dr M. Careau and Dr B. Casselman of Intergovernmental and International Affairs.

The format of the Canadian visit differed considerably from the other field visits in the Americas or in Europe conducted by this consultant. Most of the personal contact with officials was achieved in Canada through an extraordinary all-day working conference held on 11 December 1978 at the Department of National Health and Welfare. The working conference was attended by 21 officials from several branches and units of that Department, and from the Department of Justice, the Canadian Law Reform Commission, the Canadian Human Rights Commission, and the Central Mortgage and Housing Corporation. The entire group arrived early and stayed throughout the day. Commentary was received and exchanged on a wide range of topics. A tape recording was made of the discussion.

The meeting was arranged and chaired by Mr Saul Tunis who made an opening statement describing the constitutional and statutory powers of the Federal Government in matters of health. The morning session of the working conference was devoted to a discussion of the series of questions in the WHO questionnaire sent to Canada concerning the Digest and the information exchange programme in health legislation. The afternoon session concerned responses to the eight points on health legislation posed by Mr K. Uemura, Director of the Division of Health Statistics at WHO headquarters in Geneva, to the consultant, and forwarded by him to Mr Thompson and Mr Tunis. The format was sufficiently flexible in both the morning and in the afternoon to allow for a full examination of the health legislation programme of Canada and its relationship to the World Health Organization.

A few private, informal discussions were also a part of the Ottawa visit, particularly with Mr Tunis, Dr Careau, Dr Casselman, and Mr J. D. McCarthy, and with the representatives of the Canadian Law Reform Commission, Mr Keyserlingk and Ms Dillon.

Canada is the northern-most country in the Americas. In area it is one of the largest countries in the world (9.8 million km²). Yet it is also one of the world's most sparsely populated countries, with only 22.9 million people (2.3 per km²). Some 85% of the population is clustered in a band of cities and towns and cultivated areas north of the nearly 6500 km of border with the United States of America.¹

¹ Woodcock, G., Canada and the Canadians, Harrisburg, Stackpole, 1970.

Canada is a part of the British Commonwealth. It has a federal form of government with 10 provinces and two territories. Canada is officially bilingual in English and French. The French language and cultural traditions are found primarily in the provinces of Quebec and, to a lesser degree, New Brunswick. The remainder of the provinces are primarily English in language and in their use of the English Common Law system. The British North America Act of 1867 serves as the constitutional foundation for the Government of Canada.

Governmental health authority

In the British North America Act sections on the distribution of legislative powers, the only specific mention of federal health authority relates to quarantine and the operation of marine hospitals. The provincial governments are given authority concerning hospitals and other health services and programmes. The federal activities in health over recent decades have come mainly through the spending powers in such areas as health insurance, research support, pensions, and vocational rehabilitation services. The Federal Criminal Code also contains several health-related regulatory programmes such as the Food and Drugs Act, the Narcotic Control Act, the Radiation Emitting Devices Act, the Environmental Contaminants Act, and the Hazardous Products Act. Federal regulations have also been adopted in special areas such as atomic energy control, Indian health, the health of seamen, and health programmes in the Yukon and the Northwest Territories of Canada.

Mention was made earlier of specific federal powers relating to quarantine (at the maritime ports and airports) and marine hospitals. These activities obviously relate to intergovernmental and foreign commerce, but the Canadian Federal Government does not, under the British North America Act, possess full and exclusive powers concerning international matters. These powers were originally retained by the British Crown. They have since devolved over to the Canadian Government. The federal level exercises power and authority in foreign relations and diplomacy, but cooperation is maintained with the provincial governments in health areas of intergovernmental and international concern.

Leadership in the health field at the Federal Government level is provided by the Department of National Health and Welfare. The health-related units of the Department are the Health Services and Promotion Branch, the Medical Services Branch, the Health Protection Branch, and the Fitness and Amateur Sport Branch. Other ministers in the Federal Government also carry responsibility for important health and safety programmes in areas such as environmental health and the control of hazardous products.

