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SECTION27 submission

State Liability Amendment Bill 16 of 2018

19 October 2018

1. SECTION27 is a public interest law centre that uses and develops the law to advance human rights. The organisation conducts research, advocacy and litigation to challenge the socio-economic conditions that undermine the exercise of fundamental rights. One of our areas of work is the right to access to quality health care services.

2. We are aware that, in recent years, there has been a surge in both the number of medical negligence claims, and the quantum of these claims for damages for future medical expenses.[1] We are also aware that there are several competing demands on provincial health budgets, and that the significant increase in both the number of medical negligence claims and the quantum of these claims only adds to these demands. We note that these observations have no bearing on the merits of medical negligence claims, nor should they have any impact on the content and meaning of the right of access to quality health care services.

[1] In the Eastern Cape, medico-legal claims increased by 2228% from R716 million in 2010/11 to R16.6 billion in 2016/17; in the Free State, claims increased by 3642% from R40 million in 2010/11 to R1.5 billion in 2016/17; and in Gauteng, claims increased by 2699% from R665 million to R18.6 billion in 2016/17. As at 31 March 2017, medico-legal claims amounted to R51.2 billion nationally. This contingent liability accounts for almost one third of the health budget in the provinces. The total amount spent on legal services in medico-legal claims was reported to be R994 million.

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3. We understand that the purpose of the State Liability Amendment Bill is to reduce the impact of lump sum payments on provincial health budgets, allowing provincial health departments to better manage the competing demands on their resources. According to the memorandum, reducing the impact of lump sum payments for medical negligence will allow the State to channel the savings towards improving health care services for all, thereby reducing the overall incidence of medical negligence.

4. We are of the view, however, that the proposed amendment to the State Liability Act is not the appropriate solution to reducing the burden of medical negligence claims and we accordingly do not support the promulgation of the State Liability Amendment Bill.

5. We lay out below some of our concerns with the approach taken to this matter, before reflecting briefly on specific concerns with the Bill itself.

Health system weaknesses

6. We should note from the outset that we view the rise in medical negligence claims largely as symptomatic of the general decline in the health system. Severe human resource constraints which have led to increased workload, failure to maintain equipment, medicine stock outs and poor planning, budgeting and record keeping all contribute to the grim state of health care and directly to the increase in medical negligence claims in South Africa.[2] We see the impact of the collapsing health care system on users of that system in our daily work. As such it is our view that unless these issues are addressed first, the proposed amendments will not achieve their intended goals.

[2] Oosthuizen WT & Carstens PA Medical malpractice: The extent, consequences and causes of the problem 2015 (78) *THRHR* 269.

7. This state of affairs cannot be fixed by changing the legal framework in which medical negligence claims are adjudicated. Rather, the solution lies in strengthening health systems by investing in more trained health care workers, ensuring that health care workers are appropriately equipped and keeping proper records. In that way, all health care users will have access to quality health care services and the incidence of medical negligence claims will reduce.

Interim solutions

8. Of great concern is that the memorandum to the Bill states that the Bill is promoted in the interim, pending the outcome of a larger investigation into medico-legal claims by the South African Law Reform Commission (an investigation that has been ongoing for many years).[3] We can only assume from the statement that the Bill is "promoted", that the intention is to apply the provisions of the Bill as a temporary measure, pending a broader overhaul of medico-legal claims. However, no information as to what this overhaul will entail, or when it will occur, is available.

9. The Bill envisages significant changes to the medico-legal system and to the rights of claimants. Further, the implementation of the proposed changes will require significant resources to ensure that provincial hospitals are capacitated to administer periodic payments. As such, we are of the view that the adoption of such changes on an interim basis is impractical.

10. This is not to say that, pending a final decision on changes to the medico-legal system, no action should be taken to manage the competing demands on provincial health budgets, in a manner that promotes the right of access to quality health care services.

[3] South African Law Reform Commission Issue paper 33 Project 141 Medico-Legal Claims 20 May 2017.

