



DISCUSSION PAPER 154
PROJECT 141
MEDICO-LEGAL CLAIMS

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SOUTH AFRICAN LAW REFORM COMMISSION

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Request for comments

The SALRC was established by section 2 of the SALRC Act. According to section 4 of the SALRC Act, the main object of the SALRC is to do research with reference to all branches of the law of South Africa and to study and investigate all such branches of the law in order to make recommendations for the development, improvement, modernisation or reform thereof.

Project 141: Medico-Legal Claims was included in the SALRC's research programme pursuant to requests from the Department of Health and the Minister of Justice and Correctional Services to the SALRC to conduct an investigation into medico-legal claims, especially claims against the state. Issue Paper 33, the first document that was published during the course of this investigation, was published on 17 July 2017 for general information and public comment.

This discussion paper was prepared to elicit responses on the **preliminary findings and proposals** put forward in the paper. It will serve as a basis for the SALRC's further deliberations in the development of a report with proposed draft legislation; therefore the opinions, conclusions and proposals in this paper should not be regarded as the SALRC's final views. Respondents are not restricted to the issues covered in this paper and are welcome to draw other relevant matters to the SALRC's attention.

No legislation currently exists in South Africa to specifically address legal claims in the medical field, which means that claims based on medical negligence are dealt with under the common law. The escalation in medical negligence litigation against the State, and in particular the increase in the size of the damages sought and awarded, has become a major cause for concern. There is an urgent need to undertake reform of the law to regulate a system that will become paralysed if no action is taken. It is crucial to cut down on litigation that consumes time and money.

Respondents are requested to submit written comments and representations to the SALRC by **31 January 2022**. Comments and representations sent electronically should be submitted in PDF or MS Word format, **NOT** as scanned copies of printed documents (apart from a signed covering letter). Address correspondence to the Secretary of the SALRC, **for the attention of Ms Ronel van Zyl, the researcher assigned to this project and the drafter of this paper** (with the exception of Chapter 8 and the first draft of Chapter 10). Contact details appear on the previous page.

The SALRC assumes that respondents agree that the SALRC may quote from or refer to their comments, and may attribute comments to the respondent concerned, unless marked as confidential. Respondents should be aware that the Commission may be required to release information contained in their submissions under the Promotion of Access to Information Act 2 of 2000.

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ABBREVIATIONS AND ACRONYMS

	Acronym	Explanation
1.	ADR	alternative dispute resolution
2.	ARVs	antiretrovirals
3.	ASSA	Actuarial Society of South Africa
4.	BAS	Basic Accounting System
5.	CC	Constitutional Court
6.	CCU	critical care unit
7.	CEO	chief executive officer
8.	CFA	Contingency Fees Act 66 of 1997
9.	CHC	community health centre
10.	CHAI	Clinton Health Access Initiative
11.	CHW	community health worker
12.	CLA	Civil Liability Act 2000 (Australia)
13.	CMPA	Canadian Medical Protective Association
14.	CP	cerebral palsy
15.	CPA	Consumer Protection Act 68 of 2008
16.	CPI	Consumer Price Index
17.	CTG	cardiotocography
18.	DG	Director-General
19.	DHIS	District Health Information System
20.	DOH	Department of Health
21.	DOJ&CD	Department of Justice and Constitutional Development
22.	DPME	Department of Planning, Monitoring and Evaluation
23.	DPW	Department of Public Works
24.	EC	Eastern Cape
25.	EMS	emergency medical services
26.	FS	Free State
27.	GCB	General Council of the Bar
28.	GDP	gross domestic product
29.	GHS	General Household Survey
30.	GMG	Gynaecology Management Group
31.	GP	Gauteng Province
32.	HE/HEs	health establishment / health establishments
33.	HIV	human immunodeficiency virus
34.	HMI	Health Market Inquiry
35.	HOD	head of department
36.	HPCSA	Health Professions Council of South Africa

	Acronym	Explanation
37.	HR	human resource / human resources
38.	IC	ideal clinic
39.	ICU	intensive care unit
40.	IHRM	ideal hospital realisation and maintenance
41.	ILPACOS	Institution of Legal Proceedings against Certain Organs of State Act 40 of 2002
42.	IP 33	Issue Paper 33 on Project 141: Medico-Legal Claims
43.	IST	Integrated Support Team
44.	IT	information technology
45.	KZN	KwaZulu-Natal
46.	LRCHK	Law Reform Commission of Hong Kong
47.	LRCI	Law Reform Commission, Ireland
48.	J&CS	Justice and Correctional Services
49.	MAC	Ministerial Advisory Committee
50.	M&E	monitoring and evaluation
51.	MEC	Member of the Executive Council
52.	M&M	morbidity and mortality
53.	MPS	Medical Protection Society
54.	MRI	magnetic resonance imaging
55.	MTEF	Medium Term Expenditure Framework
56.	MTSF	Medium Term Strategic Framework
57.	MTT	Ministerial Task Team
58.	NCS	National Core Standards
59.	NDOH	national Department of Health
60.	NDP	National Development Plan 2030
61.	NFC	no-fault compensation
62.	NHA	National Health Act 61 of 2003
63.	NHC	National Health Council
64.	NHI	National Health Insurance
65.	NHS	National Health Service
66.	NICA	Birth-Related Neurological Injury Compensation Association
67.	NPC	National Planning Commission
68.	NSDA	Negotiated Service Delivery Agreement
69.	NSLR	National Litigation Strategy Report
70.	NW	North West
71.	OHSC	Office of Health Standards Compliance
72.	OTASA	Occupational Therapy Association of South Africa
73.	PAIA	Promotion of Access to Information Act 2 of 2000
74.	PAP CD	Pre-Action Protocol for the Resolution of Clinical Disputes
75.	PERSAL	Personnel and Salary System

	Acronym	Explanation
76.	PFMA	Public Finance Management Act 1 of 1999
77.	PHC	primary health care
78.	PHS	Presidential Health Summit 2018
79.	POPIA	Protection of Personal Information Act 4 of 2013
80.	PPSA	Public Protector South Africa
81.	PSI	patient safety incident
82.	QIP	Quality Improvement Plan
83.	RAF	Road Accident Fund
84.	RCOG	Royal College of Obstetricians and Gynaecologists
85.	RWOPS	remunerative work outside the public service
86.	SA	South Africa / South African
87.	SAHA	South African Hospital Association
88.	SAHRC	South African Human Rights Commission
89.	SALRC	South African Law Reform Commission
90.	SAMA	South African Medical Association
91.	SAMLA	South African Medico-Legal Association
92.	SANC	South African Nursing Council
93.	SAOA	South African Orthopaedic Association
94.	SAPPF	South African Private Practitioners Forum
95.	SASA	South African Society of Anaesthesiologists
96.	SASOG	South African Society of Obstetricians and Gynaecologists
97.	SASS	South African Spine Society
98.	SASSA	South African Social Security Agency
99.	SCA	Supreme Court of Appeal
100.	SIU	Special Investigating Unit
101.	SLA	State Liability Act 20 of 1957
102.	SOP	Standard Operating Procedure
103.	TAC	Treatment Action Campaign
104.	TB	tuberculosis
105.	UK	United Kingdom
106.	USA	United States of America
107.	WC	Western Cape
108.	WHO	World Health Organization
109.	ZACC	Constitutional Court of South Africa
110.	ZASCA	Supreme Court of Appeal of South Africa

EXECUTIVE SUMMARY

Introduction

1 South Africa has changed dramatically over the past 30 years with its transition to a constitutional democracy, the introduction of a strong culture of human rights, protection of the freedoms of the individual by means of a progressive Bill of Rights and the establishment of the Constitutional Court as the apex court to protect and enforce these rights. Among the people of South Africa there is also an increased awareness of their rights. In a constitutional democracy such as ours this is a positive development. However, one of the consequences of this increased awareness seems to be an upsurge in litigation to protect a perceived breach of individual rights.

2 This trend is also apparent in the huge escalation in delictual claims based on medical negligence over the past 12 years or so, in both the public as well as the private health sectors. Apart from the increase in the numbers of claims instituted, the exponential rise in the compensation claimed and awarded is a major cause for concern. No legislation currently exists in South Africa to specifically address legal claims in the medical field, which means that claims based on medical negligence are dealt with under the common law.

3 The national Department of Health (NDOH) and the Minister of Justice and Correctional Services requested the SALRC to include an investigation into medico-legal claims in the SALRC research programme. This request flowed from the challenges faced by the public health sector due to the escalation in claims for damages based on medical negligence, the increasing financial implications for the fiscus, and medical negligence case law.

4 The NDOH held a medico-legal summit on 9 and 10 March 2015 in Centurion to deliberate the growing crisis with regard to medico-legal claims in South Africa. A Medical Malpractice Workshop in the form of interactive panel discussions was held in Johannesburg on 3 March 2017 to discuss matters pertaining medico-legal litigation. Both events were attended by representatives from the medical and legal fraternities,

officials from national and provincial state departments, actuarial scientists, academics, mediators, and the insurance industry.

5 The last significant event was the Presidential Health Summit held in Boksburg on 19 and 20 October 2018. Nine commissions were set up to enable participants to deliberate on the massive challenges the health system is facing and to suggest interventions to improve the quality of health care. Each commission made recommendations on short-term, medium-term and long-term solutions to address the challenges facing the health care system. The proposed solutions were not considered as binding resolutions, but served as inputs to the Presidential Health Summit 2018 Compact and action plan that were developed after the summit.

6 A number of documents and reports pertaining to the public health sector – developed by or at the behest of the President, Auditor-General, Public Protector, SA Human Rights Council, Minister of Health, Office of Health Standards Compliance, Department of Health, National Treasury, or funded by the government – were reviewed for this paper, including:

- Reports on the provision and administration of public health services in some of the provinces published by the Public Protector;
- Hearing and investigation reports on public health services or aspects of public health services published by the South African Human Rights Commission;
- Consolidated General PFMA Reports on National and Provincial audit outcomes for the years 2017-18, 2018-19 and 2019-20 published by the Auditor-General;
- Annual inspection reports for the years 2015/16, 2016/17, 2017/18 and 2018/19 published by the Office of Health Standards Compliance;
- Clinton Health Access Initiative *Medico-Legal Claims Analysis for National Treasury* (December 2019);
- *Presidential Health Summit 2018 Compact* (July 2019);
- *Presidential Health Summit 2018 Report* (February 2019);
- South African Lancet National Commission *Confronting the Right to Ethical and Accountable Quality Health Care in South Africa* (December 2018);
- Health Ministerial Task Team *Hospital Mismanagement and Poor Service Delivery Closure Report* (May 2017);
- Declaration following Medico-Legal Summit of March 2015 (March 2016);
- Steve Biko Centre for Bioethics *Discussion Document prepared in Preparation for a Medico-Legal Summit* (September 2013);

- National Litigation Strategy Report (2012);
- Chapter 10 (“Promoting health”) of the National Development Plan (August 2012);
- Reports of the Integrated Support Teams (April and May 2009).

7 In addition to the matters referred to above, Chapter 1 provides a snapshot of the scope of the problem and explains briefly what the investigation is aiming to achieve. Chapter 2 reviews the aspects of the South African legal landscape that pertain to medico-legal claims by reference to current government policies; the elements of delict; the test for medical negligence; the common law, including the “once and for all” rule; vicarious liability; and compensation for damages.

8 Chapter 3 gives an overview of the constitutional provisions pertinent to the field of medico-legal claims and the various statutes applicable to this field of the law. Subordinate legislation, government-issued guidelines and measures and proposed legislation are also touched upon. This is followed by an overview of important case law involving medical negligence claims against the state and the development of the common law in Chapter 4.

9 Chapter 5 provides a synopsis of the submissions received in response to Issue Paper 33 and the views of authors and commentators. The problems identified and concerns raised about the public health sector is of special importance. Relevant highlights of the reports pertaining to the public health system published by the Public Protector and the SA Human Rights Commission, the Auditor-General’s consolidated general PFMA reports on national and provincial audit outcomes for the years 2017-18, 2018-19 and 2019-20, and the annual inspection reports for the years 2015/16, 2016/17, 2017/18 and 2018/19 published by the Office of Health Standards Compliance are also presented in Chapter 5. Chapter 6 offers an overview of the findings made and recommendations put forward in previous government-initiated reports with regard to the public health sector.

10 Chapter 7 considers the legal position in other countries, in particular in relation to compensation systems. Chapter 8 sets out the steps for a strategy to deal with legal action when instituted.

11 Chapter 9 puts proposals forward for dealing with medico-legal claims against the state, while Chapter 10 contains a list of respondents to Issue Paper 33.

12 The proposals put forward by the SALRC in Chapter 9 focus mainly on measures to alleviate the financial burden of medico-legal claims against the state on the fiscus, and to provide for alternative procedures for the speedy resolution of medical negligence claims.

Summary of recommendations

13 The constitutional right of access to courts can never be denied, but taking a matter to court should be avoided as far as possible. A uniquely South African system is proposed, which – having regard to our particular circumstances and history – is a hybrid of specific international examples and an expansion of the development of the common law that has already been initiated by the Constitutional Court.

14 It is proposed that a system be developed that starts at the hospital when a serious adverse event occurs, through prescribed compulsory procedures to attempt early resolution, ending in compensation that provides fair restitution to the aggrieved health care user without bankrupting and eventually crippling the public health system.

Proposed components

15 The proposal is divided into different components, which are:

- 1) Prerequisites
- 2) Improving quality of public health care
- 3) Record keeping
- 4) Patient safety and patient safety incident reporting
- 5) Mediation
- 6) Certificate of merit
- 7) Redress
- 8) Pre-action protocol
- 9) Litigation
- 10) Compensation
- 11) Birth defects and serious permanent injuries
- 12) Other proposals.

Prerequisites

16 There are a number of prerequisites that are critical to the proposals put forward in this paper for dealing with the medico-legal crisis in South Africa. These prerequisites are the following:

- 1) National strategy for dealing with medico-legal claims that must be adhered to in each province.
- 2) Strategy for handling medico-legal claims in the Office of the State Attorney that dovetails with the national medico-legal strategy followed in the provinces.
- 3) Dedicated medico-legal unit in each province made up of suitably experienced medical and legal professionals, with their own administrative support, which should preferably be situated in the office of the provincial head of health.
- 4) Proper system of record keeping supported by a state-owned information technology system. The same system and technology should be used in all provinces and the national department.
- 5) Reporting system supported by the same system and technology to enable data sharing and a centralised data base. The information to be reported and the manner of reporting should be determined at national level and the guidelines should be followed by all provinces.
- 6) Compulsory budgeting for medico-legal litigation (projected legal costs) and compensation payments by provinces in accordance with normal budgeting practices. The assistance of National Treasury should be sought where necessary.
- 7) Dedicated alternative dispute resolution team in each province. For the sake of impartiality, the members of the team cannot be employed by the state, but should be from outside government.
- 8) Introduction of patient safety measures in all provinces. The implementation of these measures could be staggered over a determined period of time, prioritising measures based on the magnitude of the underlying risk and the frequency of particular types of incident.
- 9) Establishment of a dedicated national monitoring body to ensure that applicable legislation, national guidelines and the corrective measures proposed in audit reports, OHSC reports, government-initiated reports and other documents are implemented and applied. This body should not duplicate the current functions of the Office of Health Standards Compliance, but should either be a separate body or a separate unit within the OHSC that monitors compliance on a broader strategic level.

10) A possible alternative is the establishment of a national statutory body comparable to the NHS Resolution Authority in the UK. However, it may be argued that such a body would not be in line with the Constitution and the National Health Act.

17 Apart from the National Health Act 61 of 2003 (NHA), there are regulations on norms and standards and several national guidelines about various matters such as record keeping, a complaints system and patient safety incident reporting. A huge amount of work has been done and several shortcomings and challenges identified by means of various government and government-initiated reports. These include the consolidated general PFMA reports on national and provincial audit outcomes published by the Auditor-General, annual inspection reports published by the Office of Health Standards Compliance, *Presidential Health Summit 2018 Compact*, *Presidential Health Summit 2018 Report*, Clinton Health Access Initiative's *Medico-Legal Claims Analysis for National Treasury*, Lancet National Commission's *Confronting the Right to Ethical and Accountable Quality Health Care in South Africa* and the Health Ministerial Task Team *Hospital Mismanagement and Poor Service Delivery Closure Report*.

18 The Commission, as a law reform body, cannot make recommendations on the delivery of quality health care; which includes the operation and management of health care facilities, service delivery, human resources, health service capacity and related matters. The shortage of medical personnel, constrained budgets, inadequate health infrastructure, shortage of medical equipment, medicines and other supplies and inadequate supervision of junior staff also merit mentioning.

19 As mentioned before, there is a profusion of legislative provisions, regulations and guidelines under the National Health Act, as well as several reports about deficiencies in the public health care system. However, there is a distinct lack of implementation of these instruments. It seems that a number of the provincial departments of health have neither the skills nor the capacity to address the issues highlighted in the audit reports, OHSC reports and government-initiated reports.

20 The Commission therefore propose that –

20.1 national expert teams be established to oversee and assist the provinces to address identified problems and implement the proposed solutions;

- 20.2 proper record keeping systems be introduced and maintained, as proper record keeping is critical both in terms of patient care as well as evidence in legal processes;
- 20.3 record keeping guidelines be developed that address the NHA provisions and related regulations, and which provide for the entire “life-cycle” of a health record: from origin to final disposal, addressing any deficiencies or pitfalls at any point along the way;
- 20.4 specific provision be made for access to health records, over and above the PAIA and POPIA processes;
- 20.5 reporting and learning guidelines be properly applied and implemented, followed by monitoring and evaluation;
- 20.6 current reporting guidelines be reviewed in light of the latest developments in patient safety reporting systems and the WHO *PSI* (2020) to ensure that the reporting system is optimally structured and utilised and allows for sharing of information, while ensuring that information provided by a health worker cannot be discovered for purposes of court proceedings, or from being used in disciplinary proceedings against the person who made the report;
- 20.7 as a compromise between introducing mediation as a completely voluntary option and introducing compulsory mediation, mediation should be voluntary, but it should be compulsory to attempt mediation before instituting court proceedings;
- 20.8 the parties to medico-legal court proceedings will have to justify failure to mediate the matter to the satisfaction of the court;
- 20.9 mediation could be attempted to agree on some of the issues, even if the entire claim cannot be resolved through mediation;
- 20.10 pre-mediation clauses be included in the admission forms of public hospitals, which will assist efforts to raise awareness about the advantages of mediation;
- 20.11 a list of accredited mediators be created in each province;
- 20.12 the state should fund medico-legal mediation when the state is a party , since early expenditure on proper ADR will save a huge amount of money later;
- 20.13 it is crucial that the person representing the state in mediation proceedings must be able to make proposals and take decisions with financial implications or have immediate and direct access to a person with the authority to approve a proposal or take a decision;

- 20.14 to ensure compliance with the solution agreed upon during the mediation process, the final agreement should be a formal, binding contract complying with the law of contracts; alternatively, the court should be approached to approve the mediation agreement formally as a settlement agreement by order of court;
- 20.15 to avoid frivolous, meritless, fraudulent or abandoned claims, a certificate of merit affidavit by an accredited and suitably qualified medical practitioner form part of the papers when action is instituted for damages based on medical negligence;
- 20.16 South Africa adopts an administrative compensation system, based on the Welsh redress system, for smaller medical negligence claims;
- 20.17 once a plaintiff formally accepts an offer for redress under a redress system, the plaintiff cannot pursue a medical negligence claim in court anymore;
- 20.19 a pre-action protocol be introduced that is similar to the *Pre-Action Protocol for the Resolution of Clinical Disputes* of the UK, which will require amendments to civil procedure and court rules and which applies to health care providers in both the public and private sectors;
- 20.20 attempting to resolve a dispute by means of the pre-action protocol would be a prerequisite for instituting formal court proceedings, introducing additional steps to the civil process;
- 20.21 civil process changes be introduced to limit delays and expedite proceedings: ensuring that requirements such as filing a certificate of merit affidavit, seeking redress where appropriate or complying with the pre-action protocol must take place before a case can proceed to a court hearing;
- 20.22 civil procedure be amended to allow a summons to lapse if not timeously acted upon, improve pre-trial procedures and court case flow and management to expedite and simplify the finalisation of claims, for example earlier exchange of information, expert notices, summaries and witness statements; as well as early expert meetings and pre-trial conferences;
- 20.23 elements of the inquisitorial system (similar to existing provisions of the Criminal Procedure Act, 1977) be introduced into civil proceedings to allow parties to agree on certain facts or events before the formal court hearing commences;
- 20.24 in view of the duties of an expert and the obligation to objectivity, the parties to a legal action use joint expert witnesses;
- 20.25 to address concerns about single expert witnesses for specialised technical medical evidence, a panel of three joint expert witnesses from the discipline

concerned be appointed from an official list compiled by the court in cooperation with the relevant medical professional body;

- 20.26 the Superior Courts Act 10 of 2013 and the Uniform Rules of Courts be amended to provide for the appointment of specialist assessors on application of either of the parties, or if the court is of the view that it would be in the interests of justice, or specifically when the case is of a complex nature involving highly technical expert evidence;
- 20.27 a no-fault compensation system is not a viable solution to South Africa's medico-legal claims crisis;
- 20.28 the decisions of the Constitutional Court in the cases of *MEC, Health and Social Development, Gauteng v DZ obo WZ*¹ and *MEC for Health, Gauteng Provincial Government v PN*² be confirmed and expanded in legislation;
- 20.29 public health services funds be retained within the public health sector as far as possible;
- 20.30 structured settlements should be the norm for compensation awarded for damages suffered due to medical negligence by state employees, and that the components of a structured settlement should be the following:
- 1) Lump sum awards should only be paid for past expenditure and damages, and immediate and necessary expenses (eg rehabilitation costs, assistive devices, adjustments to living environment and so forth).
 - 2) Future health care services must be provided in state hospitals as far as possible. Where state health services cannot provide the full range of services required, some of the state services are inadequate or services are not of an acceptable standard, monetary compensation should be paid for private health care only to the extent that the services offered by the state are insufficient. The monetary award for private health care should be included and paid as part of the periodic payment as calculated per annum.
 - 3) Periodic payments in the nature of an annuity (not down payments on a lump sum amount) should be awarded for future maintenance, loss of earnings and the portion of future medical care, treatment, rehabilitation and therapy that the court is not satisfied the state would be able to deliver or where the health service delivered by the state is not of an acceptable

¹ *MEC, Health and Social Development, Gauteng v DZ obo WZ* [2017] ZACC 37.

² *MEC for Health, Gauteng Provincial Government v PN* [2021] ZACC 6.

standard. Periodic payments calculated on an annual basis should be the default compensation option for all future compensation not delivered as services.

- 20.31 compensation should be awarded in the form of a structured settlement – with part of the compensation paid in a lump sum, part of the compensation paid as periodic payments, and part of the compensation provided as payments “in kind” by means of the delivery of services – allowing a combination of these methods and determining the ratio of one aspect in comparison to another aspect by considering the circumstances of each particular case;
- 20.32 the underlying principle for the calculation of future loss of income be changed, and that calculations of future loss of income be premised on a structured format or a guideline based on the average national income, or the average income of the area where the claimant lives;
- 20.33 it may be necessary to cap any damages other than special damages – such as constitutional damages and general damages (non-pecuniary damages) – to ensure that it does not become punitive damages in disguise;
- 20.34 a schedule of benefits for specific injuries or conditions be compiled that can be adjusted annually or that could be linked to an index of average values for automatic adjustment every year;
- 20.35 a deviation from the common law “once and for all” rule should be possible for adjusting periodic payments in exceptional circumstances.

21 The Commission does not support the creation of trusts for administering large lump sum compensation payments, unless there are exceptional circumstances to justify the creation of a trust.

Other proposals

22 South Africa’s public health system is heavily reliant on nurses. However, many concerns were raised about nurses in comments received and literature reviewed. The following proposals are made with regard to nurses:

- 1) Review the training of nurses to reconsider the curriculum, practical training, quality of training and so forth.

- 2) Adequate nursing numbers should be determined and every effort made to fill posts, supported by campaigns to encourage more people to enter the profession.
- 3) Interventions are required to address issues with oversight of junior nurses, the administrative burden on nurses and attitudes of nursing staff towards patients.
- 4) Some of the administrative and managerial tasks performed by nurses should be assigned to other staff, freeing nurses to focus more on the care of patients.
- 5) Consider re-establishing state-run nursing colleges that were closed in the mid-1990s and re-introduce vocational training of nurses (additional to higher education training of nurses at universities).

23 In response to the some of the submissions received, the Commission proposes a number of additional measures:

- Amend the Contingency Fees Act, 1997 to provide for a sliding scale for the determination of contingency fees in relation to the size of a compensation award.
- Introduce a “Good Samaritan” law exempting a medical practitioner acting in an emergency situation from negligence claims as long as certain conditions are complied with.
- Amend the Institution of Legal Proceedings Against Certain Organs of State Act 40 of 2002 where appropriate as indicated by the State Attorney, Pretoria.
- Ensure that the matters raised in the *2015 Report of the Ministerial Task Team (MTT) to Investigate Allegations of Administrative Irregularities, Mismanagement and Poor Governance at the Health Professions Council of South Africa (HPCSA): A Case of Multi-System Failure* (the Mayosi Report) have been addressed.
- Address the concerns about the length of time it is taking the Nursing Council to review the training and qualifications of nurses.

24 Several private entities, hospital groups, medical professionals, insurance companies and so forth offered to assist the public health sector. Most of the offers for assistance made by persons and organisations in the private health sector appear to be well-intentioned, intended to aid the public health sector to benefit the health sector as a whole. However, the goodwill and offers of assistance and cooperation from the private health sector have not been taken up in full.

CHAPTER 1: INTRODUCTION

A Background

1.1 South Africa has changed dramatically over the past 30 years with its transition to a constitutional democracy, the introduction of a strong culture of human rights, protection of the freedoms of the individual by means of a progressive Bill of Rights and the establishment of the Constitutional Court as the apex court to protect and enforce these rights. Among the people of South Africa there is also an increased awareness of their rights. In a constitutional democracy such as ours this is a positive development. However, one of the consequences of this increased awareness seems to be an upsurge in litigation to protect a perceived breach of individual rights.

1.2 This trend is also apparent in the huge escalation in delictual claims based on medical negligence over the past 12 years or so, in both the public as well as the private health sectors. Apart from the increase in the numbers of claims instituted, the exponential rise in the compensation claimed and awarded is a major cause for concern. Media reports abound of medical negligence claims instituted against the state for damages suffered in public hospitals; claims instituted against private practitioners and the rising incidence and cost of medical negligence claims. No legislation currently exists in South Africa to specifically address legal claims in the medical field, which means that claims based on medical negligence are dealt with under the common law.

1.3 The national Department of Health (NDOH) requested the SALRC to include an investigation into medico-legal claims in the SALRC research programme. This request flowed from the challenges faced by the public health sector due to the escalation in claims for damages based on medical negligence and the increasing financial implications thereof for the fiscus.

1.4 The Minister of Justice and Correctional Services (the Minister) wrote to the SALRC Chairperson on 16 January 2015. The reason for the letter was a request from the Gauteng Department of Health to the Department of Justice and Constitutional Development (DOJ&CD) for legislation to address the matters raised in the case of *Souls*

Cleopas and the Premier of Gauteng in 2014 (*Souls Cleopas* case).³ The case was brought on the basis of negligent medical treatment that the plaintiff had received from staff at Gauteng hospitals.

1.5 The Minister discussed the *Souls Cleopas* case in his letter to the SALRC. He expressed the opinion that the legislation proposed by the Gauteng Department would in effect abolish the common law “once and for all” rule in respect of certain issues, without an in-depth investigation having been conducted into the matter. The Minister was of the view that it would be advisable to await the outcome of such an investigation. The Minister then indicated, in light of the complexity of the matter, that it would be appreciated if the SALRC could consider conducting an in-depth investigation into the matter and then provide the Minister with a report on its findings.

1.6 The SALRC subjected the requests referred to above to the SALRC’s selection criteria for requests for new investigations. After considering the requests and conducting a preliminary investigation, a proposal paper was compiled, which recommended the inclusion of the requests for an investigation into medico-legal claims in the SALRC’s programme. On recommendation of the Commission, the Minister subsequently on 10 September 2015 approved the investigation for inclusion in the SALRC’s programme of investigations.

1.7 An official from the Office of the State Attorney: Johannesburg, requested a meeting with the SALRC via the DOJ&CD to discuss the increase in claims based on medical negligence against the State. As a result of this meeting the SALRC agreed to look into the manner in which compensation for medical malpractice is determined and paid, the influence of the common law “once and for all rule” on medico-legal claims and lump sum payments, as part of an investigation into medico-legal claims against the state.

³ *Souls Cleopas v Premier of Gauteng* Unreported case 09/41967, Gauteng South High Court, April 2014.

B Significant developments

1 Medico-Legal Summit of March 2015

1.8 The NDOH held a medico-legal summit on 9 and 10 March 2015 to deliberate the growing crisis with regard to medico-legal claims in South Africa. The summit was attended by the Minister of Health; the MECs for health of the various provinces; representatives from the World Health Organisation; representatives from statutory bodies such as the Office of Health Standards Compliance and the Health Professions Council of South Africa; representatives of professional bodies such as the Medical Association of South Africa, Hospital Association of South Africa, Medical Protection Society and South African Medico Legal Society; officials from national and provincial Departments of Health; medical practitioners in various fields; hospital managers; medical therapists; pharmacists; nurses; state attorneys from various regions; academics; legal practitioners; actuaries; legal advisers at health care facilities; labour organisations in the health care sector; and others.

2 Medical Malpractice Workshop of March 2017

1.9 A Medical Malpractice Workshop was held in Johannesburg on 3 March 2017 at the initiative of the Department of Health. The workshop was attended by Ms Naledi Pandor, the Minister of Science and Technology, and Dr Aaron Motsoaledi, the Minister of Health. The workshop brought judges, legal practitioners, legal advisors, medical professionals, actuarial scientists, academics, mediators, the insurance industry and representatives from the Office of the State Attorney, Department of Health, SALRC and Road Accident Fund together to discuss medical malpractice and propose solutions to dealing with this problem. The workshop took the form of interactive panel discussions where the following topics were discussed:

- 1) Navigating our way around medical malpractice litigation: Mediation vs litigation
- 2) A matter of record: Reconciling the Prescription Act relating to minors and the medical practitioner's duty to keep records
- 3) Contingency fees: The pros and cons
- 4) The capping of claims and payment of future damages by way of annuities
- 5) Compulsory professional indemnity insurance for the medical profession.

3 Presidential Health Summit 2018

1.10 President Cyril Ramaphosa hosted the first ever Presidential Health Summit, which was held in Boksburg on 19 and 20 October 2018. The summit was convened to find solutions to the crisis in the SA health system. Representatives from a wide range of stakeholders from the public and private sectors attended the summit, including state departments, statutory bodies, health and allied health professionals, public health entities, health users, traditional health practitioners, legal professionals, civil society, labour, business, academia, researchers and scientists.

1.11 Nine commissions were set up to enable participants to deliberate on the massive challenges the health system is facing and to suggest interventions to improve the quality of health care. The commissions covered the following topics:⁴

- 1) Human Resources for Health (Health Workforce)
- 2) Supply Chain Management, Medical Products, Equipment and Machinery
- 3) Infrastructure Plan
- 4) Private Sector Engagement
- 5) Health Service Provision (Delivery)
- 6) Public Sector Financial Management
- 7) Leadership and Governance
- 8) Community Engagement
- 9) Information Systems.

1.12 Each commission made recommendations on short-term, medium-term and long-term solutions to address the challenges facing the health care system. The proposed solutions were not considered as binding resolutions, but served as inputs to the *Presidential Health Summit 2018 Compact* and action plan that was developed after the summit.

C Previous reports and documents

1.13 A number of documents and reports pertaining to the public health sector, audit outcomes, and inspection reports were reviewed for this paper. These documents were

⁴ South African Government *Presidential Health Summit Report: Strengthening the South African Health System towards an Integrated and Unified System* (February 2019) 9.

developed by or at the behest of the President, Auditor-General, Public Protector, South African Human Rights Commission, Minister of Health, Office of Health Standards Compliance, Department of Health, National Treasury, or funded by the government.

The following documents were considered:

- 1) Clinton Health Access Initiative *Medico-Legal Claims Analysis for National Treasury* (Unpublished report December 2019)
- 2) South African Government *Presidential Health Summit 2018 Compact: Strengthening the South African Health System towards an Integrated and Unified System* (25 July 2019)
- 3) South African Government *Presidential Health Summit 2018 Report: Strengthening the South African Health System towards an Integrated and Unified System* (February 2019)
- 4) South African Lancet National Commission *Confronting the Right to Ethical and Accountable Quality Health Care in South Africa* (December 2018)
- 5) Health Ministerial Task Team *Hospital Mismanagement and Poor Service Delivery Closure Report* (May 2017)
- 6) Declaration following Medico-Legal Summit (March 2016) (summit hosted by the national Department of Health at the initiative of the Minister of Health)
- 7) Steve Biko Centre for Bioethics *Discussion Document prepared in Preparation for a Medico-Legal Summit to be held by the Minister of Health* (Unpublished report September 2013)
- 8) National Litigation Strategy Report (Unpublished report 2012) (compiled by task team established by the Minister of Health)
- 9) National Planning Commission – Chapter 10 (“Promoting health”) *National Development Plan 2030* (August 2012)
- 10) Reports of the Integrated Support Teams (April and May 2009) (facilitated by the Department of Health at the initiative of the Minister of Health).

1.14 Other authoritative documents reviewed include the following:

- 1) Auditor-General *Consolidated General PFMA Reports* for the years 2017-18, 2018-19 and 2019-20.
- 2) Office of Health Standards Compliance *Annual Inspection Report* for the years 2015/16, 2016/17, 2017/18 and 2018/19.
- 3) Reports published by the Public Protector on the provision and administration of health services in a number of provinces.

- 4) Reports on the public health sector or aspects of the public health sector published by the South African Human Rights Commission.

D Scope of problem

1.15 The 2020 mid-year estimate of the population of South Africa is 59,62 million people.⁵ According to the most recent household survey conducted by Statistics South Africa, 72,5% of households indicated that public health facilities are their first port of call for health care, while 26,8% of households would go to a private doctor, clinic or hospital as a first step.⁶ Since only 17,2% of the South African population belongs to medical schemes,⁷ the Department of Health surmised in a document on the envisaged national health insurance [NHI (2015)] and subsequent National Health Insurance Policy [NHI (2017)] that the public health sector provides health care to the rest of the population.⁸

1.16 The disparity between the Statistics SA figures⁹ and the information in NHI (2015) and NHI (2017)¹⁰ could be explained by health care users paying for private health care until they can no longer afford it; or utilising public health care services for more expensive procedures. Many find medical scheme membership too expensive, or gave up their membership due to the rising cost thereof. NHI (2015) revealed that the rate of medical inflation is nearly double the rate of general inflation:¹¹

The schemes contributions for members have been increasing with an annual average increase that is almost double the CPI for 2015 (9.2 % when CPI is approximately 4.6%).

1.17 The increase in the number and value of claims is evident from the information provided by National Treasury in the tables below. Comparing the financial year 2012/13

⁵ Statistics South Africa home page accessed 17 July 2021 www.statssa.gov.za.

⁶ Department: Statistics *General Household Survey 2019* at 25 [GHS (2019)].

⁷ GHS (2019) at 25.

⁸ Department of Health *National Health Insurance for South Africa: Towards Universal Health Coverage* (December 2015) 17 para 92 [NHI (2015)]; Department of Health *National Health Insurance Policy: Towards Universal Health Coverage* in GN 627 of 2017 GG 40955 of 30 June 2017 15–16 para 71 [NHI (2017)].

⁹ GHS (2019) at 25.

¹⁰ NHI (2015) at 17 par 92; NHI (2017) at 15–16 par 71.

¹¹ NHI (2015) at 13 par 69.

to the financial year 2020/21, it is clear how claims have escalated over time.¹² The Commission was criticised for using information on contingent liabilities for medical malpractice claims against the state in Issue Paper 33, hence information on claims paid out is provided in this paper in addition to information on contingent liabilities.¹³

1.18 The Eastern Cape has consistently paid out the biggest amount in claims for the past three financial years, setting a new record for the highest pay-out each year. The Eastern Cape alone paid out the staggering amount of R920 981 000 in the 2020/21 financial year. The year 2018/19 saw the biggest combined pay-out, totalling nearly R2 billion (which can also be expressed as R2 000 000 000-00, or two thousand million rand) for all the provinces.

Table 1: Payments: claims against health departments from 2012/13 to 2019/20

Payment trend on claims against health departments between 2012/13 and 2019/20										
R'000	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21 (March, 21)	Growth rates 2012/13- 2020/21
Eastern Cape	63,359	74,775	74,868	255,561	208,503	423,263	797,434	766,399	920,981	56.2%
Free State	440	700	196	1,728	1,560	376	3,600	22,655	3,484	41.2%
Gauteng	145,071	181,802	241,085	572,815	751,082	358,230	586,453	502,148	392,126	18.0%
KwaZulu-Natal	20,679	97,433	103,536	90,367	251,278	461,919	438,819	180,444	115,933	33.3%
Limpopo	8,040	25,022	35,073	9,622	74,830	26,773	7,045	83,572	79,233	46.4%
Mpumalanga	13,918	44,080	7,628	15,211	34,255	67,782	39,268	45,534	18,632	5.0%
Northern Cape	1,437	10,705	3,828	4,844	823	9,493	3,550	40,735	34,327	69.7%
North West	5,502	10,896	13,246	6,422	29,539	33,274	14,450	18,912	44,479	41.7%
Western Cape	6,928	23,015	19,272	28,073	38,381	86,984	62,140	60,140	131,729	63.4%
Total	265,374	468,428	498,732	984,643	1,390,251	1,468,094	1,952,759	1,720,539	1,740,924	36.8%

Table 2: Medico-legal claims: contingent liability

Medico Legal Claims - contingent liability as at 31 March 2021										
R'000	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	% Share 2020	Year on year increase	% Year on year increase
Eastern Cape	8,210,838	13,421,136	16,772,732	24,193,619	32,864,497	35,425,811	38,842,976	32.3%	3,417,165	9.6%
Free State	540,365	940,545	1,306,928	1,842,917	2,874,754	4,013,121	4,525,725	3.8%	512,604	12.8%
Gauteng	10,079,281	13,452,064	17,844,047	21,701,514	19,625,835	21,227,633	21,710,437	18.0%	482,804	2.3%
KwaZulu-Natal	6,724,865	9,957,126	10,292,463	16,638,734	20,110,314	23,600,177	26,417,906	22.0%	2,817,729	11.9%
Limpopo	1,196,787	1,606,657	2,115,529	4,874,800	8,265,440	10,315,607	11,939,335	9.9%	1,623,728	15.7%
Mpumalanga	1,459,497	2,366,010	5,242,757	7,472,985	9,451,927	9,529,412	9,543,268	7.9%	13,856	0.1%
Northern Cape	174,111	342,829	1,220,527	1,605,291	2,104,584	1,624,354	1,689,178	1.4%	64,824	4.0%
North West	33,881	855,737	1,285,126	1,697,205	1,982,272	5,395,624	5,582,950	4.6%	187,326	3.5%
Western Cape	193,395	182,025	135,700	90,350	110,599	33,155	80,400	0.1%	47,245	142.5%
Total	28,613,020	43,124,129	56,215,809	80,117,415	97,390,222	111,164,894	120,332,175	100%	9,167,281	8.2%

¹² Information obtained from National Treasury [Jonatan Davén, Public Finance: Health, National Treasury “Re: Medico-legal, accruals etc” email to SALRC researcher (11 October 2021)].

¹³ Issue Paper 33 (IP 33) respondent: Parliamentary Committee of the General Council of the Bar “Commentary: Issue Paper 33: Project 141: Medico-Legal Claims” 6 (GCB).

E Aim of investigation

1.19 This investigation aims to propose possible solutions to dealing with the increase in medical negligence claims against the state and to explore alternative options for the manner in which damages are determined and awarded. The extent of medical negligence claims against the state has reached critical levels and intervention on several fronts is urgently required, with legislative intervention being one of the most necessary. The possibility of introducing legislation to address certain aspects of the challenges faced by the public health sector was investigated and proposals on the form that such legislation might take are made.

1.20 **It must be stated emphatically that legislative intervention alone cannot address the myriad of challenges faced by the public health sector.** As is often said, there is no claim without negligence. Legislation can address procedure, establish bodies to deal with some issues, create interventions that do not currently exist, alter the method and timing of compensation and so forth; but legislation cannot address systemic problems with leadership, governance, management, budgeting and procurement, quality of care, lack of skills, personnel shortages, training, attitudes of staff and maintenance of facilities and equipment. The best legislation in the world will not make any difference unless it is applied, implemented, complied with and monitored.

1.21 The following matters were considered:

- 1) Budgeting for medico-legal litigation and compensation.
- 2) Collection, processing and management of information.
- 3) Record keeping and management.
- 4) Establishment of medico-legal units in provinces to screen and evaluate medical negligence claims against the state.
- 5) Developing a uniform strategy in the provincial DOHs to deal with medico-legal litigation.
- 6) Establishing a dedicated medico-legal unit within the relevant offices of the State Attorney.
- 7) Developing a uniform strategy in the various offices of the State Attorney to deal with medico-legal litigation.
- 8) Developing a specific strategy for dealing with cerebral palsy type claims.
- 9) Improving midwifery training of nurses.
- 10) Improving administrative management of claims.

- 11) Strategy for dealing with potential medical negligence claims in state health establishments, starting with hospital admission forms and proper complaints procedures through to reporting and investigation of “adverse events”.
- 12) Implementation of formal procedure for reporting, investigating and dealing with serious “adverse events” in health establishments.
- 13) The role of mediation.
- 14) Introducing a certificate of merit as a prerequisite for formal legal action.
- 15) Instituting an administrative process to deal with claims of a lower value.
- 16) Amendments to civil procedure to improve court case flow and management and to expedite and simplify the finalisation of claims, for example earlier exchange of information, expert notices, summaries and witness statements; early expert meetings; pre-trial conferences.
- 17) Using joint expert witnesses.
- 18) Appointing specialist assessors to assist judges when hearing highly technical or complicated cases.
- 19) Manner of payment of compensation.
- 20) The concept of structured settlements, including periodic payments.
- 21) Introducing limits on certain aspects of compensation, such as capping of general damages.
- 22) Legal and constitutional justification for proposed measures.
- 23) Implementing recommendations to address problems pertaining to health care, including monitoring and evaluation.
- 24) Various possible options for the payment of compensation:
 - a) Purely monetary.
 - b) Court to decide whether monetary compensation should be a lump sum payment or by means of periodical payments.
 - c) Court compelled to order periodical payments for future care and maintenance.
 - d) Court given the option to order part of the compensation to be in the form of health services offered at state health establishments.
 - e) Court given the option to structure the compensation award in the following manner:
 - lump sum payment for past expenses and immediate current expenses;
 - health services of an acceptable standard delivered by the state for future medical care;
 - periodical payments for future damages, including maintenance, loss of income and the portion of future medical care that the court is not satisfied

the state would be able to deliver or where the health services delivered by the state is not of an acceptable standard.

f) Court compelled to make the above order.

1.22 The methodology followed with this investigation was as follows:

- 1) Chapter 1 gives the background to this investigation.
- 2) Chapter 2 presents an overview of the present South African legal landscape relevant to medico-legal claims.
- 3) Chapter 3 reviews pertinent constitutional provisions, legislation, subordinate legislation, Bills and guidelines.
- 4) Chapter 4 discusses the development of case law in this area of the law.
- 5) Chapter 5 considers the extent of the problem as reflected in academic literature, submissions received on Issue Paper 33, popular media, reports published by the Public Protector, South African Human Rights Commission and Office of Health Standards Compliance, as well as the consolidated general PFMA audit reports published by the Auditor-General for the years 2017-18, 2018-19 and 2019-20.
- 6) Chapter 6 summarises the findings and recommendations of previous government-initiated reports published since 2009.
- 7) Chapter 7 entails a comparative legal study of the compensation systems of other countries.
- 8) Chapter 8 proposes a national strategy to deal with medical negligence claims (contributed by Dr David Bass, advisory committee member).
- 9) Chapter 9 contains detailed proposals on addressing the challenges and developing a strategy for dealing with medico-legal claims.
- 10) Chapter 10 lists the respondents who submitted comments on *Issue Paper 33 on Project 141: Medico-Legal Claims* (July 2017), recapping the gist of each respondent's submission.

F Other concerns

1.23 There is considerable support for legislative intervention in the private health sector as well, since medico-legal litigation against private hospitals and private medical practitioners is also sharply on the rise and this trend has been prevalent for a number of years. (see paragraph 2.10). Prof Ames Dhai, one of the members of the advisory committee for this investigation, expressed concern about the situation in the private

sector, signifying that it is already affecting the availability of medical practitioners in especially the high risk specialities. As explained in Issue Paper 33, this investigation was included in the SALRC's research programme in response to requests from the Department of Health and the Minister of Justice and Correctional Services regarding concerns about the enormous increase in medico-legal litigation against the state and the impact of the litigation and the resulting claims on the fiscus, which is the reason why this investigation is focusing on the public health sector. However, a number of the proposals for dealing with medico-legal claims against the state set out in Chapter 9 are of general application, and will also benefit the private health sector.

1.24 Section 5 of the South African Law Reform Commission Act 19 of 1973 deals with the powers and duties of the Commission. Section 5(1) enjoins the Commission to draw up programmes on the matters which in its opinion require consideration. The programmes must be submitted to the Minister of Justice and Correctional Services for approval. Section 5(2) determines that the Commission may include any suggestion relating to its objects received from any person or body. The Commission could therefore include an investigation into the impact of medico-legal litigation on the private health sector if requested to conduct such an investigation, or it could decide to include such an investigation of its own volition.

1.25 It has come to the attention of the Commission that a coalition of nine healthcare bodies have written a letter to the Minister of Justice and Correctional Services to request that the SALRC conduct an investigation into the possible review of the law of culpable homicide and the application thereof in a health care setting.¹⁴ The Commission would be willing to entertain such a request should the Commission receive a proposal in this regard.

¹⁴ Suthentira Govender "Doctors say they should not be criminally charged when patients die due to errors" *Times Live* (5 November 2021) accessed 8 November 2021 www.timeslive.co.za/news/south-africa/2021-11-05-doctors-say-they-should-not-be-criminally-charged-when-patients-die-due-to-errors/; Katharine Child "SA doctors protest at low bar for criminal charges" *Business Day* (8 November 2021) accessed 8 November 2021 bd.pressreader.com/article/281539409190217.

CHAPTER 2: SOUTH AFRICAN LEGAL LANDSCAPE

A Conclusion

2.1 There is an urgent need to undertake reform of South African law in the area of medico-legal claims in order to regulate a system that will become paralysed if no action is taken. This is supported by numerous submissions received in response to the publication of the SALRC's *Issue Paper 33 on Project 141: Medico-Legal Claims*.

2.2 Government policies and legal principles make up the legal landscape that impacts upon medico-legal claims. Broader government policy for the health sector is principally contained in two important documents. The National Planning Commission released the *National Development Plan 2030* (NDP) in August 2012. The NDP is a plan for South Africa to eliminate poverty and reduce inequality by 2030 through various measures, including measures pertaining to health set out in Chapter 10 of the NDP. The national Department of Health developed a strategic plan for the period 2020/2021 to 2024/2025 to respond to the goals of the NDP Implementation Plan 2019-2024 and priorities set out in the Medium Term Strategic Framework for 2019 to 2024. Medico-legal litigation and some of the concerns with health care services feature in the strategic plan, but, probably due to its nature as a strategic document, the plan does not contain much detail.

2.3 Common law principles that are relevant to medico-legal claims are the law of obligations, and flowing from that, the law of delict and test for medical negligence. However, the practice of awarding compensation as lump sum payments, ostensibly as a result of the "once and for all" rule, is questioned. There are several practical advantages to alternative forms of compensation, such as periodic payments and payment in kind, as components of structured settlements tailored to fit plaintiffs' circumstances.

2.4 Due to failures at national government level and the very real danger of the collapse of some provincial departments of health, the ghost of litigation based on constitutional infringements, including the right of access to health care services, could

become a reality if systemic problems in the public health sector and concerns about the quality of public health care services are not addressed.

B Introduction

2.5 The paper that preceded this discussion paper, *Issue Paper 33 on Project 141: Medico-Legal Claims*,¹ contained information on aspects of the current South African legal situation and health system planning that are relevant to medico-legal claims. The discussion paper is not an expanded version of the issue paper and the intention is not to replicate the contents of the issue paper in the discussion paper. However, to put the submissions received from respondents who commented on Issue Paper 33 and the arguments and proposals put forward in this paper into context, it is necessary to repeat the exposition of the relevant legal and policy principles underlying medico-legal claims.

2.6 As was stated in *Issue Paper 33*, there is an urgent need to undertake reform of the law in order to regulate a system that will become paralysed if no action is taken. It is crucial to cut down on litigation that consumes time and money. Apart from the impact of medical litigation on the public purse, the negative effect of such litigation on the rendering of health services in the private sector must also be considered. Regardless of the nature of the changes, legislation will be required to effect such changes.²

2.7 There is no South African legislation at present that specifically deals with legal claims based on medical negligence. A claim resulting from medical negligence is treated like any other delictual claim, which means that such a claim is dealt with in terms of the common law. The seemingly unbridled escalation in medical negligence litigation, and in particular the increase in the size of the damages sought and awarded, has become a major cause for concern in the public and private health sectors. More and more voices are being raised in support of legislative intervention in the public health sector: voices

¹ South African Law Reform Commission *Issue Paper 33 on Project 141: Medico-Legal Claims* (July 2017) available on SALRC website at www.justice.gov.za/salrc/ipapers.htm.

² Some authors and respondents expressed their disagreement with or concern about this statement – William Oosthuizen *Reconciling patient safety and liability: Lessons from a Just Culture* (Unpublished LLD thesis, University of Pretoria 2017) at 455 & 464. Issue Paper 33 [IP 33] respondents: Nicky GunnClark. Other respondents consider legislative amendments of the common law, the “once and for all” rule and lump sum payments as unnecessary or undesirable: General Council of the Bar 6; Joseph’s Inc 25; John Mullins 8.

from government,³ the health sector,⁴ the legal fraternity,⁵ practitioners and academia,⁶ the insurance industry,⁷ as well as actuaries, dispute resolution organisations and other stakeholders such as the Medical Protection Society (MPS) and SAMLA.⁸

³ IP 33 respondents: National Treasury, provincial Treasuries of Eastern Cape, KwaZulu-Natal and North West Province; provincial Departments of Health of Free State, Gauteng, KwaZulu-Natal and Western Cape; State Attorney: Bloemfontein and State Attorney: Pretoria. The Minister of Health convened a Medico-Legal Litigation Task Team in 2015. The Minister of Justice and Constitutional Development introduced the State Liability Amendment Bill 16–2018 in Parliament. National Treasury, the Department of Justice and Constitutional Development and the Department of Health had all been actively involved in the SALRC investigation.

⁴ IP 33 respondents: Clinix Health Group; Life Healthcare Group; Mediclinic; Netcare Ltd; Occupational Therapy Association of South Africa (OTASA); South African Private Practitioners Forum (SAPPF); South African Society of Anaesthesiologists (SASA); South African Society of Obstetricians and Gynaecologists (SASOG); combined response from South African Medical Association (SAMA) membership, SASA and the South African Orthopaedic Association (SAOA); medical practitioners: Dr Paul Dalmeyer (on behalf of SASOG, Mediation in Motion and personal views as a qualified clinician and mediator); Dr Jonathan Larsen; Dr Georg Scharf; psychologist: Ms Sasja van der Merwe. The Gynaecology Management Group (GMG), Dalmeyer and SASA aver that the traditional common law system, in particular the law of delict, is no longer adequate for medico-legal issues in the light of the complexities of the health system, the impact of modern medicine, changes in the field of personal injury law, various service providers, funding issues and current legislation such as the Consumer Protection Act and the NHA [GMG 2; Dalmeyer 1; SASA 1–2]. GMG argue that this shortcoming affects the constitutional right of access to health care services, as less resources are available for services to poor and vulnerable populations which, in turn, increase the risk of malpractice. In fact, GMG consider legislative reform as a constitutional imperative. [GMG 2].

⁵ IP 33 respondents: Friedman and Associates Attorneys; Nicky GunnClark; Joseph's Incorporated Attorneys; Paul du Plessis Attorneys; André Oosthuizen SC; Ric Martin Inc Attorneys; Bowman Gilfillan Attorneys – comments relate to Contingency Fees Act 66 of 1997; General Council of the Bar – procedural amendments only; John Mullins SC – opposed to law reform, apart from “some scope for careful capping, ... provision for structured settlements” and “some scope for reducing the prescription period when it comes to minors”.

⁶ Michael S Pepper & M Nöthling Slabbert “Is South Africa on the verge of a medical malpractice litigation storm?” *SAJBL* 4:1 (20 June 2011) 29–35; Graham Howarth & Pieter Carstens “Can private obstetric care be saved in South Africa?” *SAJBL* 7:2 (November 2014) 69–73; D Roytowski *et al* “Impressions of defensive medical practice and medical litigation among South African neurosurgeons” *SAMJ* 104:11 (November 2014) 736–738; Ames Dhai “Medico-legal litigation: Balancing spiralling costs with fair compensation” *SAJBL* 8 1 (May 2015) 2–3; Graham Howarth & Emma Hallinan “Challenging the cost of clinical negligence” *SAMJ* 106:2 (February 2016) 141–142; Letitia Pienaar “Investigating the Reasons behind the Increase in Medical Negligence Claims” (2016) *PELJ/PER* 1–22; Ames Dhai “Medical negligence: Alternative claims resolution an answer to the epidemic?” *SAJBL* 9:2 (May 2016) 2–3; Henry Lerm “Medical Malpractice Litigation: Do We Need a Paradigm Shift in Our Approach to Handling Medical Negligence Disputes?” *Obiter* 38 2 (2017) 324–341 [Lerm (2017)]; AB Wessels “The expansion of the state's liability for harm arising from medical malpractice: Underlying reasons, deleterious consequences and potential reform” *TSAR* (2019) 1–24; AB Wessels & J Wewege “The State Liability Amendment Bill – further evaluation and commentary” *TSAR* (2019) 484–509. *Medical Brief* “SA’s bleak medico-legal dilemma: How to avoid *Jarndyce v Jarndyce*” – discussion with Donald Dinnie and Volker von Widdern (11 July 2018).

2.8 Pepper & Nothling Slabbert suggest that legislative intervention will be required to reduce the impact of litigation.⁹ Howarth & Carstens put forward the possibility of a no-fault system or the capping of non-economic damages, both interventions that would require amending the law.¹⁰ Roytowski et al state that legal reform in some USA states has assisted with controlling personal injury liability costs and could be considered for SA.¹¹ Dhai (2015) moots the possible “establishment of a statutory national litigation authority or council where litigation claims could be considered and settled by mediation”.¹² Howarth & Hallinan say the following: “There is growing recognition of the need for legal reform in SA, not only to reduce the burden of mounting costs but also to create a system that both ensures reasonable compensation for patients and allows for a fair and robust defence where necessary. An efficient and cost-effective legal system that works for patients and their families, as well as for healthcare professionals, is crucial.”¹³ Pienaar considers possible reasons for the increase in medical negligence claims, suggesting “that legislation is at the very least a contributing factor to the increase in medical negligence claims”. She contends that the solution to this problem therefore might be legislation, which should be further investigated.¹⁴

2.9 Dhai (2016) suggests alternative claims resolution involving a range of possible solutions, including non-judicial, specialised health courts with specialised judges; state-appointed neutral experts; medical review and screening panels to dispose of meritless claims and encourage speedy settlement of meritorious claims; peer review of expert testimony; negotiation and mediation; greater disclosure of medical errors; apology laws protecting statements of apology from being used as evidence in litigation procedures;

⁷ Tarryn Paterson “Reconstructive surgery required to future medical expenses awards” *Insurance Xchange* (30 January 2017) www.insurancegateway.co.za/Healthcare/Consumers/PressRoom; IP 33 respondents: Camargue; EthiQal.

⁸ IP 33 respondents: other stakeholders: The Medical Protection Society (MPS) and the South African Medico-Legal Association (SAMLA). Actuaries: Riskhouse Africa. Dispute resolution organisations: joint comments received from African Centre for the Constructive Resolution of Disputes (ACCORD); Africa Dispute Resolution (ADR) and ACCORD Development Consulting (ADC) in relation to mediation.

⁹ Pepper & Nothling Slabbert 33.

¹⁰ Howarth & Carstens 72.

¹¹ Roytowski et al 738.

¹² Ames Dhai “Medico-legal litigation: Balancing spiralling costs with fair compensation” *South African Journal of Bioethics and Law* 8:1 (May 2015) 2–3 at 3 [Dhai (2015)].

¹³ Howarth & Hallinan 141.

¹⁴ Pienaar 18.

staggered payments of damages; and capping of claims for non-economic and punitive damages.¹⁵ Lerm makes a number of proposals that would necessitate legislative reform, such as introducing a certificate of merit, establishing specialist medical courts or introducing expert assessors, and providing legislative protection for an early apology and remedial action.¹⁶ Wessels argue that substantial changes to the common law should be effected by the legislature rather than the judiciary, for example changes to compensation methods such as introducing periodic payments or rendering health care services in lieu of money. He also refers to case law that affirms the legislature as the primary vehicle for law reform.¹⁷ Wessels & Wewege recognise that legislative reform is required to improve the financial position of the DOH.¹⁸ Several court decisions have made the point that development of the common law in regard to medical negligence claims would best be left to the legislator.¹⁹

2.10 There is considerable support for possible legislative intervention in the private health sector, since increased medico-legal litigation is fast becoming just as problematic in the private health sector as it is in the public health sector.²⁰ A huge concern for the private health sector is the enormous and unsustainable increase in the cost of indemnity insurance for medical malpractice,²¹ the increase in the size of excess payments, the decreasing pool of insurers still willing to insure medical practitioners and health establishments, the significant costs and stress caused by complaints and litigation, and

¹⁵ Ames Dhai “Medical negligence: Alternative claims resolution an answer to the epidemic?” *South African Journal of Bioethics and Law* 9:2 (May 2016) 2–3 at 2 [Dhai (2016)].

¹⁶ Lerm (2017) 329, 331 & 336.

¹⁷ Wessels 16, 18 & 19.

¹⁸ Wessels & Wewege 487.

¹⁹ *Souls Cleopas v The Premier of Gauteng* Unreported case 09/41967, Gauteng South High Court (April 2014) par 22; *MEC for Health and Social Development, Gauteng v [DZ] obo [WZ]* (2016) ZASCA 185 par 12; *AD & IB v MEC for Health and Social Development, Western Cape* (27428/10) [2016] ZAWCHC 116 (7 September 2016) par 64 & 65; *Premier, Western Cape v Kiewitz* 2017 4 SA 202 (SCA) 204 par 12; *Ngalonkulu v MEC for Health, Gauteng* (217/2019) [2019] ZASCA 66 (17 June 2020) par 28.

²⁰ Donald Dinnie “Periodic payments in medico-legal claims welcome, but must be extended” *Medical Brief* 27 June 2018; Wessels 5; Pieter Pauw “Alternative relief in medical malpractice claims – further developments” *TSAR* (2019) 91–97 at 95. IP 33 respondents: Clinix Health Group; Discovery Health; Hospital Association of SA; Louise Mallory; Mediclinic; Netcare; SA Society of Obstetricians and Gynaecologists; SA Spine Society.

²¹ IP 33 respondent: Oosthuizen; Scarf. Scarf suggests that patients should take out their own insurance for pregnancy and birth adverse events [Scharf 2].

the knock-on effect of medical practitioners leaving high-risk specialities or choosing not to specialise in high-risk practice areas like obstetrics, neurosurgery and spinal surgery.²²

C Broader government policy

1 National Development Plan 2030

2.11 Developing legislation in the field of medical law will further the implementation of broader government policy. The National Planning Commission (NPC) is a government agency, established in 2010, that is instrumental in strategic planning for South Africa. To this end the NPC developed the *National Development Plan 2030* (NDP) released in August 2012. The object of the NDP is explained in the foreword:²³

The National Development Plan is a plan for the country to eliminate poverty and reduce inequality by 2030 through uniting South Africans, unleashing the energies of its citizens, growing an inclusive economy, building capabilities, enhancing the capability of the state and leaders working together to solve complex problems.

2.12 Chapter 10 of the NDP deals with the promotion of health in South Africa, summarising the key points as follows:²⁴

- 1) Greater intersectoral and inter-ministerial collaboration is central to the Commission's proposals to promote health in South Africa.

²² Howarth & Carstens 69–73; Howarth et al “Public somnambulism: A general lack of awareness of the consequences of increasing medical negligence litigation” *SAMJ* 104:11 (November 2014) 752; Medical Protection Society *Challenging the Cost of Clinical Negligence: The Case for Reform* (November 2015) 5 [MPS *Clinical Negligence*]; IP 33 respondents: Clinix; EthiQal; GMG; Life Healthcare; Mallory; Mediclinic; Oosthuizen; SAPPF; SASS; Scharf. SASOG highlight the trend of obstetricians ceasing to practice midwifery due to the debilitating cost of litigation insurance. They also point to other consequences: “The result of no private obstetricians in any area means that specialist paediatric facilities will probably also be suspended, and anaesthetists will similarly be affected. Labour wards will close if family physicians are unable to fill the void. Obviously they are generally unable to perform difficult vaginal deliveries or emergency caesarean deliveries, resulting in the unscheduled transfer of patients in labour to public facilities for further management.” [SASOG (unpaged)]. Scarf suggests that patients should take out their own insurance for medical injury risks [Scharf 2].

²³ National Planning Commission *National Development Plan 2030: Our Future – make it work* (August 2012) at 1 [NDP (2012)].

²⁴ NDP (2012) 329.

- 2) Health is not just a medical issue. The social determinants of health need to be addressed, including promoting healthy behaviours and lifestyles.
- 3) A major goal is to reduce the disease burden to manageable levels.
- 4) Human capacity is key. Managers, doctors, nurses and community health workers need to be appropriately trained and managed, produced in adequate numbers, and deployed where they are most needed.
- 5) The national health system as a whole needs to be strengthened by improving governance and eliminating infrastructure backlogs.
- 6) A national health insurance system needs to be implemented in phases, complemented by a reduction in the relative cost of private medical care and supported by better human capacity and systems in the public health sector.

2.13 The national Department of Health (NDOH) is the custodian of South Africa's national health system. The department is the main vector for the implementation of the goals, indicators and actions set out in Chapter 10 of the NDP. The NDOH is responsible for the development of government health policy in South Africa, as well as monitoring, evaluation and oversight. The provincial departments of health are responsible for the delivery of health care services.²⁵

2 Health Strategic Plan for 2020/2021 to 2024/2025

2.14 The NDOH developed a strategic plan for the health sector for the period covered by the financial years 2020/2021 to 2024/2025 to respond to the priorities identified by Cabinet as set out in the Medium Term Strategic Framework (MTSF) for the period 2019 to 2024, and the NDP Implementation Plan 2019-2024 goals. These are aligned to the Pillars of the *Presidential Health Summit 2018 Compact*.²⁶ The national DOH's strategic focus is encompassed in its vision: "A long and healthy life for all South Africans", and its mission: "To improve the health status through the prevention of illness, disease, promotion of healthy lifestyles, and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability."²⁷

²⁵ South African Government "Health" *About SA* accessed 27 August 2021 www.gov.za/about-sa/health.

²⁶ Department of Health *Strategic Plan 2020/2021 – 2024/2025* (undated) 9 (*Strategic Plan*).

²⁷ *Strategic Plan* 12.

2.15 Medico-legal litigation is mentioned under MTSF Priority 3: Education, Skills and Health, impact B: Universal Health Coverage for all South Africans progressively achieved and all citizens protected from the catastrophic financial impact of seeking health care by 2030. The MTSF intervention is stated as “Develop a comprehensive policy and legislative framework to mitigate the risks related to medical litigation”, with the outcome indicated as “Management of Medico-legal cases in the health system strengthened”. The target, from a baseline of contingent liability at R90bn in March 2019, is to reduce medico-legal cases to under 50% by 2021/22, and 80% by 2024/25 for all claims on the register.²⁸ The management of medico-legal cases in the health system is identified as a risk.²⁹

2.16 Other MTSF interventions mentioned in the *Strategic Plan* that may impact on medico-legal litigation are “Roll-out a quality health improvement programme in public health facilities to ensure that they meet the quality standards required for certification and accreditation for NHI”;³⁰ “Establish provincial nursing colleges with satellite campuses in all 9 provinces”; “Develop and implement a comprehensive HRH strategy 2030 and a HRH plan 2020/21 – 2024/25 to address the human resources requirements, including filling critical vacant posts” and “Implement the costed infrastructure plan to improve efficiency and effectiveness of health services delivery”.³¹ The *Strategic Plan* does not contain much detail on how these interventions and medical litigation risks will be achieved, but details are generally reserved for implementation plans, not featuring in strategic plans.

D Common law

1 Law of obligations

2.17 Medico-legal claims in South Africa are dealt with in terms of the common law. As explained by Carstens & Pearmain, the legal basis for health service delivery in South

²⁸ *Strategic Plan* 31.

²⁹ *Strategic Plan* 35.

³⁰ *Strategic Plan* 32.

³¹ *Strategic Plan* 33.

Africa is the law of obligations.³² They state that “health service delivery is essentially a theme to be broadly accommodated under the law of obligations, thus either the law of contracts or the law of delict.”³³ Although the relationship between doctor and patient or hospital and patient is traditionally a contractual relationship, the majority of health service cases that came before the courts in recent times have been decided on the basis of the law of delict.³⁴

2 Elements of delict

2.18 In South African private law the five elements of delict that must be proven by a plaintiff to claim successfully from a defendant are: conduct, wrongfulness, damage, causation and fault.³⁵ Conduct for purposes of delictual liability means a voluntary act or omission by a human being.³⁶ Wrongfulness is present if the act or omission infringes a right protected by law or breaches a legal duty owed by one person to another.³⁷

2.19 The next element of a delict to be referred to here is the element of damage. The plaintiff must be able to prove that loss has resulted from the wrongful conduct and that the plaintiff has suffered damages that can be compensated in monetary terms.³⁸ If no harm has been suffered, there is no delict. When suffering loss due to negligence, an aggrieved party can claim damages; that is, compensation or satisfaction. The purpose of the compensation is to restore the plaintiff to the position he or she would have been in had the wrongful act not been committed.³⁹

2.20 Causation means that there must be a causal nexus between the defendant's conduct and the harm suffered by the plaintiff. The question to be asked is whether the defendant's act or omission is the cause of the loss that the plaintiff incurred. To

³² PA Carstens & D Pearmain *Foundational Principles of South African Medical Law* (2007).

³³ Carstens & Pearmain 283.

³⁴ Carstens & Pearmain 284.

³⁵ See in general J Neethling & JM Potgieter *Neethling Potgieter Visser Law of Delict* 7 ed (2015).

³⁶ Neethling & Potgieter 25; Carstens & Pearmain 496; JR Midgley & JC van der Walt “Delict” in WA Joubert (founding ed) *LAWSA Vol 8 Part 1 2 ed* (2005) par 58 [Midgley in *LAWSA vol 8*].

³⁷ Neethling & Potgieter 33; *LAWSA vol 8* par 60.

³⁸ Neethling & Potgieter 222; *LAWSA vol 8* par 142.

³⁹ Carstens & Pearmain 523–524; *LAWSA vol 8* par 143.

determine whether there is a causal nexus between an act and a result, two factors must be present. First, factual causation, that is, the factual relation between the defendant's reprehensible conduct and the harm sustained by the plaintiff must be established.⁴⁰ Once the factual link had been established, it must be determined whether there is legal causation. In the authoritative case *Minister of Police v Skosana*⁴¹ the court explained that the second problem is "... whether the negligent act or omission is linked to the harm sufficiently closely or directly for legal liability to ensue or whether, as it is said, the harm is too remote."⁴²

2.21 Fault (blameworthiness) is constituted by either intentional or negligent conduct and is determined by examining the defendant's state of mind, mental disposition, or the degree of care the defendant exhibited in his or her conduct towards the plaintiff. In this sense fault is a subjective factor, however, negligence is determined objectively by measuring the conduct of the defendant against the yardstick of the conduct of a reasonable person in the same circumstances.⁴³ Claims for medical malpractice are mostly based on negligence.

3 Test for medical negligence

2.22 The test for negligence was formulated by Holmes JA in the 1966 matter of *Kruger v Coetzee*⁴⁴ as follows:

For the purposes of liability culpa arises if –

- (a) a diligens paterfamilias in the position of the defendant –
 - (i) would foresee the reasonable possibility of his conduct injuring another in his person or property and causing him patrimonial loss; and
 - (ii) would take reasonable steps to guard against such occurrence; and
- (b) the defendant failed to take such steps".

2.23 It is evident that the test for negligence applied in medical negligence cases cannot be the same as the customary reasonable man test used to determine negligence

⁴⁰ Neethling & Potgieter 183; Carstens & Pearmain 509; LAWSA vol 8 par 128.

⁴¹ *Minister of Police v Skosana* 1977 1 SA 31 (A).

⁴² *Skosana* case 34–35.

⁴³ Neethling & Potgieter 129; Carstens & Pearmain 303; LAWSA vol 8 par 103.

⁴⁴ *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430 E–F.

in other delictual claims. In the case of a medical practitioner, the test is adapted to the standard of the reasonable medical practitioner, or the reasonable medical specialist in that field, with a similar degree of professional skill, in the same circumstances as the defendant.⁴⁵ The court articulated the test for negligence in relation to a medical practitioner in *Mitchell v Dixon* through Innes ACJ:⁴⁶

A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of professional skill, but he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not.

2.24 Carstens & Pearmain point out that the term “medical malpractice” incorporates all forms of intentional and negligent professional medical misconduct, such as a physician’s duty of confidentiality to a patient, the trust relationship between a doctor and patient as well as professional negligence of medical practitioners. In their discussion of the specific blameworthiness of medical practitioners based on negligence as an element of delict, they prefer to refer to “professional medical negligence”, rather than “medical malpractice”.⁴⁷

2.25 McQuoid-Mason & Dada defines professional negligence as follows:⁴⁸

Professional negligence by doctors occurs where a patient is harmed because a doctor has failed to exercise the degree of skill and care of a reasonable competent doctor in his or her branch of the profession.

2.26 They also describe professional standards:⁴⁹

Professional standards refer to the level of skill and care that a reasonably competent practitioner in that particular branch of health care would be expected to demonstrate.

2.27 As indicated above, the test for professional negligence as it pertains to medical practitioners is an objective test comparing the conduct of a particular practitioner to the

⁴⁵ Carstens & Pearmain 619; DJ McQuoid-Mason “Medical Professions and Practice” in *Law of South Africa* Vol 17 Part 2 2 ed (2008) par 44 [LAWSA vol 17 part 2]; Pieter Albert Carstens *Die Strafregtelike en Deliktuele Aanspreeklikheid van die Geneesheer op grond van Nalatigheid* (Unpublished LLD thesis, University of Pretoria 1996) 144.

⁴⁶ *Mitchell v Dixon* 1914 AD 519 at 525.

⁴⁷ Carstens & Pearmain 599.

⁴⁸ David McQuoid-Mason & Mahomed Dada *A-Z of Medical Law* (2011) 339.

⁴⁹ McQuoid-Mason & Dada 343.

conduct of the hypothetical reasonable practitioner in the same circumstances. It is therefore important to understand what professional negligence and the standard used to measure such negligence entail.

4 *Res ipsa loquitur* doctrine

2.28 The debate about the *res ipsa loquitur* doctrine has been a factor in medical negligence cases in South Africa for a long time. The term *res ipsa loquitur* translates as “the thing speaks for itself” or “the case speaks for itself”. The effect thereof is that an inference of negligence is made if an event occurs in a manner that would not usually occur unless there has been negligence, but there is no direct evidence of the negligence.⁵⁰ Although the courts⁵¹ generally and some authors⁵² rely on the case of *Van Wyk v Lewis*⁵³ as authority to conclude that the doctrine does not apply in medical negligence cases in South Africa, voices have been raised reasoning that the doctrine is an evidentiary aid that could be developed for application in such cases.⁵⁴

2.29 However, Ponnán JA in the matter of *Goliath v MEC for Health, Eastern Cape*⁵⁵ finally laid the matter to rest. Ponnán JA quotes a statement made by Brand JA⁵⁶ (referring in turn to *Van Wyk v Lewis*) that the maxim *res ipsa loquitur* “could rarely, if ever, find application in cases based on alleged medical negligence”.⁵⁷ Ponnán JA acknowledges the “evident reluctance of our courts to apply the maxim”. He refers to

⁵⁰ Carstens & Pearmain 567; McQuoid-Mason & Dada 359.

⁵¹ See for example *Mitchell v Dixon* 1914 AD 519; *Pringle v Administrator, Transvaal* 1990 (2) SA 379 (W); *Castell v De Greef* 1994 (4) SA 408 (C).

⁵² See for example SA Strauss *Doctor, Patient and the Law* (1984) 245.

⁵³ *Van Wyk v Lewis* 1924 AD 438.

⁵⁴ See in general Pat van den Heever & Natalie Lawrenson “Inference of negligence – is it time to jettison the maxim *res ipsa loquitur*?” *De Rebus* (July 2015) 32; Patrick van den Heever & Pieter Carstens *Res Ipsa Loquitur and Medical Negligence: A Comparative Survey* (2011) 145–183; Bhavna Patel “Medical negligence and *res ipsa loquitur* in South Africa” *SAJBL* Vol 1 No 2 (December 2008) 57–60 at 59; Patrick van den Heever *The Application of the Doctrine of Res Ipsa Loquitur to Medical Negligence Actions: A Comparative Survey* (Unpublished LLD thesis, University of Pretoria 2002) 320–348; Carstens 342–349.

⁵⁵ *Goliath v MEC for Health, Eastern Cape* (085/2014) [2014] ZASCA 182 (25 November 2014).

⁵⁶ *Goliath* par 9.

⁵⁷ *Buthlezi v Ndaba* (575/2012) [2013] ZASCA 72; 2013 (5) SA 437 (SCA) (29 May 2013) par 16.

what Lord Denning MR said in *Hucks v Cole*:⁵⁸ “with the best will in the world things sometimes went amiss in surgical operations or medical treatment. A doctor was not to be held negligent simply because something went wrong”. Ponnann JA concludes: “For to hold a doctor negligent simply because something had gone wrong, would be to impermissibly reason backwards from effect to cause.”⁵⁹

2.30 Ponnann AJ agreed with the view expressed by Lord Justice Hobhouse in *Ratcliffe v Plymouth and Torbay Health Authority*⁶⁰ to jettison the *res ipsa loquitur* maxim from our legal lexicon and replace it with the phrase “a prima facie case”. Lord Justice Hobhouse stated: “*Res ipsa loquitur* is not a principle of law: it does not relate to or raise any presumption. It is merely a guide to help to identify when a prima facie case is being made out. Where expert and factual evidence has been called on both sides at a trial its usefulness will normally have long since been exhausted.”⁶¹

2.31 Following on the reasoning of the court in the *Goliath* case, Wessels concluded “it would seem that, for practical purposes, the maxim does not apply in the context of medical malpractice and that the patient would not be able to rely thereon. In short, the patient has the onus to prove negligence on the basis of the test outlined above.”⁶² This view is supported.

5 Common law “once and for all” rule

2.32 An aggrieved person, who suffered damages due to medical negligence of a medical practitioner, will have to take legal action to claim compensation or satisfaction for damages suffered as a result of the unlawful act or omission. However, in claims for damages the common law “once and for all” rule applies. Visser and Potgieter explain the common law “once and for all” rule in the following manner: “In claims for compensation or satisfaction arising out of a delict, breach of contract or other cause,

⁵⁸ *Hucks v Cole* [1968] 118 New LJ 469 ([1993] 4 Med LR 393) as quoted by Ponnann JA *Goliath* par 9.

⁵⁹ *Goliath* par 9.

⁶⁰ *Ratcliffe v Plymouth and Torbay Health Authority* [1998] EWCA Civ 2000 (11 February 1998) as cited by Ponnann JA.

⁶¹ Lord Justice Hobhouse quoted by Ponnann JA in the *Goliath* case par 12.

⁶² Wessels 5.

the plaintiff must claim damages once for all damages already sustained or expected in future in so far as it is based on a single cause of action.”⁶³

2.33 The origin of the “once and for all” rule dates back more than 300 years to the English case of *Fetter v Beale*.⁶⁴ In this matter the plaintiff was barred from claiming from the defendant a second time on the basis of an incident of battery (assault) for which the plaintiff had previously instituted action and been awarded damages. The rule forms part of South African law, which was confirmed by the Appellate Division of the Supreme Court as far back as 1917 in the case of *Cape Town Council v Jacobs*. Solomon JA observed that:⁶⁵

[O]nce the magistrate has finally decided the application the workman is debarred from making any further claim in respect of the same accident. That in an action at common law for damages for injuries sustained by an accident the plaintiff is only entitled to sue once and for all cannot I think be questioned. It may be that after he has recovered damages, it may transpire that the injuries are far more severe than appeared at the date of trial, but he is nevertheless precluded from claiming further damages in a subsequent action.

2.34 The application of the rule in South African law was affirmed in several subsequent cases, such as *Kantor v Welldone Upholsterers*;⁶⁶ *Green v Coetzer*;⁶⁷ *Mouton v Mynwerkersunie*;⁶⁸ *Marine and Trade Insurance Company Ltd v Katz NO*;⁶⁹ *Evins v Shield Insurance Company Ltd*;⁷⁰ *Souls Cleopas v The Premier of Gauteng*;⁷¹ *The Premier of the Western Cape Provincial Government N.O. v Kiewitz*;⁷² and *MEC for*

⁶³ JM Potgieter, L Steynberg & T Floyd Visser and Potgieter’s *Law of Damages* 3 ed (2012) 153.

⁶⁴ *Fetter v Beale* (1699) ER 11, affirmed (1702) 91 ER 1122.

⁶⁵ *Cape Town Council v Jacobs* 1917 AD 615 at 620.

⁶⁶ *Kantor v Welldone Upholsterers* 1944 CPD 388.

⁶⁷ *Green v Coetzer* 1958 (2) SA 697 (W).

⁶⁸ *Mouton v Mynwerkersunie* 1977 (1) SA 119 (A).

⁶⁹ *Marine and Trade Insurance Company Ltd v Katz NO* 1979 (4) SA 961 (AD).

⁷⁰ *Evins v Shield Insurance Company Ltd* 1982 (SA) 814 (A).

⁷¹ *Souls Cleopas v The Premier of Gauteng* unreported case 09/41967, Gauteng South High Court (April 2014).

⁷² *Premier of the Western Cape Provincial Government N.O. v Kiewitz* (158/2016) [2017] ZASCA 41.

Health and Social Development, Gauteng v DZ.⁷³ The question of the development of the common law to modify the “once and for all” rule was considered by the Constitutional Court in the matter of *MEC for Health and Social Development, Gauteng v DZ (DZ case)*. The case is discussed in detail in Chapter 4.

6 *Res judicata*

2.35 Apart from the “once and for all rule”, which has its origins in English law, the Roman Dutch law also gives recognition to the plea of *res judicata*. The literal translation of *res judicata* (also spelled *res iudicata*) is “judged matter”. Corbett et al explain:⁷⁴

As a matter of general principle – sometimes referred to as the ‘once and for all’ rule – a person may only bring one action against the same defendant upon a single cause of action. Once he has brought that action his remedies at law are exhausted and he is precluded by the principle of *res iudicata* from bringing a further action. Thus, if a plaintiff claims damages for either delict or breach of contract, he must claim damages for all the damage flowing from that cause of action because, if he fails to do so, he will thereafter be precluded from claiming further damages in a subsequent action.

2.36 The *res judicata* principle is discussed in more detail in Chapter 4 as part of the discussion about the common law “once and for all” rule. It must be borne in mind that *res judicata* can be pleaded “in bar”, defeating the applicant’s claim.⁷⁵ The applicant is then debarred from making any further claim in respect of the same incident.⁷⁶

E Compensation

2.37 The main purpose of compensation awarded for damages suffered due to delict or breach of contract is to put the injured party in the same position he or she would have been in if he or she had not been injured. This principle is called *restitutio in integrum*.⁷⁷

⁷³ *MEC for Health and Social Development, Gauteng v DZ* 2018 (1) SA (335) (CC); [2017] ZACC 37.

⁷⁴ MM Corbett, JL Buchanan & JJ Gauntlett *The Quantum of Damages in Bodily and Fatal Injuries: General Principles* (Jutastat e-publications 2009) 7.

⁷⁵ “A plea in bar sets forth matters that deny the plaintiff’s right to maintain his or her lawsuit” *The Free Dictionary by Farlex*: legal-dictionary.thefreedictionary.com.

⁷⁶ *Cape Town Council v Jacobs* 1917 AD 615 at 620.

⁷⁷ The literal translation of *restitutio in integrum* is “restoration to the whole (ie uninjured state”. In legal terms, it means “[r]estoration of an injured party to the situation which would

In South Africa, the tendency with regard to compensation for delictual damages has traditionally been lump sum monetary awards. However, in some foreign jurisdictions there has been a trend towards greater flexibility when granting compensation by allowing alternatives to lump sum awards, such as periodic payments and “payment in kind”, or a structured settlement which combines two or more compensation options. In order to consider the advantages and disadvantages of the different compensation options, it is necessary to have a better understanding of the terminology.

1 Lump sum payments

2.38 The usual practice by the courts when awarding damages for a successful claim on the basis of a contractual or delictual obligation is to issue an order awarding payment of compensation in a lump sum. The term “lump sum payment” means “[o]ne time payment of money as opposed to smaller payments over time Here, a single sum of money serves as complete payment. It satisfies all of the benefits owed to the recipient.”⁷⁸ The expression “lump sum award” refers to “an award granted by a court that covers past losses and losses likely to be suffered in the future”.⁷⁹

2.39 The Law Reform Commission, Ireland says that when calculating a lump sum award “future losses must be reduced to present value by taking a complex variety of factors into account”.⁸⁰ An assessment must be made of all past and future losses at a certain point in time and a lump sum is then awarded that should cover everything.⁸¹ The losses considered include pecuniary loss (special damages) as well as non-pecuniary loss (general damages). Special damages include out-of-pocket expenses, for example medical expenses, cost of assistive devices, loss of income and loss of earning capacity.⁸² It also includes forthcoming expenses such as future medical treatment.⁸³

have prevailed had no injury been sustained; restoration to the original or pre-contractual position.” (*Lexico* accessed 18 August 2021 www.lexico.com/definition).

⁷⁸ US Legal “Law and Legal Definition” accessed 17 August 2021 definitions.uslegal.com.

⁷⁹ US Legal “Law and Legal Definition” accessed 17 August 2021 definitions.uslegal.com.

⁸⁰ Law Reform Commission, Ireland *Report on Personal Injuries: Periodic Payments and Structured Settlements* (1996) 2 [LRCI (1996)].

⁸¹ Working Group on Medical Negligence and Periodic Payments *Report of the Working Group on Medical Negligence and Periodic Payments* (Ireland October 2010) at 11 (Working Group).

⁸² McQuoid-Mason & Dada 126; HB Klopper *Damages* (2017) 13.

⁸³ Klopper 14.

General damages are awarded to compensate for harm that are of a personal nature and that cannot be mathematically calculated, for example physical or mental pain and suffering, physical impairment, loss of amenities, reduced quality of life, or emotional harm.⁸⁴

2 Advantages and disadvantages of lump sum payments

2.40 One of the biggest flaws in the award of lump sum payments is the uncertainty inherent in the calculation of lump sum payments for especially future special damages. The award will inevitably be either too high or too low. Factors that must be considered when calculating the amount of a lump sum payment include the likely life expectancy of the plaintiff, cost of future medical care and treatment, loss of earnings, inflation rates and interest rates.⁸⁵

2.41 The Law Reform Commission of Hong Kong opines that “uncertainties inherent in assessing the future loss components of a lump sum award inevitably mean that such awards prove in the course of events to be inaccurate in being either too high or too low and thus fail to meet the goal of *restitutio in integrum*”⁸⁶. This is echoed by the Irish Working Group on Medical Negligence and Periodic Payments: “The one virtual certainty about a lump sum award to pay for future care is that the wrong amount will be awarded. That is inescapable.”⁸⁷

2.42 Arguments put forward in favour of a lump sum award is that it leaves the plaintiff in possession of a large sum of money to invest or use as the plaintiff sees fit. It brings conclusiveness and certainty in the resolution of a claim. The defendant can dispose of the matter and close the file, so to speak.⁸⁸ However, in view of the risks visited upon both the plaintiff as well as the defendant by lump sum awards, this argument is outweighed by the disadvantages of this method of compensation. It is especially

⁸⁴ McQuoid-Mason & Dada 125; Klopper 13.

⁸⁵ Working Group 13; Law Reform Commission of Hong Kong *Periodical Payments for Future Pecuniary Loss in Personal Injury Cases Sub-Committee: Consultation Paper* (2018) at 90 [LRCHK (2018)]; GA Whittaker *Medical Malpractice in the South African Public Sector* (Actuarial Society of South Africa 2021) at 127. IP 33 respondents: Discovery Health 5.

⁸⁶ LRCHK (2018) 90.

⁸⁷ Working Group 13.

⁸⁸ LRCI (1996) 121; Working Group 15; Whittaker 127.

plaintiffs that require long-term care or permanent incapacity that suffer the risk of outliving their award. On the other hand, if the plaintiff dies before the money runs out, the plaintiff's estate would be unjustly enriched.⁸⁹

3 Structured settlements and periodic payments

2.43 Hindert et al define a structured settlement as “an agreement to settle a personal injury claim, where the claimant accepts a defined package of financial products, generally cash and periodic payments, on specified terms”. The authors define periodic payment to mean “a commitment to make future payments to a claimant according to an agreed schedule on specified terms”.⁹⁰

2.44 The first reported incidents of structured settlements in personal injury cases occurred in Canada in the 1960s. Several claims were instituted against a drug company on behalf of children born with severe birth defects, especially phocomelia, as a result of the use of the drug Thalidomide by their mothers during pregnancy. The children faced life-long dependency at huge cost to their families. Since the drug company could not afford covering the cost of lump sum payments in full, the company resolved the claims through structured settlements, undertaking to make periodic payments to the victims over the course of their lifetimes.⁹¹

2.45 The practice of awarding damages by means of structured settlements or periodic payments has since increased. Apart from Canada, courts in countries such as the United States of America, United Kingdom, Australia, New Zealand, Finland, France, Germany, Luxembourg, Portugal, Spain and Sweden may order defendants to pay damages for certain future losses in periodic payments or as a lump sum.⁹²

⁸⁹ Working Group 14 & 15.