Recent policy and legislative trends

The most significant development in recent years at the national level in Canadian health policy has been the release in April 1974 of a working paper called A New Perspective on the Health of Canadians prepared by the then Minister of National Health and Welfare, Mr Marc Lalonde. The basic theme was developed in a speech by the Minister at a PAHO Conference held in Ottawa in September 1973. The new concept was endorsed unanimously by the Ministers of Health of the Canadian provincial governments at meetings on 13 and 14 February 1974 prior to the release of the final document in April.

Public health people would be pleased with the document. It was as strong an endorsement of the public health concept of health strategy as this consultant has ever seen at a national policy level. It admitted that improvement in the health of the people and reduction of mortality at the younger age levels would likely be achieved in the future not through progress in medical care but through improvement in the environment of life, moderation of personally imposed risks and damaging life styles, and increased knowledge of human biology. The document indicated that the Federal Government and the provinces would seek two broad objectives:

- reduction in personal mental and physical health hazards; and
- improved accessibility to adequate health care for people where present access is unsatisfactory.

In pursuit of these objectives, five strategies were proposed in the areas of health promotion, federal regulatory activity, research programmes, health care efficiency (including not only cost but accessibility and effectiveness), and goal setting (in quantitative terms with stated time limits).

The second-listed strategic area of regulatory programmes is essentially legal and legislative, of course. Fields marked out for future implementation were food nutrient controls; alcohol and driving regulation; control of advertising of hazardous products; federal pollution controls; and better legislation to control health hazards from communicable diseases, radiation, medical devices, and cosmetics.

Among the most important federal legislative enactments in recent years have been the following:¹

1. Canadian Centre for Occupational Health and Safety Act of 1978, which establishes such a centre to promote the health and safety of the workplace, to participate in establishing and maintaining high standards, to collect and distribute statistics and other information, to assist in training personnel for the field, and to conduct and evaluate research in the field.
2. Federal-Provincial Fiscal Arrangements and Established Programmes Financing Act of 1977, which modifies methods of federal financing and provides greater flexibility for the provinces in administration of federally financed programmes.
3. Government Organization (Scientific Activities) Act of 1977, which reorganizes the various governmental scientific research groups including the Medical Research Council.
4. Medical Care (Amendment) Act of 1976 which affects cost limitations in federal-provincial contributions, housekeeping, etc.
5. Quarantine (Amendment) Act of 1976, which affects the federal activities in controlling diseases constituting a grave danger to the public health.
6. Proprietary and Patent Medicines (Amendments) Acts of 1975 and 1976, concerning the sale, labelling, and distribution of such products in Canada.
7. Environmental Contaminants Act of 1975, which establishes a regulatory programme concerning such substances harmful to health or the environment. Administration of the Act is under the Minister of the Environment, but the Department of National Health and Welfare has areas of concurrent authority.
8. National Dental Examining Board Act of 1973, redefining the purposes and powers in regulation of dental practice.
9. Radiation Emitting Devices Act of 1972, controlling the sale of such devices under standards set by the Department.

Information exchange in health legislation

As indicated earlier, the morning session of the working conference in Ottawa on 11 December 1978 was spent responding to the questions in the WHO questionnaire concerning the International Digest of Health Legislation and health legislation information exchange.

The first two questions concerned needs in health legislation and WHO cooperation: Canada has a sophisticated body of health legislation. There has been some retrenchment of

¹ This list was prepared from documents made available to the consultant from the working conference in Ottawa on 11 December 1978, and from suggestions received directly from Professor Bernard M. Dickens of the Faculty of Law, University of Toronto, in personal correspondence of 5 December 1978.

Federal Government financial participation in health programmes in recent years because of inflationary trends. The national policy in health was set in 1974 by the Working Document mentioned earlier. Canada cooperates actively in the programmes of PAHO in the Region of the Americas.

In the health legislation field, WHO collaboration would be most appreciated in helping to develop computerized methods of legislative information exchange. Also, WHO's help would be appreciated in developing methods of evaluation for health regulatory and legislative programmes. Areas where such evaluative information could be used currently are in legislative definition of death, living wills, and control of clinical experimentation on human beings. One experienced commentator observed that Canada needs help in selecting technical and legislative consultants more than it needs help on information exchange. The group felt that legislative information services should be centralized in WHO headquarters, Geneva, but that technical cooperation and evaluation of health legislation could be decentralized to the regional offices of WHO and could be arranged bilaterally between nations.