11. Different provinces around the country have developed different approaches to medico-legal claims. Those used in the Eastern Cape and the Western Cape are described in papers submitted to the Constitutional Court in *MEC for Health and Social Development, Gauteng v DZ obo WZ.*[4]

12. In the Western Cape, for example, damages for future medical expenses are paid, in lump sum, into a ring-fenced trust account that is administered by suitably qualified persons who ensure that the funds are used only to meet future medical expenses. The trust deed also makes provision for adding on to the amount in the trust, or reverting the balance in the trust to the State in the event of death.[5] Such an arrangement is made by agreement between the parties. However, should it be required in the future, the Western Cape noted its intention to request development of the common law to allow such an arrangement absent agreement by the parties. This was not addressed in the Court's judgment, and nor are there, to our knowledge, any reported decisions in which such a development of the common law has been discussed.

13. Whilst adopting such an approach would not immediately alleviate the pressure that lump sum payments impose on health budgets, it would ensure that damages paid in respect of future medical expenses are used appropriately. In other words, this approach ensures that a successful claimant has access to quality health care services as required and that the funds in the trust account are applied only for that purpose and to the extent that the services are actually received. Any funds that remain in the trust account following the death of the injured party can be reverted to the State.

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[4] *Member of the Executive Council for Health and Social Development, Gauteng v DZ obo WZ* [2017] ZACC 37; 2017 (12) BCLR 1528 (CC); 2018 (1) SA 335 (CC).

[5] See the Founding Affidavit of the Western Cape Department of Health intervening as amicus curiae in this case: https://collections.concourt.org.za/bitstream/handle/20.500.12144/3892/05Founding%20Affidavit%20Application%20for%20Admission%20as%20Amicus%20Curiae%20MEC%20for%20Health%20Western%20%20anonymised.pdf?sequence=55&isAllowed=y

14. Moreover, this allows for a claimant to access the required health care services within the bounds of the once and for all rule, which permits only one claim for damages arising from the same cause of action.

Alternative dispute resolution

15. We are also aware that the Minister of Health appointed a Ministerial Task Team to consider mediation as a form of alternative dispute resolution for medico-legal claims and understand that mediation is already used in this way in some claims against the State.

16. In addition to allowing the parties to come to an agreement regarding the satisfaction of the settled damages i.e. how, when and to whom the damages would be paid, alternative dispute resolution can be far more efficient in terms of both time and resources. It can also mitigate any hostility or loss of trust caused by an adversarial court process.

17. We would therefore favour the use of alternative dispute resolution, including mediation, where this is an appropriate mechanism for the resolution of a claim.

Artificial separation of public and private health sectors

18. The private sector is far from immune from the burden of high medico-legal bills. In the private sector, particularly in practice areas such as obstetrics, the cost of professional liability insurance is rising rapidly to meet the increasing need to cover the contingency of claims for medical negligence.

19. While this fact does not currently affect the State budget directly, it does lead to the loss of doctors from practice and the further concentration of some practice

areas. It also results in the higher cost of professional liability insurance being passed on to health care users, making private health care less affordable and restricting the right of access to quality health care services.

20. Under the proposed NHI, services procured from private health facilities would be paid for by the fund. The cost of professional liability insurance will also need to be a consideration in determining payment by the NHI Fund to private providers under NHI as it is a significant cost of practice in the private sector. Failure to do so, may result in health care providers in the private sector refusing to provide care to users who do not have medical aid.

21. We are therefore of the view that an approach that singles out claims in the public sector, in the absence of consideration of the private sector, creates an artificial separation between the two which should be avoided.

22. If the State is to deal with medico-legal claims, it should do so with a longer term view, taking account of the health, legal and insurance systems as a whole.

Specific concerns with the Bill

23. In the light of the above, we do not support promulgation of the State Liability Amendment Bill and do not, therefore, provide detailed comment on our specific concerns with the Bill itself. We do however, briefly outline some concerns which would, in our view, be relevant to all legislative interventions to manage the payment of future medical expenses awarded as a result of medical negligence.

    a. Terminology used - The preamble of the Bill states that its purpose is to amend the State Liability Act, 1957 so as to provide for structured settlements for the satisfaction of claims against the State as a result of "wrongful medical treatment" of persons by servants of the State; and to provide for matters connected with. The term "wrongful medical treatment"

is not used elsewhere in the law, and so its meaning is unclear, particularly in the light of the meaning ascribed to the term "wrongfulness" in the law of delict. We submit that to avoid confusion, the terminology of "medical negligence" should be consistently adhered to.