⁹⁰ Daniel W. Hindert, Joseph Julnes Dehner & Patrick J. Hindert *Structured Settlements and Periodic Payment Judgments* (2005) 1-3.

⁹¹ Hindert et al 1-36.

⁹² Hindert et al 1-37 to 1-40.

4 Advantages and disadvantages of periodic payments

2.46 The UK's *Royal Commission on Civil Liability and Compensation for Personal Injury* of 1978 (referred to as the Pearson Commission) considered the advantages and disadvantages of periodic payments.⁹³ According to the Pearson Commission periodic payments would be more effective than lump sum payments, especially if coupled with a review mechanism.⁹⁴

2.47 A strong argument in favour of structured settlements and periodic payments is the shortcomings of the lump sum award system, especially taking into consideration that a conventional lump sum award for future damages will inevitably either over-compensate or under-compensate the plaintiff. In addition, the defendant will not have to pay in full in year one for a claim that is calculated on the basis of future inflation up to for argument's sake year 30.

2.48 An argument often raised against periodic payments is the possibility that the payments would not be maintained over a long period of time. A defendant will have to furnish security to the court's satisfaction to ensure that periodic payments are kept up in the long term.

5 Additional considerations

2.49 From the discussion above it is clear that there are good arguments for deviating from the practice of awarding damages or compensation in the form of lump sum payments. Although neither the "once and for all" rule nor the *res iudicata* principle as such prohibits the payment of damages as structured settlements, in instalments or as periodic payments, the common practice by the courts in awarding damages has been to order lump sum payments.

2.50 In the majority of jurisdictions that expressly allow structured settlements or periodic payments, the awarding of damages in that manner is left to the discretion of the courts. An example of an obligation imposed to award periodic payments is to be found in the 1990 Courts of Justice Act of Ontario, Canada. Section 116.1 of that Act

⁹³ *Royal Commission on Civil Liability and Compensation for Personal Injury* 1978 (HMSO, Cmnd 7054) (Pearson Commission).

⁹⁴ Pearson Commission par 566.

determines that in medical malpractice actions, for awards that exceed a certain amount, “the court **shall** ... order that the damages for the future care costs of the plaintiff be satisfied by way of periodic payments.” [emphasis added].

2.51 Though the “once and for all” rule and the plea of *res iudicata* bar multiple claims based on the same cause of action; a careful review of the case law (see Chapter 4) reveals that it does not bar damages awarded by means of structured settlements or periodic payments. The courts have indicated that legislative intervention would be required before orders can be made that compel plaintiffs to accept awards in the form of undertakings or structured settlements, as provided, for example, by section 17 of the Road Accident Fund Act.⁹⁵

6 Existing South African legislation

2.52 There are current statutory measures in South Africa that provide for structured settlements or periodic payments. Examples of such measures are discussed below.

(a) ***Occupational Diseases in Mines and Works Act 78 of 1973***

2.53 According to the long title of the Occupational Diseases in Mines and Works Act 78 of 1973 the purpose of the Act is to consolidate and amend the law relating to the payment of compensation in respect of certain diseases contracted by persons employed in mines and works and matters incidental thereto. Chapter VI of the Act pertains to compensation under the Act and sets out the various monthly “pensions” payable under the Act and the amounts thereof.

(b) ***Compensation for Occupational Injuries and Diseases Act 130 of 1993***

2.54 According to the long title of the Compensation for Occupational Injuries and Diseases Act 130 of 1993 the purpose of the Act is to provide for compensation or disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, or for death resulting from such injuries or diseases, and to provide for matters connected therewith. Section 22 deals with the right

⁹⁵ *MEC for Health and Social Development, Gauteng v [DZ]* (1020/2015) [2016] ZASCA 185 (30 November 2016); *Souls Cleopas v the Premier of Gauteng* Unreported case no. 09/41967 Gauteng South High Court (April 2014).

of an employee to compensation, while sections 49 and 54 deals with the payment of compensation, including the payment of a monthly pension.

(c) Road Accident Fund Act 56 of 1996

2.55 According to the long title of the Road Accident Fund Act, the purpose of the Act is to provide for the establishment of the Road Accident Fund (RAF); and to provide for matters connected therewith. Section 17 of the Act relates to the liability of RAF and agents. Section 17(4)(b) specifically makes provision for the possibility of payment of a claim for future loss of income or support in instalments as agreed upon.⁹⁶ Apart from provision for periodic payments of claims, section 17(4)(a) determines that the Fund may furnish a third party with an undertaking to compensate the third party for future accommodation in a hospital or nursing home, rendering a service or supplying goods.⁹⁷

F Basis for state liability

1 Vicarious liability

2.56 The legal principle of vicarious liability refers to a situation where the law holds one person responsible for the wrongful conduct of another, even though the person being held responsible is innocent of any wrongdoing.⁹⁸

2.57 One of the instances where vicarious liability is relevant is in an employer-employee relationship. An employer would be held liable generally for a delict committed by an employee if the employee's wrongful act was committed in the course and scope

⁹⁶ (4) Where a claim for compensation under subsection (1) –
(b) includes a claim for future loss of income or support, the amount payable by the Fund or the agent shall be paid by way of a lump sum or in instalments as agreed upon;

⁹⁷ (4) Where a claim for compensation under subsection (1) –
(a) includes a claim for the costs of the future accommodation of any person in a hospital or nursing home or treatment of or rendering of a service or supplying of goods to him or her, the Fund or an agent shall be entitled, after furnishing the third party concerned with an undertaking to that effect or a competent court has directed the Fund or the agent to furnish such undertaking, to compensate – [list of claims / expenses follows].

⁹⁸ Carstens & Pearmain 545; McQuoid-Mason & Dada 433; DJ McQuoid-Mason "Vicarious and Strict Liability" in WA Joubert (founding ed) *LAWSA* Vol 30 2ed (2011) par 285 [*LAWSA* vol 30].

of his or her employment. This also holds true for employees of the state.⁹⁹ Action for the commission of a delict in such a case would be instituted against the employer of the person who committed the delict.

2.58 Section 2 of the State Liability Act 20 of 1957 (SLA) stipulates that proceedings are to be taken against the executive authority of the department concerned. In the event of claims based on medical negligence instituted against the state, the MEC for Health in the province concerned must be cited as the defendant. Section 2(1) of the SLA states as follows:

(1) In any action or other proceedings instituted by virtue of the provisions of section 1, the executive authority of the department concerned must be cited as nominal defendant or respondent.

2 Constitutional and public obligations

2.59 Apart from state liability on the basis of vicarious liability resulting from the employer / employee relationship between the state and its workers, the state could be liable on an altogether different level due to the state's constitutional obligations towards its citizens. In addition to the rights espoused in section 27(1)(a)¹⁰⁰ and 27(2),¹⁰¹ other relevant constitutional rights include the right to dignity; life; freedom and security of the person, specifically bodily integrity; privacy; access to courts; and the right to approach a court for the granting of appropriate relief if a right in the Bill of Rights has been infringed or threatened.¹⁰² Moodley refers to the foundational rights to dignity, equality and life, but also lists the social rights that affect health, such as adequate water, social security, housing and education.¹⁰³

2.60 The NDOH, under the leadership of the Minister of Health as the responsible member of the executive, is the government department responsible for providing

⁹⁹ Coetzee & Carstens 1271; *LAWSA* vol 30 par 289 and 294.

¹⁰⁰ (1) Everyone has the right to have access to –
(a) health care services, including reproductive health care;

¹⁰¹ (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

¹⁰² Sections 1; 1(a); 10; 11; 12(1) and (2); 14, 34 and 38 respectively.

¹⁰³ K Moodley *Medical Ethics, Law and Human Rights – A South African Perspective* (2011) 97.

direction and policy guidance on the implementation of the constitutional right to health care services. To this end the National Health Act 61 of 2003 was adopted, which provides a framework for a structured health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services.¹⁰⁴

2.61 The constitutional protection of the right of access to health care services and related rights has impacted on the legal philosophical foundation for the exercise of individual rights. Traditionally, the basis of the relationship between a doctor and a patient, or a hospital and a patient, was contractual.¹⁰⁵ This mostly still holds true for private health care, but as pointed out by Carstens & Pearmain, “in the wake of the South African Constitution of 1996, national legislation and the reality that the majority of South African citizens are dependant upon health services as delivered by the public sector, there has been a shift to considerations of public law.”¹⁰⁶

G Constitutional damages

2.62 It is conceivable that constitutional damages may be sought against the state for harm suffered for a breach of a constitutional right, such as the right to have access to health care services. Koen remarks that “[t]he award of [constitutional] damages serves to re-assure society that their rights are protected and that there is some recompense for violation of these absolute rights.”¹⁰⁷ If the quality of health care services offered in the public health sector continues to deteriorate, or if a provincial department of health collapses as the Auditor-General fears, claims for constitutional damages because of a non-functioning public health system could become a reality. An overview of case law dealing with constitutional damages would therefore be of value.

¹⁰⁴ Long title to the National Health Act, Act 61 of 2003.

¹⁰⁵ Carstens & Pearmain 283 & 413.

¹⁰⁶ Carstens & Pearmain 283.

¹⁰⁷ Lynne Koen “Constitutional damages and the Life Esidemeni decision” *Without Prejudice* (May 2018) 14–15 at 14.

1 Constitution of the Republic of South Africa, 1996

2.63 Chapter 2 of the Constitution of the Republic of South Africa, 1996 contains the Bill of Rights, which "... enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom."¹⁰⁸ Section 38 of the Constitution deals with the enforcement of rights and grants anyone listed in that section the right to approach court if one of his or her rights in the Bill of Rights has been infringed or threatened. Section 38 further states that the court may grant appropriate relief, including a declaration of rights, in the event of a constitutional right being infringed or threatened.¹⁰⁹

2 Appropriate relief

2.64 The issue of appropriate relief for a breach of an individual's constitutional rights was considered by the Constitutional Court in the seminal case of *Fose v Minister of Safety and Security*,¹¹⁰ where Ackermann J said the following about "appropriate relief":¹¹¹

Appropriate relief will in essence be relief that is required to protect and enforce the Constitution. Depending on the circumstances of each particular case the relief may be a declaration of rights, an interdict, a *mandamus* or such other relief as may be required to ensure that the rights enshrined in the Constitution are protected and enforced. If it is necessary to do so, the courts may even have to fashion new remedies to secure the protection and enforcement of these all-important rights.

2.65 The wording of section 7(3)¹¹² of the Constitution of the Republic of South Africa, 1993 (Act 200 of 1993), is very similar to the wording of section 38 of the Constitution. Both the Constitution as well as the interim 1993 Constitution refer to "appropriate relief" for an infringement of or threat to a constitutional right.

¹⁰⁸ Section 7(1) of the Constitution.

¹⁰⁹ Anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights (in relevant part).

¹¹⁰ *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC).

¹¹¹ *Fose* par 19.

¹¹² When an infringement of or threat to any right entrenched in this Chapter is alleged, any person referred to in paragraph (b) shall be entitled to apply to a competent court of law for appropriate relief, which may include a declaration of rights.

2.66 In *Dikoko v Mokhatla*,¹¹³ the Constitutional Court affirmed, per Moseneke DCJ, the application of the dictum in the *Fose*-case to the term “appropriate relief” as employed in section 38 of the Constitution:¹¹⁴

Although these remarks in *Fose* were directed at the remedy provision of the interim Constitution, it seems to me that the same considerations apply to the ‘appropriate relief’ envisaged in s 38 of the Constitution when an award of damages is necessary to vindicate, that is to protect and enforce, rights which aside their common-law pedigree are also enshrined in the Bill of Rights. There appears to be no sound reason why common law remedies, which vindicate constitutionally entrenched rights, should not pass for appropriate relief within the reach of s 38. If anything, the Constitution is explicit that, subject to its supremacy, it does not deny the existence of any other rights that are recognised and conferred by the common law.

3 Constitutional remedies

2.67 Currie and De Waal maintain that the failure of the Constitution to explain or give more information on “appropriate relief” and that no particular remedy is prescribed for the breach of a constitutional right, means that “s 38 sanctions a flexible approach to remedies.”¹¹⁵ They describe constitutional remedies as “forward looking, community-orientated and structural rather than backward-looking, individualistic and corrective or retributive.”¹¹⁶

2.68 The main forms of constitutional remedies discussed by Currie and De Waal are:¹¹⁷

- Declarations of invalidity
- Declarations of rights
- Interdictory relief
- Damages.

¹¹³ *Dikoko v Mokhatla* 2006 (6) SA 235 (CC).

¹¹⁴ *Dikoko v Mokhatla* par 91.

¹¹⁵ Ian Currie & Johan de Waal *The Bill of Rights Handbook* 6 ed (2013) 181.

¹¹⁶ Currie & De Waal 181.

¹¹⁷ Currie & De Waal 183–205.

2.69 Currie and De Waal further contend that the Constitution does not prevent a court from awarding damages as a remedy for the violation of fundamental rights.¹¹⁸ It would therefore serve to consider the basis for awarding damages for a breach of or threat to constitutional rights.

2.70 In the *Fose*-case the court regarded the award the plaintiff would be able to claim for the conduct of the police officials as sufficient, and did not find it necessary for an additional award of constitutional damages.¹¹⁹ Ackermann J said that:¹²⁰

The South African common law of delict is flexible and under s 35(3) of the interim Constitution should be developed by the Courts with 'due regard to the spirit, purport and objects' of chap 3. In many cases the common law will be broad enough to provide all the relief that would be 'appropriate' for a breach of constitutional rights. That will of course depend on the circumstances of each particular case.

2.71 It is important to note that the Constitutional Court, in the *Fose*-case, does not exclude the possibility of awarding constitutional damages when appropriate.¹²¹

[T]here is no reason in principle why 'appropriate relief' should not include an award of damages, where such an award is necessary to protect and enforce chap 3 rights. ... When it would be appropriate to do so, and what the measure of damages should be will depend on the circumstances of each case and the particular right which has been infringed.

2.72 This view is also expressed by former Judge of the Constitutional Court, Justice Kate O'Regan. In reflecting on the topic of constitutional remedies, Justice O'Regan affirms that:¹²²

The South African law of delict provides suitable remedies for the breach of constitutional rights and requires relatively little adjustment to meet this purpose. In most cases, therefore, where a constitutional right has been infringed and loss or harm occasioned, a claim for damages will lie under one or other delictual action.

¹¹⁸ Currie & De Waal 200.

¹¹⁹ *Fose* par 67.

¹²⁰ *Fose* par 58.

¹²¹ *Fose* par 60.

¹²² Kate O'Regan "Fashioning constitutional remedies in South Africa: some reflections" *Advocate* (April 2011) 41–44 at 43.

2.73 Davidow and Wagner reiterate the exceptional nature of an award of constitutional damages:¹²³

It is clear from the jurisprudential development since the inception of the Constitutional era that an award of constitutional damages is an exceptional remedy, in light of the fact that constitutional remedies ought to be forward-looking. Constitutional damages are, by their very nature, not forward-looking, but require our courts to look back to determine how best to compensate the victim or to punish and deter the violator. Our courts' approach to constitutional damages is tempered with caution.

4 Awards for or recognition of damages for constitutional infringements

(a) *Constitutional Court*

2.74 The Constitutional Court awarded **constitutional damages** in 2005 in the matter of the *President of the Republic of South Africa & Another v Modderklip Boerdery (Pty) Ltd*.¹²⁴ The court awarded compensation to the respondent Modderklip (plaintiff) based on the infringement of Modderklip's constitutional rights under section 34 of the Constitution (access to courts). Although the property of Modderklip Boerdery was invaded by several thousand illegal occupiers, the state failed to take reasonable steps to ensure effective relief for the applicant.

2.75 In 2001 the Constitutional Court recognised the principle of holding the state liable on the basis of omissions by its officers to protect a person's constitutional rights to dignity, life and freedom and security of the person (sections 10, 11 and 12 of the Constitution respectively) in *Carmichele v Minister of Safety and Security*.¹²⁵ The officers of the state had failed to oppose a bail application brought by a known sexual offender who seriously assaulted the plaintiff while he was out on bail. The Constitutional Court referred the matter back to the High Court to develop the common law in accordance with section 39(2) of the Constitution. The plaintiff (applicant) eventually succeeded with

¹²³ Raizel Davidow & Kristen Wagner "Constitutional damages: punitive damages?" *Without Prejudice* (August 2018) 18–20 at 19.

¹²⁴ *President of the Republic of South Africa & Another v Modderklip Boerdery (Pty) Ltd* 2005 (5) SA 3 (CC).

¹²⁵ *Carmichele v Minister of Safety and Security and Another (Centre for Applied Legal Studies intervening)* 2001 (4) SA 938 (CC).

a delictual claim for damages against the state in the Supreme Court of Appeal. Harms JA held that there is no “reason in this case to depart from the general principle that the State will be liable for its failure to comply with its Constitutional duty to protect the plaintiff.”¹²⁶

2.76 The Constitutional Court found in favour of the plaintiff (applicant) in 2005 in the case of *K v Minister of Safety and Security*¹²⁷ on the basis of delict for damages suffered as a result of the conduct of members of the police, who had raped the plaintiff while they were on duty. The constitutional rights referred to were the applicant’s constitutional right to freedom and security of the person, and in particular, the right to be free from all forms of violence from either public or private sources (s 12) as well as her right to dignity (s 10), right to privacy (s 14) and right to substantive equality (s 9).¹²⁸

2.77 The Constitutional Court entertained an application for relief for the cancellation of the applicant’s disability grant in the case of *Njongi v MEC, Department of Welfare, Eastern Cape*,¹²⁹ heard in 2007. Summarising the cause of action, Yacoob J stated that:¹³⁰

This application for leave to appeal is concerned with the right to receive a disability grant within the context of the socio-economic rights embraced by our Constitution. In particular it concerns the right of grant receivers to lawful administrative action when social grants are cancelled ...

2.78 The court upheld the appeal and declared the MEC’s (respondent) administrative action of terminating the plaintiff’s (applicant) social grant to be invalid, setting the administrative action aside. The court awarded monetary compensation, which included interest. To demonstrate its displeasure with the manner in which the state conducted this case, the court ordered the MEC to pay the costs of the applicant in the High Court, the full court, the SCA and the Constitutional Court, on the scale as between attorney and client.¹³¹

¹²⁶ *Carmichele* par 44.

¹²⁷ *K v Minister of Safety and Security* 2005 (6) SA 419 (CC).

¹²⁸ *K* case par 14.

¹²⁹ *Njongi v MEC, Department of Welfare, Eastern Cape* 2008 (4) SA 237 (CC).

¹³⁰ *Njongi* par 1.

¹³¹ *Njongi* par 92

(b) Supreme Court of Appeal

2.79 The Supreme Court of Appeal awarded **constitutional damages** to the plaintiff in 2006 in *MEC, Department of Welfare, Eastern Cape v Kate*.¹³² The court held, per Nugent AJ, that "... the only appropriate remedy in the circumstances is to award constitutional damages to recompense Kate for the breach of her right."¹³³ The right found to have been breached was the plaintiff's (respondent) right to social assistance (section 27(1)(c) of the Constitution) due to the "[u]nreasonable delay in considering claimant's application for disability grant resulting in denial of claimant's right to social assistance during period of delay."¹³⁴

2.80 In 2002, the Supreme Court of Appeal found in favour of the respondent (the plaintiff) in the matter of *Minister of Safety and Security v Van Duivenboden*.¹³⁵ The plaintiff brought a delictual claim for damages for injuries he had suffered after being shot by a person who should have been deprived of his firearms by the police due to his tendency to threaten to shoot people when drunk. The plaintiff's constitutional rights to human dignity, to life and to personal security had been placed in peril (s 10, 11 and 12 of the Constitution respectively).

2.81 Nugent JA made it clear in the *Van Duivenboden*-case that the protection of constitutional rights need not be limited to actions for damages, but could also be secured through the political process or another remedy:¹³⁶

Where the conduct of the state, as represented by the persons who perform functions on its behalf, is in conflict with its constitutional duty to protect rights in the Bill of Rights in my view the norm of accountability must necessarily assume an important role in determining whether a legal duty ought to be recognized in any particular case. The norm of accountability, however, need not always translate constitutional duties into private law duties enforceable by an action for damages, for there will be cases in which other appropriate remedies are available for holding the state to account. Where the conduct in issue relates to questions of state policy, or where it affects a broad and indeterminate segment of society, constitutional accountability might at times be

¹³² *MEC, Department of Welfare, Eastern Cape v Kate* 2006 (4) SA 478 (SCA).

¹³³ *Kate* par 33.

¹³⁴ *MEC, Department of Welfare, Eastern Cape v Kate* quoted from headnote.

¹³⁵ *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA).

¹³⁶ *Van Duivenboden* par 21.

appropriately secured through the political process, or through one of the variety of other remedies that the courts are capable of granting.

2.82 In 2004, the Supreme Court of Appeal held the state liable for delictual damages for the infringement of a person's right to bodily integrity (section 12(2)) in the case of *Minister of Safety and Security v Hamilton*.¹³⁷ The police had negligently issued a firearm licence to a mentally disabled person, who subsequently shot the plaintiff (respondent), causing him a permanent spinal injury.

5 Constitutional damages not awarded

(a) Constitutional Court

2.83 The Constitutional Court considered a challenge to sections 17(4)(c) and 21 of the Road Accident Fund Amendment Act 19 of 2005, as well as of regulation 5(1) of the regulations under the Road Accident Fund Act 56 of 1996, in *Law Society of South Africa and Others v Minister for Transport and Another*,¹³⁸ heard in 2010. Regarding the protection of a constitutional right by means of a delictual remedy, Moseneke DCJ declared:¹³⁹

It seems clear that in an appropriate case a private-law delictual remedy may serve to protect and enforce a constitutionally entrenched fundamental right. Thus a claimant seeking 'appropriate relief' to which it is entitled, may properly resort to a common-law remedy in order to vindicate a constitutional right. It seems obvious that the delictual remedy resorted to must be capable of protecting and enforcing the constitutional right breached.

2.84 The court eventually found sections 17(4)(c) and 21 of the RAF Amendment Act to be valid on the basis that the sections constitute reasonable and justifiable limitations to constitutional rights and were rational in view of the purpose it sought to achieve.¹⁴⁰

¹³⁷ *Minister of Safety and Security v Hamilton* 2004 (2) SA 216 (SCA).

¹³⁸ *Law Society of South Africa and Others v Minister for Transport and Another* 2011 (1) SA 400 (CC).

¹³⁹ *Law Society* par 74.

¹⁴⁰ *Law Society* pars 80 and 86.

2.85 In the 2012 case of *Lee v Minister for Correctional Services*¹⁴¹ the Constitutional Court awarded the plaintiff's (applicant) claim for delictual damages subsequent to the plaintiff contracting tuberculosis in prison. The Constitutional Court would not allow an additional claim for constitutional damages, applied for only at this stage, on technical grounds. Nkabinde J, delivering the majority judgement, explained:¹⁴²

The granting of an amendment and allowing a claim for constitutional damages at this stage of appeal proceedings will be prejudicial to the respondent. New evidence may have to be presented. Apart from the fact that the raising of a new claim on appeal raises procedural and evidential difficulties, it is generally not in the interests of justice for this court to sit as a court of first and final instance on appeal. Accordingly, the application should be dismissed.

(b) Supreme Court of Appeal

2.86 In its 2001 decision in *Olitzki Property Holdings v State Tender Board and Another*¹⁴³ the Supreme Court of Appeal dismissed the plaintiff's (applicant) appeal for a claim for damages for a failed tender based on section 187 (Procurement administration) of the interim 1993 Constitution. Cameron JA referred to *Fose v Minister of Safety and Security*¹⁴⁴ regarding the impact cases of this nature could have on the exchequer,¹⁴⁵ quoting the relevant part of the *Fose* judgement.¹⁴⁶ The court however declined to take a decision on the issue of whether a lost profit can be claimed as constitutional damages, leaving this possibility open: "It is, however, not necessary to decide that a lost profit can never be claimed as constitutional damages."¹⁴⁷

¹⁴¹ *Lee v Minister for Correctional Services* 2013 (2) SA 144 (CC).

¹⁴² *Lee* par 36.

¹⁴³ *Olitzki Property Holdings v State Tender Board and Another* 2001 (3) SA 1247(SCA).

¹⁴⁴ *Fose v Minister of Safety and Security* 1997 (3) SA 786 (CC).

¹⁴⁵ *Olitzki Property Holdings* par 41.

¹⁴⁶ In a country where there is a great demand generally on scarce resources, where the government has various constitutionally prescribed commitments which have substantial economic implications and where there are "multifarious demands on the public purse and the machinery of government that flow from the urgent need for economic and social reform", it seems to me it would be inappropriate to use these scarce resources to pay punitive constitutional damages to plaintiffs who are already fully compensated. [*Fose v Minister of Safety and Security* par 72].

¹⁴⁷ *Olitzki Property Holdings* par 42.

2.87 The case of *Minister of Safety and Security v Van Duivenboden*¹⁴⁸ gave rise to another case, decided in the SCA in 2008. Neil Brooks, the perpetrator in the *Van Duivenboden*-case, who had killed his wife and daughter and injured the plaintiff, was incarcerated because of the fatal shooting incidents. His son, Aaron Brooks, who was 14 at the time, was left without parental support as a result of the death of his mother and the incarceration of his father. Aaron Brooks also instituted a claim against the state in the case of *Brooks v Minister of Safety and Security*¹⁴⁹. Aaron Brooks' application was summarised thus:¹⁵⁰

On appeal it was submitted on behalf of the appellant that the common-law action for loss of support ought to be extended to someone in the appellant's position so as to accord with the norms and values reflected in the Constitution.

2.88 The SCA, however, dismissed plaintiff (appellant) Aaron Brooks' claim for parental support.

2.89 The issue of loss of parental support came before the SCA again in 2014 in *Minister of Police v Mboweni*.¹⁵¹ The two plaintiffs (respondents), are the mothers of the daughters of Mr Wisani Mahlati, who died as a result of an assault perpetrated by fellow inmates while he was held overnight in a cell at a police station. The respondents pursued claims against the Minister of Police for damages based "on an allegation that their daughters' 'right to parental care as provided for in Section 28(1)(b) [of the Constitution] was impaired' when their father died as a result of 'the unconstitutional conduct' of the members of the force for whom the minister was in law liable."¹⁵² The SCA, in upholding the appeal, held that the court *a quo* did not consider the matter fully.

2.90 One of the issues that the SCA stated had not been aired adequately was the police's duty in relation to the children:¹⁵³

It also required the court to decide whether the police owed a legal duty to the children to avoid, or prevent them from suffering, a loss of parental care. Not every breach of constitutional duty is equivalent to unlawfulness

¹⁴⁸ *Minister of Safety and Security v Van Duivenboden* 2002 (6) SA 431 (SCA).

¹⁴⁹ *Brooks v Minister of Safety and Security* 2009 (2) SA 94 (SCA).

¹⁵⁰ *Brooks* headnote.

¹⁵¹ *Minister of Police v Mboweni and Another* 2014 (6) SA 256 (SCA).

¹⁵² *Mboweni* headnote.

¹⁵³ *Mboweni* par 18.

in the delictual sense and therefore not every breach of a constitutional obligation constitutes unlawful conduct in relation to everyone affected by it.

2.91 The SCA criticised the manner in which the High Court arrived at its conclusion in the matter on appeal:¹⁵⁴

The [High] court should first have considered the adequacy of the existing remedy. If it were inadequate then it should have considered whether the deficiency could be remedied by a development of the common law to accommodate a claim more extensive than one for pecuniary loss. ... Another consideration is that the infringement of constitutional rights may often be appropriately vindicated by resort to public-law remedies.

6 Considerations for awarding constitutional damages

2.92 Taking her cue from the *Fose* case, Toxopeüs extracted the following four issues with regard to appropriate relief for an infringement of or threat to a constitutional right:¹⁵⁵

- 1) Courts should look at the circumstances of each case to determine what relief will best ensure the *protection* and *enforcement* of the rights enshrined in the Constitution and may, where necessary, formulate fresh remedies to do so.
- 2) In several instances, the common law will be broad enough to encompass all the relief that will be “appropriate” to remedy a violation of constitutional rights.
- 3) In principle, “appropriate relief” may include an award for constitutional damages where such an award is necessary to protect and enforce rights in the Bill of Rights.
- 4) In a country where there is a heavy demand for scarce resources with which the state must fulfil several constitutional obligations, courts ought not to award punitive constitutional damages to a claimant who is already fully compensated for any loss or damage.

2.93 Toxopeüs also refers to the further guidelines set out by the SCA for consideration when determining whether it would be appropriate to award constitutional damages:

¹⁵⁴ *Mboweni* par 22.

¹⁵⁵ Michelle Toxopeüs “Constitutional damages: Recent decisions in focus” Helen Suzman Foundation (20 June 2018) hsf.org.za/publications/hsf-briefs/constitutional-damages-recent-decisions-in-focus.

- the nature and relative importance of the rights that are in issue;
- alternative remedies that may be available to assert and vindicate the rights;
- the consequences of breaching these rights for the claimants.

7 Other types of damages

(a) *Damages for victims of constitutional rights infringements*

2.94 It is clear from the discussion above that the victim, being the person who has suffered a breach or injury to his or her constitutional rights, will be entitled to damages. While the precedents to date for the awarding of constitutional damages have been for an infringement of the right of access to courts (in the Constitutional Court)¹⁵⁶ and the right to social assistance (in the Supreme Court of Appeal),¹⁵⁷ the highest courts in the land have recognised and given effect to the principle of the awarding of constitutional damages in SA law. The courts have not yet awarded constitutional damages for rights such as the right to equality, human dignity, life, freedom and security of the person, privacy, property, health care services or children's rights (sections 9, 10, 11, 12, 14, 25, 27, and 28 respectively). There are several examples, however, of delictual damages awarded for the breach of constitutional rights.

2.95 The common element in matters where damages were awarded for constitutional infringements is the fact that all these awards were made to the person whose constitutional rights had been infringed. The cases of *Brooks* and *Mboweni* discussed above were brought to court for the infringement of constitutional rights that flowed from the infringement of the constitutional rights of other persons. Both cases were brought for loss of parental support in breach of parts of section 28 (children) of the Constitution. Both applications failed.

(b) *Psychiatric injury or emotional shock*

2.96 There are matters that were brought successfully by applicants for suffering harm as a result of harm caused to another person. One of the instances where this is possible is harm suffered due to psychiatric injury, or nervous shock. The first case that gave

¹⁵⁶ *President of the Republic of South Africa & Another v Modderklip Boerdery (Pty) Ltd* 2005 (5) SA 3 (CC).

¹⁵⁷ *MEC, Department of Welfare, Eastern Cape v Kate* 2006 (4) SA 478 (SCA).

recognition to the principle of awarding damages for psychiatric injury is the 1972 case of *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk*¹⁵⁸ heard in the Supreme Court of Appeal.

2.97 The appellant brought a delictual action for damages for shock, pain, suffering and disablement in his capacity as the legal guardian of a minor child, Deon. Deon and his brother Werner were crossing a street when a car collided with Werner. Werner died later the same day of his injuries. Deon suffered a severe shock, resulting in an anxiety neurosis due to the “psychiatric injury” or “emotional shock” suffered by him at the time of the accident because of the danger to himself, witnessing the fatal accident injuring his brother which occurred immediately behind him and the fear and feeling of guilt arising therefrom.

2.98 Botha AJ found in favour of the appellant. The court held that:¹⁵⁹

There is no reason in our law why somebody who, as the result of the negligent act of another, has suffered shock or psychiatric injury with consequent indisposition, should not be entitled to compensation, provided the possible consequences of the negligent act should have been foreseen by the reasonable person who should find himself in the place of the wrongdoer. This does not refer to insignificant emotional shock of short duration which has no substantial effect on the health of the person, and in respect of which compensation would not ordinarily be recoverable.

2.99 The next significant case before the Supreme Court of Appeal that dealt with nervous shock, or psychiatric injury, was the 1998 matter of *Barnard v Santam Bpk*.¹⁶⁰ The plaintiff (appellant) was the mother of a teenage son. Although she did not witness her son’s death or saw his body after his death, she suffered nervous shock upon being

¹⁵⁸ *Bester v Commercial Union Versekeringsmaatskappy van SA Bpk* 1973 (1) SA 769 (A).

¹⁵⁹ *Bester v Commercial Union Versekeringsmaatskappy* 769 at F-G (English translation of headnote as part of the reported case). The original Afrikaans version reads as follows: “Geen rede bestaan in ons reg waarom iemand, wat as gevolg van die nalatige handeling van 'n ander, senuskok of psigiatriese besering met gevolglike ongesteldheid opgedoen het, nie op genoegdoening geregtig is nie, mits die moontlike gevolge van die nalatige handeling voorsien sou gewees het deur die redelike persoon wat hom in die plek van die onregpleger sou bevind het. Hierdie verwys nie na niksbeduidende emosionele skok van kortstondige duur wat op die welsyn van die persoon geen wesenlike uitwerking het nie, en ten opsigte waarvan genoegdoening gewoonlik nie verhaalbaar sou wees nie.

¹⁶⁰ *Barnard v Santam Bpk* 1999 (1) SA 202 (SCA).

informed of his death. The court per Van Heerden CJA made a number of significant findings. Some of the important issues relevant to these notes are the following:

- 1) it might be possible for a person to claim damages in circumstances where he sustained psychological trauma not induced by nervous shock.¹⁶¹
- 2) 'nervous shock' was an outmoded and misleading term that lacked psychiatric content, and that the only relevant question was whether the claimant had sustained a detectable psychiatric injury."¹⁶²
- 3) the nervous shock suffered by appellant would have been foreseen as a reasonable possibility by the *diligens paterfamilias*: ... and the closer the relationship between the primary victim and the traumatised person, the more reasonable the inference that shock was reasonably foreseeable.¹⁶³
- 4) plaintiffs would ... have to present psychiatric evidence to prove that they had indeed suffered an identifiable psychiatric injury.¹⁶⁴
- 5) as to appellant's claim for 'grief', that it clearly did not refer to a psychological injury, otherwise the question of law formulated in relation thereto would have been tautological. It accordingly had to be accepted that the parties had only emotional grief in mind, and the parties correctly conceded that no damages could be claimed for such grief.¹⁶⁵

2.100 The SCA pronounced on a claim for damages for the negligent causation of emotional shock and resultant detectable psychiatric injury again in 2001 in the matter of *Road Accident Fund v Sauls*.¹⁶⁶ Plaintiff (respondent) had witnessed her fiancée being struck by a truck. It later turned out that he had not been seriously injured, but plaintiff initially thought that he had been killed or paralysed. Olivier JA made the following pronouncements:

- It must be accepted that in order to be successful a plaintiff in the respondent's position must prove, not mere nervous shock or trauma, but that she or he had sustained a detectable psychiatric injury. That this must

¹⁶¹ *Barnard* 205 at F (English translation of headnote as part of the reported case).

¹⁶² *Barnard* 205 at G (English translation of headnote as part of the reported case).

¹⁶³ *Barnard* 206 at B-C (English translation of headnote).

¹⁶⁴ *Barnard* 206 at F (English translation of headnote).

¹⁶⁵ *Barnard* 206 at H-I (English translation of headnote).

¹⁶⁶ *Road Accident Fund v Sauls* 2002 (2) 55 (SCA).

be so is, in my view, a necessary and reasonable limitation to a plaintiff's claim.¹⁶⁷

- I can find no general, 'public policy' limitation to the claim of a plaintiff, other than a correct and careful application of the well-known requirements of delictual liability and of the *onus* of proof. It is not justifiable to limit the sort of claim now under consideration, as has been offered as one solution, to a defined relationship between the primary and secondary victims, such as parent and child, husband and wife, etc.¹⁶⁸
- [I]n determining limitations a court will take into consideration the relationship between the primary and secondary victims. The question is one of legal policy, reasonableness, fairness and justice, ie was the relationship between the primary and secondary victims such that the claim should be allowed, taking all the facts into consideration.¹⁶⁹

2.101 The principle of awarding damages for psychiatric injury, or nervous shock or emotional shock, was also recognised in these cases. In the matter of *Clinton-Parker v Administrator, Transvaal, Dawkins v Administrator, Transvaal*,¹⁷⁰ the defendant's maternity ward staff negligently swapped the plaintiffs' babies at birth. The court *inter alia* awarded damages for nervous shock resulting in psychiatric illness. The court held that "... it was now settled law in South Africa that the general principles of delict applied to cases where nervous shock or psychiatric damage were the consequence of a negligent act, the crucial issue being whether, in all the circumstances of the specific case, the consequence was reasonably foreseeable."¹⁷¹

2.102 The matter of *Swartbooi v Road Accident Fund*¹⁷² 2013 (1) SA 30 (W) pertained to an action for damages for emotional shock suffered as a result of the death of the plaintiff's child in a motor vehicle accident. In *Mngomezulu v Minister of Law and Order*¹⁷³ the plaintiff successfully instituted an action for damages on the basis of the negligent shooting of her daughter by members of the South African Police Services. Apart from loss of support, plaintiff suffered severe emotional shock which caused her to become ill

¹⁶⁷ *Sauls* 61 par 13.

¹⁶⁸ *Sauls* 62 par 17.

¹⁶⁹ *Sauls* 63 par 17.

¹⁷⁰ *Clinton-Parker v Administrator, Transvaal, Dawkins v Administrator, Transvaal* 1996 (2) SA 37 (W).

¹⁷¹ *Clinton-Parker* (summary from headnote).

¹⁷² *Swartbooi v Road Accident Fund* 2013 (1) SA 30 (W).

¹⁷³ *Mngomezulu v Minister of Law and Order* (Case no 6373/2007) [2014] ZAKZDHC 34.

as a result of severe depression and anxiety. In the matter of *Mbhele v MEC Health, Gauteng*¹⁷⁴ the SCA awarded general damages of R100 000 based on emotional shock to the plaintiff after her baby was stillborn due to the negligence of the defendant's employees. The court found that her claim for constitutional damages based on the right to rear a child failed to make out a case for the recognition of such a right.¹⁷⁵

2.103 The widely publicised matter of *Komape v Minister of Basic Education*¹⁷⁶ concerned a claim by the parents and siblings of a little 5-year old boy, who had tragically drowned after falling into an unsafe pit latrine at school. One of the lines of argument pursued by the appellants was that the decision in the *Mbhele* case had relaxed the law with regard to the requirement of proving psychiatric injury, since the court awarded damages in the case even though the existence of a psychiatric lesion had not been specifically proved in *Mbhele*. As Neethling pointed out, a plaintiff cannot institute an action for damages on the basis of mere emotional sorrow or grief, since it is not considered to be a psychiatric lesion.¹⁷⁷

2.104 Leach AJ, who wrote the judgment in the *Komape* case, disagreed with the contention that the *Mbhele* case had changed the law with regard to psychiatric injury, stating that the *Mbhele* case was **not** authority for a change of the law:¹⁷⁸

But even more importantly, no reference was made to any of the authorities which have previously prescribed that grief, without an underlying psychiatric lesion associated therewith, cannot be the subject of a damages claim. Without those cases and the ratio of their decisions having been debated and adjudicated, it cannot be said that they have been overruled by a simple passing comment relating to grief. The decision in *Mbhele* is therefore no authority for the proposition that our law has changed and that this court has recognised a claim for grief where there is no psychiatric lesion.

¹⁷⁴ *Mbhele v MEC for Health for the Gauteng Province* [2016] ZASCA 166 (18 November 2016).

¹⁷⁵ *Mbhele* par 9.

¹⁷⁶ *Komape v Minister of Basic Education* [2019] ZASCA 192 (18 December 2019).

¹⁷⁷ Johann Neethling "Vonnisbespreking: Deliktuele vergoeding weens verlies ("bereavement") as gevolg van 'n sterfgeval in die familie: *RK v Minister of Basic Education* [2019] ZASCA 192 (18 Desember 2019)" *LitNet Akademies* 17:1 (2020) ISSN 1995-5928 527–535 at 529.

¹⁷⁸ *Komape* par 39.

2.105 The SCA in *Komape* was satisfied that “the existence of the psychiatric lesions was not only common cause but established by the evidence” and awarded damages “for a pathological grief disorder forming part of [the plaintiffs’] psychiatric injury”. The SCA considered it unnecessary to develop the common law further, as the appellants had already obtained redress for the pathological grief disorder.¹⁷⁹ The court also did not consider it necessary to award constitutional damages, stating that:

[T]here is no reported decision in this country where constitutional damages have been awarded as a solatium for breach of a right where there has been no financial loss, either direct or indirect, or where the compensation had been awarded for a physical or psychiatric injury.¹⁸⁰

...

... [W]here, as here, persons have been compensated for their damages suffered by reason of an injury, physical or psychiatric, any further damages would effectively amount to a punishment for breach of a right for which compensation has already been granted.¹⁸¹

2.106 Neethling avers that Justice Dikgang Moseneke, former DCJ of the Constitutional Court and the arbitrator in the alternative dispute resolution proceedings on the Life Esidimeni tragedy, deviated from the common law when he awarded constitutional damages for bereavement to the families of mentally ill patients who had died because of state officials’ negligence.¹⁸² This contention by Neethling is supported. Leach JA remarks that an award made in arbitration proceedings does not establish binding legal precedent. In addition, the facts in the Life Esidimeni matter are very different from the facts in the *Komape* case.¹⁸³

2.107 In the matter of *Hlubi v MEC Health, Gauteng*¹⁸⁴ plaintiff’s little girl of 2 years of age died due to the negligence of defendant’s employees in diagnosing and treating her hydrocephalus. She had also suffered extensive burns due to their negligence. The High Court, Gauteng Division, Pretoria, awarded general damages of R1,1 million in total to the plaintiff for emotional shock and trauma and the loss of the enjoyment of the

¹⁷⁹ *Komape* par 48.

¹⁸⁰ *Komape* par 58.

¹⁸¹ *Komape* par 59.

¹⁸² Neethling 527.

¹⁸³ *Komape* par 62.

¹⁸⁴ *Hlubi v MEC Health, Gauteng* case no 57301/15 (8 February 2021).

amenities of life,¹⁸⁵ as well as general damages in her capacity as executor of the minor child's estate.¹⁸⁶

2.108 Having regard to all of the aforementioned, this court held that the reasonable amount which should be awarded in respect of Naledi's general damages is the sum of R500 000.00. To this must be added (by consent) an additional sum of R100 000.00 in respect of general damages for the extensive burns suffered by Naledi as a result of the further negligence of the defendant's employees.

2.109 In conclusion, according to *McQuoid-Mason and Dada*,¹⁸⁷ the courts have required proof of the effect of emotional shock for conditions such as the following:

- (a) a stroke leading to death;
- (b) a miscarriage;
- (c) high blood pressure, trembling and collapse;
- (d) a detectable and a recognised psychiatric injury or lesion that is not passing or trivial, such as anxiety neurosis, acute depression, mixed anxiety depressive disorder, post-traumatic stress disorder, impaired sleep or emotional trauma.

8 "Payment in kind"

2.110 Investopedia explains "payment-in-kind" as "the use of a good or service as payment instead of cash".¹⁸⁸ In terms of the situation in the South African public health system, "payment in kind" mostly entails the delivery of health care services in a public health establishment to a plaintiff who had instituted a successful claim based on medical negligence against a provincial DOH. The issue of "payment in kind" is addressed in Chapter 4 as part of the discussion of the 2017 and 2021 Constitutional Court cases of *MEC, Health and Social Development, Gauteng v DZ*¹⁸⁹ and *MEC Health, Gauteng Provincial Government v PN*.¹⁹⁰

¹⁸⁵ *Hlubi* par 61.

¹⁸⁶ *Hlubi* par 70.

¹⁸⁷ *McQuoid-Mason & Dada* 125.

¹⁸⁸ *Investopedia* accessed 18 August 2021 www.investopedia.com/terms/p.

¹⁸⁹ *MEC, Health and Social Development, Gauteng v DZ* [2017] ZACC 37.

¹⁹⁰ *MEC Health, Gauteng Provincial Government v PN* [2021] ZACC 6.

CHAPTER 3: LEGISLATION AND PRESCRIPTS

A Conclusion

3.1 Certain constitutional provisions, several Acts, regulations, other types of subordinate legislation and guidelines are pertinent to the field of medico-legal claims. The relevant constitutional provisions include the right to respect for and protection of inherent dignity; freedom and security of the person; to be free from all forms of violence; bodily and psychological integrity; privacy; access to information; access to health care services and access to courts. The duty on the state to take reasonable measures to achieve progressive realisation of the right to health care services, the limitation of rights in Bill of Rights and enforcement of rights are also important.

3.2 Apart from the National Health Act 61 of 2003 (NHA), there are various other statutes that impact on the public health sector. These include the Promotion of Access to Information Act 2 of 2000, Protection of Personal Information Act 4 of 2013, Consumer Protection Act 68 of 2008, State Liability Act 20 of 1957, Institution of Legal Proceedings against certain Organs of State Act 40 of 2002 and the Prescription Act 68 of 1969. The Acts that pertain to health and related professions are also significant, as no amendments to the training or qualifications of health care providers registered under these Acts are possible without the cooperation of the responsible councils. The Acts concerned are the Pharmacy Act 53 of 1974, Health Professions Act 56 of 1974, Dental Technicians Act 19 of 1979, Allied Health Professions Act 63 of 1982 and Nursing Act 33 of 2005. There are also the remnants of the Health Act 63 of 1977 that are still in force in those provinces that had not repealed the Act yet (parts of the Health Act 1977 were assigned to provinces in 1994).

3.3 The National Health Act establishes a framework for the responsibilities and duties of each of the three levels of government and the interaction and cooperation required between the national, provincial and local health sectors. The Act makes provision for structures to provide guidance and direction; necessitates cooperation, coordination and interaction between government levels and the public and private sectors; requires budgeting, human resource planning and the establishment and implementation of a national health information system; establishes the Office of Health Standards Compliance to monitor and enforce norms and standards; compels

the Minister to appoint the Ombud to consider, investigate and dispose of complaints; and authorises regulations on norms and standards, matters such as environmental health and compiling guidelines and various other tools to give effect to the Act.

3.4 Some respondents to *Issue Paper 33* and various commentators remarked on the need for regulations and guidelines on anything from infrastructure, patient complaints, reporting and learning from adverse events to record keeping, facilities maintenance and management of health establishments. A review of the provisions of the NHA and the regulations, guidelines and other tools published in terms of the NHA reveals that various documents on these matters do exist and are available. The NHI Bill, currently before Parliament, will also have an impact, if adopted. The question for now, however, remains: are the NHA, the regulations, the norms and standards, guidelines and other tools being properly implemented?

B Constitution of the Republic of South Africa, 1996

3.5 The obvious point of departure for constitutional considerations is the Constitution of the Republic of South Africa, 1996 (the Constitution). The constitutional rights relevant to the area of law pertaining to medico-legal claims are the following:

- 1) Section 10: right to respect for and protection of everyone's inherent dignity.
- 2) Section 12(1): right to freedom and security of the person.
- 3) Section 12(1)(c): right to be free from all forms of violence.
- 4) Section 12(2): right to bodily and psychological integrity.
- 5) Section 14: right to privacy.
- 6) Section 27(1)(a): right to have access to health care services.
- 7) Section 27(2): the duty on the state to take reasonable legislative and other measures to achieve progressive realisation of the right to health care services.
- 8) Section 32: right of access to information.
- 9) Section 34: right of access to courts.
- 10) Section 36(1): limitation of the rights in the Bill of Rights in terms of law of general application.
- 11) Section 38: enforcement of rights.

3.6 Human dignity is the first of the values listed in section 1(a) of the Constitution underpinning the Republic of South Africa:

The Republic of South Africa is one, sovereign, democratic state founded on the following values:

- (a) Human dignity, the achievement of equality and the advancement of human rights and freedoms.

3.7 The importance of human dignity is underscored by section 10, which states that “[e]veryone has inherent dignity and the right to have their dignity respected and protected.” The human dignity provision is considered so important that it appears chronologically before section 11, which deals with the right to life. The Constitutional Court per O’Regan J confirmed the importance of the right to dignity: “This Court has on several occasions emphasised the importance of human dignity to our constitutional scheme. It is clear from the text of the Constitution itself that human dignity is a fundamental value of our Constitution.”¹

3.8 Accessing health care can place a person in a very vulnerable position; therefore it is particularly important to respect and protect the dignity of a health services user.² In the public health sector indigent users are especially susceptible and they often express dissatisfaction with the lack of respect and poor treatment they receive from health professionals.³ A case study found that the right to dignity of an especially vulnerable health services user and his mother had been infringed upon several times.⁴ The South African Human Rights Commission (SAHRC) stated that “[h]uman dignity, the inherent worth of all human beings, underpins all human rights.”⁵

3.9 Section 12(1) protects freedom and security of the person, while section 12(1)(c) specifically refers to the right to be free from all forms of violence. It is important to remember that aspects of medical treatment could be equated to assault upon the body

¹ *Dawood and Another v Minister of Home Affairs and others* 2000 (3) SA 936 (CC) par 34.

² See also: Wihan Joubert “When constitutional guarantees meet reality in health care” *De Rebus* (June 2017) 42–44 at 42.

³ Ritshidze *Gauteng: State of Health* (December 2020) 9, 17 & 18; Ritshidze *Mpumalanga: State of Health* (May 2021) 23 & 28; Ritshidze *North West: State of Health* (June 2021) 22, 23 & 28; Ritshidze *Limpopo: State of Health* (August 2021) 5, 22 & 28; Ritshidze *Free State: State of Health* (September 2021) 5 & 30. Ritshidze *Eastern Cape: State of Health* (September 2021) 3 & 34.

⁴ Johan Wilhelm Joubert *A case study of the constitutionality of proposed financial limitations on medical negligence claims* (unpublished MPhil dissertation, University of Pretoria November 2016).

⁵ SAHRC *Hearing report of the South African Human Rights Commission into access to emergency medical services in the Eastern Cape 24 & 25 March 2015* (2015) at 10 [SAHRC (2015)].

of a person, which is why it is important for health care providers to be cognisant of this provision. Section 12(2) expands the right to freedom and security of the person by protecting the right to bodily and psychological integrity. Given the personal nature of health care – on a physical as well as a mental level – the potential for the breach of the right to bodily and psychological integrity is self-evident. These rights are particularly relevant to personal injury claims, since the harm caused as a result of personal injury frequently involves a breach of the rights protected by section 12. The protection of privacy afforded by section 14 is essential in relation to health care. For example, it would not be possible to treat injury or disease without knowledge of personal information about a health services user, hence it is crucial to respect a user's privacy by maintaining confidentiality and using the knowledge acquired only for legitimate purposes.

3.10 The right to have access to health care services afforded by section 27(1)(a) is central to the public health sector and the provision of health care by the state. Section 27(2) imposes an obligation upon the state to “take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation” of the rights set out in section 27, including access to health care services. This obligation would encompass legislation about medical negligence claims against the state, should it be demonstrated that such legislation would further the aims of section 27.

3.11 It would be impossible for someone feeling aggrieved by a possible breach of his or her rights to enforce those rights without access to relevant information. A health care user with a potential medical negligence claim will be unable to pursue the claim without access to his or her health records. These are some of the reasons why access to information as protected by section 32; and the right to have a legal dispute resolved by a court or other independent and impartial tribunal or forum as guaranteed by section 34, are pertinent to medico-legal claims. The right to approach a court for appropriate relief if a constitutional right has been infringed or threatened is protected by section 38. Taking a matter to court would be the final step when pursuing a medical negligence claim.

3.12 A balance has to be struck between the various constitutional rights. It stands to reason that no single individual may exercise his or her rights in a manner that would infringe upon the constitutional rights of another. No right in the Bill of Rights is absolute, therefore it must be possible to limit rights in certain circumstances. Section 36 provides for the limitation of rights and describes the conditions for such limitations. Bearing in

mind the rights relevant to medico-legal claims discussed above, it would be possible to introduce limits to these rights in line with section 36. Section 36(1) states as follows:

- (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including –
- (a) the nature of the right;
 - (b) the importance of the purpose of the limitation;
 - (c) the nature and extent of the limitation;
 - (d) the relation between the limitation and its purpose; and
 - (e) less restrictive means to achieve the purpose.

3.13 There are other matters covered by the Constitution that also deserve to be mentioned here. Section 8 of the Constitution pertains to the application of the Bill of Rights set out in Chapter 2 of the Constitution. Section 8(3)(a) charges a court to apply, or if necessary, develop, the common law to the extent that legislation does not give effect to a right enshrined in the Bill of Rights. Although a court can therefore develop the common law where legislation does not give effect to the Bill of Rights, a court cannot legislate. Section 165 of the Constitution vests the judicial authority of the Republic in the courts, while section 43 of the Constitution vests the legislative authority of the national sphere in the Republic in Parliament.⁶

3.14 The Constitution explicitly provides for the different functions of the legislature (sections 42 – 82), the executive (sections 83 – 102), and the judiciary (sections 165 – 180), giving recognition to the doctrine of the separation of powers. According to Mojapelo “the doctrine means that specific functions, duties and responsibilities are allocated to distinctive institutions with a defined means of competence and jurisdiction. It is a separation of three main spheres of government, namely, Legislative, Executive and Judiciary.”⁷

⁶ In the Republic, the legislative authority –

- (a) of the national sphere of government is vested in Parliament, as set out in section 44;
- (b) of the provincial sphere of government is vested in the provincial legislatures, as set out in section 104; and
- (c) of the local sphere of government is vested in the Municipal Councils, as set out in section 156.

⁷ PM Mojapelo “The doctrine of separation of powers (a South African perspective)” *Advocate* (April 2013) 37–46 at 37.

3.15 Mojapelo explains the main objective of the separation of powers as follows:⁸

The main objective of the doctrine is to prevent the abuse of power within different spheres of government. In our constitutional democracy public power is subject to constitutional control. Different spheres of government should act within their boundaries. ... Within the context of the doctrine of separation of powers the courts are duty bound to ensure that the exercise of power by other branches of government occurs within the constitutional context. The courts must also observe the limit of their own power.

3.16 The doctrine of the separation of powers is a crucial component of a constitutional democracy. It is an important aspect of the checks and balances that are part of such a system. Mojapelo states that “the aim of separation of functions and personnel is to limit the power; the purpose of checks and balances is to make the branches of government accountable to each other.”⁹

C National legislation

3.17 Section 43 of the Constitution, 1996 provides for the legislative authority of the national, provincial and local spheres of government:

In the Republic, the legislative authority –

- (a) of the national sphere of government is vested in Parliament, as set out in section 44;
- (b) of the provincial sphere of government is vested in the provincial legislatures, as set out in section 104; and
- (c) of the local sphere of government is vested in the Municipal Councils, as set out in section 156.

3.18 Section 44 deals with national legislative authority. The relevant parts of section 44 determines as follows:

- (1) The national legislative authority as vested in Parliament –
 - (a) confers on the National Assembly the power-
 - ...
 - (ii) to pass legislation with regard to any matter, including a matter within a functional area listed in Schedule 4, but excluding, subject to subsection (2), a matter within a functional area listed in Schedule 5; and

⁸ Mojapelo 38.

⁹ Mojapelo 40.

- ...
- (b) confers on the National Council of Provinces the power –
- ...
- (ii) to pass, in accordance with section 76, legislation with regard to any matter within a functional area listed in Schedule 4 and any other matter required by the Constitution to be passed in accordance with section 76; and
- ...
- (3) Legislation with regard to a matter that is reasonably necessary for, or incidental to, the effective exercise of a power concerning any matter listed in Schedule 4 is, for all purposes, legislation with regard to a matter listed in Schedule 4.

3.19 Section 104, dealing with the legislative authority of provinces, states in part that:

- (1) The legislative authority of a province is vested in its provincial legislature, and confers on the provincial legislature the power –
- ...
- (b) to pass legislation for its province with regard to-
- (i) any matter within a functional area listed in Schedule 4;
- ...
- (4) Provincial legislation with regard to a matter that is reasonably necessary for, or incidental to, the effective exercise of a power concerning any matter listed in Schedule 4, is for all purposes legislation with regard to a matter listed in Schedule 4.

3.20 Schedule 4 of the Constitution lists the functional areas of concurrent national and provincial legislative competence. “Health services” is one of the items listed in Schedule 4, meaning that Parliament and provincial legislatures can pass legislation on health matters. There are several pieces of national legislation that are of relevance to the field of medical law, and in particular to medical negligence claims against the state.

1 National Health Act 61 of 2003

3.21 The national DOH, under the leadership of the Minister of Health as the Cabinet member responsible for the administration of health, is the government department responsible for providing direction and policy guidance on the implementation of the constitutional right to health care services. To this end the National Health Act was adopted, which provides a framework for a structured health system within the Republic, taking into account the obligations regarding health services imposed by the Constitution

and other laws on national, provincial and local governments.¹⁰ Relevant parts of the NHA are discussed in greater detail below.

3.22 The definitions in section 1 considered significant for medico-legal purposes are: “Director-General”,¹¹ “health care provider”,¹² “health establishment”,¹³ “health services”,¹⁴ “hospital”,¹⁵ “Minister”,¹⁶ “national Department”,¹⁷ “national health policy”,¹⁸ “national health system”,¹⁹ “norm”,²⁰ “organ of state”,²¹ “provincial department”,²² “public

¹⁰ Long title to the National Health Act 61 of 2003.

¹¹ **‘Director-General’** means the head of the national department.

¹² **‘health care provider’** means a person providing health services in terms of any law, including in terms of the –

- (a) Allied Health Professions Act, 1982 (Act 63 of 1982);
- (b) Health Professions Act, 1974 (Act 56 of 1974);
- (c) Nursing Act, 1978 (Act 50 of 1978);
- (d) Pharmacy Act, 1974 (Act 53 of 1974); and
- (e) Dental Technicians Act, 1979 (Act 19 of 1979).

¹³ **‘health establishment’** means the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services.

¹⁴ **‘health services’** means –

- (a) health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution;
- (b) basic nutrition and basic health care services contemplated in section 28 (1) (c) of the Constitution;
- (c) medical treatment contemplated in section 35 (2) (e) of the Constitution; and
- (d) municipal health services.

¹⁵ **‘hospital’** means a health establishment which is classified as a hospital by the Minister in terms of section 35.

¹⁶ **‘Minister’** means the Cabinet member responsible for health.

¹⁷ **‘national department’** means the national Department of Health.

¹⁸ **‘national health policy’** means all policies relating to issues of national health as approved by the Minister.

¹⁹ **‘national health system’** means the system within the Republic, whether within the public or private sector, in which the individual components are concerned with the financing, provision or delivery of health services.

²⁰ **‘norm’** means a statistical normative rate of provision or measurable target outcome over a specified period of time.

²¹ **‘organ of state’** means an organ of state as defined in section 239 of the Constitution.

²² **‘provincial department’** means any provincial department responsible for health.

health establishment”,²³ “relevant member of the Executive Council”²⁴ and “user”.²⁵ The objects of the NHA, as set out in section 2, are to regulate national health and provide uniformity in respect of health services across the nation. This is to be achieved by –

- establishing a national health system;
- setting out the rights and duties of health care providers, health workers, health establishments and users;
- protecting, respecting, promoting and fulfilling the rights of the people of South Africa.

3.23 The national health system encompasses public and private providers of health services and should provide “in an equitable manner the population of the Republic with the best possible health services that available resources can afford.”²⁶ The rights of the people of South Africa contemplated in section 2 of the NHA include the right to the progressive realisation of the constitutional right of access to health care services, including reproductive health care. The other constitutional rights mentioned are the right to an environment that is not harmful to the health or well-being of the people, and children’s rights to basic nutrition and basic health care services. Section 2 also refers to the rights of vulnerable groups such as women, children, older persons and persons with disabilities.

3.24 Section 3 deals with the responsibility for health. It imposes certain duties upon the Minister of Health and the public health sector:

- (1) The Minister must, within the limits of available resources –
- (a) endeavour to protect, promote, improve and maintain the health of the population;

²³ **‘public health establishment’** means a health establishment that is owned or controlled by an organ of state.

²⁴ **‘relevant member of the Executive Council’** means the member of the Executive Council of a province responsible for health.

²⁵ **‘user’** means the person receiving treatment in a health establishment, including receiving blood or blood products, or using a health service, and if the person receiving treatment or using a health service is –

(a) below the age contemplated in section 39 (4) of the Child Care Act, 1983 (Act 74 of 1983), ‘user’ includes the person’s parent or guardian or another person authorised by law to act on the firstmentioned person’s behalf; or

(b) incapable of taking decisions, ‘user’ includes the person’s spouse or partner or, in the absence of such spouse or partner, the person’s parent, grandparent, adult child or brother or sister, or another person authorised by law to act on the firstmentioned person’s behalf.

²⁶ Section 2(a)(ii) of the NHA.

- (b) promote the inclusion of health services in the socio-economic development plan of the Republic;
- (c) determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population;
- (d) ensure the provision of such essential health services, which must at least include primary health care services, to the population of the Republic as may be prescribed after consultation with the National Health Council; and
- (e) equitably prioritise the health services that the State can provide.

(2) The national department, every provincial department and every municipality must establish such health services as are required in terms of this Act, and all health establishments and health care providers in the public sector must equitably provide health services within the limits of available resources.

3.25 Section 4 of the NHA deals with eligibility for free health services in public health establishments, authorising the Minister to prescribe conditions for eligibility. Section 4(3) imposes an obligation upon state-funded community health centres and clinics to provide health services to particular categories of persons, such as children under six years and pregnant and lactating women.²⁷ Section 5 states that no health care provider, health worker or health establishment may refuse a person emergency medical treatment.

3.26 Section 6 requires health care providers to provide health services users with full information on matters such as diagnostic procedures, treatment options, benefits, risks, the user's health status and right to refuse health services. Section 7 prohibits the provision of health services to a user without the user's informed consent and sets out the alternatives when a user is unable to give informed consent. Section 8 establishes a user's right to participate in decisions affecting his or her personal health and treatment.

3.27 Section 12 imposes a duty on the national and provincial departments of health, public health establishments and municipalities to ensure that appropriate, adequate and comprehensive information is disseminated on the health services for which they are

²⁷ (3) Subject to any condition prescribed by the Minister, the State and clinics and community health centres funded by the State must provide –

- (a) pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services;
- (b) all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with free primary health care services; and
- (c) women, subject to the Choice on Termination of Pregnancy Act, 1996 (Act 92 of 1996), free termination of pregnancy services.

responsible. Sections 13 to 17 pertain to health records. Section 13 requires the person in charge of a health establishment to establish and maintain a health record with prescribed information for every user of health services. Section 14 provides for confidentiality of health records, while sections 15, 16 and 17 deal with access to health records, access to health records by health care providers and protection of health records, respectively. Section 18 provides for laying of complaints and requires MECs and municipal managers to establish a procedure for laying complaints. Section 19 sets out the duties of users. Section 19 could be relevant in medico-legal litigation if it can be proved that a user did not comply with section 19 to the extent that it could have had an influence on the liability of the defendant, or that there was contributory negligence.

3.28 Section 21 sets out the general functions of the national department of health, obliging the Director-General of Health to ensure the implementation of national health policy in so far as it relates to the national department, and to issue guidelines for the implementation of health policy. Other functions that must be performed by the DG include international liaison; issuing and promoting adherence to norms and standards on health matters; identifying national health goals and priorities and monitoring progress with the implementation thereof; preparing strategic, medium-term health and human resources plans; and integrating the health plans of the national department and provincial departments annually for submission to the National Health Council. The provision of health services, including social, physical and mental health care, is one of the areas that require national norms and standards.

3.29 Section 22 of the NHA establishes the National Health Council (NHC). The NHC is chaired by the Minister and consists of, among others, the provincial MECs for health, the top management of the national DOH, the heads of the provincial departments of health, and the head of the South African Military Health Service. In terms of section 23, the NHC must advise the Minister on a range of issues, including:

- 1) targets, priorities, norms and standards relating to the equitable provision and financing of health services;
- 2) co-ordination of health services;
- 3) human resources planning, production, management and development;
- 4) equitable financial mechanisms for the funding of health services;
- 5) programmes for referral of users between health establishments or health care providers, or to enable integration of public and private health establishments;
- 6) proposed legislation pertaining to health matters;
- 7) norms and standards for the establishment of health establishments;

- 8) the implementation of national health policy.

3.30 Section 24 requires the Minister to establish a National Consultative Health Forum to promote and facilitate interaction, communication and sharing of information on national health issues between the national DOH, identified national organisations and the provincial consultative bodies contemplated in section 28.

3.31 Section 25 provides for provincial health services and the functions of provincial departments. Section 25(1) tasks the MECs of provinces with the duty to ensure the implementation of national health policy, norms and standards in his or her province. Section 25(2) lists the functions of the heads of the provincial DOHs, which include the following:

- 1) provide specialised hospital services;
- 2) plan and manage the provincial health information system;
- 3) interprovincial and intersectoral co-ordination and collaboration;
- 4) plan, co-ordinate, monitor and evaluate the rendering of health services;
- 5) plan, manage and develop human resources for the rendering of health services;
- 6) plan the development of public and private hospitals, other health establishments and health agencies;
- 7) control and manage the cost and financing of public health establishments and public health agencies;
- 8) facilitate and promote the provision of comprehensive primary health services and community hospital services;
- 9) control the quality of all health services and facilities;
- 10) provide health services contemplated by specific provincial health service programmes;
- 11) provide and maintain equipment, vehicles and health care facilities in the public sector;
- 12) provide occupational health services.

3.32 The provincial head of department (HOD) must also prepare strategic, medium term health and human resources plans annually for providing health services in the province for submission to the DG of Health. Section 25(4) determines that provincial health plans must conform with national health policy.

3.33 Section 26 establishes a provincial health council for each province. In the same manner that the NHC must advise the Minister on the range of issues listed in section

23, a provincial health council must advise the MEC of a province on a similar range of issues listed in section 27 of the NHA. Section 28 requires health MECs to establish a provincial consultative body to promote and facilitate interaction, communication and sharing of information on provincial health issues between the provincial DOH and identified provincial and municipal organisations. Sections 29 to 34 pertain to district health systems, district health councils, district health plans and municipal health services. Section 35 authorises the Minister to make regulations about the classification of health establishments. Sections 36 to 40, providing for certificates of need and related matters, have not been put into operation yet.

3.34 Section 41 pertains to the provision of health services at public health establishments. The Minister, in respect of central hospitals; and provincial MECs, in respect of all other public health establishments in a province, may do the following:

- 1) determine the range of health services provided at a public health establishment;
- 2) prescribe the procedures and criteria for admission to and referral from a public health establishment;
- 3) prescribe schedules of fees, including penalties;
- 4) in consultation with the relevant provincial Treasury, determine the proportion of revenue generated by a hospital that may be retained by that hospital, and how those funds may be used.

3.35 In terms of section 44(1), a user may attend any public health establishment for health services. However, section 44(2) stipulates that, if a public health establishment is not capable of providing the necessary treatment or care, the public health establishment must transfer the user to another public health establishment capable of providing the necessary treatment or care. The manner or terms may be determined by the Minister or the relevant MEC.

3.36 Section 45(1) imposes an obligation upon the Minister to prescribe mechanisms to enable a co-ordinated relationship between private and public health establishments in the delivery of health services. Section 45(2) states that the national or provincial DOHs, as well as municipalities, may enter into an agreement with any private practitioner, private health establishment or nongovernmental organisation in order to achieve any object of this Act. Such an agreement must comply with the Public Finance Management Act 1 of 1999 (PFMA), or municipal finance management legislation.

3.37 Section 46 requires private health establishments to maintain insurance cover sufficient to indemnify a user for damages that he or she might suffer as a consequence of a wrongful act by any member of its staff or by any of its employees.²⁸

3.38 Section 47 states that all health establishments must comply with the quality requirements and standards prescribed by the Minister after consultation with the Office of Health Standards Compliance (OHSC). These quality requirements and standards may relate to human resources, health technology, equipment, hygiene, premises, the delivery of health services, business practices, safety, and the manner in which users are accommodated and treated. Section 47(3) compels the OHSC to monitor and enforce compliance with the quality requirements and standards.

3.39 Chapter 7 is about human resources planning and academic health complexes. Section 48 requires the National Health Council to develop policy and guidelines for, and monitor the provision, distribution, development, management and utilisation of, human resources within the national health system. The policy and guidelines must facilitate and advance issues such as:

- the adequate distribution of human resources;
- the provision of appropriately trained staff at all levels of the national health system to meet the population's health care needs;
- the effective and efficient utilisation, functioning, management and support of human resources within the national health system.

3.40 Section 49 compliments section 48 by requiring that the Minister, with the concurrence of the National Health Council, must determine guidelines to enable the provincial departments and district health councils to implement programmes for the appropriate distribution of health care providers and health workers.

²⁸ The Gynaecology Management Group, in their submission in response to Issue Paper 33, criticised the scope and wording of section 46: in the first place because it only applies to private health establishments; and secondly because it proposes "to indemnify a user for damages". In reality health personnel should be indemnified, while users should be compensated. The provision also does not distinguish between "trips and slips" and professional wrongful acts, both of which should be covered [GMG 4]. The South African Private Practitioners Forum also point out that section 46 will have to be amended if public sector health practitioners are to be insured [SAPPF 4]. SASA criticise section 46 for being poorly worded, limited to the private sector, indemnifying the patient instead of the staff, uncertainty about the differentiation between "staff" and "employees", reference to an establishment only, while medical professionals in private practice cover their own insurance costs [SASA (unpaged) item 4 question 3].

3.41 Section 50 establishes the Forum of Statutory Health Professional Councils. The NHA indicates that all the statutory health professional councils must be represented on the forum through their chairpersons and registrars or chief executive officers. In addition to the representatives from the health professional councils, the Minister must appoint two representatives from the national DOH, three community representatives (who are members of any of the statutory health professional councils), and two representatives of tertiary education institutions to the Forum. The Minister must also appoint a suitable person as chairperson.

3.42 Section 50(4) is a comprehensive list of the duties of the Forum, which includes protecting the interests of the public and users; ensuring communication and liaison between statutory health professional councils; promoting interprofessional liaison and communication between registered professions; good practice in health services and information sharing between the health professional councils. The Forum must also advise the Minister on the development of policies relating to the education, training, optimal utilisation and distribution of health care providers; and monitor and advise the Minister on the implementation of health policy that impacts on health care providers and the registered professions.

3.43 Section 51 entitles the Minister to, in consultation with the Minister of Education, establish academic health complexes to educate and train health care personnel and to conduct research in health services as well as co-ordinating committees performing prescribed functions where necessary.

3.44 Human resources are critical to a properly functioning health system. Section 52 authorises the Minister to make regulations that encompass a broad spectrum of issues pertaining to human resources. Section 52 provides as follows:

The Minister may make regulations regarding human resources within the national health system in order to –

- (a) ensure that adequate resources are available for the education and training of health care personnel to meet the human resources requirements of the national health system;
- (b) ensure the education and training of health care personnel to meet the requirements of the national health system;
- (c) create new categories of health care personnel to be educated or trained;
- (d) identify shortages of key skills, expertise and competencies within the national health system and to prescribe strategies which are not

in conflict with the Higher Education Act, 1997 (Act 101 of 1997), for the –

- (i) recruitment of health care personnel from other countries; and
 - (ii) education and training of health care providers or health workers in the Republic,
- to make up the deficit in respect of scarce skills, expertise and competencies;
- (e) prescribe strategies for the recruitment and retention of health care personnel within the national health system;
 - (f) ensure the existence of adequate human resources planning, development and management structures at national, provincial and district levels of the national health system;
 - (g) ensure the availability of institutional capacity at national, provincial and district levels of the national health system to plan for, develop and manage human resources;
 - (h) ensure the definition and clarification of the roles and functions of the national department, provincial departments and municipalities with regard to the planning, production and management of human resources; and
 - (i) prescribe circumstances under which health care personnel may be recruited from other countries to provide health services in the Republic.

3.45 Chapter 8 (sections 53 to 68) controls the use of blood, blood products, tissue and gametes in humans. Chapter 9 (sections 69 to 76) regulates national health research and information. Section 69 requires the Minister to establish the National Health Research Committee, while section 72 of the NHA establishes the National Health Research Ethics Council.

3.46 The importance of health information and health data is often remarked upon. Section 74 provides for the coordination of a national health information system. Section 74(1) compels the national DOH to facilitate and co-ordinate the establishment, implementation and maintenance by provincial departments, district health councils, municipalities and the private health sector of health information systems at national, provincial and local levels in order to create a comprehensive national health information system. Section 74(2) allows the Minister to, for the purpose of creating, maintaining or adapting databases within the national health information system, prescribe categories or kinds of data for submission and collection and the manner and format in which and by whom the data must be compiled or collated and be submitted to the national department.

3.47 Section 75 states that a provincial MEC must establish a committee for his or her province to establish, maintain, facilitate and implement the health information systems contemplated in section 74 at provincial and local level. Section 76 requires every district health council and every municipality which provides a health service to establish and maintain a health information system as part of the national health information system contemplated in section 74.

3.48 Chapter 10 deals with the Office of Health Standards Compliance (OHSC), inspections and environmental health investigations, health officers and inspectors, and complaints and appeal procedures. The OHSC is established by section 77 of the NHA. Section 78 sets out the objects of the OHSC, which are to protect and promote the health and safety of users of health services in the following manner:

- Monitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister in relation to the national health system.
- Ensuring consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical and expeditious manner.

3.49 Section 79 sets out the functions of the OHSC in detail. Section 79(1) deals with the functions that the OHSC is compelled to perform, while section 79(2) deals with the functions that the OHSC has a discretion to perform. Section 79 stipulates the following:

- (1) The Office must –
 - (a) advise the Minister on matters relating to the determination of norms and standards to be prescribed for the national health system and the review of such norms and standards;
 - (b) inspect and certify health establishments as compliant or non-compliant with prescribed norms and standards or, where appropriate and necessary, withdraw such certification;
 - (c) investigate complaints relating to breaches of prescribed norms and standards;
 - (d) monitor indicators of risk as an early warning system relating to serious breaches of norms and standards and report any breaches to the Minister without delay;
 - (e) identify areas and make recommendations for intervention by a national or provincial department of health, a health department of a municipality or health establishment, where it is necessary, to ensure compliance with prescribed norms and standards;
 - (f) publish information relating to prescribed norms and standards through the media and, where appropriate, to specific communities;
 - (g) recommend quality assurance and management systems for the national health system to the Minister for approval;

- (h) keep records of all its activities; and
 - (i) advise the Minister on any matter referred to it by the Minister.
- (2) The Office may –
- (a) issue guidelines for the benefit of health establishments on the implementation of prescribed norms and standards;
 - (b) collect or request any information relating to prescribed norms and standards from health establishments and users;
 - (c) liaise with any other regulatory authority and may, without limiting the generality of this power, require the necessary information from, exchange information with and receive information from any such authority in respect of –
 - (i) matters of common interest; or
 - (ii) a specific complaint or investigation; and
 - (d) negotiate cooperative agreements with any regulatory authority in order to –
 - (i) coordinate and harmonise the exercise of jurisdiction over health norms and standards; and
 - (ii) ensure the consistent application of the principles of this Act.

3.50 Section 79A establishes the Office of Health Standards Compliance Board. The OHSC functions under the control of the Board, which is also the accounting authority of the OHSC. The Board must determine the policy of the Office; do the necessary planning in connection with the functions of the Office; and perform the other functions assigned to it by the NHA. Sections 79B to 79K deal with various matters relating to the management and functioning of the Board, such as the composition of the Board; meetings and committees of the Board; appointment of Board members, chairperson, vice-chairperson and chief executive officer (CEO); functioning and accountability of and reporting by the chief executive officer.

3.51 Section 80 regulates the appointment of health officers and inspectors. Section 81 obliges the Minister to appoint an Ombud. Section 81A sets out the functions of the Ombud and section 81B provides for the independence, impartiality and accountability of the Ombud. Section 82 regulates the powers of inspection of health officers and inspectors, while section 82A deals with compliance notices issued for non-compliance with norms and standards. Section 83 empowers health officers to conduct environmental health investigations under certain conditions.

3.52 Section 84 provides for entry and search of premises or health establishments with a warrant by a health officer or inspector. Section 85 provides for measures regarding identification prior to entry, and resistance against entry, by a health officer or inspector. Section 86 provides for the circumstances when a health officer or inspector

may enter and search premises or health establishments without a warrant. Section 86A determines that any entry upon or search of any premises or health establishment in terms of this Act must be conducted with strict regard to decency and good order and reiterates the constitutional rights of persons to dignity, freedom and security and privacy.

3.53 Section 87 provides for the disposal of items seized by a health officer or inspector. Section 88 determines that, for the purposes of the NHA, the head of a national or provincial department, the municipal manager or the head of a health establishment is regarded as an employer and the owner and occupier of any premises or health establishment that the national or provincial department or the municipality occupies or uses. Section 88A provides for an appeal procedure against decisions of the OHSC and the Ombud. Section 89 sets out offences and penalties in relation to health officers, inspectors and the Ombud.

3.54 Section 90 lists the matters that the Minister may make regulations about. The list includes the following:

- 1) the norms and standards for the national health systems;
- 2) human resource development;
- 3) co-operation and interaction between private health care providers and private health establishments on the one hand and public health care providers and public health establishments on the other;
- 4) health technology and health research;
- 5) the national health information system contemplated in section 74.

3.55 In addition, the Minister may in a regulation made under the NHA:

- designate as authoritative any methodology, procedure, practice or standard that is recognised as authoritative by internationally recognised health bodies within the relevant profession; and
- require any person or body to comply with the designated methodology, procedure, practice or standard.

3.56 Section 91 allows the Minister, after consultation with the National Health Council, to establish advisory and technical committees to achieve the objects of the NHA. Section 92 authorises the Minister and provincial MECs, subject to the PFMA and certain exemptions, to assign any duty and delegate any power imposed or conferred upon him or her by the NHA to a person in the employ of the State, or a council, board or committee established in terms of this Act.

2 Promotion of Access to Information Act 2 of 2000

3.57 The Promotion of Access to Information Act 2 of 2000 (PAIA) was promulgated to give effect to section 32(2) of the Constitution.²⁹ This is confirmed in the long title of the Act, which states that the purpose of the Act is to give effect to the constitutional right of access to any information held by the State and any information that is held by another person and that is required for the exercise or protection of any rights; and to provide for matters connected therewith.

3.58 PAIA was quite extensively amended by the Protection of Personal Information Act 4 of 2013 (POPIA), which amendments came into operation on 30 June 2021. The two Acts, PAIA and POPIA, are now both administered by the Information Regulator, a juristic person established by section 39 of POPIA. The provisions of PAIA that are relevant to medico-legal claims are discussed below.

3.59 The PAIA definitions relevant to medico-legal claims are the definitions of “access fee”, “health practitioner”, “information officer”, “Information Regulator”, “personal information”, “public body”, “record”, “request for access”, and “requester”. POPIA added the definition of “Information Regulator” and substituted the definition of “personal information”. The amendments effected to PAIA by POPIA came into operation on 30 June 2021.

3.60 The expression “access fee” is defined by reference to section 22(6) of PAIA. Section 22(6) requires a person requesting access to the records of a public body to pay an access fee for the costs associated with the search for, reproduction and preparation of the requested record. The term “health practitioner” refers to a person, registered in terms of legislation, who carries on an occupation involving the provision of care and treatment for the physical or mental health or well-being of others.

3.61 The expression “information officer” refers to the Public Service Act, 1994 in order to indicate who would be the information officer for a national department or provincial administration. In the case of a national state department, the director-general of the department is the information officer, while the head of the relevant provincial department

²⁹ (2) National legislation must be enacted to give effect to this right [access to information], and may provide for reasonable measures to alleviate the administrative and financial burden on the state.

is the information officer for that department. In the case of any other public body (such as a public health establishment), the chief executive officer or equivalent would be the information officer. The municipal manager is the information officer for a municipality. A person requesting access to health records held by a public establishment will have to direct his or her request to the information officer of that establishment as the first step. Access to health records is further regulated by POPIA. The “Information Regulator” is the independent juristic person established by section 36 of POPIA which must exercise the powers and perform the functions in accordance with PAIA and POPIA.

3.62 The definition of “personal information” in PAIA was substituted by section 110 of POPIA with effect from 30 June 2021. Almost all the components of the definition of “personal information” apply to health records. The new definition states as follows:

‘personal information’ means information relating to an identifiable natural person, including, but not limited to –

- (a) information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and birth of the person;
- (b) information relating to the education or the medical, financial, criminal or employment history of the person;
- (c) any identifying number, symbol, email address, physical address, telephone number, location information, online identifier or other particular assigned to the person;
- (d) the biometric information of the person;
- (e) the personal opinions, views or preferences of the person;
- (f) correspondence sent by the person that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence;
- (g) the views or opinions of another individual about the person; and
- (h) the name of the person if it appears with other personal information relating to the person or if the disclosure of the name itself would reveal information about the person,

but excludes information about an individual who has been dead for more than 20 years;

3.63 A “public body” is any state department or administration in the national or provincial sphere of government or any municipality, as well as any other functionary or institution exercising a public power or performing a public function in terms of the Constitution or any legislation. Public health establishments play a vital role in relation to the right of access to health care services protected by section 27 of the Constitution and the delivery of health services in terms of the NHA.

3.64 A “record” means any recorded information, regardless of form or medium, in the possession or under the control of a public or private body, whether the record was created by that body or not. The definition of “request for access” refers to section 11 in relation to a request for access to a record of a public body, and to section 50 in relation to a request for access to a record of a private body. The definition of “requester” in essence means any person (or person acting on behalf of that person) requesting access to a record, including a public body or an official of a public body when a request is made for access to a record of a private body.

3.65 Section 10 compels the Information Regulator to update the existing guide compiled by the South African Human Rights Commission (SAHRC) containing information on exercising the rights contemplated in PAIA and POPIA. The guide must, among others, describe the assistance available from the information officer of a public body (which would include a health establishment) and the Information Regulator, as well as all remedies in law available regarding an act or failure to act in respect of a right or duty conferred or imposed by PAIA or POPIA.

3.66 Section 11 provides for a requester’s right of access to a record of a public body. Section 11(2), however, was amended by POPIA. Before amendment by POPIA, section 11(2) stated as follows:

(2) A request contemplated in subsection (1) **includes** a request for access to a record containing personal information about the requester [emphasis added].

3.67 After amendment by POPIA, section 11(2) states as follows:

(2) A request contemplated in subsection (1) **excludes** a request for access to a record containing personal information about the requester [emphasis added].

3.68 Since the operationalisation of the amendment of section 11 of PAIA by section 110 of POPIA, access to personal information and to special personal information is regulated by sections 23 and 26, in conjunction with section 32 and the definitions in section 1 of POPIA of “personal information” and “special personal information”. The relevant sections of POPIA are discussed in paragraphs 3.72 to 3.83 below.

3.69 Section 17 makes provision for the designation of as many deputy information officers as are necessary to make the public body as accessible as reasonably possible

for requesters of its records. Section 17(3) allows the information officer to delegate the powers or duties conferred or imposed on him or her by PAIA to a deputy information officer.

3.70 Section 30 of PAIA pertains to access to health and other records. Section 30 refers to section 11 in relation to “a request for access to a record provided by a health practitioner”.³⁰ In spite of the amendment of section 11 of PAIA to **exclude** “a request for access to a record containing personal information about the requester”, section 30 of PAIA is still applicable to requests for health records, since section 23(4)(b) of POPIA stipulates that the “provisions of sections 30 [in relation to access to a record of a public body] and 61 [in relation to access to a record of a private body] of the Promotion of Access to Information Act are applicable in respect of access to health or other records”.

3.71 Section 30 allows an information officer, when disclosing a record, to consult with a nominated health practitioner if the information officer is of the view that disclosing the record might cause serious harm to the physical or mental health of the requester or person to whom the record relates. If the health practitioner agrees with the information officer about the potential harm of disclosing the record, the “information officer may only give access to the record if the requester proves to the satisfaction of the information officer that adequate provision is made for such counselling or arrangements as are reasonably practicable before, during or after the disclosure of the record to limit, alleviate or avoid such harm”.³¹

3 Protection of Personal Information Act 4 of 2013

3.72 According to the long title of the Protection of Personal Information Act 4 of 2013 (POPIA), the Act aims to promote the protection of personal information processed by public and private bodies; to introduce certain conditions so as to establish minimum requirements for the processing of personal information; to provide for the establishment of an Information Regulator to exercise certain powers and to perform certain duties and functions in terms of this Act and the Promotion of Access to Information Act, 2000; to provide for the issuing of codes of conduct; to provide for the rights of persons regarding unsolicited electronic communications and automated decision making; to regulate the

³⁰ Section 30(1) of PAIA.

³¹ Section 30(3)(a) of PAIA.

flow of personal information across the borders of the Republic; and to provide for matters connected therewith.

3.73 The Information Regulator, a juristic person established by section 39 of POPIA, is responsible for exercising certain powers and performing certain duties and functions in terms of both POPIA as well as PAIA. POPIA amended PAIA quite extensively and each Act contains numerous references and cross-references to the other Act.

3.74 Section 110 of POPIA, which amends several laws, came into operation on 30 June 2021. It effected an important change with regard to access to personal information, in that access to a record of personal information held by a public body must now be sought in terms of section 23 of POPIA and no longer in terms of section 11 of PAIA.

3.75 There are a number of definitions in section 1 of POPIA that are relevant to medico-legal matters. The first is the definition of “data subject”, meaning “the person to whom personal information relates”. The definition of “information officer” in POPIA refers to section 1 of PAIA and to section 17 of PAIA (in relation to a deputy information officer).