Question 3 concerned types of legislative information (full text, summaries, titles, surveys, etc.). The Canadian officials gave a variety of answers here. They seemed to agree that the comparative surveys were the most valuable feature, but stressed that the surveys should go beyond analysis of the text and into an investigation of experience under the different types of legislative approaches. The recent survey of mental health laws was appreciated because of its wider and deeper analytic examination and treatment of experience in the countries surveyed. It was indicated that administrative regulations (decrees, etc.) were often more difficult to obtain than parliamentary legislation. The Digest would perform a most valuable service in calling attention to such regulations in important areas.

Question 4 concerned the use of WHO sources of information exchange, including the Digest, and whether these currently fully cover the needs of Canada in this field: the answer was clearly in the negative. The Digest is used in Canada, but when a particular matter comes up and legislation is planned, the tendency is to seek direct personal contact with key officials and agencies operating similar programmes and legislation in other countries. In this way, the information gathered is up to the minute and complete and includes experience in implementing the legislation and/or the regulations. The help of WHO in establishing contact with other countries would be appreciated if PAHO and WHO headquarters, Geneva, could act quickly and arrange connexion with the most important, most experienced officials or academic authorities.

Question 5 concerned suggestions for modification of the Digest: there was no voice at the conference advocating the substitution of a newsletter for the current format of the Digest. It was felt that a newsletter or bulletin becomes dated very quickly and is very difficult to index properly. The Digest has a much greater continuing value as a practical tool in legislative drafting and as a source of new ideas for health programme direction. However, it was felt that some type of "explanatory notes" would help to set the published documents in perspective concerning reasons for enactment, etc. It was felt that an arrangement by subject matter would be more helpful than the current country arrangement. There was no sentiment expressed for a regional arrangement, especially due to the Canadian interest in legislative developments in Western Europe. There was also an interest in hearing about movements toward uniformity in law internationally and among the substates of federal countries. It was felt that some international and national health associations could help WHO in gathering commentaries on health law for publication in the Digest. Publication of titles could be useful, especially if administrative and ministerial decrees and regulations were included and could be obtained, but no radical change in the Digest format was suggested.

It was indicated that the Digest is not specifically referred to or used by the legislative legal counsel or draftsmen at the Parliament (Questions 6 and 7).

Representatives of the Canadian Law Reform Commission thought the Digest valuable in its current investigations regarding legislation to protect life (statutory definition of death, euthanasia, behaviour modification, human experimentation, living wills, and human values in life in the context of ethics, medicine, and law).

It was not known whether the Digest is used in academic research. Medicolegal organizations, mainly of the more traditional forensic medicine and forensic psychiatry type, exist in various parts of Canada, but there are no health law or legislation centres. Mention was made of a planned centre or foundation in law and medicine in Calgary for which a suitable director was being sought.

Question 8 concerned the use of information resources and publications other than the Digest: it was indicated that a variety of resources were utilized, but none were comprehensive or entirely satisfactory. The MEDLARS medical library search system was found valuable for collecting some specialized references, if contained in that system. Newspapers and various bulletins were reviewed for clues to innovations and trends in health legislation. Representatives of the Law Reform Commission reported that questionnaires or letters were sent to foreign embassies seeking data on relevant legislation or studies in those countries, but results were generally poor. Representatives of the Health Services and Promotion Branch indicated that information exchange has been established through formal agreements with similar agencies in other countries in areas such as food and drug legislation, medical devices, environmental pollution, etc. Health officials in Canada also attend or send representatives to WHO conferences and other international meetings for the purpose of exchanging experience and viewpoints on health legislative programmes. These meetings are also a means of establishing informal, personal contact with counterparts in similar regulatory and policy-making programmes in other countries.

In answer to the concluding question (Question 9), the attendees at the working conference supported the Digest in its current form, a separate English and a French edition, both of which are highly valuable in bilingual Canada. It was suggested that from time to time the Digest editorial office could bind and distribute collections of comparative surveys, selected laws and regulations, and other materials on special subjects. There is often an excellent market for and a keen interest in such specialized publications, it was observed.