b. Minimum threshold amount (clause 2A) - The minimum threshold amount for which a court may order structured settlement is R1 million. Fixing the threshold in the legislation itself would have the effect of making the Act inflexible and non-responsive to the changing cost of living. A solution could be for the minimum threshold amount to either be determined by the Minister in regulations (which allows for fairly easy amendment) or be left to the discretion of the judge.

c. Heads of damages affected (clause 2A(1)) - The Bill proposes that claims for past expenses and damages, and for necessary immediate expenses would also be subject to an order for a structured settlement. In our view, these heads of damages do not fall within the ambit of the difficulties that the amendment seeks to address which relate to long term care and treatment for permanent incapacities. The proposed solution should therefore apply only to future medical expenses and the principles and mechanisms applicable to those expenses must remain unchanged.

d. Basis of calculation and payment of private providers (clause 2A(2)) - Given the change in approach to medico-legal claims laid out in the Bill, it is unclear whether the amounts to be paid in periodic payments under this section would be calculated on the basis of the cost of care in the public or in the private sector. We understand that courts may order the provision of treatment in the public sector, but that where the relevant public sector facilities do not meet the norms and standards set by the Office for Health Standards Compliance, a claimant may obtain services from a private facility, and the amount payable will be limited to the cost of those services in the public sector. This will likely have the effect of restricting or preventing access to health care services. This is because there is no reason to expect that the private facility would charge rates in line with public sector rates and the injured party may not be able to pay the difference. This is an unjust

limitation of the liability of the State that limits access to health care services that become necessary as a result of the State's negligence and in circumstances in which its own facilities do not comply with minimum norms and standards. A distinction should be made between circumstances where appropriate treatment is available at a public health facility but one chooses to attend a private facility,[6] and those circumstances where treatment of the required standard is not available at a public facility and an injured party has no option but to seek care in a private facility.

e. Provision of services in the public sector – While the concern about the quality of care to be provided to an injured party in the public sector may be met by the requirement for OHSC accreditation of the facility, the most recent OHSC reporting indicates the tiny proportion of facilities that would meet the criteria for OHSC accreditation currently (0,7% of facilities inspected in the 2016/17 financial year).[7] There is a high likelihood, therefore, that an injured claimant may find themselves without an OHSC compliant facility in close proximity. Of course, the importance of compliance with the OHSC's norms and standards extends beyond liability for medical negligence claims. An improvement in compliance with these norms and standards would have a positive effect in reducing the incidence of medical negligence.

f. Limiting the right to be attended to by a health care provider of choice – Clause 2A(2) of the Amendment Bill appears to set the public health care sector as the default for continued care, resorting to private health care facilities only where OHSC accreditation criteria are not met. Restricting the type of health establishment from which an injured party may receive care

[6] The Court in *Ngubane* had had to decide the question whether a defendant could lead evidence to the effect that medical services sought by the appellant can be provided at state or provincial hospitals, either at no fee or at a lesser fee. The SCA's finding were affirmed by the Constitutional Court in *MEC for Health and Social Development v DZ obo WZ*, which held that "Ngubane is authority for allowing a defendant to produce evidence that medical services of the same or higher standard, at no or lesser cost than private medical care, will be available to a plaintiff in future. If that evidence is of a sufficiently cogent nature to disturb the presumption that private future healthcare is reasonable, the plaintiff will not succeed in the claim for the higher future medical expenses" (*MEC for Health v DZ obo WZ* at paras 19 – 21).

[7] Office of Health Standards Compliance Annual Inspection Report 2016/2017 http://ohsc.org.za/wp-content/uploads/OHSC-2016-17-ANNUAL-INSPECTION-REPORT-FINAL.pdf

has the effect of limiting their right to be attended to by a health care provider of their choice.[8] In *Ngubane v South African Transport Services*, the appellant claimed future medical expenses on the basis that he would receive treatment in a private facility.[9] The defendant argued that since the treatment could be provided in State facilities at no charge or at a nominal fee, it was reasonable to expect the appellant to make use of State facilities. The defendant therefore argued that it should not be ordered to pay damages for future medical costs delivered at a private facility. The court affirmed an injured party's right to exercise the freedom to elect their choice of health services providers.[10] The court also held that it is not unreasonable for a party who suffered injuries to seek medical attention in a well-run and properly equipped private hospital.[11] This reasoning cannot be divorced from the fact that only 0.7% of public health care facilities meet the OHSC's accreditation criteria. As such, the Bill may well be subject to challenge on this basis, as may a court order under section 2A(2)(b).