3.76 The expression “personal information” is defined in both Acts. Although there are some similarities between the definition in PAIA and the definition in POPIA, there are also a few significant differences. The definition of “personal information” in PAIA is replicated in paragraph 3.57. The expression “personal information” is defined in POPIA in the following manner:

‘personal information’ means information relating to an identifiable, living, natural person, and where it is applicable, an identifiable, existing juristic person, including, but not limited to –

- (a) information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and birth of the person;
- (b) information relating to the education or the medical, financial, criminal or employment history of the person;
- (c) any identifying number, symbol, e-mail address, physical address, telephone number, location information, online identifier or other particular assignment to the person;
- (d) the biometric information of the person;
- (e) the personal opinions, views or preferences of the person;
- (f) correspondence sent by the person that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence;
- (g) the views or opinions of another individual about the person; and

- (h) the name of the person if it appears with other personal information relating to the person or if the disclosure of the name itself would reveal information about the person;

3.77 POPIA introduces an important concept, namely “processing”, that does not appear in PAIA except in relation to a cross-reference to POPIA. Since the information contained in a health record is definitely processed according to the definition of “processing” in POPIA, it is useful to repeat it:

‘processing’ means any operation or activity or any set of operations, whether or not by automatic means, concerning personal information, including –

- (a) the collection, receipt, recording, organisation, collation, storage, updating or modification, retrieval, alteration, consultation or use;
- (b) dissemination by means of transmission, distribution or making available in any other form; or
- (c) merging, linking, as well as restriction, degradation, erasure or destruction of information;

3.78 A “public body” is a state department or an administration at national or provincial level or a municipality. It could also be any other functionary or institution exercising a power or performing a duty under the Constitution or exercising a public power or performing a public function in terms of any legislation.

3.79 The definition of “record” in POPIA is much more comprehensive than the definition of the same expression in PAIA. The expression “record” is defined as follows:

‘record’ means any recorded information –

- (a) regardless of form or medium, including any of the following:
 - (i) Writing on any material;
 - (ii) information produced, recorded or stored by means of any tape-recorder, computer equipment, whether hardware or software or both, or other device, and any material subsequently derived from information so produced, recorded or stored;
 - (iii) label, marking or other writing that identifies or describes any thing of which it forms part, or to which it is attached by any means;
 - (iv) book, map, plan, graph or drawing;
 - (v) photograph, film, negative, tape or other device in which one or more visual images are embodied so as to be capable, with or without the aid of some other equipment, of being reproduced;
- (b) in the possession or under the control of a responsible party;
- (c) whether or not it was created by a responsible party; and

(d) regardless of when it came into existence;

3.80 PAIA refers to the “Information Regulator” established in terms of section 39, but POPIA uses the term “Regulator” to describe the same body. The term “responsible party” means a public or private body or any other person who determines the purpose of and means for processing personal information. The expression “special personal information” means personal information as referred to in section 26.

3.81 Access to personal information is regulated by section 23 of POPIA. Access to a record containing personal information held by a public body was previously provided for in section 11 of PAIA. The relevant parts of section 23 determines as follows:

(1) A data subject, having provided adequate proof of identity, has the right to –

- (a) request a responsible party to confirm, free of charge, whether or not the responsible party holds personal information about the data subject; and
- (b) request from a responsible party the record or a description of the personal information about the data subject held by the responsible party, including information about the identity of all third parties, or categories of third parties, who have, or have had, access to the information –
 - (i) within a reasonable time;
 - (ii) at a prescribed fee, if any;
 - (iii) in a reasonable manner and format; and
 - (iv) in a form that is generally understandable.

(2) If, in response to a request in terms of subsection (1), personal information is communicated to a data subject, the data subject must be advised of the right in terms of section 24 to request the correction of information.

(3) If a data subject is required by a responsible party to pay a fee for services provided to the data subject in terms of subsection (1) (b) to enable the responsible party to respond to a request, the responsible party –

- (a) must give the applicant a written estimate of the fee before providing the services; and
- (b) may require the applicant to pay a deposit for all or part of the fee.

(4) (a) A responsible party may or must refuse, as the case may be, to disclose any information requested in terms of subsection (1) to which the grounds for refusal of access to records set out in the applicable sections of Chapter 4 of Part 2 and Chapter 4 of Part 3 of the Promotion of Access to Information Act apply.

(b) The provisions of sections 30 and 61 of the Promotion of Access to Information Act are applicable in respect of access to health or other records.

(5) If a request for access to personal information is made to a responsible party and part of that information may or must be refused in terms of subsection (4) (a), every other part must be disclosed.

3.82 Section 26 prohibits the processing of special personal information, which includes personal information concerning the health or sex life of a data subject. Section 27 provides for general authorisation with regard to special personal information, stating that the prohibition on processing personal information does not apply if the processing is carried out with the data subject's consent, or the processing is necessary for the establishment, exercise or defence of a right or obligation in law.

3.83 Section 32 provides for exemptions to section 26 concerning special personal information about a data subject's health or sex life. Section 32(1)(a), which is relevant for the purposes of health records, states that the prohibition on processing personal information concerning a data subject's health or sex life (as referred to in section 26) does not apply to the processing of such information by medical professionals, healthcare institutions or facilities or social services, if processing is necessary for the proper treatment and care of the data subject, or for the administration of the institution or professional practice concerned.

4 Consumer Protection Act 68 of 2008

3.84 The Consumer Protection Act 68 of 2008 (CPA), according to its long title, aims to promote a fair, accessible and sustainable marketplace for consumer products and services and for that purpose establishes national norms and standards relating to consumer protection, to provide for improved standards of consumer information, to prohibit certain unfair marketing and business practices, to promote responsible consumer behaviour, to promote a consistent legislative and enforcement framework relating to consumer transactions and agreements, to establish the National Consumer Commission, and to repeal provisions in other Acts.

3.85 The CPA defines the expressions "consumer", "supplier" and "service". It is generally accepted that a health services user is included under the definition of "consumer", that a medical practitioner is included under the definition of "supplier", and

that health services are included under the definition of “service”.³² Applied to the health services sector, a health services user/ patient (consumer) enters into an agreement with a health establishment/ hospital or health care provider/ medical practitioner (supplier) for the delivery of health services (service). When a consumer and the supplier of a service enters into an agreement, sections 48 and 49 in Part G of the CPA are of particular importance. Part G pertains to the “Right to fair, just and reasonable terms and conditions”. Section 48 deals with unfair, unreasonable or unjust contract terms, while section 49 provides for circumstances when a consumer’s attention must be drawn to terms and conditions in agreements.

3.86 Section 49 of the CPA provides as follows:

- (1) Any notice to consumers or provision of a consumer agreement that purports to –
- (a) limit in any way the risk or liability of the supplier or any other person;
 - (b) constitute an assumption of risk or liability by the consumer;
 - (c) impose an obligation on the consumer to indemnify the supplier or any other person for any cause; or
 - (d) be an acknowledgement of any fact by the consumer,
- must be drawn to the attention of the consumer in a manner and form that satisfies the formal requirements of subsections (3) to (5).

3.87 Section 52 empowers the court to make certain orders about a transaction or agreement that is, in whole or in part, unconscionable, unjust, unreasonable or unfair. When adjudicating on a transaction or agreement, section 52(2)(b) requires the court to consider, among others, the nature of the parties to the transaction or agreement, their relationship and relative capacity, education, experience, sophistication and bargaining position.

5 State Liability Act 20 of 1957

3.88 According to the long title of the State Liability Act 20 of 1957 (SLA), the aim of the SLA is to consolidate the law relating to the liability of the State in respect of acts of

³² Department of Trade and Industry *Consumer Protection Act: Your Guide to Consumer Rights & How to Protect Them* (2011) 6; M Nöthling Slabbert & Michael S Pepper “The Consumer Protection Act: No-fault liability of health care providers” *SAMJ* 2011 Vol 101:11 800-801 at 800; Moore Stephens *Consumer Protection Act Guide* (2018) accessed 21 July 2021 southafrica.moorestephens.com/MediaLibsAndFiles/media/southafricaweb.moorestephens.com/Guides-2018/MS-Consumer-Protection-Act-Guide.pdf.

its servants. The heading of section 1 of the State Liability Act 20 of 1957 (SLA) is “Claims against the State cognizable in any competent court”. Section 1 states as follows:

Any claim against the State which would, if that claim had arisen against a person, be the ground of an action in any competent court, shall be cognizable by such court, whether the claim arises out of any contract lawfully entered into on behalf of the State or out of any wrong committed by any servant of the State acting in his capacity and within the scope of his authority as such servant.

3.89 In the context of medico-legal litigation, this means that a court should adjudicate a claim against the state based on medical negligence by one of the state’s employees in the same manner that the court would adjudicate a similar medical negligence case against a person.

3.90 Section 2(1) requires a plaintiff or applicant in any action or other proceedings instituted against the state, to cite the executive authority of the department concerned as nominal defendant or respondent. In terms of section 4A, the executive authority of a national department is the Cabinet member who is accountable to Parliament for that department; while the executive authority of a provincial department is the MEC who is accountable to the provincial legislature for that department. Section 2(2) determines that the plaintiff or applicant must serve a copy of the summons or notice on the State Attorney within seven days of issuing the original summons or notice.

3.91 Section 3 details how final court orders sounding in money must be satisfied, setting out timeframes and steps to be taken by the State Attorney or attorney of record, accounting officer of the department concerned (as referred to in section 36 of the PFMA), judgment creditor, relevant treasury (National Treasury or provincial treasury), registrar or clerk of the court and the sheriff of the court. The actions that may be taken to satisfy a court order for the payment of money, include attaching and selling movable property belonging to the state as a last resort. The State Liability Act 20 of 1957 was amended in 2011 subsequent to the case of *Nyathi v MEC for Department of Health, Gauteng*.³³ The Constitutional Court had declared section 3 of the SLA “to be inconsistent with the Constitution to the extent that it does not allow for execution or

³³ *Nyathi v MEC for Department of Health, Gauteng* 2008 (5) SA 94 (CC). The matter resulted from a claim based on medical negligence.

attachment against the state and that it does not provide for an express procedure for the satisfaction of judgment debts".³⁴

3.92 Section 3(3) indicates that a court order against a department for the payment of money must be satisfied within 30 days of the date of the order becoming final or the time period agreed between the judgment creditor and the accounting officer. The payment must be charged against the appropriated budget of the department concerned.

3.93 Section 11(3) authorises treasury departments to take certain actions to ensure that judgment debts are satisfied, such as:

- 1) making or issuing appropriate regulations, instructions, circulars, guidelines and reporting rules;
- 2) issuing directions to departments to satisfy any outstanding final court orders;
- 3) conducting investigations, inspection or review into failures;
- 4) issuing instructions to take remedial action or to obtain specified support;
- 5) withholding sufficient funds to provide for the satisfaction of an outstanding final court a department's voted funds;
- 6) satisfying outstanding final court orders on behalf of a department.

3.94 Section 3(12) allows the withholding of funds in terms of subsection (11)(e) or the satisfaction of a final court order over more than one financial year in terms of an arrangement with a judgment creditor. Section 3(13) states that satisfaction of an outstanding final court order on behalf of a department by the relevant treasury is regarded as satisfaction of the order by the department concerned. The accounting officer of the department concerned therefore remains responsible, accountable and liable in terms of the Public Finance Management Act and remains liable for financial misconduct. The PFMA must be complied with in all events. The expenditure must be classified and processed and it must be indicated whether the expenditure was unauthorised, irregular, fruitless or wasteful.

3.95 Section 3(15) imposes an obligation upon the accounting officer of a department to put in place appropriate budgeting procedures to ensure timeous satisfaction of final court orders, including measures for the appropriate identification and recording of potential contingent liabilities which may arise as a result of claims which have been

³⁴ *Nyathi* par 92.

initiated against the department concerned. Section 3(16) determines that failure to comply with this section, applicable regulations, instructions, circulars or guidelines constitutes financial misconduct and is an offence in terms of the PFMA. The accounting officer may not assign the duty to ensure timeous satisfaction of final court orders in accordance with section 3 to another official.

6 Institution of Legal Proceedings against Certain Organs of State Act of 2002

3.96 The aim of the Institution of Legal Proceedings against Certain Organs of State Act 40 of 2002 (ILPACOS), according to the long title of the Act, is to regulate prescription and to harmonise the periods of prescription of debts for which certain organs of state are liable; to make provision for notice requirements in connection with the institution of legal proceedings against certain organs of state in respect of the recovery of debt; to repeal or amend certain laws; and to provide for matters connected therewith.

3.97 The preamble to ILPACOS recognises the need to harmonise and create uniformity in respect of existing laws. The Act substitutes different notice periods for the institution of legal proceedings against certain organs of state for the recovery of a debt with a uniform notice period. In addition, the Act makes the provisions of Chapter III of the Prescription Act, 1969 applicable to all debts. The term “debt” is defined as a debt arising from any cause of action arising from delictual, contractual or any other liability for which an organ of state is liable for payment of damages. This includes a cause of action which relates to an act performed under any law or an omission to do something which should have been done in terms of any law.

3.98 An “organ of state” includes any national or provincial department, a municipality, a functionary or institution exercising a power or performing a function in terms of the Constitution or a provincial constitution, and any person for whose debt an organ of state is liable. Section 1(4) states that legal proceedings are instituted by service of any process for payment of a debt (excluding a notice) on an organ of state.

3.99 Section 3(1) determines that no legal proceedings for the recovery of a debt may be instituted against an organ of state unless the creditor has given the relevant organ of state notice in writing of the intention to institute legal proceedings. If no notice was given, or if the notice was defective, legal proceedings can be instituted if the relevant

organ of state has given written consent thereto. Section 3(2) stipulates that the notice must be served on the organ of state in accordance with section 4(1) within six months from the date on which the debt became due. The notice must set out particulars such as the facts giving rise to the debt and such particulars of the debt as are within the knowledge of the creditor.

3.100 Section 3(3) states that, for purposes of subsection (2)(a), a debt may not be regarded as being due until the creditor has knowledge of the identity of the organ of state and of the facts giving rise to the debt. A creditor is regarded as having acquired knowledge when he or she or it could have acquired the knowledge by exercising reasonable care, unless the organ of state wilfully prevented the acquisition of such knowledge.

3.101 Section 3(4) is an interesting provision. Paragraph (a) states that, if an organ of state relies on a creditor's failure to serve a notice in terms of subsection (2)(a), the creditor may apply to a court for condonation of such failure. The court may grant the application if it is satisfied that the following three conditions are present:

- the debt has not been extinguished by prescription;
- good cause exists for the creditor's failure; and
- the organ of state was not unreasonably prejudiced by the failure.

3.102 In terms of section 3(4)(b) the court may grant leave to institute the legal proceedings in question on such conditions regarding notice to the organ of state as the court may deem appropriate. Section 4 sets out the requirements for serving a notice on an organ of state and the person on whom it must be served.

3.103 Section 5 deals with service of process and stipulates that a process by which any legal proceedings contemplated in section 3(1) are instituted, must be served in accordance with section 2 of the State Liability Act, 1957. Process may only be served once 60 days have expired after notice has been served on the organ of state in terms of section 3(2)(a). Should the organ of state repudiate liability for the debt within the 60-day period, the creditor may serve the process on the organ of state.

7 Prescription Act 68 of 1969

3.104 The Prescription Act 68 of 1969 consolidates and amends the laws relating to prescription. The standard period for the extinction of a debt by prescription in terms of section 11 of the Prescription Act, 1969 is three years, unless another Act (or another provision of the Prescription Act) provides otherwise. Prescription may be interrupted by judicial process or the completion of prescription may be postponed in certain instances (for example when prescription is running against a minor).

8 Acts regarding health and related professions

3.105 The NHA defines a “health care provider” as a “person providing health services in term of any law, including in terms of the following five Acts:

- 1) Pharmacy Act 53 of 1974
- 2) Health Professions Act 56 of 1974
- 3) Dental Technicians Act 19 of 1979
- 4) Allied Health Professions Act 63 of 1982
- 5) Nursing Act 33 of 2005.

3.106 The Acts all provide for the establishment of a council to regulate a particular profession or professions. Each council is vested with specified objects, powers and functions. The most important aspects of the functions of the councils are to exercise control over the education, training, registration and practising of the professions that each council is responsible for. The councils also have disciplinary powers over the persons registered to practice under the auspices of the relevant council.

3.107 For purposes of the public health sector, the Pharmacy Act 53 of 1974, Health Professions Act 56 of 1974 and the Nursing Act 33 of 2005 are most relevant in relation to government employees. The South African Pharmacy Council (SAPC) established by the Pharmacy Act 53 of 1974 registers all professionals practicing in the pharmacy professions, which are the following: pharmacy student, pharmacist intern, pharmacist, responsible pharmacist, assessor / moderator, learner, pharmacist’s assistant (basic and post basic); pharmacy technician and pharmacy owner.³⁵

³⁵ Pharmacy Council of South Africa “Registered Persons” accessed 19 August 2021 www.pharmcouncil.co.za/registered-persons.

3.108 The Health Professions Council of South Africa (HPCSA) registers the broadest range of medical practitioners. The HPCSA registers and regulates persons practicing professions in the following areas:³⁶

- 1) Dental Assisting, Dental Therapy & Oral Hygiene
- 2) Dietetics and Nutrition
- 3) Emergency Care
- 4) Environmental Health
- 5) Medical and Dental
- 6) Medical Technology
- 7) Occupational Therapy, Medical Orthotics, Prosthetics and Arts Therapy
- 8) Optometry and Dispensing Opticians
- 9) Physiotherapy, Podiatry and Biokinetics
- 10) Psychology
- 11) Radiography and Clinical Technology
- 12) Speech Language and Hearing.

3.109 The South African Nursing Council (SANC) established by the Nursing Act 33 of 2005 registers persons as a midwife, staff nurse, auxiliary midwife and auxiliary nurse under section 31 of the Nursing Act, while students register as a learner nurse or learner midwife under section 32 of the Nursing Act. Additional qualifications are registered in terms of section 34 of the Nursing Act and covers the following areas: Clinical: Child, Community Health, Critical Care (Adult), Critical Care (Child), Emergency, Forensic, Infection Prevention and Control, Mental Health, Midwifery, Nephrology, Occupational Health, Oncology and Palliative, Ophthalmic, Orthopaedic, Perioperative and Primary Care; non-clinical: Health Services Management, and Nursing Education.³⁷

3.110 Any amendments to education, training or qualifications of health professionals and any issues concerning professional conduct, discipline, suspension or revocation of registration of health professionals fall under the auspices of the relevant professional council and will require buy-in and cooperation from the council concerned. The councils liaise with training facilities, are involved in the development of curricula, the evaluation

³⁶ Health Professions Council of South Africa “Professional Boards” accessed 19 August 2021 www.hpcsa.co.za.

³⁷ South African Nursing Council “Schedule of post-graduate diploma” accessed 19 August 2021 www.sanc.co.za/education-and-training/.

and assessment of students and requirements for post-graduate education. It would be impossible to make changes to the training of nurses, for example, without involving the South African Nursing Council.

D Provincial health legislation

3.111 The memorandum on the objects of the National Health Bill, published as part of the Bill when the Bill was tabled in Parliament, indicates that the Bill has implications for provinces:³⁸

Provincial health legislation will have to be revised in order to be consistent with the provisions of the Bill insofar as the Bill prevails over such legislation in terms of the Constitution.

3.112 The SALRC conducted a review of legislation administered by DOH as part of its Project 25: Statutory Law Revision. The Report made the following statement about provincial health legislation:³⁹

From the overview of current provincial legislation ... it seems that the envisaged revision of provincial health legislation has not been completed yet. Provincial health legislation is a labyrinth of old provincial health ordinances, assigned national and former TBVC states Acts and provincial statutes adopted post-1994. ... It has therefore become imperative that the NHA is fully implemented and provincial legislation brought in line with the NHA as soon as possible.

3.113 The *DOH Report* gives an overview and provides a complete list of all the pieces of health legislation that still apply in the provinces.⁴⁰ It is not clear how many of these pieces of legislation are still utilised in the provinces and to what extent. Apart from pre-1994 provincial ordinances and post-1994 provincial Acts that prevail in the provinces, the President had assigned the administration of the Health Act 63 of 1977, excluding certain sections, to the provinces by Proclamation 152 of 1994 published on 31 October 1994, with effect from that date.⁴¹ This was done in terms of section 235(8) of the 1993 Constitution.

³⁸ Item 5 of the Memorandum of Objectives of the National Health Bill [B32B—2003].

³⁹ SALRC *Report on Statutory Law Revision: Legislation administered by Department of Health* (June 2018, published in February 2019) at 172 (*DOH Report*).

⁴⁰ *DOH Report* Chapter 10 at 174–189 and Annexure I at 443.

⁴¹ Proclamation R 152 of 1994 published in *Government Gazette* 16049 of 31 October 1994.

3.114 Parts of the Health Act, 1977 were initially retained at the national level, but had since been repealed by the NHA.⁴² In spite of the repeal of the Health Act, 1977 by the NHA, some or all of the assigned sections of Act 63 of 1977 remain in force in the provinces, since Parliament cannot repeal provincial legislation. The *DOH Report* recommends that: “For the sake of uniformity and legal certainty the national DOH should engage with the provincial departments of health on the repeal by the provinces of the sections of Act 63 of 1977 assigned to them”.⁴³

E Regulations, guidelines norms and standards

3.115 The public health sector is often criticised for inadequate regulations or a lack of uniform guidelines on issues such as human resource planning, quality of health care, budgeting, record-keeping, poor procurement and control practices, lack of equipment and medicines, reporting of adverse events, evaluation and monitoring, system failures, inadequate infrastructure, poor maintenance of facilities and so forth. As is apparent from the overview of relevant parts of the NHA in paragraphs 3.21 to 3.56, a number of the issues referred to above is covered in the NHA. The Minister has made regulations under the NHA that add another layer of legislation to support the implementation, application and enforcement of the NHA. In addition several policies, government or general notices, guidelines and other tools on a range of issues have been published to further the NHA.

3.116 The Minister of Health determined the policies, made the regulations and issued the government notices listed below to give effect to the Constitution and the NHA:

- 1) Regulations relating to Categories of Hospitals (2012) – regulations made in terms of section 35 read with section 90 of the NHA.⁴⁴
- 2) Policy on the Management of Public Hospitals (2012) –in terms of sections 3(1)(c) and 23(1) of the NHA.⁴⁵

⁴² Date of repeal of sections 14–16, 18, 19, 21–26, 29–31, 41 and 53 of the Health Act, 1977: 2 May 2005; date of repeal of the rest of the Health Act, 1977: 1 March 2012.

⁴³ *DOH Report* 173.

⁴⁴ *Regulations relating to Categories of Hospitals* GN R185 in GG 35101 of 2 March 2012.

⁴⁵ *Policy on the Management of Public Hospitals* GN R186 in GG 35101 of 2 March 2012.

- 3) National Environmental Health Policy (2013) (NEH Policy)⁴⁶ – guideline and framework for the implementation of Environmental Health Services in SA to give effect to the Constitution⁴⁷ and the 1997 White Paper on the Transformation of Health Services.⁴⁸
- 4) Establishment of Ministerial Advisory Committee on E-Health (2015) – committee established in terms of section 91 of the NHA after consultation with the National Health Council.⁴⁹
- 5) Norms and Standards Regulations Applicable to Different Categories of Health Establishments, 2017 – regulations made under section 90(1A) of the NHA.⁵⁰ The regulations deal with the following:
 - a) User rights
 - user information
 - access to care
 - b) Clinical governance and clinical care
 - user health records and management
 - clinical management
 - infection prevention and control programmes
 - waste management
 - c) Clinical support services
 - medicines and medical supplies
 - diagnostic services
 - blood services
 - medical equipment
 - d) Facilities and infrastructure
 - management of buildings and grounds
 - engineering services
 - transport management
 - security services

⁴⁶ *National Environmental Health Policy* GN 951 in GG 37112 of 4 December 2013.

⁴⁷ In particular health care services as defined in the NEH Policy, which includes reproductive health care and emergency medical treatment contemplated in section 27; basic nutrition and basic health services contemplated in section 28(1)(c); and medical treatment contemplated in section 35(2)(e) of the Constitution.

⁴⁸ GenN 667 of 1997.

⁴⁹ GN 595 in GG 38981 of 10 July 2015.

⁵⁰ GN 67 in GG 41419 of 2 February 2018.

- e) Governance and human resources
 - governance
 - human resources management
 - occupational health and safety
- f) General
 - adverse events
 - waiting times.

3.117 In addition to the regulations and policies listed above, the national DOH has issued several other documents, guidelines and tools. Some of these documents are listed below:

- 1) *Patient Rights Charter* (1999) – sets out the rights of patients with regard to a healthy and safe environment, participation in decision making, access to health care, knowledge of one’s health insurance / medical aid scheme, choice of health services, be treated by a named health care provider, confidentiality and privacy, informed consent, refusal of treatment, be referred for a second opinion, continuity of care, complain about health services, responsibilities of patient or client.⁵¹
- 2) *Notice of Publication of Health Infrastructure Norms and Standards Guidelines* (2014) – Health Infrastructure Norms and Standards Guidelines in relation to Building Engineering Services, Infrastructure Design for Waste Management in Healthcare Facilities and Emergency Centres published by the Minister of Health in terms of the NHA. The guidelines are for public reference information and for application by provincial DOHs in the planning and implementation of public sector health facilities.⁵²
- 3) *National Environmental Health Norms and Standards for Premises and Acceptable Monitoring Standards for Environmental Health Practitioners* (2015) – set by the Director-General: DOH in terms of section 21(2)(b)(ii) of the NHA.⁵³
- 4) *Health for All: A health promotion tool for health professionals* (2018) – provides an approach to health promotion in the primary care setting. It serves as an aid

⁵¹ Department of Health *Patients’ Rights Charter* (undated). The *PRC* is undated, but a public health pamphlet issued by UCT indicates that the *PRC* “has been around since 1999”. [University of Cape Town *The Patients’ Rights Charter* (undated pamphlet) 2nd page accessed 26 July 2021 www.publichealth.uct.ac.za/sites/default/files/image_tool/images/8/HHR%20pamphlet3%20English%20web%20cc.pdf.

⁵² GN R116 in GG 37348 of 17 February 2014.

⁵³ GenN 1229 in GG 39561 of 24 December 2015.

to the clinician in identifying and mitigating the health risks to the patient either from lifestyle and/or existing disease conditions and to ensure that consistent health promoting and educating messages are conveyed to the users of the health service at each encounter.⁵⁴

- 5) *Health for All: Health promotion tool for community health workers* (June 2018) – tool designed to support community health workers (CHWs) in carrying out their critical tasks within communities.

3.118 The NDOH launched the Ideal Clinic Programme in July 2013. All frameworks, manuals, handbooks, policies and guidelines relevant to the Ideal Clinic Programme are available on the website <https://www.idealhealthfacility.org.za/> hosted by the national Department of Health. It is a highly useful resource with a huge amount of information and pictures of neat, properly equipped and well-maintained facilities. The website provides information about the Ideal Clinic programme and the fast-tracking of the programme via Operation Phakisa.⁵⁵ It also contains a myriad of documents, the most relevant of which are listed below:

Ideal health facility

- 1) Ideal Clinic Framework (definitions, components and checklists) (April 2020) – updated May 2021
- 2) Ideal Clinic Manual (April 2020) – updated May 2021
- 3) Ideal CHC Framework (April 2020) – updated May 2021
- 4) Ideal Community Health Centre (CHC) Manual – updated May 2021
- 5) Ideal Hospital Realisation and Maintenance Framework Manual (2018)
- 6) Ideal Hospital Maintenance Framework (Hospital Tool) (October 2018)

⁵⁴ The publication is undated, but since the messages and design of *Health for All: Health promotion tool for community health workers* (June 2018) are stated to be similar to and synchronise with *Health for All: The health promotion tool for health professionals* (*Promotion tool for CHWs* under “Acknowledgement” at beginning of publication), it is assumed that the publication was also released in 2018.

⁵⁵ Department of Health “Ideal Clinic South Africa” accessed 8 October 2021 www.idealhealthfacility.org.za. The website provides links to the NDOH website and the Knowledge Hub website www.knowledgehub.org.za. Knowledge Hub is a professional development platform aiming to connect health professionals to development opportunities and resources for purposes of continuous professional development (CPD). Operation Phakisa (“phakisa” means “hurry up” in Sesotho) is an initiative of the South African government. The initiative was designed to fast track the implementation of solutions on issues highlighted in the National Development Plan 2030. It falls under the auspices of the Department of Planning, Monitoring and Evaluation (DPME). [Operation Phakisa accessed 8 October 2021 www.operationphakisa.gov.za/Pages/Home.aspx.]

Manuals, handbooks and frameworks

- 7) Integrated Clinical Services Management Manual (undated)
- 8) Primary Health Care Laboratory Handbook (May 2018)
- 9) National Infection Prevention and Control Strategic Framework (March 2020)
- 10) National Infection Prevention and Control Practical Manual (October 2021)
- 11) COVID-19 Infection Prevention and Control Guidelines (May 2020)

Policies

- 12) District Health Management Information System Policy (DHMIS) (2011)
- 13) National Adolescent and Youth Health Policy (2017)
- 14) National Referral Policy for SA Health Services and Implementation Guidelines (August 2020)

Clinical services

- 15) Standard Treatment Guidelines and Essential Medicine List for Primary Health Care (2020)
- 16) Adult Hospital level Standard treatment guidelines and Essential medicines list for 2019 Adult Primary Care Guide 2019-20
- 17) Integrated Management of Childhood illness Booklet (2019)
- 18) Paediatric Hospital level Standard treatment guidelines and Essential medicines list for 2017
- 19) Road to Health Booklet (2017)
- 20) New-born Care Charts – Management of sick and small new-borns (2014)

National health priorities

- 21) Antiretroviral Treatment Clinical Guidelines (Oct 2019)
- 22) Guidelines for Maternity Care (2016)
- 23) Infant and Young Child Feeding Policy (2013)
- 24) Management of Rifampicin resistance – A clinical reference guide (2019)
- 25) National Guidelines Management of TB in children (2013)
- 26) National TB management guidelines (2014)
- 27) National Guidelines on Epidemic Preparedness and Response

Complaints, compliments, suggestions

- 28) National Guideline to Manage Complaints, Compliments and Suggestions (March 2017)

- 29) Guideline for Districts to develop a SOP (standard operating procedure) to Manage Complaints Compliments and Suggestions (April 2017)
- 30) Guideline for Hospitals to develop a SOP to Manage Complaints, Compliments and Suggestions (April 2017)

PSI reporting and learning

- 31) Guideline for District offices to develop a SOP for Patient Safety Incident Reporting and Learning (April 2017)
- 32) Guideline for Hospitals to develop a SOP for Patient Safety Incident Reporting and Learning (April 2017)
- 33) National Guideline for Patient Safety Incident Reporting and Learning (March 2018)

General

- 34) Quality Improvement Guide (2012)
- 35) Final Draft National Clinical Record Audit Guideline for PHC (primary health care) facilities (March 2018)
- 36) National Guideline for Filing, Archiving and Disposal of Patient Records in PHC facilities (July 2018)
- 37) National Guideline to conduct Patient Experience of Care Surveys (October 2017)
- 38) Template for six monthly district/sub-district clinical performance review report (undated)
- 39) Draft National Guideline to Manage Patient Waiting Times in Health Facilities (Jan 2019)

Training material

- Training Manual for Patient safety incident reporting (February 2018)
- Training Manual for Complaints Compliment and suggestion reporting (February 2018)

Training modules for Ideal Health Facility

- 1) Training Module IV part I for IC software - Introduction to software
- 2) Training Module IV part II for IC software - Capture data on Offline software
- 3) Training guide to capture Ideal Clinic and CHC Status Determinations on Web based software 2020

- 4) Training Module IV part IV for IC software – Generate Dashboard and Report on software
- 5) Presentation Background on Ideal Clinic Initiative
- 6) Presentation Ideal Clinic Software
- 7) IHRM Web based Information Guide 2020
- 8) Training Guide for Ideal Health Facility Software – Capture QIP on web based software

3.119 It is evident from the list of documents above that there is an abundance of regulations, guidelines, policies and tools. Just the sheer volume of prescripts that must be complied with is problematic, regardless of the fact that the majority of provinces simply do not have sufficient resources or capacity to implement all these measures. Regulations, policies and guidelines are necessary, but if the measures are unrealistic, overly complicated or difficult to implement, provinces will not apply it or not apply it in full, which means that it becomes a mere paper exercise. It can also lead to a false sense of security because of the danger that state departments consider the existence of the prescript or guideline as the outcome, instead of measuring the practicality and the impact of the prescript or guideline.

F Relevant Bills

3.120 There are two Bills that will have an impact on medico-legal claims if passed by Parliament, namely the State Liability Amendment Bill 16–2018 (SLA Bill), and the National Health Insurance Bill 11–2019 (NHI Bill). It seems that the SLA Bill will not go forward, while the NHI Bill is currently before Parliament.

1 State Liability Amendment Bill 16–2018

3.121 The Commission made the following suggestion in Issue Paper 33:

Due to the detrimental impact of the substantial amounts awarded as compensation for medical negligence claims, it is recommended that consideration be given to amending the State Liability Act 20 of 1957 as an interim measure. The purpose of the amendment would be to make specific provision for structured settlement orders, which would include periodic payments, in cases of medical negligence claims against the state.

3.122 The DOJ&CD acted on the suggestion and the Minister of J&CS introduced the State Liability Amendment Bill 16–2018 in the National Assembly in Parliament on 30 May 2018. The Portfolio Committee on Justice and Correctional Services held public hearings on the Bill on 31 October 2018. The Bill was not finalised by the time Parliament was dissolved before the national and provincial elections of 8 May 2019, which meant that the Bill then lapsed. On 29 October 2019 the National Assembly took a resolution that the House resume proceedings on the Bill.

3.123 Representatives from DOJ&CD briefed the Portfolio Committee on Justice and Correctional Services (National Assembly committee that deal with Justice legislation) on the Bill on 26 January 2021. However, the Portfolio Committee decided not to process the Bill further. The Committee suggested that amendments to legislation pertaining to medico-legal claims should not be introduced in a piecemeal fashion while the SALRC is still researching a more holistic approach to medico-legal claims.

3.124 Although it appears that the State Liability Amendment Bill 16–2018 will not proceed any further at this stage, the submissions received and presentations made during the Parliamentary process were very helpful with regard to highlighting concerns and problems pertaining to the public health sector in general and medico-legal litigation in particular. A number of commentators contributed valuable insights into the Bill and offered proposals on the Bill or comparable legislative provisions, which will be consulted when drafting legislation to give effect to the Commission’s proposals. Views put forward by Pauw,⁵⁶ Wessels,⁵⁷ and Wessels and Wewege⁵⁸ are of particular benefit.

2 National Health Insurance Bill 11–2019

3.125 The aim of the National Health Insurance Bill 11–2019, according to the long title, is as follows:

To achieve universal access to quality health care services in the Republic in accordance with section 27 of the Constitution; to establish a National Health Insurance Fund and to set out its powers, functions and governance structures; to provide a framework for the strategic purchasing of health care services by the Fund on behalf of users; to

⁵⁶ Pieter Pauw “Alternative relief in medical malpractice claims – further developments” 2019 (1) *TSAR* 91–97 at 95–97 [Pauw (2019)].

⁵⁷ Wessels 21–23.

⁵⁸ Wessels & Wewege 490, 492, 495, 497 & 503–507.

create mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund to meet the health needs of the population; to preclude or limit undesirable, unethical and unlawful practices in relation to the Fund and its users; and to provide for matters connected herewith.

3.126 The memorandum of objects of the NHI Bill explains that the Bill seeks to provide for universal access to health care services in accordance with the Constitution and the National Health Insurance White Paper. The Bill envisages establishing the National Health Insurance Fund, which will purchase health care services for all users registered with the Fund. The Bill sets out the powers, functions and governance structures of the NHI Fund and creates mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund to meet the health needs of users and limit undesirable, unethical and unlawful practices in relation to the Fund and its users.

3.127 The NHI Bill was introduced into Parliament in August 2019. The Bill is currently under consideration by the National Assembly. Public hearings on the NHI Bill have been ongoing since 18 May 2021, with the 19th day of public hearings taking place on 10 September 2021. The NHI Bill has been quite controversial with arguments for and against the Bill. There is general support for the principle of universal health coverage,⁵⁹ but a lot of criticism has been levelled at government for the manner in which the NHI Bill seeks to achieve universal health coverage. Concerns are also raised about the affordability of the proposed system.⁶⁰

3.128 Dhai reviewed the objectives of the proposed national health insurance (NHI) system as revealed in the Green Paper on the National Health Insurance published in August 2011.⁶¹ She considered the affordability of the NHI against the backdrop of the World Health Report published by the World Health Organisation in 2000,⁶² the Constitution of South Africa and the NHA. The World Health Report examines four health

⁵⁹ See for example Narnia Bohler-Muller and Moremi Nkosi “The NHI Bill is the best way to attain universal health coverage and health equity” *Daily Maverick* (6 June 2021).

⁶⁰ See for example Alex van den Heever “Why South Africa’s plans for universal healthcare are pie in the sky” *The Conversation* (19 August 2019) theconversation.com/why-south-africas-plans-for-universal-healthcare-are-pie-in-the-sky-121992; South African Medical Association “Submission to the Parliamentary Portfolio Committee on Health in respect of The National Health Insurance Bill” (29 November 2019).

⁶¹ Ames Dhai “Healthcare reform in South Africa: A step in the direction of social justice” *SAJBL* 4:2 (December 2011) [Dhai (2011)].

⁶² WHO *The World Health Report: Health Systems: Improving Performance* (2000).

systems functions: service delivery, input production, financing and stewardship. The Report considers stewardship as the most important of the four functions:⁶³

[T]he ultimate responsibility for the overall performance of a country's health system must always lie with government. Stewardship not only influences the other functions, it makes possible the attainment of each health system goal: improving health, responding to the legitimate expectations of the population, and fairness of contribution. The government must ensure that stewardship percolates through all levels of the health system in order to maximize that attainment.

3.129 According to Dhai (2011), “[m]anaging the well-being of the population carefully and responsibly is the very essence of good government”. She then refers to section 27 of the Bill of Rights of the Constitution, which provides for the right of access to health care services. Section 27 requires the state to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right. The NHA gives structure to the section 27 right to health care services. Section 3 of the NHA makes the Minister of Health responsible for providing health care services, listing the Minister's functions. Section 3 adds the proviso “within the limits of available resources”, which Dhai articulates as “the provision of the best possible health services that available resources can afford in an equitable manner for the population of South Africa”.⁶⁴

3.130 Dhai (2011) remarks that health financing in South Africa will have to be reformed comprehensively to attain the objectives of the NHI. She refers to views expressed by members of the World Bank, WHO officials and South African health economists at the National Health Insurance Conference: Lessons for South Africa (National Consultative Health Forum), held on 7 and 8 December 2011. The prevailing opinion at the conference was that funds for NHI are available within the South African health system in conjunction with employment taxation and other innovative methods of revenue collection, but that the funds must be effectively managed and used, while corruption must be eradicated.⁶⁵

⁶³ World Health Report (2000) 119.

⁶⁴ Dhai (2011) 48.

⁶⁵ Dhai (2011) 48.

CHAPTER 4: DEVELOPMENT OF CASE LAW

A Conclusion

4.1 The significance of the judgment in the 2017 Constitutional Court case of *MEC, Health and Social Development, Gauteng v DZ obo WZ* cannot be over-emphasized. Considering the serious financial predicament the majority of provincial departments of Health find themselves in because of enormous medico-legal pay-outs, the case could have a major positive impact.

4.2 What is also noteworthy, is that all the Constitutional Court judges agreed on the final verdict, albeit based on different reasons. The differences in opinion between the judges is more of an academic than a practical nature, regardless of the interesting theoretical debate that has arisen around it. The implication of the judgment is that the door is open to compensating victims of medical negligence in alternative ways, but without bankrupting the state or running the risk of the collapse of public health care services in some provinces.

4.3 Provinces will still have to prepare and prove a proper case, in particular with regard to the availability of public health establishments that are equipped to deliver the required standard of health care services. In some of the provinces this may be a problem. However, the difference between a well-prepared case that satisfied the court with regard to the health care services that the state can offer, and a case that did not convince the court at all, is evident from the Gauteng case of *MSM obo KBM v MEC Health, Gauteng*¹ and the KwaZulu-Natal case of *PH obo SH v MEC Health, KwaZulu-Natal*.²

4.4 In the *MSM* case the Gauteng Local Division in Johannesburg ordered the MEC to render certain medical services to the child KBM at a Johannesburg hospital. In the *PH* case the KwaZulu-Natal Local Division in Durban said that the defendant (the MEC) was “very vague about the existence of public healthcare facilities which

¹ *MSM obo KBM v MEC Health, Gauteng* (4314/15) [2019] ZAGPJHC 504; 2020 (2) SA 567 (GJ); [2020] 2 All SA 177 (GJ) (18 December 2019).

² *PH obo SH v MEC Health, KwaZulu-Natal* (11198/2016) [2020] ZAKZDHC 38; 2021 (1) SA 530 (KZD) (31 August 2020).

are as good as or better than private health care facilities”.³ The Gauteng court was not convinced by the arguments raised by the MEC to permit periodic payments. The KwaZulu-Natal court was not convinced by the defendant’s reasons for amending her plea to raise the “public health care” defence.

B Introduction

4.5 The single most significant matter with regard to medical negligence cases against the state is the Constitutional Court case of *MEC, Health and Social Development, Gauteng v DZ obo WZ*.⁴ The judgment in the matter brought necessary direction and clarity on the development of the common law with regard to this particular area of the law. It also opened the door to further developments, giving recognition to the principle of compensating plaintiffs for damages suffered at the hand of the state, while acknowledging the constraints that the state is operating under. The *DZ* case is the culmination of earlier court decisions on the principle of compensation sounding in money, the common law “once and for all” rule, the plea of *res judicata* and “payment in kind” as a component of compensation awards.

C Development of common law in South Africa

1 Roman Dutch law

4.6 When the Dutch established a settlement in the Cape in 1652, they brought with them the law of the province of Holland, as influenced by and adapted from Roman law.⁵ The British occupied the Cape for a second time in January 1806 after defeating the small multi-racial force of the Batavian Republic.⁶ The Cape was ceded to Great Britain on 13 August 1814 by the Convention between Great Britain and the United Netherlands. The citizens and inhabitants of the Cape retained the facilities, privileges and protection

³ *PH* par 24.

⁴ *MEC, Health and Social Development, Gauteng v DZ obo WZ* [2017] ZACC 37.

⁵ Rena van den Bergh “The Remarkable Survival of Roman-Dutch Law in Nineteenth-Century South Africa” *Fundamina* Vol 18(1) 2012 (Unisa) 71–90 at 72.

⁶ Willem Steenkamp “Day of Destiny: The Battle of Blaauwberg 8 January 1806” *Military History Journal* Vol 13 No. 4 (December 2005) The South African Military History Society.

pertaining to commerce and the security of their property and persons that they had while the Cape was under the control of the Dutch.⁷

2 Influence of English law

4.7 In spite of article 4 of the 1814 Anglo-Dutch Convention, which included the retention of the Roman-Dutch law as the common law of the Cape, there was a move towards transitioning to English law over time. Legislation and practices based on English laws and processes were introduced that strengthened the impact of English law on the local legal system. Van den Bergh refers to proclamations by the Governor of the Cape Colony, English rules of procedure and evidence and laws on companies, negotiable instruments, insolvency, maritime and shipping law, fire, life and marine insurance and immaterial property rights.⁸

4.8 Apart from easy access to English sources and case law, many judges and advocates had been trained in England or Scotland. The judges of the Supreme Court of the Cape of Good Hope had to have been admitted as barristers in England or Ireland, or as advocates in Scotland or the Cape Supreme Court. In addition, in its role as the final court of appeal for the Cape Colony, the Privy Council of the United Kingdom materially affected the administration of justice in the Cape.⁹

4.9 The short-lived Boer Republic of Natalia was annexed by the British in 1843. Natal subsequently became a dependency of the Cape Colony subject to Cape laws. As was the case in the Cape Colony, Roman Dutch law was established as the law of the District of Natal. When Natal was declared a separate self-governing territory in 1845, Roman-Dutch law was still acknowledged as the common law of the Natal colony, however, the strong British character of Natal also impacted upon the administration of the law in the colony.¹⁰

4.10 Both the Boer republics, namely the *Oranje Vrijstaat* and the *Zuid Afrikaansche Republiek* (later referred to as Transvaal) specified Roman Dutch law as the common

⁷ Van den Bergh 73.

⁸ Van den Bergh 74–75.

⁹ Van den Bergh 75.

¹⁰ Van den Bergh 76; “Natal” *Encyclopaedia Britannica* accessed 24 March 2021 www.britannica.com/place/Natal-historical-province-South-Africa.

law of their republics, even listing the writers considered as authoritative sources of Roman Dutch law.¹¹ The influence of English law, however, was also felt in the Boer Republics, since the majority of the trained judges received part of their legal training in Britain and were admitted to the English Bar and the Cape Bar.¹² Decisions of the Cape Supreme Court had persuasive authority in the courts of the Boer republics.¹³

4.11 The Union of South Africa was established in 1910 by the South Africa Act of 1909, a British Act of Parliament. The Supreme Court of South Africa was established by section 95 of the South Africa Act, while the Appellate Division of the Supreme Court was established by section 96 of the South Africa Act. With the exception of one judge, all the Appeal Court judges received part of their legal training in the United Kingdom and had been called to the English Bar.¹⁴

4.12 The influence of English law on the South African legal system is clear from the discussion above. It sometimes occurred that a Roman Dutch legal principle was anglicized, or that a rule was imported from English law in spite of an existing Roman-Dutch rule. This was the case with the common law “once and for all” rule. The Roman Dutch plea of *res judicata* could be pleaded in bar if a matter based on the same facts was brought before the court again, yet the “once and for all” rule was incorporated by citing English case law as authority for decisions.

D Case law introducing common law principles

4.13 Just about every important court case that considered compensation for delictual damages, awards for future maintenance and care, awards for the cost of future medical treatment, the common law “once and for all” rule, the *res judicata* principle, and lump sum payments vs periodic payments vs payments in kind; referred to particular earlier court decisions. With the exception of the case of *Wynberg Valley Railway Company v Eksteen*,¹⁵ which was heard by the Supreme Court of the Cape of Good Hope, the other

¹¹ Van den Bergh 77 & 80.

¹² Van den Bergh fn 51 at 78 and fn 72 at 80.

¹³ Van den Bergh 79.

¹⁴ Van den Berg fn 95 at 84–85; Liezl Wildenboer “The Judicial Officers of the Transvaal High Court, 1877–1881” *Fundamina* Vol 25 (2) 2019 256–290 at 277.

¹⁵ *Wynberg Valley Railway Company v Eksteen* (1861–1867) 1 Roscoe 70.

decisions were judgments of the Appellate Division of the Supreme Court, renamed the Supreme Court of Appeal in February 1997.

4.14 On reading the original court decisions, it becomes apparent that the legal counsel referring the court to these seminal cases did not always reread the original decisions, sometimes only citing the parts of the decisions that were previously referred to by other judges in earlier decisions. Passages are often quoted selectively or merely cited, though not always in the correct context or necessarily supportive of the argument being made. To put these cases into perspective, the cases that are routinely cited or referenced and that were referred to in the *DZ* case are briefly discussed below, adding some historical information where relevant.

1 ***Wynberg Valley Railway Company v Eksteen (1863)***

4.15 The matter of *Wynberg Valley Railway Company v Eksteen*¹⁶ is the oldest of these cases, dating back to 1863. The passage from the case that has been quoted so often that it has become trite, is the phrase cited by Bell J¹⁷ (referring to other sources), that “money is the measure of all things”.¹⁸ The subject of the matter before the court in the *Wynberg Valley Railway Company* case was not delictual damages, but an objection to an arbitration award made under the 18th section of the Wynberg Railway Act of 1861. The arbitrators awarded compensation partly in money and partly in kind (in brick clay excavated from the land that the WVR Company had taken possession of). The Act, however, provided for “the amount of recompense or compensation” to be ascertained, hence the matter was referred back to the arbitrators to determine the value of the material removed.

4.16 The phrase “money is the measure of all things” from the *Wynberg Valley Railway Company* case is quoted to justify the practice of awarding money in full compensation

¹⁶ *Wynberg Valley Railway Company v Eksteen* (1861–1867) 1 Roscoe 70.

¹⁷ Judge Bell was of Scottish origin and was educated at the University of Edinburgh, Scotland and later in London. Scotland, like South Africa, has a mixed or hybrid legal system, which incorporates elements of civil law and common law, including civil (Roman) law as developed by the jurists of Holland and France [James Irvine Smith “Scottish law” *Encyclopaedia Britannica* accessed 9 March 2021 www.britannica.com/topic/Scottish-law]. For this reason, Scottish lawyers was generally better versed in Roman Dutch law than English lawyers.

¹⁸ *Wynberg Valley Railway Company* 74.

for delictual damages rather than “payment in kind”. However, when considering the phrase in the context of the whole of Bell J’s statement on this point, it appears that the learned judge was actually of the view that compensation need not necessarily only sound in money. In the words of Bell J:¹⁹

It is no doubt true, as an abstract proposition, that when damages are due by law they are to be awarded in money, as, to use the language of the commentators, “money is the measure of all things” (Domat III. 53; Rolle’s Abr. Arb.B. 10, 11; Hemsworth vs Brian 11*), **but that proposition may fail in its application according to the particular circumstances of the case to which its application is directed.** It would seem also that the particular terms of the Act in this case contemplate that the payment of the recompense or compensation is to be in money, and in nothing else, as to which I do not feel it necessary at present to express any decided opinion. [Emphasis added.]

2 *Cape Town Council v Jacobs (1917)*

4.17 The next significant case is the matter of *Cape Town Council v Jacobs*,²⁰ which is widely referred to as the case that introduced the “once and for all” rule into the South African legal system. The “once and for all” rule is a common law rule that was introduced into the South African legal system from the English law. Visser and Potgieter explain the common law “once and for all” rule in the following manner:²¹

In claims for compensation or satisfaction arising out of a delict, breach of contract or other cause, the plaintiff must claim damages once for all damages already sustained or expected in future in so far as it is based on a single cause of action.

4.18 This 1917 case dealt with statutory compensation for occupational injury in terms of the Workmen’s Compensation Act 25 of 1914. The plaintiff had been awarded compensation in the form of periodical payments for a period of 12 months, after which he returned to court to claim for compensation in the form of a lump sum award for permanent partial incapacity. Judgment was delivered by Solomon J. Solomon J did not mention the common law “once and for all” rule in the judgment as such, but referred to the plea of *res judicata* in relation to barring a claim that had been adjudicated upon

¹⁹ *Wynberg Valley Railway Company* 74.

²⁰ *Cape Town Council v Jacobs* 1917 AD 615.

²¹ Visser & Potgieter *Visser and Potgieter’s Law of Damages* 3 ed (2012) 153.

before.²² He cited Lord Halsbury's statement from the English case of *Darley Main Colliery Co v Mitchell*, which dealt with the recovery of compensation for a house damaged by mining operations:²³

No one will think of disputing the proposition that for one cause of action you must recover all damages incident to it by law once and for ever. A house that has received a shock may not at once show all the damage done to it, but it is damaged none the less then to the extent that it is damaged, and the fact that the damage only manifests itself later or by stages does not alter the fact that the damage is there ...

E MEC, Health and Social Development, Gauteng v DZ obo WZ

1 Background to DZ case

4.19 The Constitutional Court judgment in *MEC, Health and Social Development, Gauteng v DZ obo WZ* [2017] ZACC 37 is seminal. The matter originated in the Gauteng Local Division of the High Court in Johannesburg (Gauteng South). The plaintiff was DZ, mother and guardian of the minor child WZ and acting on her behalf. WZ was born at the Chris Hani Baragwanath Hospital in Johannesburg on 19 November 2009, and was later diagnosed with cerebral palsy due to asphyxia during delivery.

4.20 DZ successfully instituted action for damages caused by the negligent conduct of the hospital staff, who are employees of the Gauteng MEC for Health and Social Development. During the initial hearing the MEC conceded negligence, accepting vicarious liability on the merits of the claim. However, before the further hearing on the quantum of the damages, the MEC amended her plea to include two further issues for determination, which subsequently formed the subject of an appeal to the Supreme Court of Appeal (SCA).

²² *Cape Town Council v Jacobs* 620.

²³ *Darley Main Colliery Co v Mitchell* 11 A.C. 132.

2 DZ case before the SCA

4.21 In the matter of *MEC for Health and Social Development, Gauteng v [DZ] obo [WZ]*,²⁴ heard by the SCA, the MEC requested the SCA to consider the following pleas (in summary):

- Direct the MEC to pay service providers directly for services rendered to the child WZ, rather than paying monetary compensation for future medical expenses. Should it be found that the law does not provide for this, the MEC pleaded that the law must be developed to provide for such an arrangement.
- The portion of the compensation awarded for future medical expenses should not be considered for the determination of fees under the contingency fee agreement.

4.22 The Court a quo (Gauteng Local Division, Johannesburg) denied the MEC's plea based on the common law "once and for all" rule and awarded compensation in a lump sum. The SCA quoted *Casely NO v Minister of Defence*,²⁵ where it was stated (in part):²⁶

Under the common law a person or his dependant is only accorded a single, indivisible cause of action for recovering damages for all his loss or damage for the wrongful act causing his disablement or death.

4.23 The court acknowledged the plaintiff's contention in the *Casely* case that a claim for non-economic loss is in the nature of *solatium*²⁷ for pain, suffering, shock, disfigurement and loss of amenities. The court concluded, however, that "it nevertheless still is an indivisible part of that single cause of action of the disabled person".²⁸

²⁴ *MEC for Health and Social Development, Gauteng v [DZ] obo [WZ]* (1020/2015) [2016] ZASCA 185 (30 November 2016).

²⁵ *Casely NO v Minister of Defence* 1973 (1) SA 630 (A). Plaintiff claimed on behalf of his son for non-economic loss for pain, suffering, shock, disfigurement and loss of amenities as a result of injuries suffered as a member of the Citizen Force of the SA Defence Force. The War Pensions Act 82 of 1967 absolved the State from liability for the death or disablement of a volunteer, save for liability as provided for in Act 82 of 1967. Plaintiff therefore attempted to claim for non-economic loss as a separate claim.

²⁶ *Casely* 642C.

²⁷ "*Solatium*" as defined in SOED 2007: A sum of money or other compensation given to a person to make up for loss, inconvenience, injured feelings, etc.; spec. in Law, such an amount awarded to a litigant over and above the actual loss.

²⁸ *Casely* 642D-E.

4.24 The SCA stated that the order sought by the MEC (the appellant in this case), namely to pay service providers directly for WZ's future medical expenses rather than paying the total amount of compensation in a lump sum, "is precluded by the common law rule that a person or his dependent is only accorded a single, indivisible cause of action to recover damages for all the loss or damage suffered as a result of the wrongful act causing disablement or death".²⁹

4.25 With regard to the MEC's plea that the common law "once and for all" rule should be developed to provide for direct payment to service providers by the MEC for future medical treatment, the SCA held that there "is no evidence to show that the 'once and for all' common law rule requires development in the manner suggested by the appellant." Due to the lack of evidence, the SCA also rejected the MEC's contention that the payment of a lump sum award for WZ's future medical expenses would compromise her ability to give effect to the constitutional right of access to health care services.³⁰

4.26 Citing *Carmichele v Minister of Safety and Security & another*, the SCA stated that, in exercising their power to develop the common law, judges have to be "mindful of the fact that the major engine for law reform should be the Legislature and not the Judiciary".³¹ The courts should limit itself to incremental changes to keep the common law in step with the needs of society, while substantial changes should be dealt with by the legislature.³²

4.27 With regard to the contingency fee agreement, the SCA found that the Contingency Fees Act 66 of 1997 does not confer any power upon the court to alter the amount payable in terms of a contingency fee agreement.³³ For the reasons set out above, the SCA dismissed the MEC's appeal.

²⁹ DZ (SCA) par 6. Pauw criticised the SCA for this statement and submits that it "shows a misunderstanding of the so-called 'once and for all' rule. That rule precludes further litigation on a single cause of action (for damages) on which a court has already pronounced. Once a court has quantified damages, that quantification is *res judicata*." [Pauw (2017) 848].

³⁰ DZ (SCA) par 11.

³¹ *Carmichele v Minister of Safety and Security & another (Centre for Applied Legal Studies Intervening)* 2001 (4) SA 938 (CC) par 36.

³² DZ (SCA) par 12. Pauw (2017) at 850 does not fully agree with this statement: "While the legislature may be the 'major engine for law reform; ... the courts have a major role to play in the development of the law. The courts have constitutional obligations to develop the common law and to take into account in that regard the interests of justice.

³³ DZ (SCA) par 17.

3 **DZ case before Constitutional Court**

4.28 The MEC sought leave to appeal the order of the SCA to the Constitutional Court. In addition, the MECs of the provincial departments of Health of the Eastern Cape and the Western Cape requested to be admitted as *amici curiae* (friends of the court). The matter of *MEC, Health and Social Development, Gauteng v DZ obo WZ*³⁴ was heard on 17 August 2017 and judgment handed down on 31 October 2017. The Constitutional Court took a more expansive approach than the SCA when considering the issues before the court for adjudication.

4.29 The Constitutional Court summarised the judgment of the SCA:³⁵

- The “once and for all” rule at common law precludes payment of future medical expenses in the form sought by the Gauteng MEC.
- If intervention is necessary to correct this alleged defect, it would best be left to the legislature.
- The Gauteng MEC failed to present any evidence why her preferred method would enhance access to healthcare.

4.30 The MEC Health, Eastern Cape wanted to ensure that the decision in this case would still allow her to raise two defences in pending court cases in the Eastern Cape. The two defences, both of which would require a development of the common law, are as follows:³⁶

- A “public healthcare defence”, that would allow claims for future medical expenses to be satisfied by providing medical services in the public healthcare sector.
- An “undertaking to pay” defence, that would allow medical services and supplies that cannot be provided in the public healthcare sector, to be paid for when such claims arise in the future.

4.31 The MEC Health Western Cape wanted to be able to present, for consideration in other matters, her proposal to make the establishment of a ring-fenced trust a condition for a damages award. The trust would be administered by a case manager and a trustee

³⁴ *MEC, Health and Social Development, Gauteng v DZ obo WZ* [2017] ZACC 37; 2018 (1) SA 335 (CC).

³⁵ *DZ* par 3.

³⁶ *DZ* par 6.

and the purpose of the trust would be to meet the child's future medical expenses. The deed of trust would contain "top-up" and "claw-back" provisions to allow additional payments should the fund become depleted, and the return of the balance in the fund to the state when the child's dies.³⁷

4.32 The Constitutional Court granted leave to appeal in this matter, giving the following reasons:³⁸

The development of the common law, and the potential impact of damages awards in medical negligence claims against public healthcare authorities on their ability to discharge their constitutional obligation to provide access to healthcare to everyone, raise constitutional issues that attract this Court's jurisdiction.

4.33 The Court listed the constitutional issues that attend personal injury claims:³⁹

- 1) Developing common law rules to limit a right in accordance with section 36(1).⁴⁰
- 2) The right to freedom and security of the person, which includes the right to be free from all forms of violence.⁴¹
- 3) The right to bodily integrity.⁴²
- 4) The right of access to health care services.⁴³
- 5) The duty on the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to health care services.⁴⁴
- 6) The obligation on courts to promote the spirit, purpose and objects of the Bill of Rights when developing the common law.⁴⁵

4.34 In its deliberation on the matter, the Constitutional Court considered the following propositions put forward by the appellant (the MEC):⁴⁶

³⁷ DZ par 7.

³⁸ DZ par 8.

³⁹ DZ fn 3

⁴⁰ Section 8(3)(b) of the Constitution.

⁴¹ Section 12(1) and 12(1)(c).

⁴² Section 12(2).

⁴³ Section 27(1)(a).

⁴⁴ Section 27(2) read with section 27(1)(a).

⁴⁵ Section 39(2).

⁴⁶ DZ par 12.

- 1) Compensation for a delictual claim need not necessarily be paid in money, but may also be paid in kind.
- 2) The “once and for all” rule is only relevant for determining liability on the merits of a claim, not for the quantification of damages suffered due to the delict; therefore the quantum of damages is in the discretion of the court.
- 3) A defendant may challenge the amount claimed as compensation for damages as being unreasonable. This is based on the premise that the plaintiff will likely use public rather than private health care, and that public healthcare is as good as, though cheaper than, private healthcare.
- 4) In some instances it would be better to provide actual medical services to a plaintiff for future medical care, rather than money.

4.35 Linked to this is “the contention that damages awards in medical negligence claims against public healthcare authorities must also be assessed against the impact they may have on healthcare budgets and the adverse effect they may have on the provision of access to public healthcare for everyone.”⁴⁷

4.36 Although the judges hearing the matter concurred on the decision, there were differing views about whether the existing law allows for damages to be paid by means of periodic payments. Jafta J was of the view that the common law at present “does not prohibit periodic payments of delictual damages”,⁴⁸ while Froneman J, who penned the majority decision, adopted “the somewhat more cautious approach that this has not yet been definitively decided ...”.⁴⁹

(a) Majority decision

4.37 Froneman J deliberated on two common law principles in relation to the current common law in South Africa. In the first place, with regard to the principle that the payment of compensation for a delictual claim sounds in money, he referred to the case of *Standard Chartered Bank Ltd v Nedperm Bank Ltd*,⁵⁰ in which Harmse J stated that

⁴⁷ DZ par 13.

⁴⁸ DZ par 87.

⁴⁹ DZ par 25.

⁵⁰ *Standard Chartered Bank Ltd v Nedperm Bank Ltd* 1994 (4) SA 747 (A). The judgment in part pertains to a decision on whether compensation for loss suffered by a Canadian Bank as a result of a refusal by a South African bank to honour a bill of exchange should be calculated in South African Rand or in foreign currency (which is not legal tender in South Africa). The bill of exchange was the method of payment for a transaction between a Canadian company and a South African company at a time when it was not considered

the “purpose of an Aquilian claim is to compensate the victim in money terms for his loss”.⁵¹ Harmse J referred to *Wynberg Valley Railway Company v Eksteen*,⁵² where Bell J averred that damages due by law are to be awarded in money because “money is the measure of all things”.⁵³ Froneman J hence concluded that this rule still stands.⁵⁴

4.38 He then considers the “once and for all” rule, explaining the importation of the rule from the English law by reference to *Evins v Shield Insurance Co Ltd*.⁵⁵ In *Evins v Shield Insurance* Corbett JA expounded on the rule and the origin of the rule:⁵⁶

The concept of a cause of action ... [is] of particular significance in regard to the application of the so-called ‘once and for all’ rule and also in connection with the related questions of *res judicata* and prescription. The ‘once and for all’ rule applies especially to common law actions for damages in delict Expressed in relation to delictual claims, the rule is to the effect that in general a plaintiff must claim in one action all damages, both already sustained and prospective, flowing from one cause of action. This rule appears to have been introduced into our practice from English law. ... Its introduction and the manner of its application by our Courts have been subjected to criticism ... but it is a well-entrenched rule. Its purpose is to prevent a multiplicity of actions based upon a single cause of action and to ensure that there is an end to litigation.

prudent to transact openly with South African companies. Although the application of the *lex Aquilia* for damages claims has undergone development over time [Midgley in *LAWSA* vol 15 par 8], an important outcome of the development was that the *lex Aquilia* became a purely compensatory remedy [Midgley in *LAWSA* vol 15 par 9].

⁵¹ *Standard Chartered Bank* 782D-F.

⁵² *Wynberg Valley Railway Company v Eksteen* 1 Roscoe 70. Decided in 1863, the court had to consider an objection to an arbitration award made under the 18th section of the Wynberg Railway Act of 1861. The arbitrators awarded compensation partly in money and partly in kind (in brick clay excavated from the land that the Wynberg Valley Railway Company had taken possession of). The 1861 Act however provided for “the amount of recompense or compensation” to be ascertained, hence the matter was referred back to the arbitrators to determine the value of the material removed.

⁵³ *Wynberg Valley Railway Company* 74.

⁵⁴ *DZ* par 14.

⁵⁵ *Evins v Shield Insurance Co Ltd* 1980 (2) SA 814 (A). The matter before the court arose from a claim for damages and for loss of support suffered by the plaintiff as a result of a motor vehicle accident in which she was injured, and her husband was killed. An important aspect of the case was whether the appellant (plaintiff) had a single cause of action or two causes of action arising from the same events. This was relevant in order to determine whether the claim had prescribed.

⁵⁶ *Evins* 835A-E.

4.39 Corbett JA also alluded to the *res judicata* principle:⁵⁷

Closely allied to the ‘once and for all’ rule is the principle of *res judicata* which establishes that, where a final judgment has been given in a matter by a competent court, then subsequent litigation between the same parties, or their privies, in regard to the same subject-matter and based upon the same cause of action is not permissible The object of this principle is to prevent the repetition of lawsuits, the harassment of a defendant by a multiplicity of actions and the possibility of conflicting decisions The principle of *res judicata*, taken together with the ‘once and for all’ rule, means that a claimant for Aquilian damages who has litigated finally is precluded from subsequently claiming from the same defendant upon the same cause of action additional damages in respect of further loss suffered by him (ie loss not taken into account in the award of damages in the original action), even though such further loss manifests itself or becomes capable of assessment only after the conclusion of the original action The claimant must sue for all his damages, accrued and prospective, arising from one cause of action, in one action and, once that action has been pursued to final judgment, that is the end of the matter.

4.40 Froneman J explains the effect of the “once and for all rule” for delictual claims:⁵⁸

What can be drawn from these authorities is that, in relation to delictual claims, the “once and for all” rule is to the effect that a plaintiff must generally claim in one action all past and prospective damages flowing from one cause of action. The corollary is that the court is obliged to award these damages in a lump sum, the object of which is to prevent the repetition of lawsuits, the harassment of a defendant by a multiplicity of actions and the possibility of conflicting decisions. It is buttressed by the *res judicata* principle, the purpose of which is to prevent a multiplicity of actions based upon a single cause of action and to ensure that there is an end to litigation.

4.41 Based on the analysis of our current law, Froneman J concludes that the MEC’s first two proposals (delictual compensation need not sound in money; the “once and for all” rule only relates to the determination of liability on the merits, not to the quantification of damages) are not supported.⁵⁹

⁵⁷ *Evins* 835E-H.

⁵⁸ *DZ* par 16.

⁵⁹ *DZ* par 17.

4.42 The court then considered the MEC's third proposition (a defendant may challenge the amount of compensation as unreasonable because the plaintiff will probably use public health care, which is as good as private health care, though cheaper). Referring to *Ngubane v South African Transport Services*⁶⁰ the court accepted an approach that would allow a defendant to prove that medical services of the same or higher standard would be available in the public health sector.⁶¹ In *Ngubane* Kumblebe JA observed that to his knowledge it is customary for a plaintiff to base a claim for future medical expenses on the cost of private medical care. A defendant who contends that "medical services of the same, or an acceptably high, standard" is available in the public health sector, must prove that contention.⁶²

4.43 Froneman J held that this approach does not offend the "once and for all" rule.⁶³

This approach does not offend the "once and for all" rule. It is a "once and for all" factual assessment on the evidence adduced that, although the claimant will need medical care in future, it has not been proved on a balance of probabilities that this entails a loss in the sense that the claimant's patrimony after the delict is less than it would have been had the delict never occurred. It is not the mere injury and its future consequences that justify an award of damages, but the actual diminution in the claimant's patrimony.

4.44 On this point Froneman J concluded that a defendant must present evidence to substantiate a defence that plaintiff suffered less damages than what is claimed for future medical services. The MEC did not present such evidence.⁶⁴

4.45 The Constitutional Court then turned to the development of the common law, referring to the statement by O'Regan J in *K v Minister of Safety and Security*,⁶⁵ that "the

⁶⁰ *Ngubane v South African Transport Services* [1990] ZASCA 148; 1991 (1) SA 756 (A). The court considered an action for damages by plaintiff for injuries suffered when he fell out of the open door of a moving train after being jostled by other passengers. One of the issues that the court had to consider was whether it was reasonable to expect plaintiff to use public health care facilities.

⁶¹ *DZ* par 21.

⁶² *Ngubane* 785C–D.

⁶³ *DZ* par 22.

⁶⁴ *DZ* par 26.

⁶⁵ *K v Minister of Safety and Security* [2005] ZACC 8; 2005 (6) SA 419 (CC); 2005 (9) BCLR 835 (CC). The court had to consider whether the respondent should be held liable on the basis of vicarious liability for the wrongful conduct of his employees. Three police officials (employees of the respondent) raped the applicant while they were on duty and in uniform. The court found it necessary to develop the common law in this instance to hold the

common law develops incrementally through the rules of precedent".⁶⁶ Froneman J sets out the approach to the development of the common law under section 39(2):⁶⁷

The general approach to development of the common law under section 39(2) is that a court must: (1) determine what the existing common law position is; (2) consider its underlying rationale; (3) enquire whether the rule offends section 39(2) of the Constitution; (4) if it does so offend, consider how development in accordance with section 39(2) ought to take place; and (5) consider the wider consequences of the proposed change on the relevant area of the law.

4.46 If the common law is compatible with the Bill of Rights, yet is deficient in some other way, the common law can be developed under section 173, as explained by the learned judge:⁶⁸

However, development may be possible in terms of section 173 of the Constitution, which stipulates that the Constitutional Court, the Supreme Court of Appeal and the High Court have the inherent power to develop the common law, taking into account the interests of justice. In these cases, the general approach to the development of the law will be similar, except that the enquiry into the common law will not be restricted to whether it offends the normative framework of the Constitution. The enquiry will be whether, even if the common law is constitutionally compliant, there are wider interests of justice considerations that necessitate its development.

The common law may also be developed when applying a provision of the Bill of Rights to a natural or juristic person, in order to give effect to the right to the extent that legislation does not do so, and to limit a right, provided that the limitation is in accordance with section 36(1) of the Constitution.

4.47 It is important to bear in mind always that the legislature should still be the major engine for law reform, in line with the principle of the separation of powers.⁶⁹ Considering the possible further development of the common law, Froneman J refers to the origin of the common law rule that damages must sound in money.⁷⁰ He explained that the law of

respondent liable because of the intimate connection between the delict committed by the policemen and the purposes of their employer.

⁶⁶ *K v Minister of Safety and Security* par 16.

⁶⁷ *DZ* par 31.

⁶⁸ *DZ* par 31.

⁶⁹ *DZ* par 34.

⁷⁰ *DZ* par 37.

delict developed from private vengeance for wrongdoing, to exacting similar harm on the wrongdoer, to demanding money to cover patrimonial loss.⁷¹ Apart from common law, customary law is also one of the sources of South African law, as recognised by the Constitution. Customary law “has an important role to play in giving context to the normative value system of our Constitution and thereby shaping the development of our common law”.⁷² Froneman J also referred to the challenge of bringing about the Africanisation of the common law.⁷³

4.48 Froneman J cited a remark made by Howie P in *Sechaba Transnet Ltd v Sechaba Photoscan (Pty) Ltd* about the objective of delictual damages:⁷⁴

The award of delictual damages seeks to compensate for the difference between the actual position that obtains as a result of the delict and the hypothetical position that would have obtained had there been no delict.⁷⁵

4.49 Applying this statement to the case under consideration, Froneman J averred that, “in principle, the actual rendering of these services would fulfil the two-fold purpose of redressing damage and compensating the victim”.⁷⁶ In the judge’s view, therefore, “compensation in a form other than money does not appear to be incompatible” with Howie P’s statement in the *Sechaba Photoscan* case about the purpose of delictual damages.

4.50 The compensation in money requirement appears to be a common law “evaluative normative choice”.⁷⁷ While the learned judge expressed the view that the Constitution and modern life do not preclude us from using money as the general method of compensation, constitutional considerations introduced new factors. An additional

⁷¹ According to Midgley (*LAWSA* vol 15 para 9) this final stage in the development of the Aquilian action occurred in the Roman Dutch law. Reinhard Zimmerman *The Law of Obligations: Roman Foundations of the Civilian Tradition* (Juta 1990) at 914, as quoted by Froneman J, stated that there was no specific precedent for this development of the Aquilian action in the Roman sources.

⁷² *DZ* par 41.

⁷³ *DZ* par 39.

⁷⁴ *Transnet Ltd v Sechaba Photoscan (Pty) Ltd* [2004] ZASCA 24; 2005 (1) SA 299 (SCA). The case dealt with the question whether a plaintiff can claim compensation for the loss of prospective profits as delictual damages.

⁷⁵ *Sechaba Photoscan* par 15.

⁷⁶ *DZ* par 41.

⁷⁷ *DZ* par 44.

factor is the impact of the modern social-security system on the law and the trend towards collectivisation of losses.⁷⁸

Neither the Constitution nor the realities of modern life oblige us to find that money cannot be the measure of things. But it is arguable that the fundamental right of everyone to have access to healthcare services and the state's obligation to realise this right by undertaking reasonable measures introduce factors for consideration that did not exist in the pre-constitutional era.

4.51 Froneman J discussed the situation in the UK, where the common law “once and for all” rule originated. Section 2(1) of the UK Damages Act 1996 introduced the concept of court-ordered periodical payments for damages in an action for personal injury, but only with the consent of the parties. Since Froneman J only refers to the original version of section 2 of the Damages Act and not the version of the Damages Act as amended by the Courts Act of 2003, it seems that the court had not had sight of the amended section 2. Section 100 of the Courts Act of 2003 substituted section 2 of the Damages Act 1996. The new section 2 provides for much broader use of periodical payments in personal injury cases and, importantly, removed the requirement of the consent of the parties for “future pecuniary loss”.

4.52 The amended section 2(1) grants a court the discretion to order damages for “future pecuniary loss” in personal injury cases to be paid in the form of periodical payments, partly or in full. In addition, it imposes a duty on the court to consider making such an order.⁷⁹ Section 2(2) allows the court to make an order for periodical payments for “other damages” as well, but, in this instance, only if the parties consent.⁸⁰ Subsections (3) to (7) of section 2 deal with the continuity of periodical payments being reasonably secure and subsections (8) and (9) pertain to the amount of payment to vary by reference to the retail prices index.

⁷⁸ *DZ* par 45.

⁷⁹ (1) A court awarding damages for future pecuniary loss in respect of personal injury—
 (a) may order that the damages are wholly or partly to take the form of periodical payments, and
 (b) shall consider whether to make that order.

⁸⁰ (2) A court awarding other damages in respect of personal injury may, if the parties consent, order that the damages are wholly or partly to take the form of periodical payments.

4.53 Froneman J alluded to the criticism levelled against the common law “once and for all” rule, especially with regard to the speculative nature of an estimate of damages for future loss as highlighted in *Southern Insurance Association Ltd v Bailey NO*.⁸¹ As Nicholas JA remarked in the *Southern Insurance Association* case, “[a]ll that the court can do is to make an estimate, which is often a very rough estimate, of the present value of the loss”.⁸² The system of periodic payments (also referred to as the rent system), however, is also criticised. Points of criticism referred to are piecemeal consideration of injuries, variations up and down and problems with adjustment for inflation.⁸³

4.54 Froneman J came to the conclusion that both options are justifiable under the Constitution:⁸⁴

Although the “once and for all” rule, with its bias towards individualism and the free market, cannot be said to be in conflict with our constitutional value system, it can also not be said that the periodic payment or rent system is out of sync with the high value the Constitution ascribes to socio-economic rights. There is no obvious choice at this highest level of justification. What appears to be called for is an accommodation between the two.

4.55 In the final instance, Froneman J leaved the door open to utilising either option:⁸⁵

Resolution of the dilemma may lie in leaving the choice at the level of each individual case, depending on which form of payment will best meet its particular circumstances.

4.56 Though willing to consider development of the common law, there is not factual evidence before the court in the present case to serve as a basis for the development of the common law. However, it is evident from Froneman J’s remarks that further development is still possible:⁸⁶

We have seen, in this regard, that any development of the common law requires factual material upon which the assessment whether to develop the law must be made. Here that factual material is absent.

⁸¹ *Southern Insurance Association Ltd v Bailey NO* 1984 (1) SA 98 (A). In this case the court had to determine a value for the loss of earning capacity of a young child who suffered a permanent brain injury after being knocked down by a motor vehicle.

⁸² *Southern Insurance Association Ltd v Bailey NO* 113G.

⁸³ *DZ* par 52.

⁸⁴ *DZ* par 54.

⁸⁵ *DZ* par 55.

⁸⁶ *DZ* par 57 & 58.

But the failure of the appeal does not mean that the door to further development of the common law is shut. We have seen that possibilities for further development are arguable. Factual evidence to substantiate a carefully pleaded argument for the development of the common law must be properly adduced for assessment. If it is sufficiently cogent, it might well carry the day.

(b) Concurring decision based on different reasons

4.57 Jafta J agreed with the order of the court, but disagreed with the reasons forwarded by the majority for its decision.⁸⁷ In his view the common law “once and for all” rule does not prohibit periodic payments and only prohibits multiple lawsuits based on a single cause of action. This view is supported by Pauw⁸⁸ and Mukheibir.⁸⁹

I do not agree that the “once and for all” rule prohibits periodic payments. This rule regulates judicial process and not execution of the payment of a judgment debt. The rule does not require that once the amount of compensation is determined it must be paid in a single payment.⁹⁰

What is prohibited by the “once and for all” rule is a multiplicity of lawsuits based on a single cause of action or occurrence.⁹¹

4.58 Jafta J also referred to the case of *Evins v Shield Insurance* as authority for his view on the common law “once and for all” rule⁹² and the *res judicata* principle.⁹³ In addition, he discussed execution to enforce a judgment or order of court, describing it as an administrative function rather than as a judicial function. Linking this to section 66 of the Magistrates’ Courts Act 32 of 1944, which empowers magistrates’ courts to order

⁸⁷ DZ par 61.

⁸⁸ Pieter Pauw “Alternative relief in delictual claims?” 2017 (4) TSAR 846–856 at 853, where he states: “I could, historically, find no prohibition against an alternative method to compensate a plaintiff for damages suffered.”

⁸⁹ André Mukheibir “(Mis)understanding the once-and-for all rule: *Member of The Executive Council for Health and Social Development, Gauteng v DZ obo WZ* 2018 (1) SA 335 (CC)” *Obiter* (2019) 252–262. Mukheibir reviewed the Constitutional Court judgment on the DZ matter and the case law on the “once and for all rule” cited in the judgment. Mukheibir agrees with the views expressed by Jafta J in the minority judgment, raising five pertinent points in her conclusion at 261 & 262.

⁹⁰ DZ par 75.

⁹¹ DZ par 76.

⁹² DZ par 76.

⁹³ DZ par 78.

periodic payment of a judgment debt, he questions the avowal “that the superior courts lack the power to order periodic payments only because there is no statute that empowers them to do so” in view thereof that the superior courts possess inherent powers to regulate its processes and to develop the common law in terms of section 173 of the Constitution.

4.59 Jafta J alluded to case law pertaining to the authority of a magistrate’s court to order payment of a judgment debt in instalments,⁹⁴ debts arising from monetary orders made by the High Court,⁹⁵ and execution processes against all forms of property.⁹⁶ He extrapolated the cited case law to the issue under consideration, questioning the logic of an interpretation that limit an order for the payment of judgment debts in instalments only to the types of matters cited. The learned judge found it absurd that the High Court should be unable to order payment of damages in instalments, while being able to make an order for payment in instalments when overseeing the execution of that order.⁹⁷

4.60 While he also found against the appellant (the MEC) due to the lack of any evidence in support of periodic payments of damages for future medical expenses. Jafta J did express his opinion that the current common law does not prohibit periodic payments of damages in delict:⁹⁸

I conclude that in its present form the common law does not prohibit periodic payments of delictual damages. In fact, the High Court has an inherent power to determine whether such damages may be paid in instalments or as a lump sum. Ordinarily a lump sum payment applies unless specific facts warranting a departure from this rule are placed before a High Court for the exercise of the inherent power to order payment by instalments. Here the Gauteng MEC failed to lead evidence supporting the periodic payment of the damages in respect of future medical expenses.

⁹⁴ *Jaftha v Schoeman; Van Rooyen v Stoltz* [2004] ZACC 25; 2005 (2) SA 140 (CC); 2005 (1) BCLR 78 (CC).

⁹⁵ *Gundwana v Steko Development CC* [2011] ZACC 14; 2011 (3) SA 608 (CC); 2011 (8) BCLR 792 (CC).

⁹⁶ *University of Stellenbosch Legal Aid Clinic v Minister of Justice and Correctional Services; Association of Debt Recovery Agents NPC v University of Stellenbosch Legal Aid Clinic; Mavava Trading 279 (Pty) Ltd v University of Stellenbosch Legal Aid Clinic* [2016] ZACC 32; 2016 (6) SA 596 (CC); 2016 (12) BCLR 1535 (CC).

⁹⁷ *DZ* par 86.

⁹⁸ *DZ* par 87.

4.61 Jafta J further remarked that the authority of the courts to adjudicate disputes and issue orders is derived from the Constitution, not the common law:⁹⁹

Therefore an approach that says a High Court may not order periodic payment of damages awarded by it misses the point. That approach conflates the High Court's competence, which derives from the Constitution, with what may not be permissible under the common law. It must be remembered, however, that the common law also draws its legal force from the same Constitution. It would be wrong to hold that the common law precludes the High Court from exercising its constitutional power. This illustrates that, even if there were a common law rule that prohibited periodic payment of damages, it would not have the effect of denying the High Court the authority to make such an order. To conclude otherwise would be tantamount to placing the common law above the Constitution.

F Impact of *DZ* case

1 Academic debate

4.62 The *DZ* case, especially the reasoning of Jafta J in delivering the minority judgment, caused an interesting debate among commentators. Although there is mostly agreement with the result of the decision, there are differences of opinion about the further development of the common law. Pauw had commented on the judgment of the Supreme Court of Appeal in the *DZ* case. He remarks that he could not, historically speaking, find a prohibition on alternative compensation methods for damages suffered by plaintiffs.¹⁰⁰

4.63 Pauw followed this up with a contribution on the Constitutional Court *DZ* case.¹⁰¹ He asserts that the lump sum rule and the "once and for all" rule had different historical origins, which were not linked. According to him, tendering compensation "in kind" would be a valid proposal, regardless of whether the common law or the Constitution is the foundation for the offer. He proposes factors that could be considered to provide the

⁹⁹ *DZ* par 90.

¹⁰⁰ Pieter Pauw "Alternative relief in delictual claims?" 2017 (4) *TSAR* 846–856 at 853 [Pauw (2017)].

¹⁰¹ Pieter Pauw "Alternative relief in delictual claims – a step in the right direction" 2018 (1) *TSAR* 176–182 [Pauw (2018)].

supporting proof for the new remedy, for example the budgeting process, available budget and the increase in claims.¹⁰² It will be important to provide information about the available public health care facilities: “Expert testimony will probably be required to compare the facilities available in the public sector to those in the private sector to inform the court that the quality of the service in the public sector is as good as that in the private sector and that these services can be rendered to claimants at no cost.”¹⁰³

4.64 Mukheibir wrote a note on the *DZ* case “to show that the majority decision in *MEC Health* is based on an incorrect understanding of the nature and purpose of the [‘once and for all’] rule, and that the rule does not necessarily exclude periodic or instalment payments”.¹⁰⁴ After examining Van der Walt’s analysis¹⁰⁵ of *Cape Town Council v Jacobs* and *Darley Main Colliery v Mitchell*, the English case cited by Solomon J in the *Cape Town Council* case as authority for applying the “once and for all” rule, Mukheibir opines that the rule “operates as a defence against liability, rather than a rule relating to the quantification of damages”. She adds that the *Darley Main* case did not refer to lump-sum payments as an absolute requirement and avers that “there is no logical explanation for the conclusion that payments for future losses have to be made in a lump sum.”

4.65 Ironically, as Van der Walt points out, the English court did not apply the “once and for all” rule in the *Darley Main* case, but confirmed that there are exceptions to the “once and for all” rule and that the facts in the *Darley Main Colliery* matter justifies an exception.¹⁰⁶ Van der Walt expressed the view that the authority that the Appellate Division’s decision hinges on in *Cape Town Council v Jacobs* does not confirm the absolute or general validity of the “once and for all” rule, but rather the opposite [own translation].¹⁰⁷

¹⁰² Pauw (2018) 181–182.

¹⁰³ Pauw (2018) 182.

¹⁰⁴ Mukheibir 252.

¹⁰⁵ CFC van der Walt *Die Sommeskadeleer en die “once and for all”-reël* (Unpublished LLD thesis UNISA 1977) at 329–335.

¹⁰⁶ Van der Walt 333–334.

¹⁰⁷ Van der Walt 335: “Uit die voorgaande is dit myns insiens duidelik dat die Appèlafdeling se beslissing in *Cape Town Council v Jacobs* nie op gesag rus wat die absolute of algemene gelding van die “once and for all”-reël bevestig nie, maar eerder die teendeel.”

4.66 Mukheibir reviewed the Constitutional Court judgment on the *DZ* case and the case law on the “once and for all rule” cited in the judgment. She agrees with the views expressed by Jafta J in the minority judgment, raising five pertinent points in her conclusion (in summary):¹⁰⁸

- 1) Lump sum awards for future losses are speculative, either over- or under-compensating the plaintiff (flouting the sum-formula rule and the compensatory aspect of damages).
- 2) The “once and for all” rule does not preclude periodic payments.
- 3) The rule exists to benefit the defendant by preventing multiple claims based on a single cause of action. The defendant can waive the protection offered by the rule (as in the *DZ* case where the defendant offered periodic payments).
- 4) The historical development of the rule does not appear to exclude periodic payments.
- 5) In her view and, she states, coupled with Jafta J’s minority decision, it is safe to say that the “rule does not require any development for periodic payments [orders] to be made by the courts.”

4.67 Wessels lauded the decision of the Constitutional Court. He remarks: “Generally, given the financial challenges facing the department of health, the notion of periodic payments ought to be welcomed. Together with the option of providing medical services to victims, this may improve the financial position of the department. In turn, this could allow it to expand its public healthcare offering and give effect to its section 27 obligations.”¹⁰⁹

2 Aftermath of *DZ* case

4.68 The most significant outcome of the judgment of the Constitutional Court’s in this case is that it leaves the door open to alternative forms of compensation, doing away with the notion that a lump sum payment is the only viable form of compensation for a delictual claim on the basis of medical negligence. Although the majority decision delivered by Froneman J and the minority judgment delivered by Jafta J differ in the motivation for coming to the same conclusion, the crux of the matter is that the state may

¹⁰⁸ Mukheiber 261 & 262.

¹⁰⁹ AB Wessels “The expansion of the state’s liability for harm arising from medical malpractice: Underlying reasons, deleterious consequences and potential reform” *TSAR* 2019 (1) 1–24 at 18.

offer payment in kind (such as treatment in state hospitals) and periodic payments *in lieu* of lump sum awards. All other measures, procedures and rules, however, must still be complied with.