Technical cooperation in health legislation

As indicated earlier, there was strong support for an enlarged WHO programme of technical cooperation in the field of health legislation. It was felt that such a programme could be developed in conjunction with the biomedical information exchange programme of WHO headquarters, Geneva, and also with special health legislation services at PAHO and other regional offices of WHO.

The Canadian interest in providing, as well as seeking, the services of consultants would fit into such a WHO service in a practical manner. It was observed that the best type of international legislative consultants would be persons with wide experience in the drafting and implementing of legislation and with the personal characteristics of flexibility and openmindedness necessary to understand and adapt to different conditions in different countries. The consultants would need to be aware of limitations in resources for law enforcement and in health professional manpower for implementation of the health legislation programmes they might be examining. Canada could be a donor country as well as a receiver of technical assistance, since Canada has many experienced experts in health legislation and is a country where industrial areas and sparsely populated areas must be considered in administering the national health programme.

Legislative developments for WHO's five-year report

The afternoon session of the working conference in Ottawa was devoted to a consideration of the eight points on health law developments for the WHO report on the world health situation.¹

¹ As proposed by the Director of the Division of Health Statistics, WHO, Geneva, 6 April 1978, noted earlier.

Point 1 on the list concerned development of a constitutional or legislative right to health or to health care; it was indicated that no such right of a general nature had been enacted specifically by law in Canada.

One of the legal scholars present, Ms Dillon of the Canadian Law Reform Commission, observed that under purist legal philosophy, a "right" merely granted under governmental legislation or decree, such as a right to health care services, was not considered a basic human right since it could as easily be revoked by the same or a later government for budgetary or political reasons. Such entitlements should be called "privileges" rather than "rights".

There are Canadian laws, however, which use rights language in their titles or statements of purpose. The Canadian Human Rights Act of 1977 speaks of equal opportunity for every individual to make the life he or she wants without discrimination on the basis of race, origin, colour, religion, age, sex, marital status, conviction of a crime which has been pardoned, or physical handicap. The Act also deals with personal privacy.

The latest federal law with a provision concerning human rights is the 1978 law establishing the Canadian Centre for Occupational Health and Safety, mentioned earlier. This Act (Chapter 29, Section 2, 26-27 Elizabeth II) provides as its purpose the promotion of "the fundamental right of Canadians to a healthy and safe working environment".

It should also be noted that the 1974 Working Document on health policy set as one of its primary goals the provision of equal access to health care services for all Canadians. This could amount to a statement of a goal of health care as a right (or privilege) of the people. Currently about 95%-99% of all eligible residents are covered by some health insurance plan in the provinces. By April 1972 all of the provincial governments had joined the federal programme developed under the Medical Care Act of 1966.

Point 2 concerned legislation on the environment such as housing conditions, working establishments, etc. There have been a number of important legislative developments in this area in Canada, including the Environmental Contaminants Act of 1975 and the Canadian Centre for Occupational Health and Safety Act of 1978, both referred to earlier. Also mentioned at the conference was progress in the housing field through the Central Mortgage and Housing Corporation to provide adequate sewerage and water-supply systems in municipalities.

Point 3 concerned legislation relating to the health status of the population and control of diseases. It was pointed out that in Canada this area is primarily the responsibility of the provinces, not the Federal Government. At the federal level, however, the past five-year period has seen the enactment of important new legislation concerning quarantine, as noted earlier.

Point 4, which concerned preventive medical programmes, was also described as fundamentally a provincial concern. Nevertheless, the Federal Working Paper described earlier is more concerned with preventive measures than with curative medicine. The carrying out of this health policy will be a cooperative federal-provincial effort, however.

Point 5 dealt with legislative developments in curative medicine, including health care manpower controls and licensing. It was pointed out that several of the provinces, such as Ontario and Quebec, have enacted comprehensive new licensing laws in the health professional fields. There has been some retrenchment of federal support for health services, as pointed out earlier. However, the Canadian programmes in this field remain quite strong with a comprehensive system of health insurance, rehabilitation, and family and child welfare covering nearly all the population.