g. Inflationary increases in periodic payments (Clause 2A(3)) - While there is provision in the Bill for an increase in the periodic payments in line with the Consumer Price Index (CPI), medical price inflation tends to exceed CPI.[12] The medical inflation index indicates the rate at which medical prices (medical products and medical services) increase annually. A CPI-linked increase in payments will thus be insufficient to meet the ongoing costs of medical services required by an injured party. Instead, the increase to periodic

[8] Clause 2.5 of the Patient's Charter states that everyone has the right to choose a particular health care provider for services or a particular health facility for treatment, provided that such choice shall not be contrary to the ethical standards applicable to such health care provider or facility.
[9] *Ngubane v South African Transport Services* [1990] ZASCA 148; 1991 (1) SA 756 (A).
[10] Id at para 61 -62.
[11] Id at para 63.
[12] According to research conducted by Alexander Forbes, over the past 18 years, the CPI inflation has averaged 5.8%, while medical inflation has averaged 7.6%, resulting in an average gap of 1.8% a year. www.iol.co.za/personal-finance/healthcare-industry-and-consumers-battle-rocketing-medical-costs-12386402. The Consumer Price Index Report for August 2018 indicated that the medical services index was 1.7%.

payments should be based on the medical care price index in order to ensure continued access to quality health care services.

h. Retrospective application of the State Liability Amendment Bill (clause 4) – The Bill provides that it applies to matters that are already before court but have not been concluded. Such retrospective application is contrary to ordinary principles of statutory interpretation and application and may interfere with the administration of justice. It may lead to delays in the conclusion of matters as parties will have to reformulate (in a material way) the relief that they seek. They may also be required to lead further factual evidence and expert evidence, even if this means reopening the process where evidence has already been concluded. It will also introduce additional considerations that the judge may not previously have considered in determining just and equitable relief.

i. Enforcing judgments against the State – the Amendment Bill does not include any proposed amendments to sections 4 – 12 of the State Liability Act, which make provision for the remedies that are available to a creditor in the event that the State fails to satisfy a debt within the agreed time periods. These provisions are onerous, and operate over extended periods of time. Given that creditors in medico-legal matters would in terms of the Bill be entitled to possibly annual payments by the State, there is a need for different provisions that make it easier for claimants to secure payment timeously. It is quite possible that in some instances, the right of injured parties to access health care services will be impeded by the State's failure to satisfy the debt timeously, particularly if the failure to satisfy the debt is repeated annually. This will lead to a regression in access to health care services, a direct violation of section 27 of the Constitution.

Abuse of the medico-legal claim system by lawyers

24. While there is no such reference in the Bill, we note that there has been significant reporting on the abuse of the medico-legal system by lawyers for their own gain. The Western Cape in the *DB obo WZ* case refers in particular to the impact of statutory limitations on claims against the Road Accident Fund process

on the expansion of medico-legal claims.[13] Collusion between the State Attorney and private attorneys for the settlement of claims regardless of merit has also been reported.[14] Accordingly, tailoring efforts to curb and eliminate corruption would likely reduce the strain on the system that the government is attempting to lessen through this Amendment.

25. These are matters of real concern and we support full investigation and development of measures to prevent such abuse and to punish it, where it occurs.

Conclusion

26. While we recognise the urgency felt by the State regarding the need to respond to escalating medico-legal claims, we are of the view that the State Liability Amendment Bill is not the answer. We urge the Department of Health and the Department of Justice to consider alternative interim measures to deal with escalating medico-legal claims and ultimately to develop a process for such claims that meets the concerns that it expresses while protecting the rights of injured parties.

27. We thank you for your consideration and trust that our submissions will be well received. Should you require any further information, please contact Tendai Mafuma at Mafuma@section27.org.za.

[13] https://collections.concourt.org.za/bitstream/handle/20.500.12144/3892/05Founding%20Affidavit%20Application%20for%20Admission%20as%20Amicus%20Curiae%20MEC%20for%20Health%20Western%20%20anonymised.pdf?sequence=55&isAllowed=y at para 18.

[14] https://www.medicalbrief.co.za/archives/medical-malpractice-cartel-cost-sa-least-r60bn-motsoaledi/