4.69 The practical implications of the judgment in *MEC Health v CZ obo WZ* are the following:

- 1) The state may offer to pay compensation in the form of periodic payments.
- 2) The state may raise the reasonableness of public versus private health care.
- 3) The state must place evidence before the court to substantiate a contention that public health care would be reasonable.
- 4) The state may offer future medical treatment in public health care facilities.
- 5) The state must provide factual evidence of the treatment to be offered in public health care establishments and the quality of the treatment.
- 6) The state may offer to pay for private medical treatment that the state is unable to offer or where treatment offered by the state is of an unacceptable standard.

4.70 Two high court matters have since been reported where the MEC of the relevant province offered treatment in public health care establishments for the future health care component of compensation awards. The MEC of Gauteng was successful, the MEC of KwaZulu-Natal was not.

4.71 In the matter of *MSM obo KBM v MEC Health, Gauteng*¹¹⁰ the court held that the wider interests of justice require development of the common law to permit compensation in kind in appropriate cases. Although the court held that the MEC did not place sufficient evidence before it to justify development of the common law to permit periodic payments, the court did order the MEC to render certain medical services to the child KSM at the Charlotte Maxeke Johannesburg Academic Hospital.¹¹¹

4.72 In the matter of *PH obo SH v MEC Health, KwaZulu-Natal*¹¹² on the other hand, the court was not convinced by the defendant's reason for her application to amend her plea to raise the "public health care" defence. The defence entails that the court orders

¹¹⁰ *MSM obo KBM v MEC Health, Gauteng* (4314/15) [2019] ZAGPJHC 504; 2020 (2) SA 567 (GJ); [2020] 2 All SA 177 (GJ) (18 December 2019).

¹¹¹ *MSM* par 214.

¹¹² *PH obo SH v MEC Health, KwaZulu-Natal* (11198/2016) [2020] ZAKZDHC 38; 2021 (1) SA 530 (KZD) (31 August 2020).

the MEC to “provide the care that is required by the minor child who has been diagnosed with cerebral palsy at a public institution” if the care provided is “at the level equivalent or better to that in the private sector”.¹¹³ Mngadi J was of the view that the defendant did not demonstrate a necessity for the proposed development of the common law¹¹⁴ and that the defendant was “very vague about the existence of public healthcare facilities which are as good as or better than private health care facilities”.¹¹⁵

4.73 The Constitutional Court in 2021 considered another case brought against the state based on medical negligence. The matter of *MEC Health Gauteng v PN obo EN*¹¹⁶ also pertained to a minor child suffering from cerebral palsy due to injuries suffered during birth. In this case the MEC appealed against an interpretation of a court order that would have the effect of precluding the applicant from leading evidence to request developing the common law, and that the court determining quantum may not consider this development.¹¹⁷ The Constitutional Court held per Madlanga J that:¹¹⁸

In sum, the respondent’s interpretation of Moshidi J’s order is at odds with the right of access to courts and potentially undermines the right of everyone to have access to healthcare services and of every child to basic healthcare services. It also has the effect of limiting the power of the court determining quantum to develop the common law in accordance with section 173 of the Constitution.

¹¹³ *PH* par 12.

¹¹⁴ *PH* par 22.

¹¹⁵ *PH* par 24.

¹¹⁶ *MEC Health, Gauteng v PN obo EN* [2021] ZACC 6.

¹¹⁷ *PN* par 26.

¹¹⁸ *PN* par 30.

CHAPTER 5: RESPONSES AND COMMENTS

A Conclusion

5.1 From the submissions received on Issue Paper 33, the presentations made on the 2016 State Liability Amendment Bill during the public hearings in Parliament and the research conducted for this investigation, it is clear that the problems besetting the public health sector in South Africa is much broader than just medico-legal litigation. There are grave and justified concerns about the quality of health care services in the public health sector, and the financial viability, even the very survival, of some of the provincial departments of health.

5.2 The information reviewed in relation to public health care services and medico-legal litigation – whether submissions received in response to Issue Paper 33, surveys, case studies, or literature – generally raise the same concerns. It is disquieting, however, that the national and provincial departments of health are by and large familiar with the issues discussed in this chapter, that their awareness is not of recent origin, that they often have the means to do something about the problems identified, but that they seem to be unable to rise to the challenge and face the crisis head-on.

5.3 Two of the state institutions supporting constitutional democracy established under section 181 of the Constitution (the Chapter 9 institutions) have conducted investigations into or held hearings on the public health sector and related matters. The Public Protector investigated identified hospitals in the Eastern Cape, Gauteng, KwaZulu-Natal, Limpopo and Mpumalanga to assess the provision and administration of health services at public hospitals. The South African Human Rights Commission published reports on investigations into Eastern Cape hospitals, a public inquiry into access to state health care services, hearings on emergency medical services in the Eastern Cape and an investigation into screening, diagnosing and treating cancer in the KwaZulu-Natal province. All the reports published point to severe systemic problems in the public health sector, with issues such as leadership and governance, poor planning and financial management, shortages of staff and equipment and failure to maintain infrastructure, equipment and facilities repeatedly mentioned.

5.4 The consolidated general Public Finance Management Act reports on national and provincial audit outcomes for the years 2017-18, 2018-19 and 2019-20 published by the Auditor-General, and the annual inspection reports for the years 2015/2016, 2016/2017, 2017/2018 and 2018/2019 published by the Office of Health Standards Compliance, are especially illuminating. These reports are not conjecture: the data and observations reflected in the reports are based on facts, figures, and first-hand observations. The reports paint a grim picture of a public health system that is woefully inadequate and on the verge of collapse in some provinces. Shortcomings in the areas of leadership and governance, operational management, and public health (in that order), is especially worrying. Yet, the rare instances of proper planning, effective budgeting, good governance, efficient management, dedication and commitment shining through prove that it is possible to salvage the crisis.

B Introduction

5.5 The SALRC received nearly 50 submissions in response to *Issue Paper 33 on Project 141: Medico-Legal Claims*.¹ Chapter 6 of Issue Paper 33 posed a number of questions for consideration, but respondents were invited to raise any relevant issues in addition to the questions in Chapter 6. Apart from considering the submissions received in response to Issue Paper 33, the researcher reviewed the opinions of commentators on medico-legal claims against the state and related matters, as well as other relevant reports and publications.

5.6 As explained in Chapter 1, the SALRC can only make proposals that pertain to possible legal solutions. However, from the submissions received in response to Issue Paper 33, the presentations made to the Portfolio Committee on Justice and Correctional Services during the public hearings in Parliament on the State Liability Amendment Bill 16–2018, and information that the researcher collected during the course of conducting research for this investigation, it is clear that the problems besetting the public health sector in South Africa is much broader than just medico-legal litigation.

¹ SALRC *Issue Paper 33 on Project 141: Medico-Legal Claims* (July 2017). The issue paper is available on the SALRC website at www.justice.gov.za/salrc/ipapers.htm.

C Views and submissions considered

5.7 The result of research conducted and the contents of the submissions that the SALRC received are set out in broad below. It is treated thematically rather than by author, individual or organisation, since commentators and respondents generally raised similar concerns or commented on the same issues. Where relevant, specific authors and respondents are cited throughout this paper, especially in Chapter 9 where the Commission's preliminary proposals are explained.

1 Reasons for rise in medico-legal litigation

5.8 There is no specific factor that can be singled out as the reason for the sharp increase in medical negligence claims against the state during the past 10 to 15 years. Rather, the rise in both the number and value of claims has been ascribed to various reasons.

(a) Patient awareness

5.9 Patients are more aware of their rights under the Constitution and under legislation containing provisions on consumer protection, information, accountability and transparency such as the Consumer Protection Act 68 of 2008; National Health Act 61 of 2003; Promotion of Access to Information Act 2 of 2000; Children's Act 38 of 2005; Mental Health Care Act 17 of 2002 and Protection of Personal Information Act 4 of 2013. Persons who are more aware of their rights are more disposed towards pursuing litigation to enforce their rights.² In some cases claimants only become aware of their rights long after the negligence had occurred, which lead to a flurry of claims in some instances.

² LC Coetzee & Pieter Carstens "Medical Malpractice and Compensation in South Africa" (2011) 86 *Chi-Kent L Rev* 1263–1301 at 1301; J Malherbe "Counting the cost: The consequences of increased medical malpractice litigation in South Africa" *SAMJ* 103:2 (February 2013) 83–84 at 83; Janet Seggie "The 'boom' in medical malpractice claims – patients could be the losers" (July 2013) 103 *SAMJ* 433; Steve Biko Centre for Bioethics *Discussion Document prepared in Preparation for a Medico-Legal Summit to be held by the Minister of Health* (2013) 1 [SBCB]; WT Oosthuizen & PA Carstens "Medical malpractice: The extent, consequences and causes of the problem" (2015) 78 *THRHR* 269–284 at 284 (Oosthuizen & Carstens *Malpractice*); MPS *Clinical Negligence* 6; Mavundla Mhlambi "Medical malpractice claims and the mistakes attorneys make" (May 2016) *Risk Alert Bulletin* 2; Letitia Pienaar "Investigating the Reasons behind the Increase in Medical Negligence Claims" (2016) *PELJ/PER* 1–22 at 19; Patrick van den Heever "Medical Malpractice: The other side" (October 2016) *De Rebus* 49–50 at 49; Neil Kirby "SA lawyers: Motsoaledi, we're not the reason gyneas won't deliver babies" *Bhekisisa* (12

(b) Litigious climate and patient-centred jurisprudence

5.10 IP 33 respondent Dalmeyer blames the escalation in medico-legal claims in the private as well as the public health sectors on the current litigious climate prevailing in South Africa.³ Jurisprudence favouring patients is also a factor.⁴ The courts have recognised patients' right to autonomy, informed consent, privacy of information and the best interest of a child.⁵

(c) Patient expectations

5.11 Patients are better informed, want to be more involved in their own healthcare and have certain expectations about their health care and the outcome of medical treatment.⁶ Patients sometimes harbour unrealistic expectations, giving rise to litigation if not fulfilled or not understood.⁷

(d) Amendment of Road Accident Fund Act

5.12 The 2005 amendment of the Road Accident Fund Act 56 of 1996 came into operation on 1 August 2008. The amendment, among others, introduced capped claims. This may have caused attorneys to turn to other types of personal injury litigation, such as medical negligence, which may appear more lucrative.⁸ The current poor financial

June 2017) accessed 14 June 2017 bhekisisa.org/article/2017-06-12-00-sa-lawyers-motsoaledi-were-not-the-reason-gynes-wont-deliver-babies; B Taylor et al "Medicolegal storm threatening maternal and child healthcare services" (March 2018) 108 *SAMJ* 149–150 at 149; AB Wessels "The expansion of the state's liability for harm arising from medical malpractice: Underlying reasons, deleterious consequences and potential reform" (2019) *TSAR* 1–24 at 9. IP 33 respondents: National Treasury; KZN DOH; State Attorney, Pretoria; Western Cape DOH; Camargue; Gary Austin Attorneys; Larsen; Life Healthcare; MPS *IP 33 Response*; Mediclinic; Mullins; OTASA; Paul du Plessis Attorneys; SAMLA. The General Council of the Bar point out that the rise in civil litigation against the state is not limited to medical malpractice claims, but that there has been a sharp rise in claims against the South African Police Service as well [GCB 7].

³ IP 33 respondent: Dalmeyer.

⁴ Pienaar 12–17. IP 33 respondent: Dalmeyer.

⁵ Pienaar 12–17.

⁶ Kirby *Bhekisisa* (2017); IP 33 respondent: Netcare.

⁷ Taylor et al 149. IP 33 respondents; Larsen; MPS *IP 33 Response*; Netcare; SASOG; Scharf.

⁸ Steve Biko Centre for Bioethics 24; Malherbe 83; Oosthuizen & Carstens *Malpractice* 283; Mhlambi 2; Van den Heever 49; Taylor et al 149; Wessels 8. IP 33 respondents: KZN DOH; National Treasury; State Attorney, Pretoria; Friedman & Associates; Gary Austin Attorneys; General Council of the Bar (not a major impact); Life Healthcare; MPS *IP 33 Response*; Netcare; OTASA; SASS.

situation of the Road Accident Fund (RAF) is also blamed for the increase in medico-legal litigation.⁹

5.13 Taylor et al refers specifically to birth-related injuries:¹⁰

Given the significant quantum of potential damages that can be claimed in terms of minors with severe disabilities, there is reason to believe that the high number of claims in relation to supposed birth-related injuries reflects, at least in part, a shift of contingency-based litigation from road accident victims to those harmed on the basis of alleged neglect by the healthcare system (the highest proportion of claims brought against government hospitals relate to birth-related injuries, particularly cerebral palsy).

(e) Contingency fees

5.14 The Contingency Fees Act 66 of 1997 (CFA) makes it possible for patients, who would normally not be able to afford litigation, to institute legal proceedings on a “no win no fee basis”. The principle underpinning the CFA is improved access to justice, which is broadly supported. The CFA has enabled indigent public sector patients to institute claims for medical negligence that would not have been possible in the past. This has definitely contributed to the increase in medico-legal litigation against the state, a view that is shared by a several respondents to Issue Paper 33.¹¹

(f) Conduct of lawyers

5.15 Advertising by lawyers and the active pursuit of patients with possible claims due to medical negligence is considered to be a contributing element.¹² There are allegations of touting and even of theft of files.¹³ Touting is prohibited under paragraph 18.22 of the *Code of Conduct for all Legal Practitioners Candidate Legal Practitioners and Juristic*

⁹ Kirby *Bhekisisa* (2017); Clinton Health Access Initiative *Medico-Legal Claims Analysis for National Treasury* (unpublished report December 2019) 5 [CHAI (2019)].

¹⁰ Taylor et al 149.

¹¹ Janet Seggie “The ‘boom’ in medical malpractice claims – patients could be the losers” *SAMJ* 103:7 (July 2013) 433; Van den Heever (2016) 49; IP 33 respondents: KZN DOH; National Treasury; Dalmeyer; EthiQal; Gary Austin Attorneys; General Council of the Bar; GunnClark; Mediclinic; Mullins; Netcare; Paul du Plessis Attorneys; SAMA; SAMLA; SASS.

¹² Steve Biko Centre for Bioethics 6; Oosthuizen & Carstens *Malpractice* 283; Pienaar 7; Van den Heever 49. IP 33 respondents: National Treasury; Camargue; Dalmeyer; Gary Austin Attorneys; Mallory; Mediclinic; Netcare; SAMLA; SASA; SASS; Scarf.

¹³ IP 33 respondents: National Treasury; Eastern Cape Treasury; Free State DOH; Dalmeyer; Mallory; Netcare; SAMLA; SASS.

Entities,¹⁴ while the theft of files is obviously a criminal offence. Fraudulent practices by lawyers is also mentioned as one of the reasons for the rise in medico-legal litigation.¹⁵ Other factors mentioned are opportunistic lawyers, as well as unethical conduct and exploitation of the system by lawyers.¹⁶

(g) *Inadequate complaints system*

5.16 The MPS hold the view that the “lack of a patient-centered and robust complaints system is leaving many patients with litigation as the only viable avenue for redress”.¹⁷ The lack of a proper patient-centred complaints system is bemoaned by other IP 33 respondents as well, some of whom made suggestions to improve the situation.¹⁸ The NDOH has published three sets of guidelines for a complaints system, although it appears to be insufficiently applied:

- 1) *National Guideline to Manage Complaints, Compliments and Suggestions in the Public Health Sector of South Africa* (April 2017)
- 2) *Guideline to develop a Hospital specific Standard Operating Procedure to manage complaints, compliments and suggestions* (April 2017)
- 3) *Guideline to develop a Sub-District/District specific Standard Operating Procedure to manage Complaints, Compliments and Suggestions* (April 2017) – guideline to assist sub-district/ districts in developing their own procedure.

¹⁴ *Code of Conduct for all Legal Practitioners, Candidate Legal Practitioners and Juristic Entities* published by the Legal Practice Council by GenN 168 of 2019 in GG 42337 of 29 March 2019, as corrected by GenN 198 of 2019 published in GG 42364 of 29 March 2019.

¹⁵ CHAI (2019) 5.

¹⁶ IP 33 respondents: Eastern Cape Treasury; KwaZulu-Natal Treasury; Eastern Cape DOH; SASOG.

¹⁷ *MPS Clinical Negligence* 6.

¹⁸ IP 33 respondents: GunnClark; Mallory; MPS *IP 33 Response*; SAMA; SAMLA. GunnClark suggests improvements: “Currently the complaints system is inadequate and does not offer sufficient redress. DOH could expand the role of clinical governance under the CEO at each facility, to investigate and explain errors/adverse events to patients, link clinical governance to complaints procedures and mediation, and then complainants are less likely to become litigants.” [GunnClark 5]. Mallory advises that “perhaps the consent forms should have a standard set of information on who to contact and what steps to follow in the event of a complaint ...” [Mallory 5]. SAMA mentions the link between complaints resolution and possible litigation: “Local patient complaints resolution processes are supported – poor local resolution was highlighted as one of the contributors of patients seeking legal assistance.” [SAMA 5]. SAMLA states that “[t]he implementation of a consistent, efficient and patient-centered complaints process needs to be supported for it would form part of the future risk management system.” [SAMLA 20].

(h) Claim size

5.17 Medical and technological progress add to the value of claims, as medical progress increased life expectancy (resulting in higher costs for future maintenance, loss of income and health care), while technological progress increased the range of assistive devices.¹⁹ The sheer size of the compensation awarded in numerous medico-legal cases serves as an incentive for plaintiffs and attorneys to pursue medical negligence claims against the state.²⁰ There is also a perception that lawyers inflate claims to increase their own fee, thus enlarging the overall size of the claim.²¹

(i) Doctor/patient relationship

5.18 The doctor/patient relationship has an impact on the decision to institute a claim or not. Poor communication, especially about the possible outcome and the risks inherent to some procedures, a perception that the medical practitioner does not care about the patient, patient dissatisfaction and poor management of adverse events often precede the decision to institute legal proceedings.²² Coetzee & Carstens consider “greater specialisation in medicine and the less personal nature of the relationship between specialists and patients [as] another possible contributing factor.”²³

(j) Quality of health services and clinical errors

5.19 A significant number of respondents commenting on Issue Paper 33 bemoan the deterioration in the quality of public health services and the standard of care, citing it as one of the main reasons, if not the main reason, for the medico-legal litigation crisis.²⁴ Some commentators are of the view that the problem extends beyond just the public health sector, blaming a decline in professionalism or skills among healthcare practitioners generally, especially nurses.²⁵ Discovery Health highlights the importance

¹⁹ Malherbe 83; Pienaar 5 and 6; Wessels 9. IP 33 respondent: Oosthuizen.

²⁰ Steve Biko Centre for Bioethics 25. IP 33 respondents: Dalmeyer; Gary Austin Attorneys; Larsen; National Treasury; Netcare; SASS; Van der Merwe.

²¹ Oosthuizen & Carstens *Malpractice* 283. IP 33 respondent: Oosthuizen.

²² Oosthuizen & Carstens *Malpractice* 280 & 282; Pienaar 5; Van den Heever (2016) 49. IP 33 respondents: GunnClark; MPS *IP 33 Response*; SAMLA; SASS.

²³ Coetzee & Carstens 1301.

²⁴ IP 33 respondents: Life Healthcare; Gary Austin Attorneys; General Council of the Bar; Netcare; OTASA; Paul du Plessis Attorneys; SAMLA; Scharf; Van der Merwe.

²⁵ CHAI (2019) 5; Malherbe 83. IP 33 respondents: Eastern Cape Treasury; Free State Department of Health; KZN DOH; State Attorney, Pretoria; Mullins; OTASA; SAMLA; SASOG. SASOG express disquiet about nursing issues, citing inexperienced staff that are

of quality health care and point to the need for continuous and systemic improvements in patient care. Ongoing monitoring and evaluation are critical to achieving good health care outcomes. Adherence to protocols is an important aid to distinguish between the risks of medical treatment and negligence.²⁶ The Western Cape DOH refers to the importance of improved patient safety to avoid clinical errors. Paul du Plessis Attorneys highlight the failure to implement well-established standards of care,²⁷ saying that accountability is key to improving standards of care.²⁸ GunnClark states that the increase in the number of patients will necessarily lead to more adverse events.²⁹

2 Concerns about public health system

(a) *Public health care in crisis*

5.20 There are major problems in the public health system. The National Development Plan makes the following statement: “At institutional level, health-care management is in crisis”.³⁰ Commentators and respondents express grave concerns about the state of the public health care system, citing issues such as shortages of staff, equipment and medicines; declines in the skills levels of health professionals;³¹ overcrowding, an overburdened health care system; an influx of foreign nationals;³² a lack of leadership at health institutions; poor management of staff; and inadequate management of risks and complaints.³³ Their apprehensions are justified by reports published by the Public

unable to interpret CTG tracings. According to SASOG, the best midwives often leave for greener, better paid pastures [SASOG unpagued].

²⁶ IP 33 respondent: Discovery Health 4.

²⁷ IP 33 respondent: Paul du Plessis Attorneys 2.

²⁸ IP 33 respondent: Paul du Plessis Attorneys 4.

²⁹ IP 33 respondent: GunnClark 5.

³⁰ National Planning Commission *National Development Plan 2030* (August 2012) 52.

³¹ IP 33 respondent: Scarf is apprehensive about the knowledge and skills of medical practitioners who were trained abroad [Scarf 1–2].

³² IP 33 respondents: Anecdotal evidence of an influx of foreign nationals is cited as one of the reasons why the public health system is so overwhelmed [SAMLA 1; Scharf 1].

³³ A Dhai & S Mahomed “Healthcare in crisis: A shameful disrespect of our Constitution” *SAJBL* 11:1 (2018) 8–10: Dhai & Mahomed describe the dire situation in the Gauteng public health sector, where the Gauteng DOH has decided, despite existing serious staff shortages, that they will not fill posts once vacated because of budgetary constraints. Illegal strike action in North West and Gauteng closed a number of hospitals down, meaning that the most vulnerable and poorest of people were denied access to health care services. Dhai & Mahomed aver that the people affected by the problems in the health system are the victims of failing leadership, incompetent management, poor governance, legislative constraints and illegal labour action. Often already vulnerable due to a range of illnesses,

Protector, SAHRC, Auditor-General and OHSC, as well as the government-initiated reports discussed in Chapter 6. It is worrying that many of the shortcomings identified in 2007 and 2009 have not been addressed to date and are still prevalent. What is even more alarming is the fact that most of the problems have actually become worse.³⁴ A big concern, however, is that another challenge has been added to the mix: corruption.³⁵

(i) *Corruption*

5.21 Disquiet about corruption surfaces in the *Presidential Health Summit 2018 Report* (published February 2019) in relation to human resource systems, supply chain management, health service delivery and leadership and governance.³⁶ The *Presidential Health Summit 2018 Compact* (published July 2019) details the plan that was developed subsequent to the Presidential Health Summit 2018 to solve the problems in the public health sector. The PHS Compact contains measures pertaining to corruption in respect of public sector financial management, systems and processes, as well as governance and leadership to improve oversight, accountability and health system performance.³⁷

these people also experience poor healthcare because of a lack of access, exacerbated by institutional and functional failures [Dhai & Mahomed 8]. Maphumulo & Bhengu highlight inadequate human resources, prolonged waiting times, adverse events, poor hygiene and infection control measures, shortages of medicines and equipment and poor record-keeping [Winnie T. Maphumulo & Busisiwe R. Bhengu “Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review” *Curationis* 42:1 (2019) 1901]. IP 33 respondents: Free State DOH; Dalmeyer; Friedman & Associates; Gary Austin Attorneys; General Council of the Bar; Joseph’s Inc; Life Healthcare; Mediclinic; Riskhouse Africa; SASA.

³⁴ SASA and Scharf are concerned that the problems will only increase once the NHI is implemented, as the system will be so much bigger [SASA (unpaged) item 4 question 1; Scharf 1].

³⁵ The term “corruption” is mentioned in the *Presidential Health Summit 2018 Report* [PHS Report (2019)] several times: in the President’s opening message; in the “Aims, objectives and outcomes of the Summit”; and in relation to human resources, supply chain management, health service provision and leadership and governance. The word “corruption” does not appear in the 2009 Integrated Support Team Report at all. See also N Aikman “The crisis within the South African health care system: A multifactorial disorder” *SAJBL* 2019 2(2) 52–56 at 53.

³⁶ South African Government *Report on the Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system* (February 2019) 30, 33, 34, 41, 43, 50, 51 and 52 [PHS Report (2019)].

³⁷ South African Government *Presidential Health Summit 2018 Compact: Strengthening the South African health system towards an integrated and unified health system* (25 July 2019) 61 & 66 [PHS Compact (2019)].

5.22 Corruption Watch³⁸ published a report in July 2020 that deals exclusively with corruption in the South African health sector.³⁹ Corruption Watch's working definition of corruption is "the abuse of entrusted power for personal or private gain."⁴⁰ According to the report, Corruption Watch received 670 reports of incidences of corruption in the public health sector since their launch in 2012 until the end of 2019.⁴¹ On a national level employment corruption was the most prevalent form of corruption (39%), followed by procurement corruption (22%), and the misappropriation of resources (16%).⁴²

5.23 The employment corruption entailed absenteeism, nepotism and favouritism. The report states that officials with the authority to determine the criteria to fill vacant posts or who have a say in making appointments are often the culprits. Unilateral decisions, lack of consultation, coercion and even bribes play a part in the appointment of persons to positions that they are not qualified for or that are too demanding for their capabilities, contributing to poor service delivery.⁴³ Procurement corruption includes actions such as price inflation, destroying or amending documents to benefit certain service providers, preferential treatment and kickbacks. Misappropriation of resources takes place when employees mismanage funds; or use resources, equipment, state vehicles and accommodation for their own benefit, leading to shortages of medication, damaged or lost equipment and lifestyles funded by public money.⁴⁴

5.24 In their conclusion, Corruption Watch says:⁴⁵

The hundreds of corruption cases received by Corruption Watch and discussed in this report illustrate the significant problem plaguing the health sector in South Africa. It should be of great concern to all that in a country where the right to access healthcare is enshrined in the

³⁸ Corruption Watch is a non-profit organisation launched in 2012 that provides a platform to the South African public for reporting corruption. Corruption Watch conducts selected investigations, publicising their findings and referring information to the relevant authorities for further action where appropriate. [Corruption Watch "Who we are – about Corruption Watch" accessed 8 October 2021 www.corruptionwatch.org.za/about-us/who-we-are/about-corruption-watch/].

³⁹ Corruption Watch *X-ray: The Critical State of the Health Sector in SA* (July 2020) [CW X-ray].

⁴⁰ CW X-ray 4.

⁴¹ CW X-ray 1 & 2.

⁴² CW X-ray 4.

⁴³ CW X-ray 5.

⁴⁴ CW X-ray 6 & 7

⁴⁵ CW X-ray 9.

Constitution and where economic disparities are incredibly vast, approximately 13% of the country's annual budget is siphoned, pillaged and misused.

5.25 The Special Investigating Unit released two reports this year regarding corruption in the public health sector. The first report (*SIU Procurement Report*) pertains to the procurement of goods and services (also in relation to immovable property) during the Covid-19 national state of disaster,⁴⁶ while the other report deals with the illegal Digital Vibes contract involving the former Minister of Health and high-ranking NDOH officials.⁴⁷ Both reports recommend that disciplinary steps and in some instances criminal action be taken against persons involved.

5.26 The *SIU Procurement Report* observed that the declaration of the national state of disaster gave rise to the phenomenon of managers in the provincial governments believing that all procurement could be conducted on an emergency basis, and that the normal prescripts that apply to public sector procurement could be ignored. However, even emergency procurements have to comply with prescripts and must still be fair, equitable, transparent, competitive and cost-effective as required by section 217(1) of the Constitution. This total disregard for prescripts led to huge irregularities, as well as fruitless and wasteful expenditure.

5.27 In the *Digital Vibes Report* the SIU found that the procurement processes in respect of the NHI and Covid-19 media campaigns were irregular and that the agreements entered into with Digital Vibes are void. Irregular expenditure amounting to about R150 million and fruitless and wasteful expenditure amounting to between R72 million and R80 million was incurred by the NDOH.

⁴⁶ Special Investigating Unit *Finalised matters in respect of the Investigation into the procurement of, or contracting for goods, works and services, including the construction, refurbishment, leasing, occupation and use of immovable property, during, or in respect of the National State of Disaster, as declared by Government Notice No. 313 of 15 March 2020, by or on behalf of the State Institutions* Proclamation No. R. 23 of 2020 (23 July to 25 November 2020) – released in February 2021.

⁴⁷ Special Investigating Unit *Report to the President of the Republic of South Africa His Excellency, President MC Ramaphosa regarding the Investigation of the National Department of Health / Digital Vibes (Pty) Ltd contracts* Proclamation No R. 23 of 2020 (30 June 2021).

(ii) OHSC reports

5.28 The Office of Health Standards Compliance published four annual inspection reports to date, for the periods 2015/2016, 2016/2017, 2017/2018 and 2018/2019 (see paragraphs 5.223–5.241). The OHSC select a different sample of health establishments for inspection each year, setting a performance score for inspection coverage as a percentage of the total number of public health establishments in the country. The inspection reports so far paint a concerning picture of mostly below par compliance with the National Core Standards.

(iii) Ritshidze reports

5.29 “Ritshidze” (which means “Saving Our Lives” in TshiVenda) is a community-led system that monitors public sector primary health care facilities, collecting data through observations and interviews with healthcare users and healthcare providers. Ritshidze has published six reports about the state of health care services delivered in clinics and community healthcare centres in Gauteng, Mpumalanga, North West, Limpopo, the Free State and the Eastern Cape.⁴⁸ Ritshidze sounds a warning bell over the public health care system:⁴⁹

[T]he South African public healthcare system is in crisis. This is a crisis characterised by widespread understaffing and shortages of health workers, stockouts of medicines and other essential medical supplies, poor TB infection control measures, and long waiting times – underpinned by maladministration and mismanagement. Given ongoing political uncertainty, a stagnating economy and a shrinking health budget in real terms, this crisis seems likely to continue.

(iv) Treatment Action Campaign Manifesto

5.30 The Treatment Action Campaign (TAC), one of the implementers of the Ritshidze project, released their publication *Peoples Health Manifesto 2021* on 14 October 2021. TAC subsequently organised a march to the Union Buildings in Pretoria to deliver a memorandum to the President and the Minister of Health. The march, which took place on 18 October 2021, “will mark the start of a radical campaign to advocate for the improvement of the state of healthcare in the country and for greater accountability for

⁴⁸ Ritshidze *Gauteng: State of Health* (December 2020); Ritshidze *Mpumalanga: State of Health* (May 2021); Ritshidze *North West: State of Health* (June 2021); Ritshidze *Limpopo: State of Health* (August 2021); Ritshidze *Free State: State of Health* (September 2021). Ritshidze *Eastern Cape: State of Health* (September 2021).

⁴⁹ Ritshidze *Gauteng 2*.

private and public power”.⁵⁰ The strongly worded memorandum demands an adequate response to all concerns, and that action be taken against executives and officials implicated in corruption. Relevant extracts from the memorandum state:⁵¹

The Treatment Action Campaign is marching today because the health system is in crisis. People wait for hours to be seen, only to be sent home empty handed or without all the medicines they need. Healthcare workers are overburdened and overstretched to breaking point. Doctors are scarce. Buildings are falling apart and equipment is missing. Hospitals are in shambles. Patients are found sleeping on corridor floors. Ambulances are scarce and unreliable. Community-led monitoring carried out by TAC and Ritshidze confirms the extent of this crisis at clinics and hospitals across the country. The dignity of poor people is being trampled upon every day. The reality is that our peoples’ Constitutional right to healthcare is being violated.

...

Underpinning the collapse of the health system is pervasive corruption and a dire lack of accountability of public officials. Corruption and theft of public funds is rife in the Department of Health at all levels. This takes away resources needed for quality healthcare delivery.

...

We call on you as State President to act quickly to bring all perpetrators of corruption and financial mismanagement and maladministration to book ...

...

We also demand that there be an urgent turnaround of the collapse of the health system. If not, we will hold the President and the health department accountable for their indifference to the suffering of poor people. We will not rest until we have an adequate response to all concerns. If the President and Minister of Health do not take our demands seriously, we will be back here in our numbers. We will protest in ways you have never seen before. It is time to deliver on your Constitutional mandate, or face the consequences.

5.31 The *People’s Health Manifesto 2021* flows from the Ritshidze reports regarding problems in the public primary health care system (see paragraph 5.29). The *Manifesto’s* opening paragraph is a problem statement:⁵²

⁵⁰ Treatment Action Campaign “Media Alert – Call to End Corruption to Fix the Public Healthcare System” accessed 19 October 2021 www.tac.org.za/news/media-alert-call-to-end-corruption-to-fix-the-public-healthcare-system/.Presidnet.

⁵¹ Treatment Action Campaign “Memorandum delivered to President Cyril Ramaphosa and Minister of Health Dr Joe Phahla” (Pretoria, 18 October 2021).

⁵² Treatment Action Campaign *People’s Health Manifesto 2021* (October 2021) first par third page of document (unpaged) [TAC *Manifesto*].

The vast majority of people in South Africa are reliant on the public healthcare system – including the vast majority of our members. It's an ailing system that at its best is under-resourced; at its worst it is severely dysfunctional.

5.32 It is illuminating that the TAC *Manifesto* ultimately ascribes the lack of progress with fixing the health system to governance and political interests:⁵³

Many of the bottlenecks standing in the way of fixing our healthcare system stem from poor quality governance and prioritising political interests over people. Often, politically appointed individuals, including councillors, lack the competence, commitment, or political will to address the very serious problems plaguing our healthcare system at various levels.

5.33 The TAC developed the *Manifesto* to obtain inputs from the various political parties on key health-related issues in the run-up to the local elections. The *Manifesto* requests political parties to respond to 12 questions under three broad topics, which are:

- fixing the health system
- HIV and TB
- governance and accountability.

5.34 The issues raised under the topic “fixing the health system” are:

- 1) Poor condition of the health facility infrastructure, especially buildings and toilets.
- 2) Shortage of healthcare workers – doctors, professional and enrolled nurses, cleaners, additional male health care workers; and long waiting times, mostly due to staff shortages (which also prevent clinics from extending their operational hours) and exacerbated by the chaotic filing system.
- 3) Stockouts and shortages of antiretroviral drugs (ARVs), tuberculosis and other medicines, contraceptives and health products.
- 4) Emergency medical services and planned patient transport systems – characterised by long waiting times, lack of reliability and indignity.
- 5) Medical negligence – avoidable adverse events, medical negligence leading to disability, recurrent or new medical issues, extended hospital stay, re-admission, loss of income, avoidable death, obstetric problems, indignant and disrespectful treatment of pregnant women and woman in labour. Malpractice claims due to

⁵³ TAC *Manifesto* third par fourth page.

medical negligence cost the provinces money that should have been used for health care services.

- 6) Access to medicines – ongoing and unnecessary delays to change domestic laws to reflect relaxed measures on patents agreed to internationally.

5.35 The matters covered under the topic HIV and TB are:

- 1) HIV – short dispensing times, unnecessary trips to clinics with long waiting times instead of utilising additional external pick-up points and adherence clubs.
- 2) TB and drug-resistant TB are still a leading cause of death in South Africa, yet clinics fail to follow the simple six item good practice checklist:
 - i. ensure enough space for patients to wait without overcrowding;
 - ii. keep windows open;
 - iii. display TB information posters prominently;
 - iv. reduce clinic waiting times to less than an hour and 15 minutes on average;
 - v. screen all arriving patients for TB symptoms;
 - vi. separate patients who are coughing when they arrive at the clinic.
- 3) Key populations (including men who have sex with men, transgender people, people who use drugs and sex workers) often struggle to access services due to stigma, discrimination and criminalisation.

5.36 Under the topic “governance and accountability”, the *Manifesto* seeks responses to the following matters:

- 1) Accountability: clinic committees and hospital boards – governance structures that are supposed to ensure accountability and community participation – are non-functional, ineffective, lack understanding of their roles and responsibilities, do not have enough members to constitute a valid body or are manipulated for political reasons. Political office bearers lack the political will to get these structures working.
- 2) Corruption and theft of public funds: The *Manifesto* states that “corruption and theft of public funds is rife in the Department of Health at all levels”. They urge measures to prevent corruption and the prosecution of persons responsible for stealing public funds.
- 3) End the austerity budget and increase resources for health.

(iv) *Study on Free State health system*

5.37 Malakoane et al conducted a situational appraisal in the Free State to identify health system challenges prevalent in the province.⁵⁴ Dr Benny Malakoane was the MEC for Health in the Free State at the time. Two of the co-authors were employees of the Free State DOH and two co-authors were from the University of the Free State.⁵⁵ The study appears to have been a massive undertaking, as described under the heading “Methods” in the Abstract of the article:⁵⁶

The study entailed a multi-method situation appraisal utilising information collated in 44 reports generated in 2013 through presentations by unit managers, subdistrict assessments by district clinical specialist teams, and group discussions with district managers, clinic supervisors, primary health care managers and chief executive and clinical officers of hospitals. These data were validated through community and provincial health indabas including non-governmental organisations, councils and academics, as well as unannounced facility visits involving discussions with a wide range of functionaries and patients. The reports were reviewed using the World Health Organization health system building blocks as a priori themes with subsequent identification of emerging subthemes. Data from the different methods employed were triangulated in a causal loop diagram showing the complex interactions between the components of an (in) effective health system.

5.38 The authors refer to the succession of “charters, policies, strategies and plans [put] in place in an effort to strengthen public health system performance and enhance service delivery”, but state that “public health programme performance and outcomes remained poor while the burden of disease increased”.⁵⁷ They point to the chronic underfunding of the public health system that lead to major health system challenges, including “negative staff attitudes, long waiting times, unclean facilities, medicine stock-outs, insufficient infection control and compromised safety and security of both staff and patients. ... While South Africa spends more on health than any other African country, health outcomes are not commensurate with spending”.⁵⁸

⁵⁴ B Malakoane et al “Public health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening” *BMC Health Services Research* (2020) 20:58 <https://doi.org/10.1186/s12913-019-4862-y>.

⁵⁵ Malakoane et al 12.

⁵⁶ Malakoane et al 1.

⁵⁷ Malakoane et al 1.

⁵⁸ Malakoane et al 2.

5.39 Many of the findings of the Free State study mirror findings reported in the OHSC inspection reports (see par 5.223 and further below), including weak leadership⁵⁹ and the decreasing number of health professionals.⁶⁰ Another problem highlighted by Malakoane et al is “fragmentation of services at the implementation level”.⁶¹ Lack of coordination and disjointed referral systems are also mentioned.⁶²

(b) Human resources

5.40 Several respondents to Issue Paper 33 and commentators register alarm over the human resources situation in the public health sector. All the reports by Chapter 9 institutions and OHSC reports (see paragraphs 5.140 and further for more detailed discussions of the various reports), government-initiated reports (see Chapter 6) and the Ritshidze reports published to date express concerns about human resources, citing staff shortages (including shortages of supporting staff eg data capturers and cleaners),⁶³ skills and capacity of staff, and staff attitudes.⁶⁴ Respondents to Issue Paper 33 highlight the same issues.⁶⁵ Longer waiting times for treatment or procedures is partly blamed on a shortage of staff.⁶⁶ Discovery Health point to the importance of maintaining staffing and infrastructure at adequate levels to ensure good quality care.⁶⁷ Attraction and retention of skilled staff, especially in the rural areas, is a major headache.⁶⁸

⁵⁹ Malakoane et al 8.

⁶⁰ Malakoane et al state: “As emphasised by stakeholders in the current situation appraisal, while the burden of disease had been increasing, the numbers of health professionals were decreasing in the Free State.” [Malakoane et al 9].

⁶¹ Malakoane et al 8.

⁶² Malakoane et al 9.

⁶³ Ritshidze Gauteng 5; Ritshidze Mpumalanga 6 & 14; Ritshidze North West 14; Ritshidze Limpopo 7 & 16; Ritshidze Free State 8 & 15; Ritshidze Eastern Cape 7 & 10.

⁶⁴ Ritshidze Gauteng 9, 17 & 18; Ritshidze Mpumalanga 23 & 28; Ritshidze North West 22, 23 & 28; Ritshidze Limpopo 5, 22 & 28; Ritshidze Free State 5 & 30; Ritshidze Eastern Cape 3 & 34.

⁶⁵ IP 33 respondents: Eastern Cape Treasury; Free State DOH; KZN DOH; KZN Treasury; National Treasury; North West Treasury; State Attorney, Pretoria; Friedman & Ass; Gary Austin Attorneys; Larsen; Mullins; OTASA; SAMLA.

⁶⁶ Maphumulo & Bhengu (unpaged); Aikman 53.

⁶⁷ IP 33 respondent: Discovery Health 4.

⁶⁸ “The single most important challenge with regard to human resources is the recruitment and retention of health professionals” [IST Report (2009) 69]. “To address challenges relating to human resources for health (HRH) it is imperative that the moratorium on human resources be lifted; a human resource (HR) roadmap is required and should include occupational health and safety; recognition and reward for personnel; talent management;

5.41 The dwindling numbers of health professionals, in real terms as well as in comparison to managerial and administrative posts, is flagged. The *Presidential Health Summit 2018 Report* has the following to say about human resources and the ratio of clinical staff to admin and managerial staff:⁶⁹

The health system is plagued by endless challenges relating to inadequate funded posts; maldistribution of posts relative to need; poor service delivery planning; clinicians who are over worked; safety concerns for staff in facilities; lack of financial resources to absorb junior doctors in the public health sector etc. ...The organisational design in hospitals and clinics is characterised as top heavy, with many managers appointed and the duplication of roles.

5.42 The 2009 report of the Integrated Support Team highlighted this concern a decade before the 2019 PHS Report, yet not much has changed:

Organisational structuring in the provinces is not done according to agreed benchmarks or aligned with existing plans or resources. Of serious concern is the considerable and continued growth in management and administrative positions across the various provinces, especially in provincial head offices, relative to the growth in health care professional positions.⁷⁰

...

Medical and nursing staff numbers showed little growth, even with an increase in national population and disease burden over the timeframe. Management staff grew by almost 160% or 671 people. Administrative staff grew by 30.5% or 8 743 people. Hospital and health services staff declined by 26% or 21 067 people. Together, management and administrative staff grew with 32,3 % or 9 414 people. This raises the question whether management structures are appropriately prioritised relative to frontline service providers.⁷¹

5.43 **However, merely employing more staff members will not solve the problem.** Proper planning is essential: the distribution of staff and the ratio of professional staff to administrative, managerial and support staff are critical factors in the delivery of quality health care. Staff cannot do their work if they do not have the infrastructure, drugs,

attraction and incentivisation; retention and support.” [PHS Report (2019) 9]. See also Aikman 54.

⁶⁹ PHS Report (2019) 28 & 29.

⁷⁰ IST Report (2009) 13.

⁷¹ IST Report (2009) 69.

equipment and facilities that they require to perform their functions. Two surgeons with properly equipped and functional operating theatres, the right support staff and the correct medicines in adequate quantities will achieve far more than five surgeons with one barely usable operating theatre, support staff without the requisite skills and constant medicine stock-outs.

5.44 A number of commentators and respondents are concerned about the nursing profession in particular. Comments pertaining to nurses refer to the ratio of nursing staff to patients; shortage of nurses; decline in standards of care, decline in professionalism, lack of experience, inadequate supervision and the need to implement proper systems. Training is mentioned often, including inadequate training, not enough midwifery training, deficient practical and basic healthcare training, and lack of training on equipment. Respondents remark on nurses' attitude towards patients, culminating in a lack of dedication, empathy and the concept of selfless caring for others, while the closure of nursing colleges after 1994 and the brain drain, especially of experienced and skilful nurses, midwives and nursing trainers, are lamented.⁷²

(c) State of public health establishments

5.45 Oosthuizen & Carstens aver that the "institutional weaknesses and systemic challenges present in the public sector have made it especially susceptible to malpractice litigation",⁷³ and that "systemic problems in the public health system have contributed to poor health outcomes and increased malpractice litigation".⁷⁴ Other problems mentioned are a decline in professionalism among healthcare practitioners, poor management, lack of accountability, allegations of a rise in the incidence of negligence, decreasing quality of care and lower standards of health care, lack of supervision and oversight, excessive workloads, staff burn-out, low staff morale, bad attitude of staff; sleep deprivation and an under-resourced public sector that lacks strong management in many areas.⁷⁵ Poor oversight and management of persons performing remunerative work outside the public

⁷² Aikman 54; Maphumulo & Bengu (unpaged). IP 33 respondents: GunnClark; Kaseke; Larsen; Mediclinic; Mullins; OTASA.

⁷³ Oosthuizen & Carstens *Malpractice* 272.

⁷⁴ Oosthuizen & Carstens *Malpractice* 275.

⁷⁵ Coetzee & Carstens 1300 & 1301; Malherbe 83; Pienaar 6; Van den Heever (2016) 49; Taylor et al 149; Oosthuizen 5; Maphumulo & Bhengu (unpaged). IP 33 respondents: KZN DOH; National Treasury; North West Treasury; State Attorney, Pretoria; Gary Austin Attorneys; General Council of the Bar; Joseph's Inc; Kaseke; Larsen; OTASA; Paul du Plessis Attorneys; RiskHouse Africa; SAMA; SAPPF.

service (RWOPS) is another source of disquiet,⁷⁶ as are public health sector nurses moonlighting in the private sector. Training of health workers is also affected: since medical practitioners and nurses are mostly trained in the public health sector, the deterioration of the public health sector is negatively impacting on the training of medical practitioners for the whole country.⁷⁷

5.46 Seggie describes the worrying situation in public health establishments:⁷⁸

[T]he situation that exists in many of our public sector hospitals ... a mix of too many, too sick patients, human resource constraints, lack of equipment, non-functioning equipment and recurring shortages of supplies, added to which is lack of experience on the part of interns and community service medical officers, who are all too often left to function unassisted and unadvised by senior personnel. The Health Professions Council of South Africa reports an increase in complaints from patients and in the number of doctors found guilty of unprofessional conduct: refusing to treat patients, misdiagnosing, practising outside their scope of competence

5.47 Oosthuizen summarises the concerns raised by several commentators:⁷⁹

The public health system suffers from a range of systemic weaknesses that have likely impaired the provision of quality care. These weaknesses, along with other factors, may have made the public sector especially vulnerable to malpractice litigation. The substantial amounts spent on claims, cannot be spent on improving healthcare infrastructure and services. Unfortunately, this could potentially compound the problem, and lead to more frequent and more severe harmful outcomes – with a greater number of subsequent claims. Those in the private sector have also raised concerns about the current situation. Increasing claims have contributed to escalating indemnity insurance premiums, which could lead to passed-on costs, resource waste and reduced access to care.

⁷⁶ Government employees may apply for permission to perform remunerative work outside the public service (RWOPS). Several public sector medical practitioners have obtained such permission, but it is unfortunately often abused. This is mainly because of inadequate oversight and lack of accountability of medical practitioners who perform RWOPS during the hours when they should be on duty in a state hospital. There is anecdotal evidence of junior doctors working without adequate supervision because of the absence of senior doctors performing RWOPS. IP 33 respondents: SAMA; SAPPF.

⁷⁷ IP 33 respondent: SAMLA 2.

⁷⁸ Seggie 433.

⁷⁹ Oosthuizen 551–552.

5.48 A number of commentators and respondents hold the view that improving the quality of public health care services is the most important aspect of addressing medico-legal litigation.⁸⁰ In this regard, the General Council of the Bar opines: “It goes without saying that if the standard of service delivery in the public health care system improves, the medical malpractice claims instated will decrease.”⁸¹

5.49 The inspection reports published by the Office of Health Standards Compliance for the years 2015/2016 to 2018/2019 paint a concerning picture of poor compliance with the national core standards (NCS). The 2015/2016 report indicates that five health establishments (two tertiary hospitals, three clinics) out of the 627 health establishments inspected achieved the 80% compliance score.⁸² In a press briefing subsequent to the release on 5 June 2018 of the OHSC 2016/17 annual inspection report, it was confirmed that only five health establishments (two clinics and three hospitals) out of the 696 public health establishments inspected during the 2016-2017 financial year achieved the required 80% pass mark for compliance with the national norms and standards.⁸³ The 2018/2019 inspection report (the most recent published inspection report) reveal that three hospitals and five clinics (out of 730 health establishments, including 631 clinics) achieved the compliance score of 80% or more.⁸⁴ The reports are discussed in more detail below (see paragraphs 5.223–5.241).

(d) Financial situation

5.50 The financial situation of the majority of the provincial departments of health is dismal. The consolidated PFMA reports for the years 2017-18 to 2019-20 reveal just how bad the state of affairs is (see paragraphs 5.197 to 5.222). The public health sector’s financial woes are not of recent origin. Schreiber conducted a case study that focused on the financial situation in the sector over the period 2009 to 2017. Apart from doing literature research, Schreiber interviewed several senior government officials in National Treasury, the NDOH and the Western Cape who were responsible for or closely involved

⁸⁰ IP 33 respondents: Friedman & Associates; Gary Austin Attorneys; General Council of the Bar; Life Healthcare; Paul du Plessis Attorneys; RiskHouse Africa.

⁸¹ IP 33 respondent: GCB 19.

⁸² OHSC *Annual Inspection Report 2015/2016* (April 2017).

⁸³ OHSC “Annual Inspection Report for the public-sector health establishments inspected during the 2016/17 Financial Year” (information about report) accessed 27 August 2021 ohsc.org.za/ohsc-annual-inspection-report-for-the-public-sector-health-establishments-inspected-during-the-2016-17-financial-year/.

⁸⁴ OHSC *Annual Inspection Report 2018/2019* (March 2020) at 9.

with the process of health budgeting and financial management. He sketched the background to the financial crisis that had developed in the provincial departments of health by 2009 due to overspending and poor financial controls following the 2008 global financial crisis.⁸⁵

5.51 Schreiber describes the methodology for allocating funds to the provincial DOHs. South Africa has a decentralised public health sector, as determined by the Constitution and the NHA. Section 214 of the Constitution provides for “the equitable division of revenue raised nationally among the national, provincial and local spheres of government” in accordance with each province’s equitable share. Provinces’ equitable shares are paid over to the provincial treasuries, and provinces allocate and manage their own budgets, including budgeting for the delivery of health care services. NDOH only holds sway over the so-called conditional grants, which are funds allocated to the provincial DOHs in order to implement national priorities. The NDOH design and monitor the conditional grants. The conditional grants are earmarked for a specific purpose, and provinces may thus not spend conditional grants on anything else.⁸⁶

5.52 Schreiber refers to the investigation commissioned by Barbara Hogan, who was Minister of Health at the time, into the projected overspending and budget deficits faced by the provincial DOHs in the 2008–2009 financial year.⁸⁷ The *Consolidated Report of the Integrated Support Team* [IST Report (2009)] that resulted from this initiative is discussed in more detail in Chapter 6. Some of the findings of the IST Report (2009) relate to a lack of leadership and stewardship by the NDOH and the lack of a plan providing guidance on reforming the public health system over a five to ten year period.⁸⁸

5.53 Under the leadership of a newly appointed minister, Dr Aaron Motsoaledi, the NDOH determined a new strategic direction for the public health sector in the 2009–2014 Medium Term Expenditure Framework (MTEF), and adjusted conditional grants to the provinces to reflect the new priorities. A novel type of grant, referred to as “allocations in

⁸⁵ Leon Schreiber “Staying afloat: South Africa keeps a focus on health priorities during a financial storm, 2009–2017” *Innovations for Successful Societies* (2018 Princeton University) successfulsocieties.princeton.edu/.

⁸⁶ Schreiber 2.

⁸⁷ Schreiber 2.

⁸⁸ Peter Barron et al *Consolidated Report of the Integrated Support Team: Review of health overspending and macro-assessment of the public health system in South Africa* (May 2009) 11 [IST Report (2009)].

kind", allowed the NDOH to procure certain budget items, such as medicines, on behalf of provinces.⁸⁹ This practice, linked to improved supply chain management, led to huge savings, especially for ARVs.⁹⁰ In spite of these improvements the majority of provinces could still not budget effectively, failed to control expenditure and struggled to identify the needs in their areas. Schreiber opines that ongoing poor financial management and budget cuts lead to disasters such as the Life Esidimeni tragedy.⁹¹

5.54 The only province that managed to deal with the shrinking budget is the Western Cape. They achieved this by –

- 1) giving managers estimates of budget increases and decreases beforehand, resulting in more realistic budget proposals;
- 2) changing budget planning from a top-down to a bottom-up process;
- 3) protecting equipment and maintenance spending rather than the wage bill;
- 4) holding collaborative workshops to draw up the final budgeting proposals;
- 5) improving communication and building relationships with the provincial treasury to create an understanding for the business of health care and demonstrate what the numbers meant in practical terms with regard to the delivery of health care services.⁹²

5.55 Another critical component of the Western Cape's success is improved collection of user fees. The Western Cape DOH is allowed to retain user fees collected by hospitals and clinics within the department, thereby boosting the health department's revenue and encouraging health establishments to actually collect the fees. The process is facilitated by a software programme created by the Western Cape DOH that automatically calculate which users are exempt from fees, which users qualify for a subsidised fee and which users should pay in full. The health department oversees health establishments, using monitoring software that collate information from the human resources data base and the Basic Accounting System (BAS). The information allows the department to follow up on discrepancies and is useful for budget planning.⁹³

⁸⁹ Schreiber 8.

⁹⁰ Schreiber 12.

⁹¹ Schreiber 15.

⁹² Schreiber 16.

⁹³ Schreiber 17.

5.56 The Western Cape DOH is the only provincial DOH that implements proper financial management and budgeting, but its methods prove that the MTEF alone is not enough. To be successful, it is necessary to do proper planning, improve financial management and increase capacity. Schreiber quotes Craig Househam, former head of the Western Cape DOH: “You can have the best budgeting systems in the world, but financial management improves only when fraud, corruption, and incompetence become intolerable; when people get fired; and when there are consequences for mismanagement of funds.”⁹⁴ The continued success of the Western Cape system is borne out by the PFMA Consolidated General Reports for 2017-18, 2018-19 and 2019-20, which indicate that the Western Cape consistently achieved the best audit outcomes of all the provinces.

5.57 Apart from the need to improve budgeting and financial management of the provincial DOHs in general,⁹⁵ the management of medico-legal claims in particular must be attended to. Dinnie remarks that “[a]t a State level there is a need and opportunity to focus on and structure financial accountability for medico-legal exposure and claims in a far better way than has been done before”.⁹⁶

(e) Budgeting

5.58 Another proposal is to end the practice of paying for litigation expenses and the payment of compensation out of the operational budgets of health establishments.⁹⁷ It is not clear why this practice is followed, as National Treasury has confirmed that litigation and compensation payments can and should be budgeted for in terms of the PFMA.⁹⁸

(f) Leadership and governance

5.59 The South African Human Rights Commission (SAHRC) conducted an inquiry into access to health care services as far back as 2007. One of the issues highlighted by

⁹⁴ Schreiber 20.

⁹⁵ PHS Report (2019) 47 & 50; Malakoane et al 11.

⁹⁶ Donald Dinnie “The NHI, funding healthcare and medico-legal claims” Insurance Xchange (9 August 2018) insurancegateway.co.za/HealthcareConsumers/PressRoom/ViewPress/Irn=18809&URL=The+NHI+funding+healthcare+and+medicolegal+claims+1#.XUwjlk-P5fd.

⁹⁷ IRP 33 respondent: General Council of the Bar 19–20.

⁹⁸ Auditor-General of South Africa *Consolidated General Report on National and Provincial Outcomes: PFMA 2019-20* at 59: “Departments usually do not budget for claims. Especially in the health sector, not budgeting for medical negligence claims means that all successful claims will be paid from funds earmarked for the delivery of services, resulting in these departments using more than what had been allocated to them.”

the SAHRC was the centralisation of decision-making authority. In this regard the SAHRC made the following recommendations:⁹⁹

- Decentralise power by delegating decision-making to CEOs and district and facility managers, especially with regards to human resources and financial management.
- Conduct skills audits of senior management and implement appropriate interventions such as training and awareness campaigns to capacitate senior staff.
- Improve financial management and overall operational delivery efficiency by placing greater emphasis on capacity development, PFMA, good governance, implementation and accountability.

5.60 The *Presidential Health Summit 2018 Report* lists concerns about issues affecting human resources, with a lack of delegation of authority mentioned as one of the factors.¹⁰⁰ The PHS Report refers to a lack of appropriate leadership and management capacity among many leaders and managers in public health.¹⁰¹ The PHS Report recommends separation of powers and delegation of authority.¹⁰² Malakoane et al blame centralised decision-making for being one of the causes of poor leadership and management, since the lack of meaningful delegations deprive managers of the means to lead and manage.¹⁰³

5.61 Malakoane et al report stakeholder views that service delivery in the Free State public health system is negatively affected by poor leadership and governance. Leadership and governance are critical for quality health care, but are difficult to define and measure.¹⁰⁴ According to Malakoane et al this “requires attention because without appropriate investment in the leadership and governance of health systems, any gains that are realised from investment in public health service delivery are unlikely to be sustained over the long term.”¹⁰⁵ The PHS Report recommends continuous leadership

⁹⁹ SAHRC *Public Inquiry: Access to Health Care Services* (2009) at 7. On the cover the publication is described as “A report and recommendations based on the submissions and proceedings of the Public Hearings conducted at the national office of the South African Human Rights Commission, Parktown, Johannesburg from 30 May to 1 June 2007.”

¹⁰⁰ PHS Report (2019) 27.

¹⁰¹ PHS Report (2019) 29.

¹⁰² PHS Report (2019) 50.

¹⁰³ Malakoane et al 11.

¹⁰⁴ Malakoane et al 11.

¹⁰⁵ Malakoane et al 11.

and management training for all management.¹⁰⁶ Another concern is the organisational design of the leadership structure in hospitals and clinics, which is top heavy with too many managers and a duplication of roles.¹⁰⁷

5.62 Malakoane et al makes the following observation:¹⁰⁸

[S]takeholders believed that where there was weak leadership and poor governance in the presence of good policies but poor implementation, unsatisfactory priority setting and lack of governance structures to ensure accountability, the risk to patient care increased and provision of quality health service was compromised. The risk to patient care was further exacerbated by the absence of hospital boards in the majority of hospitals.

(g) Political interference

5.63 The PHS Report has a lot to say about political interference. The following statements appear in the report:

- Political interference and patronage networks in the management of public hospitals has resulted in the challenges that plague the public health sector.¹⁰⁹
- There must be a separation between the political and administrative leadership in public health ...¹¹⁰
- The political interference in health care operations results in the deployment of incompetent managers for party political reasons.¹¹¹
- Develop a policy that will stop political interference in service delivery and unfunded mandates within all departments and provincial administrations.¹¹²
- Stop political interference (directly or indirectly) in resource allocation.¹¹³
- There is political interference in management with corruption eroding the ability to deliver health care.¹¹⁴

¹⁰⁶ PHS Report (2019) 30.

¹⁰⁷ PHS Report (2019) 29.

¹⁰⁸ Malakoane et al 11.

¹⁰⁹ PHS Report (2019) 29.

¹¹⁰ PHS Report (2019) 30.

¹¹¹ PHS Report (2019) 43.

¹¹² PHS Report (2019) 43.

¹¹³ PHS Report (2019) 47.

¹¹⁴ PHS Report (2019) 50.

- Professionalise the public service employment based on ability and care, not political affiliation.¹¹⁵

5.64 The Ministerial Task Team Hospital Mismanagement Report of 2017 made the following statements:¹¹⁶

- Hospitals are operating under extreme service pressure within an environment of constrained financial, technical and human resources.
- The situation is exacerbated by the ongoing instability of management appointments and political office bearers and an apparent environment characterised by uncertainty and at times interference in the line functions of appointed officials at the hospitals.¹¹⁷
- It is recommended that the separation of powers and functions between political office bearers and management are clarified and entrenched as set out in the relevant legislation in particular the Public Finance Management Act, 1999 (Act 1 of 1999), as amended and the Public Service Act, 1994 (Act 103 of 1994), as amended taken together with the relevant regulations.¹¹⁸

5.65 The 2009 report of the Integrated Support Team (IST) on health overspending and macro-assessment of the public health system in South Africa refer to concerns about politically motivated appointments at various levels expressed during interviews with staff members at health establishments.¹¹⁹ The report refers to a case of political interference in performance management procedures and withholding resultant bonuses.¹²⁰

(h) Patient safety incident reporting

5.66 Patient safety incident (PSI) reporting is considered to be a critical component of quality health care in modern times.¹²¹ In spite of the national guidelines on PSI reporting issued by the NDOH, reporting on adverse events in South African health establishments

¹¹⁵ PHS Report (2019) 50.

¹¹⁶ Nomvula Marawa *Health Ministerial Task Team Hospital Mismanagement and Poor Service Delivery Closure Report* (19 May 2017) [MTT Report (2017)].

¹¹⁷ MTT Report (2017) 7.

¹¹⁸ MTT Report (2017) 8.

¹¹⁹ IST Report (2009) 51.

¹²⁰ IST Report (2009) 71.

¹²¹ Oosthuizen 11; IP 33 respondent: Discovery Health 5.

is not on par.¹²² Mjadu and Jarvis analysed the attitude of registered nurses to critical incident reporting/ patient safety incident (PSI) reporting in three adult intensive care units in tertiary level provincial hospitals in KwaZulu-Natal, using questionnaires.¹²³ Although “[r]espondents agreed that an incident reporting policy was available; clearly defined; easy to use; reporting was timeous, registered nurses were able to learn from their mistakes, and feedback was given to the unit involved”, the survey revealed that “registered nurses were not comfortable to report incidents due to fear of blame, breach of anonymity and that confidentiality was not preserved”.¹²⁴ They express concerns about under-reporting, pointing out that no feedback is possible if a PSI is not reported, which results in the loss of a learning opportunity while opening the door to possible medico-legal litigation.¹²⁵

5.67 GunnClark suggests that adverse events should be investigated thoroughly and transparently and improvements instituted on the basis thereof. Explain errors and adverse events to patients. Link clinical governance to a complaint procedure and mediation.¹²⁶ Mediclinic also recommend investigating the circumstances of adverse events and taking steps to rectify problems. They argue that the resulting reports should not be discoverable.¹²⁷ Bashir et al highlight the importance of good communication and proper interpretation of results.¹²⁸ Gqaleni and Bhengu reviewed the patient safety incident reporting system in the critical care units of ten hospitals in the eThekweni district, KZN.¹²⁹ They sound a warning note about the prevalence of patient safety incidents in South Africa:¹³⁰

South Africa is among the developing countries that have a higher percentage of PSIs because of increased disease burden, aggravated by

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- ¹²² IP 33 respondents: National Treasury, North West Treasury; Western Cape DOH.
- ¹²³ TM Mjadu & MA Jarvis “Patients’ safety in adult ICUs: Registered nurses’ attitudes to critical incident reporting” *International Journal of Africa Nursing Sciences* 9 (2018) 81–86.
- ¹²⁴ Mjadu & Jarvis 83.
- ¹²⁵ Mjadu & Jarvis 84.
- ¹²⁶ IP 33 respondent: GunnClark 5.
- ¹²⁷ IP 33 respondent: Mediclinic 6 & 9–10.
- ¹²⁸ AA Bashir et al “An analysis of adverse events and human error associated with the imaging of patients at a major trauma centre in South Africa” *SAMJ* 109:9 (September 2019) 693–697 at 693.
- ¹²⁹ Thusile M Gqaleni & Busisiwe R Bhengu “Analysis of Patient Safety Incident reporting system as an indicator of quality nursing in critical care units in KwaZulu-Natal, South Africa” *Health SA Gesondheid* (2020) 25(0) a. 1263 1–8 at 1.
- ¹³⁰ Gqaleni & Bhengu 1–2.

the human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) pandemic, which have a profound impact on critical care units (CCUs), resulting in complicated illnesses.

5.68 According to Gqaleni and Bhengu, the high prevalence of patient safety incidents in critical care units is related to longer hospital stays and higher mortality and morbidity rates.¹³¹ Despite thereof that PSI reporting is supposed to be used to improve quality of care and not for punitive purposes, Gqaleni and Bengu point to the fear of repercussions as a leading cause of under-reporting.¹³²

This study reveals that the occurrence of PSIs in CCUs is still high and is of a serious nature, which affects quality patient care and patient safety. It was also noted that the reporting system for PSIs was not effectively utilised, mainly because of fear of litigation and disciplinary action. Implementation of uniform national reporting system of PSIs is crucial to improve quality patient care in CCUs.

(i) Record-keeping, information management and filing

5.69 There are problems with record keeping, information management and filing across the board. The importance of good record keeping is self-evident,¹³³ but several respondents to Issue Paper 33 and commentators raise concerns about inadequate record keeping at state health establishments¹³⁴ and problems getting access to records held by the state.¹³⁵ Basic infrastructure (computers, mobile devices, internet connectivity, databases to store data, components of cybersecurity) must be improved, computer availability is often insufficient, software like the District Health Information System (DHIS) is not always accessible and internet connectivity is often unreliable, especially in the rural areas. An electronic system for record-keeping and data storage is preferred over a manual system, and would be indispensable to the development of a viable national system (which is critical for universal health coverage).

5.70 Malakoane et al point out that local hospitals do not always have computers and the necessary software, resulting in a return to manual record keeping systems. Manual

¹³¹ Gqaleni & Bhengu 7.

¹³² Gqaleni & Bhengu 7.

¹³³ IP 33 respondents: Camargue; Discovery Health.

¹³⁴ IP 33 respondents: National Treasury; KZN Treasury; North West Treasury; Joseph's Inc; Mallory; SAPPF.

¹³⁵ IP 33 respondents: KZN Treasury; Camargue; Discovery Health; Joseph's Inc.

systems cause delays, increase patient waiting times and give rise to duplications and losses of files. Manual capturing of medicine prescriptions is prone to errors, leading to poor medicine tracking and resulting in stock-outs. Apart from insufficient access to computer hardware and software, some community health care centres and district hospitals do not have a reliable internet connection, which means that they struggle to transmit information to the national and provincial DOHs. This in turn impact on the monitoring of disease patterns and treatment programme outcomes.¹³⁶ The problems with internet connectivity is also highlighted in the Public Protector's report on health services at public hospitals in KZN (see paragraph 5.148 below).

(j) Facilities and infrastructure

5.71 Infrastructure problems is a recurring theme in the various state-initiated reports discussed in Chapter 6. Clinics are the backbone of primary health care and the entry point for health care services. The Ritshidze reports on Gauteng and Mpumalanga primary public health care facilities charge provincial DOHs, in conjunction with the Department of Public Works, to “strengthen the Infrastructure Unit (engineers, maintenance crew, quantity surveyors, quality control) to address backlog maintenance, routine maintenance and the building of new health facilities and to prevent any unnecessary under expenditure of the Health Infrastructure Grant”.¹³⁷ Apart from the concerns about the state of buildings, the Ritshidze reports mention other problems such as a shortage of space,¹³⁸ inadequate cleaning services and even dirty and unhygienic facilities,¹³⁹ supplementing the reports with photographs to illustrate the point. SAMLA remarked on the bad state of hospital infrastructure.¹⁴⁰

5.72 The Minister of Health gave notice on 17 February 2014 of the publication of the Health Infrastructure Norms and Standards Guidelines in relation to building engineering services, infrastructure design for waste management in healthcare facilities and emergency centres for public reference information and for application by provincial departments of health in the planning and implementation of public sector health

¹³⁶ Malakoane et al 9.

¹³⁷ Ritshidze Gauteng 29; Ritshidze Mpumalanga 14.

¹³⁸ Ritshidze Gauteng 28; Ritshidze Mpumalanga 14; Ritshidze Limpopo 16; Ritshidze Free State 15; Ritshidze Eastern Cape 16 & 17.

¹³⁹ Ritshidze Mpumalanga 14; Ritshidze Limpopo 17; Ritshidze Free State 15 & 17. Toilets in bad condition in clinics monitored is a particular problem: over 50% in Mpumalanga; 74% in Limpopo; 60% in the Free State and 80% in the Eastern Cape.

¹⁴⁰ IP 33 respondent: SAMLA 2.

facilities. However, the *Presidential Health Summit 2018 Report* makes the following disheartening statement:¹⁴¹

The National Department of Health has a health infrastructure plan but to date the country has had neither the expertise nor adequate funding to implement the plan. In some cases, health infrastructure construction that has been successfully completed has either cost more than the initial budgeted amount or facilities have been constructed that either fail to meet the need for the services required. In other instances, facilities have not been provided with adequate funding to operationalise the new facilities fully. The result has been reactive crisis management to the consequences of this mismatch as well as the failure to replace facilities.

3 Litigation concerns

(a) *Abuse of civil process*

5.73 A number of respondents registered their discontent with abuses of the civil process.¹⁴² This is especially relevant for defendants (in the public and private sectors) that have to bear the brunt of unmeritorious or frivolous claims, or incur expenses to prepare to defend claims that turn out to be unsubstantiated or are abandoned. It is averred that some plaintiff attorneys leave it to the last minute to furnish the defendant with the particulars of the claim, expert opinions and so forth. Even though parties are in theory entitled to recover their costs, it is often not practicable to pursue claims to recover costs against indigent plaintiffs.¹⁴³ Miller described his troubles with law firms that allowed his claims to prescribe on more than one occasion.¹⁴⁴ The Legal Practice Act 28 of 2014 was implemented in full on 1 November 2018, which will hopefully provide recourse for the kind of problems experienced by Miller. Mallory highlights the problem of legal practitioners that issue fraudulent or inflated claims. SAMA, SAPPF and SASA opine that the Legal Practice Council should do more to address illegal and unethical conduct by legal practitioners.¹⁴⁵

¹⁴¹ PHS Report (2019) 35.

¹⁴² IP 33 respondents: Clinix; Dalmeyer; Netcare; SASOG.

¹⁴³ IP 33 respondent: Clinix submitted detailed information illustrating the difficulties that defendants encounter when preparing for court hearings.

¹⁴⁴ IP 33 respondent: Neil Miller “Comments on medico-legal claims reform” (email message to researcher, 13 September 2021).

¹⁴⁵ IP 33 respondents: Mallory 1; SAPPF 4; SASA item 4 question 4.

(b) Inadequate response and preparation by state as defendant

5.74 A number of respondents are critical of the office of the State Attorney with regard to the poor quality of their representation of the state and inadequate preparation for cases against the state, as well as the money wasted during the litigation process.¹⁴⁶ In the matter of *Lushaba v MEC Health, Gauteng* (October 2014),¹⁴⁷ which pertained to a claim for damages on the basis of medical negligence for a child suffering from cerebral palsy, Robinson AJ was highly critical of the conduct of the State Attorney and the MEC's legal officials in dealing with the case, issuing a rule nisi order on the costs. At the hearing on the rule nisi order in *Lushaba v MEC Health, Gauteng* (November 2014),¹⁴⁸ Robinson AJ went so far as to award personal cost orders against the state attorney, legal services official and the medical professional who testified for the defendant.

5.75 Although the costs order was eventually set aside by the Constitutional Court on appeal by the MEC in *MEC Health, Gauteng v Lushaba*,¹⁴⁹ Robinson AJ's remarks and the detailed timeline set out in the November 2014 hearing, especially in relation to the conduct of the state attorney involved, makes for interesting reading. Mention is made of non-compliance with time periods and Rules of Court, failures to respond to correspondence, wasted costs, inertia, lethargy and incompetence.¹⁵⁰ Robinson AJ also refers to several other court pronouncements, including matters heard in the Constitutional Court, that criticised state officials and the office of the State Attorney.

5.76 Mnyongani and Slabbert, in a discussion of the *Lushaba* matter, state that "indifference impacts on the valuable time of the court and the plaintiff, the reputation of the various institutions involved, quality of life of the child born with cerebral palsy as a result of indifference, the dignity of both the mother and her son and, of course, the

¹⁴⁶ IP 33 respondents: Friedman & Associates, Gary Austin Attorneys, Joseph's Inc, Kaseke and Mullins detail problems experienced with the State Attorney's offices, as well as poor management and mismanagement of cases, and wasted costs (which are sometimes quite substantial).

¹⁴⁷ *Lushaba v MEC Health, Gauteng* (17077/2012) [2014] ZAGPJHC 407 (October 2014).

¹⁴⁸ *Lushaba v MEC Health, Gauteng* [2015] JOL 32431 (GJ).

¹⁴⁹ *MEC Health, Gauteng v Lushaba* (CCT156/15) [2016] ZACC 16; 2016 (8) BCLR 1069 (CC); 2017 (1) SA 106 (CC) (June 2016).

¹⁵⁰ *Lushaba* (November 2014) pars 85–88.

taxpayers' money".¹⁵¹ A number of persons who commented on Issue Paper 33 highlighted problems with and concerns about state attorneys and their handling of medico-legal claims,¹⁵² while others point to the very high work load, decreasing capacity, budget constraints and insufficient staff compliment at the various state attorney offices.¹⁵³

5.77 Rogers cautions against pursuing a "hopeless" case, expressing the view that it is unethical for a legal practitioner to advance such a matter. He remarks on private and public litigants with adequate resources who "sometimes drag out cases by pursuing claims or defences which are unmeritorious", but reminds the reader that the court may order a legal practitioner to pay costs *de bonis propriis* (straight from the pocket / out of one's own pocket). He continues: "The court may stay proceedings which are an abuse of process. To advance a claim or defence which is hopeless is one form of abuse. It must be improper for a lawyer to assist a litigant to abuse the court's process."¹⁵⁴ Klaasen contends that the state has a duty to act fairly in litigation, but it is submitted that the state often falls woefully short of the requirements set out by him. Klaasen says the following:¹⁵⁵

When an organ of state gets involved in a legal dispute, this gives rise to constitutional obligations. The same holds true should the dispute result in litigation. The organ of state must act fairly, justly and honestly. There is also a constitutional duty on the state litigant to assist the courts and to ensure the effectiveness of the courts. This requires the state litigant to place all relevant information in its possession before the courts to assist the courts to come to a correct and just finding. It is trite that there is also a legal duty on the private litigant and private legal representative to behave ethically and honestly when litigating. However, the state litigant must be held to a stricter and higher standard than the private litigant. The state litigant has the positive constitutional duty to uphold, defend and respect the Constitution of the Republic of South Africa, 1996 ('the Constitution'). Moreover, given that the state litigant is publicly funded, the state litigant must represent the public interest in litigation. In other

¹⁵¹ Freddy Mnyongani and Magda Slabbert "The cost of indifference in a medical negligence case: *Lushaba v MEC for Health, Gauteng* (17077/2012 [2014] ZAGPJHC 407 (16 October 2014))" *Obiter* (2018) 561–573 at 562.

¹⁵² IP 33 responses: Friedman & Associates; Gary Austin Attorneys; Joseph's Inc; Kaseke; Paul du Plessis Attorneys; SAMLA.

¹⁵³ IP 33 respondents: State Attorney, Bloemfontein; State Attorney, Pretoria; Western Cape DOH; SAMLA.

¹⁵⁴ Owen Rogers "The ethics of the hopeless case" *Advocate* (December 2017) 46–51 at 49.

¹⁵⁵ Abraham Klaasen "The duty of the state to act fairly in litigation" 2014 (3) *SALJ* 616–638 at 616.

words, **an organ of state can litigate only when it is in the public interest to do so, and/or if the litigation will vindicate the Constitution.** [Emphasis added.]

(c) Legal system

5.78 In response to a specific question on whether “the traditional common law system is still the most appropriate response to dealing with medical negligence in the current environment” in Issue Paper 33, some respondents expressed support for the common law system,¹⁵⁶ while others feel it is time for a change to our legal system.¹⁵⁷ Some respondents consider the common law “once and for all” rule as problematic and suggest that the rule should be reviewed.¹⁵⁸ The MPS response to Issue Paper 33 is critical of the adversarial system, since parties are “unwilling to ‘disclose their hand’ until obliged to by court rules”.¹⁵⁹ A few respondents think that the inquisitorial system would be preferable to the current South African adversarial system,¹⁶⁰ while other respondents would like to see aspects of the inquisitorial system incorporated into the SA system.¹⁶¹ Many criticise the current system of legal representation and the conduct of lawyers with regard to practices such as touting.¹⁶² SASA advocate training of lawyers and court officials on medical law and health-related matters.¹⁶³ SASS remarked on costs: “We are concerned about the fact that the cost of health care has escalated, especially in the

¹⁵⁶ IP 33 respondents: General Council of the Bar; SAMA; Scarf. The GCB and SAMA express satisfaction with the common law system, but suggest that changes to civil procedure should be considered [GCB 2; SAMA 4]. The Western Cape DOH consider the common law as the best system, but believe that the system is being abused [WC DOH re par 6.3].

¹⁵⁷ IP 33 respondents: Dalmeyer; GMG; SASA. Dalmeyer refers to the case of *AD & IB v MEC Health and Social Development, Western Cape* (on quantum only) that spanned 49 court days, involved 12 legal counsel and entailed 5 necessary witnesses and 37 expert witnesses, one of whom was flown in from California, USA.

¹⁵⁸ IP 33 respondents: GunnClark; Netcare; Van der Merwe.

¹⁵⁹ IP 33 respondent: MPS *IP 33 Response 2–3*.

¹⁶⁰ IP 33 respondents: Kaseke; SAMA; SASA; SASS.

¹⁶¹ IP 33 respondents: SAMLA is highly critical of the adversarial system, saying that it is too formalistic and time-consuming, open communication between litigants is discouraged and there is little prospect of an early settlement, among others [SAMLA 6–9]. Scarf suggest that the opinion of qualified medical expert witnesses should be heard more fully as statements, rather than by examination in chief, cross examination and re-examination [Scarf 2].

¹⁶² IP 33 respondents: Clinix; Dalmeyer; SASA; SASS.

¹⁶³ IP 33 respondent: SASA [SASA (unpaged) item 4 question 7].

private sector as many expensive special investigations are conducted, which are often unnecessary as the treating doctors are forced to practise defensive medicine.”¹⁶⁴

(d) Quantum hearing for lump sum payment

5.79 The matter of *AD & IB v MEC Health and Social Development, Western Cape*¹⁶⁵ serves as an excellent illustration of the complexities of determining the quantum for a lump sum payment in a matter involving a young child. The parents of the child IDT instituted action on the basis of medical negligence in the Western Cape High Court in Cape Town. The child IDT had suffered brain damage within 10 days of his birth due to jaundice that was not treated timeously. The defendant had conceded merits, hence the trial dealt with quantum only.

5.80 Roger J summarised the extent of the documentation and witnesses gathered for this case:¹⁶⁶

- 1) The trial ran for 45 days from 16 February to 16 June 2016 and the judge heard argument over four days in August 2016, thus a total of 49 court days.
- 2) The plaintiff eventually engaged seven legal practitioners: one Johannesburg attorney, one attorney in Cape Town, three silks and two juniors.
- 3) The defendant engaged three legal practitioners: two silks and one junior.
- 4) The amicus curiae were represented by two counsel.
- 5) The transcript of oral evidence covers 4880 pages; the plaintiffs’ expert reports 947 pages; the defendant’s expert reports 388 pages; joint minutes of experts 72 pages; the pleadings, further particulars, pre-trial minutes, amendment application and other court documents 775 pages and the documentary exhibits over 1100 pages.
- 6) The plaintiffs served expert reports from 22 experts of whom 13 testified.
- 7) The defendant served expert reports from 15 experts of whom six testified.
- 8) In most instances the experts filed two and sometimes three reports.
- 9) Apart from the expert witnesses, five necessary witnesses were also involved.
- 10) An expert on life expectancy was flown in by business class from California, USA.

¹⁶⁴ IP 33 respondent: SASS [SASS (unpaged) re part F].

¹⁶⁵ *AD & IB v MEC Health and Social Development, Western Cape* (27427/10) [2017] ZAWCHC 17; 2017 (5) SA 134 (WCC) (1 March 2017).

¹⁶⁶ *AD & IB* pars 4 & 5.

5.81 The expert evidence heard in court went into the detail of how well the injured child could feed himself, the hourly rate he could have earned as an artisan and even what socks would be most suitable for him to wear. The bigger issue, on which the imported expert gave evidence, was the life expectancy of a seven year old boy suffering from athetoid cerebral palsy. Structured settlements that include the rendering of services for future medical care and periodic payments for other future expenses will be a much simpler calculation than calculating future health care and loss of earnings for nearly 50 years hence.

(e) Prescription

5.82 Several respondents commented on the effect of prescription on medico-legal claims, mostly with regard thereto that the completion of prescription is delayed for minors in terms of section 13(1) of the Prescription Act 68 of 1969.¹⁶⁷ Paul du Plessis Attorneys point out that the majority of claims are brought on behalf of cerebral palsy sufferers, who are often mentally disabled as well. Apart from minors, section 13(1) also delays the completion of prescription with regard to a person who is “insane” or under curatorship.¹⁶⁸ The SALRC has recently completed its investigation into Project 125: Prescription Periods. The final report is being considered by the Minister of Justice and Correctional Services, where after the report will be published. This investigation will await the publication of the final report on Project 125: Prescription Periods before making any proposals on the issue of prescription.

5.83 The judgment of the Constitutional Court in the matter of *Links v Department of Health, Northern [Cape] Province*¹⁶⁹ warrants mentioning. The applicant (Links) had instituted a claim against the respondent (the Northern Cape province) after his thumb had to be amputated and he lost function in his left arm due to the negligence of the province’s employees. The Court a quo dismissed his claim on the basis that his claim had prescribed.

5.84 Link’s thumb was amputated on 5 July 2006 due to plaster of paris that had been applied too tightly to his arm, causing ischemia (restriction of blood flow leading to oxygen starvation). He subsequently lost the use of his arm because of nerve damage.

¹⁶⁷ IP 33 respondents: Eastern Cape Treasury; National Treasury; Clinix; Dalmeyer; Mallory; Mullins; SAPPF.

¹⁶⁸ IP 33 respondent: Paul du Plessis Attorneys 7.

¹⁶⁹ *Links v Department of Health, Northern [Cape] Province* 2016 (4) SA 414 (CC).

His lawyers instituted action and summons was served on the respondent on 6 August 2009. The defendant raised a plea that the claim had prescribed because summons was served more than 3 years after the amputation of applicant's thumb.

5.85 The court found, on the facts, that the applicant did not know at the time of the operation why his thumb had to be amputated. By 6 August 2006 he still did not know why the amputation had been performed. This date is material to the plea in that the claim had purportedly prescribed because summons was served on 5 August 2009. The court stated that a person wishing to institute a claim of this nature would need to be aware of such a material fact.¹⁷⁰ The applicant would not have been able to establish the reason for the amputation without consulting a medical practitioner.¹⁷¹ In the words of Zondo J: "It seems to me that it would be unrealistic for the law to expect a litigant who has no knowledge of medicine to have knowledge of what caused his condition without having first had an opportunity of consulting a relevant medical professional or specialist for advice."¹⁷²

5.86 In a discussion of the *Links* case, Ditsela drew the following conclusion:¹⁷³

The implications of paras 47 to 49 is that in certain cases involving medical negligence matters, a claimant is entitled to first obtain independent medical advice in order for prescription to commence running in circumstances where the claimant is found not to have acquired knowledge of the 'facts'. In the absence of such independent medical advice, a claimant cannot be deemed to have had knowledge of the facts from which a debt arises. ... [T]he running of prescription in certain medical negligence cases may now involve obtaining medical advice from an expert on the 'facts' from which a claim arises insofar as a plaintiff may not have direct or constructive knowledge from other sources.

(f) Abuse of Contingency Fees Act

5.87 The respondents generally support the Contingency Fees Act 66 of 1997 (CFA), but some expressed disquiet about non-compliance with and abuse of the CFA, while

¹⁷⁰ *Links* par 46.

¹⁷¹ *Links* par 47.

¹⁷² *Links* par 47.

¹⁷³ Lekwalo Jones Ditsela "Time heals all wounds – the law of Prescription in medical negligence" *De Rebus* (February 2017) 30.

several respondents suggest that the CFA should be reviewed and amended.¹⁷⁴ Mallory is of the view that contingency fees should be banned.¹⁷⁵ A few respondents state that the “no win no fee” mantra is misleading, since advertising attorneys do not usually disclose that an unsuccessful plaintiff is liable for the costs of a successful defendant.¹⁷⁶ Bowmans Attorneys and Netcare advise that legal practitioners that take a matter on a contingency fee basis must be required to disclose that information, and that contingency fee agreements should be discoverable documents, while the Eastern Cape DOH suggest that contingency fee agreements should be disclosed.¹⁷⁷ EthiQal propose the addition of a disclaimer or caveat to advertisements to inform litigants that they may be held liable for the costs of the successful defendant should the claimant be unsuccessful.¹⁷⁸ Netcare suggested that it should be possible to join legal practitioners (who take matters on a contingency fee basis) to proceedings as an additional plaintiff for purposes of costs as a third party funder. They should also purchase an insurance policy for protection against an adverse costs order.¹⁷⁹ A worrying new trend is developing where persons or organisations who are not attorneys engage in litigation funding. Litigation funders do not have to comply with the CFA since they are not attorneys. These fee agreements are not subject to taxation or oversight by the courts; hence they can charge whatever portion of the compensation award that they agree upon with the plaintiff.¹⁸⁰ MPS also refer to the so-called “funding companies”, expressing concern about the fact that these companies “in many ways offer the same service a plaintiff lawyer would”, but are not regulated.¹⁸¹

(g) Compensation awards

5.88 The escalating size of compensation awards granted by the courts is a source of disquiet in both the public as well as the private health sectors, having the potential to cripple the health system. The cost of indemnity cover for medical practitioners is fast

¹⁷⁴ Oosthuizen & Carstens *Malpractice* 283; Wessels 8; IP 33 respondents: EC Treasury; KZN DOH; National Treasury; Bowmans; Dalmeyer; Discovery Health; EthiQal; GunnClark; Netcare; OTASA; Ric Martin Attorneys; SAMA; SAMLA; SAPPF; SASS; Scharf.

¹⁷⁵ IP 33 respondent: Mallory 1.

¹⁷⁶ IP 33 respondents: Bowmans; Camargue; EthiQal;

¹⁷⁷ Bowmans par 13.3; ECDOH 9; Netcare par 7.5.4.3.

¹⁷⁸ EthiQal propose wording along the lines of: “should you be unsuccessful you may be liable for the legal costs of the defendant”.

¹⁷⁹ IP 33 respondent: Netcare par 7.5.4.

¹⁸⁰ IP 33 respondents: Paul du Plessis Attorneys 6; Ric Martin Inc Attorneys 5.