Point 6 concerned health legislation dealing with special population groups. No large new programme was mentioned, but there have been developments of medicolegal interest. British Columbia enacted in 1978 a new compulsory treatment programme for heroin addicts. In Ontario, legislation has been proposed to authorize the removal of pituitary glands at autopsy when needed for transplantation, except when the deceased has, during his or her life, expressed an objection.

Point 7 was on the subject of legislative developments in health insurance. The most significant federal acts in this area during the five-year period were mentioned earlier: the Federal-Provincial Financing Act of 1977 and the Medical Care (Amendment) Act of 1976. The Canadian health insurance system is very comprehensive, covering 95%-99% of the population.

Point 8 was a general category including recodifications of health law or other changes in substance or procedure in health legislation. The discussion on this point was far-ranging, as expected. It was indicated that there has been a trend on the federal level and in a number of provinces toward a more effective blending of the health services and the social or welfare services available to the people. There was also a greater tendency to allow the provinces discretion and flexibility in carrying out federally supported health and welfare programmes. The new Mental Health Act of Ontario was also mentioned, along with the new Mental Health Act in Alberta as establishing a new trend toward human rights procedural protection for alleged mentally ill people. It was said, however, that many psychiatrists are unhappy with the new law in Ontario, which makes it difficult or impossible to obtain hospitalization for some non-dangerous but severely ill mental patients.

PART 4

BRIEF NOTES ON OTHER COUNTRIES

The earlier pages reported upon the visits to countries in the WHO Region of the Americas. The consultant also utilized the responses to the WHO questionnaire received from many other countries in the Region. The responses available were those summarized in the Geneva report of 31 August 1978. There were 21 replies from the same number of countries, virtually all from the national health ministries of those countries.¹ The report on the Canadian visit herein constitutes a response to the questionnaire from that country, thus making 22 country responses in total at this time.

It had been hoped that a visit could be arranged to one of the English-speaking countries of the Caribbean, but this did not prove possible. Some questionnaire responses were received from that part of the Region, however.

Among the non-responding nations were the Bahamas, Barbados, Cuba, Jamaica, Mexico, Trinidad and Tobago and the United States of America. The absence of such responses makes commentary on the Caribbean and on the North American continent except for Canada rather incomplete. Some comments can be made concerning the United States of America, however. Informal contact was made by the consultant with lawyers at the Office of the General Counsel, Federal Department of Health, Education, and Welfare, United States of America. It was indicated that the Digest is seldom consulted by legal draftsmen or researchers in that Office. It was felt, however, that the comparative surveys of health legislation contained in the Digest had been valuable to that Office and other federal agencies. The surveys on health professional licensing, abortion, and mental health were cited as particularly helpful. It was believed that the Digest is used frequently by the Department of Health, Education, and Welfare's Office of International Health, which has its own subscription.

WHO records list 347 subscriptions to the Digest from the United States of America, the largest number for any single country. The list includes a number of federal agencies, medical and public health libraries, and health-related industries in all 50 states of the United States of America. Nearly all are paid subscriptions.

The size and complexity of the health care system in the United States defy simplistic commentary. It would be virtually impossible to describe the United States of America health scene in a few paragraphs. There are multiple and fragmented programmes with a large private

¹ The responses were received from Anguilla, Antigua, Argentina, British Virgin Islands, Bolivia, Brazil, Caymans, Chile, Colombia, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Panama, St Vincent, and Turks and Caicos Islands.

sector, making legislation and regulation particularly important and necessary. The environmental hazards are very serious in a highly industrialized society.¹ There is a great deal of interest in health law in the United States of America. The subject, with a number of fields of subspecialization,² is a part of the regular curriculum in many law schools, medical schools, and public health schools.

The number of subscriptions to the Digest from the United States of America is evidence of strong support for the periodical in that country. It seems likely that these subscribers would favour continued publication of texts and authoritative summaries of legislation and regulations. Court decisions are very influential in developing as well as in interpreting health law in the United States of America. Some United States subscribers would therefore probably support a commentary section in the Digest which noted important court cases in this field around the world, especially in areas of human rights. The recent United States of America and Federal Republic of Germany decisions on the constitutionality of abortion statutes would be examples. Also, coverage of international court cases would be valuable additions to a commentary section.

There would be interest, we are sure, in the development of collaborating centres in health legislation. In the Federal Government, the Fogarty International Center at the National Institutes of Health would be a natural liaison, though the Center is not a legal unit. There are a number of important university resources with an international capacity in the health law field including those at Columbia University in New York (the Legislative Drafting Research Fund, which is quite active and experienced in health legislation); the University of California (the UCLA School of Public Health in its collaboration with the Institute of Social Medicine, University of Copenhagen, Denmark, mentioned in the report on the European Region); Case-Western Reserve University in Cleveland, Ohio (the Law-Medicine Centre); Harvard University in Cambridge, Massachusetts (advanced health law training; international law library resources); Tufts University in Medford, Massachusetts (population studies and law at the Fletcher School of Law and Diplomacy); and Georgetown University in Washington, DC (notably in bioethics at the Kennedy Institute). Universities with a particular interest in Latin America include Tulane University in New Orleans, Louisiana; Harvard University; the University of Miami, Florida; Columbia University; and the University of Texas at Austin.

¹ I am indebted to Mrs Ruth Roemer, one of the other consultants in this project, for her suggestions on this discussion of the health programmes of the United States of America.

² Curran, W. J., Titles in the medicolegal field: a proposal for reform, American Journal of Law and Medicine, 1975, 1, 1-11.

PERSONS INTERVIEWED IN THE REGION OF THE AMERICAS

Pan American Health Organization
(WHO Regional Office for the Americas)
Washington, DC

Dr Héctor R. ACUÑA, Regional Director

Mr Miguel A. SEGOVIA, Regional Adviser, Administration of Health Services, Division of Health Services

Dr Enrique FEFER, Regional Adviser, Drug Control, Division of Disease Control

Dr Jorge CASTELLANOS, Regional Adviser, Health Care and Medical Administration, Division of Health Services

Dr Rene GONZALES, Regional Adviser, Mental Health, Division of Family Health

Eng. Guillermo DAVILA, Consultant, PAHO/WHO, Sanitary Engineering, Division of Environmental Health

Brazil

Dr Federico BRESANI, Area Representative, PAHO/WHO, Brasília

Dr Humberto TORLONI, National Secretary for Special Programmes, Ministry of Health, Brasília

Dr Hélio PEREIRA DIAS, Legal Consultant, Ministry of Health, Brasília

Dr Roderico FRANCO, National Secretary of Basic Actions, Ministry of Health, Brasília

Dr Guilardo MARTINS ALVES, Vice President, Oswaldo Cruz Foundation, Rio de Janeiro

Dr Carlos André SALLES, Oswaldo Cruz Foundation, Rio de Janeiro

Dr Aldo VILLAS BOAS, President, SESP Foundation (Public Health Service Foundation), Rio de Janeiro

Eng. Pedro MONTERIO GONDRIN, SESP Foundation, Rio de Janeiro

Eng. Carlos Leopoldo PHILIPOVSKY, SESP Foundation, Rio de Janeiro

Dr Luis Fernando FERREIRA, Director, National School of Public Health, Oswaldo Cruz Foundation, Rio de Janeiro

Professor Elsa RAMOS PAIM, Health services administration, National School of Public Health, Rio de Janeiro

Professor S. E. CYNAMON, Sanitary engineering, National School of Public Health, Rio de Janeiro

Annex A

Colombia

Dr Mateo BUDINICH, Country Representative, PAHO/WHO, Bogotá

Dr Carlos A. LOPEZ ORE, Consultant, PAHO/WHO, Bogotá

Dr Gustavo COMBATT LACHARME, Head of the Legal Office, Ministry of Health, Bogotá

Dr Ricardo GALAN MORERA, Director of Investigations, Ministry of Health, Bogotá

Dr Luis Fernando DUQUE, Vice-Minister of Health, Ministry of Health, Bogotá

Dr Jesús María ROJAS GIRALDO, Colombian Institute of Family Health, Bogotá

Dr Carlos AGUALIMPIA, Legal Division, Medical Institute of Social Security, Bogotá