¹⁸¹ MPS *Clinical Negligence* 25.

becoming unaffordable, leading to doctors practicing defensive medicine,¹⁸² desist from specialising in high-risk areas such as obstetrics and neuro-surgery, or leaving the profession.¹⁸³ Discovery Health is of the view that lump sum payments could serve as a perverse incentive for litigation on a contingency fee basis.¹⁸⁴

(h) Cerebral palsy

5.89 The consolidated general PFMA report for 2019-20 published by the Auditor-General registers concern about the increase in litigation against state departments, having flagged it in the 2019-20 report as an emerging risk for the third consecutive year. The report states that total claims against state departments amounted to R147,12 billion at the end of the 2019-2020 financial year. A staggering 72% of this liability originated from the provincial DOHs, adding up to R105,83 billion.¹⁸⁵ National Treasury requested the Clinton Health Access Initiative (CHAI) Health Financing team to investigate the medico-legal situation across the country. The resulting report presented an overview of the state of affairs up to the 2018/2019 financial year, based on qualitative and quantitative data obtained from the provincial DOHs.¹⁸⁶ The inference drawn from the data is that about 50% of all claims are cerebral palsy-type claims (birth asphyxia, neonatal encephalopathy, cerebral palsy), making up more than 60% of the liabilities in six out of the nine provinces.¹⁸⁷

5.90 There is a common misunderstanding that cerebral palsy is mostly caused by birth trauma. Medical negligence claims for babies with CP are often successful on the basis that the baby suffers from CP because the mother was not adequately monitored during birth and delivery by caesarean section was not performed in time, resulting in brain damage to the baby due to insufficient oxygen during the birth process. In medical terms it is referred to as acute intrapartum hypoxia due to birth asphyxia. Intrapartum

¹⁸² D Roytowski et al "Impressions of defensive medical practice and medical litigation among South African neurosurgeons" *SAMJ* 104:1 (11 November 2014) 736–738; IP 33 respondent: SASS (re F. General concerns).

¹⁸³ Howarth & Carstens 69–73; Howarth et al 752–753. IP 33 respondent: EthiQal par 38 & 39.

¹⁸⁴ IP 33 respondent: Discovery Health 5.

¹⁸⁵ Auditor-General of South Africa *Consolidated general report on national and provincial audit outcomes: PFMA 2019-20* at 60 (PFMA general report 2019-20).

¹⁸⁶ Clinton Health Access Initiative *Medico-Legal Claims Analysis for National Treasury* (December 2019) 3 [CHAI (2019)].

¹⁸⁷ CHAI (2019) 15.

means occurring during the act of birth,¹⁸⁸ hypoxia is a deficiency of oxygen reaching the tissues,¹⁸⁹ and asphyxia is a condition that arise when the body is deprived of oxygen.¹⁹⁰

5.91 A baby born under these conditions is said to be suffering from hypoxic ischemic encephalopathy (HIE), which “is a type of brain dysfunction that occurs when the brain doesn’t receive enough oxygen or blood flow for a period of time. Hypoxic means not enough oxygen; ischemic means not enough blood flow; and encephalopathy means brain disorder”.¹⁹¹ More recent research, however, suggests that the cause of neonatal encephalopathy, which is the terminology used currently to describe such babies, is not so simply explained. MacLennan, Thompson & Gecz reviewed research conducted about CP from 2014 onwards to update clinicians on the latest findings. They explain that there are many manifestations and causes of CP, and that CP incidence due to birth injury is actually quite low.¹⁹²

CP is a heterogeneous condition with multiple causes; multiple clinical types; multiple patterns of neuropathology on brain imaging; multiple associated developmental pathologies, such as intellectual disability, autism, epilepsy, and visual impairment; and more recently multiple rare pathogenic genetic variations (mutations). CP would be better named “the cerebral palsies” given that within the CP clinical spectrum there are many causal pathways and many types and degrees of disability. ... Only a small percentage of cases are associated solely with acute intrapartum hypoxia. Despite this, many cases are mislabeled as due to birth asphyxia. ... “Birth asphyxia” is an outdated term that may wrongly convey that a baby born with signs of fetal and neonatal compromise must have undergone an acute hypoxic event in late labor and/or birth. These clinical signs may also be present when there has been much longer-standing fetal compromise with possible secondary hypoxia near delivery. Similarly, the term “hypoxic ischemic encephalopathy” has been replaced by the term “neonatal encephalopathy” as the large majority of newborn infants showing signs of encephalopathy does not have objective proof of acute hypoxia or ischemia at birth, but have other causes of perinatal compromise such as infectious or genetic. Of note,

¹⁸⁸ Merriam-Webster Online Dictionary www.merriam-webster.com.

¹⁸⁹ SOED (2007).

¹⁹⁰ Merriam-Webster Online Dictionary www.merriam-webster.com.

¹⁹¹ University of California, San Francisco “Neonatal hypoxic ischemic encephalopathy” Bennioff Children’s Hospitals, (The Regents of the University of California 2020-2021) accessed 6 June 2021 www.ucsfbenioffchildrens.org/conditions/neonatal-hypoxic-ischemic-encephalopathy.

¹⁹² Alastair H. MacLennan, Suzanna C. Thompson & Jozef Gecz “Cerebral palsy: causes, pathways, and the role of genetic variants” *American Journal of Obstetrics & Gynecology* (December 2015) 779–788 at 779.

only 13% of term babies who exhibit neonatal encephalopathy are later diagnosed with CP.

5.92 The more modern term “neonatal encephalopathy” is described as follows:¹⁹³

[A] heterogeneous, clinically defined syndrome characterized by disturbed neurologic function in the earliest days of life in an infant born at or beyond 35 weeks of gestation, manifested by a reduced level of consciousness or seizures, often accompanied by difficulty with initiating and maintaining respiration, and by depression of tone and reflexes.

5.93 MacLennan, Thompson & Gecz compared the prevalence of CP births with the rise in caesarean deliveries over a period of fifty years. Although the rate of caesarean deliveries has increased steadily over time and are now six times higher than in the 1960s, the prevalence of CP births remained stable at about 2 to 2.5 births per 1000.¹⁹⁴ MacLennan et al sets out the “International consensus criteria to determine a severe acute hypoxic event as a potential cause of cerebral palsy”:¹⁹⁵

Essential criteria to show presence of hypoxia at birth are:

- 1) A metabolic acidosis at birth (pH <7.00 and Base Excess <-12).
- 2) Early moderate to severe neonatal encephalopathy.
- 3) Cerebral palsy of spastic quadriplegic or dyskinetic type.
- 4) Exclusion of other identifiable causes of cerebral palsy, for example, coagulation or genetic disorders, infectious conditions, intrapartum pyrexia, antepartum hemorrhage, prematurity, intrauterine growth restriction, tight nuchal cord, complications of multiple pregnancy.

Five nonspecific criteria collectively point toward acute or chronic causes of hypoxia. If most are met they suggest timing of neuropathology near delivery. If most are not met they suggest longer-standing pathological process. These criteria are:

- 5) Sentinel (signal) hypoxic event sufficient to cause sudden severe hypoxia in healthy fetus, eg, cord prolapse, antepartum hemorrhage, ruptured uterus.
- 6) Sudden sustained fetal heart rate bradycardia from that event.
- 7) Apgar score <4 after 5 min.
- 8) Signs of multisystem failure in neonate.
- 9) Early (within 5 d) neuroimaging signs of edema and intracranial hemorrhage.

¹⁹³ Yvonne Wu “Clinical features, diagnosis, and treatment of neonatal encephalopathy” *UpToDate* (15 March 2021) www.uptodate.com/contents/clinical-features-diagnosis-and-treatment-of-neonatal-encephalopathy.

¹⁹⁴ MacLennan, Thompson & Gecz 781.

¹⁹⁵ MacLennan, Thompson & Gecz 780.

5.94 The USA research is supported by eminent South African experts. Bhorat et al caution against oversimplifying the causes of CP, especially in medico-legal cases before the courts:¹⁹⁶

High-value claims against obstetricians in litigation in both the public and private sectors are mostly related to cerebral palsy (CP) cases on the basis of intrapartum hypoxia resulting in neonatal encephalopathy (NE) and, by extension, invoking ‘negligent intrapartum care’. This development has resulted in steep rises in insurance premiums, placing service delivery under serious threat. It is widely assumed that CP is the direct result of an adverse event at birth and that it could have been prevented, yet only 10 – 14% of CP instances are caused by intrapartum hypoxia. Clinical epidemiological studies have shown that most CP cases are not related to intrapartum hypoxia. ... Numerous risk factors and causes are associated with CP. We need to be careful not to oversimplify CP, which involves complex pathophysiological processes, often juxtaposed on possible priming of the fetal brain on sometimes undetected antenatal insults.

5.95 Bhorat et al refer to the nine criteria developed in 2014 by the USA Cerebral Palsy Expert Task Force,¹⁹⁷ (also referred to by MacLennan, Thompson & Gecz) that can be applied to assist with the determination of whether an acute hypoxic-ischaemic¹⁹⁸ event occurred during labour and delivery. The writers accepted these criteria, adding one additional criterium – placental histology – to expand the list to 10 criteria.¹⁹⁹ The writers “offer the 10 criteria set out in this document to assist in implicating intrapartum hypoxia-ischaemia in neonatal encephalopathy as a guideline in the medico-legal setting”:²⁰⁰ The criteria are summarised below:²⁰¹

¹⁹⁶ Ismail Bhorat et al “Cerebral palsy and criteria implicating intrapartum hypoxia in neonatal encephalopathy – an obstetric perspective for the South African setting” *SAMJ* (March 2021) 111:3 (Suppl 1278.) 277–279 at 277.

¹⁹⁷ The task force included the American College of Obstetrics and Gynaecology and the American Academy of Paediatrics.

¹⁹⁸ The term “ischaemic” is derived from “ischemia”, which is “what happens when there is a decrease in blood supply to tissues, leading to a decrease in oxygen and nutrients to the affected area” (Topdoctors United Kingdom “Ischemia” accessed 1 October 2021) www.topdoctors.co.uk/medical-dictionary/ischaemia).

¹⁹⁹ Bhorat et al 278.

²⁰⁰ Bhorat et al 278 “Conclusion”.

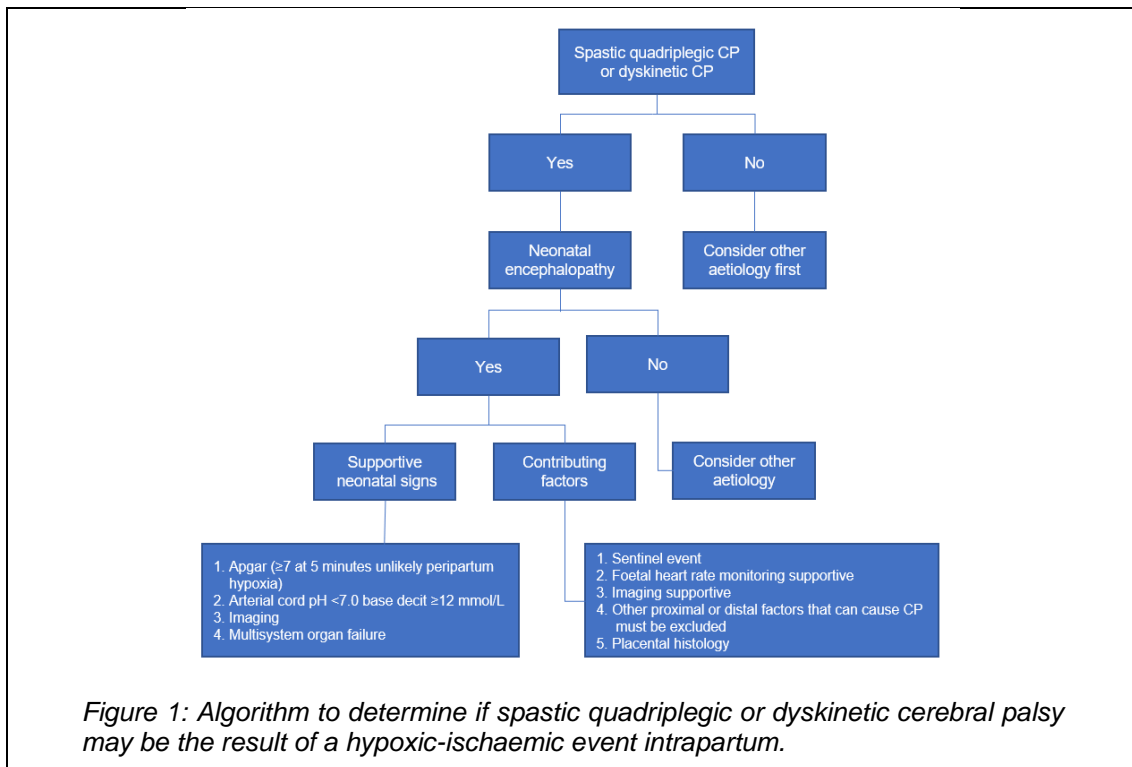
²⁰¹ Summary of ten criteria as set out and explained by Bhorat et al 278. The information in square brackets was added by the researcher for the sake of clarity.

- 1) **Case definition:** “Neonatal encephalopathy is a clinically defined syndrome of disturbed neurological function in the earliest days of life in an infant born at or beyond 35 weeks’ gestation.”
- 2) **Apgar score:** low Apgar scores at 5 and 10 minutes after birth could be suggestive of intrapartum asphyxia. It must be borne in mind that it is a subjective assessment that does not always correlate with other clinical information. Most babies with low Apgar scores do not develop CP.
- 3) **Cord pH:** Bhorat et al explains that “[f]etal umbilical artery pH <7.0, and/or base deficit ≥ 12 mmol/L, increases the probability that neonatal encephalopathy is the result of an intrapartum hypoxic event; **however, cord blood testing is often not done.**”²⁰² [The expression “intrapartum hypoxic” refers to lack of oxygen during labour.]
- 4) **Multi-system organ failure:** the probability of hypoxic ischaemic injury is increased if a new-born infant suffered brain damage as well as organ failure [“hypoxic” refers to lack of oxygen, “ischaemic” refers to reduced blood flow].
- 5) **Intrapartum sentinel events:** examples of sentinel events during labour is *abruptio placentae* [placenta detaches from womb before delivery of baby], ruptured uterus and cord prolapse, as well as sudden-onset foetal bradycardia [low heart rate] of unknown cause.
- 6) **Foetal heart rate monitor patterns:** tracing of the foetal heart rate by a cardiotocography (CTG) machine could assist if combined with other clinical findings. Bhorat et al caution that the interpretation of CTG tracings is subjective and open to differing opinions, even among experts.
- 7) **Neuroimaging studies:** magnetic resonance imaging (MRI) is of value if performed at the right time, or otherwise in conjunction with other information. Bhorat et al state:

If the child’s MRI is performed beyond three weeks of life, it cannot on its own delineate if the injury occurred during labour. Imaging abnormalities need to be correlated with the known sequence of events during pregnancy, childbirth and infancy. In SA, MRIs are mostly performed later in childhood, but may still be of value as long as there is clinical correlation.
- 8) **Evidence of other proximal or distal factors:** There is evidence that some babies may be more vulnerable to oxygen deficiency while the mother is in labour because of factors present during pregnancy.

- 9) **Developmental outcome:** There are different types of CP, but according to Bhorat et al “CP of the spastic quadriplegic or dyskinetic type is consistent with the possibility of hypoxic-ischaemic brain injury.”
- 10) **Placental histology:** An examination of the placenta could reveal abnormalities that affect the health of the foetus [tenth criterium added by Bhorat et al].

5.96 Figure 1 provides a graphic illustration of the application of the criteria discussed above.²⁰³



5.97 Bhorat et al concludes:²⁰⁴

Taking into consideration antenatal factors and fetal priming, it is simplistic to base causation of CP on only an intrapartum perspective with radiological ‘confirmation’, as is often the practice in medico-legal cases in SA courts. CP is a complex medical condition with numerous contributing variables and factors, and causal pathways are often difficult to delineate. **Medico-legal cases involving CP in SA courts are mainly judged on MRI and CTG findings to assess causation and liability. These two modalities that retrospectively attempt to determine causation in courts are inadequate when used in isolation.** Unless a holistic scientific review of the case including contributing clinical factors

²⁰³ Figure 1 duplicated from Bhorat et al 278.

²⁰⁴ Bhorat et al 278.

(antepartum, intrapartum and neonatal), fetal heart rate monitoring, MRI, and placental histology is carefully considered, success for the plaintiff or defendant in a court of law will depend on eloquent legal argument rather than true scientific causality. [Emphasis added.]

5.98 Sartwelle & Johnston are highly critical of the importance ascribed to electronic foetal monitoring. They cite the International Cerebral Palsy Task Force Report published in 1999, and the American College of Obstetricians and Gynecologists – American Academy of Pediatrics Cerebral Palsy Consensus Statement published in 2003, indicating that both these documents “acknowledged that electronic fetal monitoring does not predict cerebral palsy, does not prevent cerebral palsy, and that retrospective electronic fetal monitoring reanalysis with a known outcome was highly biased”.²⁰⁵ Sartwelle and Johnston explain the misconceptions that CTG evidence create in court cases.²⁰⁶

The cardinal driver of birth injury cerebral palsy claims was and is electronic fetal monitoring. It is the cornerstone of all birth injury lawsuits. Electronic fetal monitoring precipitated, nurtured, and continues to be the primary cudgel against defendant physicians in the world’s courtrooms. But electronic fetal monitoring is based on 19th-century childbirth myths. Its scientific foundation is almost nonexistent. Its false positive rate exceeds 99%. It does not predict cerebral palsy. After 40 years of continuous use and supposed improvements, electronic fetal monitoring has not reduced the cerebral palsy risk. It has, however, increased the cesarian section rate.

5.99 Blickstein considered the criteria on the link between hypoxic injury and cerebral palsy during childbirth. He explains that “only cerebral palsy involving spastic quadriplegia is associated with an acute interruption of the blood supply [and] purely dyskinetic or ataxic cerebral palsy generally is genetic in origin”.²⁰⁷ Blickstein expressed reservations about electronic foetal monitoring more than a decade before Sartwelle & Johnston.²⁰⁸

Prompt cesarean section in cases of nonreassuring fetal heart-rate pattern does not decrease the rate of intrapartum brain damage. Nor has

²⁰⁵ Thomas P Sartwelle & James C Johnston “Cerebral Palsy Litigation: Change Course or Abandon Ship” *Journal of Child Neurology* (2015) 30:7 828-841 at 831.

²⁰⁶ Sartwelle & Johnston 828.

²⁰⁷ Isaac Blickstein “Cerebral palsy: A look at etiology and new task force conclusion” *OBG Management* (May 2003) 40–50 at 41.

²⁰⁸ Blickstein 49.

the implementation of electronic fetal monitoring during labor changed the incidence of cerebral palsy – mainly because such monitoring has an extremely high false-positive rate.

5.100 Whittaker conducted an in-depth study of medical malpractice in the South African public sector, which was published by the Actuarial Society of South Africa.²⁰⁹ This up-to-date study provides valuable insights into the current medico-legal situation, considering the magnitude of the problem, audit and inspection reports, the basis for state liability, litigation processes, contingent liabilities and medical negligence claims payments by provinces, the reasons for medical malpractice claims, data collection, actuarial claims and the goals of medical malpractice systems.²¹⁰

5.101 Whittaker provides an analysis of court judgments in matters involving the provincial DOHs, focusing on the element of causation in medical negligence judgments in particular. He highlights two issues that may have a significant impact on the outcome of a medical negligence case, but demonstrates that these issues are seldom raised. Birth weight, although a known risk factor for developing cerebral palsy, was not indicated in 59 out of 81 cerebral palsy judgments studied. There are several risk factors that may increase the possibility of developing CP and that are within the mother's control, yet arguing contributory negligence to achieve an apportionment of damages was even less prevalent.²¹¹

5.102 In light thereof that the majority of claims against the state are premised on alleged negligent treatment causing cerebral palsy (in terms of net worth as well as number of claims), Whittaker offers a comprehensive overview of medical literature on cerebral palsy, detailing the risk factors that increase the possibility of developing CP. These risk factors are the following:²¹²

- 1) maternal obesity
- 2) maternal alcohol consumption and smoking
- 3) maternal thyroid disorder
- 4) infections

²⁰⁹ Gregory Whittaker *Medical Malpractice in the South African Public Sector* (Actuarial Society of South Africa 2021).

²¹⁰ Whittaker Chapter 2.

²¹¹ Whittaker 46.

²¹² Whittaker 55–60.

- 5) gestational age²¹³
- 6) low birthweight
- 7) lack of prenatal care
- 8) multiple births
- 9) intrauterine growth restriction (IUGR)
- 10) tight/entangled umbilical cord.

5.103 The single biggest risk factor for CP is gestational age, with birth weight in the second place.²¹⁴ The likelihood of a premature baby developing CP is up to 30 times higher,²¹⁵ while babies with a very low birth weight are up to 24 times more likely to develop CP.²¹⁶ Other risk factors include:²¹⁷

- 1) history of another relative with CP;
- 2) bleeding during pregnancy;
- 3) illicit drug use;
- 4) mothers having three or more previous miscarriages;
- 5) hypertension in pregnancy;
- 6) instrumental deliveries (as opposed to spontaneous vaginal or elective caesarean deliveries) and breech delivery;
- 7) low maternal age (younger than 20 years) and advanced maternal age (older than 35 years);
- 8) intellectual disability and seizures present in the mother;
- 9) short or long interpregnancy interval; and
- 10) infertility treatment.

5.104 The outdated belief that CP is caused by asphyxia during labour or the perinatal period²¹⁸ is unfortunately still prevalent today. We now know that CP is rather the result

²¹³ “‘Gestational’ the length of time for which an embryo or fetus has been developing in the womb’ [SOED 2007].

²¹⁴ MacLennan et al 781.

²¹⁵ MacLennan et al 781.

²¹⁶ Whittaker 55.

²¹⁷ Whittaker 60.

²¹⁸ The period just before and just after birth.

of a series of events, as opposed to a single occurrence.²¹⁹ Ellenberg and Nelson cautions against drawing conclusions on insufficient facts:²²⁰

The current data do not support the belief, widely held in the medical and legal communities, that birth asphyxia can be recognized reliably and specifically on the basis of clinical signs such as aberrant fetal heart rate patterns, Apgar scores, respiratory depression, neonatal seizures, or acidosis, or that most CP is due to birth asphyxia.

...

Although not optimal, the best identifier now available at a population level for asphyxial birth is the occurrence of sentinel events such as uterine rupture, major placental abruption, or cord prolapse.

...

The ultimate demonstration of an asphyxial etiology of CP would be that an intervention designed to improve oxygenation of the fetus during birth results in a decrease in CP. To date there has been no such evidence.

5.105 It has become almost standard practice to consider cardiotocography (CTG) monitoring during the trial: the courts have ruminated on the frequency or infrequency of conducting monitoring, the disappearance of the CTG tracing print-outs from the file, interpretation of the tracing print-outs, and so forth. A CTG machine monitors the baby's heart rate and the mother's uterine contractions, tracing the information on strips of paper that are printed out and filed. The notion underpinning CTG monitoring is that the tracings may reveal that a baby is in distress, necessitating expedited delivery by caesarean section or by forceps. CTG monitoring, also referred to as electronic foetal monitoring, is unfortunately not an exact science. Once promoted as the magic wand that will drastically reduce the incidence of cerebral palsy, mental retardation and babies dying during labour, some question whether CTG monitoring hold any real advantages.

5.106 The Gynaecology Management Group (GMG),²²¹ in their submission in response to Issue Paper 33, affirmed that "cerebral palsy is a heterogeneous condition with multiple causes and many clinical types and multiple patterns of neuropathology, most of which are not caused by a hypoxic ischaemic injury sustained during labour. The retrospective use in Court of cardiotocographic (CTG) evidence in cases in which the

²¹⁹ Whittaker 61.

²²⁰ Jonas H Ellenberg & Karin B Nelson "The association of cerebral palsy with birth asphyxia: a definitional quagmire" *Developmental Medicine & Child Neurology* 210–216 at 215 DOI: 10.1111/dmnc.12016.

²²¹ The Gynaecology Management Group Ltd (GMG), a practice management entity and sister-organisation of the South African Society of Obstetrics and Gynaecology.

outcome (cerebral palsy) is known has unjustly resulted in many innocent caregivers being unfairly blamed for an outcome that was not of their making"²²² GMG goes so far as stating that CTG evidence is junk science that should not be allowed in court.²²³ Given the high prevalence of CP litigation, the detrimental impact of the enormous pay-outs on the fiscus and the knock-on effect on the delivery of health care services, the state will be well-served by getting the science right when defending a matter of this nature.

4 Submissions from government institutions and officials

(a) *National Treasury and provincial treasuries*

5.107 The SALRC received submissions from National Treasury and the provincial Treasuries of Eastern Cape, KwaZulu-Natal and North West. National Treasury provided figures and trends on the massive rise in medical malpractice litigations, indicating that actual payments have increased by 45% per year on average. National Treasury sounds the alarm with regard to the possible impact on the health sector of the ever-increasing risk posed by medico-legal litigation:²²⁴

If this trend continues, it will pose a serious threat to the provision of medical services, the financial viability of provincial departments of health and the availability of specialists in key disciplines in the health profession, both in the public and private sector.

5.108 While National Treasury acknowledge the need to improve the quality of public health care and recognises the challenges experienced by the sector, they contend that the increase in medico-legal litigation is not in line with known medical malpractice and negligence trends, pointing to additional issues. National Treasury question the state's capacity to properly dispute and defend claims, citing the active pursuit of claimants by malpractice attorneys as a factor contributing to the increase in claims.²²⁵

5.109 National Treasury point to poor health service delivery as a major concern, referring to challenges such as shortage or maldistribution of human resources, medical equipment, medicines and other supplies; constrained budgets; bad attitudes and poor

²²² IP 33 respondent: GMG 3.

²²³ IP 33 respondent: GMG 3.

²²⁴ National Treasury par 1.

²²⁵ National Treasury par 2.

communication from health care staff; and the growing wage bill that has brought about budget pressures on essential goods and services items.²²⁶ Yet, there is a disparity between the phenomenal rise in medical malpractice claims and the generally improved health outlooks for South Africans, such as a longer average life expectancy and lower maternal and infant mortality rates.²²⁷

5.110 National Treasury is troubled by the track record of poor record keeping and management, especially considering the importance of patient records when mounting a defence to a medical negligence claim. Inadequate legal capacity at the provincial DOHs is another source of disquiet, as defensible cases may have been lost due to lack of capacity and poor preparation.²²⁸ National Treasury support measures such as periodic payments, capping of some damages awards, reforming the Contingency Fees Act (see paragraphs 9.105 & 9.106), and reviewing the statute of limitations in respect of minors (see paragraph 5.82). They proposed the establishment of a national medico-legal claims tribunal or authority to adjudicate claims. In view of the proposals put forward in Chapter 9, however, the creation of a special tribunal is not supported at this stage, but other suggestions made by National Treasury is discussed in Chapter 9.

5.111 National Treasury and the Eastern Cape Treasury both support contracting legal support from the private sector, referring to Mpumalanga's success in reducing their medico-legal claims costs by nearly R270 million by using specialist teams to investigate claims and mediate prior to going to court.²²⁹ Provincial DOHs are already empowered to utilise external expertise under current legislation and prescripts, hence legislative reform is not required for this purpose. The researcher was informed that the Eastern Cape province also employed private legal practitioners to assist them to deal with medico-legal claims. However, it is contended that utilising private legal expertise is a short to medium-term solution that can be quite expensive in the long term. The establishment of medico-legal units within provincial DOHs with suitably qualified and experienced legal and medical practitioners will achieve the same outcome, while these units can still use external expertise as and when necessary. There is an existing successful model that has been functioning in this manner for quite some time now in

²²⁶ National Treasury par 13.

²²⁷ National Treasury par 14.

²²⁸ National Treasury pars 15 & 16.

²²⁹ Eastern Cape Treasury 2; National Treasury par 24(c).

the Western Cape. It must be reiterated that the appointment of capable and suitably qualified persons in such units is critical to the success thereof.

5.112 The provincial treasuries of KwaZulu-Natal and North West both highlight the importance of proper record keeping and the part that poor record keeping practices play in the rise in medico-legal litigation.²³⁰ Proposals about record keeping is dealt with in more detail in Chapter 9. The KZN Treasury remarks that a patient complaints system as well as reporting and investigation of adverse events are required under existing prescripts. The relevant prescripts and guidelines are listed in Chapter 3. The KZN Treasury however points out the flaw in the system: the measures are poorly implemented.²³¹ North West Treasury refers to other problems such as the lack of transport for medical services, inadequate supervision and poor management.²³²

(b) Provincial departments of health

5.113 The provincial departments of health of the Eastern Cape, Free State, Gauteng, KwaZulu-Natal and Western Cape made submissions in response to Issue Paper 33. Only certain aspects are highlighted here, since remarks that pertain to topics covered above and in Chapter 9 are referenced where relevant.

5.114 The Eastern Cape DOH (EC DOH) propose an amendment to the NHA with regard to the disclosure of health records / health information. The EC DOH further propose that it should be possible to recover costs from attorneys for frivolous litigation. They support the recognition of the public health care defence and provision of health care services and medical supplies in public health care facilities in lieu of lump sum payments. They are in favour of periodic payments and a designated budget for structured settlements, but question whether the state has the capacity to manage periodic payments. They propose the possible establishment of a separate entity to deal with periodic payments.

5.115 The EC DOH contends that the provision of health care services in public hospitals will hold certain additional advantages:²³³

²³⁰ KZN Treasury 1; NW Treasury 1.

²³¹ KZN Treasury 2.

²³² NW Treasury 1.

²³³ EC DOH 7.

- 1) create an incentive to improve standards in public health care facilities;
- 2) allow for the benefit of economies of scale (eg for obtaining medicines, medical supplies, assistive devices etc);
- 3) optimise allocation of scarce health resources;
- 4) a court order directing provision of public health care services ensures a right on the part of a disabled child to the full range of required services and equipment for the rest of the child's life.

5.116 On a practical level, they propose that, in addition to the usual clinical notes made by medical staff, a "scribbler" should accompany medical teams while doing rounds to take notes, or that medical staff be equipped with encrypted devices linked to a central data base to make recordings. Interventions such as these would not require legislative reform, but it might be viewed as a breach of a person's right to privacy to be recorded during a medical consultation and examination, or to have another person present taking notes, unless permission is expressly sought and granted.

5.117 The Free State DOH suggest the creation of a state-run insurance fund, referring to SASRIA (the government-initiated insurer for special risk insurance) as an example. They suggest compulsory mediation and, if mediation fails, referral to a special tribunal that will determine liability. The Gauteng Province DOH (GP DOH) are strongly in support of the provision of undertakings to pay service providers, or the rendering of services for future medical care; rather than making lump sum payments. They refer to the provisions of the RAF Act by way of example. The GP DOH suggest that a fund could be established for making payments.

5.118 The KwaZulu-Natal DOH (KZN DOH) out that the State Attorney's office seldom tries to recover costs after cases that were successfully defended by the DOH.²³⁴ They are in favour of mediation, proposing that points costs orders could be used to make sure that parties attempt mediation. They caution that mediation is not free and has to be paid for.²³⁵ The KZN DOH supports structured settlements, suggesting that **the rendering of health care services need not be limited to public hospitals since provincial DOHs can enter into fee agreements with private hospitals.**²³⁶

²³⁴ KZN DOH 3.

²³⁵ KZN DOH 4.

²³⁶ KZN DOH 5.

5.119 The Western Cape DOH (WC DOH) support joint expert witnesses. They recount their experience of matters pertaining to birth injury or injury suffered by young children where the department has conceded the merits, meaning that the court case then only has to deal with quantum. The current practice, however, is for the plaintiff to engage between 20 and 30 experts on merits. The defendant then has to engage a similar number of rebuttal experts. A negotiated settlement can only be attempted once the between 20 and 30 pairs of experts have finalised the joint minutes. The matter of *AD & IB v MEC Health and Social Development, Western Cape*²³⁷ discussed in paragraphs 5.79 to 5.81 is a case in point.

5.120 The WC DOH remark on the high number of spurious claims against health providers, putting it at 75%. This is indicative of lawyers over-exploiting the easier access to justice made possible by the Contingency Fees Act. They propose that periodic payments should be considered for high value claims only because of the expected administrative burden it will create. They express disquiet about some injury specialists whose reports seem to focus on increasing the quantum rather than providing a realistic view of the plaintiff's future care and prospects.

(c) State attorneys

5.121 Two state attorney's offices, Bloemfontein and Pretoria, responded to Issue Paper 33. Ian Gough from the State Attorney, Bloemfontein and Sybrand Botes from the State Attorney, Pretoria prepared and submitted comprehensive responses to the issues raised in Issue Paper 33. Gough also sent a wealth of additional material relating to medico-legal claims. Only certain aspects are highlighted here, since remarks that pertain to topics covered above and in Chapter 9 are referenced where relevant.

5.122 Both respondents point to the serious shortage of staff in the State Attorney's offices and the heavy workload that each state attorney has to deal with, while the office also has to contend with budget constraints. Litigation against the state has increased exponentially over the last few years, with no commensurate increase in staff numbers. People leave, posts are not filled, increasing the burden on the remaining attorneys. The

²³⁷ *AD & IB v MEC Health and Social Development, Western Cape* (27427/10) [2017] ZAWCHC 17; 2017 (5) SA 134 (WCC) (1 March 2017).

state attorneys are overwhelmed by the number of medical negligence matters that they receive, especially cerebral palsy matters.²³⁸

(i) *State Attorney, Bloemfontein*

5.123 Gough explains that state attorneys are mostly generalist lawyers with some areas of specialisation. Lawyers that institute action against the state can be divided into three categories: first, the chancers; second, generalists who deal with medical malpractice or personal injury as part of their practice; and third, specialist attorneys who only deal with personal injury and medical malpractice. Some specialist attorneys specialise even further, for example focusing only on cerebral palsy matters. The specialists tend to be selective about the cases that they take on, limiting the number of cases to a few cases a year that they are sure will succeed. They read medical reports as well as a medical practitioners and often employ experienced nurses and midwives to screen potential claimants. They use experts that specialise in examining plaintiffs and writing medical reports.

5.124 The state attorneys find it difficult to engage experts, as the medical specialists available to them are usually in practice or lecture at academic institutions or both, who have to fit this work in with their other duties. By the time proceedings are instituted the plaintiff has had ample time to prepare, while the defendant is left with very little time to mount a defence. It is very difficult for the under-resourced state attorney's office to succeed on the merits against claims brought by these specialist attorneys.²³⁹

5.125 Gough indicates the Bloemfontein office's support for mediation, but states that mediation requirements and procedures should be prescribed, including the scope of mediation (quantum or merit or both), information to be exchanged, the procedure after failed mediation, for example, arbitration, adjudication or appeal. Even if mediation of the main dispute is unsuccessful, there could be agreement on certain issues, which would then not have to be adjudicated by the court. Resolution by mediation can also provide for broader settlement terms, such as an apology. With regard to training of mediators, Gough refers to the example of the one year course required for mediators in the construction industry. Training should cover mediation methods, handling of disputes and relevant legal principles.

²³⁸ State Attorney Bloemfontein 7; State Attorney Pretoria 13.

²³⁹ State Attorney Bloemfontein 8.

5.126 Gough refers to the problems caused by poor record keeping and inadequate records. He suggests that the state can learn from the insurance industry about dealing with claims. He also proposes that, when the establishment of a trust is proposed for a plaintiff's compensation, the trust instrument should be disclosed to the defendant. There should be proper oversight of trusts created for young children. Gough support the appointment of assessors in court cases to assist and report to the court. He indicates that only a small number of persons who suffer damages as a result of negligence of medical staff institute a claim.

(ii) State Attorney, Pretoria

5.127 Botes describes the long-standing problems caused by inadequate record keeping and poor records, indicating that poor and incomplete records could render a claim indefensible.²⁴⁰ Apart from criminal prosecution of an unauthorised person accessing or removing health records or parts thereof, a patient that remove his or her own file should also be criminally charged. Understaffing of public health establishments is a huge problem. In the experience of the state attorneys understaffing contributes to many potential medico-legal claims. The extent of understaffing in the provincial legal sections is equally problematic, causing delays in obtaining information and instructions from provinces.

5.128 Botes points out that there are challenges with regard to the guardian's fund administered by the Master's Office. The Master of the high court would require a budget and competencies similar to running a beneficiary trust or retirement fund if the fund is to be managed in that manner. The fund does not have trustees that could be held accountable on the basis of legally enforceable fiduciary duties. The measures available under the PFMA do not address liability issues adequately.

(d) Submission from former state employee

5.129 Ms Trudy Kaseke, a professional nurse and qualified attorney who had been employed in both capacities in the public and private sectors and was a compliance

²⁴⁰ This was the case in the matter of *Khoza v MEC Health, Gauteng* (2012/20087) [2015] ZAGPJHC 15; 2015 (3) SA 266 (GJ); [2015] 2 All SA 598 (GJ) (6 February 2015), which Botes refers to in the submission of the State Attorney, Pretoria.

inspector at the OHSC, made a submission based on her work experience.²⁴¹ She highlighted the following challenges in the public health sector:

- 1) Poor public health care services.
- 2) Health care authorities that are in denial with regard to the failures of the health care system, resorting to pointing fingers at other professions, especially lawyers.
- 3) Health care authorities' lack of understanding of relevant legislation.
- 4) Failure to prioritise medical negligence solutions.
- 5) Defending cases that should be settled.

5.130 Poor health service delivery is caused by systems failures and human failures. Systems failures require intervention by health care authorities from national government, the persons responsible for planning health care delivery for the whole country, and the persons in charge of health care in the provinces and local government. Human failures require in-house solutions like introspection, change of attitude, training, good management and leadership.

5.131 The rise in patient numbers and the lack of planning on how to deal with the increased patient numbers impose a burden on health system resources, resulting in poor health care. South Africa still has a large rural population. Many rural areas have no private hospitals or private medical practitioners, or the available private health care is too expensive. The vast majority of South African citizens can only access health care services at state clinics and state hospitals.

5.132 Access to health care is often difficult due to distance from health establishments, lack of transport, inability to take time off etc. This can lead to delayed medical attention, resulting in complications setting in, creating a potential for negligence claims. Poor referral systems, from primary health care to the next level of care, cause undue delays and lead to sub-standard care. Poor referral systems are linked to inadequate emergency services/ ambulances. Sometimes roadworthy ambulances are gathering dust in government service garages. However, government has not intervened to deal with this common problem.

5.133 Nurses are considered to be the backbone of the health system. Health care standards dropped when nursing training colleges were closed after 1994. No action was

²⁴¹ Ms Kaseke is one of the advisory committee members for this investigation.

taken when highly experienced nurses and nursing trainers were lured to other countries, resulting in a brain drain. The shortage caused by the brain drain has never been addressed. Human resources planning should be prioritised. Some provinces over-produce nurses, while others do not train enough nurses to supply the demand. With the disease burden increasing throughout the country, quality training and producing adequate numbers of healthcare professionals should be prioritised.

5.134 Working conditions for nurses have deteriorated drastically because of staff shortages, yet there is an ever-increasing influx of patients. Many public sector nurses went to the private sector, or left the health sector, often out of sheer frustration with their working conditions. Trainee nurses in the public sector are no longer exposed to night duty and weekend work (which trainee nurses performed in the past under supervision of senior nurses), meaning that they struggle to cope with night duty and weekend work once they qualify, often resorting to absenteeism.

5.135 There should be more focus on learning from adverse events to avoid the same mistakes in future, especially in health establishments with high incidences of events leading to medico-legal litigation. Not enough attention is paid to patient safety. The current level of litigation does not reflect the actual number of avoidable adverse events, since only a small number of adverse events result in medico-legal litigation. Health authorities do not understand constitutional health care rights and statutory consumer protection.

5.136 The government does not prioritise implementing existing medical negligence solutions, preferring to blame lawyers and the Contingency Fees Act for the health care crisis. Health authorities should do some introspection, improve their own systems and improve patient safety strategies at all levels of care. Poor coordination between different healthcare units/ divisions cause unnecessary delays, for example between trauma units and dispatchers of emergency medical services.

5.137 The Quality Unit in the NDOH is under-resourced and under-staffed, suffering from a lack of leadership. Provinces do not know who at NDOH to approach to assist with setting up and improving quality standards. The OHSC started inspecting institutions in 2011, but inspections are not addressing the problems. Compliance inspectors inspect facilities, point out problems, report problems to the relevant health authorities, make recommendations to remedy identified defects, only to return to the facility a few months later to find that nothing has changed.

5.138 Consequence management is a foreign term in the health care system. There is a lack of coordination between what is happening on the ground and what appears on paper. Failure to comply with health legislation contributes to the enormous increase in medical negligence litigation, yet health authorities seem to believe that scrapping the human rights that underpin legislation like the Contingency Fees Act will stop the rise in litigation. The NDOH fails to give guidance and direction on policies that are critical to ensuring quality care and promoting patient safety. Provinces are left to use their own discretion when implementing cross-cutting policies without oversight from NDOH.

5.139 Some state legal advisors and state attorneys have an obsession to defend each and every case, regardless of the evidence. Complaints are poorly investigated with no serious attempts made at linking the allegations to the clinical record, and no attempts made at early settlement of cases even in the face of obvious negligence. The unnecessary litigation lead to a huge amount of state money wasted. Lawyers exploit the state's weakness in dealing with the causes of medical negligence and its weakness in handling cases.

D Reports by constitutional and legal institutions

5.140 Section 181(1) of the Constitution establishes state institutions to strengthen democracy in South Africa, commonly referred to as the Chapter Nine institutions. Three of the institutions – the Public Protector, South African Human Rights Commission and Auditor-General – have published reports that pertain to the public health system or that include information on the public health system.

5.141 The SAHRC was the first Chapter 9 institution to release a report, which was published in 2003. The most recent reports were published by the Public Protector on 1 October 2021, continuing a series of reports released subsequent to investigations as an own initiative intervention in terms of section 6(4) of the Public Protector Act 23 of 1994. The Auditor-General publish a consolidated report on the national and provincial audit outcomes in terms of the PFMA every year. Since the 2017/2018 financial year, these reports include specific information about medico-legal claims and litigation.

1 Recent Public Protector Reports

5.142 Section 182 of the Constitution pertains to the functions of the Public Protector of South Africa (PPSA). Section 182(1) determines as follows:

- (1) The Public Protector has the power, as regulated by national legislation –
- (a) to investigate any conduct in state affairs, or in the public administration in any sphere of government, that is alleged or suspected to be improper or to result in any impropriety or prejudice;
 - (b) to report on that conduct; and
 - (c) to take appropriate remedial action.

5.143 As required by section 182(1), Parliament adopted the Public Protector Act to provide for matters incidental to the office of the Public Protector as contemplated in the Constitution. Section 182(1)(b) gives the Public Protector of South Africa (PPSA) the power to conduct an investigation, and section 8(1) affords the Public Protector the discretion to make the report known in the manner that the PPSA sees fit.

5.144 Under the powers referred to above the PPSA conducted a number of own initiative or intervention investigations following disquieting media reports about public health care services in South Africa. The media reports related to inadequate health care services, maladministration of services and poor conditions in health establishments in South Africa. Investigation teams from the office of the PPSA visited identified hospitals in the Eastern Cape, KwaZulu-Natal, Gauteng, Limpopo and Mpumalanga to assess the provision and administration of health services at public hospitals.

5.145 The investigation teams conducted site inspections to assess matters such as the quality of health care services; available human resources; condition of physical infrastructure, availability of vital equipment and machinery; quality and availability of personal protective equipment (PPE); and staff morale, considering also additional pressure due to the Covid-19 pandemic. Apart from the site inspection, the team conducted random interviews with medical and nursing staff, organized labour and patients.

5.146 The issues identified for investigation was whether the provision and administration of health services by the relevant provincial DOH at the hospital concerned accords with the obligations imposed by the Constitution and the law and if not, whether such failure amounts to improper conduct and maladministration, or,

whether the allegations of administrative deficiencies led to systemic challenges in the delivery of primary health care services at the hospital and if yes, whether such failure amounts to improper conduct and maladministration.

(a) Eastern Cape: PPSA Report 11 of 2021/22

5.147 The PPSA conducted an investigation into poor conditions at health facilities and hospitals in the Eastern Cape Province as an own initiative intervention in terms of section 6(4) of the Public Protector Act. The PPSA decided to conduct the investigation on the grounds of media reports that came to the attention of the Public Protector. The investigation commenced on 30 July 2020 and officials from the office of the PPSA visited the Uitenhage Hospital at Kariega, Livingstone Hospital in Gqeberha, Mthatha Hospital at Mthatha and Sulenkama Hospital (also known as the Nessie Knight Hospital) at Qumbu.²⁴²

(b) KwaZulu-Natal: PPSA Report 50 of 2021/2022

5.148 The PPSA conducted an investigation into poor provision and maladministration of health care services at public hospitals in KwaZulu-Natal as an own initiative intervention in terms of section 6(4) of the Public Protector Act. The PPSA decided to conduct the investigation on the grounds of media reports that came to the attention of the Public Protector. The investigation commenced in October 2020 and officials from the office of the PPSA visited the Christ the King District Hospital at Ixopo, Rietvlei District Hospital at uMzimkhulu, Mbongolwane District Hospital at Eshowe, Mbongolwane Reserve and KwaMagwaza District Hospital at Melmoth.²⁴³

(c) Mpumalanga: PPSA Report 51 of 2021/2022

5.149 The PPSA conducted an investigation into the state of health facilities at Themba Hospital, Kabokweni following allegations of poor conditions at the hospital. The Public Protector conducted an own initiative investigation in terms of section 6(4) of the Public Protector Act. The Public Protector and the Deputy Public Protector visited the Themba

²⁴² PPSA Report 11 of 2021/22: *Report of the Public Protector in terms of section 182(1)(b) of the Constitution of the Republic of South Africa, 1996 and section 8(1) of the Public Protector Act, 1994: Allegations of worsening conditions within the health facilities/hospitals in the Eastern Cape Province* (June 2021) at 3 & 4 [PPSA Report 11 of 2021/2022].

²⁴³ PPSA Report 50 of 2021/22: *Report of the Public Protector in terms of section 182(1)(b) of the Constitution of the Republic of South Africa, 1996 and section 8(1) of the Public Protector Act, 1994: Report on an own initiative investigation into the provision and administration of health services at public hospitals in the province of KwaZulu-Natal* (September 2021) at 4 [PPSA Report 50 of 2021/2022].

Hospital at Kabokweni on 04 September 2020. The Public Protector decided to conduct an in-depth investigation on the basis of her own observations and challenges raised by hospital management, representatives from organised labour and staff during her visit.²⁴⁴

5.150 A particular problem was encountered in Mpumalanga with regard to the filling of vacant posts. The Mpumalanga DOH decided that, if the recruitment process for filling a post is not finalised within three months, the hospital loses the post because it would no longer be funded. This practice is very detrimental to the hospital, perpetuating the challenges faced by the hospital due to staff shortages and loss of personnel budget.²⁴⁵ Another concern was the length of time it is taking to plan and build a desperately needed new maternity ward.²⁴⁶ The maternity ward has been in the offing since 2007, but has not been built yet.²⁴⁷ However, the Mpumalanga DOH and Public Works indicated that the planning and design for the proposed construction of the new maternity ward has been completed. The project is planned to start in the second quarter of 2021/22 and is estimated to take 36 months to complete, thus in 2024/25.²⁴⁸

(d) Limpopo: PPSA Report 52 of 2021/2022

5.151 The PPSA conducted an investigation into allegations of maladministration and systemic deficiencies affecting service delivery at the WF Knobel Hospital, Ga-Ramoshwane as an own initiative investigation or intervention in terms of section 6(4) of the Public Protector Act. The investigation was part of the Public Protector's initiative to embark on a nationwide inspection of health facilities to have a closer look at their state of readiness to deal with cases of Covid-19 infections as well as the general conditions of health facilities.²⁴⁹

²⁴⁴ PPSA Report 51 of 2021/22: *Report of the Public Protector in terms of section 182(1)(b) of the Constitution of the Republic of South Africa, 1996 and section 8(1) of the Public Protector Act, 1994: Report on an investigation into the state of health facilities at Themba Hospital, Mpumalanga Province* (October 2021) at 3 [PPSA Report 51 of 2021/22].

²⁴⁵ PPSA Report 51 of 2021/22 at 6.

²⁴⁶ The current maternity ward offers no privacy to patients and has only two delivery beds, while 15 to 18 babies are delivered at the hospital every day (PPSA Report 51 of 2021/22 at 7).

²⁴⁷ PPSA Report 51 of 2021/22 at 37.

²⁴⁸ PPSA Report 51 of 2021/22 at 7.

²⁴⁹ PPSA Report 52 of 2021/22: *Report of the Public Protector in terms of section 182(1)(b) of the Constitution of the Republic of South Africa, 1996 and section 8(1) of the Public Protector Act, 1994: Report on an investigation into allegations of maladministration and systemic deficiencies affecting service delivery at the WF Knobel Hospital by the Limpopo Department of Health* (October 2021) at 3 [PPSA Report 52 of 2021/2022].

(e) Gauteng: PPSA Report 71 of 2021/2022

5.152 The PPSA conducted an investigation to determine the state of readiness of public hospitals designated as COVID-19 health facilities in Gauteng as an own initiative or intervention investigation intervention in terms of section 6(4) of the Public Protector Act. The PPSA decided to conduct the investigation on the grounds of media reports that came to the attention of the Public Protector. The investigation commenced in August 2020. Officials from the office of the PPSA visited the Jubilee District Hospital at Temba, Dr George Mukhari Academic Hospital at Ga-Rankuwa, Steve Biko Academic Hospital in Pretoria, Chris Hani Baragwanath Academic Hospital in Soweto, Lilian Ngoyi Community Health Centre in Johannesburg and Charlotte Maxeke Johannesburg Academic Hospital in Johannesburg.²⁵⁰

(f) Findings

5.153 The PPSA found that the provincial DOHs have “failed to ensure appropriate conditions for the enjoyment, delivery and access to adequate as well as effective health care services for the community [concerned]” in respect of the majority of hospitals inspected.²⁵¹ The PPSA consequently made the following finding:²⁵²

Such failure by [the province] amounts to contravention of section 195(1) (e) and (f) of the Constitution,²⁵³ section 237 of the Constitution,²⁵⁴ section

²⁵⁰ PPSA Report 71 of 2021/2022: Report of the Public Protector in terms of section 182(1)(b) of the Constitution of the Republic of South Africa, 1996 and section 8(1) of the Public Protector Act, 1994: Report on an investigation into the administration, management and the responsiveness of certain Gauteng hospitals to the Covid-19 pandemic (October 2021) at 3–5 [PPSA Report 71 of 2021/22].

²⁵¹ PPSA Report 11 of 2021/22 at 5–8; PPSA Report 50 of 2021/22 at 5–9; PPSA Report 52 of 2021/22 at 5.

²⁵² PPSA Report 11 of 2021/22 at 5–9; PPSA Report 50 of 2021/22 at 5–9; PPSA Report 52 of 2021/22 at 5; PPSA Report 71 of 2021/22 at 9, 12, 17, & 19.

²⁵³ (1) Public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles:

(e) People's needs must be responded to, and the public must be encouraged to participate in policy-making.

(f) Public administration must be accountable.

²⁵⁴ All constitutional obligations must be performed diligently and without delay.

27(1)²⁵⁵ and section 25(1) and (2) of the NHA²⁵⁶ as well as the Regulations, as shown in the application of the law to the facts. ... The conduct of the [province] accordingly constitutes improper conduct as envisaged in section 182(1)²⁵⁷ of the Constitution and maladministration in terms of section 6(4)(a)(i)²⁵⁸ of the Public Protector Act.

5.154 The investigations revealed systemic deficiencies in all the hospitals inspected:

- 1) shortages of staff / human resources: leadership positions, critical posts, interns;²⁵⁹
- 2) difficult to retain employees at deep rural hospitals;²⁶⁰
- 3) leadership instability because of undue delays in filling senior management positions such as the post of CEO;²⁶¹
- 4) shortages of non-clinical staff lead to numerous challenges: non-clinical staff are required such as administration clerks, human resources clerks, supply chain

²⁵⁵ Section 27 of the NHA deals with the functions of the provincial health council. Section 27(1) requires the provincial health council to advise the MEC of the relevant province on various matters, including policy concerning any matter that will protect, promote, improve and maintain the health of the population within the province; targets, priorities, norms and standards relating to the equitable provision and financing of health services; human resources planning, production, management and development; development, procurement and use of health technology within the province; equitable financial mechanisms for the funding of health services within the province; and the implementation of national and provincial health policy.

²⁵⁶ Section 25 pertains to provincial health services, and general functions of provincial departments. Section 25(1) imposes a duty upon the relevant MEC to ensure the implementation of national health policy, norms and standards in his or her province. Section 25(2) sets out the functions of a head of a provincial department, which include the duty to provide specialised hospital services; plan and manage the provincial health information system; plan, co-ordinate and monitor health services and evaluate the rendering of health services; plan, manage and develop human resources for the rendering of health services; control and manage the cost and financing of public health establishments and public health agencies; facilitate and promote the provision of comprehensive primary health services and community hospital services; controlling the quality of health services and facilities; and providing and maintaining equipment, vehicles and health care facilities in the public sector. This must be done in accordance with national health policy and the relevant provincial health policy.

²⁵⁷ See par 5.142.

²⁵⁸ (4) The Public Protector shall, be competent –
 (a) to investigate, on his or her own initiative or on receipt of a complaint, any alleged-
 (i) maladministration in connection with the affairs of government at any level;

²⁵⁹ PPSA Report 11 of 2021/22 at 5, 6 & 8; PPSA Report 50 of 2021/22 at 5, 6, 7 & 8.

²⁶⁰ PPSA Report 50 of 2021/22 at 58.

²⁶¹ PPSA Report 11 of 2021/2022 at 67.

- management clerks; kitchen and laundry staff, safety officer, waste management officer, foreman (maintenance), plumber and electrician;²⁶²
- 5) shortage of clerks, cleaners and porters lead to dirty and unhygienic conditions in hospitals²⁶³ and medical professionals having to assist with clerical and porting duties;²⁶⁴
 - 6) lack of skills in midwifery and psychiatry services;²⁶⁵
 - 7) undue delays with filling of posts as authority to fill posts must be obtained from both Treasury and the Office of the Premier; the approval of several posts is awaited;²⁶⁶
 - 8) high rate of absenteeism due to staff burn out, which is directly attributed to the moratorium on the employment of non-exempted staff as non-critical/ non-exempted posts are not filled when staff vacate their positions;²⁶⁷
 - 9) some health care services can no longer be offered due to staff shortages;²⁶⁸
 - 10) the workload for the doctors is too high and they are often expected to work excessive hours as a result of clinical staff shortages;²⁶⁹
 - 11) inadequate medical equipment – some hospitals do not have equipment such as monitors, resuscitation material, defibrillators, infusion pumps, humidifiers and gauges for oxygen, emergency trolleys and stretchers;²⁷⁰
 - 12) vital machines/equipment are not being maintained, as a result patients are transferred to private hospitals at high cost;²⁷¹
 - 13) theft of medicine;²⁷²
 - 14) poor IT connectivity;²⁷³
 - 15) delays within the supply chain management process;²⁷⁴

²⁶² PPSA Report 50 of 2021/22 at 30.

²⁶³ PPSA Report 11 of 2021/2022 at 67; PPSA Report 52 of 2021/22 at 26.

²⁶⁴ PPSA Report 11 of 2021/2022 at 76.

²⁶⁵ PPSA Report 50 of 2021/22 at 58.

²⁶⁶ PPSA Report 50 of 2021/22 at 34.

²⁶⁷ PPSA Report 11 of 2021/2022 at 75; PPSA Report 50 of 2021/22 at 73.

²⁶⁸ PPSA Report 11 of 2021/2022 at 76.

²⁶⁹ PPSA Report 11 of 2021/2022 at 81.

²⁷⁰ PPSA Report 11 of 2021/2022 at 5, 6; PPSA Report 50 of 2021/22 at 71.

²⁷¹ PPSA Report 11 of 2021/2022 at 68.

²⁷² PPSA Report 11 of 2021/2022 at 68.

²⁷³ PPSA Report 50 of 2021/22 at 5, 6, 7 & 8.

²⁷⁴ PPSA Report 71 of 2021/22 at 19.

- 16) insufficient supply of resources like personal protective equipment;²⁷⁵
- 17) substandard items are sometimes supplied;²⁷⁶
- 18) only one male and one female ward – all patients are admitted to the same ward with no separation between infectious and non-infectious diseases and mental health care patients and other patients;²⁷⁷
- 19) deplorable maternity ward conditions;²⁷⁸
- 20) lack of linen or shortage of clean linen;²⁷⁹
- 21) inadequate office equipment;²⁸⁰
- 22) shortage of office space;²⁸¹
- 23) shortage of space for archives and filing;²⁸²
- 24) shortage of storerooms;²⁸³
- 25) lack of laundry services;²⁸⁴
- 26) service provider appointed for the maintenance and repairs of laundry machines does not have the capacity to fix the machines;²⁸⁵
- 27) shortage of staff residences;²⁸⁶
- 28) poor physical infrastructure such as dilapidated buildings;²⁸⁷
- 29) lack of vehicles, either because none were allocated or because vehicles were attached by the Sheriff due to the hospital owing service providers;²⁸⁸
- 30) poor supply of water;²⁸⁹
- 31) leaking water and steam pipes;²⁹⁰

²⁷⁵ PPSA Report 11 of 2021/2022 at 5, 6 & 8.

²⁷⁶ PPSA Report 71 of 2021/22 at 20.

²⁷⁷ PPSA Report 50 of 2021/22 at 9.

²⁷⁸ PPSA Report 51 of 2021/22 at 4.

²⁷⁹ PPSA Report 51 of 2021/22 at 5; PPSA Report 52 of 2021/22 at 26.

²⁸⁰ PPSA Report 11 of 2021/2022 at 6.

²⁸¹ PPSA Report 11 of 2021/2022 at 6.

²⁸² PPSA Report 50 of 2021/22 at 30.

²⁸³ PPSA Report 50 of 2021/22 at 10.

²⁸⁴ PPSA Report 11 of 2021/2022 at 5; PPSA Report 50 of 2021/22 at 5, 7 & 8.

²⁸⁵ PPSA Report 51 of 2021/22 at 5.

²⁸⁶ PPSA Report 50 of 2021/22 at 30.

²⁸⁷ PPSA Report 11 of 2021/2022 at 5 & 6; PPSA Report 50 of 2021/22 at 5, 7, 8.

²⁸⁸ PPSA Report 11 of 2021/2022 at 5, 6, 8 & 58.

²⁸⁹ PPSA Report 11 of 2021/2022 at 5.

²⁹⁰ PPSA Report 52 of 2021/2022 at 3.

32) waste management at the hospital and the surrounding environment is not compliant with the legal requirements, national standards and good practice.²⁹¹

5.155 The Finance MEC of the Eastern Cape has requested National Treasury for financial assistance to address shortfalls due to budget cuts, increasing accruals and payables, an increase in the medico-legal claims and additional appointments to address the Covid-19 pandemic.²⁹²

5.156 The PPSA made specific recommendations with regard to medico-legal claims. Based on their findings in Eastern Cape hospitals, the PPSA recommended that a submission be made to the Provincial or National Treasury for assistance with the timely settlement of medico legal claims relating to hospitals to avoid the attachment of their assets.²⁹³

5.157 The impact of huge medical negligence payments on the Eastern Cape DOH is quite severe. The department is unable to fill critical vacancies, procure necessary medical supplies and effect repairs to ageing hospital infrastructure and equipment. When the department is unable to make payments in terms of court orders, the Sheriff attaches its movable assets (cars, office furniture and computer equipment), even the Department's bank account.²⁹⁴

5.158 The PPSA referred to the 2021 Constitutional Court case of *MEC Health, Gauteng v PN*,²⁹⁵ in terms whereof it is now possible to arrange for structured settlements and periodical payments for the satisfaction of claims against the state based on negligent medical treatment of persons by servants of the state. The PPSA recommended to the DGs of NDOH and DOJ&CD to make such arrangements in order to protect the constitutional right of access to health care services, which is at risk due to increasing budget pressures facing the Eastern Cape DOH.²⁹⁶ In addition, the PPSA

²⁹¹ PPSA Report 50 of 2021/22 at 71.

²⁹² PPSA Report 11 of 2021/2022 at 12.

²⁹³ PPSA Report 11 of 2021/2022 at 10.

²⁹⁴ PPSA Report 11 of 2021/2022 at 89–90.

²⁹⁵ *MEC Health, Gauteng v PN* [2021] ZACC 6.

²⁹⁶ PPSA Report 11 of 2021/2022 at 14.

recommended that the National Department of Health should consider taking over medico-legal claims as most provinces are affected by such claims.²⁹⁷

5.159 Other recommendations include:

- 1) refer the PPSA's findings to the HOD of the Eastern Cape DOH to consider financial support and oversight to public health establishments where it appears necessary;²⁹⁸
- 2) develop a cost based strategy for planning and budget allocation over the MTEF for refurbishment of some health facilities;²⁹⁹
- 3) conduct routine and scheduled maintenance at hospitals;³⁰⁰
- 4) conduct a comprehensive security assessment for additional security at some hospitals to inform the 2021/2022 Procurement Plan;³⁰¹
- 5) repair air conditioners and lifts in the hospital;³⁰²
- 6) find a suitable storage facility to archive patient records and devise measures to limit loss of active files;³⁰³
- 7) draw up a plan for upgrading water and sewerage systems;³⁰⁴
- 8) do general repairs and renovations to the hospital and do maintenance and repairs at an institutional level;³⁰⁵
- 9) DOH should consider increasing capacity of referral hospitals/ establishments providing involuntary care, treatment and rehabilitation of mental health care users.³⁰⁶

5.160 In the KZN report, the Public Protector indicates that they will refer the matter to the MEC of the Department of Public Works: KZN for consideration of technical infrastructural support and renovation needs as enjoined by section 13(1)(d) of the

²⁹⁷ PPSA Report 11 of 2021/2022 at 15.

²⁹⁸ PPSA Report 11 of 2021/2022 at 14; PPSA Report 50 of 2021/22 at 13.

²⁹⁹ PPSA Report 11 of 2021/2022 at 12.

³⁰⁰ PPSA Report 11 of 2021/2022 at 12.

³⁰¹ PPSA Report 11 of 2021/2022 at 13.

³⁰² PPSA Report 11 of 2021/2022 at 13.

³⁰³ PPSA Report 50 of 2021/22 at 9.

³⁰⁴ PPSA Report 50 of 2021/22 at 10.

³⁰⁵ PPSA Report 50 of 2021/22 at 10.

³⁰⁶ PPSA Report 50 of 2021/22 at 10.

Government Immovable Assets Management Act 19 of 2007 in relation to the identified hospitals and other public health facilities in the province of KwaZulu-Natal.³⁰⁷

5.161 The Information Technology (IT) systems at the Christ the King Hospital are continuously malfunctioning and staff struggle with access to Persal and BAS. Staff are obliged to use equipment in the District Office of the Department or travel 90 kilometres to the Provincial Office in Pietermaritzburg for an internet connection so that they can do their work.³⁰⁸

5.162 The PPSA highlighted some specific examples of wasted expenditure, poor planning and bad management practices at the Livingstone Hospital (Eastern Cape). There are no industrial technicians and clinical engineers available to assist with critical equipment, maintenance of equipment or even minor repairs. All maintenance and repairs depend on service level agreements. However, there are no maintenance contracts and service level agreements in place.³⁰⁹

5.163 The hospital procured advanced imaging equipment for the catheterization laboratory (cath lab) in 2018 for an amount of R17 800 000 (seventeen million eight hundred thousand rand). The reason for purchasing the machine was to improve the quality of service and reduce the need to have certain procedures performed in private hospitals. A cath lab is a specialised facility for minimally invasive tests and advanced cardiac procedures for diagnosing and treating cardiovascular disease. It is equipped with superior imaging technology, which is used to view the arteries and examine blood flow to and from the heart.³¹⁰ However, the machine at the Livingstone hospital has never been used. It was purchased without a maintenance plan and was never fully installed. The warranty is no longer valid.³¹¹

5.164 The PPSA make the following remark with regard to the Livingstone Hospital:³¹²

³⁰⁷ PPSA Report 50 of 2021/22 at 13.

³⁰⁸ PPSA Report 50 of 2021/22 at 30.

³⁰⁹ PPSA Report 11 of 2021/2022 at 72.

³¹⁰ San Antonio Regional Hospital "Cardiac Catheterization Laboratory (Cath Lab)" accessed 4 October 2021 www.sarh.org.

³¹¹ PPSA Report 11 of 2021/2022 at 73.

³¹² PPSA Report 11 of 2021/2022 at 76. "There was an almost total failure of support services during the run up and height of the initial surge of Covid-19. This led to huge amounts of stress in the entire system. There was no Information Technology (IT) and administrative

To date, the institution has managed to stand on its feet because of dedicated officials who showed loyalty and took it upon themselves to ensure that services and leadership remain paramount. The posts approved for the hospital to function optimally are still hanging between the ECDoH Head Office Human Resources and the PCCC.

2 South African Human Rights Commission Reports

5.165 The SAHRC also published reports that pertain to the public health sector:

- Report: Site visits and Investigation Eastern Cape Hospitals: March to May 2003 (2003)
- Public Inquiry: Access to Health Care Services: A report and recommendations based on the submissions and proceedings of the Public Hearings conducted at the national office of the South African Human Rights Commission, Parktown, Johannesburg from 30 May to 1 June 2007 (2009)
- Hearing report of the South African Human Rights Commission into access to emergency medical services in the Eastern Cape 24 & 25 March 2015 (2015).
- Investigative Report: Dr Imran Keeka, DA, MPL v Addington Hospital and others (15 June 2017) (regarding cancer treatment in KZN).

(a) **Report: Investigation Eastern Cape Hospitals (2003)**

5.166 The reasons for the investigation into Eastern Cape hospitals are explained in the introduction to the report:³¹³

There were frequent complaints from NGO's and individuals about the poor quality of health services in a number of hospitals in the Eastern Cape. The media also carried features about the collapse of health services in the province. A number of hospitals were singled out for criticism, which covered shortage of medicine, staff problems, inaccessibility and corruption, which if found to exist would constitute violations of Section 27(1)(a) of the Bill of Rights ...

assistance available and everything had to be done by the doctors alone at huge cost to them. ... Doctors and sisters were compelled to spray beds themselves, clean floors and surfaces, buy their own bleach and mops and provide any cleaning assistance. Deficiencies in staff were highlighted with regards to porter services, general assistance, laundry, linen bank, seamstresses and nursing staff. Total collapse of the EMS with inability to collect patients and move patients from hospitals to a transfer facility, such as the field hospitals." (PPSA Report 11 of 2021/2022 at 77–78).

³¹³ SAHRC Report: *Site visits and Investigation Eastern Cape Hospitals: March to May 2003* (2003) at 3 [SAHRC (2003)].

5.167 Some of the problems identified by the SAHRC are the following:

- 1) Problems with overcrowding of hospitals because of the wide catchment area.³¹⁴
- 2) As a result of the shortage of staff the present staff members are overworked and there are no incentives.³¹⁵
- 3) Hospitals often provide primary health care because the clinics in the area do not function well because of a lack of staff and medicines.³¹⁶
- 4) Orders and tenders are not finalised in time or deliveries are delayed.³¹⁷
- 5) Provincial governments take a long time to fill vacant posts.³¹⁸
- 6) Shortages of medicine because of theft, mismanagement and corruption.³¹⁹
- 7) Some hospitals lack equipment.³²⁰

5.168 The SAHRC report refers to an instance of a public hospital that is being managed by a private company. There are enough medicines and drugs and strict control is exercised over stock with regular stock taking by an independent service provider. There is adequate food and linen and efficient cleaning services. It seems that the management and administration at the facility is effective and efficient and that many nurses prefer to work at this hospital rather than at government-controlled hospitals. The hospital offers incentives for staff that work long hours, something that does not happen in state hospitals. The company determines its own salary for all staff. Some retired nurses are working in this hospital.³²¹

5.169 By contrast, hospitals managed by the province experience serious staff shortages. Nurses are overworked and receive no incentive for working longer hours. The hospitals are overcrowded and they have to resort to “floor beds” for patients, or patients have to share beds.³²² There are frequent shortages of cleaning materials and

³¹⁴ SAHRC (2003) 5.

³¹⁵ SAHRC (2003) 5.

³¹⁶ SAHRC (2003) 6 & 10.

³¹⁷ SAHRC (2003) 6.

³¹⁸ SAHRC (2003) 8.

³¹⁹ SAHRC (2003) 22.

³²⁰ SAHRC (2003) 26 & 27.

³²¹ SAHRC (2003) 10 & 11.

³²² SAHRC (2003) 26.

linen.³²³ Food is a serious problem – sometimes patients go without food.³²⁴ In cases where the catering function had been outsourced, the companies often stop providing food after a while due to non-payment.³²⁵ At some hospitals there are unfinished construction projects that had been abandoned years ago. Construction companies apparently abandon the projects because of non-payment by the province.³²⁶

5.170 The majority of problems with catering services, medical supplies, computer services and construction problems can be traced back to poor administration. Service providers are not paid and eventually abandon projects or default on the delivery of services.³²⁷ Poor administration and lack of leadership is at the root of many of the problems.³²⁸ There is a serious shortage of staff. The only way to improve service delivery is to fill the vacant posts. Health services in the hospitals visited are in a poor state and could constitute violations of human rights.³²⁹

(b) Public Inquiry: Access to Health Care Services (2009)

5.171 In “Chapter 1: Introduction”, the motivation for the public inquiry into access to state health care services is explained:³³⁰

The SAHRC has received many complaints with regard to poor service delivery in the public health care system in all provinces in South Africa. These complaints point to the lamentable state of many public hospitals in the country due to many factors, including a shortage of trained health care workers, a lack of drugs in clinics, lengthy waiting periods that patients endure before receiving treatment, poor infrastructure, a disregard for patients’ rights, a shortage of ambulance services and poor hospital management.

5.172 In response to the complaints received and the SAHRC’s provincial review, the SAHRC decided to hold public hearings into the right to access health care services. Participants could submit written submissions or make a presentations at the public

³²³ SAHRC (2003) 5, 6, 12.

³²⁴ SAHRC (2003) 27.

³²⁵ SAHRC (2003) 13.

³²⁶ SAHRC (2003) 12.

³²⁷ SAHRC (2003) 32.

³²⁸ SAHRC (2003) 27.

³²⁹ SAHRC (2003) 28.

³³⁰ SAHRC *Public Inquiry: Access to Health* (2009) at 4 [SAHRC (2009)].

hearings. This report followed a more holistic approach than many of the other investigations and reviews of the public health sector, bringing some fresh perspectives to the table. The report considered a number of components that are relevant to health services provision.

5.173 The report assesses availability of health care, including stewardship, finance, management, health workers, physical infrastructure, equipment, availability of drugs and provision of specialised services.³³¹ Apart from availability of health care, health care users must be able to access health care. Access to health care is affected by payment for health care by patients, transports costs, emergency transport, waiting time, and access to information.³³²

5.174 The Constitution states that no person may be refused emergency medical treatment, but there is no further provision for the exercise of the right. During the public hearings the SAHRC heard presentations about ambulance services in the country, “which for some hospitals was at best inadequate and at worst non-existent”.³³³ The effect of this deficiency is that, in areas where patients do not have access to alternative transport arrangements, they cannot exercise the right to emergency medical treatment.

5.175 An important characteristic of the South African health system is the divide between the public and the private health sectors. The private health sector goes hand in hand with the system of medical aid schemes. Membership growth of medical aid schemes is in decline, mostly due to rising costs and overburdened consumers cutting back on spending.³³⁴

5.176 The financing of health care is determined by the public/private sector divide. The public health system is funded by means of general taxation. Users of public health care are expected to pay for the service if they can. Users are subjected to a means test to determine how much they should pay for the service, based on their income. However, patient fees make up a very small portion of the public health care budget.³³⁵ Private

³³¹ SAHRC (2009) 28.

³³² SAHRC (2009) Chapter 4.

³³³ SAHRC (2009) 42.

³³⁴ Competition Commission *Health Market Inquiry: Final findings and recommendations report* (September 2019) at 34 [HMI (2019)].

³³⁵ SAHRC (2009) 29; HMI (2019) 44.

healthcare is funded by private patients, mostly made up of the approximately 16% of the population with private medical insurance.³³⁶

5.177 The next relevant component is management. Several presentations identified management-related issues as a concern, which was also observed during the provincial reviews. Liaison between the different levels of government in the public health care sector and interaction between state departments are especially problematic. The weak relationship between the NDOH and the Department of Public Works (DPW) impacts on the ability of especially the provincial DOHs to provide services.³³⁷

5.178 Poor financial and human resource management are particularly worrying, since poor management decisions with regard to recruitment and employment have a knock-on effect in light of the staff shortages throughout the sector. Sub-optimal management arrangements that affect transport and infrastructure causes further limitations on access to health care.

5.179 The SAHRC makes the following statement with regard to the impact of management structures:³³⁸

Research ... concluded that dysfunctional management structures coupled with underfunding and understaffing has resulted in public hospitals that are overstretched, which impacts upon clinical outcomes. Fragmentation of management structures arising from decision making processes, which are centralised, is one critical component of this ... lack of functioning and results in both a lack of authority and a lack of accountability for managers. ... Fragmented structures also resulted in poor decision making ...".

5.180 The lack of delegations to facility managers (a long-standing dilemma), the perception of leadership failings in the provincial DOHs, inadequate consultation, poor communication, cumbersome reporting lines and overly bureaucratic processes – causing long delays – exacerbate the problems. Deficiencies in coordination between various state departments, especially where DOH is dependent on the DPW, serves to aggravate the situation.³³⁹

³³⁶ HMI (2019) 44.

³³⁷ SAHRC (2009) 33.

³³⁸ SAHRC (2009) 33.

³³⁹ SAHRC (2009) 34.

5.181 The next component is human resources. The SAHRC (2009) report makes an important observation:

Health workers are integral to the functioning of the health care system. Without sufficient numbers of adequately trained and motivated health workers no health care system can fulfil its human rights obligations.

5.182 The following factors are of particular relevance with regard to medical personnel in the public health care sector:³⁴⁰

- 1) adequate distribution of health care personnel
- 2) retention of health care staff
- 3) incentives
- 4) accommodation
- 5) working conditions
- 6) management-staff relations
- 7) training.

5.183 Physical infrastructure is also critical. The biggest challenge is inadequate infrastructure: old and dilapidated buildings, facilities that are too small for the purpose they have to serve, overcrowding, lack of space, lack of privacy, inadequate pharmaceutical facilities, small waiting areas, water shortages and poor security.³⁴¹ Inaccessible roads were mentioned in the SAHRC (2003) report.

5.184 The DOHs have embarked on a drive to build new clinics. In addition, the Hospital Revitalisation Programme was launched, focusing on infrastructure, equipment, organisational development and quality. However, there are delays due to drawn-out procurement processes and lack of technical capacity at DPW. Although hygienic conditions and cleanliness are vital in a health environment, there are health establishments where this is not up to standard.³⁴²

5.185 Equipment and drugs is another aspect of health care services. Adequate health care services require a range of consumables and equipment: from soap, linen, office equipment (telephones, computers, printers, fax machines, photocopiers, filing cabinets)

³⁴⁰ SAHRC (2009) 34–39.

³⁴¹ SAHRC (2009) 39.

³⁴² SAHRC (2009) 40.

to medical equipment, information technology and maintenance. Delays in tender and procurement processes complicate acquisition and maintenance.³⁴³

(c) *Hearing report: Access to EMS in Eastern Cape (2015)*

5.186 The investigation into access to emergency medical services in the Eastern Cape flowed from complaints received from members of the community.³⁴⁴

In March 2013 the Commission received a complaint relating to a lack of emergency medical services in the rural areas of the Eastern Cape, where its preliminary investigation revealed that the continuing denial of access to emergency medical services, particularly in rural areas, exacerbates existing vulnerabilities of some of the poorest communities and perpetuates the enduring inequality, while giving rise to substantial rights violations.

5.187 The abbreviation EMS refers to “emergency medical services”. According to the SAHRC report (2015), the EMS unit of the Eastern Cape DOH is divided into two sub-programmes, namely emergency medical services and planned patient transport (PPT). EMS provides emergency medical services, including ambulance services, special operations, communications and air ambulance services. Pre-hospital ambulances (also called community ambulances) are used for responding to emergency medical situations. The planned patient transport (PPT) programme provides transport for local outpatient transport (within the boundaries of a town or local area) and for intercity or intertown outpatient transport (into referral centres). Maternity obstetric units (MOUs) and inter-facility transfer (IFT) vehicles are used to transfer patients being moved between facilities.³⁴⁵

5.188 Access to transport is a critical element in relation to access to health care services. The constitutional injunction against refusal of emergency medical treatment is hollow without the means to access emergency medical treatment when required. The lack of ambulances to respond to medical emergencies have the practical effect of barring some people from accessing their constitutional health entitlements.³⁴⁶

³⁴³ SAHRC (2009) 40.

³⁴⁴ SAHRC *Hearing report of the South African Human Rights Commission into access to emergency medical services in the Eastern Cape 24 & 25 March 2015* (2015) at 12 [SAHRC (2015)].

³⁴⁵ SAHRC (2015) 35.

³⁴⁶ SAHRC (2015) 12.

5.189 Accessing health care services is particularly challenging for vulnerable people (the elderly, children and persons with disabilities), indigent people and people in rural areas (who often are indigent as well). They face a plethora of obstacles to get to a health establishment, which include:³⁴⁷

- 1) lack of public transport;;
- 2) high cost of private transport;
- 3) bad roads;
- 4) distance from health establishment; and
- 5) pre-existing diseases or conditions.

5.190 Emergency medical services are available in some areas, but numerous impediments exist:³⁴⁸

- 1) insufficient number of ambulances;
- 2) even fewer operational ambulances that are able to respond to emergencies;
- 3) shortage of qualified emergency service personnel;
- 4) poor state of the roads , which are getting progressively worse;
- 5) distances that must be covered;
- 6) difficult terrain (requiring vehicles with 4x4 capabilities);
- 7) poorly equipped ambulances;
- 8) severely inadequate numbers of planned patient transport and inter-facility transport vehicles to respond to the need;
- 9) long response times (10 to 14 hours);³⁴⁹
- 10) difficulties experienced with finding locations and addresses of patients;³⁵⁰
- 11) poor treatment of patients requiring medical attention; and³⁵¹
- 12) calls placed through the call centre are often not answered.³⁵²

5.191 The report concludes that the current fleet size is inadequate.³⁵³

³⁴⁷ SAHRC (2015) 12.

³⁴⁸ SAHRC (2015) 12.

³⁴⁹ SAHRC (2015) 59.

³⁵⁰ SAHRC (2015) 65.

³⁵¹ SAHRC (2015) 71.

³⁵² SAHRC (2015) 81.

³⁵³ SAHRC (2015) 99.

The problems stemming from the already under-resourced fleet size are further compounded by an equally under-resourced staff profile, a shortage of highly qualified EMS personnel, low numbers of ambulances that are currently operational, and a majority of the current fleet unable to navigate the difficult terrain to respond to emergencies in large parts of the province, particularly in rural areas.

5.192 The SAHRC is critical about the performance of the Eastern Cape DOH:³⁵⁴

Shortages of medical supplies, equipment and staff; inappropriate policy design and implementation; insufficient consultation and provision of access to information; unreliable information management systems; and poorly managed and resourced call centres have further contributed to a severely constrained EMS programme and an unequal provision of services.

(d) Investigative Report: Cancer treatment KZN (2017)

5.193 The reason for the investigation is the following:³⁵⁵

This report sets out findings and recommendations in respect of the complaint lodged by Dr Imran Keeka with the South African Human Rights Commission. ... The complaint relates to both shortages of staff and a lack of functional health technology machines for screening, diagnosing and treating cancer in the KwaZulu-Natal Province (KZN Province). This, it is alleged, has a negative effect on the provision of oncology services in the KZN province.

5.194 Dr Imran Keeka from the Democratic Alliance laid a complaint with the SAHRC, raising a number of challenges with regard to the provision of health care services to oncology patients in KZN. He contended that –

- 1) the delay was caused by insufficient radio-therapy treatment devices;
- 2) the radiotherapy machine, known as the Varian Rapid Arc Linear Accelerator (VRALA) machine, at the Addington Hospital was not working;
- 3) there were delays in the treatment of oncology patients due to the shortage of functional health technology;
- 4) the KZN DOH was failing to provide oncology patients with adequate health care services.

³⁵⁴ SAHRC (2015) 100.

³⁵⁵ South African Human Rights Commission *Investigative report: Dr Imran Keeka, DA MPL vs Addington Hospital and 3 others, KwaZulu-Natal* (15 June 2017) 1–2 [SAHRC (2017)].

5.195 The SAHRC found that the rights of patients with cancer to have access to health care services at the Addington and Inkosi Albert Luthuli Central Hospitals had been violated in the manner set out in the complaint. In addition, the KZN DOH has failed to retain and recruit suitably qualified staff, and failed to implement appropriate interim models to meet needs. The failure to provide access to adequate oncology services violated the rights to human dignity and life of affected patients.³⁵⁶

5.196 The SAHRC recommended that the KZN DOH immediately take steps to repair and monitor health technology, adopt a management plan to deal with patient backlogs, adopt an interim referral management plan to refer patients to private service providers, develop a strategy for staffing challenges, expand oncology services, and prioritise capacity building and health technology procurement. The SAHRC additionally required the KZN DOH to provide the SAHRC with an action plan on implementing the recommendations and report to the SAHRC on all the actions taken (in summary).³⁵⁷

3 PFMA general reports published by Auditor-General

5.197 The Auditor-General publish a consolidated PFMA general report on national and provincial audit outcomes every year. Starting from the 2017-18 financial year, the PFMA general reports include specific information on medico-legal litigation against the state and the effect thereof on the finances of the provinces. The PFMA general reports for the years 2017-18, 2018-19 and 2019-20 published by the Auditor-General contain information about medical negligence claims against provincial departments of health and the impact thereof on the budgets and service delivery of these departments. Audit reports are based on financial information. Figures do not allow for excuses or emotions, giving an objective account of the facts. The PFMA general reports make for depressing reading as far as the financial state of the majority of the provincial departments of health is concerned.

5.198 A small consolation is that the information in the reports could be used to prepare for court cases against the provincial departments of health. In a number of instances the courts criticised the state for failing to produce evidence relating to the detrimental impact of excessive medical negligence litigation against the provinces. The information

³⁵⁶ SAHRC (2017) 64.

³⁵⁷ SAHRC (2017) 65–67.

in the PFMA reports comes from an impeccable source and has been verified; therefore it could surely be used in litigation.

(a) PFMA general report 2017-18

5.199 The report for 2017-18 is the first PFMA general report to report on litigation and claims against state departments, including medico-legal litigation. The first reference to this new area of reporting appears in the executive summary.³⁵⁸

An emerging risk is the increased litigation and claims against departments. Almost a third of the departments had claims against them in excess of 10% of their next year's budget. Departments do not budget for such claims, which means that all successful claims will be paid from funds earmarked for the delivery of services, further eroding the ability of these departments to be financially sustainable.

5.200 The PFMA report 2017-18 expresses alarm over the financial health of the provincial departments of health and education.³⁵⁹

The financial health of the provincial departments of health and education needs urgent intervention to prevent the collapse of these key service delivery departments. In comparison with other departments, these sectors were in a bad state.

5.201 The provincial departments of health are in the worst situation:³⁶⁰

The provincial health departments were in an even worse state, with three in a vulnerable position (Eastern Cape, Free State and Northern Cape). The total deficit of the health departments stood at R8,4 billion. All the departments (except Western Cape and Free State) had claims against them **that were more than their 2018-19 total operational budget** – in the Eastern Cape, it was over three times more. [emphasis added]

5.202 The provincial overviews were even more disquieting, with the Western Cape being the only glimmer of light in a very dark picture:

Eastern Cape

[T]he medical legal claims and commitments for housing disclosed by Health and Human Settlements could put significant strain on the provincial revenue fund and the finances of the province as a whole.

³⁵⁸ Auditor-General of South Africa *Consolidated general report on national and provincial audit outcomes: PFMA 2017-18* at 3 [PFMA report 2017-18].

³⁵⁹ PFMA report 2017-18 at 4.

³⁶⁰ PFMA report 2017-18 at 4.

During the year under review, such claims and commitments continued to threaten the financial viability of the province. Medical legal claims disclosed by Health increased to R24,4 billion from R16,8 billion in the previous year. ... These claims and commitments require urgent attention to prevent their materialisation into actual liabilities that may prevent the delivery of services and proper functioning of the provincial government.³⁶¹

Free State

Health was the defendant in lawsuits of R1,8 billion (2016-17: R1,5 billion). Should these claims materialise, it could derail service delivery by this department, as these claims have not been budgeted for.³⁶²

Gauteng

Health's financial health continued to deteriorate due to a funding shortfall. Consequently, creditors were still not paid within 30 days, infrastructure deficiencies were not addressed, and there were staff shortages at health facilities. Adding to these financial sustainability concerns, was the R21,7 billion in medical legal claims against the department.³⁶³

KwaZulu-Natal

The provincial treasury's intervention team was unsuccessful in assisting Health to address qualification areas, as officials did not always cooperate with the implementation of audit turnaround plans.³⁶⁴

Health disclosed an amount of R16,8 billion (2016-17: R14,1 billion) for possible medical legal claims.³⁶⁵

Limpopo

Claims (contingent liabilities) instituted against Health and Agriculture exceeded their next year's budget.³⁶⁶

Mpumalanga

Health, with the second largest budget, had significant findings relating to poor storage and stock management practices, staff shortages, insufficient training, and medical equipment that was not in a good working condition. These issues contributed to the poor education and

³⁶¹ PFMA report 2017-18 at 41–42.

³⁶² PFMA report 2017-18 at 45.

³⁶³ PFMA report 2017-18 at 47.

³⁶⁴ PFMA report 2017-18 at 49.

³⁶⁵ PFMA report 2017-18 at 51.

³⁶⁶ PFMA report 2017-18 at 53.

health services in the province. The main drivers of the shortcomings at these departments were poor project management together with staff vacancies and instability.

...