Canada

Mr R. S. G. THOMPSON, Director for Legal Services, Department of National Health and Welfare

Mr Saul TUNIS, Legal Advisor, Legal Services, Department of National Health and Welfare

Professor Bernard M. DICKENS, Faculty of Law, University of Toronto

Mr Michael CAREAU, Intergovernmental and International Affairs Branch, Department of National Health and Welfare

Dr B. CASSELMAN, Intergovernmental and International Affairs Branch, Department of National Health and Welfare

Attending Working Conference

Mr Edward W. KEYSERLINGK, Canadian Law Reform Commission

Miss Janice DILLON, Canadian Law Reform Commission

Dr Ross CHAPMAN, former Director-General, International Health Services, Department of National Health and Welfare (RET)

Mr J. W. MCCARTHY, Consultant, Department of Justice

Dr Donald SMITH, Intergovernmental and International Affairs Branch, Department of National Health and Welfare

Dr David STEWART, Health Services and Promotion Branch, Department of National Health and Welfare

Mr G. E. MacDONALD, Environmental Health Directorate, Department of National Health and Welfare

Dr W. H. FROST, Medical Services Branch, Department of National Health and Welfare

Dr R. H. LENNOX, Consultant, Maternal and Child Health, Department of National Health and Welfare

Annex A

Dr Norman STEPHENSON, Health Protection Branch, Department of National Health and Welfare

Dr Donald MacLEOD, Health Services and Promotion Branch, Department of National Health and Welfare

Mr Scott SERSON, Social Services and Promotion Branch, Department of National Health and Welfare

Mr J. MacDONALD, Canadian Human Rights Commission

Mr Maurice GOULET, Legal Services, Central Mortgage and Housing Corporation

Mr Bernard STARKMAN, Policy and Planning Programme Development, Department of Justice

Dr Stanley ACRES, Bureau of Epidemiology, Department of National Health and Welfare

Mr E. G. EWASCHUK, Criminal Law Amendments, Department of Justice

Mr Stanley COHEN, Criminal Law Amendments, Department of Justice

United States of America

Mrs Ruth ROEMER, Lecturer in Health Law, School of Public Health, University of California at Los Angeles; Consultant, WHO

Ms Elizabeth DUNST, Office of the General Counsel, Department of Health, Education, and Welfare, Washington, DC

Mr Sidney EDELMAN, Office of the General Counsel, Department of Health, Education, and Welfare, Washington, DC

PROGRAMA DE DIREITO CURSO DE SAÚDE PÚBLICA

Dr Hélio Pereira Dias
Brasília, Brazil

1. Direito Sanitário. Sua institucionalização como ramo independente do Direito Administrativo. Conexão e relação com os demais ramos do Direito
2. Direito Público e Direito Privado. Implicações na Administração Pública. Diferença essencial entre ambos
3. Hierarquia das normas jurídicas. Leis. Decretos e Regulamentos. Regimentos. Portarias. Resoluções. Circulares
4. Competência da União, dos Estados e dos Municípios. Delegação de competência
5. Conceito de polícia sanitária. Finalidade e abrangência. Controle e fiscalização. Normatividade e execução
6. Atos administrativos. Incidência. Atos vinculados e atos regradados. Poder discricionário e poder de arbitrio. Poder disciplinar. Finalidade do ato administrativo
7. Acordos, convênios e outros contratos. Competência para a lavratura
8. Hierarquia funcional. Relações entre dirigentes e subordinados. Relações entre as autoridades do Ministério da Saúde e com as de outros órgãos públicos do Governo Federal e de outras pessoas de direito público interno
9. Processo administrativo. Regras elementares de organização e instrução
10. Autoridades e agentes sanitários. Competência e atribuições. Limitações
11. Legislação sanitária. Preceitos de ordem pública. Incidência e prevalência. Como se aplica
12. Infrações sanitárias. Decreto-lei No. 785 de 25 de agosto de 1969. Aplicação e processo

= = =