Seven departments had claims against them that exceeded 10% of the next year's budget, with Health reporting the highest claims of approximately R7,9 billion (156% of the next year's budget). As the department would not have budgeted for such claims, any successful claims would then need to be paid from funds earmarked for the delivery of health services, further eroding the ability of this department to be financially sustainable, thereby negatively affecting service delivery.³⁶⁷

...

The main root cause of the financial health challenges indicated above was departments' inability to budget properly, which led to unauthorised expenditure of R37 million.³⁶⁸

Northern Cape

Health, as one of the three departments that received the biggest cut of the budget in the province ... has remained qualified for the sixth year in a row. Since all of the qualification areas from the previous year were repeated in the current year and findings were again raised on performance reporting and compliance, it is clear that the efforts of the oversight structures (provincial oversight, executive leadership and audit committee) and the internal audit unit had a minimal impact on improving the audit outcome of the department.³⁶⁹

North West

Historically, the most financially vulnerable department is Health. As reported in the previous general report, there were litigations and claims in excess of R1,2 billion against the department as well as accruals and payables in excess of 30 days. The analysis of Health is excluded this year, as the audit was outstanding at the cut-off date for inclusion in this report. However, the entire province's finances will be affected adversely should these claims be successful and outstanding creditors be payable immediately.³⁷⁰

Western Cape

We also assessed key projects at Education and Health. ... [W]e focused on patients initiated and remaining on antiretroviral treatment, condoms distributed, and the prevention of mother to child transmission of HIV at

³⁶⁷ PFMA report 2017-18 at 56.

³⁶⁸ PFMA report 2017-18 at 57.

³⁶⁹ PFMA report 2017-18 at 58.

³⁷⁰ PFMA report 2017-18 at 61.

Health. We raised no significant findings on the key projects assessed at either of these departments and noted no material defects.³⁷¹

5.203 In the overview of the financial management of the provinces, the report states:

An emerging risk is the increased litigation and claims against departments. Claims are made against departments through litigation for compensation as a result of a loss caused by the department – the most common claims are the medical negligence claims against provincial health departments. Departments do not budget for such claims, which means that all successful claims will be paid from funds earmarked for the delivery of services, further eroding the ability of these departments to be financially sustainable. This is the first year we analysed the extent of such claims and, as indicated in the table above, almost a third of the departments had claims against them in excess of 10% of their next year's budget. If paid out in 2018-19, this would use up more than 10% of these departments' budget meant for other strategic priorities.³⁷²

. . .

The financial health of provincial departments of health and education needs urgent intervention to prevent the collapse of these key service delivery departments.³⁷³

(b) PFMA general report 2018-19

5.204 The PFMA general report 2018-19 repeats the sentiments expressed in the 2017-18 report with regard to the emerging risk of increased litigation and claims against state departments. The PFMA report 2018-19 cautions against the practice of paying current expenses out of a future budget:

This continuing trend of using the next year's budget to pay the current year's expenses had a negative impact on departments' ability to pay creditors on time and to deliver services.³⁷⁴

5.205 The PFMA report 2018-19 commends the Western Cape for maintaining good financial management practices:

The Western Cape continued to produce the best results with 79% clean audits and the lowest irregular as well as fruitless and wasteful expenditure. At 74%, the province also had the highest number of

³⁷¹ PFMA report 2017-18 at 65.

³⁷² PFMA report 2017-18 at 75.

³⁷³ PFMA report 2017-18 at 76.

³⁷⁴ Auditor-General of South Africa *Consolidated general report on national and provincial audit outcomes: PFMA 2018-19* at 11 [PFMA report 2018-19].

auditees with a good financial health status and there were no auditees with unauthorised expenditure. Over the five years, there has been a solid and consistent pattern of good audit outcomes in the Western Cape, which can be attributed to the provincial leadership and accounting officers and authorities instilling a culture of accountability and good governance, and implementing initiatives to strengthen this culture in a deliberate manner.³⁷⁵

5.206 The Auditor-General identified a material irregularity with regard to the payment of medical negligence claims in Gauteng:

Medical claims were not paid within the period specified in court judgements, resulting in interest being charged. The action taken by the accounting officer was not appropriate to address the material irregularity.³⁷⁶

5.207 The Auditor-General remarked on claims against departments through litigation for compensation as a result of a loss caused by the department:

This is the second year we analysed the extent of such claims [J]ust over a third of the departments had claims against them in excess of 10% of their next year's budget. If paid out in 2019-20, this would use up more than 10% of these departments' budget meant for other strategic priorities. These claims totalled R100,9 billion at the 2018-19 year-end. The health departments in Gauteng, KwaZulu-Natal, Mpumalanga and Limpopo as well as the Department of Police were the highest contributors to this amount, with a combined value of R70,9 billion (70% of the total claims).³⁷⁷

5.208 The report cites the impact of claims on service delivery on the Mpumalanga DOH by way of example:

The department's budget for claims in 2018-19 amounted to R68 million, but the total claims paid out for the year amounted to R499 million. As a result, vacant positions of chief executive officers and nurses were not filled timeously at some hospitals. The maintenance and purchasing of new ambulances were also affected, which in turn had an impact on the services rendered by hospitals.³⁷⁸

³⁷⁵ PFMA report 2018-19 at 13.

³⁷⁶ PFMA report 2018-19 at 33.

³⁷⁷ PFMA report 2018-19 at 48.

³⁷⁸ PFMA report 2018-19 at 48.

5.209 The report emphasises that the provincial departments of health and education are yet again the departments in worst shape, requiring urgent intervention to prevent their collapse.³⁷⁹ The Eastern Cape DOH garnered the dubious honour of being the top contributor to unauthorised expenditure in the country, with most of the overspending being in relation to medical claims that had not been budgeted for.³⁸⁰

5.210 The complications caused by medical negligence problems in the Eastern Cape is evident from the following remark:

The medical legal claims disclosed by Health increased to R29 billion from R24 billion in the previous year and exceeded the department's annual budget allocation by R5 billion. An amount of R797 million was paid in the current year relating to these claims, of which R460 million was funded by an overdraft facility. This funding model was not sustainable and placed further pressure on the provincial fiscus.³⁸¹

5.211 The report mentions the impact of poor filing practices and poor planning on service delivery in KwaZulu-Natal:

The audit at Health revealed concerns on increased waiting times for patients at health care facilities due to poor filing systems. Additionally, various deficiencies were identified on the planning, use and maintenance of radiology equipment.³⁸²

5.212 The report commented on the lack of consequences for poor performance in the Northern Cape:

Over the years, we have received numerous commitments from the executive leadership, but the impact of these commitments was minimal, as very little was done to implement and monitor them. There were also no consequences when the responsible officials did not ensure that these commitments translated into actions and results.³⁸³

5.213 All provinces had to deal with medical negligence claims in 2018-19, and in most instances the claims instituted and paid in 2018-19 was higher than claims instituted and paid in 2017-18.

³⁷⁹ PFMA report 2018-19 at 48.

³⁸⁰ PFMA report 2018-19 at 98.

³⁸¹ PFMA report 2018-19 at 144.

³⁸² PFMA report 2018-19 at 155.

³⁸³ PFMA report 2018-19 at 168.

(c) PFMA general report 2019-20

5.214 As is apparent from the PFMA general report 2019-20, the situation did not improve:

At year-end, 87% of the departments had claims against them, totalling R147,12 billion. Claims are made against departments through litigation for compensation as a result of a loss caused by the department – the most common claims are medical negligence claims against provincial health departments. The total claims for provincial health departments (including medical claims) stood at R105,8 billion. Departments do not budget for such claims, which means that all successful claims will be paid from funds earmarked for other strategic priorities, including the delivery of services, further eroding the ability of these departments to be financially sustainable. A third of the departments had claims against them in excess of 10% of their next year's operational budget – for five health departments, the unpaid claims at year-end were more than the next year's entire operational budget. This continuing trend of using the next year's budget to pay the current year's expenses and claims had a negative impact on departments' ability to pay creditors on time and to deliver services.³⁸⁴

5.215 The Eastern Cape DOH was the worst performer yet again:

The Eastern Cape Department of Health made payments of R763 million relating to medical claims that were not budgeted for, which resulted in unauthorised expenditure. By year-end, the department still had R36,75 billion in unpaid medical claims – the highest of all national and provincial auditees.³⁸⁵

5.216 The Gauteng province was lauded for improving their audit outcomes and not incurring any unauthorised expenditure during the reporting period, although they are still under pressure due to unbudgeted medical negligence claims of R23,8 billion.³⁸⁶ Claims against the KwaZulu-Natal DOH increased from R20,1 billion in 2018-19 to R23,4 billion in 2019-20.³⁸⁷ The financial situation of the Northern Cape worsened and the Northern Cape DOH remained vulnerable.³⁸⁸ The North West DOH had outstanding

³⁸⁴ Auditor-General South Africa *Consolidated General Report on National and Provincial Audit Outcomes: PFMA 2019-20* at 13 [PFMA report 2019-20].

³⁸⁵ PFMA report 2019-20 at 15.

³⁸⁶ PFMA report 2019-20 at 16.

³⁸⁷ PFMA report 2019-20 at 17.

³⁸⁸ PFMA report 2019-20 at 18.

medical negligence claims of R5,5 billion, more than 92% of the department's budget for the following year.³⁸⁹

5.217 Although the Western Cape maintained its position as the top performer with 70% clean audit outcomes, the Auditor-General registered a concern about an increase in irregular expenditure in the Western Cape:

There has been a solid and consistent pattern of good audit outcomes in the Western Cape but a significant rise in irregular expenditure is of concern. ...The increase in irregular expenditure was due to non-compliance with supply chain management prescripts.³⁹⁰

5.218 A material irregularity³⁹¹ was reported in the Gauteng DOH because of medical negligence claims that were not paid within the period determined in court judgments, which resulted in interest being charged. The material irregularity was investigated and one of the findings was that the internal control system to track medical claims received, processed and settled, was ineffective.³⁹²

5.219 The PFMA report 2019-20 flagged unauthorised expenditure as a result of inadequate budgeting:

Departments usually do not budget for claims. Especially in the health sector, not budgeting for medical negligence claims means that all successful claims will be paid from funds earmarked for the delivery of services, resulting in these departments using more than what had been allocated to them.³⁹³

5.220 The increase in litigation and claims was highlighted once again:

We also continued to see an increase in litigation and claims against departments, and have flagged this as an emerging risk for the third year now.³⁹⁴

³⁸⁹ PFMA report 2019-20 at 19.

³⁹⁰ PFMA report 2019-20 at 19.

³⁹¹ “ ‘Material irregularity’ means any non-compliance with, or contravention of, legislation, fraud, theft or a breach of a fiduciary duty identified during an audit performed under the Public Audit Act that resulted in or is likely to result in a material financial loss, the misuse or loss of a material public resource or substantial harm to a public sector institution or the general public” [section 1 of Public Audit Act 25 of 2004].

³⁹² PFMA report 2019-20 at 35.

³⁹³ PFMA report 2019-20 at 59.

³⁹⁴ PFMA report 2019-20 at 60.

5.221 The Auditor-General raised the alarm about the increasing risk of medical negligence claims:

The health sector is responsible for 13,7% of the budget of departments. It is in an even worse state than the education sector. Deficits and unauthorised expenditure are common, and the departments in the Eastern Cape, Free State and Northern Cape disclosed significant doubt whether they will be able to continue with their operations as planned based on their current financial position. The biggest risk to this sector's ability to operate is medical claims.³⁹⁵

5.222 In all three the reports referred to above, the Auditor-General commented on the concerning state of the DOHs of particular provinces. Some provinces owed more for possible medical negligence claims than their entire budget for the following financial year, which had a severe impact on their ability to deliver services and fill vacancies.

2 Inspection reports published by OHSC

5.223 The four inspection reports published by the OHSC for the financial years 2015/16, 2016/17, 2017/18 and 2018/19 paint a grim picture of the state of public health establishments. As explained above (see paragraph 5.28) the OHSC select a sample of health establishments – central hospitals, tertiary hospitals, regional hospitals, district hospitals, clinics and community health care centres – for inspection each year, setting a target for inspection coverage as a percentage of the total number of public health establishments in the country. The OHSC employ a sampling strategy to determine which health facilities to visit in a particular year, taking into consideration the location of the health establishments, distance between targeted establishments, and available resources, including budget, number of inspectors and the time allowed for the inspections.³⁹⁶

(a) *National Core Standards*

5.224 The NDOH published the National Core Standards in February 2011.³⁹⁷ The main purpose of the National Core Standards (NCS) is to:

³⁹⁵ PFMA report 2019-20 at 63.

³⁹⁶ OHSC *Annual Inspection Report 2018/19* (March 2020) at 3 [OHSC 2018/19].

³⁹⁷ National Department of Health *National Core Standards for Health Establishments in South Africa* (2011) [NCS (2011)].

- Develop a common definition of quality care which should be found in all health establishments in South Africa, as a guide to the public and to managers and staff at all levels;
- Establish a benchmark against which health establishments can be assessed, gaps identified and strengths appraised; and
- Provide for the national certification of compliance of health establishments with mandatory standards.³⁹⁸

5.225 The NCS are informed by the values of universality, relevance, validity, reliability and logic.³⁹⁹ The NCS are “intended to set out the basics for quality of care from the 6 dimensions of quality which are: acceptability, safety, reliability, equity, accessibility and efficiency”.⁴⁰⁰ The OHSC conduct inspections to monitor compliance with the NCS. The inspection tool is structured to cover the following seven domains:⁴⁰¹

- 1) patient rights
- 2) patient safety, clinical governance and clinical care
- 3) clinical support services
- 4) public health
- 5) leadership and corporate governance
- 6) operational management
- 7) facilities and infrastructure.

5.226 Domains are further subdivided into subdomains and standards. The outcome of the application of the assessment tool is a percentage score for each domain, sub-domain or standard. The result is weighted to reflect the impact of that item on patient safety on the basis of a risk rating level of **vital** (measures to safeguard the safety of patients and staff that could lead to unnecessary harm or death if lacking), **essential** (fundamental to the provision of safe, decent, quality care) or **developmental** (quality care elements that health management should aspire to in order to achieve optimal care).

5.227 In addition, the OHSC looked at the state of health establishments in relation to six identified priority areas (often referred to as ministerial performance areas), namely:

- 1) waiting times
- 2) cleanliness

³⁹⁸ NCS (2011) 3.

³⁹⁹ NCS (2011) 3.

⁴⁰⁰ OHSC 2018/19 at 2.

⁴⁰¹ OHSC 2018/19 at 4.

- 3) values and attitudes
- 4) patient safety
- 5) infection prevention and control
- 6) availability of medicines.

5.228 Compliance of health establishments is determined according to the Compliance Judgement Framework, which scores health establishments in the following manner:⁴⁰²

≥80%	Compliant
70%-79%	Compliant with requirement
60%-69%	Conditionally compliant
50%-59%	Conditionally compliant with serious concerns
40%-49%	Non-compliant
<40%	Critically non-compliant

Figure 2: Compliance Judgement Framework⁴⁰³

Score	Status	Grade	Follow up mechanism	Inspection frequency/ type of inspection
≥ 80%	Compliant	A	Regular routine reporting	Annual reporting; 4 yearly inspection
70%-79%	Compliant with requirement	B	Self-reporting corrections, regular routine reporting	Review/verification
60%-69%	Conditionally compliant	C	Improvement and self-reported review	Review / verification
50%-59%	Conditionally compliant with serious concerns	D	Improvement and specific reporting	Specific Re-inspection
40%-49%	Non-compliant	E	Urgent intervention and complete re-inspection	Complete re-inspection
< 40%	Critically non-compliant	F	Urgent intensive intervention with disciplinary steps	Enforcement inspection

(b) OHSC public health facilities audit results 2014/15

5.229 The OHSC did not publish their 2014/15 inspection report in the same manner that they published subsequent inspection reports, but briefed the Portfolio Committee on Health on 16 March 2016 on the public health facilities audit results for 2014/15. The OHSC reported that they achieved about 10% inspection coverage (exact number not mentioned). The lowest average score for hospitals across the nine provinces was Limpopo at 37%, while the highest was Gauteng at 58%. The best performing province in respect of hospitals overall was KwaZulu-Natal. The best hospital in the country among the health establishments inspected that year was the Steve Biko Academic Hospital in Gauteng, achieving a score of 96%. By contrast, the poorest performing hospital was the De Aar Hospital in the Northern Cape, with a score of 37%. The OHSC

⁴⁰² OHSC *Annual Inspection Report 2016/17* (June 2018) at 27.

⁴⁰³ OHSC 2016/17 at 27.

remarked upon the myriad of challenges faced by primary healthcare facilities and hospitals, but singled out poor leadership and governance as the biggest issues that are negatively affecting healthcare facilities.⁴⁰⁴

(c) OHSC inspection report 2015/16

5.230 During the 2015/16 year the OHSC achieved a target of 13% for inspection coverage. The OHSC covered all 9 provinces, inspecting 4 central hospitals, 11 provincial tertiary hospitals, 9 regional hospitals, 27 district hospitals, 9 community health care centres and 567 clinics – a total of 627 health establishments.⁴⁰⁵ The highest average score for all health establishments inspected was achieved by Gauteng with 55% (also the only province with an average score that was over 50%), while Limpopo had the lowest score of 39%.⁴⁰⁶ According to the 2015/2016 report five health establishments (two tertiary hospitals and three clinics) out of 627 health establishments inspected, achieved the overall 80% compliance score.

5.231 The four central hospitals scored in a range between 65% and 76%, the 11 provincial tertiary hospitals varied between 47% and 91%, the nine regional hospitals ranged from 40% to 73%, and the 27 district hospitals varied between 41% and 67%. The best hospital was the Grey's Tertiary Hospital in KwaZulu-Natal with an overall score of 91% compliance, the poorest performing hospital was the Kimberley Tertiary Hospital with a score of 47%.⁴⁰⁷ Only one community health care centre out of six inspected achieved a score of over 50% and the majority of clinics in the country scored less than 50% (most clinics in the poorer provinces of Eastern Cape, Free State and Limpopo scored below 40%).⁴⁰⁸ Considering that clinics, community health care centres and district hospitals are the backbone of the public health system, these figures are worrying indeed.

⁴⁰⁴ Portfolio Committee on Health *Public Health Facilities audit results: Office of Health Standards Compliance (OHSC) briefing PMG* (16 March 2016) pmg.org.za/committee-meeting/22233/. OHSC *OHSC Inspection results national coverage 2014-2015* (slide presentation).

⁴⁰⁵ OHSC *Annual Inspection Report 2015/16* (April 2017) at 176 [OHSC 2015/16].

⁴⁰⁶ OHSC 2015/16 at 27.

⁴⁰⁷ OHSC 2015/16 at 116.

⁴⁰⁸ OHSC 2015/16 at 51 (central hospitals), 116 (tertiary hospitals), 156 (regional hospitals), 159 (district hospitals), 177–189 (clinics), 191 (community health care centres).

(d) OHSC inspection report 2016/17

5.232 In the 2016/17 year, the OHSC inspected 17% of South Africa's public health establishments, which translates to 696 health establishments.⁴⁰⁹ Health establishments inspected across the nine provinces included one central hospital, two provincial tertiary hospitals, 11 regional hospitals, 32 district hospitals, 32 community health care centres and 619 clinics.⁴¹⁰ The average score achieved for hospitals was 59%, while community health care centres scored 50% and clinics 47%.⁴¹¹ The lowest average score across the board for a specific domain was for Leadership and Governance.⁴¹² The best hospital was the Paarl Hospital in the Western Cape with an 81% compliance score, the worst was the Maclear Hospital in the Eastern Cape with a score of 30%. The Laudium Clinic in Gauteng achieved 83%, the Lephepane Clinic in Limpopo scored only 20%.

5.233 The OHSC found that 62% of health establishments were non-compliant with regard to norms and standards for healthcare quality. The OHS report 2016/17 indicates that urgent intervention is necessary in the majority of health establishments to improve compliance status. The final outcome for the 2016/17 inspections was:⁴¹³

- 1) Seven health establishments were compliant, scoring 80% or more.
- 2) A total of 32 health establishments were compliant with requirement and achieved scores between 70% and 79%.
- 3) A total of 87 health establishments were conditionally compliant with scores between 60% and 69%.
- 4) A total of 194 health establishments were conditionally compliant with serious concern, achieving scores between 50% and 59%.
- 5) A total of 308 health establishments were non-compliant with scores between 40% and 49%.
- 6) A total of 224 health establishments were critically non-compliant, scoring below 40%.

⁴⁰⁹ OHSC *Annual Inspection Report 2016/17* (June 2018) at 10 [OHSC 2016/17].

⁴¹⁰ OHSC 2016/17 at 15.

⁴¹¹ OHSC 2016/17 at 17.

⁴¹² OHSC 2016/17 at 18.

⁴¹³ OHSC 2016/17 at 31.

(e) OHSC inspection report 2017/18

5.234 The OHSC inspection report for 2017/18 observes in general that:⁴¹⁴

There is a need to address human resource, leadership and corporate governance issues in HEs including strategies to address current infrastructural gaps.

5.235 The target for inspections for the 2017/18 year was 18% inspection coverage, (689 out of 3816 public HEs), but the final sample size number (n=) reflected in the inspection results is 923 health establishments (887 clinics and 36 hospitals).⁴¹⁵

5.236 The average score achieved was 61% for hospitals and 48% for clinics. Although no hospitals achieved 80% or more, 30 hospitals (83%) scored between 50% and 79%. The best-scoring hospital was the Dundee Hospital in KZN with 79%,⁴¹⁶ while De Aar Hospital in the Northern Cape was the worst, scoring only 39%.⁴¹⁷ The Lotus Gardens clinic in Gauteng scored 88%,⁴¹⁸ the Bekhulwandle clinic in KZN only achieved 20%.⁴¹⁹ A total of 11 clinics achieved a score of 80% or higher, but it is perturbing that 510 clinics out of 887 inspected (nearly 60%) scored less than 50% (non-compliant and critically non-compliant).⁴²⁰ The lowest average score across the board for a specific domain was 22% for Leadership and Governance (45% for hospitals; 14% for clinics).⁴²¹

5.237 The final outcome for the 2017/18 inspections was:⁴²²

- 1) No hospitals, but 11 clinics were compliant and scored 80% or more.
- 2) A total of 7 hospitals and 17 clinics were compliant with requirement and scored between 70% and 79%.
- 3) A total of 14 hospitals and 103 clinics were conditionally compliant with scores between 60% and 69%.

⁴¹⁴ OHSC *Annual Inspection Report 2017/18* (December 2019) at 1 [OHSC 2017/18].

⁴¹⁵ OHSC 2017/18 at 4 & 11.

⁴¹⁶ OHSC 2017/18 at 43.

⁴¹⁷ OHSC 2017/18 at 83.

⁴¹⁸ OHSC 2017/18 at 27.

⁴¹⁹ OHSC 2017/18 at 43.

⁴²⁰ OHSC 2017/18 at 11.

⁴²¹ OHSC 2017/18 at 15.

⁴²² OHSC 2017/18 at 11.

- 4) A total of 9 hospitals and 246 clinics were conditionally compliant with serious concern, achieving scores between 50% and 59%.
- 5) A total of 5 hospitals and 301 clinics were non-compliant with scores between 40% and 49%.
- 6) One hospital and 209 clinics were critically non-compliant, scoring below 40%.

(f) OHSC inspection report 2018/19

5.238 The OHSC inspection report for 2018/19 indicated that the target was 19% inspection coverage, translating to 726 health establishments out of 3816 in South Africa.⁴²³ In the end, 730 health establishments were inspected.⁴²⁴ The lowest average score across the board for a specific domain was for Leadership and Governance once again, which totalled 22%.⁴²⁵

5.239 The average score for all health establishments inspected was 53%. Three hospitals, five clinics and one community health care centre scored 80% or more. At the other end of the spectrum, two hospitals, two community health care centres and 99 clinics scored less than 40%.⁴²⁶ More than half the clinics inspected (325 out of 631) scored below 50% (non-compliant and critically non-compliant). The best hospital was Edendale in KZN with a score of 86%,⁴²⁷ the worst was Kakamas in the Northern Cape with a score of 30%.⁴²⁸ The best clinic was the Mamelodi West clinic in Gauteng scoring 85%,⁴²⁹ compared to the Mecklenburg Gateway clinic in Limpopo with a score of 25%.⁴³⁰

5.240 The final outcome for the 2018/19 inspections was:⁴³¹

- 1) A total of three hospitals, five clinics and one community health care centre were compliant and scored 80% or more.
- 2) A total of 8 hospitals, 25 clinics and 4 community health care centres were compliant with requirement and scored between 70% and 79%.

⁴²³ OHSC *Annual Inspection Report 2018/19* (March 2020) at 3 [OHSC 2018/19].

⁴²⁴ OHSC 2018/19 at 9.

⁴²⁵ OHSC 2018/19 at 10.

⁴²⁶ OHSC 2018/19 at 9.

⁴²⁷ OHSC 2018/19 at 45.

⁴²⁸ OHSC 2018/19 at 78.

⁴²⁹ OHSC 2018/19 at 38.

⁴³⁰ OHSC 2018/19 at 54.

⁴³¹ OHSC 2018/19 at 9.

- 3) A total of 17 hospitals, 86 clinics and 16 community health care centres were conditionally compliant with scores between 60% and 69%.
- 4) A total of 8 hospitals, 190 clinics and 16 community health care centres were conditionally compliant with serious concern, with scores between 50% and 59%.
- 5) A total of 12 hospitals, 226 clinics and 10 community health care centres were non-compliant with scores between 40% and 49%.
- 6) Two hospitals, 99 clinics and two community health care centres were critically non-compliant, scoring below 40%.

5.241 The OHSC published their Bi-Annual Inspection Report 2020-2022 recently. The report is undated and no accompanying media statement or other information about the report could be found, hence the date of publication is uncertain. The report only contains lists of the health establishments inspected during the 2020 to 2022 period, with no further information provided.⁴³²

⁴³² Office of Health Standards Compliance *Bi-Annual Inspection Report 2020-2022* (undated).

CHAPTER 6: PREVIOUS REPORTS

A Conclusion

6.1 The mission statement of the national Department of Health is centred on improving the health status of individuals, and improving the health care delivery system. As far as the improvement of the health care delivery system is concerned, the NDOH's mission is to "consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability". However, all indications are that the improvement of the health care delivery system is lagging, and that health care delivery services are actually deteriorating in some provinces.

6.2 The Commission, as a law reform body, is limited in so far as it cannot propose changes beyond the scope of the law. It cannot make recommendations on the delivery of quality health care services, constrained budgets, human resources, lack of skills and capacity, shortage of medical personnel, operation and management of health establishments, inadequate health infrastructure, supply chain management, shortage of medical equipment, medicines and other supplies, inadequate training and supervision, and so forth.

6.3 All the issues relating to quality health care services, however, had been dealt with extensively by a range of reports, published investigation results, declarations and other publications making findings and putting forward recommendations since 2009. The only issue that is still outstanding, is full implementation of these documents.

B Introduction

6.4 An enormous amount of work and research has been done over the past 13 years to investigate the causes of and propose solutions for addressing the crisis in the public health sector and associated medico-legal litigation. Investigations had been conducted and reports compiled over the years at the behest of the President, Minister of Health, Department of Health and National Treasury. The results of these efforts provide much insight into the root causes of the problems and likely solutions. It just requires actual implementation.

6.5 Some of the earlier government-initiated reports were initially not generally published, but were made available to the SALRC and became available in the public domain over time. The following documents were reviewed:

- 1) Clinton Health Access Initiative *Medico-Legal Claims Analysis for National Treasury* (Unpublished report December 2019).
- 2) *Presidential Health Summit 2018 Compact* (July 2019).
- 3) *Report on the Presidential Health Summit 2018* (February 2019).
- 4) South African Lancet National Commission *Confronting the Right to Ethical and Accountable Quality Health Care in South Africa* (December 2018).
- 5) Health Ministerial Task Team Hospital Mismanagement and Poor Service Delivery Closure Report (May 2017).
- 6) Declaration following Medico-Legal Summit (March 2016) – summit hosted by the Minister of Health.
- 7) Steve Biko Centre for Bioethics *Discussion Document prepared in Preparation for a Medico-Legal Summit to be held by the Minister of Health* (Unpublished report September 2013).
- 8) National Litigation Strategy Report (Unpublished report 2012) – compiled by task team established by the Minister of Health.
- 9) Reports of the Integrated Support Teams (April and May 2009) – facilitated by the Department of Health at the initiative of the Minister of Health.

6.6 On comparing the first 2009 report to the most recent reports, familiar themes of lack of leadership and governance, staff shortages, critical posts that are vacant, budgetary constraints, lack of delegations, accruals, political interference, lack of equipment, poor maintenance of facilities, fragmented IT systems, stock-outs, poor quality health care, poor procurement systems and supply chain management, the impact of medico-legal claims and so forth are apparent.

C Overview of government-initiated reports

1 Medico-Legal Claims Analysis (December 2019)

(a) *Background*

6.7 This document is an investigation and analysis of the medico-legal situation across the country.¹ National Treasury requested the Clinton Health Access Initiative (CHAI) Health Financing team in March 2019 to investigate the medico-legal situation across South Africa. The subsequent report “aims to offer an overview of the status quo, considering qualitative and quantitative data collected from provinces. Thereafter, recommendations are made for execution at both national and provincial levels.”² CHAI tried to determine the scope and major drivers of medical litigation in each province, whether there are similar trends across provinces, and whether there are examples of best practice that could be shared with other provinces.

(b) *Findings*

6.8 The main findings of the investigation, listed per category, can be summarised as follows:

Qualitative data synthesis

(i) Quality of healthcare

- 1) Some cases are not worth defending given the certainty of negligence.
- 2) Inability to follow standard midwifery protocols.
- 3) There is a legal presumption that public healthcare is not a reasonable standard of compensation.
- 4) Hospitals in rural areas may be at greater risk of litigation.
- 5) The facility where a claim is said to be located is not necessarily to blame.

(ii) Administration of claims

- 1) Medical records are not easily accessible and may be insecure.
- 2) The high volume of claims, low capacity of medico-legal teams, and the subsequent backlog impairs high quality claims management.

¹ Clinton Health Access Initiative *Medico-Legal Claims Analysis for National Treasury* (Unpublished report December 2019) 3 [CHAI (2019)].

² CHAI (2019) 5.

- 3) Obtaining expert opinions is sometimes challenging.
- 4) Attend to differences in quantum valuations.
- 5) Data is generally not collected or analysed effectively.

(iii) *Financial impact*

- 1) The inability to budget for medico-legal payments in certain provinces impacts on service delivery in unexpected (unplanned) ways.
- 2) The state attorney in some provinces may be inflating bills.

(c) **Recommendations**

6.9 The report acknowledges that the medico-legal problem is incredibly complex and should be dealt with holistically by multidisciplinary experts. The report states as follows:

[T]he most sustainable solution to prevent claims is to tackle the standard of care from which error and subsequent indefensible litigation arises. The overarching recommendation of this report is therefore that the root causes of claims need to be investigated and addressed and a proactive strategy needs to be taken by each province.

6.10 The report makes the following specific recommendations:

Office of the Accountant General

- Provide guidance to provinces on budgeting for medical litigation.
- Provide guidance on the classification of contingent liabilities.

Provincial Departments of Health

- Improve data collection and maintenance (urgent).
- Improve medical report filing, especially birth files (urgent).
- Filter claims according to 'defend' or 'settle' to increase efficiency of case management.
- Early warning systems should alert litigation managers of a possible impending claim (before a summons is actually sent).
- Conduct informal mediation at the time of an adverse event to avoid both legal costs and [an increase in] the quantum of claims.
- Expand and capacitate multidisciplinary medico-legal units (with both clinical and legal expertise) at provincial level.
- Introduce quality improvement interventions targeted specifically at obstetrics and gynaecology.

- Prioritise quality improvement of rehabilitation centres, especially to convince the courts that the state is able to provide future medical care in lieu of lump sum payments for future medical expenses.

National Department of Health

- Provide clarity on the management and implementation plan for the medico-legal expert assistance tender.
- Investigate standardisation of quantum method (approach the Actuarial Society of South Africa to consider standard guidelines for computing medical malpractice claims).
- Develop targeted risk management protocols for the 'at-risk' specialisations.
- Provide guidance on best practices in managing medico-legal claims.

2 Presidential Health Summit 2018 Compact (July 2019)

(a) Background

6.11 The Presidential Health Summit 2018 Compact (PHS Compact) is an agreement consented to by government and key stakeholders whose work impacts on the health system.³ Following on the Presidential Health Summit held in October 2018, a post-Presidential Health Summit working group was convened to prepare a health compact.

6.12 The Presidential Health Summit brought together the Presidency, Ministry of Health and key stakeholders to identify challenges facing the health system and to seek solutions to prevent further deterioration of the health system.⁴ As stated in the PHS Compact:⁵

This Compact outlines the key interventions that the Government and stakeholders will undertake or support over the next five years (2019 - 2024). The collective objective is to strengthen the South African health system to ensure that it provides access to quality health services for all in an equitable, efficient and effective manner.

³ South African Government *Presidential Health Summit 2018 Compact: Strengthening the South African health system towards an integrated and unified health system* (25 July 2019) [PHS Compact (2019)].

⁴ PHS Compact (2019) 19.

⁵ PHS Compact (2019) 33.

(b) Aim and scope of Compact

6.13 The Compact lists commitments made by the parties to the Compact, put forward as nine “pillars”, to strengthening the South African health system. In the message from the President introducing the PHS Compact, the President makes the following statement about the aim and scope of the Compact:⁶

This Presidential Health Compact is an agreement consented to by government and key stakeholders whose work impacts on the health system. The Compact places the accountability on stakeholders to meet the commitments made within the allocated timeframe. The parties to this document are committed to implementing this Compact, the results of which should be visible to all in the country.

(c) Methodology

6.14 After several organisations raised concerns about healthcare in South Africa and a meeting between the President and the Progressive Health Forum, the President convened a Health Colloquium in August 2018. Following that, the multi-stakeholder Steering Committee on the Presidential Health Summit was established in the Presidency, tasked with preparing for and arranging the Presidential Health Summit held on 19 and 20 October 2018.⁷

6.15 The Summit brought together key stakeholders within the health sector, including various government departments, statutory councils, health professionals, allied health professionals, traditional health practitioners, the business community, civil society, health service user groups, labour, regulators, academia and research organisations as well as public health entities.⁸ This consultative meeting saw participants collaborating to come up with proposals to deal with the crisis in the public health sector. Nine Commissions were established to deliberate on health system challenges and recommend solutions.⁹

⁶ PHS Compact (2019) 1.

⁷ PHS Compact (2019) 1.

⁸ The groups comprised of 76 health professions organisations, 11 allied health professions organisations, 118 user groups, 14 civil society groups, 32 academic and research organisations, 5 science councils, 48 businesses (private sector organisations), 8 public health entities, 11 traditional healer practitioner organisations, 16 government departments, 12 labour organisations, 12 statutory councils [PHS Compact (2019) 1]. Contributing organisations are listed in the PHS Compact (2019) at 13 to 18.

⁹ See discussion on the *Report on the Presidential Health Summit 2018* below.

6.16 Subsequent to the Summit stakeholders consulted their constituencies to propose interventions to stop the deterioration of the health system and improve its functioning. The Steering Committee facilitated the work of various task teams to develop the PHS Compact and the actions plans to support the implementation of the Compact. The interventions are coupled with action plans that detail activities and the expected outcomes. The action plans also indicate the relevant accountable institutions for the listed activities, as well as critical success factors and time frames.¹⁰ Stakeholders have committed cooperating for the next five years to improve the health system.¹¹

(d) Outcome

6.17 The PHS Compact was jointly signed on 25 July 2019 by the President of South Africa and representatives of stakeholder groups. The Compact aims to ensure that the interventions suggested are implemented by the government and all stakeholders. Each of the nine pillars is augmented by a table stipulating key interventions, key activities, indicators, timelines (generally April of 2021, 2022 and 2024) and the accountability (lead) and responsibility (support) for executing the activities. The biggest concern is that the NDOH and provincial DOHs are accountable and responsible for the majority of the indicators and activities. Since the current crisis is to a large extent attributable to the inability of the NDOH and provincial DOHs to implement all the previous plans, it is not clear what will change now.

(e) Findings

6.18 The PHS Compact is a social agreement setting out interventions in the public health sector to be implemented by all stakeholders. The compact is the result of the deliberations that took place at the October 2018 Presidential Health Summit. The Compact does not repeat the challenges faced by the public health sector, as these are set out in the *Report on the Presidential Health Summit 2018* released in February 2019. The Compact focuses on the interventions determined upon to address the crisis in the public health sector and to achieve the objective of a universal health care system. These interventions are summarised below:

Pillar 1: Augment human resources for Health Operational Plan.

¹⁰ PHS Compact (2019) 2.

¹¹ PHS Compact (2019) 19.

- 1) Human resources for health policy.
- 2) Governance, leadership and management in human resources.
- 3) Education, training and development.
- 4) Partnerships.
- 5) Health workforce wellbeing.
- 6) Advocacy.

Pillar 2: Ensure improved access to essential medicines, vaccines and medical products through better management of supply chain equipment and machinery.

- 1) Centralised procurement.
- 2) Training/ human resource capacitation.
- 3) Communication strategy.
- 4) Supply chain management.
- 5) Regulation and registration.
- 6) Budget and financing.
- 7) Health technology assessment.
- 8) Health information systems.
- 9) Indigenisation of pharmaceutical production.
- 10) Improving access to medicine and essential devices.
- 11) Partnerships.
- 12) Innovating and incorporating new technologies.

Pillar 3: Execute the infrastructure plan to ensure adequate, appropriately distributed and well-maintained health facilities.

- 1) Health infrastructure planning to ensure appropriate facilities on a sustainable basis.
- 2) Health infrastructure delivery.
- 3) Health infrastructure financing.

Pillar 4: Engage the private sector in improving the access, coverage and quality of health services.

- 1) Support to alleviate staffing shortages on a sustainable basis.
- 2) Bolster the training of nurses to meet country needs.
- 3) Contribute to patient-centric contractual model.
- 4) Twinning solutions to contribute to improved management of healthcare facilities.
- 5) Governance assistance based on the needs identified in specific regulatory entities.

- 6) Expand healthcare access for those at school.
- 7) Patient education to empower the healthcare user.
- 8) Improved processes and outcomes of medico-legal disputes.
- 9) Public Private Engagement Mechanism.

Pillar 5: Improve the quality, safety and quantity of health services provided with a focus on to primary health care.

- 1) Engaging and empowering people and communities.
- 2) Scaling up community-based health services and bring care closer to people, empowering and engaging communities.
- 3) Reaching the underserved, marginalised and vulnerable populations.
- 4) Reorienting the model of care: defining an essential package of health services based on life course needs.
- 5) Building reliable primary healthcare-based systems in both the public and private sectors.
- 6) Coordinating services for a continuum of care: coordinating individuals, health programmes and providers.
- 7) Coordinating across sectors.
- 8) Addressing health determinants: prioritising promotion, prevention and public health.
- 9) Creating an enabling environment: conduct appropriate research to inform the health transformation agenda.
- 10) Striving for quality improvement and safety.
- 11) Reduce the incidence and impact of malpractice and medical litigation.
- 12) Aligning regulatory frameworks.

Pillar 6: Improve the efficiency of public sector financial management systems and processes.

- 1) Improve health sector capacity to effectively manage the public sector financial management and address corruption and wastage.
- 2) Fund the accumulated accruals in the provincial health budgets.
- 3) Improving funding and reforming payment systems.
- 4) Equitable allocation of budgetary resources across national, provincial and district levels.
- 5) Review the efficiency of HIV and other conditional grants.
- 6) Improve the financing and management of central hospitals and the training of health professionals including specialists.

- 7) Increase public sector hospital revenue.
- 8) Optimise the funding needs of health entities, institutions and the Health Ombudsman.
- 9) Strengthen the Office of the Health Ombudsman.

Pillar 7: Strengthen Governance and Leadership to improve oversight, accountability and health system performance at all levels.

- 1) Strengthen accountability mechanisms at the national, provincial and institutional level within the current constitutional framework.
- 2) Provide practical policy guidance across the health sector.
- 3) Ensure effective oversight through robust health information, research and evidence.
- 4) Address corruption decisively.
- 5) Update and reinforce health sector regulations to improve quality, transparency, accountability and efficiency in the health sector (public and private).
- 6) Coordination across the health sector and building strategic partnerships.

Pillar 8: Engage and empower the community to ensure adequate and appropriate community-based care.

- 1) Strengthen governance capacity of bodies involving communities.
- 2) Monitoring, evaluation and compliance.
- 3) Training and education of community health workers and health professionals.
- 4) Community health services.
- 5) Enhance health literacy for better outcomes: enhance health literacy and use of technology for better health.
- 6) Referral and outreach systems.
- 7) Inter-sectoral collaborations.
- 8) Partnership.

Pillar 9: Develop an information system that will guide the health system policies, strategies and investments.

- 1) Integrated Health Information System (patient and management).
- 2) Standardisation of diagnostic and procedure coding systems.
- 3) Healthcare technology infrastructure and architecture.
- 4) Capacity building and skills transfer for digital health.
- 5) Development of business intelligence for the health sector.

3 Report on the Presidential Health Summit 2018 (February 2019)

(a) Background

6.19 The Presidential Health Summit, hosted by President Cyril Ramaphosa, took place on 19 and 20 October 2018. The *Report on the Presidential Health Summit* is an account of the deliberations held at the Summit. The Summit was attended by stakeholders that included government, health and allied health professions, civil society, labour, business, academia, scientists and health users. The aim of the summit was strengthening the South African health system towards an integrated and unified health system.

(b) Objective

6.20 The Summit was convened to discuss the crisis in the South African health system. The objectives of the Presidential Health Summit 2018 were to:¹²

- Advance collective efforts to promote good health care services as an essential foundation to health for all in South Africa.
- Outline the roadmap towards a unified health care system by committing to rebuild the health system to provide quality health care to all.
- Identify actions to strengthen co-ordination, monitoring and evaluation of the health system.
- Identify actions to strengthen co-ordination to deal with corruption, waste and abuse to improve accountability and transparency in the health system.
- Address and action solutions to end the crisis in the health system.

6.21 The expected outcome of the Presidential Health Summit was that the objectives stated above will be met through the development of a mutually accepted and agreed action-oriented health compact. The Presidential Health Summit was also aimed at developing a roadmap for the implementation of the identified interventions. A commitment from all stakeholders including the private sector, civil society, health professionals, labour unions, health service users, academics and the public is required to achieve the broad goals of ensuring access to quality health services for all.

¹² South African Government *Report on the Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system* (February 2019) 15 [PHS Report (2019)].

(c) Scope of review

6.22 Deliberations at the Summit was held along the following nine themes:¹³

- 1) Human Resources for Health (Health Workforce)
- 2) Supply Chain Management, Medical Products, Equipment and Machinery
- 3) Public Financial Management
- 4) Infrastructure Planning
- 5) Private Sector Engagement
- 6) Health Service Provision (Delivery)
- 7) Leadership and Governance
- 8) Community Engagement
- 9) Information Systems.

6.23 For the purpose of discussions at the summit, a commission was established for each of the themes referred to above. Delegates deliberated on the challenges the health system is facing in the commissions and made recommendations on solutions. Where possible, proposals were divided into short-term, medium-term and long-term solutions.¹⁴ The commissions were expected to do the following:¹⁵

- Identify commission specific action solutions that will address the health crisis.
- Identify areas of consensus among constituencies and highlight in plenary the key disagreements in the commissions.
- Begin to identify key building blocks of the road map towards universal health coverage from the identified action solutions.

(d) Outcome

6.24 A post-Presidential Health Summit working group was established to prepare a health compact to be signed by the President of South Africa and representatives of stakeholder groups. This forms part of an initiative to include all stakeholders to address the crisis in the health sector, as government cannot deal with the implementation of proposed solutions on its own.

¹³ PHS Report (2019) 25.

¹⁴ PHS Report (2019) 25.

¹⁵ PHS Report (2019) 25.

(e) Findings

6.25 The findings of the nine Commissions are summarised below. The findings are set out in some detail, since the findings of the PHS mostly repeat in greater or lesser detail the findings of previous reports.

Commission 1: Human Resources for Health (Health Workforce)

6.26 The specific concerns raised with regard to human resources were vacant posts, performance management, poor planning, inadequate remuneration, poor coordination at different spheres of government, lack of leadership, management and governance, lack of delegation of authority, harmonisation and stewardship.¹⁶

6.27 The need for alignment and harmonisation was highlighted, including planning and budgeting to meet health needs, and education and training that are in line with health system requirements. The five pillars of human resources management are policy, finance, education, partnership and leadership. Continuous monitoring and evaluation are essential to ensure that human resources meet the needs of the health sector.¹⁷

6.28 Some of the major challenges experienced are inadequately funded posts; maldistribution of posts relative to need; poor service delivery planning; clinicians who are over-worked; safety concerns for staff in facilities; and lack of financial resources to absorb junior doctors in the public health sector.¹⁸

Commission 2: Supply Chain Management, Medical Products, Equipment and Machinery

6.29 The World Health Organisation considers medicine as a priority, meaning that “medicine should be available at all times and in adequate amounts, in appropriate dosage and quality and at an affordable price for individuals and communities.”¹⁹ Effective supply chain processes and procedures, from procurement and selection through to distribution and supply, are vital; especially in view thereof that medicine is the second largest expenditure item in the health system.

¹⁶ PHS Report (2019) 27.

¹⁷ PHS Report (2019) 27.

¹⁸ PHS Report (2019) 28.

¹⁹ PHS Report (2019) 33.

6.30 There are several gaps in supply chain management in the South African public health system, such as limited supply chain management skills; inadequate monitoring and governance on available systems; shortage of equipment and consumables resulting in poor quality of care; corruption; tedious and cumbersome supply chain management processes; inadequate information systems; suppliers not being paid on time, which impacts on medicine availability; poor procurement systems and processes; and procurement systems and processes that are not standardised across all levels. Medical consumables are impacted by a lack of regulation on quality, failure to adhere to a national catalogue of products and ineffective monitoring of availability systems.²⁰

Commission 3: Infrastructure Plan

6.31 Although the National Department of Health has a health infrastructure plan, South Africa has neither the expertise nor the funding to implement the plan. In instances where health infrastructure has been constructed, the initial budgets were exceeded; the facilities did not meet the needs for the services required; or there are not enough funds to put the new facilities into full operation.²¹ The Report states: “The result has been reactive crisis management to the consequences of this mismatch as well as the failure to replace facilities.”²²

6.32 Other challenges are differences between demonstrated infrastructure priorities and the existing work plan; insufficient capacity for project implementation, monitoring and evaluation. In spite of the Infrastructure Delivery Management System, there is poor management capacity in the national and provincial health departments, and inadequate alignment with the Department of Public Works in relation to health infrastructure.²³

Commission 4: Private Sector Engagement

6.33 There is significant inequity in health care delivery between the public and private sectors. The public sector, which delivers public health care to 84% of the population, remains the foundation of health care delivery, but experiences serious delivery and capacity challenges. However, in engagements with the private sector the need for

²⁰ PHS Report (2019) 33.

²¹ PHS Report (2019) 35.

²² PHS Report (2019) 35.

²³ PHS Report (2019) 37.

equity, fairness, efficiency and sustainability must be recognised. The amounts paid by private health care subscribers are becoming unsustainable. A change towards universal health care would require an investigation into the medical scheme environment.²⁴

6.34 A shift is required from the historical distinction between the public and private health sectors to “an integrated health system that has a shared vision, common higher purpose and tangible commitment to meeting the needs of the total population.”²⁵ Although the public health sector serves the majority of the SA population, the private sector has excess infrastructural capacity and capabilities that could assist the public health sector. The health system should be redesigned to improve cooperation between the public and private sectors.²⁶

Commission 5: Health Service Provision (Delivery)

6.35 The Report identifies a number of challenges and shortcomings with regard to health services provision:

- Variable leadership and management skills across the system.
- Failure or inability to act on identified deficiencies.
- Political interference in health care operations resulting in deployment of incompetent managers for party political reasons.
- Inadequate revenue collection, adding to public sector funding constraints.
- Corruption at all levels.
- Lack of accountability and of consequences.
- Poor disciplinary procedures.
- Inadequate human resources – critical posts are unfilled.
- Decrease in professionalism in health care professions (e.g. nursing education).
- Negative staff attitudes and absenteeism.
- Health workers subject community members to abuse, who in turn abuse health care workers.
- Ineffective supply chain management systems.
- Drug stock-outs.
- Overcrowded facilities with long waiting times for treatment.

²⁴ PHS Report (2019) 39.

²⁵ PHS Report (2019) 39.

²⁶ PHS Report (2019) 39.

- Unequal access to services in rural areas.
- Accessibility of services for vulnerable people, the elderly and disabled.
- The health system is mainly centred around hospitals.
- There should be more focus on promotive and preventative health care.
- Substandard health facilities – ageing infrastructure and unsafe facilities.
- Unsatisfactory maintenance and repair services.
- Safety and security of patients and staff.
- Lack of infection control.
- Fragmented health information systems.
- Lack of data for planning.²⁷

Commission 6: Public Sector Financial Management

6.36 Provincial health budgets are mainly funded through the equitable share (of revenue raised nationally) and conditional grants, with revenue collection making a small contribution. The national DOH transfers conditional grants, but these grants are subject to specific conditions which are determined at national level.²⁸

6.37 The financial position of the provincial governments has an impact on hospitals' ability to provide quality health care. The Report states that: "The provincial treasuries should be engaged on the baseline allocations (equitable share formula) to the provincial Departments of Health." **There are significant differences in allocations for health services between the provinces since there is no coherence on a formula to determine an equitable allocation.** Health care should be a priority, especially in view of the dependency of rural communities on public health services.²⁹

6.38 The budget is under severe pressure due to over expenditure; accruals, including accruals for personnel expenditure such as overtime and rank promotions; unfunded mandates; deteriorating service delivery; health financial allocation is not protected and is in the discretion of provincial treasuries, who can reprioritise health funding; lack of financial delegation to facility managers, impacting negatively on service delivery; structural, functional and capacity challenges; lack of norms and standards enforcement

²⁷ PHS Report (2019) 41 & 43.

²⁸ PHS Report (2019) 45.

²⁹ PHS Report (2019) 46.

mechanisms and support; and financial impact of medical malpractice claims on provision of health care services.³⁰

Commission 7: Leadership and Governance

6.39 Leadership and governance require a multi-level governance framework that is not limited to the departments of health. Governance at present is split between health and treasury; political and technical accountability; vertical programmes and service delivery; managers and clinicians/ health workers.³¹ Leadership and governance challenges include:

- Poor implementation of governance policies.
- Lack of policy clarity between national, provincial and institutional authority.
- Poorly aligned roles and responsibilities across levels of the system.
- Political interference in management.
- Corruption that erodes the ability to deliver health care.
- Insufficient training of clinicians on leadership, ethics and governance.
- Insufficient training of management on patient-centred care; and
- Lack of transparency and standards for clinic committees and hospital boards' appointments.³²

Commission 8: Community Engagement

6.40 The Reconstruction and Development Programme (RDP) released in 1994 determined that community participation in the planning, managing, delivery, monitoring and evaluation of health services in their areas must be encouraged. The World Health Organisation recognises the importance of health care that is universally accessible to communities through their participation.³³ However, organised input from communities via mandated community structures is on the decline.³⁴ Governance structures in health facilities (such as boards and committees) are not functional and are viewed as an extension of political power. There is lack of clarity on accountability of these structures. The existing provincial consultative forums are not functional.³⁵

³⁰ PHS Report (2019) 46 & 47.

³¹ PHS Report (2019) 49.

³² PHS Report (2019) 50.

³³ PHS Report (2019) 53.

³⁴ PHS Report (2019) 53.

³⁵ PHS Report (2019) 54.

6.41 Community health workers (CHWs) are vital in maintaining the link between communities and health facilities and must have a relationship with both. The relationship between CHWs and the community are blighted by distrust and a lack of confidentiality and professionalism. There is lack of CHW supportive supervision. The CHW programme requires review on role clarification, absorption by employer, staff benefits in relation to other benefits e.g. SASSA grants, clarity on who CHWs are accountable to, accurate reporting on functionality of Ward Based Outreach Teams, career-paths for CHWs and recognition of training by universities and colleges.³⁶

Commission 9: Information Systems

6.42 The current health information systems within the public health sector and between the public and private health sectors are plagued by the following problems:

- The systems are fragmented, which pose a major challenge to effective supervision and management of the system.
- The coding systems for medical information are not standardised.
- One platform is required whereby information can be exchanged between the disparate systems.
- There is poor compliance to the health normative standards framework (HNSF) by existing systems in the country.
- Budget allocation is insufficient with lack of prioritisation of eHealth and health information systems.
- Progress in information systems is plagued by inadequate connectivity (particularly at primary health care facilities); high costs of broadband connectivity and network infrastructure; as well as cyber-security issues.³⁷

(f) Recommendations

6.43 The participants at the summit tabled solutions to address the challenges identified as summarised above. They proposed interventions under each of the themes discussed. In most instances the interventions are further categorised in terms of immediate actions, short-term actions and immediate actions. However, in order to limit the amount of information reflected in this paper, the information has been summarised as far as possible.

³⁶ PHS Report (2019) 54.

³⁷ PHS Report (2019) 57.

Commission 1: Human Resources for Health (Health Workforce)

6.44 There are several issues of concern pertaining to human resources and a number of recommendations were put forward to resolve these challenges. The following synopsis is provided:³⁸

- A human resource (HR) roadmap is required that should include occupational health and safety; recognition and reward for personnel; talent management; attraction and incentives; retention and support.
- Staffing and funding policies must meet the needs of the health system. Evidence and needs-based human resource planning and financing, and the equitable distribution of human resources are required.
- Review the roles and responsibilities of each sphere of government in relation to health services.
- Lift the moratorium on human resources. Unfreeze and finance critical posts, especially posts that impact on service delivery.
- Fast-track implementation of the policy on foreign trained medical practitioners.
- The state must fulfil its obligation regarding the statutory employment of health professionals.
- Address inadequate supervision of junior staff and the absence of senior colleagues.
- Review the policy on Remuneration of Work Outside Public Sector [*sic*] (RWOPS: “remunerative work outside of the public service”).
- Validate and optimise the use of the Integrated Human Resource, Personnel and Salary System (PERSAL) and the HR management information system.
- Review the public sector organisational design to address the top-heavy structure.
- There must be a separation between political and administrative leadership.
- All management must undergo continuous leadership and management training.
- Review the working hours of health care professionals to align working hours with the health care needs of the community, and to bring working hours within the reasonable capacity of the available staff.
- Review training programmes, taking the NHI policy into consideration.

³⁸ PHS Report (2019) 9, 29 & 31.

- Address the shortage of trainee posts.
- Improve public private partnership collaborations to develop the human resources needed for universal health care.
- Improve engagement with healthcare worker professional associations.
- Improve security measures at health facilities.
- Address corruption related to the abuse of HR systems.
- Base service plans on good information on population health needs, training capacity of institutions of higher education and posts available at provincial health departments.

Commission 2: Supply Chain Management, Medical Products, Equipment and Machinery

6.45 There are several gaps in supply chain processes and procedures. Proposals made to address the challenges discussed at the summit are:³⁹

- Ring-fence pharmaceutical budgets to avoid funds being redirected, which results in unavailability of medicine.
- A database with medical consumables and medical equipment specifications, which also defines equipment in clinical and/or functional terms, is critical.
- An efficient, patient-centred supply chain management is crucial for the successful implementation of NHI.
- Give consideration to a centralised procurement and logistical management system with standardised procurement systems and processes at national and provincial level to improve efficiency, and to deal with corruption and economy of skills and scale.
- There should be Service Level Agreements and maintenance agreements with suppliers for capital equipment purchases.
- Information technology is critical to efficient procurement processes.
- Establish strong government structures at all levels, including planning structures.
- There is a need to develop skills and capacity locally for pharmaceutical manufacturing, production and logistics.
- Shortage of clinical engineers for complex bio-medical equipment, technicians for minor medical equipment and end user expertise in procurement processes.

³⁹ PHS Report (2019) 9–10 & 33–34.

- Establish a state-owned pharmaceutical company, which must be innovative, competitive and highly skilled.
- Support innovative private sector initiatives rooted in an ethos of social responsibility.
- Address and deal with corruption in the supply chain management system.
- Institute a performance management system for equipment maintenance.
- Engage the private sector to advise on inventory management.
- Establish a catalogue and standards for non-medical items /consumables.
- Set up health technology assessment committees.
- Centralise procurement systems (with clear governance mechanisms) at national and provincial level.
- Establish a timely payment system of suppliers to avoid stock-outs.
- National Treasury should investigate the implications of sector-specific procurement systems and develop specific policies for health care procurement.

Commission 3: Infrastructure Plan

6.46 As indicated above, the NDOH has a health infrastructure plan, but to date the country has had neither the expertise nor the funding to implement the plan. Commission Three in short made the following submissions regarding the infrastructure plan.⁴⁰

- Revise the national master infrastructure plan.
- The infrastructure plan cannot be static and must respond to changing population and clinical dynamics.
- The infrastructure plan must facilitate equity through well-managed coordinating mechanisms such as the NDOH, Independent Development Trust (IDT), Council for Scientific and Industrial Research (CSIR), Development Bank of South Africa (DBSA), National Treasury and Department of Public Works (DPW).
- Co-ordinate interventions with other government departments, in particular DPW.
- Explore alternative funding mechanisms for the infrastructure plan, for example, through the PSI, a special health infrastructure fund, corporate social investment, social impact bonds, project bonds, enhanced revenue collection, public private partnerships, and crowd funding.
- Establish a 'back to basics' system to revitalise clinics and hospitals e.g. painting, furniture, toilets, broken windows.

⁴⁰ PHS Report (2019) 10 & 37–38.

- Infrastructure in the public and private health sectors should meet OHSC requirements.
- The OHSC must be adequately resourced and capacitated.

Commission 4: Private Sector Engagement

6.47 The private health care sector is indispensable to achieving universal health care and the implementation of the NHI in South Africa. A harmonious working relationship between the private and public health care sectors is therefore critical to realising these goals in the interests of the South African people. Commission Four dealing with private sector engagement submitted as follows:⁴¹

- Sustain the inclusive process and mechanism started with this summit.
- Collective leadership and stewardship involving both sectors are required to achieve unity on common goals.
- Develop a charter or framework and a set of principles (a “modus co-operandi”) as a foundation for collaboration between the public and private health sectors based on principles such as affordability and good governance.
- The positive energy released via the summit is indicative of both sectors’ willingness and desire to be part of the solution.
- Maintain this energy through transparency, effective communication and feedback to stakeholders, allowing for opportunities to be part of the response to the health care crisis.
- Access to data is vital and both sectors need access to data pertaining to costing, patient activity, quality of health care, outcomes etc.
- Monitor the movement of funds, specifically with regard to inadvertent consequences of weakening the public sector.
- Enable medico-legal cover for private practitioners operating in the public sector.
- Strengthen health care supply regulation, including prices, establishment of new facilities and certificates of need.
- Determine and define public-sector service needs that could be addressed by the private sector, especially with regard to access and under-utilised capacity.
- Encourage local experiments with collaboration, innovative service delivery models and governance arrangements, also using it as a learning opportunity.
- Engage with the report of the Health Market Inquiry.

⁴¹ PHS Report (2019) 10 & 39–40.

- Integrate the outputs from Commission Four, the Health Market Inquiry report and other commissions in a coherent manner.
- Address social and commercial determinants, including health industries that impact negatively on health outcomes and service pressures.
- Clarify the model under NHI and roles and responsibilities pertaining to contracting and service models.

Commission 5: Health Service Provision (Delivery)

6.48 Health service users are often dissatisfied with the quality of the health care they receive and their experience of the service. To attain South Africa's health goals, service delivery under a unified national health system should offer a comprehensive quality service in the field of preventative, curative, palliative, rehabilitative and promotive health care. South Africans need access to affordable, available and acceptable health services delivered at health facilities that meet OHSC standards, OHSC certification being a prerequisite for contracting in NHI.⁴²

6.49 The recommendations made by Commission Five with regard to health service delivery include:⁴³

- Implement a coordinated quality improvement plan in all health facilities.
- Integrate and streamline the referrals system.
- Invest more in community-based health care.
- Focus on promotive and preventive rather than curative health care.
- Prioritise vacancies at primary health care level.
- Formalise roles and training of and appoint more community health workers.
- Contain malpractice expenditure.
- Introduce mediation as a first option for settling medico-legal cases.
- Stop political interference in service delivery.
- Cease unfunded mandates within all departments and provincial administrations.
- Consider the impact of migration from neighbouring countries on the SA health system.

⁴² PHS Report (2019) 10.

⁴³ PHS Report (2019) 43–44.

Commission 6: Public Sector Financial Management

6.50 Reporting on the solutions proposed by Commission Six that engaged on public sector financial management, the Report makes the following important statement:⁴⁴

Provincial health departments must reduce accruals and make efforts to understand cost drivers. They must stick to budgets allocated and monitor expenditure against service delivery standards. Provincial health departments must also establish budget and expenditure rules, e.g. maximum cost of equity (COE) share of the allocated budget. Moreover, they must instil accountability and transparency in governance and procurement.

6.51 Commission Six made several recommendations on financial management:⁴⁵

(i) *Revise resource allocation process*

- Develop a strategy and mechanisms to address accruals on an urgent basis.
- Revisit the equitable share formula for health, taking relevant issues such as the burden of disease and cross border flows into account.
- Review the provincial budget allocation to health: the current allocation of 27% of the provincial budget should be upwardly adjusted to about 38%.
- Cease unfunded mandates from national to provincial and within provinces. There should be no new mandates without clear resource allocation plans.

(ii) *Conditional grants*

- Limit the role of conditional grants as a principal resource allocation mechanism.
- Protect provincial budgets from being “hollowed out” through conditional grants.
- Assess inefficiency and fragmentation caused by restrictive conditions.

(iii) *Budget allocations*

- Monitor and manage budget allocations at all levels.
- Stop political interference in resource allocation.
- Ensure appropriate delegations.
- Develop benchmarking processes and monitoring systems.
- Build capacity of people and systems in financial management.

⁴⁴ PHS Report (2019) 47.

⁴⁵ PHS Report (2019) 47–48.

(iv) Value for money

- Prioritise primary health care and the district health system as the most cost-effective components of the health care system.
- Reconsider the human resource mix of the health system.
- Address bloated management structures and focus on staffing service delivery.

(v) Revenue collection

- Create incentives for better revenue collection.
- Develop billing systems, drawing on private sector expertise.
- Revise the tariff structure.

(vi) Important considerations

- Review budget allocations to hospitals to provide temporary relief of the unmanageable budgetary allocation. There are limited funds for goods and services since 75% or more of budgets are spent on staff remuneration.
- Develop a policy to allow for the re-negotiation of accruals.

Commission 7: Leadership and Governance

6.52 Leadership, governance and accountability are cross-cutting themes that should be assessed across the board. Issues of governance are not addressed within the Department of Health alone.⁴⁶ Commission Seven proposed comprehensive solutions with regard to leadership, governance and accountability. These are in summary the following:⁴⁷

(i) Develop structures

- Develop coherent and aligned structures across the health system to cascade responsibility down the hierarchy to improve accountability.
- The structures should be underpinned by a legislative framework lending authority for actions and providing for accountability.
- Review the roles and responsibilities of each sphere of government.
- There should be a clear separation of political vs administrative leadership.
- Politicians must have oversight but not get involved in the execution of policies.

⁴⁶ PHS Report (2019) 10.

⁴⁷ PHS Report (2019) 50–52.

(ii) Implement policies

- Analyse the National Development Plan and existing policies to establish progress made with a view to implementation.
- Clarify the Minister's authority in implementing policy at provincial level.
- Streamline governance policies within and across provinces.
- Policies must be evidence-based and involve all affected parties.

(iii) Strengthen governance, leadership and management capacity

- Strengthen training and education of management in leadership and governance.
- Utilise existing government-supported leadership training programmes.
- Management key performance indicators must be patient-centred and form part of induction on appointment.
- Professionalise public service employment practices by basing appointments on ability and care, not political affiliation.
- Professionalise the management of health care including appropriate financial and human resource skills to ensure good management.
- Train health professionals in clinical governance, human rights and medical law.
- Base performance assessment on patient experiences, such as waiting times and health outcomes.
- Make ethical leadership a key focus area.

(iv) Clinical committees and hospital boards

- Set up a structured and transparent processes and criteria to appoint and manage members of clinical committees and hospital boards.
- Capacitate committees, boards and structures in accordance with standardised guidelines as part of the quality improvement plan.
- Empower committees to act within accountability frameworks.

(v) Address corruption

- Prevent corruption at source: put systems in place to achieve this and segregate responsibilities in the supply chain.
- Establish an anti-corruption forum in the health care system.
- Expand the Special Investigations Unit anticorruption task team to analyse corruption in vulnerable sectors.
- Detection, reporting, independent investigations and actions and consequence management are important.

- Take appropriate action – criminal, civil and disciplinary actions.
- Harness existing skills and resources, with appropriate and competent oversight.
- Act on reports – ensure consequences for and punishment of offenders.

(vi) *Restore values*

- Prioritise patient care.
- Focus on ethics training and capacitation.
- Include leadership and ethics in the curriculum of health care professionals.
- Culture of institutions must be inclusive, and patient centred.

(vii) *Separation of powers*

- Resolve accountability at national, provincial and institutional level within the current constitutional framework.
- Practice separation of powers and ensure clear delegations of authority.
- Appoint administrators on the basis of capability.
- Consider innovative business models.
- Resolve and respect lines of authority and accountability between trade unions and management, while still engaging staff in solutions.
- Provide systems of support, accountability and authority to operate, but ensure consequences for non-performance.
- Empower people from the bottom up.

(viii) *Strengthen Institutions*

- Budget appropriately, perform training and capacitate institutions.
- Ensure office bearers understand their roles (e.g. through induction processes).
- Tap into private sector expertise.
- Leverage partnerships between Higher Education and Health, and with the private sector.
- Strengthen cooperation between departments (e.g. Public Works to build health facilities).

(ix) *Enhance IT Systems*

- Improve systems for aligned performance management, monitoring and measurement.
- Implement a single health care patient information system across the public and private sectors.

(x) Expand War Room Activity

- Focus on the crisis interventions required.
- In finding solutions, recognise the failure in leadership and management that led to the current crisis and focus on short, medium and long-term interventions.
- Involve key stakeholders and groups instrumental to implementation.
- Do not undermine legitimate accountability and processes, but deal with the crisis.

Commission 8: Community Engagement

6.53 The community must be actively engaged in unifying the health system. Community health workers are a vital link between communities and health facilities.⁴⁸

The interventions proposed by Commission 8 include:⁴⁹

- Health facility committees and boards should adopt a social accountability approach to hold health officials answerable.
- Civil society groups in oversight structures (parliamentary committees, hospital boards etc) represent citizens' voices and need to function optimally.
- Invest in community health systems.
- Develop a national database of community health workers.
- Enhance accountability at political, professional and societal level.

Commission 9: Information Systems

6.54 Bearing patient confidentiality in mind, information systems that are able to produce usable information timeously are crucial for a quality health system. All levels of management require information for decision-making and monitoring. Electronic health records are indispensable to the NHI.⁵⁰ Commission Nine proposed the following interventions with regard to information systems:⁵¹

Utilising an existing IT infrastructure despite challenges for maximum benefit is crucial to get started with NHI implementation. The existing IT infrastructure system should be enhanced by improving information, communication and technology (ICT) infrastructure connectivity and use

⁴⁸ PHS Report (2019) 10.

⁴⁹ PHS Report (2019) 54–55.

⁵⁰ PHS Report (2019) 11.

⁵¹ PHS Report (2019) 57–59.

of ICTs to support data collection and reporting for assessment, screening and intervention programmes.⁵²

(i) *Infrastructure*

- The health care system requires connectivity and reliable bandwidth at a reasonable cost.
- Improve basic infrastructure (computers, mobile devices, internet connectivity, databases to store data, components of cyber security) and consider return on investment.
- Return on investment includes job creation, improved health through better monitoring, early detection of diseases, less litigation and improved access to education as education facilities can share the health infrastructure.
- Connectivity is essential to ensure technology is utilised, especially in remote health facilities.
- Hold service providers such as the State Information Technology Agency (SITA) accountable.
- IT connectivity grant and investment in the IT infrastructure is required, linking with National Treasury and Department of Telecommunications.
- Create a data centre that accesses data from the all systems and levels of care.
- Create a health observatory using standardised e-health design and increased digitisation.

(ii) *Strategic Interventions*

- Investment should follow strategies: the NDP, NHI green and white papers and the national e-health strategy all support for technology and information systems.
- Robust change management processes are vital as technology alone cannot solve the problems in the health sector.
- Engage communities, clinicians and health workers (end users) in health information system design and development and the use of IT.
- Develop fit for purpose policy. Do not allow a vendor driven systems to become policy (SVS, Rx Solution etc.).
- A ministerial task team on information systems should explore the long-term view of health information systems in South Africa.

⁵² PHS Report (2019) 11.

- Use existing private sector business (banks, Clicks etc.) platforms, such as biometric systems, to capture patient data and save costs.

(iii) *Workforce*

- Proper health information systems (necessary for NHI) would require e-health technicians and persons knowledgeable in health matters.
- Create a responsive health information system workforce.
- Improve the skills of the current health information systems workforce.
- Explore utilising graduates to help support development of the health information system.

(iv) *Information Access and Use*

- Enhance privacy and security measures.
- Implement health observatories with analysed data and research outputs that can be put on a public platform for improved accountability.
- Clean up human resources and supply chain systems data and use it effectively.
- Leverage existing skills in other government agencies (e.g. Statistics South Africa field workers and community health workers).

(v) *Leadership and Governance*

- Revise the e-health strategy to promote an integrated health information system for both the private and public sectors.
- Directors General should not be political appointments and should remain regardless of changes in administration.

(vi) *Services and Applications*

- Shift from aggregated data to clinical information on patients to be shared by patients and health care providers.
- Standardise systems using the health standards normative framework for interoperability.
- Health information systems should focus on structural processes, health outcomes and use of information for evidence-based decision making.
- Digital health care, with patients being custodians of health records.
- Strategy on health information and management information systems should be followed by investment.

- Health departments should focus on their core business and training. Connectivity should be managed by relevant departments outside health. The State Information Technology Agency should guide the process.
- Establish a platform to continue with the e-health dialogue, including with Home Affairs as governance verifier and for biometry/linking. Develop systems to identify patients, using national identity numbers and linking to Home Affairs.
- Address the issue of patients without identification.

4 Ethical and Accountable Quality Healthcare in South Africa (December 2018)

(a) Background

6.55 The report reflects the consensus of a 13-member Lancet National Commission on High Quality Health Systems in South Africa. The National Commission was tasked with assessing critically the state of quality of care in the health system, and proposing evidence-based recommendations to decision-makers and practitioners on achieving a high-quality health system.⁵³ The majority of the findings and recommendations of the Lancet Commission are repeated in the Presidential Health Summit Report.

(b) Findings

6.56 The Commission made the following findings:

- 1) Poor people bear the brunt of the poor quality of care.
- 2) Medico-legal litigation and claims in the public health sector impose a huge burden on the distressed health system and reduce the financial resources for health services provision. In the private health sector the long-term average claim frequency for doctors was 27% higher in 2015 compared to 2009.
- 3) Despite the Constitution, strong health legislation and numerous health policies, failures in ethical leadership, management and governance contribute to the poor quality of care. It is exacerbated by mismanagement, inefficiencies and incompetence at all levels of the health system.
- 4) Corruption and fraud are major threats to equitable access to quality health care.

⁵³ South African Lancet National Commission *Confronting the Right to Ethical and Accountable Quality Healthcare in South Africa* (December 2018) [Lancet Commission (2018)].

- 5) The human resources for health crisis are characterised by staff shortages, inequities and maldistribution between urban and rural areas and between the public and private health sectors. Unprofessional behaviour and poor staff motivation and performance will undermine high-quality universal health coverage.
- 6) Quality of care indicators focus primarily on structure, process and outputs in both the public and private health sectors. Data quality remains a huge barrier to assessing health system performance on the quality of care.
- 7) There are numerous encouraging quality improvement initiatives in South Africa, but the impact is limited because of fragmentation across health conditions, levels of care and between the public and private health sectors. This is exacerbated by lack of implementation of quality audits, especially in the public health sector.

(c) *Recommendations*

6.57 The Lancet Commission made the following recommendations:

- 1) Design an integrated, quality improvement programme of action for the entire health system and all modes of health care delivery. Prioritise implementation in rural and under-served areas and in the public health sector.
- 2) Embark on a national campaign to educate patients and communities about their health rights and responsibilities.
- 3) Strengthen community governance structures.
- 4) Increase the capacity of the Office of Health Standards Compliance.
- 5) Strengthen the Council for Medical Schemes to implement the recommendations of the Health Market Inquiry.
- 6) Strengthen governance, effectiveness and efficiency of the various health professions councils.
- 7) Include a compulsory module on quality of care in pre-service training and continuing professional development programmes of health professionals.
- 8) Invest in and transform human resources for health in support of a high-quality health system.
- 9) Prevent and combat fraud and corruption.
- 10) Develop and enforce an integrated national health system performance dashboard.

5 Hospital Mismanagement and Poor Service Delivery Report (May 2017)

(a) Background

6.58 This is a report on an investigation by a Ministerial Task Team (MTT) of allegations of mismanagement, poor service delivery and unacceptable conditions at various identified hospitals. The MTT was established on 14 July 2015 by Dr Aaron Motsoaledi, the Minister of Health at the time.⁵⁴

6.59 Given complaints the Ministry of Health had received, the MTT was required to investigate the state of affairs at identified hospitals, and to provide findings and recommendations to the Minister for action and follow-up. The MTT visited identified hospitals to investigate allegations of unacceptable conditions and/or incompetent management or lack of service delivery and poor quality of care.

6.60 The MTT had to investigate and make findings and recommendations on:

- (a) the state of operational management, service delivery and quality of care;
- (b) whether or not:
 - the rights of any patients were violated;
 - any health professional breached any professional health ethical or other code of conduct;
 - the conduct of the management of the hospital contributed in any manner to the state of affairs at the hospital;
 - support services are functioning optimally;
 - procurement procedures are in place and compliance adherence thereof;
 - the oversight role of the provincial health department and district management to the hospital was exercised adequately;
 - the role supervisors played in bringing the state of affairs in the hospital to the attention of the provincial health department, national Department of Health and the Health Professions Council of South Africa (HPCSA); and
 - make recommendations on the corrective measures required to address whatever shortcomings or transgressions have been found.

⁵⁴ Nomvula Marawa *Health Ministerial Task Team Hospital Mismanagement and Poor Service Delivery Closure Report* (19 May 2017) [MTT Report (2017)].

(b) Outcome

6.61 The five provincial MTT reports with a summary of the findings and recommendations were handed to the Minister on 22 March 2017. The Minister requested that the MTT should further investigate and assess the implementation of financial, supply chain management, human resource and infrastructure delegations and report again to the NHC, but it is unknown whether this was pursued. However, on perusal of the findings and recommendations, familiar themes of staff shortages, critical posts that are vacant, budgetary constraints, accruals, political interference, lack of equipment, and poor maintenance facilities maintenance come to the fore.

6.62 The Minister of Health addressed the National Assembly Portfolio Committee on Health on 14 September 2017 on the findings and recommendations of the MTT. The team's 25 recommendations were adopted at the meeting. There was a resolution to engage provincial executives on the matters that were of concern, especially regarding funding and procurement.

(c) Findings

6.63 The findings of the MTT are summarised as follows:

- (a) Hospitals are operating under extreme service pressure with constrained financial, technical and human resources.
- (b) There is ongoing instability with managerial appointments and political office bearers, as well as uncertainty and at times interference in the functions of hospital officials.
- (c) A significant number of key managerial posts in the provincial departments of health has been vacant for a considerable time.
- (d) Provincial and hospital management tend to defer accountability for deficiencies to others.
- (e) Hospitals are unable to recruit and retain skilled clinical staff (doctors, nurses and allied health professionals) and support staff (administrative and technical), negatively impacting on the provision of quality healthcare.
- (f) There are critical shortages of staff, particularly medical and nursing staff, due to the "freezing of posts" at hospitals.
- (g) The difficulty in recruiting staff to rural provinces, particularly staff with scarce skills, has resulted in severe clinical and non-clinical skills shortages at hospitals in these provinces. Limiting factors in retaining staff include the cost and availability of housing and schools, especially in smaller towns.

- (h) There are moratoriums on all staff appointments in many provinces, with the exception of clinical staff appointments in some provinces. In several provinces the MEC for Health has to approve all appointments, since the MEC has not approved human resource delegations.
- (i) The limited delegation of human resource management functions to hospital management, centralisation of appointments and the moratorium on staff appointments have worsened the situation. There are examples of suitably qualified persons applying for critical posts at hospitals going elsewhere due to delays in the appointment process.
- (j) The overall financial position of provincial governments and the provincial departments of health impacts on the ability of hospitals to fulfil their mandate of providing quality clinical care to the patients they serve.
- (k) Significant budgetary pressures lead to over-expenditure and accruals, including accruals for personnel expenditure such as overtime and rank promotions, which appear to be irregular.
- (l) The current budget allocations to hospitals are:
 - either inadequate for current staff establishments, with the personnel budget amounting to up to 75% of the total budget – as opposed to the ideal of around 60% for hospitals – resulting in inadequate funding of goods and services required to operate the hospitals effectively; or
 - adequate, but with a staff establishment that is inappropriately large and incorrectly distributed in terms of staff categories for the effective delivery of quality healthcare.
- (m) Several provinces centralised all procurement to provincial level. This has a very significant and detrimental impact on the ability of hospitals to ensure the availability of medical consumable items and equipment.
- (n) Limited financial management delegations to hospital management impacts severely on the ability of hospitals to function efficiently. The impact of these steps on the functioning of hospitals cannot be minimised. It is unclear whether the restrictions are required by budgetary constraints or by the need to exercise governance over the functioning of hospitals. The result of this is, for example, an inability to procure essential equipment and services at hospitals timeously.
- (o) The absence of, or inability to access, appropriate transversal provincial or institutional contracts places undue emphasis on procurement by quotation rather than an ordered procurement process governed by need, having tested the market and ensured that the best value for money is obtained in every case. The result is that limited resources are not being utilised appropriately, leading to e.g. a lack of

maintenance. Despite the existence of transversal national contracts in certain instances, hospitals are prevented from accessing these contracts due to Provincial Treasury instructions.

- (p) Patients are managed in unacceptable conditions in some hospitals due to the unavailability of essential medical equipment, medical consumables and linen; and because of crumbling infrastructure due to maintenance failures. This leads to interruptions of water supply, sewerage blockages, failure of lifts and unserviceable air conditioning, amongst others.
- (q) Many hospitals suffer from various infrastructural and design challenges, which militate against the cost-efficient delivery of healthcare. Correction would require significant capital investment. Nevertheless, with improved maintenance and judicious replacement of equipment and technology the functionality of hospitals could be significantly improved.
- (r) The MTT's observations suggest a need for emergency relief as the current approach to procurement has led to decreasing levels of patient care and increasing levels of wastefulness.
- (s) Poor management of procurement has a direct bearing on low levels of staff morale and teamwork, poor financial and operational efficiencies and levels of care and service. It negatively impacts on patient rights.

(d) Recommendations

6.64 The MTT made 25 broad recommendations:

- 1) Accept the managerial and operational challenges experienced by hospitals as real and not necessarily related only to managerial inadequacies at hospitals. There is need of urgent and decisive managerial intervention.
- 2) Clarify and entrench the separation of powers and functions between political office bearers and management as set out in relevant legislation, in particular the Public Finance Management Act 1 of 1999, Public Service Act, 1994 and their regulations.
- 3) The challenge to improve the performance of hospitals does not reside solely with the hospitals, but reflects a wider challenge within provincial departments of health and the respective provincial governments.
- 4) The instability of management as evidenced by the number of managers in acting positions at provincial departments of health and within hospitals must be urgently addressed, as a turn-around strategy is unlikely to succeed without managerial stability and certainty of tenure.

- 5) Develop appropriate national human resource delegations, which must be approved by the provincial MECs for Health, to enable the timeous and efficient appointment of key clinical, technical and administrative staff at hospitals.
- 6) Expedite the undertaking of Workload Indicators of Staffing Need (WISN) or similar standardisation of staff establishment exercises at hospitals in order to implement evidence-based and collectively agreed-on staffing norms within facilities.
- 7) Develop and utilise an approved post list of funded posts within the allocated budget to manage the appointment of staff.
- 8) The authority to fill posts must be decentralised to hospitals within the framework of the approved post list to enable more effective recruitment and appointment of staff, particularly in the scarce-skills disciplines.
- 9) Leadership and governance require urgent decisive action, including effective implementation of accountability and consequence management. Monitoring and follow-through are important.
- 10) Quality of care and patients' rights needs attention at all levels given increasing litigation, vacant critical posts, and poor productivity and performance management of clinical and support staff.
- 11) Engage provincial treasuries on baseline allocations to the provincial departments of health. Priority of healthcare services, particularly given the very high dependency of rural communities on the public health sector, must be highlighted and addressed.
- 12) The share of the provincial budget allocated to health departments must be adequate at about 38% of the total provincial budget, which is not the case in several provinces.
- 13) Provincial health budgets should not be made unrealistic by an initial subtraction of accruals without consideration of the service consequences.
- 14) In the case of significant outstanding accruals a financial management plan must be developed with the respective provincial treasury to amortise these accruals over a manageable period and amount per annum.
- 15) Once the final health budget has been allocated, it should be accepted by the health department as binding and cannot be exceeded.
- 16) Undertake a process in provinces whereby budgets are equitably and realistically allocated to health facilities (hospitals), taking into account the respective priorities of each facility in line with provincial priorities. This process will require an analysis of historical budget allocations and the breakdown of these budgets

- according to standard items (personnel and goods and services) as reflected in provincial budget documents.
- 17) Review budget allocations to hospitals urgently with a view to temporarily relieve the unmanageable situation where 75% or more of the total budget allocated to hospitals are for personnel expenditure. As with provincial health budget allocation, each facility budget must take accruals into account where these exist. An agreed strategy must be adopted at provincial level to manage these accruals to a zero figure.
 - 18) In exchange for budgetary relief, undertake an urgent and time-bound investigation (six months) of staff establishments to address the need to reduce personnel expenditure progressively over three years towards the accepted norm of a maximum of 65%.
 - 19) Review the decision to centralise procurement to the provincial department urgently where this has occurred. Procurement, with the necessary control measures, for non-contract and contract medical consumables and medical equipment should be undertaken at hospitals. Ensure financial compliance.
 - 20) Give urgent attention, possibly with the assistance of National Treasury (Central Procurement Officer) and the national Department of Health, to the implementation of provincial (ultimately national) contracts to facilitate the procurement of essential goods and services by hospitals in the most cost-effective and efficient manner to address the need to provide quality health services.
 - 21) Review provincial goods and services expenditure and prioritise according to the need to ensure that essential items, maintenance and equipment is available at all health facilities in a province, but especially at key hospitals.
 - 22) Put systems in place that allow management at all levels, namely: national (Treasury and Health), provincial (Treasury and Health), regional, district and facility (hospital), to actively monitor and control the levels of expenditure against the standard items referred to above. The current system of “non-negotiables” instituted by the NHC is an after-the-event mechanism that identifies “symptoms” rather than allowing management of the problem. Although National Treasury, the national Department of Health and the provinces have access to both the Personal and Salary Information System [*sic*] (PERSAL: Personnel and Salary System) and Basic Accounting System (BAS), an extraction of this data is required in such a manner that it is applicable and accessible to the level of management concerned. In the case of hospitals, it should be to the level of the CEO and the management team within the hospital.

- 23) Give urgent attention to the functionality of primary and regional health service platforms (equipment and staff) from where patients are currently referred to tertiary and central hospitals to reduce unnecessary referrals and walk-in patients to hospitals.
- 24) Once managerial stability has been achieved with the necessary support, hospitals must develop detailed, action-orientated and time-bound action plans to address the following:
 - a) clinical services, focusing on the provision of quality care at the most appropriate level in cooperation with regional and district health services supported by a participatory system of clinical governance;
 - b) human resource management, focusing on the appointment of key staff and the review and restructuring of staff establishments to within affordable limits, cognisant of the need to address staff morale;
 - c) financial management, focusing on budgetary control to limit expenditure within the allocated budget and supply chain management to ensure cost-effective procurement of goods and services; and
 - d) equipment and physical infrastructure to facilitate and ensure the optimum delivery of quality health services within the allocated resources.
- 25) Although the procurement system is broken, corrective action must be considered as the current system will not cope with immediate, complex and far-reaching interventions. Adopt a phased approach in the following manner:
 - a) Phase 1: Get basic systems working with simple interventions and improved governance to get products to the hospital. Use the current system with some changes and a set of priorities.
 - b) Phase 2: Establish the required foundational capabilities and infrastructure to ensure that the procurement system functions as required by policy and service outcomes. This should be based on a centre-led model and differentiated procurement strategies for each of the critical items used by hospitals.
 - c) Phase 3: Systematically migrate all procurement operations onto the new system.

6 Declaration following Medico-Legal Summit (March 2016)

6.65 Subsequent to the Medico-Legal Summit held on 9 and 10 March 2015, the Minister of Health appointed a task team to consolidate recommendations made by the various commissions at the summit and to formulate a declaration for the Minister's

consideration and signature. The declaration was publicly released in March 2015.⁵⁵ The declaration addressed the following matters:

(a) On patient safety

- a) Enforce patient safety and medical accountability; implement Patients' Rights Charter.
- b) Implement clinical governance uniformly, including Morbidity and Mortality (M&M) reviews and clinical audits of adverse events.
- c) Develop and implement safety checklists.
- d) Focus on patient safety in education and training of health professionals; implement the National Core Standards in all institutions.
- e) Multidisciplinary approach in functions such as ward rounds, M&M and peer review meetings, keep proper minutes of meetings.
- f) Empathetic explanatory communication following an adverse event.
- g) Continual patient safety campaigns.
- h) Emergency Medical Services (EMS) transport must always be available.
- i) Refer patients at an early and appropriate time.
- j) Avoid preventable safety failures – adhere to standard operating procedures and scope of practice.

(b) On administration

- a) Reliable, complete and accurate record-keeping, safekeeping of high risk records, prioritize electronic record keeping.
- b) Manage medical records properly; eradicate unlawful destruction and theft of records.
- c) Review legislation regarding destruction of medical records.
- d) Review job requirements of hospital management: CEOs, clinical managers, nursing managers and support services.
- e) Adequate and appropriate supervision.
- f) Take early action upon receipt of letters of demand or complaints.
- g) Open and honest communication and securing valid informed consent must be standard procedure.
- h) Implement a Uniform National Reporting System of adverse events related to patient safety.

⁵⁵ Ministry of Health *Declaration Medico-Legal Summit* (15 March 2016).

- i) Hospital administrators must be accountable for their actions.
- j) Good management is essential and must ensure the following: positive staff morale; on-going training to improve capacity and skills; effective and efficient procurement; environmental safety; human resource management that ensures appropriate numbers of staff with appropriate competencies and knowledge; employee wellness; disciplinary processes.
- k) Empower district specialist health teams to promote and enforce patient safety.
- l) Hospital administrators must support patients with regard to complaint systems.
- m) Hospital administrators to ensure training of staff on communication with patients; to improve their competency and skills; to know and understand ethical and legal requirements in healthcare; and to ensure improvement in staff attitudes.
- n) Manage Remunerative Work Outside the Public Service (RWOPS) actively.
- o) Institute disciplinary proceedings against offending healthcare workers and officials.

(c) *On legal*

- a) Implement mediation consistent with policy developed by Department of Justice.
- b) Explore the establishment of a tribunal or specialized court for medico-legal claims.
- c) Explore removing Common Law 'once and for all-rule' in medico-legal litigation.
- d) Prompt intervention and early resolution of pending litigation.
- e) Always consider legal settlements as a first option, being mindful of costs.
- f) Improve legal capacity in government departments to manage medico-legal claims.
- g) Use external expertise where appropriate – need for specialization in this area.
- h) Invest in research of medico-legal matters to improve practice.
- i) Develop the capacity for quantum assessment.
- j) Report vexatious, frivolous and unethical conduct by attorneys.
- k) Inform SASSA of all settlements by sending court orders to avoid double-dipping.
- l) Encourage litigants to save costs by appointing ONE expert for both parties.
- m) Improve cooperation and relationships between national and provincial departments in preparation of medico-legal claims.
- n) Strengthen, review and enforce the roles and functions of the statutory councils.

(d) On future options to reduce claims

- 6.66 Possible options that should be explored as part of the law reform process:
- a) Establishment of a National Litigation Authority.
 - b) Comparative studies from other countries.
 - c) Alternative compensation options, e.g. health services and medical devices.
 - d) Possible alternatives to courts.
 - e) Capping of settlements.
 - f) Contingency fees, including the possible capping thereof.
 - g) Double-dipping.
 - h) Guidelines on the calculation of quantum of future medical costs.
 - i) Prevention measures.
 - j) Compensation models, e.g. periodic payment, cessation of payments in case of death.
 - k) Settlement review panel.
 - l) Fairness and equity.
 - m) Loss of future earning capacity.
 - n) Review the management and functions of the Office of the State Attorney.

(e) Extent of implementation

6.67 Some of the recommendations have been overtaken by events, such as the appointment of the Health Ombudsman and the SALRC investigation included as Project 141: Medico-Legal Claims. The Ministerial Task Team (later referred to as the Ministerial Advisory Committee) visited and held workshops in eight provinces (excluding the Western Cape) to explain and discuss the declaration. All the provincial workshops were attended by the top management of the province concerned and varying levels and numbers of staff members from the provincial Department of Health and health establishments in that province. The extent of implementation by the provinces of the recommendations set out in the declaration is however not known.

7 Discussion Document for Medico-Legal Summit (September 2013)

(a) Background

6.68 The full title of this document is *Discussion Document Prepared by the Steve Biko Centre for Bioethics in preparation for a Medico-Legal Summit to be held by the*

Minister of Health.⁵⁶The medico-legal summit was originally scheduled for September 2013, but by the time the document, in the format of a report, was finalised, the summit had been postponed indeterminately. The summit eventually took place in March 2015.

6.69 The Democratic Alliance posed a parliamentary question to the Minister of Health in March 2013 (Question No. 627 published in Internal Question Paper No. 10 on 28 March 2013) regarding claims instituted against the Department. The Minister provided (in part) the following reply in June 2013:

The issue of the escalation of medico-legal claims and associated legal costs is the top priority of the Department as the same is viewed as posing a serious threat to the survival of both public and private health. As a response to this challenge, I have set up a Medico Legal Task Team to investigate the root causes and make recommendations on the policy options. In addition to this ongoing research I have sensitized Cabinet on the medico-legal claims and legal costs crises. I will only be able to shed any light on the matter after the team has finalised its work.

6.70 It is not clear whether the Medico Legal Task Team that the Minister mentioned in his response is a reference to the committee that compiled the Discussion Document.

(b) Objective

6.71 The Discussion Document explains its aims in the following terms:⁵⁷

The aim of this document is to place the trends in medical malpractice litigation into perspective by considering data provided to us by the public and private sectors. We further consider the factors that are leading to the increase in the claim's trajectory over the past 7 years in accordance with the terms of reference set out below. After an analysis of public and private sector data, we consider the international approach and provide recommendations which will be best suited to the South African context.

(c) Scope of report

6.72 The Discussion Document investigated and drew comparisons between provinces in the following areas:

- Public sector litigation trends

⁵⁶ Steve Biko Centre for Bioethics *Discussion Document prepared in Preparation for a Medico-Legal Summit to be held by the Minister of Health* (Unpublished report September 2013) [SBCB (2013)].

⁵⁷ SBCB (2013) 1.

- Adverse events and patient safety
- Proposed factors contributing to the steady escalation of medico-legal litigation in South Africa

(d) Methodology

6.73 The committee analysed literature, local and international law, documents obtained from the relevant provincial and national state departments and documents obtained from the Medical Protection Society. The committee conducted informal interviews with relevant role players where necessary.

6.74 The Discussion Document refers to two important documents drafted previously to explain the factors contributing to the rise in medico-legal litigation. The documents referred to are the *National Litigation Strategy Report* discussed below, and *Medical Error and Malpractice Litigation: The Western Cape Experience 1999-2011*. As indicated in the Discussion Document the *National Litigation Strategy Report* was still in draft form at the time when the Discussion Document was finalised in September 2011.

6.75 The Discussion Document examines and discussed in some detail the issues highlighted in the National Litigation Strategy as factors which have contributed towards the rise in medico-legal litigation.⁵⁸ These factors are the following:

- 1) Insufficient/ inadequate ineligible clinical notes in patients' medical records – Department therefore unable to defend cases.
- 2) Patients not observed or monitored as prescribed or required.
- 3) Health establishments inadequately equipped according to their level of classification, including academic health establishments and referral institutions.
- 4) Patients' files, in particular files of complainants and persons instituting legal action against a provincial health department, are apparently removed from storage or made to disappear. It is therefore difficult or even impossible for the department to defend legal action brought against it as there are no documents to explain what transpired during the alleged negligent conduct.
- 5) Post-mortems are not routine when patients die under mysterious circumstances.
- 6) Shortages of legal officers.

⁵⁸ SBCB (2013) 79–86.

- 7) Cases are defended irrespective of whether they are defensible or not.
- 8) Cases are protracted due to a policy decision to defend all cases; a lack of practical experience in dealing with litigation amongst legal officers; a lack of clinicians to advise the Department on liability.
- 9) Indigent claimants are disadvantaged as they lack the necessary resources to engage the services of competent and experienced legal representatives (some of the cases end up being abandoned or dismissed by the courts).
- 10) Inadequate management and tracking of cases which are mostly deferred to the Office of the State Attorney.

8 National Litigation Strategy Report (2012)

(a) *Background*

6.76 The National Litigation Strategy Report (NLSR) was a litigation audit of medico-legal cases/ claims/ complaints. Provincial visits were undertaken to five provinces, namely Eastern Cape, Gauteng, KwaZulu-Natal, Northern Cape and Western Cape to conduct a litigation audit of medico-legal cases/ claims/ complaints.

(b) *Objective*

6.77 The report explained its main objective:⁵⁹

The main objective in establishing the Medico-Legal Task Team was to assist the Department in reviewing and where necessary investigating pending medico-legal claims of alleged negligent care brought against the Department by patients at health establishment[s], and to recommend corrective or preventive measures to deal with such incidents in the future. (Department of Health *National Litigation Strategy Report* (2012) at 7.)

(c) *Methodology*

6.78 A sample of medico-legal cases was analysed in the following manner:⁶⁰

- (a) a particular litigation file would be perused, and the facts thereof analysed;
- (b) legal issues raised by the case would thereafter be established;
- (c) followed by establishing whether there was any action taken by the provincial department in response to the case/claim;

⁵⁹ Department of Health *National Litigation Strategy Report* (2012) at 7 [NLSR (2012)].

⁶⁰ NLSR (2012) 18.

- (d) If no action was taken in response to the case/claim, to establish the reason(s) for such an omission;
- (e) If ever action was taken, determine whether the response by the department was appropriate in the circumstances.

(d) Outcome

6.79 The DOH NLSR report identified the following challenges in the provinces:

- 1) Inadequate clinical notes
- 2) Inadequate monitoring of patients
- 3) Disappearance of patients' files
- 4) Lack of post-mortems after mysterious deaths
- 5) Health establishment not adequately equipped
- 6) Provincial legal advisors' lack of practical experience in litigation
- 7) Shortage of provincial legal officers
- 8) Inadequate Management and Tracking of Litigation Files
- 9) Head of Department heed advice of higher ranked officials rather than officials with professional experience
- 10) Management of litigation files
- 11) Plight of indigent patients
- 12) Protracted litigation
- 13) Lack of clinicians at departments to advise on medico-legal cases
- 14) Difficulty in obtaining patients' medical records.

(e) Recommendations

6.80 The Report made short-term recommendations for immediate implementation by health establishments and provincial Departments of Health, as well as long-term recommendations pertaining to the national Department of Health. The long-term recommendations on medico-legal cases would require the development of the necessary infrastructure and processes, including drafting legislation for the central management of medico-legal claims and apology laws. The proposals are summarised in the table below as contained in the Report.⁶¹

⁶¹ NLSR (2012) 42.

SHORT-TERM	LONG-TERM
HEALTH ESTABLISHMENTS	NATIONAL DEPARTMENT
Clinical notes: proper record keeping	National framework for professional development programs
Regular visits to health establishments	Education, training and development
Develop mechanism to ensure deterrence	Collaboration with the Department of Justice and Constitutional Development
Disappearance of files: <ul style="list-style-type: none"> • Computerized Patients Information System • Digitize patient's past medical record 	On-going performance, monitoring and evaluation
Keep records of potential medico-legal incidents	Submission of quarterly reports and surveillance system
Establishment of Adverse Event Monitoring Review Committee	Establishment of National Litigation Authority
PROVINCIAL DEPARTMENTS	Constitutional authority of national Department to Intervene
Establishment of Clinical Review Committee	Role of national Department in terms of the Constitution
Clinicians to give clear direction of whether a case should be defended or not	Jurisdiction of the provincial Department of Health
Compensate where there was negligence	
Out of court settlements	
Human resources	
All relevant documents to be kept in the litigation file	
Medical records, court documents and correspondence to be kept in separate sub-files	
Annexure to the litigation file	

9 National Development Plan (August 2012)

(a) Background

6.81 The National Planning Commission (NPC) is a South African government agency which was set up in May 2010 to develop a long term vision and strategic plan for South Africa. The Commission's main focus at present is the implementation of the *National Development Plan 2030* (NDP). The NPC developed the NDP, which was officially launched on 15 August 2012. The NDP offers a long-term perspective for South Africa that aims to eliminate poverty and reduce inequality by the year 2030. The NDP sets out the role the various sectors of society can play to build capabilities, grow an inclusive

economy, promote partnerships and facilitate cooperation to solve the country's complex challenges. It seeks to harness the energies of the South African people.⁶²

(b) Scope of NDP

6.82 The NDP proposes a framework covering 13 thematic areas, including health care:

- 1) Economy and Employment
- 2) Economic infrastructure
- 3) Environmental sustainability and resilience
- 4) Inclusive rural economy
- 5) South Africa in the region and the world
- 6) Transforming Human Settlements
- 7) Improving education, training and innovation
- 8) Health care for all
- 9) Social protection
- 10) Building Safer Communities
- 11) Building a capable and developmental state
- 12) Fighting corruption
- 13) Nation building and social cohesion.

(c) Methodology

6.83 The NPC had hundreds of interactions with South Africans, received input from tens of thousands of people, conducted extensive research, consulted widely and engaged in robust debate throughout the country in the development of the NDP.⁶³

(d) Outcome

6.84 The NDP was formally launched on 15 August 2012. The NDP aims to serve as a blueprint to eliminate poverty and reduce inequality in South Africa by the year 2030.

⁶² South African Government "National Development Plan 2030" (Government of South Africa) accessed 4 October 2021 www.gov.za/issues/national-development-plan-2030; National Planning Commission "About us" (The Presidency: Republic of South Africa) accessed 4 October 2021 www.nationalplanningcommission.org.za/Aboutus; Mary Alexander *Brand South Africa* "The National Development Plan: A vision for 2030 (23 July 2017) accessed 4 October 2021 www.brandsouthafrica.com/south-africa-fast-facts/social-facts/the-national-development-plan-a-vision-for-2030.

⁶³ National Planning Commission *National Development Plan 2030: Our Future – make it work* (Government of South Africa, August 2012) at 1 & 61 [NDP (2012)].

The intention is that it should be taken into consideration by all sectors of society and in the strategic planning of state departments.

(e) Findings and recommendations

6.85 Chapter 10 of the NDP, entitled “Promoting health”, deals with the South African health system. Some of the salient points made in the chapter are summarised below. A number of key points are stated up front, the most relevant of which are the following:⁶⁴

- 1) Greater intersectoral and inter-ministerial collaboration is central to the Commission’s proposals to promote health in South Africa.
- 2) Human capacity is key. Managers, doctors, nurses and community health workers need to be appropriately trained and managed, produced in adequate numbers, and deployed where they are most needed.
- 3) The national health system as a whole needs to be strengthened by improving governance and eliminating infrastructure backlogs.
- 4) A national health insurance system needs to be implemented in phases, complemented by a reduction in the relative cost of private medical care and supported by better human capacity and systems in the public health sector.

6.85 The NDP reiterates the necessary reform of our health system. The NDP further recognises the importance of committed leadership throughout the various levels of health care services, remarking that it has been a critical factor in countries that have succeeded in reforming their health systems.⁶⁵

6.86 Primary health care and the district health system form the basis of the South African health system. Some of the elements of primary health care are:⁶⁶

- 1) prevention;
- 2) better access to and use of first-contact care;
- 3) an approach that is patient-focused, rather than disease-focused;
- 4) a long-term perspective;
- 5) comprehensive and timely services;
- 6) home-based care when necessary.

⁶⁴ NDP (2012) 329.

⁶⁵ NDP (2012) 330.

⁶⁶ NDP (2012) 330–331.

6.87 The district health system encompasses a decentralised, area-based, people-centred approach to health care. The NDP refers to the six elements of the district health system as identified by the World Health Organisation:⁶⁷

- 1) service delivery
- 2) the health workforce
- 3) health information
- 4) medical products, vaccines and technologies
- 5) sound health financing
- 6) good leadership and governance.

Health system

6.88 South Africa's health spending is relatively high in relation to its GDP. We also have good policies in place. In spite thereof, the performance of South Africa's health system since 1994 has been poor. While the dual system of public and private health care services is problematic, the inability to get primary health care and the district health system to function effectively is a significant contributor to the failure of the health system.⁶⁸

6.89 Several problems beset the public health system. Provincial budgets are limited and health has to compete with other departments for funding. The links between the different levels of services are weak. The management style in the health system is centralised and top-down, with provincial governments controlling hospital budgets and performing functions like supply chain management. This is detrimental to the managers of health facilities. They are responsible for delivering health care services, yet do not have the authority to manage effectively. In addition, the health sector is facing a human resources crisis. Some of the staff-related challenges are poor discipline, failure to adhere to policy, lack of accountability, inadequate oversight and low staff morale. Clinicians feel marginalised.⁶⁹

6.90 During the first years of our new democracy progressive policies were developed. The public health system was transformed into an integrated, comprehensive national health system. Unfortunately implementation and health outcomes have fallen short of

⁶⁷ NDP (2012) 331.

⁶⁸ NDP (2012) 331.

⁶⁹ NDP (2012) 332.

expectations because of inconsistent management and inadequate capacity.⁷⁰ The NDP states that “[t]here was a misguided attempt to change everything at once, when many aspects of the system were not faulty.”⁷¹

6.91 The NDP sets out a number of long-term system-related health goals for the country:⁷²

Goal: Complete health system reforms

- Integrate the different parts of the health system.
- Develop an information system for managing diseases.
- Separate policy-making from oversight and operations.
- Decentralise authority and devolve administration to the lowest levels.
- Rationalise clinical processes and systematise the use of data, incorporating community health, prevention and environmental concerns.
- Address infrastructure backlogs, making more use of information communications technology.

Goal: Primary healthcare teams provide care to families and communities

- Establish primary health care teams throughout the country with the required number of doctors, specialists, physicians and nurses.

Goal: Universal health care coverage

- Everyone must have access to an equal standard of care, regardless of their income.
- A common fund should enable equitable access to health care, regardless of what people can afford or how frequently they need to use a service.

Goal: Fill posts with skilled, committed and competent individuals

- Increase capacity to train health professionals.
- Set procedures and competency criteria for appointing hospital managers.
- Set clear criteria for the removal of underperforming hospital managers.

6.92 There are critical shortages of health professionals in a number of occupational categories. More health professionals need to be trained and funding allocated to create

⁷⁰ NDP (2012) 332.

⁷¹ NDP (2012) 332.

⁷² NDP (2012) 334.

additional posts in the public health sector. The health sector should engage with partners and other departments to ensure that the negative impact of other policies on health outcomes is understood and mitigated, and promote policies that result in positive health outcomes.⁷³

6.93 The NDP also determines priorities for achieving the goals of the 2030 vision. The priority elements most relevant for purposes of this paper are highlighted below.

Priority: Strengthen the health system

Required actions

- Establish a coherent and vision-based executive decision-making process.
- Promote quality, including measuring and benchmarking actual performance against standards for quality.
- Define an appropriately specialised, more accountable operational management model for health service delivery, including revised roles and responsibilities for the national department, provinces, districts and public hospitals. This should also cover governance and capacity requirements.
- Bring in additional capacity and expertise to strengthen a results-based health system, particularly at district level. This should include partnerships between the private and public sector, deployment and training for district health management teams, and revised legislation to make it easier to recruit foreign skills.
- Implement a national health information system to ensure that all parts of the system have the required information to effectively achieve their responsibilities.
- Establish a human resource strategy with national norms and standards for staffing, linked to a package of care.
- Develop an implementation strategy and partnerships to leverage funding, increase health sector efficiencies and accelerate the implementation of the national strategic plan.⁷⁴

Leadership and management

- The health system requires competent leaders and managers at all levels – from clinic to tertiary hospital. From a governance perspective, competent leaders are required in all structures – from district to national level. Anyone who does not meet the competency requirements for a job should be replaced. People who lead

⁷³ NDP (2012) 335.

⁷⁴ NDP (2012) 336.

institutions must have the required leadership capability and high-level technical competence in a clinical discipline.

- Review national, provincial and district organisational structures to support the focus on primary health care.
- Revise roles and responsibilities for all public health care facilities to improve services.
- Prioritise functional competence and commitment to quality service.
- Improve communication and coordination mechanisms within departmental spheres, across clusters and with private partners to prevent silo funding and operations.
- Strengthen technical capacity at national and provincial levels to provide overall guidance.
- Policies must be effectively implemented, monitored and assessed.⁷⁵

Accountability to users

- Governance and management frameworks, from national to local levels, must be effective, with the emphasis on accountability to users/communities.
- Align centralised guidance, technical support and monitoring with decentralised, devolved responsibility and decision-making.
- Give more attention to collaboration within and between national, provincial and district or local strategies and plans.
- Appropriate delegations can consolidate the responsibilities of chief executive officers and district managers.⁷⁶

Additional capacity and expertise

- The focus of training and mentorship should be on rolling out best practice.
- Boost partnerships with the private and non-profit sectors to strengthen a results-based health system, particularly at the district level.
- Use trainers and mentors to improve capacity in district health management, clinics, hospitals, and community-based outreach primary health care.⁷⁷

⁷⁵ NDP (2012) 336–337.

⁷⁶ NDP (2012) 337.

⁷⁷ NDP (2012) 337.

Quality control

- Infrastructure and equipment in health facilities are in a desperate state. Health personnel are unevenly distributed. Remote facilities in rural areas face dire shortages.
- Facilities in major urban centres have more personnel, but are under severe strain due to growing urban populations. They often service populations from far beyond their catchment areas and in some instances from beyond national borders.⁷⁸

Priority: Improve health information systems

- Prioritise the development and management of effective data systems. Credible data is necessary for decision-making and regular system-wide monitoring.
- Integrate the national health information system with the provincial, district, facility and community-based information systems. The national health information system should link to secure, online, electronic patient records and other databases, such as for financial, pharmacy, laboratory and supply-chain management data. It should also link with other government, private sector and non-profit databases.
- Establish national standards for integrating health information systems. Integrating data between different software and financial systems is difficult.
- Undertake regular, independent, data quality audits.
- Develop human resources for health information. Replace existing ad hoc training with ongoing training.
- Strengthen the use of information.
- Expand data reporting. Address the increasing demands on health workers for data through a structured approach, using sentinel sites.⁷⁹

Priority: Financing universal healthcare coverageNHI

- South Africa's proposals for a national health insurance (NHI) system represent a profound break with the past.
- South Africa is working towards this objective of universal coverage, but the approach has to be tailored to the South African context.⁸⁰

⁷⁸ NDP (2012) 337.

⁷⁹ NDP (2012) 337–338.

⁸⁰ NDP (2012) 339.

- The success of NHI in South Africa will depend on the functioning of the public health system. The NPC supports attempts to improve the public health system, starting with the auditing of facilities and setting appropriate standards.⁸¹

Priority: Improve human resources in the health sector

Community-based health care

- A core component of re-engineering primary health care is to emphasise population-based health and health outcomes. This includes a new strategy for community-based services through primary health care outreach teams, based on community health workers.⁸²
- Community health workers would undertake a range of activities, spanning the full breadth of rehabilitative / palliative care, treatment, preventive and promotive interventions. They would form the base of the health pyramid.
- In addition to making health care more accessible and equitable, the primary health care system will create more jobs and thus indirectly improve health by reducing the prevalence and depth of poverty.⁸³

Appropriately skilled nurses

- The core of the primary health care outreach team will be a professional nurse, a staff nurse and community health workers. Many more trained nurses are needed, and their skills to carry out and support primary health care need to be strengthened.
- Training more midwives and deploying them in the appropriate levels in the health system could have an immediate positive impact on maternal, neonatal and child health, which would reduce maternal and child mortality.
- The rapid expansion and reorientation of nursing training is required, and the policy decision to reopen and expand nurse training colleges supports this. But a curriculum review is needed. This must include advisers external to the current nurse training bodies (the South African Nursing Council and the Sector Education and Training Authorities), with expertise in public health and experience in countries that have implemented a comprehensive, district-based approach.⁸⁴

⁸¹ NDP (2012) 344–345.

⁸² NDP (2012) 345.

⁸³ NDP (2012) 346.

⁸⁴ NDP (2012) 347.

Doctors and specialist support teams

Family physicians in district specialist support teams will be mainly responsible for developing a district-specific strategy and implementation plan for clinical governance. Patient care in many district hospitals is poor. Prevention, primary health care and the quality of care is neglected. Specialised medical training is currently out of step with what South Africa needs.⁸⁵

Increased investment in health personnel development

- To implement policies that are more appropriate to the health care needs of South Africa, there must be a massive and focused investment in training health personnel.
- Government could incentivise the production of appropriately trained personnel in sufficient numbers within a realistic but short time.⁸⁶

Priority: Review management positions and appointments and strengthen accountability mechanisms

The percentage growth of management posts has greatly exceeded the growth of service delivery posts.⁸⁷

Strengthen human resources management

Human resources need to be strengthened at all levels by:

- ensuring that human resource management personnel in the health sector are appropriately accredited;
- continuously reviewing remuneration;
- putting into operation incentive schemes, such as the occupation-specific dispensation, to boost services in underserved areas.

Effective performance management frameworks are an important aspect of human resources management. Managing performance and retaining staff should receive as much attention as producing new professionals. Poor management is the reason most doctors give for leaving the public sector.⁸⁸

⁸⁵ NDP (2012) 347.

⁸⁶ NDP (2012) 348.

⁸⁷ NDP (2012) 348.

⁸⁸ NDP (2012) 349.

Priority: Improve quality by using evidence

Health services are costly, and it is essential to base planning, resource allocation and clinical practice on empirical evidence. Evidence-based evaluation, planning and implementation improves the quality of planning. The health workforce, particularly leadership, needs to become familiar with using evidence in all aspects of practice.⁸⁹

Priority: Meaningful public-private partnerships

Meaningful public-private partnerships in the health sector are important, particularly for NHI. South Africa needs robust debates between public and private sector partners, including civil society organisations. Key issues include:⁹⁰

- legal and governance frameworks;
- the public-private partnership policy environment;
- the socio-political dimension of such partnerships;
- public sector capacity;
- the business and financial implications of partnership implementation.

These partnerships should be guided by best practice principles in purchasing, provisioning, procuring and sound financial management of health services. They should create incentives for improving access, greater equity, higher quality, more innovation and serving the poor with efficiency.⁹¹

Conclusion

We need to mobilise and use resources efficiently. This includes addressing financing inequalities, training and employing more health personnel, improving the physical infrastructure in health facilities, effective supply chain and inventory management practices to ensure health facilities do not run out of essential drugs, better management of patient records and strengthening the delegation of powers to those closest to ground.⁹²

⁸⁹ NDP (2012) 349.

⁹⁰ NDP (2012) 349–350.

⁹¹ NDP (2012) 350.

⁹² NDP (2012) 350.

10 Reports of Integrated Support Teams (April and May 2009)

(a) *Background*

6.94 A total of ten Integrated Support Teams (ISTs) conducted extensive reviews of health overspending and the public health system in South Africa. The review culminated in ten reports: a report on each province and a consolidated report. The review was referred to as “Review of health overspending and macro-assessment of the public health system in South Africa”. The IST was established in February 2009 at the initiative of the then Minister of Health, Ms Barbara Hogan,⁹³ although the programme commenced in November 2008.⁹⁴

6.95 The review was conducted as part of the UK Government’s Department for International Development Rapid Response Health Fund. The “negative difference” between the public health sector budget and the actual funding required to implement agreed upon policies, causing most of the provinces to project an over-spending, necessitated an in-depth review of the underlying factors behind the overspending.⁹⁵

(b) *Scope of reports*

6.96 The report reviewed the following areas:

- 1) Finance
- 2) Leadership, governance and service delivery
- 3) Human resources
- 4) Information management
- 5) Medical products
- 6) Laboratory
- 7) Technology and infrastructure.

(c) *Methodology*

6.97 The review was done in two main parts. The first part of the review was a desk top review, which included detailed financial analyses, an analysis of public documents and of documents obtained from the national and provincial departments of health. The

⁹³ Peter Barron et al *Consolidated Report of the Integrated Support Team: Review of health overspending and macro-assessment of the public health system in South Africa* (May 2009) [IST Report (2009)].

⁹⁴ IST Report (2009) 115.

⁹⁵ IST Report (2009) 23.

second part of the review was done through in-depth interviews with senior managers at provincial and national level and key informants at national, provincial and district levels. About 150 interviews were conducted.⁹⁶

(d) Outcome

6.98 The reports highlighted shortcomings in all the areas investigated. As stated in the report:⁹⁷“The review, however, found many shortcomings, ranging from strategic planning and leadership, through to financial management and monitoring and evaluation.” The reports did result in some budget reforms, but clearly not all the findings and recommendations were attended to, as many of the problems highlighted in 2009 still persist today.

(e) Findings and recommendations

6.99 The consolidated report summarised the findings and recommendations of the nine provincial reports on the public health system. Only the most important findings and recommendations as set out in the executive summary of the consolidated report are listed below.⁹⁸

1) Finance

Findings

- Overspending due to bank overdrafts, over-expenditure and unpaid accruals.
- Unfunded mandates and inadequate budgeting.

Recommendations

- Cost changes in service delivery from a properly determined baseline budget.
- Improve financial management at all levels, starting with the budget bid process.
- Link annual operational plans to the available budget. Ensure no over-spending through effective accountability, Track and report on operational improvements.

⁹⁶ IST Report (2009) 25.

⁹⁷ IST Report (2009) 8.

⁹⁸ IST Report (2009) 9–22.

2) Leadership, governance and service delivery

Findings

- Inadequate leadership and stewardship from NDOH. NDOH cannot ensure that available health resources are sufficient for levels of service and targets envisaged by national policies.
- Fragmented planning within NDOH and between NDOH and provinces.
- Implementation of norms, standards and guidelines varies considerably across the nine provinces.
- Lack of coordination and communication between national and provinces.
- The core business of the public sector, namely actual service delivery and the quality of service delivery, does not receive sufficient attention from senior managers at national and provincial levels.

Recommendations

- Develop a national, affordable service transformation plan as a complementary, but linked, activity to the national vision and strategy.
- Review the role and required expertise of strategic health programme managers at national, provincial and district levels in line with the governance and accountability framework.

3) Human resources

Findings

- Organisational structuring in the provinces is not done according to agreed benchmarks or aligned with existing plans or resources. Of serious concern is the considerable and continued growth in management and administrative positions across the various provinces, especially in provincial head offices, relative to the growth in health care professional positions.
- The Provincial Treasury or the HODs in the majority of provinces have withdrawn delegations resulting in day-to-day management by head office, leading to lack of accountability and feelings of disempowerment. Roles and responsibilities among various branches and clusters were not evident.
- The shortage and retention of health professionals in rural areas remain a major challenge, while lengthy recruitment processes compound this problem.
- Performance management is not functioning properly. Performance management criteria rarely link to service delivery performance or rewards.

- Training of current staff is not receiving sufficient attention. Training budgets are reduced as a cost containment measure, which will have long term negative consequences.
- PERSAL is not fully used as a management and planning tool. Limited, inconsistent HR indicators are found in different official documents.

Recommendations

- Review and align national and provincial organisational structures. Strengthen technical capacity at national level to provide stewardship and leadership to provinces to achieve health outcome goals.
- Establish minimum staffing levels and optimal management and administrative positions based on objectively agreed benchmarks, optimal application of scarce skills, the public health sector's strategic and service delivery priorities and resource availability. Consider a moratorium on establishing additional provincial head office positions until the review is concluded.
- Re-institute appropriate delegations to improve service delivery and efficiency, accompanied by a clear matrix of delegation of authorities and decision-making at various levels.
- Improve recruitment processes urgently in consultation with DPSA to shorten appointment times.
- Review the performance management system to ensure employee performance that is linked to organisational performance, employee development, team-based performance where appropriate and rewards based on clear performance goals.
- Review the national health professional and scarce skills retention strategy.
- Define training and development programmes and align it to the service delivery priorities of the provinces. Maintain well-considered and prioritised commitments to relevant training, even during times of cost containment.
- Undertake an assessment to establish reasons for under-utilisation of systems. Implement improved measures, including the full use of PERSAL as an HR management tool.

4) Information management

Findings

- There is a lack of a properly functioning monitoring and evaluation (M&E) system for the health sector; national guidelines and norms and standards. Alignment between planning, implementation and monitoring and evaluation is lacking.

- Managerial accountability for the attainment of service related targets is lacking. M&E does not appear to be part of managerial performance assessment.
- There are inadequate analysis and interpretation and little utilisation of information for decision-making. Hence poor quality indicators derived from the data find their way to NDOH and National Treasury, where there is also little interrogation and feedback.

Recommendations

- Prioritize monitoring and evaluation as a matter of urgency. Develop a national M&E system with commensurate financial and human resources and technical expertise to ensure successful implementation.
- M&E should become a central component of all managerial activity with objective information forming the basis for decision-making.
- Develop an urgent plan to achieve an integrated and affordable National Health Information System (NHIS).

5) Medical products

Findings

- Pharmaceuticals are not treated as a major strategic issue, despite its critical nature to overall health care delivery, and despite it being a major cost driver.
- Some provinces have experienced a shortage of medicines as a result of over-expenditure, affecting many aspects of service delivery: from the vaccination of infants through to the continuation of patients on ARVs.
- All health departments experience capacity constraints. According to reports responsible staff members at provincial levels have insufficient and inappropriate skills to manage pharmaceutical budgets of millions of rand.
- Monitoring and control of pharmaceutical products is inadequate.

Recommendations

Carry out a review of all aspects of management, operations and skills requirements of provincial medical depots.

6) Laboratory

Findings

- Laboratory costs are a major cost driver and many provinces reported that the NHLS costs are extremely high compared with private sector costs.

- There is no national essential laboratory test list and clinicians and managers have not developed methods of prioritising laboratory tests or of working within a fixed budget for laboratory services.
- Monitoring and control of laboratory services is inadequate.

Recommendations

- The NDOH should establish a national working group of clinicians, managers and NHLS staff to develop essential laboratory test lists for different levels of health care and to work out limits on laboratory usage, drawing on some good practices that exist within provincial health departments.
- Do a review to benchmark laboratory costs of the NHLS and to develop appropriate national guidelines.

7) Technology and infrastructure

Findings

- The current Information Technology and Telecommunication infrastructure is inadequate to support planning, monitoring and evaluation and service delivery.
- Facility and equipment maintenance are insufficient and impacts negatively on service delivery and retention of staff.
- Capital and operational infrastructure budgets are not aligned.
- Security measures across various provinces require attention.

Recommendations

- Information and communication technology infrastructure architecture should form part of a plan to achieve an integrated and affordable National Health Information System.
- Capital programmes should incorporate planning for operational requirements and expenditure and include quality and service guidelines for contractors.
- Review medical equipment urgently, with special focus on rural areas.

11 Comparison between reports finalised in 2019 and 2009

6.100 A comparison between the *Report on the Presidential Health Summit* published in 2019 and the *Consolidated Report of the Integrated Support Team* finalised in 2009 is useful. It provides an opportunity to consider whether the concerns and problems identified in 2009 and recommendations made then had been acted upon, as well as

identifying the issues that remain problematic nearly a decade later. The statements in the table were copied almost verbatim from the respective reports, except for minor changes to correct grammatical errors and to leave out superfluous words. (The number in brackets indicate the page number where the statement appears in the cited report.)

6.101 An attempt was made to compare the reports by means of the listed themes for each report. However, this proved impossible. The lists of themes are not quite the same. In some instances a particular issue was classified under one heading in one report, while the same issue was classified under a different heading in the other report. Sometimes the same issues were repeated under different headings. For these reasons it was decided to rather use key phrases to compare items.

6.102 From the comparison above, it is clear that many problems and concerns had not been addressed in the nearly 10 years between the reports. Budget shortages and overspending were the main concerns in 2009, while monitoring and evaluation also featured strongly. The word “corruption” does not appear in the IST Report (2009) at all, but is mentioned 18 times in the *Report on the Presidential Health Summit 2018*.

6.103 The word “litigation” appears once in the 2009 report in the context of litigation for insufficient security and theft. The expressions “claim”, “claims”, “malpractice”, “medico-legal” and “negligence” do not feature in the 2009 report at all. On the other hand, in the 2019 report the expressions “claim” or “claims” appear eight times, “medico-legal” is mentioned four times, “malpractice” features three times and “litigation” and “negligence” are alluded to once each.

Action	<i>Report on the Presidential Health Summit 2018</i>	<i>Consolidated Report of the Integrated Support Team</i>
Publication	February 2019	May 2009
Release	Released into the public domain immediately.	Marked “Strictly Private & Confidential”. Released into the public domain in May 2010 after pressure from Section 27 and TAC.
Methodology	A commission was established for each of the themes. Delegates deliberated on the challenges the health system is facing in the commissions and made recommendations on solutions. Where possible, proposals were	A team of six consultants conducted the review at national level and nine teams of three consultants worked at provincial level. Each team comprised expertise in finance, health systems strengthening and management and organisational development. The consultants had to, inter alia –

Action	Report on the Presidential Health Summit 2018	Consolidated Report of the Integrated Support Team
	divided into short-term, medium-term and long-term solutions. (25)	<ul style="list-style-type: none"> • undertake a desktop review of strategic, financial analyses, operational plans and health service delivery data of national and provincial DOHs and compile a fact file; • identify key health programme and systems focus areas from the desktop review; and • conduct in-depth interviews with senior managers at national and provincial DOHs. (25)
Themes	<ol style="list-style-type: none"> 1) Human Resources for Health (Health Workforce) 2) Supply Chain Management, Medical Products, Equipment and Machinery 3) Infrastructure Plan 4) Private Sector Engagement 5) Health Service Provision (Delivery) 6) Public Sector Financial Management 7) Leadership and Governance 8) Community Engagement 9) Information Systems 	<ol style="list-style-type: none"> 1) Finance 2) Leadership, governance and service delivery 3) Human resources 4) Information management 5) Medical products 6) Laboratory 7) Technology and infrastructure
Accountability	<p>Provide clear systems of support, accountability and authority to operate, ensuring consequences for non-performance. (51)</p> <p>To improve accountability in leadership and governance, a coherent and aligned network of 'structures' across the health system [is needed]. This must include a legislative framework that underpins the structures and their power to act and hold everyone accountable. (52)</p>	<p>Management responsibility and accountability are limited at all levels of the hierarchy, making it more difficult to maintain effectiveness and efficiency standards. There are limited, and in some instances neither formalised nor clearly defined, financial management reporting structures, formats and timeframes. (41)</p> <p>Management tended to be focused more on operational and bureaucratic issues than on strategic matters of service delivery. (54)</p> <p>There is a lack of managerial accountability for the attainment of service related targets and M&E do not appear to be part of managerial performance assessment. (77)</p>
Budget	There is little protection of the health financial allocations as health funds can be reprioritised by provincial treasuries; with provincial health allocation mostly [in] the discretion of	The budgeting process was identified as a major contributor to the current funding challenges in the public health sector. Currently, the budgeting process is a top down

Action	<i>Report on the Presidential Health Summit 2018</i>	<i>Consolidated Report of the Integrated Support Team</i>
	the provincial treasuries and departments. (47)	process instead of an interactive top down, and bottom up, process. Although inputs are compiled from operational levels and provinces, and an indicative figure is obtained, the extent to which these are utilised by National Treasury in their allocation process is uncertain. National Treasury determines the health allocation, and this indicative amount is then allocated to the provinces (mainly via the provincial equitable share). The ultimate allocation to the provincial departments of health is determined by the provincial treasuries, but is to a large extent not aligned to provincial health departments' operational plans and budgets originally submitted. (40)
	Significant budgetary pressures exist with over expenditure and accruals including personnel expenditure such as overtime and rank promotions. Provincial treasury departments should be engaged on the baseline allocations to the provincial Departments of Health and priorities in terms of health care services particularly given the very high dependency of rural communities on the public health sector. Budget allocations to hospitals need to be urgently reviewed with a view to temporary relief of the unmanageable budgetary allocation. This is necessary because 75% or more of the budget is consumed by personnel salaries. (10)	As health service delivery is people driven, the largest part of the various provincial departments' operational budgets is the compensation of employees. During the financial year 2007/08 compensation of employees ranged between 51% and 65% of the operational budget, with a 56% provincial average. It is therefore of utmost importance that the complete value chain in organisational design, human resource management and development is run optimally to ensure a high standard of health service delivery and staffing cost efficiencies. (62)
Delegation	Lack of delegation of authority.	Despite written policies on delegations, in most provinces delegations have been withdrawn by the Provincial Treasury or by the HODs, with resultant day to day management by head office, widespread feelings of disempowerment and lack of accountability. (13) The NDOH should provide provinces with clear written guidelines regarding the delegation of authority,

Action	Report on the Presidential Health Summit 2018	Consolidated Report of the Integrated Support Team
		responsibility and accountability to facility and district managers. (59)
	Financial delegation to facility managers has not been fully implemented resulting in a negative impact on service delivery. Currently there are structural, functional and capacity challenges with lack of norms and standards enforcement mechanisms and support. (47)	Appropriate delegations should be re-instituted to improve service delivery and efficiency, accompanied by a clear matrix of delegation of authorities and decision making at various levels. This should be in line with a RACI matrix where different people are responsible, accountable, consulted or informed. The responsibility level of CEOs of institutions and district managers and their district management teams (DMTs) should be reviewed and addressed. This should include a review of financial management responsibilities aligned with capabilities. (15)
Equipment	Clinical engineers for complex bio-medical equipment; technicians for minor medical equipment and involvement of end user expertise in the procurement processes is key. (34)	It was reported that basic diagnostic and medical equipment, especially at lower level hospitals and clinics, is lacking across the country. (21) Clinical engineering services are not sufficiently staffed in all provinces to support optimal maintenance of medical equipment. (95)
Finances	Provincial health departments must reduce accruals and make efforts to understand cost drivers. They must stick to budgets allocated and monitor expenditure against service delivery standards. Provincial health departments must also establish budget and expenditure rules, e.g. maximum cost of equity (COE) share of the allocated budget. Moreover, they must instil accountability and transparency in governance and procurement. (47)	There is a lack of adequate financial management, reporting and accountability processes, as envisaged in the PFMA. Overspending has occurred with minimal or no consequences. These inadequacies lead to an inability to manage overall public health sector performance. (10) Financial management is generally poor with the exception of WCDOH and NCDOH. In many provinces budgeting is not seen as a priority, expenditure control cannot be done due to the absence of, or outdated, systems. Manual cost allocations are mostly done. (94)
	There is little protection of the health financial allocations as health funds can be reprioritised by provincial treasuries; with provincial health allocation mostly, the discretion of the	The ultimate allocation to the provincial departments of health is determined by the provincial treasuries, but is to a large extent not aligned to provincial health

Action	<i>Report on the Presidential Health Summit 2018</i>	<i>Consolidated Report of the Integrated Support Team</i>
	provincial treasuries and departments. (47)	departments" operational plans and budgets originally submitted. (40)
Human resources	Concerns were raised about several issues affecting human resources particularly vacant posts; performance management; poor planning; inadequate remuneration; poor coordination at different spheres of government; lack of leadership, management and governance; lack of delegation of authority; harmonisation and stewardship. Alignment and harmonisation are required which takes into consideration the importance of human resource for planning, including planning and budgeting to meet health needs. Education and training must be aligned to health system requirements. (27)	Organisational structuring in the provinces is not done according to agreed benchmarks or aligned with existing plans or resources. Of serious concern is the considerable and continued growth in management and administrative positions across the various provinces, especially in provincial head offices, relative to the growth in health care professional positions. (13) Poor alignment between planning, implementation and monitoring and evaluation. (78)
	The health system is plagued by endless challenges relating to inadequate funded posts; maldistribution of posts relative to need; poor service delivery planning; clinicians who are over worked; safety concerns for staff in facilities; lack of financial resources to absorb junior doctors in the public health sector etc. (28) The organisational design in hospitals and clinics is characterised as top heavy, with many managers appointed and the duplication of roles. (29)	Medical and nursing staff numbers showed little growth, even with an increase in national population and disease burden over the timeframe. Management staff grew by almost 160% or 671 people. Administrative staff grew by 30.5% or 8 743 people. Hospital and health services staff declined by 26% or 21 067 people. Together, management and administrative staff grew with 32,3 % or 9 414 people. (69)
	Some of the challenges in the public health sector include poor governance structures; inadequate management capacity and administrative systems; underfunding; human resource shortages and maldistribution; inadequate and poorly maintained infrastructure and equipment; inadequate information systems, overall inefficiencies amongst others. (13)	
	To address challenges relating to human resources for health (HRH) it is imperative that the moratorium on human resources be lifted; a human	The single most important challenge with regard to human resources is the recruitment and retention of health professionals. (69)

Action	<i>Report on the Presidential Health Summit 2018</i>	<i>Consolidated Report of the Integrated Support Team</i>
	resource (HR) roadmap is required and should include occupational health and safety; recognition and reward for personnel; talent management; attraction and incentivisation; retention and support. (9)	Incorrect staffing numbers provided, including inconsistent job titles and grades in provinces. (71)
Information system	The current health information systems within the public health sector and between the public and private health sectors is fragmented and poses a major challenge to effective stewardship of the health system. (57)	Generally, the current Information Technology and Telecommunication infrastructure is inadequate to support planning, monitoring and evaluation as well as service delivery. (21)
	Health information systems are fragmented with no integrated electronic health record. The current health information system is fragmented with 42 systems with no unified electronic health record. (11)	There is no single repository of information and as a result there are conflicting sources of official information. (77)
	There are currently 42 health information systems, however one platform is required whereby information can be exchanged between the disparate systems. (57)	Inadequate leadership and guidance from NDOH have resulted in many provinces taking the lead in developing costly health information systems. For example, there are twenty eight (28) standalone systems in use in the Gauteng Department of Health (GDOH). This makes the compilation of reports cumbersome and copying and pasting data from a variety of sources makes the information vulnerable to inaccuracies. (82) A significant amount of time and resources is spent on data collection, capture and collation at all levels. However, these data are characterised by poor quality control; inadequate analysis, interpretation; and little utilisation of information for decision-making. (17)
Infrastructure	The National Department of Health (NDOH) has a health infrastructure plan but to date the country has had neither the expertise nor adequate funding to implement the plan. In some cases, health infrastructure construction that has been successfully completed has either cost more than the initial budgeted	Although a facilities and hospital revitalisation programme is underway, it is reported that some projects have an unreasonably extended lifespan and a number of provinces are underspending on capital expenditure. It was also reported that operational planning is not linked to capital expenditure and operational

Action	<i>Report on the Presidential Health Summit 2018</i>	<i>Consolidated Report of the Integrated Support Team</i>
	<p>amount or facilities have been constructed that either fail to meet the need for the services required or have not been provided with adequate funding to operationalise the new facilities fully. The infrastructure plan must respond to changing population and clinical dynamics, it cannot be static. Further, there is a need to coordinate interventions with other government departments, notably the Department of Public Works. Overall, infrastructure in both the public and private health sectors must meet the requirements of the Office of Health Standards Compliance (OHSC). (10)</p>	<p>costs for medical equipment, staffing and medical products are often not budgeted for when planning the facility. (94)</p>
Leadership	<p>To improve accountability in leadership and governance, [set up] a coherent and aligned network of 'structures' across the health system. This must include a legislative framework that underpins the structures and their power to act and hold everyone accountable. (52)</p> <p>Supply chain management has enormous challenges ranging from limited supply chain management skills; inadequate monitoring and governance on available systems; shortage of equipment and consumables exist leading to poor quality of care; corruption; tedious and cumbersome supply chain management processes; inadequate information systems; suppliers not being paid on time which impacts medicine availability; poor procurement systems and processes which are not standardised across all levels. In the case of medical consumables, there is no regulation on quality, non-adherence to a national catalogue of products and ineffective monitoring of availability systems. (33)</p>	<p>The NDOH has provided insufficient leadership and stewardship to solve the fundamental problem of ensuring that the health resources available are sufficient for the levels of service and targets envisaged by a range of national policies. (11)</p> <p>Develop a simple but effective governance and accountability framework to better align roles and responsibilities across the various clusters within NDOH and between NDOH and provincial health departments. (13)</p>
Medicine	<p>Medicine is the second largest expenditure item in the health system, thus managing drug supply is essential. Managers should focus on procurement, selection, distribution</p>	<p>Pharmaceuticals are not a treated as a major strategic issue, despite its critical nature to overall health care delivery, and despite it being a major cost driver. (19)</p>

Action	<i>Report on the Presidential Health Summit 2018</i>	<i>Consolidated Report of the Integrated Support Team</i>
	<p>and to ensure that there is an uninterrupted supply of medicine. (33)</p> <p>Supply chain management has enormous challenges ranging from limited supply chain management skills; inadequate monitoring and governance on available systems; shortage of equipment and consumables exist leading to poor quality of care; corruption; tedious and cumbersome supply chain management processes; inadequate information systems; suppliers not being paid on time which impacts medicine availability; poor procurement systems and processes which are not standardised across all levels. In the case of medical consumables, there is no regulation on quality, non-adherence to a national catalogue of products and ineffective monitoring of availability systems. (33)</p>	<p>Capacity constraints are experienced both at national and provincial departments of health. It was reported that responsible staff members at provincial levels have insufficient and inappropriate skills to manage pharmaceutical budgets of millions of rand. (19)</p> <p>Monitoring and control, including security measures of pharmaceutical products, is inadequate in most provinces. (19)</p> <p>Shortage of medical products was experienced in most provinces, although the extent and seriousness of the impact varied across the provinces. One of the reasons is that pharmaceuticals are not treated as a major strategic issue, despite its critical nature to overall health care delivery, and despite it being a major cost driver. (89)</p> <p>There is insufficient staffing due to shortage of pharmacists and skills levels at pharmaceutical depots are not appropriate. (89)</p>
Monitoring	<p>Continuous monitoring and evaluation are imperative to ensure that human resources are still aligned with the needs in the sector. (27)</p>	<p>There is a lack of a properly functioning M&E system for the health sector.</p> <p>Contributing to this is a lack of national guidelines, norms and standards as well as a lack of alignment between planning, implementation and monitoring and evaluation. (17)</p>
PERSAL	<p>Human resource management information requires urgent attention with a need to validate the information from the “Integrated Human Resource, Personnel and Salary System” (PERSAL) so that it can be effectively utilised as a reliable human resource management tool. (30)</p>	<p>PERSAL is not fully used as a management and planning tool. Limited, inconsistent HR indicators are found in different official documents. PERSAL consistently reflects large numbers of outdated and unfunded positions.</p> <p>There is a general lack of integration of information and BAS and PERSAL data are not aligned with service delivery data. At facility level (clinics and CHCs) there are often no facility-based records kept of interactions with patients. Even basic registers are not kept. This makes it difficult to</p>

Action	<i>Report on the Presidential Health Summit 2018</i>	<i>Consolidated Report of the Integrated Support Team</i>
		verify whether there has been adequate data collection. (84)
	Key to improving human resources for health challenges is to validate and optimise the use of PERSAL and HR management information system. (31)	Several respondents reported major skills capacity problems with personnel dealing with the PERSAL and BAS systems. This included problems both in capturing data and in drawing reports. (84)
Political interference	Political interference and patronage networks in the management of public hospitals has resulted in the challenges that plague the public health sector. (29) The political interference in health care operations results in the deployment of incompetent managers for party political reasons. (43) Develop a policy that will stop political interference in service delivery and unfunded mandates within all departments and provincial administrations. (44)	Concerns about politically motivated appointments at various levels were expressed during interviews. (51) Political interference in performance management procedures. (71) New facilities. The opening of clinics during a financial year without funding being provided in the budget. The opening of these clinics was based on political promises being made without ascertainment of whether running costs were available. (36)
Quality of care	The overall financial position and capability of the provincial governments and that of the provincial departments of health have impacted on the ability of the hospitals to fulfil their mandate of providing quality health care. (10)	Quality of care should be prioritised and an enabling environment to achieve quality (e.g. supportive supervision, resources, delegations and accountability) should be fostered. (60)
Security	Safety concerns for staff in facilities – improve safety of employees in facilities by putting the necessary security measures in place. (30)	Security measures across various provinces require attention. (21) Security measures across various provinces differ and serious incidents of security breaches, litigation cases due to insufficient security and theft were reported. (95)
Supply chain	Supply chain management has enormous challenges ranging from limited supply chain management skills; inadequate monitoring and governance on available systems; shortage of equipment and consumables exist leading to poor quality of care; corruption; tedious and cumbersome supply chain management processes; inadequate information systems; suppliers not being paid on time which impacts medicine availability; poor procurement systems and processes	Supply chain processes including proactive planning, stock control and distribution processes need to be optimised in most provinces. (88) In many provinces supply chain management and distribution processes, including planning, stock control, monitoring and security are sub-optimal. (89)

Action	<i>Report on the Presidential Health Summit 2018</i>	<i>Consolidated Report of the Integrated Support Team</i>
	<p>which are not standardised across all levels. (33)</p> <p>Ineffective supply chain management systems. (41)</p> <p>Human resources and supply chain systems data to be cleaned up and effectively used. (58)</p>	
Training	<p>Government must address the shortage of trainee posts and review training programmes. (30)</p>	<p>Training of current staff is not receiving sufficient attention and training budgets, with the exception of NDOH, are decreased as a cost containment measure, which will have long term negative consequences. (14)</p> <p>Training and development programmes should be clearly defined and aligned to the service delivery priorities of the provinces. Well considered and prioritised commitments to relevant training should be maintained even during times of cost containment. (16)</p> <p>However, at provincial level, it has been found that learning and development for current staff is receiving insufficient attention; the training focus does not impact on or improve health service delivery; and budgeted training expenditure is cut back to save costs. As a result, longer term health service delivery and cost effectiveness will suffer and this needs a coordinated, national view to address the situation. (72)</p>

CHAPTER 7: COMPARATIVE STUDY ON COMPENSATION SYSTEMS

A Conclusion

7.1 The upsurge in medical malpractice litigation and the huge increase in compensation claimed and awarded is a problem across the world. Different countries adopted diverse measures to address the threat that excessive medical malpractice litigation holds for the public and private health sectors. Threats to the public health sector mainly centre around the impact on the sector's ability to continue delivering services and the expense to the public purse, while the private sector is heavily affected by increased risk, leading to higher insurance liability.

7.2 There is a variety of compensation systems being applied internationally in the area of medical negligence and medical malpractice. These range from no-fault compensation systems, to limited no-fault compensation systems for specific purposes, to combined systems, to redress systems, to systems with additional civil litigation processes, to systems introducing some form of limitation or capping, to traditional tort-based or delict-based systems. The increased risk and expense of tort-based or delict-based systems, linked to often unsatisfactory outcomes, have led to more and more countries considering alternatives.

7.3 An overview of various foreign systems is helpful to find solutions for South Africa's ever-increasing medico-legal litigation problems. There is no single foreign system that could be applied locally. However, useful lessons can be learnt from the experience in other countries. It seems that a combination of different aspects of foreign systems could offer a viable way forward for South Africa.

B Introduction

7.4 The huge increase in the number of medical negligence claims and in the size of compensation awards is not a uniquely South African problem – it is a world-wide phenomenon. Countries have adopted various measures to deal with this issue, ranging from amending prevalent negligence-based systems to establishing so-called “no-fault”

systems, to capping damages, to introducing pre-litigation processes aimed at keeping claims from progressing to court.¹ The term “no-fault”, however, could be misleading. It is more correct to refer to “administrative compensation” systems rather than “no-fault” systems. The common denominator underlying the various alternative systems is not necessarily a total absence of fault, but rather the objective of creating a process for awarding compensation to patients harmed by medical treatment, but without litigation or court intervention.

C Range of compensation systems

1 Existing compensation systems

7.5 After conducting a literature search, a range of existing and proposed administrative or partly administrative compensation systems was found. The following systems were identified:

- 1) No-fault compensation for “treatment injury” – New Zealand;
- 2) Compensation under the “avoidability” rule – Sweden and Iceland;
- 3) Compensation under the “avoidability” rule or the “endurability” rule – Finland and Denmark;
- 4) Compensation for treatment failure due to error/omission (ie fault) or under the “endurability” rule – Norway;
- 5) A restricted system employing the no-fault rule for compensation only when negligence cannot be proven – France and Belgium;
- 6) Tort-based claims (with negligence as the fault component), following prescribed pre-action protocols aimed at resolving disputes without litigation – Britain;
- 7) Compensation based on fault (negligence), however, the relationship between doctor and patient is consolidated in a statutory treatment contract focused on patients’ rights – Germany;
- 8) Redress scheme: redress made in the event of “qualifying liability” based on tort – Wales;
- 9) Limited no-fault compensation scheme for birth injury – Japan and states of Florida and Virginia in the USA;

¹ Tom Vandersteegen, Wim Marneffe, Irina Cleemput & Lode Vereeck “The impact of no-fault compensation on health care expenditures: An empirical study of OECD countries” *Health Policy* 119 (2015) 367–374 at 367, 368 & 372.

- 10) Capping of damages, especially non-economic damages – some states in the USA and Australia;
- 11) Certificate of merit by an appropriate expert witness or screening of claims by an expert panel before a medical negligence action may proceed – some states in the USA;
- 12) Tort or delict-based claims requiring proof of negligence – Australia, Canada, Scotland, South Africa, the USA, and so forth.²

2 Proposed systems

7.6 The most prevalent proposals for dealing with medical negligence litigation, but which do not seem to have been implemented in any of the jurisdictions reviewed, are the following:

- Separate health courts – proposal by some USA authors;³
- Shifting liability to institutions through “enterprise liability” – proposal by some USA academics;⁴
- Private contract – the so-called “neo no-fault” contract – between medical service provider and patient to offer no-fault benefits for economic loss due to personal injury.⁵

² Vandersteegen et al 367–374; Elaine Gibson “Is It Time to Adopt a No-Fault Scheme to Compensate Injured Patients?” *Ottawa Law Review* Vol 47 No. 2 (2016) 303–338.

³ Michelle M Mello, David M Studdert, Allen B Kachalia & Troyen A Brennan “ ‘Health Courts’ and Accountability for Patient Safety” *Milbank Quarterly* 84(3) (September 2006) 459–492 doi: 10.1111/j.1468-0009.2006.00455.x [Mello et al (2006)]; Philip G Peters Jr “Health Courts?” *Boston University Law Review* Vol. 88 (2008) 227–289; Michelle M Mello, Allen Kachalia & David M Studdert “Administrative Compensation for Medical Injuries: Lessons from Three Foreign Systems” Commonwealth Fund pub. 1517 Vol. 14 (July 2011) 1–16 at 2 [Mello et al (2011)]; Philip K Howard & Rebecca G Maine “Health courts may be best cure for what ails the liability system” *Bulletin of the American College of Surgeons* 98(3) (March 2013) 29–31.

⁴ David M Studdert & Troyen A Brennan “No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention” *JAMA* (11 July 2001) 286:2 217–223 at 221; Sarah Z Hoffman “No-Fault Solutions to the Problem of Medical Injuries: A Focus on Sweden as a Model” *Annals of Health Law* Vol 18 (2009) 73–93 at 79.

⁵ Hoffman 77.

D Compensation systems: International perspective

7.7 As indicated above, a number of countries have introduced administrative systems for dealing with claims for harm suffered due to a medical professional's action or omission. In some countries it is not necessary to prove fault for a successful claim, while others require proof that error had been present. However, no two countries have exactly the same system, therefore a brief overview of the systems prevalent in a number of countries is indicated.

1 New Zealand

7.8 The New Zealand compensation system for "treatment injury" is probably the most comprehensive compensation system and the closest to a true "no fault" system. It is broader in scope than other medical injury compensation systems. This comprehensive no-fault accidental injury compensation scheme covers medical injury and accidental injury (however incurred), including workplace and automobile accident injuries.⁶

7.9 The New Zealand compensation scheme can trace its origins to a report released in December 1967 by the Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand. The report, entitled *Compensation for Personal Injury in New Zealand: Report of the Royal Commission of Inquiry*, is commonly referred to as the "Woodhouse report". The original basis for New Zealand's compensation system was workers' compensation reforms.⁷

7.10 The report resulted in the adoption of the Accident Compensation Act in 1972, which established the Accident Compensation Scheme. The scheme, administered by the Accident Compensation Corporation (the ACC, initially the "Accident Compensation Commission") was established in 1974 as a state-funded compensation system.⁸ Vandersteegen et al opine that no-fault countries with privately as well as publicly

⁶ Gibson 321.

⁷ Vandersteegen et al 368.

⁸ Ken Oliphant "Beyond Misadventure: Compensation for Medical Injuries in New Zealand" *Medical Law Review* 15 (2007) 357–391 at 357; Ruth Upperton *A Truly No-Fault Approach To Treatment Injury Cover in Accident Compensation* (Victoria University of Wellington 2013) 9 core.ac.uk/download/pdf/41338608.pdf.

financed structures have lower health spending than all other countries.⁹ Primary healthcare is provided by general practitioners in private practice, but are paid by the government. Hospital care is predominantly public and is provided free of charge. According to Mello et al and Barbot et al, most medical specialists are employed by hospitals.¹⁰

7.11 The AC Act 1972 was overhauled in 1992 due to concerns over the financial state of the ACC and court decisions favouring patients.¹¹ The expressions “medical misadventure”, “medical error” and “medical mishap” were inserted into the legislation, with “medical error” introducing the common law concept of negligence.¹² The new Accident Compensation Act, 2001 was amended again in 2005, this time to replace the afore-mentioned terminology with the single new concept of “treatment injury”.¹³ This amendment signalled an important paradigm shift away from the “fault based test of medical error”, which means that showing negligence is no longer necessary to lodge a successful claim.¹⁴

7.12 The scheme is funded by government and levies on employers and self-employed people. Levies were originally paid on a pay-as-you-go basis, but is progressing towards a fully funded accounting system, including the future cost component of the claim. Although the law allows the government to impose levies on registered health professionals and organisations that provide medical treatment, this power has not been used.¹⁵

7.13 The bodies investigating claims are composed of professional administrators, claims handlers and medical experts. Centralised information on previous similar cases and assessors with specialised knowledge are required for the adjudication of matters of

⁹ Vandersteegen et al 371.

¹⁰ Mello et al (2011) 3; Janine Barbot, Isabelle Parizot & Myriam Winance ‘ “No-fault” compensation for victims of medical injuries. Ten years of implementing the French model” *Health Policy* 114 (2014) 236–245 at 241.

¹¹ Oliphant 361.

¹² Oliphant 363.

¹³ Oliphant 378.

¹⁴ Oliphant 387.

¹⁵ Gibson 325.

this nature.¹⁶ The ACC maintain a data base for collecting and analysing claims. The information is primarily used to improve patient safety.¹⁷

7.14 Damages are assessed on the basis of statutory criteria, with the focus on rehabilitation. Weekly compensation is possible, but compensation for non-economic loss is capped. The New Zealand scheme excludes lawsuits in tort for injuries covered by the scheme, except in certain specific circumstances (primarily in cases of mental harm unaccompanied by physical injury or claims for exemplary damages).¹⁸

7.15 Studies suggest that the ratio of claimants, compared to number of persons who suffered medical injury, is higher in a pure no-fault system such as New Zealand than in a tort-based system “because physicians are less afraid to help their patients in their itinerary of repair”.¹⁹

7.16 Since deterrence and compensation is not linked, medical practitioners involved in medical malpractice cases are not personally liable for the payment of damages.²⁰ In New Zealand the no-fault compensation system is supplemented with a medical professional accountability system and medical practitioners may be reported to the Medical Council, the Health and Disability Commissioner (HDC) system and the Health Practitioners’ Disciplinary Tribunal for investigation.²¹

2 Nordic countries

7.17 The relevant Nordic countries are Sweden, Denmark, Norway, Finland and Iceland. They use the avoidability standard, that refers to injuries that could have been avoided if the care provided had been of the best quality. This standard differs from the fault standard, because it does not require proof of negligence. It also differs from a “strict liability” standard, since unexpected injuries do not in themselves justify compensation.²²

¹⁶ Barbot et al 238.

¹⁷ Mello et al (2006) 461.

¹⁸ Gibson 323–324.

¹⁹ Barbot et al 245.

²⁰ Vandersteegen et al 371.

²¹ Vandersteegen et al 372.

²² Barbot et al 237.

7.18 Punitive damages are not available and awards for non-economic loss are capped.²³ As is the case in New Zealand, the bodies investigating claims are mainly composed of professional administrators, claims handlers and medical experts because of the specialised knowledge and centralised information on previous similar cases required.²⁴

7.19 Most Nordic systems are funded by public insurance companies of healthcare providers.²⁵ The schemes in Denmark and Finland are mainly privately financed, while the schemes in Sweden, Norway and Iceland are mainly publicly financed. Since deterrence and compensation is not linked, medical practitioners involved in medical malpractice cases are not personally liable for the payment of damages.²⁶ Legal services are generally considered unnecessary in the Nordic countries.²⁷

(a) Sweden

7.20 Sweden has a universal no-fault compensation system. Sweden's national health insurance system is financed by tax revenues and most private healthcare providers are included in the national system. The Patient Damages Act, a compulsory insurance scheme for every health care giver implemented in 1997, covers harm that is caused "in connection with medical care or treatment performed in Sweden."²⁸ The Act requires a caregiver (a state entity or a private provider) to obtain insurance.²⁹ These institutions also employ medical practitioners.

7.21 Patient liability insurance is primarily maintained by county council districts.³⁰ Private insurance companies cover doctors without a contract with the district, a range of other healthcare practitioners, and nursing homes.³¹ The Patient Insurance Alliance, made up of providers' insurance companies, delegated the investigation and

²³ Gibson 324.

²⁴ Barbot et al 238.

²⁵ Barbot et al 241.

²⁶ Vandersteegen et al 371.

²⁷ Gibson 319.

²⁸ Hoffman 86.

²⁹ Mello et al (2011) 3.

³⁰ Mello et al (2011) 3.

³¹ Gibson 325.

consideration of claims to the company called Patients Damages Adjustment, referred to as “PSR” (*Personskadereglering AB*).³²

7.22 Compensation is awarded in terms of the avoidability standard, which refers to harm suffered that could have been avoided if the best care had been provided (optimal circumstances).³³ For infections the durability rule applies, which is the criterion when the extent of the injury exceeds that which the reasonable patient could be expected to endure.³⁴

7.23 Physicians actively facilitate the majority of claims by notifying patients of possible medical injuries, referring patients to social workers for assistance, and helping patients to file claims by completing a report on the alleged injury.³⁵ A national central claims office assesses the claim to determine whether the injury was caused by the treatment and whether the injury could have been avoided. Proof of negligence is not required, but proof of causality is, meaning that the patient must be able to show that there is a considerable likelihood that the damage was caused by the medical examination, care, or treatment.³⁶

7.24 As Hoffman explains, “[t]he assessment of whether the injury could have been avoided is reviewed against the standard of an experienced specialist provider under similar circumstances”. She sets out the four steps for proving causality:³⁷

- 1) Whether there is a causal connection between the medical treatment and the injury;
- 2) Whether the treatment was medically motivated;
- 3) Whether the chosen method was made in accordance with scientific knowledge and professional experience; and
- 4) Whether it would have been possible to avoid the injury if another method or treatment had been used.

7.25 Economic compensation is awarded for loss of income. Compensation is also awarded for physical as well as psychological damages, including non-pecuniary loss

³² Hoffman 85.

³³ Vandersteegen et al 368; Mello et al (2011) 4.

³⁴ Gibson 320.

³⁵ Gibson 318–319.

³⁶ Hoffman 86.

³⁷ Hoffman 86–87.

such as physical suffering.³⁸ The system does not provide for punitive damages, and awards for non-economic loss are capped.³⁹

7.26 Decisions made by the PSR can be appealed to the Board on Patients Damages. After that the matter can be taken on arbitration or to court.⁴⁰ A claim in tort is also still possible, even after recovering damages in terms of the Patient Damages Act.⁴¹ According to Gibson only injuries not covered by the no-fault scheme are taken to court, but this seldom happens since 99.9 percent of claims are resolved without the involvement of the court.⁴² Swedish legislation explicitly states that compensation for injuries caused by accident is not limited to injuries compensable under tort.⁴³ The Swedish fund impose an injury threshold, which shows that the system intends to compensate only seriously injured patients.⁴⁴

(b) Denmark

7.27 Denmark established a privately financed insurance-based compensation system in 1992. Patient liability insurance is maintained by county council districts.⁴⁵ Private insurance companies cover various healthcare practitioners, nursing homes and medical practitioners who do not have a contract with the district.⁴⁶

7.28 Denmark applies the avoidability rule to determine whether an injured person is eligible for compensation. The endurability rule is applied to unavoidable medical injuries that are unusual or serious (injuries that result in a level of disability exceeding what a patient might reasonably be expected to endure). This differs from Sweden, where the endurability rule is only applied to infections.⁴⁷

³⁸ Hoffman 87.

³⁹ Gibson 324.

⁴⁰ Hoffman 87.

⁴¹ Hoffman 88.

⁴² Gibson 323.

⁴³ Gibson 320–321.

⁴⁴ Hoffman 88.

⁴⁵ Mello et al (2011) 4.

⁴⁶ Gibson 325.

⁴⁷ Barbot et al 238; Vandersteegen et al 368; Gibson 320.

7.29 Denmark's threshold criteria are typical of the Nordic-based model, which replaces the negligence standard with broader tests. Gibson explains that there are two ways that a patient can qualify for compensation under the avoidability rule. First, the patient can be compensated if it can be shown that the injury could have been avoided if the health care provider had used another, equally effective treatment. "The other treatment method must have been available at the time of treatment, but the treatment need not have been known as equally effective—in other words, information that becomes available after the time of treatment may be used in determining its relative effectiveness."⁴⁸

7.30 Alternatively, the patient can get compensation if it can be shown that an experienced specialist in that field would have acted differently, which leads to the assumption that the injury would then not have occurred. Compensation can be obtained for an injury caused by a wrong or delayed diagnosis if the experienced specialist would, on a balance of probabilities, have acted differently. No compensation is awarded if resources or facilities were not available, unless the experienced specialist would have referred the patient elsewhere, and the referral would have prevented the injury.⁴⁹

7.31 Compensation is possible if the treatment injury was unavoidable, but the extent of the injury incurred exceeded the limits of what the reasonable patient can be expected to endure. Compensation is also possible for injury due to the malfunction of equipment used for examination or treatment.⁵⁰

7.32 In contrast with Sweden, Denmark does not allow a further lawsuit on the basis of medical negligence, except with regard to product liability.⁵¹ Health care professionals have to advise injured patients of the possibility of compensation and physicians usually help patients to file claims. Hospitals have patient counsellors to advise patients of their rights and assist with claims. Lawyers are involved in about 10% of claims. Assessors review the initial claim where after independent medical experts will appraise the claim.⁵²

⁴⁸ Gibson 319–320.

⁴⁹ Gibson 320.

⁵⁰ Gibson 319 & 320.

⁵¹ Gibson 323.

⁵² Gibson 319.

(c) Norway

7.33 The Norwegian government established a committee in January 1987 to develop rules for a compensation scheme based on strict liability, which led to the introduction of a non-statutory scheme by means of an agreement between the Social and Health Department and the county municipalities (the owners and managers of public general hospitals in Norway).⁵³ The Norwegian System of Patient Injury Compensation [*Norsk Pasientskade Erstatning* (NPE)], a government agency under the Ministry of Health and Care Services, was established in 1988 as an interim provision.⁵⁴

7.34 The Act on Patient Injury Compensation was passed in 2001, including all public health services under the arrangement. The Act came into force in 2003. In 2009, private service providers, including private hospitals and doctors with contracts with the public health service, also became part of the scheme.⁵⁵

7.35 The reasons for establishing the NPE was to strengthen patients' legal protection, and to reduce civil lawsuits against physicians and health institutions. The NPE considers compensation claims from patients for compensation due to an injury resulting from possible incorrect treatment in the health service, using experts to assist it in its work.⁵⁶

7.36 Norway applies the standard of strict liability for treatment injuries, rather than the experienced specialist standard.⁵⁷ The following four criteria must be fulfilled for a successful claim for compensation:⁵⁸

- 1) The injury to the patient must, on a balance of probabilities, be causally linked to the treatment received.
- 2) There must have been an error or omission of treatment, resulting in substandard care.

⁵³ Rolf Gunnar Jørstad "The Norwegian System of Compensation to Patients" *Medicine and Law* (2002) 681–686 at 682.

⁵⁴ Ulf E Kongsgaard et al "Complaints to the Norwegian System of Patient Injury Compensation 2001–14 following nerve blockade" *Tidsskriftet Den Norske Lægeforening* (2016) 136: 1989–92 doi: 10.4045/tidsskr.16.0368.

⁵⁵ Kongsgaard et al (unpaged).

⁵⁶ *Supra*.

⁵⁷ Gibson 321.

⁵⁸ Kongsgaard et al Box 1 (unpaged).

- 3) The injury must have caused have led to financial losses of at least a determined amount (adjusted from time to time) or a minimum level of medical disability.
- 4) The application for compensation must be brought in time.

7.37 The Patient Injury Compensation Act provides for an exception clause, called “the reasonability rule”. The rule allows for compensation to be awarded when the injury to the patient is particularly severe or unforeseeable, and not an acceptable risk to the patient, even where there is no error or omission of treatment, or objective liability.⁵⁹

(d) Iceland

7.38 Iceland adopted an insurance-based no-fault scheme for medical malpractice in 2001, abandoning their tort-based system. Iceland also applies the avoidability rule, but abolished the option of going to court in case of a medical injury.⁶⁰

(e) Finland

7.39 Finland established a privately financed insurance-based compensation system in 1986. Finland applies the avoidability rule to determine eligibility for compensation, but compensation can also be awarded for unavoidable medical injuries of an unusual or serious nature by means of the endurability rule.⁶¹

3 France

7.40 The French system underwent major changes in 2002. Prior to 2002 the French operated solely along the lines of the tort system, meaning that a person suffering harm as a result of medical negligence had to sue the responsible health care provider if no settlement could be reached with the health care provider’s insurer. Law no. 2002-303 of 4 March 2002 relative to the rights of the sick and the quality of the health system,⁶²

⁵⁹ Kongsgaard et al (unpaged).

⁶⁰ Vandersteegen et al 368.

⁶¹ Vandersteegen et al 368.

⁶² “Loi n° 2002-303 du 4 Mars 2002 relative aux droits des malades et à la qualité du système de santé” [Equal Rights Trust “France: Law no. 2002-303 of 4 March 2002 relative to the rights of the sick and the quality of the health system”] accessed 20 August 2021 www.equalrightstrust.org/content/france-law-no-2002-303-4-march-2002-relative-rights-sick-and-quality-health-system.

which came into operation on 4 March 2002, introduced a limited no-fault system into France.⁶³

7.41 Fault-based tort liability remains the principal method of seeking compensation for damages due to medical injury. However, patients who suffered serious and unpredictable injury unrelated to their state of health (and the predictable evolution thereof) before the injury may seek compensation under the 4 March 2002 law if no-one can be held liable for the harm suffered.⁶⁴ The injury must have been caused in the course of diagnosis or treatment.⁶⁵ In addition, an injured party may apply for compensation by means of a free administrative procedure during a criminal prosecution for medical negligence.⁶⁶

7.42 Compensation is also possible for persons who experience a hospital-acquired infection leading to degree of disability, persons infected with certain diseases as a result of a blood transfusion, injury due to a health professional acting outside his/her area of specialisation, harm due to growth hormones, and injury suffered because of nuclear testing.⁶⁷

7.43 The underlying reasons for the 2002 changes to French law, according to Barbot et al, is national solidarity and the adoption of a no-fault compensation scheme for the most severe injuries, while maintaining the rules relating to responsibility for medical care and treatment.⁶⁸ The changes also reduced the risks to private insurance companies, which had been threatening to withdraw from the medical liability market before the 2002 reforms.⁶⁹

7.44 The 2002 reform achieved its other objectives of limiting court proceedings against medical professionals and hospitals by creating a quicker and easier way to

⁶³ Barbot et al 237.

⁶⁴ Barbot et al 238; Gibson 322–323.

⁶⁵ Gibson 322.

⁶⁶ Florence G'ssell-Macrez "Medical Malpractice and Compensation in France: Part 1: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002" in Oliphant & Wright 131–161 at 138; Vandersteegen et al 371.

⁶⁷ Gibson 322–323.

⁶⁸ Barbot et al 244.

⁶⁹ Barbot et al 237.

obtain compensation by means of an out-of-court settlement procedure, offering free medical treatment to injured persons and restoring public confidence in the system. Persons who suffered injuries considered to be less severe must still obtain compensation from the insurer of the health care provider or pursue their claims through the normal court process.⁷⁰

7.45 The limited French no-fault compensation system is operated by the state and is financed by the *Assurance-Maladie* (Health Insurance System). The *Assurance-Maladie* is funded by social security contributions from employers and employees, general income-based contributions, and state-imposed taxes.⁷¹ ONIAM, the national office of compensation for victims of medical injuries, iatrogenic affections and infections,⁷² is responsible for the administration of the mechanism, compensating victims of no-fault injuries, and stepping in when insurance companies do not accept liability after a decision of no-fault liability.⁷³

7.46 The 2002 law created independent Medical Accident Conciliation and Compensation Commissions (CCIs).⁷⁴ The CCIs consider and take decisions on the compensation of victims of medical accidents. Each CCI is chaired by a magistrate. Users, health professionals, health establishments, insurers, ONIAM, as well as qualified individuals make up the membership of the CCIs.⁷⁵

7.47 Patients submit their own applications – physicians do not have to assist.⁷⁶ Claimants participate in the process, attending the medical expertise meetings and submitting comments to the relevant regional CCI. Victims of medical injury retain the option to go directly to court and matters can be disposed of via litigation or out-of-court

⁷⁰ Barbot et al 237–238.

⁷¹ Barbot et al 241; Gibson 325.

⁷² “Office National d’Indemnisation des Accidents Médicaux” (ONIAM) accessed 20 August 2021 www.omiam.fr

⁷³ Barbot et al 241.

⁷⁴ “Les commissions de conciliation et d’indemnisation des accidents médicaux (CCI)” Office National d’Indemnisation des Accidents Médicaux “Less CCI” accessed 20 August 2021 www.omiam.fr (translated by Google translate).

⁷⁵ Barbot et al 238; Office National d’Indemnisation des Accidents Médicaux “Less CCI” accessed 20 August 2021 www.omiam.fr (translated by Google translate).

⁷⁶ Gibson 319.

settlements.⁷⁷ Compensation covers economic and non-economic damages (sexual detriment, loss of amenity, pain and suffering, aesthetic prejudice) and is not limited. The process via the CCIs takes weeks or months, as opposed to years if adjudicated upon by the courts or by settling out of court.⁷⁸ An application is rejected if it does not meet the severity criteria (the most common reason for rejection), if the injury was predictable, or if causality between the injury and treatment, missed diagnosis or nosocomial infection could not be established.⁷⁹

4 Belgium

7.48 Belgium introduced a restricted no-fault scheme similar to the French no-fault scheme. Belgium adopted an Act with regard to the compensation of damages as a result of health care on 31 March 2010, although the Act only came into operation on 1 September 2012.⁸⁰ As is the case with the French no-fault compensation scheme, the Belgian compensation scheme is limited to damages suffered as a result of a serious and unpredictable medical casualty (“*medisch ongeval*”) in instances where no care provider can be held liable for the harm suffered (“*medisch ongeval zonder aansprakelijkheid*”). The patient must have suffered serious abnormal harm unrelated to the patient’s state of health before the medical casualty and the objectively predictable evolution thereof, and considering prevalent science.⁸¹ Applications for compensation are considered and paid by a fund, which is described as a particular service of the National Institute for disease and disability insurance.⁸²

E Birth-related injury

7.49 There are three jurisdictions, namely the states of Virginia and Florida in the United States of America (USA), and most recently Japan, that adopted no-fault

⁷⁷ Barbot et al 238.

⁷⁸ Barbot et al 241.

⁷⁹ Barbot et al 242.

⁸⁰ *Wet betreffende de vergoeding van schade als gevolg van gezondheidszorg* published in the *Belgisch Staatsblad* of 2 April 2010 at 19913.

⁸¹ Definition of “*medisch ongeval zonder aansprakelijkheid*” (medical casualty without liability) read with sections 4 and 5 of the Belgian Act.

⁸² Definition of “*Fonds*”: “*de bijzondere dienst van het Rijksinstituut voor ziekte- en invaliditeitsverzekering*” read with section 8 of the Belgian Act.

compensation systems for birth-related injury. Injuries suffered during birth are one of the most expensive (if not **the** most expensive) type of medical injury giving rise to liability of hospitals and medical professionals. The high cost of this type of injury is explained by the severity and permanency thereof.⁸³

1 Japan

7.50 To qualify for compensation under the Japanese birth injury compensation scheme, the baby must have complied with the following criteria:⁸⁴

- 1) Born after 33 weeks of pregnancy;
- 2) Weigh more than 2,000 grams at birth;
- 3) Diagnosed with severe cerebral palsy, impaired muscle coordination or other disability typically caused by brain damage before or at birth;
- 4) Did not die within the first six months.

7.51 Compensation awarded under the Japanese scheme is capped, but lawsuits are permitted.⁸⁵ Gibson explains the operation of the financing mechanism:⁸⁶

The programme is funded by a levy on each pregnant woman at participating facilities, and the money is then passed on to private insurance companies. The levy is returned to the pregnant woman through her government-sponsored health insurance plan. Ultimately, then, the program is funded through the social insurance system, with private insurance companies covering the liability and standing to incur profit or loss from its operation.

2 USA

7.52 Although there has been a lot of support for introducing no-fault compensation schemes in the USA from some quarters,⁸⁷ only the states of Florida and Virginia have so far introduced no-fault compensation schemes and that only in relation to birth-related

⁸³ Gibson 322.

⁸⁴ Gibson 322.

⁸⁵ Gibson 324.

⁸⁶ Gibson 325.

⁸⁷ Hoffman 74. See in general Paul J Barringer et al "Administrative Compensation of Medical Injuries: A Hardy Perennial Blooms Again" *Journal of Health Politics, Policy and Law* 33:4 (August 2008) 725–760.

injuries. The states of Florida and Virginia in the USA were both affected by elevated levels of litigation and rising liability insurance premiums for obstetricians, which was the main reasons for the decision to create compensation schemes for parents whose babies developed catastrophic neurological injuries during the birth process.⁸⁸

7.53 Participation in the Florida and the Virginia birth-related neurological injury schemes are voluntary for physicians, but according to Gibson “over 90 percent of eligible physicians have opted in to the Virginia and Florida programs”.⁸⁹

(a) Florida

7.54 The homepage of the website of the Florida Birth-Related Neurological Injury Compensation Association (NICA) indicates the reasons for NICA’s establishment:⁹⁰

[T]he Florida Legislature created the Florida Birth-Related Neurological Injury Compensation Association in 1988 to promote and protect the health and best interests of children with birth-related neurological injuries who have been accepted into the plan by striving to ensure that their medically necessary needs are being met. NICA is a no-fault alternative to medical malpractice lawsuits for the kind of injuries that carry the highest cost and system impact. The program shifts those costly cases out of the tort system, which helped to stabilize Florida’s medical malpractice insurance market and encouraged Florida’s obstetricians to continue delivering babies.

7.55 Compensation can only be claimed if the obstetrician who delivered the injured baby is a participant in the programme, which is an administrative alternative to litigation. The eligibility criteria set out below has to be complied with. The eligibility criteria, especially the first requirement, narrow down the number of children that qualify, ensuring that the number of claims remains fairly low.⁹¹

- Injury to the brain or spinal cord during live birth due to mechanical injury or oxygen deprivation, which causing cognitive disability requiring permanent assistance.
- The birth must have taken place in a hospital.
- Injury sustained during resuscitation immediately following delivery is included.

⁸⁸ Barringer et al 738; Gibson 318.

⁸⁹ Gibson 333.

⁹⁰ The Florida Birth-Related Neurological Injury Compensation Association “About NICA” accessed 21 August 2021 <https://www.nica.com/about-nica/>.

⁹¹ Gibson 322.

7.56 Participation in the NICA programme is optional and a claimant may still pursue a lawsuit for negligence. Once a child is accepted into the programme, however, the option of a tort-based lawsuit is no longer available.⁹² The first step when claiming via the programme is an assessment by an administrative law judge (the only jurisdiction where this happens). The programme provides for an internal appeal process, which may be taken on judicial appeal if considered necessary.⁹³

7.57 All Florida physicians and hospitals are required to pay annual assessment fees to NICA, but participating physicians and hospitals are eligible for lower insurance premiums for medical malpractice, the amount of which is fixed. The programme must be managed on an actuarially-sound basis. The state of Florida granted \$40 million to the programme when it commenced.⁹⁴

(b) Virginia

7.58 The Virginia Birth-Related Neurological Injury Compensation Program was established in 1987 to compensate eligible children by means of an administrative process. It is a no-fault scheme, hence proving negligence is not required. As is the case in Florida, compensation can only be claimed if the obstetrician who delivered the injured baby is a participant in the programme. The eligibility criteria set out below has to be complied with. The eligibility criteria, especially the first requirement, narrow down the number of children that qualify, ensuring that the number of claims remains fairly low.⁹⁵

- Injury to the brain or spinal cord during live birth due to mechanical injury or oxygen deprivation which causes cognitive disability requiring permanent assistance.
- The birth must have taken place in a hospital.
- Injury sustained during resuscitation immediately following delivery is included.

⁹² Gibson 324.

⁹³ Gibson 319.

⁹⁴ Gibson 325.

⁹⁵ Gibson 322.

7.59 Compensation can only be claimed if the obstetrician who delivered the injured baby is a participant in the programme. Legal services are commonly used in Virginia,⁹⁶ but once a baby has been admitted to the programme litigation in the courts is barred.⁹⁷

7.60 The Virginia programme is funded in the same manner as the Florida programme. All physicians and hospitals are required to pay annual assessment fees to the programme, but participating physicians and hospitals are eligible for lower insurance premiums for medical malpractice, the amount of which is fixed. The programme must be managed on an actuarially-sound basis.⁹⁸

7.61 As stated on their website, “[a]dmission into the Program is determined solely by the Virginia Workers’ Compensation Commission based on criteria outlined in state law”.⁹⁹ According to Gibson medical malpractice administrative costs have decreased in Virginia, and the administrative costs for the Program is quite low relative to the compensation awarded.¹⁰⁰

(c) Other states

7.62 Although Florida and Virginia are the only states in the USA that implemented no-fault compensation schemes, other states have introduced alternative statutory measures in an attempt to deal with escalating medico-legal claims. Some states adopted caps on economic and non-economic damages, limited joint and several liability, restricted attorneys’ fees and amended collateral source rules to reduce malpractice premiums and awards.¹⁰¹

⁹⁶ Gibson 319.

⁹⁷ Barringer et al 738.

⁹⁸ Gibson 325.

⁹⁹ Virginia Birth-Related Neurological Injury Compensation Program “Eligibility, Benefits & Claims” accessed 21 August 2021 <https://www.vabirthinjury.com/eligibility-frequently-asked-questions/>.

¹⁰⁰ Gibson 327–328.

¹⁰¹ Vandersteegen et al 368.

F Common law and mixed systems

1 Britain

7.63 The UK has commissioned several reports and conducted a number of investigations over the years that relate to or influence medical negligence claims. The introduction of pre-action protocols was an important innovation aimed at promoting early settlement of matters and avoiding taking matters to court as far as possible. The origin of pre-action protocols is the 1996 document *Access to justice: final report to the Lord Chancellor on the civil justice system in England and Wales*, commonly referred to as the Woolf Report.¹⁰² The British Lord Chancellor appointed Lord Harry Woolf in 1994 to review the civil justice system of England and Wales. An interim report was published in June 1995, followed by the final report in July 1996.¹⁰³ The introduction of pre-action protocols is one of the most important innovations of the Woolf report.¹⁰⁴ Following the release of the Woolf Report, Fabricius conducted an overview of the Woolf Report insofar as it relates to the situation in South Africa on the basis that “a similar urgent need exists here”.¹⁰⁵ See Chapter 9 for a more detailed discussion of pre-action protocols.¹⁰⁶

7.64 *Making Amends* was a consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS released by the Chief Medical Officer of the UK Department of Health (CMO) in June 2003.¹⁰⁷ The paper considered no-fault compensation but rejected it in the end due to the potential huge increase in claims and overall costs, among others.¹⁰⁸ The paper proposed an NHS redress scheme instead.¹⁰⁹ The UK Parliament subsequently adopted the NHS Redress Act 2006, based on the

¹⁰² Harry Woolf *Access to justice: final report to the Lord Chancellor on the civil justice system in England and Wales* (1996) [Woolf Report] webarchive.nationalarchives.gov.uk/ukgwa/20060213223540/http://www.dca.gov.uk/civil/final/contents.htm.

¹⁰³ Hans Fabricius “Access to Justice: The Woolf Report” *Consultus* (November 1996) 108–115 at 108.

¹⁰⁴ Woolf Report Chapter 10.

¹⁰⁵ Fabricius 108.

¹⁰⁶ For a more detailed discussion of the Woolf Report, see Oosthuizen 471–481.

¹⁰⁷ Chief Medical Officer *Making Amends: A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS* (UK Department of Health, June 2003) [*Making Amends*].

¹⁰⁸ *Making Amends* 110–113.

¹⁰⁹ *Making Amends* 119–123.

Chief Medical Officer's recommendations in the *Making Amends* report.¹¹⁰ The Act gives the Secretary of State the authority to establish a redress scheme by regulation, however, no regulations under the Act had been promulgated to date. An answer provided in the UK Parliament in response to a question about the NHS Redress Act indicated that the Act will not be implemented in the foreseeable future.¹¹¹

7.65 The UK Department of Health commissioned a study into no-fault compensation schemes, which was released in December 2016.¹¹² The study did not make proposals, only observations. The implications of the study findings are explained as follows:¹¹³

This group of studies suggests that NFCSs [no-fault compensation schemes] can confer benefits on key stakeholders, namely patients, health professionals and the health system as a whole. The possible benefits range from improved targeting of compensation to those most deserving of it, to speedier physical recovery after injury. However, the complexity of the interactions between compensation processes, individual circumstances and the health systems in which the schemes are embedded make it difficult to establish strong causal pathways, most notably regarding health outcomes. The shape of the schemes will be highly influenced by the health system context which, in turn, is affected by the prevailing political opinion about the role of the state in health care.

7.66 The UK DOH published a consultation document on 2 March 2017,¹¹⁴ seeking comments on a proposed voluntary administrative compensation scheme for severe avoidable birth injury without the need to bring a claim via the courts.¹¹⁵ In September 2017 the Comptroller and Auditor-General brought out a report which examines whether

¹¹⁰ House of Commons "The NHS Redress Bill 137 of 2005/6" *Research Paper 06/29* at 3.

¹¹¹ Question HL11820 (6 January 2021): "To ask Her Majesty's Government what plans they have to implement the NHS Redress Act 2006.;" Response (15 January 2021): "The Department is working intensively with the Ministry of Justice, other Government departments and NHS Resolution to address the costs of clinical negligence claims. We will publish a consultation on the next steps in 2021. The Department has no plans to implement the NHS Redress Act 2006 and has not made a recent assessment of the effectiveness of the Act in resolving clinical negligence claims." [UK Parliament: Written questions, answers and statements *Question 11820 for Department of Health and Social Care NHS: Compensation* (6 January 2021) questions-statements.parliament.uk/written-questions/detail/2021-01-06/hl11820#]

¹¹² Kelly Dickson et al *No-Fault Compensation Schemes: A rapid realist review to develop a context, mechanism, outcomes framework* (UK December 2016) [NFC Schemes (2016)].

¹¹³ NFC Schemes (2016) 45.

¹¹⁴ Department of Health UK *A Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury: A Consultation* (2 March 2017) [*Birth Injury* (2017)]

¹¹⁵ *Birth Injury* (2017) 7.

the costs of clinical negligence are being managed effectively.¹¹⁶ The reason for the report was the rising costs of clinical negligence claims. The most pertinent of the report's key findings are:¹¹⁷

- The cost of clinical negligence claims is rising at a faster rate year-on-year, than NHS funding.
- The government lacks a coherent cross-government strategy, underpinned by policy, to support measures to tackle the rising cost of clinical negligence.
- The rise in clinical negligence costs is due to increases in average claimant damages and legal costs, and to a higher volume of claims.

7.67 According to reports, the UK government is undertaking yet another review of their clinical negligence system due to the rising cost thereof. A complete overhaul of the system is reportedly on the cards and the UK government is planning to consult on the reform proposals before deciding on the way forward. The reform of the system will entail both the dispute resolution process and the way in which damages are calculated.¹¹⁸

2 Wales

7.68 Wales introduced the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 under the National Health Service (Wales) Act 2006. Apart from certain exclusions stipulated in regulation 14, anyone may raise a concern about a Welsh NHS service, action, omission or decision,¹¹⁹ where after a prescribed process (which may include alternative dispute resolution) must be followed for the handling and investigation of a concern. The investigation of a concern may include instructing medical experts.¹²⁰

¹¹⁶ National Audit Office *Report by the Comptroller and Auditor General: Managing the costs of clinical negligence in trusts* (September 2017) [Audit Report (2017)].

¹¹⁷ Audit Report (2017) 6–9.

¹¹⁸ John Hyde “Ministers weigh up wholesale changes to clinical negligence” *The Law Society Gazette* (UK) 6 March 2020 accessed 10 March 2020 www.lawgazette.co.uk/news/ministers-weigh-up-wholesale-changes-to-clinical-negligence/5103382.article; John Hyde “Clinical negligence reforms imminent as Hunt lambasts ‘obscene’ costs” *The Law Society Gazette* (UK) 27 September 2021 accessed 11 October 2021 www.lawgazette.co.uk/news/clinical-negligence-reforms-imminent-as-hunt-lambasts-obscene-costs/5109914.article.

¹¹⁹ Regulation 12 of the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (No. 704 W. 108)

¹²⁰ Reg 32 of the Wales Regulations.

7.69 The legal basis for the Welsh system is the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (Welsh Redress Regulations), made under the National Health Service (Wales) Act 2007. The Welsh Redress Regulations imposes a duty upon a “responsible body” (defined as a Welsh NHS provider, primary care provider or independent provider)¹²¹ to make arrangements for the handling and investigation of concerns. A “concern” is “any complaint; notification of an incident concerning patient safety or ... a claim for compensation”.¹²² Concerns may be notified to a responsible body, which body must make arrangements for handling and investigating concerns,¹²³ and which must designate a person to maintain strategic overview of the body’s operation of the arrangements.¹²⁴

7.70 Each responsible body must designate a person, referred to as the “responsible officer”, to take overall responsibility for the effective day to day operation of the arrangements for dealing with concerns.¹²⁵ The responsible body must investigate the matters raised in the notification of a concern to reach a conclusion thoroughly, speedily and efficiently. The responsible body must carry out an initial assessment to determine, among others, the depth and parameters of the investigation; whether the concern may be resolved by means of ADR; decisions about the root cause of the concern; the likelihood of a qualifying liability; and the duty to consider redress.¹²⁶

7.71 The expression “qualifying liability” is defined. It refers to a liability in tort owed in respect of personal injury or loss arising out a breach of a duty of care owed in connection with the diagnosis of illness, care or treatment of a patient, consequent to an act or omission by a health care professional and arising out of the provision of qualifying services.¹²⁷ The responsible body must respond to the concern in writing, providing certain prescribed information; including a summary of the matter, the investigation that had been undertaken, copies of expert opinions and relevant medical records (where appropriate), as well as an apology if appropriate.¹²⁸ If a Welsh NHS responsible body

¹²¹ Reg 2.

¹²² Reg 2.

¹²³ Reg 4.

¹²⁴ Reg 6.

¹²⁵ Reg 7.

¹²⁶ Reg 23.

¹²⁷ Reg 2.

¹²⁸ Reg 26.

determines that there may be a qualifying liability, it must produce an interim report and determine whether to make an offer for redress to the patient.¹²⁹

7.72 Redress comprises:¹³⁰

- 1) making an offer of compensation in satisfaction of any right to bring civil proceedings in respect of a qualifying liability;
- 2) giving an explanation;
- 3) apologising in writing;
- 4) reporting on the action taken to prevent similar cases.

7.73 The compensation offered can take the form of entry into a contract to provide care or treatment, and/ or financial compensation, or both.¹³¹ It is important to note that redress is not available in relation to a liability that is or has been the subject of civil proceedings.¹³² An offer for redress for a qualifying liability by way of financial compensation is limited to £25,000.¹³³

7.74 If a Welsh NHS body considers the value of the qualifying liability to exceed £25,000, the body may consider an offer of settlement outside the provisions of the Regulations. Damages for pain, suffering and loss of amenity is calculated on a common law basis. Welsh Ministers may from time to time issue a compensation tariff for guidance when considering the amount of financial compensation to be offered. The findings of the investigation of a concern must be recorded in an investigation report.¹³⁴

7.75 Where a Welsh NHS body has determined that a qualifying liability exists, the body must ensure that legal advice is available to a person seeking redress. If the opinion of a medical expert needs to be instructed, the Welsh NHS body must ensure that the instruction is carried out jointly by the NHS body and the person who has notified the concern. The Welsh NHS body must communicate its decision to the person who notified the concern within 12 months of the notification.¹³⁵

¹²⁹ Reg 26.

¹³⁰ Reg 27.

¹³¹ Reg 27.

¹³² Reg 28.

¹³³ Reg 29.

¹³⁴ Reg 29.

¹³⁵ Reg 32.

7.76 Each responsible body must ensure that it has arrangements in place to review the outcome of a concern that was the subject of an investigation. This must be done to ensure that any deficiencies in its actions or its provision of services, which are identified during the investigation, is acted upon and monitored, that lessons learned are identified and promulgated throughout the body to improve its services and to seek to avoid such deficiencies from recurring.¹³⁶

3 Australia

7.77 The tort most relevant to the Australian health sector is the tort of negligence.¹³⁷ Cheluvappa and Selvendran explain negligence in the Australian context:¹³⁸

To prove negligence, the plaintiff needs to demonstrate the defendant's duty of care, the standard of the defendant's expected caregiving, and legal breach of that duty of care to the plaintiff. The duty of care of a medical professional is not to cause a physical injury that is "reasonably foreseeable".

7.78 The Commonwealth of Australia convened a panel under the chairmanship of the Hon DA Ipp to conduct a review of the law of negligence.¹³⁹ According to its terms of reference, the panel had to, among others: "Inquire into the application, effectiveness and operation of common law principles applied in negligence to limit liability arising from personal injury or death". The terms of reference included reviewing the formulation of duties and standards of care; causation; the foreseeability of harm; and the remoteness of risk.¹⁴⁰ The panel also had to "develop and evaluate options for a requirement that the standard of care in professional negligence matters (including medical negligence) accords with the generally accepted practice of the relevant profession at the time of the negligent act or omission".¹⁴¹

¹³⁶ Reg 49.

¹³⁷ Rajkumar Cheluvappa & Selwyn Selvendran "Medical negligence – Key cases and application of legislation" *Annals of Medicine and Surgery* 57 (2020) 205–211 at 206.

¹³⁸ Cheluvappa & Selvendran 210.

¹³⁹ Commonwealth of Australia *Review of the Law of Negligence: Final Report* (September 2002) [Ipp Report (2002)].

¹⁴⁰ Ipp Report (2002) ix.

¹⁴¹ Ipp Report (2002) x.

7.79 The final report, commonly referred to as the Ipp Report, made a total of 61 recommendations that included the following recommendations (in summary):¹⁴²

- 1) Incorporate the panel's recommendations in a single statute – that might be styled the Civil Liability (Personal Injuries and Death) Act ('the Proposed Act') – to be enacted in each jurisdiction.
- 2) The Act should apply to any claim for damages for personal injury or death resulting from negligence regardless of the cause of action (tort, contract, statutory etc).
- 3) Set out the test for determining the standard of care in cases of professional medical negligence in treating a patient.
- 4) Set out how the standard of reasonable care should be determined.

7.80 Not all the recommendations made in the Ipp Report were followed, since each state for example still has its own civil liability legislation, with South Australia's Civil Liability Act 1936 being the oldest. It is clear from this explanation, however, that claims for medical injury in Australia are still fault-based.

4 Canada

7.81 Canada's medical malpractice system is fault-based, the main legal response to medical malpractice in Canada being a civil negligence action. A plaintiff must show that the healthcare provider owed him/her a duty of care, that the healthcare provider failed to meet the requisite standard of care, thereby causing injury to the patient, and that the injury "was not too remote from the negligent action".¹⁴³

7.82 Gibson is critical of the Canadian system, expressing the view that the system functions poorly. She points out that a very small percentage of injured patients institute legal action for medical malpractice, and that even fewer get compensated following legal action.¹⁴⁴ Gibson contends that "[t]he rate of medical malpractice compensation in response to medically induced injury is exceedingly low."¹⁴⁵

¹⁴² Ipp Report (2002) 1 & 2.

¹⁴³ Gibson 309.

¹⁴⁴ Gibson 307.

¹⁴⁵ Gibson 307.

7.83 Gibson blames this state of affairs on a number of reasons, such as the difficulties in proving causation, the considerable expense involved with obtaining expert evidence, the risk of a costs award against an unsuccessful plaintiff, and the role of the Canadian Medical Protective Association (CMPA). Apart from vigorously defending its members against medical malpractice lawsuits, the CMPA has the best medical experts at its disposal and, by shouldering the burden of paying compensation, lessen the responsible medical practitioner's incentive to settle a case.¹⁴⁶

5 Scotland

7.84 The law of Scotland, similar to the law of South Africa, was strongly influenced by Roman-Dutch law. Like South Africa, the Scottish system of personal injury is based on delict, not on tort like the UK, Canada, Australia, and the USA. It is therefore useful to consider legal developments in Scotland.

7.85 Scotland applies a fault-based compensation system for delictual claims, including medical negligence claims. A plaintiff must be able to prove that a health provider was negligent in order to obtain compensation.¹⁴⁷ Detractors of fault-based schemes for medical injury argue that the focus on proving negligence neither encourages openness nor enhances the quality of care. It discourages incidence reporting and the opportunity to learn from mistakes, and leads to defensive medical practices.¹⁴⁸ NHS Scotland does not pay compensation unless it has been proven that the NHS or its independent contractors are legally liable for harm suffered by a patient.¹⁴⁹

7.86 The No-fault Compensation Review Group, chaired by Professor Sheila McLean, was established in 2009 to deliberate on the potential benefits of a no-fault scheme for Scotland and the possibility of introducing such a scheme in conjunction with the existing clinical negligence system.¹⁵⁰ The process was started off by a research document,

¹⁴⁶ Gibson 313–314.

¹⁴⁷ Frank Stephen, Angela Melville and Tammy Krause *A Study of Medical Negligence Claiming in Scotland* (Scottish Government Social Research 2012) at 1.

¹⁴⁸ Stephen, Melville & Krause 2.

¹⁴⁹ Scottish Government *No Fault Compensation Review Group: Report and Recommendations* (February 2011) 5 [NFC Report (2011)].

¹⁵⁰ Scottish Government *Consultation Report: Consultation on Recommendations for No-Fault Compensation in Scotland for injuries resulting from clinical treatment* (April 2014) 3 [NFC Consultation Report (2014)].

released in 2010, reviewing the no-fault schemes operational in New Zealand and the Nordic countries.¹⁵¹

7.87 The Review Group released its report in February 2011. The report put forward a number of recommendations, the main recommendation being a proposal “that consideration be given to the establishment of a no fault scheme for medical injury, along the lines of the Swedish model, bearing in mind that no fault schemes work best in tandem with adequate social welfare provision”.¹⁵²

7.88 The NFC Report (2011) was followed by the NFC Consultation (2012), seeking views on the recommendations put forward by the No Fault Compensation Review Group for purposes of a “public consultation on recommendations for no-fault compensation in Scotland for injuries resulting from clinical treatment”.¹⁵³ The NFC Consultation Report (2014), which provides an overview of the responses received to the NFC Consultation (2012), was published in April 2014.

7.89 The Scottish Government released another consultation document in March 2016, requesting comments on draft proposals for a “ ‘No-blame’ Redress Scheme” in Scotland for harm resulting from clinical treatment.¹⁵⁴ The envisaged Redress Scheme, which would be a “no-blame” rather than a true “no-fault” scheme,¹⁵⁵ was to be based on the following broad principles:¹⁵⁶

- Compensate fairly for avoidable harm where it is established the harm would have been avoided by the use of “reasonable care” (excluding unavoidable risks of the procedure that caused the harm);
- Defend medically reasonable care;
- Reduce patient injuries by learning from patients’ experiences.

¹⁵¹ Anne-Maree Farrell, Sarah Devaney & Amber Dar *No-Fault Compensation Schemes for Medical Injury: A Review* (Scottish Government Social Research 2010).

¹⁵² NFC Report (2011) 57.

¹⁵³ Scottish Government *A Public Consultation on Recommendations for No-Fault Compensation in Scotland for Injuries Resulting from Clinical Treatment* (August 2012) 6. [NFC Consultation (2012)].

¹⁵⁴ Scottish Government *‘No-Blame’ Redress Scheme: A Public Consultation on Draft Proposals for a ‘No-blame’ Redress Scheme in Scotland for Harm Resulting from Clinical Treatment* (March 2016) [Redress Scheme (2016)].

¹⁵⁵ A true “no-fault” scheme would potentially cover avoidable and unavoidable harm, while a “no-blame” scheme covers avoidable harm [Redress Scheme (2016) 10].

¹⁵⁶ Redress Scheme (2016) 10.

7.90 The main proposals for the Redress Scheme were as follows:

- 1) Restrict compensation to causally connected avoidable harm that affects the injured person for a continuous period of at least 6 months.¹⁵⁷
- 2) The scheme will not be retrospective and only cover clinical events that occur after introduction thereof.¹⁵⁸
- 3) The scheme will handle claims up to £100,000.¹⁵⁹
- 4) The £100,000 cap (which includes cost of care packages and damage for loss of earnings) will effectively eliminate the most severe and complex cases (such as brain damaged children) and cases that require continuing care. These cases will be dealt with through the legal system.¹⁶⁰
- 5) For continuous future care an independent assessment of the requirements for each individual care package would be undertaken and a guarantee of treatment and care by the NHS or local authority provided.¹⁶¹
- 6) Where the care package or elements thereof cannot be provided by the NHS or local authority, the relevant NHS Board will be responsible for commissioning services from alternative providers.¹⁶²
- 7) Legislation to provide for periodic payments for continuing care costs is being considered.¹⁶³

7.91 The Scottish Government did not release any further documents or papers after the 2016 document. The SALRC researcher addressed an inquiry about the status of the No Fault Compensation Review Group process / No-blame Redress Scheme to the Scottish Law Commission (SLC). With the kind assistance of the SLC, the SALRC obtained the following response from a Scottish government official in April 2021:¹⁶⁴

There are no plans for a Scottish no-fault compensation / redress scheme at this time.

¹⁵⁷ Redress Scheme (2016) 11.

¹⁵⁸ Redress Scheme (2016) 11.

¹⁵⁹ Redress Scheme (2016) 12.

¹⁶⁰ Redress Scheme (2016) 12.

¹⁶¹ Redress Scheme (2016) 14.

¹⁶² Redress Scheme (2016) 14.

¹⁶³ Redress Scheme (2016) 15.

¹⁶⁴ Malcolm McMillan, Chief Executive, Scottish Law Commission "Re: No-fault compensation/redress scheme – Scotland". Email to SALRC researcher (20 April 2021).

The previous proposals were for a no-blame redress scheme that would have sat alongside the existing NHS compensation scheme and would offer an alternative to pursuing clinical negligence claims through court procedures.

However, despite carrying out considerable research and consultation since 2007, there has never been consensus on the need for a no-blame redress scheme in Scotland. Opposition parties and key stakeholders have consistently raised legitimate concerns about cost and complexity; how such a scheme would operate effectively; the proliferation of compensation claims; and that a redress scheme could take resources away from frontline services. There was a very modest response to the redress scheme consultation, which ended on 12 August 2016. A number of those responses raised similar concerns.

Therefore, after carefully considering:

- previous expert advice and the responses to this and previous public consultations;
- the divergent views that have been expressed over a number of years;
- the patient safety and openness and learning measures that have been put in place since the proposals for a no fault compensation scheme were first introduced in 2007;
- the financial implications of introducing a scheme in an extremely challenging financial climate; and
- proposals for a compulsory clinical negligence pre-action protocol,

The Secretary of State at the time decided not to proceed with the proposals for a redress scheme and the associated primary legislation, although there has never been a formal announcement. Instead the Scottish Government's policy has been to build on existing initiatives to further promote a culture of transparency throughout the NHS, with harm prevention and patient safety at its core.

When harm does occur the focus must be on personal contact with those affected; support and a process of review and action that is meaningful and informed by the principles of learning and continuous improvement. The organisational duty of candour procedure was introduced by statute on 1 April 2018. Its purpose is to improve professional practice, patient and service user safety and public confidence. The Safety, Openness and Learning Unit has been established in the Scottish Government's Quality & Improvement Directorate to work with key partners including Healthcare Improvement Scotland and health and care professionals. The overarching aim of the unit is to drive forward safety, openness and learning to bring about continuous improvement in the provision of health and care services.

7.92 From the missive quoted above it is clear that Scotland has no plans at this stage to introduce either a no-fault system or a no-blame redress system. Some of the

concerns raised pertain specifically to “the financial implications of introducing a scheme in an extremely challenging financial climate”. Concerns about the cost of a no-fault scheme was also raised in the responses to the NFC Consultation Report (2014):¹⁶⁵

We have noted and recorded in this report the significant concerns raised about the introduction of a no-fault compensation scheme and **in particular the major concerns raised in relation to costs** and the complexities involved if such a scheme was to be introduced and extended to independent contractors and private healthcare providers. [Emphasis added.]

7.93 The NFC Consultation Report (2014) cited a University of Manchester study of medical negligence claiming in Scotland, which formed part of the research for the work of the No Fault Compensation Group.¹⁶⁶ The study makes the following observation:¹⁶⁷

For scheme providers and their members, costs of claims need to be contained, and while savings can be made by minimising costs associated with litigation, such as excessive legal fees and expert reports, **the most significant cost driver is the number and extent of claims.** [Emphasis added.]

7.94 The NFC Consultation Report (2014) referred to work done by the Medical and Dental Defence Union Scotland (MDDUS) to help with the calculation of total additional costs. The MDDUS calculation estimated that, had a no-fault scheme been in operation in Scotland from 2004 to 2009, actual expenditure would have been between 37% and 110% higher:¹⁶⁸

The estimates provided by the MDDUS suggest a Lower Bound percentage increase of 37% and Upper Bound percentage change of 110% from the actual expenditure had the No Fault Scheme been fully operational during the period 2004–2009 and had it been extended to MDDUS members in Scotland.

7.95 The extensive work done by the Scottish government is a highly useful resource for South Africa to estimate the possible impact of a no-fault compensation scheme on health expenditure.

¹⁶⁵ NFC Consultation Report (2014) 41 par 6.10.

¹⁶⁶ Frank Stephen, Angela Melville and Tammy Krause (School of Law, University of Manchester) *A Study of Medical Negligence Claiming in Scotland* (Scottish Government Social Research 2012).

¹⁶⁷ Stephen, Melville & Krause 9.

¹⁶⁸ NFC Consultation Report (2014) 39 par 6.6.16.

G Other developments

1 Health courts

7.96 Some USA authors explored the option of administrative health courts. The concept of administrative health courts involves the establishment of new courts with specialised judges to adjudicate medical injury compensation claims as part of a no-fault compensation process. Proof of fault, in this case negligence, is not required, but a plaintiff must be able to prove causality. The courts must have ready access to neutral and experienced experts. Proponents of the system argue that it will improve patient safety, simplify the process of obtaining compensation for persons harmed by medical injury, bring the escalation of compensation under control, and restore the relationship between medical practitioners and their patients.¹⁶⁹

7.97 Mello et al, who are in favour of the system, sets out the five core features of health courts:¹⁷⁰

A health court is a system of administrative compensation for medical injuries. It has five core features. First, injury compensation decisions are made outside the regular court system by specially trained judges. Second, compensation decisions are based on a standard of care that is broader than the negligence standard (but does not approach strict liability). “Avoidability” or “preventability” of the injury is the touchstone. To obtain compensation, claimants must show that the injury would not have occurred if best practices had been followed or an optimal system of care had been in place, but they need not show that care fell below the standard expected of a reasonable practitioner. Third, compensation criteria are based on evidence; that is, they are grounded in experts’ interpretations of the leading scientific literature. To the maximum extent feasible, compensation decisions are guided by ex ante determinations about the preventability of common medical adverse events. Fourth, this knowledge, coupled with precedent, is converted to decision aids that allow fast-track compensation decisions for certain types of injury. Fifth and finally, ex ante guidelines also inform decisions about how much for economic and noneconomic damages should be paid.

¹⁶⁹ See in general Mello et al (2006) 459–492; Barringer et al 725 & 746–751; Jocelyn Bogdan “Medical Malpractice in Sweden and New Zealand: Should their systems be replicated here?” *Center for Justice and Democracy* No. 21 (July 2011) 1–8 at 2–3; Barbot et al 237; Howard & Maine 29–31.

¹⁷⁰ Mello et al (2006) 460–461.

7.98 Bogdan, who is opposed to a system of administrative health courts, points out some of the characteristics that she considers to be negative features. She refers to “judges trained by the medical establishment” who would adjudicate matters with the assistance of a panel of medical experts, the lack of a jury, and “pre-determined ‘once size fits all’ benefit schedules”. She also expresses concern about the lack of clarity on judges’ qualifications and the method of selecting judges. Bogdan is apprehensive about the proposal that judges would be trained or assisted by the medical establishment, fearing a possible pro-defendant bias.¹⁷¹

2 Enterprise liability system

7.99 In an enterprise liability system, medical practitioners affiliate with an enterprise (hospital, health plan, large group practice, or other healthcare organisation). The enterprise takes out insurance and pays the insurance premiums for all associated staff. The enterprise then becomes liable for the practitioners connected with it. For example, a hospital would be liable for incidents that occur within the hospital.¹⁷² Hoffman opines that “[a]n enterprise liability system would help solve the problem of damage apportionment and also would improve patient safety.”¹⁷³

7.100 The hospital or organisation should evaluate their affiliated practitioners and introduce patient safety measures in reaction to reported incidents, but without passing the blame on to practitioners. The hospital or health provider organisation will therefore take responsibility for the event that caused harm to the patient, rather than the medical practitioners themselves. In theory it should encourage doctors to report incidents as they will not have to face the ordeal of malpractice lawsuits.¹⁷⁴

7.101 Proponents of enterprise liability contend that the system could improve patient safety. It is argued that large organisations are better than individuals at recognising and addressing problems in health care systems and enhancing the environment in which health practitioners work, thereby reducing errors.¹⁷⁵

¹⁷¹ Bogdan 2.

¹⁷² Hoffman 79–80.

¹⁷³ Hoffman 79.

¹⁷⁴ Hofmann 80.

¹⁷⁵ Studdert & Brennan 221; Hoffman 80–81.

3 Contract

7.102 Hoffman suggests that the reluctance to introduce change by means of legislation could be overcome by promoting private contract reform. She refers to the “neo no-fault contract” concept, advanced by Jeffrey O’Connell. It entails an agreement entered into between a medical practitioner and a patient before the medical procedure, guaranteeing a post-medical intervention settlement offer, including an undertaking to offer no-fault compensation in the event of a medical injury. The patient on the other hand would waive his/her right to pursue a claim in tort.¹⁷⁶

7.103 Because there was a prior agreement, no blame would be assigned nor admission of guilt deduced. The contract could stipulate the period of time within which an offer should be accepted. The opinion is expressed that a contract would improve the risk factor for insurance purposes and incentivise patients to achieve a speedy resolution and avoid the uncertainty of litigation. Doctors would be spared the ordeal of being blamed for the outcome of medical procedures.¹⁷⁷

¹⁷⁶ Hoffman 76–77.

¹⁷⁷ Hoffman 77–78.

CHAPTER 8: NATIONAL STRATEGY TO DEAL WITH CLAIMS

A Conclusion

8.1 Medical law is a specialised area of the law. Medico-legal litigation is even more specialised. Apart from the technical difficulty to prove and defend claims based on medical malpractice or medical negligence, it is expensive to pursue litigation in this field as experts in various medical and therapeutic specialisations are often required to conduct a case.

8.2 Preparing for a medico-legal matter is time-consuming because of the amount of information and evidence that have to be collected and prepared. There are also various procedural prescripts and rules that have to be complied with and timeframes that must be adhered to, with the threat of wasted costs if this is not attended to. It is therefore advisable that there should be a strategy describing the various steps that have to be taken and procedures to be followed when preparing to defend a medico-legal case.

B Introduction

8.3 One of the proposals made in this paper is that a national strategy should be developed that can be applied by all provinces when dealing with medical-negligence claims. The strategy set out below is based on the strategy applied with great success by the Western Cape Department of Health. The Commission is indebted to Dr David Bass, a member of the advisory committee for this project and the former head of the medico-legal unit in the Western Cape, for providing all the inputs for this chapter.

8.4 The strategy is comprised of two parts. The first part entails measures to reduce medico-legal litigation. The second part is a step-by-step guide for handling medico-legal litigation against the state.

C Strategies to reduce medico-legal litigation

8.5 The approach can be subdivided from a public health perspective into:

- Primary prevention – prevent it from happening in the first instance.
- Secondary prevention – early detection and management.
- Tertiary prevention – reduce complications and consequences.

1 Primary Prevention

8.6 The national Department of Health has developed a wide-ranging set of quality of care standards and measures through the National Core Standards and Ideal Clinic initiative, which provinces should progressively try to achieve. These standards cover a wide spectrum from clinical standards to, amongst others, the working environment, infrastructure, human resources and technology to ensure a better and safer patient experience and clinical outcome. Facilities should develop quality improvement plans to address the areas where they do not meet standards. These should entail:

- 1) Evidence-based development of policies and clinical guidelines in all disciplines.
- 2) Strengthening of Outreach and Support and referral pathways across the service platform from Community based services and PHC up to central hospitals. This helps to build clinical capacity at all levels.
- 3) Staff development, including in service training, and retention of skills.
- 4) Monitoring and evaluation, accountability and supervision at the clinical coalface. Morbidity and mortality meetings are standard practice in almost all hospitals where more complex patients are discussed and lessons learnt and areas of improvement identified.
- 5) Clinical governance committees, comprising senior clinicians, that provide oversight in each medical discipline.
- 6) A range of other initiatives such as:
 - the Best Care Always project in collaboration with the private sector to reduce nosocomial infection;
 - antibiotic stewardship to reduce drug resistance; and
 - rational medicine use.

2 Secondary Prevention

(a) *Management of complaints and importance of early engagement*

8.7 Provinces should monitor and respond to all complaints and compliments which are submitted by patients or their families, whether they are verbal, written or electronic. Set, finite maximum response times should be agreed on and monitored. The importance of early, honest engagement with complainants and their families must be impressed upon all staff. All complaints must be reviewed at least monthly by a team that includes the facility manager. Root cause analyses must be done and ways devised to prevent the occurrence of similar episodes in the future. The public health sector is trying to move away from a culture of blame with regard to complaints management and towards a culture of learning, in the belief that this sort of openness will lead to root causes of complaints being more effectively addressed in the long run.

(b) *Establishment of Independent Health Complaints Committee*

8.8 Provinces should establish an independent panel, the Independent Health Complaints Committee (IHCC) to investigate complaints that have not been adequately addressed or resolved through the routine structures and processes of the provincial department of health.

(c) *Strengthening systems to monitor adverse incidents*

8.9 A system to monitor adverse incidents such as medication errors, patient falls, bed sores, et cetera is being implemented and strengthened incrementally. The national DOH has introduced a web-based system in this regard.

(d) *Moving from culture of blame to culture of learning*

8.10 It has been internationally shown that a blame culture is counter-productive and tends to drive errors underground. Provinces should commit to building a learning organisation with transparency, information sharing, collaboration and a culture of continuous quality improvement.

(e) *Feedback loops from medico-legal claims*

8.11 Risk factors identified during investigation of all lawsuits are fed back into the appropriate discipline and level of care for corrective action. Most often, those risk factors are both complex and systemic and are very seldom attributable to the actions of one employee or one technical failure.

3 Tertiary Prevention

8.12 The final leg of the prevention strategy encompasses the following:

- 1) Professional, holistic management of all medical malpractice litigation.
- 2) Fast-tracking resolution of low-value medical claims with minimal expenditure.
- 3) Just compensation of injured patients or bereaved families.
- 4) Assisting plaintiffs “in kind”, for example securing school placement of disabled minors, and ensuring seamless access to state medical care when private care is unavailable.
- 5) Securing of settlement awards in trusts to ensure appropriate accounting and disbursement of funds for future medical care.
- 6) Reversion to the Department of unspent medical funds in the event of premature death.
- 7) Challenging spurious or opportunistic practices which artificially drive up the value of claims.
- 8) Ensuring that all public money spent on settlement of valid claims is just and appropriate.

8.13 Medico-legal litigation is a globally increasing phenomenon. Provinces should build their capacity to defend claims where appropriate and contain costs. Continuous improvement in the quality of care and being patient-centred should be key focus areas. However, the escalating litigation consciousness and compensation culture is a risk and a reality that provinces will need to deal with on an ongoing basis.

D Step-by-step guide for handling claims

8.14 A step-by-step guide to handling medical malpractice claims against the State, based on practical experience of claims management in the Western Cape, is provided below.

1 Requests for patient records

8.15 The first concrete warning of litigation is usually a private attorney’s request for copies of the patient’s hospital record. These requests are usually directed to the facility manager, and should be addressed with minimal delay. The request may be “informal”, or in the form of an official application completed in terms of the Promotion of Access to

Information Act (Act 2 of 2000) (PAIA) or Protection of Personal Information Act 4 of 2013 (POPIA). Both informal and formal requests must provide clear proof that the patient (or authorised adult) has provided written consent for disclosure of the records.

8.16 The facility may levy a reasonable charge for photocopies, but requests submitted in terms of PAIA or POPIA must comply with the tariff set out in the PAIA and POPIA regulations. It is perfectly acceptable to demand payment before the copies are handed over to the private attorney.

8.17 The term “patient records” includes all written notes, laboratory reports, electronic tracings (ECG, CTG et cetera) and hard copies of imaging investigations. Only copies should be handed to the private attorney, and the originals kept as evidence for use by the State Attorney. Any staff statements created after notices of litigation are considered “privileged” and must not be copied to the private attorney. All documents compiled and received with reference to litigation should not be stored in the patient’s hospital notes, but kept secure in a separate medico-legal file.

8.18 Any request for copies of records not related to the Road Accident Fund (RAF) or life insurance claims should be regarded as an early warning of litigation, and be notified to the senior manager in the department responsible for handling litigation.

8.19 All facilities should retain original patient-related documents for a minimum of 5 years after the last contact. Any commencement of legal proceedings within the 5-year period requires that the original file be preserved until the legal matter is finally concluded.

2 Formal notice of legal proceedings and letters of demand

8.20 These may be addressed to the Head of Department, the MEC for Health or the Premier of the Province. Some attorneys may submit the notice required by the Institution of Legal Proceedings against Certain Organs of State Act 40 of 2002 and the letter of demand separately, while others may combine the two. Until proved otherwise, either should be regarded as confirmation that the patient and attorney have decided to proceed with litigation.

8.21 In order to be valid, the notice of legal proceedings must be clearly dated and handed to the office of the person correctly cited as defendant (see above) within 6

months of the patient having become aware of the grounds for a potential claim. Late notice after the 6-month interval may be condoned by the defendant if it does not prejudice the defendant in any way – this requires that all records and factual witnesses are available to assist with defence of the claim. If defendant does not condone late notice of the action, the plaintiff may file a High Court application for condonation of late notice. The courts invariably uphold such applications unless the defendant can show substantial prejudice as grounds to oppose the application.

8.22 Upon receipt of a letter of demand, a medico-legal file should be opened which contains copies of all patient data, all legal correspondence and staff statements. This file should be copied to the state attorney, and a letter should be sent to the private attorney requesting that all future correspondence be addressed to the state attorney.

8.23 It is far preferable to investigate all potential claims earlier rather than later by procuring statements from relevant staff and comment from the departmental head, and obtaining supporting documentation from other institutions where the patient might have attended. Once summons is served on the department, timeframes for assessing liability, issuing instructions and filing of pleadings become much more stringent, and it is best to be “prepared” to deal with these as early as possible.

3 Serving of papers on defendant

8.24 These “papers” take the form of a combined summons which contains the particulars of claim – the basis for the action against the defendant(s), the alleged breach in contract and/or duty of care, and details of damages sought from defendants. The combined summons is served on the defendant by an officer of the High Court for claims over R100 000, or the magistrate’s court for claims below R100 000.

8.25 The combined summons must be sent immediately to the state attorney who must file a notice of intention to defend the action. If not already done, a detailed instruction to the state attorney must be drafted, which sets out the background of the action (gleaned from hospital notes and staff statements), expresses an opinion as to whether the provincial DOH is liable or not, and which clearly recommends the most prudent course of action: to defend, or to settle the claim.

8.26 For any claim filed in the high court, (> R100 000), the state attorney will request the provincial DOH’s permission to appoint Counsel to assist with drafting of pleadings

and advise the best course of action. It is reasonable to expect that the state attorney will be competent to handle all aspects of matters filed in the magistrate's court without briefing Counsel.

8.27 The defendant must file a plea which responds to the plaintiff's particulars of claim within the timeframe set out in the summons, failing which the plaintiff will file a notice of bar, which sets a date after which the court prohibits the defendant from filing a plea. This will seriously compromise any possible defence of the action, and being placed "under bar" should be avoided at all costs. If delays are unavoidable, plaintiff's attorney should be approached sooner rather than later, and asked to grant an extension for filing of defendant's plea.

8.28 It is advisable to seek expert opinion on the merits at this stage, if this had not already been done. Expert witnesses should receive copies of all relevant clinical documentation and statements, and a clear, comprehensive summary of the clinical background to the claim. They should also receive copies of the plaintiff's particulars of claim so that they may be familiar with the basis for the claim. The expert should be asked to submit hard copies of any scientific articles or other publications cited to in his/her expert opinion.

8.29 In addition to defendant's plea, counsel may also file special pleas in respect of late statutory notice and/or prescription of claims.

4 Indemnity for witnesses and defendants

8.30 All provincial employees who become individually liable as a result of their involvement with patients who sue for damages, are indemnified by the state as set out in Chapter 12 of the Treasury Regulations. This applies as well to part-time or sessional employees. The legal status of agency staff, volunteers and visiting foreign nationals must be decided on a case-by-case basis in consultation with the state attorney.

8.31 Where a conflict in legal interests arises between the provincial DOH and an individual employee during the course of litigation, private legal representation for that individual must be sought and the costs thereof covered by the department. In terms of the Treasury Regulations, individual employees may forfeit state indemnity in certain circumstances. At the conclusion of litigation the state must indicate whether the costs

accrued by the defendant may be recovered from any individual who forfeited state indemnity for any reason.

5 Negotiating settlements

8.32 In matters that cannot be defended every effort should be made to contain legal costs by opening settlement negotiations as early as possible, and preferably without admission of liability. Concession of merits removes any risk for the plaintiff, and makes the department vulnerable to significant revision of damages claimed. Settlement offers which are carefully calculated and considered to be reasonable may be submitted as a formal tender before the trial date, that is, the offer is submitted as a court notice, thus placing the plaintiff at risk.

8.33 Where possible, an undertaking to provide future medical treatment free of charge at a state facility in lieu of future medical costs may reduce payments. If accepted by plaintiff, the undertaking should be set out in detail and form part of the deed of settlement.

6 Preparing for trial

8.34 Where a decision is taken to defend a civil suit in the High Court, every effort must be made to ensure that factual and expert witnesses are available to testify during the conduct of trial. Most factual witnesses have little or no court experience and must be schooled by the state attorney and counsel regarding court procedure, punctuality, and how to deal with cross-examination. The evidence of expert witnesses is crucial to the judge's understanding of medical matters and should be given in simple, non-technical language. Experts should constantly be reminded that their role is to inform the court, and not to prosecute the case.

8.35 The quality and completeness of documentary evidence is crucial to the defence, and it is preferable to have original hospital files available in court at all times, in case any photocopies are not entirely legible or complete.

7 Adverse judgments

8.36 With few exceptions, a trial which runs its course and ends with a judgment for the plaintiff indicates that failure to settle before or during trial was an error – and a costly one. At regular intervals before commencement of trial, counsel and expert witnesses should be asked to express an opinion as to the risk of defending a claim, and those opinions must be taken seriously. Even settlements reached during the course of trial tend to be more economical than awards handed down from the bench, and substantial trial costs themselves may be contained. In addition, judgments for the plaintiff will almost always attract media publicity, while “out of court” settlements may be kept confidential between the parties.

8.37 Adverse judgments which are unexpected and inexplicable should be carefully reviewed, and counsel requested to express an opinion as to whether it is appropriate to request leave to appeal against the judgment.

8 Risk management review of indefensible claims

8.38 As the payment of damages and legal costs shuts the book on the legal process, it should also kick-start a detailed review of all errors and failures (system- and individual-related) which contributed to the source of the claim.

8.39 A summary of the case outlining the merits, expert opinion on merits from all parties, root-cause analysis and reasons for settlement should be drafted by the departmental claims-handler. Copies of the summary are provided to heads of the relevant facilities, who are obliged to convene a task team to consider all clinical risk factors highlighted, and then provide the head of department with a written undertaking to address those risk areas. This process should be conducted within reasonable timeframes, and the medico-legal file is only closed once an acceptable risk management plan is received from all facility heads, and signed off by the head of department.

8.40 Litigation without this sequel amounts to nothing more than an embarrassing waste of time and money, and a blow to public perceptions of state health care. Litigation exploited as a learning opportunity indicates good corporate governance.

8.41 Focussed post-litigation risk management exercises as described above are recommended in addition to ongoing clinical audit as prescribed in the National Policy on Quality in Healthcare for South Africa (National Department of Health, April 2007).

9 Possible retribution

8.42 The question is often raised as to whether punitive action should be taken against individual health employees implicated in successful litigation. Punishment may be politically attractive as it shows that something has been done, and satisfies the prevailing public demand for retribution. However, penalising individuals does nothing to improve quality of health care. It also assumes that adverse events are caused by errant individuals who should be identified, named and shamed.

8.43 In fact, most adverse events result from systems errors involving several healthcare disciplines, and invariably stem from a cascade of managerial, staffing, financial and procedural breakdowns in a very complex system, with a doctor or nurse at the bedside simply being the last link in a chain of potential risk factors.

8.44 Clinical risk management requires acknowledgment, audit and address of all factors in the complex matrix of healthcare, both by means of ongoing clinical audit, and in response to errors which are highlighted by complaints, litigation or other forms of redress sought by patients and their families.

8.45 The systems approach to patient safety does not entirely exclude the option of appropriate action against individual employees. This may be appropriate action for those who emerge as serial offenders due to either professional or personal incapacity and who threaten to compromise or endanger patient care through their individual actions or omissions. Such action should fit the underlying problem and be resolute. The tendency for managers to simply “pass the buck” by shifting problematic employees to another facility is grossly irresponsible.

CHAPTER 9: PROPOSED SOLUTIONS

A South African situation

9.1 As is apparent from the discussion above, the current method of dealing with medico-legal claims in South Africa is untenable. Litigation is still the primary means of seeking compensation for damages suffered due to medical negligence. Litigation, however, is expensive, protracted and even the winning litigant is seldom completely satisfied by the final outcome. The extent of medical negligence litigation against the state has reached a level where it is adversely and prejudicially impacting in a serious manner on service delivery in the public health sector and endangering the constitutional right to have access to health care services. It is abundantly clear that an alternative solution to litigation to obtain compensation for medical negligence is necessary, but the question remains: What alternative solution could be offered that is affordable and achievable in the South Africa of today?

9.2 The constitutional right of access to courts can never be denied, but taking a matter to court should be avoided as far as possible. Costly, drawn-out court proceedings with more than two dozen expert witnesses, sometimes sourced from abroad, should be steered clear of if at all possible. After considering various alternative compensation systems in Chapter 7, it is clear that the singular state of health care in South Africa does not lend itself to applying any particular one of the compensation systems reviewed in that chapter. A uniquely South African system is therefore proposed, which – having regard to our particular circumstances and history – is a hybrid of specific international examples and an expansion of the development of the common law that has already been initiated by the Constitutional Court.

9.3 It is proposed that a system be developed that starts at the hospital when a serious adverse event occurs, through prescribed compulsory procedures to attempt early resolution, ending in compensation that provides fair restitution to the aggrieved health care user without bankrupting and eventually crippling the public health system.

B Proposed components

9.4 The proposal is divided into different components, which are discussed below in more detail. The proposed components are the following:

- 1) Prerequisites
- 2) Improving quality of public health care
- 3) Record keeping
- 4) Patient safety and patient safety incident reporting
- 5) Mediation
- 6) Certificate of merit
- 7) Redress
- 8) Pre-action protocol
- 9) Litigation
- 10) Compensation
- 11) Birth defects and serious permanent injuries
- 12) Other proposals.

1 Prerequisites

(a) *Measures to be put into place*

9.5 There are a number of prerequisites that are critical to the proposals put forward in this paper for dealing with the medico-legal crisis in South Africa. These prerequisites are the following:

- 1) National strategy for dealing with medico-legal claims that must be adhered to in each province.
- 2) Strategy for handling medico-legal claims in the Office of the State Attorney that dovetails with the national medico-legal strategy followed in the provinces (referred to above).¹
- 3) Dedicated medico-legal unit in each province made up of suitably experienced medical and legal professionals, with their own administrative support, which should preferably be situated in the office of the provincial head of health.²

¹ IP 33 respondent: supported by State Attorney, Pretoria 13.

² Several respondents to IP 33 support the establishment of medico-legal units in provinces: National Treasury par 24; KZN Treasury 3; NW Treasury 2; Western Cape DOH; KZN DOH 6; State Attorney, Pretoria 14; SAMA; SAMLA; SASA. SASA refer to the successful medico-legal unit at the Western Cape DOH item 4 question 1.

- 4) Proper system of record keeping supported by a state-owned information technology system. The same system and technology should be used in all provinces and the national department.
- 5) Reporting system supported by the same system and technology to enable data sharing and a centralised data base. The information to be reported and the manner of reporting should be determined at national level and the guidelines should be followed by all provinces.
- 6) Compulsory budgeting for medico-legal litigation (projected legal costs) and compensation payments by provinces in accordance with normal budgeting practices. Assistance from National Treasury should be sought where necessary.³
- 7) Dedicated alternative dispute resolution team in each province. For the sake of impartiality, the members of the team cannot be employed by the state, but should be from outside government. Provinces could liaise with existing recognised ADR organisations.
- 8) Introduction of patient safety measures in all provinces. The implementation of these measures could be staggered over a determined period of time, prioritising measures based on the magnitude of the underlying risk and the frequency of particular types of incident.
- 9) Establishment of a dedicated national monitoring body to ensure that applicable legislation, national guidelines and the corrective measures proposed in audit reports, OHSC reports, government-initiated reports and other documents are implemented and applied. This body should not duplicate the current functions of the Office of Health Standards Compliance, but should either be a separate body or a separate unit within the OHSC that monitors compliance on a broader strategic level.
- 10) A possible alternative to be considered is the establishment of a national statutory body comparable to the NHS Resolution Authority in the UK. However, in SA the provinces are mainly responsible for health services delivery, which differs from the situation in the UK. Provinces might be of the view that such a body is not in line with the Constitution and the National Health Act 61 of 2003.

³ IP 33 respondents: National Treasury indicated that there should be more discussion on the detail of this proposal [National Treasury 28]. Supported by the following respondents: NW Treasury 1; Western Cape DOH; State Attorney, Pretoria 12.

(b) Implementation of existing measures

9.6 From the list of legislation, guidelines, reports and other documents discussed in Chapters 3, 5 and 6 it is clear that a huge amount of work has been done and that several shortcomings and challenges have been identified. The general reports on national and provincial audit outcomes issued by the Auditor-General for the years 2017-2018, 2018-2019 and 2019-2020 indicate that the majority of the provincial departments of health are in dire straits, with some of them on the verge of collapse. The serious problems highlighted in the AG reports are also apparent from the Annual Inspection Reports issued by the OHSC for the years 2015/2016, 2016/2017, 2017/2018 and 2018/2019. The government-initiated reports discussed in Chapter 6 anticipated or confirmed the critical shortcomings that are apparent from the Public Protector reports, SAHRC reports, Auditor-General reports, the OHSC inspection reports and other studies and reviews discussed in Chapter 5. Some of the legislation and guidelines necessary to address these problems are also in place. **However, lack of implementation of existing measures is a major shortcoming.**

(c) National expert teams

9.7 In their extensive and valuable comments on Issue Paper 33, National Treasury make the following proposals:⁴

Other key interventions that could be undertaken by either the health sector, the justice sector or the two jointly include:

- a. The establishment of national expert teams on medico-legal claims to support provinces in managing, negotiating and/or preparing for the defence of cases in court.
- b. Establishment of medico-legal units within provincial Departments of Health. Such teams would be essential in the planning and administration of medico-legal cases, e.g. negotiating settlements or collecting evidence to support state attorneys in defending cases.

9.8 Although the proposal by National Treasury is supported, the Commission propose that the national expert teams should not be limited to “managing, negotiating and/or preparing for the defence of cases in court”, but that the mandate of such teams should be expanded. There is a profusion of legislative provisions, regulations and guidelines under the National Health Act, as well as several reports about deficiencies in the public health care system. However, there is a distinct lack of implementation of these

⁴ IP 33 respondent: National Treasury Annexure A par 24.

instruments. It seems that a number of the provincial departments of health have neither the skills nor the capacity to address the issues highlighted in the audit reports, OHSC reports and government-initiated reports.

9.9 The Commission therefore propose that national expert teams be established to oversee and assist the provinces to address the identified problems and implement the proposed solutions. The teams need not be permanent, but should at least exist long enough to make a noticeable difference.⁵ Where necessary, the duration of the existence of some teams could be prolonged – for example the implementation team or the medico-litigation team. Based on their performance over the past few years, it is evident that the provinces in general will be unable to extract themselves from this quagmire without additional effort and resources.⁶

2 Improving quality of public health care

9.10 Concerns about public health care and the notion that public health care services should be drastically improved is evident from almost all the submissions received.⁷ The Commission, as a law reform body, cannot make proposals on the delivery of quality health care; which includes the operation and management of health care facilities, service delivery, human resources, health service capacity and related matters. The shortage of medical personnel, constrained budgets, inadequate health infrastructure, shortage of medical equipment, medicines and other supplies⁸ and inadequate supervision of junior staff also merit mentioning. However, when reviewing the subordinate legislation and *Government Gazette* notices published under the NHA 2003, it appears that there is no shortage of norms and standards, regulations, policies, guidelines, and so forth. From the comments received on Issue Paper 33, the presentations made during the public hearings in Parliament during the process of

⁵ IP 33 respondent: SAMA support establishing an “elite medico-legal team” [SAMA 9].

⁶ Paul du Plessis Attorneys canvass the establishment of a central fund, managed according to principles of insurance by specialists in the field, to deal with medical negligence and compensation. Simply handing matters to private law firms will not solve the problem, as someone with expertise who is able to take decisions on liability, risk and quantum still has to issue instructions to the law firms [Paul du Plessis Attorneys 8].

⁷ IP 33 respondents: National Treasury par 21; Eastern Cape Treasury 4; KZN Treasury 2; NW Treasury 1; KZN DOH; Western Cape DOH; State Attorney, Pretoria 2 & 3. See Chapter 5 above, especially “2. Concerns about public health system”.

⁸ IP 33 respondents: Camargue 2; National Treasury par 13; Eastern Cape Treasury, KZN Treasury, NW Treasury.

consideration of the State Liability Amendment Bill 16-2018, OHSC inspection reports, audit reports, the several government-initiated reports and frequent media reports on problems in the public health sector, it appears that the sector's biggest challenge is the proper and full application and implementation of all these instruments. **The Commission therefore propose that the quality of health care be improved by implementing the solutions and corrective measures put forward in existing Public Protector reports; SAHRC reports, Auditor-General reports, OHSC reports and other government-initiated reports, plans and studies.**

9.11 To aid the process of improvement by addressing the matters identified in the various reports, well-functioning health care facilities and well-functioning units of health establishments at all levels could be identified and investigated to establish the reasons for their success. Training and mentoring based on the operation and management of well-performing establishments could be offered to the managers of under-performing public health establishments. The OHSC and the private health sector could be approached for assistance. This is not a proposal, but merely a suggestion. The government will have to find a way to address the problems in the public health sector that goes beyond yet another piece of paper and actually implements the myriad of legal instruments and reports already in existence.

3 Record keeping

(a) *National Health Act 61 of 2003*

9.12 Proper record-keeping is critical, both in terms of patient care as well as evidence in legal processes.⁹ The NHA deals with health records in some detail. Section 13 of the National Health Act 2003 imposes an obligation on the person in charge of a health establishment to create and maintain a health record, containing prescribed information, for every health services user. Section 14 of the NHA deals with the confidentiality of users' information, and section 15 provides for the legitimate disclosure of personal information of a user by a health worker or health care provider. Section 16 describes the circumstances when a user's records may be examined, requiring the authorisation of a user unless the user's identity is not revealed. Section 17 imposes a duty on the person in charge of a health establishment to set up control measures to protect users' health records and lists criminal actions in relation to health records.

⁹ SLA Bill 2018 submission: Actuarial Society of South Africa (ASSA).

(b) Norms and standards regulations for health establishments

9.13 The provisions of the NHA on health records are supplemented by regulation 6 of the *Norms and Standards Regulations Applicable to Different Categories of Health Establishments, 2017*. Regulation 6 confirms the obligation of health establishments to protect, manage and keep health records confidential in line with the NHA. In addition, regulation 6 imposes the obligations listed below on health establishments:

- 1) a legally compliant filing, archiving, disposing, storage and retrieval system;
- 2) ensuring confidentiality of records;
- 3) appropriate security control measures in records storage and clinical service areas;
- 4) a records system complying with section 13 of the NHA;
- 5) recording the user's biographical data, identity and contact information and the identification and contact information of the user's next of kin;
- 6) information about the examination and health care interventions of users;
- 7) having a formal process for obtaining informed consent;
- 8) issuing a discharge report to users in accordance with section 10 of the NHA.

(c) National patient records guideline

9.14 The national DOH issued the *National Guideline for Filing, Archiving & Disposal of Patient Records in Primary Health Care Facilities (Patient Records Guideline)* in 2017.¹¹ No other guidelines or documents issued by DOH about health records could be found via the internet, although there are references to more record-keeping guidelines in other DOH documents, for example "District/provincial SOP/guideline for filing, archiving and disposal of patient records".¹²

9.15 The 2017 *Patient Records Guideline* does not refer to either the provisions pertaining to health records in the NHA (sections 13 to 17) or regulation 6 of the *N&S Regulations*; only referring to the National Archives and Records Service of South Africa

¹⁰ Although the title of the *Norms and Standards Regulations (N&S Regulations)* include a reference to the year "2017", the regulations were published under Government Notice No 67 in GG 41419 on 2 February 2018.

¹¹ Department of Health *National Guideline for Filing, Archiving & Disposal of Patient Records in Primary Health Care Facilities (2017) (Patient Records Guideline)*. The link to the document on the knowledgehub.org.za website is incorrectly indicated as *National Standard Operating Procedure for Filing Archiving and Disposal of Patient Records*.

¹² Department of Health *Ideal Clinic Manual* (dated April 2020, released July 2020) 9.

Act 43 of 1996, Promotion of Access to Information Act 2 of 2000, Protection of Personal Information Act 4 of 2013, and the various provincial archives and records service Acts. While the NHA uses the expression “health records”, the Patient Records Guideline uses the expression “patient records”. The introduction to the document states that the primary purpose of the *Patient Records Guideline* is “to give guidance to employees in primary health care facilities on the procedures to follow to ensure that patient records are stored safely and filed in a systematic and orderly manner so that it can be retrieved in the most efficient manner possible.”¹³

9.16 The *Patient Records Guideline* lists the essential components of patient records, sets out the responsibilities of persons in control of records and contains measures about filing, tracking, handling, archiving and disposal of patient records, as well as the period of time that records should be kept. Special provision is made for records of minors, mentally incompetent patients, records that may be relevant to occupational health and safety matters, specific health-impacting conditions, possible claims against the state, clinical trials and clinical forensic medicine services.

(d) Access to health records

9.17 Neither the NHA, the *N&S Regulations* or the *Patient Records Guideline* makes provision for access by a health services user to his or her own health records. Until 29 June 2021 a user had to request access to his or her records held by public bodies (which would include public health establishments) in terms of section 11(1) of PAIA. In terms of the original version of section 11(2) such a request **includes** a request for access to a record containing personal information about the requester. The definition of “personal information” incorporates the kind of information contained in health records. The Protection of Personal Information Act 40 of 2013 (POPIA) came into operation on 30 June 2021. POPIA amended section 11(2) of PAIA. In terms of the amended section 11(2) such a request **excludes** a request for access to a record containing personal information about the requester.

9.18 From 30 June 2021 access to personal information is governed by section 23 of POPIA. A health services user requiring access to his or her health records would thus now request access to information held by a public health establishment in terms of section 23 of POPIA. Section 30 of PAIA still applies, which provides for a process to be

¹³ *Patient Records Guideline* 5.

followed if an information officer granting access to a record (held by a public body about the physical or mental health of the relevant person) is of the opinion that the disclosure may cause serious harm to the relevant person's physical or mental health. The right of access to the records of a private body (including personal information held by a medical professional) is still covered by section 50 of PAIA as before, read with section 23 of POPIA and section 61 of PAIA. Section 61 is similar to section 30 of PAIA but section 30 applies to public bodies, while section 61 applies to private bodies.

9.19 It is important that the ownership of health records is clear. Strauss discusses the ownership of patient records by reference to a [medical] doctor, but it follows that a health establishment is the owner of health records made by the persons employed by the health establishment. Although the situation with regard to the ownership of health records has not changed, health records are accessible through the court process, as well as under PAIA and POPIA. In the past a patient could only get access to his or her medical records once formal court proceedings had been instituted, as explained by Van den Heever & Carstens.¹⁴ Strauss is emphatic about the ownership of patient records:¹⁵

The ownership of records made by the doctor for his own purposes cannot be legally in doubt. He is the exclusive owner of these records The doctor has a moral obligation to keep the patient informed on his health, but he does not have to let the patient read his medical record.

9.20 As is the case in numerous other instances, developing legislation or guidelines about record-keeping is not enough. A study of the records management processes of health establishments in Limpopo, for example, uncovered poor, ineffective records management that is not aligned with health service delivery. This negatively affects

¹⁴ Van den Heever & Carstens are of the view that "the promulgation of [PAIA] can, however, be regarded as one of the most significant breakthroughs with regard to medical accidents from the patient's perspective. A patient was previously only entitled to inspect such records after legal proceedings had been instituted in terms of the practices of discovery of documents provided by the rules of the lower and higher courts. The fact that a patient is able to inspect his medical records prior to litigation will now enable his legal representatives to investigate the merits of a possible medical negligence claim with much more precision and may even lead to a reduction of malpractice claims, because accurate medical record-keeping with regard to the medical intervention under investigation will usually reflect the circumstances under which the medical accident occurred, and if there is little prospect of success an action will be ill-advised." [Patrick van den Heever & Pieter Carstens *Res Ipsa Loquitur & Medical Negligence: A Comparative Survey* (Juta 2011) at 170–171].

¹⁵ SA Strauss *Doctor, Patient and the Law* (1991) 110.

access to and safety and security of medical records.¹⁶ Without measures to ensure compliance with and implementation of prescribed measures and national guidelines, followed by monitoring and evaluation of the record-keeping system, the problems complained about will not improve.

9.21 A compatible electronic record-keeping system that applies uniformly across all provinces, that contains the same type of information and that can be accessed by another health facility or province should a health services user be transferred to another establishment or province, is ideal.¹⁷ Electronic health records cannot be stolen or get lost or damaged like paper records, although electronic records do require measures to keep the information secure and confidential. Where electronic record-keeping is difficult or impossible, hard copies of health records should be scanned and archived to create a digital record.

9.22 A huge obstruction hindering the successful implementation of an electronic record-keeping system across South Africa is the reliability and accessibility of internet, intranet and communication systems, especially in rural areas. Even staff at health establishments in the large metropolitan areas complain about the internet and intranet at the establishment being slow, unreliable, insecure and not user-friendly. This is exacerbated by frequent power outages and regular load-shedding being experienced by the whole country. Before an electronic record-keeping system can be successfully introduced across South Africa, these difficulties must be addressed.

(e) Comments on Issue Paper 33

9.23 Concerns about record-keeping feature prominently in the comments received on Issue Paper 33. Issues that are raised include the quality of record-keeping, records that get lost, incomplete records, staff that underestimate the importance of good record

¹⁶ See in general: Ngoako Marutha “A framework to align patient records management practices with healthcare provisions in the public hospitals in Limpopo province” *ESARBICA Journal* 38:1 (2019).

¹⁷ The need for uniform and compatible record-keeping was evident from the submission received from National Treasury. National Treasury explain that provinces do not classify information in the same manner, since some provinces capture payments for medical negligence claims under the budgetary item “Claims against the state”, while others capture it under “Legal Services” [National Treasury par 6]. There are dissimilarities with regard to the disciplines concerned, as cerebral palsy is indicated separately in some instances, but categorised under Obstetrics and Gynaecology in others [National Treasury par 9]. Information presented in meetings does not always correspond to information on the same topic reflected in annual reports [National Treasury par 9].

keeping, lack of implementation of legislation on record keeping; and anecdotal evidence of records stolen by unethical and opportunistic lawyers.¹⁸ Health services users' access to their own health information and medical records are also flagged, as well as delays and nil responses when attempting to obtain records via the PAIA route.¹⁹ Mediclinic indicated access to *post mortem* reports pertaining to unnatural deaths as particularly problematic.²⁰ Some respondents to IP 33 expressed concerns about defective record keeping.²¹ Whether this situation will improve now that POPIA applies in relation to access to health records still remains to be seen.

(f) Proposals on record keeping

9.24 As indicated above, there are legal measures in place that govern record-keeping. However, the scope of the *Patient Records Guideline* is too narrow in that it only applies to primary health care facilities and it does not incorporate all the issues mentioned in the NHA and the *N&S Regulations*. **The Commission propose that the record keeping guidelines should be reviewed, updated and implemented.** The new guidelines should address the NHA record keeping provisions and related regulations. The guidelines should provide for the entire "life-cycle" of a health record, from origin to final disposal, addressing any deficiencies or pitfalls at any point along the way. Specific provision should also be made for access to health records, since the response to applications brought under the current PAIA process is not always timeous, satisfactory or successful. It is doubtful that the POPIA process will improve matters, as it relies on the same administrative support system for providing information as the previous PAIA process.

¹⁸ IP 33 respondents: National Treasury; Eastern Cape Treasury; KwaZulu-Natal Treasury; North West Treasury; State Attorney, Pretoria; Camargue; Discovery Health; GunnClark; Joseph's Inc; Mallory; SAMLA; SAPPF.

¹⁹ SALRC *Meeting of advisory committee members on Project 141: Medico-Legal Claims* (31 May 2021).

²⁰ IP 33 respondent: Mediclinic 10.

²¹ IP 33 respondents: Camargue; Mediclinic; Netcare.

4 Patient safety and patient safety incident reporting

(a) *International patient safety movement*

9.25 Globally, patient safety has become one of the most important aspects of modern health systems. Sir Ian Donaldson (patient safety envoy, WHO) explains the origin of the patient safety movement:²²

The modern patient safety movement began in the last few years of the 20th century and has gained momentum through the first two decades of the new century. Major reports from the United States of America, *To err is human: building a safer health system* and the United Kingdom of Great Britain and Northern Ireland, *An organization with a memory* scoped the subject, drawing attention to the scale of the problem, the parallels with other high-risk industries and the weakness of health systems in provoking human error. Around the same time, a series of observational studies in different countries assessed the extent of so-called “medical errors” in hospital inpatient care.

9.26 The ground-breaking publication *To Err is Human: Building a Safer Health System* released in the USA in 2000 was the first major report to recommend moving away from a culture of blame to a systems approach:²³

Preventing errors means designing the health care system at all levels to make it safer. Building safety into processes of care is a more effective way to reduce errors than blaming individuals The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system. This does not mean that individuals can be careless. People must still be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.

9.27 The UK Department of Health’s Chief Medical Officer released the report *An Organisation with a Memory* in the same year. Referring to reliable research estimates, the report suggests that in NHS hospitals “adverse events in which harm is caused to patients occur in around 10% of admissions” (over 850 000 patients a year at the time):²⁴

²² World Health Organization *Patient Safety Incident Reporting and Learning Systems: Technical Report and Guidance* (2020) 1 [WHO PSI (2020)].

²³ Institute of Medicine *To Err Is Human: Building a Safer Health System* (2000) <https://doi.org/10.17226/9728> at 4–5.

²⁴ Department of Health (UK) *An Organisation with a Memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer* (2000) at xiii.

Human error may sometimes be the factor that immediately precipitates a serious failure, but there are usually deeper, systemic factors at work which if addressed would have prevented the error or acted as a safety-net to mitigate its consequences.

9.28 The patient safety movement has gained momentum over the past few years. The WHO has been engaging with the issue of patient safety since 2002, launching the World Alliance for Patient Safety in 2004. The WHO efforts were escalated over time, later leading to the creation of the WHO Patient Safety and Risk Management unit to coordinate, disseminate and accelerate improvements in patient safety and managing risks in health care to prevent patient harm worldwide.²⁵ The WHO highlights the importance of patient safety globally:²⁶

Patient safety is a fundamental principle of health care. A number of high-income countries have published studies showing that significant numbers of patients are harmed during health care, either resulting in permanent injury, increased length of stay in health care facilities, or even death. ... Similarly, in low- and middle income countries, a combination of numerous unfavourable factors such as understaffing, inadequate structures and overcrowding, lack of health care commodities and shortage of basic equipment, and poor hygiene and sanitation, contribute to unsafe patient care. A weak safety and quality culture, flawed processes of care, and disinterested leadership teams further weaken the ability of health care systems and organizations to ensure provision of safe health care. Ensuring the safety of patients is a high visibility issue for those delivering health care – not just in any single country, but worldwide. The safety of health care is now a major global concern. Services that are unsafe and of low quality lead to diminished health outcomes and even to harm.

(b) Patient safety in South Africa

9.29 Locally, Oosthuizen considered how patient safety can be improved in South Africa, learning from international experience. He observes that:²⁷

Patient safety is a serious global public health issue. Approximately 1 in 10 hospitalised patients are harmed by medical mistakes. Most of these adverse events are preventable. Medical error causes substantial morbidity and mortality. Unsafe care is not only responsible for immeasurable suffering, but also substantial added (and unnecessary)

²⁵ WHO *Patient Safety: Making Health Care Safer* (2017) 4.

²⁶ WHO *Patient Safety* (2017) 1.

²⁷ Oosthuizen iii.

financial expenditure. Developing countries that can ill-afford these additional costs, likely face an even greater burden of harm.

9.30 According to Oosthuizen & Carstens shifting focus to patient safety is one of the important aspects of adopting a systems approach to error rather than an approach of assigning blame to a specific individual.²⁸ Oosthuizen recommends learning from high reliability organisations to improve the management of error within hazardous industries. He discusses the five characteristics identified by Weick and Sutcliffe that high-reliability organisations share. The characteristics ensure that organisations are more resilient to failure and assist them to endure challenging times. These characteristics, referred to as “mindful organising”, are the following: preoccupation with failure; reluctance to simplify; sensitivity to operations; commitment to resilience; deference to expertise; and organisational culture.

9.31 Oosthuizen points to the strife to maintain a safety culture as an important aspect of organisational culture:²⁹

Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety and by confidence in the efficacy of preventive measures. ... Other important dimensions of a safety culture, that are most often cited in the literature, include: leadership commitment to safety; organisational learning; a nonpunitive approach to adverse event reporting and analysis; and shared belief in the importance of safety. The impact of a safety culture cannot be understated.

9.32 An important element of patient safety is reporting patient safety incidents in order to learn from such incidents and improve health care.³⁰ South Africa released national guidelines and supporting documents about patient safety incident reporting in 2017. According to the WHO, the two fundamental principles underlying patient safety incident reporting are visibility and prevention: bringing incidents to light and taking steps

²⁸ WT Oosthuizen & PA Carstens “Re-evaluating medical malpractice: A patient safety approach” 2015 (78) *Tydskrif vir Hedendaagse Romeins-Hollandse Reg* 380–397 at 395 [Oosthuizen & Carstens *Patient Safety*].

²⁹ Oosthuizen 526.

³⁰ This is a critical element of the approach advocated by Oosthuizen & Carstens: “Medical errors should be prevented by recognising that mistakes are inevitable. If a more transparent atmosphere is fostered, these errors could be more readily identified, thus enabling providers to implement systems to avoid the occurrence of future adverse events.” [Oosthuizen & Carstens *Patient Safety* 395–396].

to avoid recurrence of incidents.³¹ To achieve this, patient safety incidents must be reported and investigated, lessons learned from the causes of incidents, and measures developed to prevent it from happening again. Reporting all incidents would paralyze the best system, therefore there should be guidelines on what to report and how to report.³² Reporting serious adverse events is a good starting point, since the occurrence of such an event is often the cause of a medico-legal claim. Several commentators and respondents recognise the importance of patient safety.³³

9.33 The WHO defines an adverse event as “an incident that results in preventable harm to a patient”.³⁴ The occurrence of a serious adverse event should trigger a process for reporting, classifying and analysing the event. From a patient safety perspective the root causes of the event should be investigated and established so that corrective action can be taken to prevent a recurrence of the event. From a medico-legal point of view additional measures are necessary, such as collecting the necessary information, obtaining statements from those involved and preserving the records, bearing in mind prescription periods, especially where minor children are involved.

(c) National guidelines for PSI reporting

9.34 The national DOH released the *National Guideline for Patient Safety Incident Reporting and Learning in the Public Health Sector of South Africa* in April 2017. It was developed with input from the WHO, the SA National Blood Service and different units within the national DOH. Apart from the *National PSI Guideline*, there are two sets of guidelines for developing standard operating procedures (SOPs) in the provinces:

- *Guideline to Develop a Sub-District/District Specific Standard Operating Procedure for the Management of Patient Safety Incident Reporting and Learning* (April 2017).
- *Guideline to Develop a Hospital Specific Standard Operating Procedure for the Management of Patient Safety Incident Reporting and Learning* (April 2017).

9.35 The WHO PSI (2020) brings some new and fresh perspectives to the table, which should be taken into consideration locally. Sir Liam Donaldson, the WHO patient safety

³¹ WHO PSI (2020) 19.

³² See in general: WHO PSI (2020) 20.

³³ Mjadu & Jarvis 84; Gqaleni & Bhengu 1–2. IP 33 respondents: Free State DOH; National Treasury; North West Treasury; Western Cape DOH; GunnClark; Mallory; Mediclinic.

³⁴ WHO PSI (2020) xii.

envoy who compiled this WHO guidance document, is pragmatic about what patient safety incident reporting and learning can achieve:

Many patient safety programmes around the world have raised very high expectations about the potential impact of incident reporting and learning systems. ... Some health care organizations and facilities around the world have shown that analysis of patient safety incidents can lead to safety improvements, but this is far from the norm.³⁵

...

Data derived from incident reports can be very valuable in understanding the scale and nature of harm arising from health care, provided that the properties of the data are reviewed carefully and conclusions are drawn with caution. The use of incident reporting systems for true learning in order to achieve sustainable reductions in risk and improvements in patient safety is still work in progress.³⁶

...

The optimism that fuelled the rush to place reporting systems at the heart of patient safety programmes around the world has been replaced by scepticism (born of over a decade's experience of such systems) that reporting is not a stand-alone mechanism for reducing risk and improving safety. It needs to be part of an overall culture of curiosity and understanding about how harm occurs, a determination to expose all sources of risk to patients, coupled with well understood rules and processes of investigation and effective methods to implement change based on these learnings (the most difficult part of all) to improve safety.³⁷

(d) *PSI reporting proposals*

9.36 **The Commission propose that patient safety incident reporting and learning guidelines be properly applied and implemented, followed by monitoring and evaluation.** As is the case with other measures, the problem is not a lack of guidelines but the lack of implementation.³⁸ The provinces have been tasked with applying and implementing the guidelines. However, some provinces do not seem to have the capacity or skills to do this, as is apparent from analyses done at particular facilities.³⁹ Apart from not applying and implementing guidelines, it is not certain whether

³⁵ WHO PSI (2020) v.

³⁶ WHO PSI (2020) vi.

³⁷ WHO PSI (2020) at 1.

³⁸ IP 33 respondent: poor implementation is highlighted by the KwaZulu-Natal Treasury in their submission [KZN Treasury 2].

³⁹ AA Bashir et al "An analysis of adverse events and human error associated with the imaging of patients at a major trauma centre in South Africa" *SAMJ* 109:9 (September 2019) 693–697; Avhaphani Gladys Mphephu *Effects of nursing work loads on patients*

all provinces are fully aware of all the relevant guidelines. A recent media report on Gauteng's "shocking serious adverse events numbers"⁴⁰ referred to guidelines compiled by the School of Family Medicine and Public Health of the University of KwaZulu-Natal,⁴¹ but not to the national *PSI Guideline* or the guidelines for developing PSI reporting SOPs in the provinces.

9.37 Resources in the public health sector are limited and should be used wisely. Reporting can be time and labour-intensive, but is critical for purposes of collecting data. The information and technology systems required to capture and share information generated by reports require specific expertise and can be quite costly to establish and maintain. Collection and sharing of data over a broad front are important aspects of a patient safety system, especially to enable learning from errors. South Africa cannot afford to spend valuable resources on reporting and data collection systems that, despite lofty ideals, fail to achieve the purpose for their institution. An important consideration for the sake of honest and open reporting is confidentiality and the protection of the secrecy of sources of information.⁴² **To ensure openness and honesty, the Commission propose the introduction of legislation (as in the UK) to protect information provided by a health worker from being discovered for purposes of court proceedings, or from being used in disciplinary proceedings against the person who made the report.**

9.38 The importance of data-sharing to enable the establishment of a national data system in order to learn from errors was raised by some respondents.⁴³ The Commission agree with these suggestions and consider it to be a critical component of a patient safety system. This is also one of the reasons why a system that is compatible and accessible across all the provinces and levels of establishment is important. **The Commission propose that current reporting guidelines should be reviewed in light of the latest**

safety in the selected public hospitals in Vhembe District of Limpopo Province, South Africa (unpublished dissertation, University of Venda 2019); Gqaleni & Bengu.

⁴⁰ Thabo Molelekwa "What is behind Gauteng's serious adverse event numbers" *Spotlight* 3 June 2021 www.spotlightnsp.co.za/2021/06/03/.

⁴¹ Ozayer Mahomed *Adverse Events Monitoring and Reporting Guidelines* (undated, University of KwaZulu-Natal).

⁴² IP 33 respondents: Mediclinic; SAMLA.

⁴³ Respondents expressed the need for a central data base with shared information about adverse events and patient complaints to enable collaborative learning. IP 33 respondents: African Centre for the Constructive Resolution of Disputes (ACCORD); GunnClark; Mallory; SAMA. GunnClark also refers to a statement made in this regard by Judge Claassen from SAMLA [GunnClark 26].

developments in patient safety reporting systems and the WHO *PSI (2020)* to ensure that the reporting system is optimally structured and utilised and allows for sharing of information.

5 Mediation

(a) *Model for mediation*

9.39 Issue Paper 33 specifically requested comments about alternative dispute resolution and mediation and how it should be introduced. The issues raised for comment in this regard were phrased as follows:

Introduce alternative dispute resolution, such as mediation and pre-litigation resolution, as a first step before litigation is pursued.

Consider how mediation should be introduced:

- a) compulsory mediation; or
- b) voluntary mediation, making an attempt at mediation compulsory before bringing a court application; or
- c) completely voluntary.

9.40 Although there are respondents that do not support mediation,⁴⁴ a number of commentators and respondents from diverse backgrounds express firm support for mediation.⁴⁵ There are some differences in opinion about the preferable model for mediation (as set out in Issue Paper 33) and all three options received support. A number of respondents support compulsory mediation,⁴⁶ while others state that mediation is

⁴⁴ IP 33 respondent: Clinix: mediation will not necessarily be less expensive than litigation; parties without representation during mediation will be at a disadvantage; if mediation fails, parties still have to litigate [par 4.1–4.13].

⁴⁵ Orthopaedic surgeon: Johan Walters “An alternative to litigation in medical malpractice” *SAMJ* 104:11 (November 2014) 717–718; attorney: Marietjie Botes “Mediation: A perfect solution to healthcare disputes” *De Rebus* (April 2015) 28–30; medical ethics: Dhai (2015) 3; retired judge: Neels Claassen “Mediation as an alternative solution to medical malpractice court claims” *SAJBL* 9:1 (May 2016) 7–10; attorney: Lerm (2017) 336–340. IP 33 respondents: government: KZN DOH; KZN Treasury; Free State DOH; National Treasury; gynaecologist and obstetrician: Dalmeyer; insurance: EthiQal; gynaecology and obstetrics: GMG; attorneys: Friedman & Ass; palliative care: GunnClark; mutual society: MPS *IP 33 Response*; hospital group: Netcare; member of the Cape Bar: Oosthuizen; professional medical organisations: OTASA; SAMA; SAMLA; SAPPF; SASA; SASOG; psychologist: Van der Merwe.

⁴⁶ IP 33 respondents: Free State DOH; KZN Treasury; National Treasury; Friedman & Ass; Netcare; Van der Merwe. SAPPF support compulsory mediation, provided that mediators are accredited and trained in medical matters, medical law and malpractice law. Mediation in bad faith should be prohibited, for example mediation merely to gather information on potential defences. Should mediation fail, provision should be made for a post-mediation

voluntary by nature and that people should not be compelled to attempt mediation.⁴⁷ Supporters of voluntary mediation point to the failure of compulsory systems,⁴⁸ while supporters of compulsory mediation express concerns about mediation being disregarded as an option if it is completely voluntary.⁴⁹ Some respondents support a serious bona fide attempt at mediation before pursuing litigation.⁵⁰ As a compromise between introducing mediation as a completely voluntary option and introducing compulsory mediation, a serious attempt at mediation should be made before going to court. **The Commission propose that mediation should be voluntary, but that it should be compulsory to make a bona fide attempt at mediation before instituting court proceedings.** The parties to medico-legal court proceedings will have to justify the failure to mediate the matter to the satisfaction of the court.⁵¹ Mediation could also be attempted to agree on some of the issues, even if the entire claim cannot be resolved through mediation.⁵²

(b) Pre-mediation clauses in admission forms

9.41 The South African Medico-Legal Association (SAMLA) in its comments on Issue Paper 33 propose including pre-mediation clauses in the admission forms of public hospitals.⁵³ Other IP 33 respondents also support this proposal.⁵⁴ **The Commission supports the proposal to include pre-mediation clauses in admission forms of public hospitals as it will certainly assist efforts to raise awareness about the advantages of mediation.** This requirement should be included and briefly explained in

process, including provision for a document or certificate to be issued by the mediator [SAPPF 5].

⁴⁷ IP 33 respondents: State Attorney, Pretoria; Western Cape DOH; Mallory; SAMA.

⁴⁸ IP 33 respondent: Mediclinic refer to their experience in Namibia, where compulsory mediation is often only conducted as a formality [Mediclinic 8].

⁴⁹ IP 33 respondents – supporters of compulsory mediation: Discovery Health; EthiQal. EthiQal suggest the introduction of rules relating to mediation into the high court – similar to the mediation rules in the district and regional courts [EtiQal par 14–17].

⁵⁰ IP 33 respondents: GMG; SAMLA; SASA.

⁵¹ IP 33 respondent: GMG supports mediation, in particular the model that requires that mediation must be attempted before instituting court proceedings. If compulsory mediation is introduced, they would require that certain measures be in place. These include measures pertaining to appropriately trained and accredited mediators who are *au fait* on the subject-matter at hand; measures to prevent mediation from being used to delay resolution or embark on a fishing expedition for information or legal arguments, and measures to prevent malpractice insurers to avoid their obligations [GMG 6].

⁵² IP 33 respondent: supported by GunnClark.

⁵³ IP 33 respondent: SAMLA 12.

⁵⁴ IP 33 respondents: Dalmeyer; SASA; SASS.

the admission form when a health services user is admitted to a health care establishment. However, it is suggested that the explanation about mediation in the admission form would not be sufficient on its own. People seldom read admission forms in detail and even if they do, they do not always comprehend the information in the form. Other measures to promote mediation will be necessary, such as poster displays, distributing pamphlets and running awareness campaigns, for example mediation organisations visiting hospitals to hold information sessions.

(c) Accredited mediators in provinces

9.42 The Commission propose the creation of a list of accredited mediators in each province.⁵⁵ Successful mediation takes skilled and experienced mediators – internal hospital staff and contracted attorneys with a forty-hour mediation course that conduct mediation occasionally on an ad hoc basis will not suffice. **The Commission propose that the state should fund mediation by accredited mediators, since early expenditure on proper ADR will save a huge amount of money later.** In addition, timely access to proper health records are vital for purposes of mediation to enable informed settlement offers.

(d) Binding mediation agreements

9.43 **It is crucial that the person representing the state in mediation proceedings must be able to make proposals and take decisions with financial implications or have immediate and direct access to a person with the authority to approve a proposal or take a decision.** This requirement could be problematic in the public health sector because of the complicated decision-making system. However, if the person with the authority to take a decision is not available, mediation in state health establishments will be a useless endeavour.⁵⁶ In addition, to ensure compliance with the solution agreed upon during the mediation process, the final agreement should be a formal, binding contract complying with the law of contracts. Alternatively, the court may be approached to approve the mediation agreement formally as a settlement agreement by order of court.

⁵⁵ IP 33 respondent: Oosthuizen advocates the creation of a mediation panel.

⁵⁶ IP 33 respondent: Mullins mentions his experience of the difficulties in litigating against the state because of the "State's inability or unwillingness to mandate its representatives to enter into settlements. I can see no reason why mediation would be the magic wand which removes that problem and I can see every reason why that problem will be the death knell of mediation as an alternative solution." [Mullins 9–10.]

6 Certificate of merit

(a) *Frivolous, meritless or fraudulent claims*

9.44 There are often instances of medico-legal claims instituted against provinces that turn out to be frivolous, without merit or fraudulent. The MEC of a province, as the defendant in such cases, has to file an intention to defend all claims instituted for the recovery of damages to avoid getting a default judgment awarded against the province. It also happens quite frequently that a claim is abandoned after receiving a response to the initial letter of demand. In all these instances the province has had to spend time and incur costs to defend the matter. The Commission raised the possible introduction of a certificate of merit in Issue Paper 33 for purposes of eliciting comments on the issue.

9.45 Respondents from the private sector also expressed frustration with regard to claims that are instituted, but that are clearly without merit or fraudulent, or that are never proceeded with.⁵⁷ Lerm discussed with approval the practice in some USA states that require a certificate of merit to be filed when action is instituted or within a short period of time after action is instituted.⁵⁸ Some states in the USA require a certificate of merit/ affidavit of merit/ certificate of merit affidavit as part of the requirements for instituting a personal injury claim based on medical negligence. One such an example can be found in the Iowa Code 2021. In Iowa the plaintiff has to serve the certificate of merit affidavit on the defendant within a specified period of time after the defendant's response to the institution of action. The Iowa legislation serves as a good example of the requirements the certificate of merit affidavit has to comply with.⁵⁹

(b) *Proposal on certificate of merit affidavit*

9.46 **To avoid frivolous, meritless, fraudulent or abandoned claims, the Commission propose that a certificate of merit affidavit by an accredited and suitably qualified medical practitioner should form part of the papers when action is instituted for damages based on medical negligence.** The Commission further propose that the courts cooperate with professional medical organisations to compile lists of medical practitioners that could be accredited for this purpose. The proposal

⁵⁷ IP 33 respondents: Clinix; Mediclinic.

⁵⁸ Lerm refers to Mello and Kachalia *Evaluation of Options for Medical Malpractice System Reform 2010* [Report prepared by the Harvard School for Public Health for the Medicare Payment Advisory Commission (Med PAC) 10 [Lerm (2017) 329 & 330].

⁵⁹ Section 147.140 of the Iowa Code 2021 (General Provisions, Health-Related Professions).

should not require principal legislation, but could be effected by means of an amendment to the High Court Rules, with which the Rules Board for Courts of Law can assist. There is considerable support for the certificate of merit requirement.⁶⁰

7 Redress

(a) *No-fault compensation*

9.47 There are a few voices going up in support of a no-fault compensation system, notably among those the voice of Dr Zweli Mkhize during his time as Minister of Health.⁶¹ On the other hand, the majority of respondents are of the view that no-fault compensation is not a viable option for South Africa.⁶² As discussed in Chapter 7, various countries

⁶⁰ Chris Bateman “High-risk specialties threatened by runaway legal costs” *SAMJ* 106:1 (January 2016) 9–11 at 9–10; Lerm (2017) 330: MPS *Clinical Negligence* 19. IP 33 respondents: State Attorney, Pretoria; Western Cape DOH; Clinix; Dalmeyer, GunnClark; Joseph’s Inc; MPS *IP 33 Response*; Mediclinic; Netcare; OTASA; SAMA; SAMLA; SAPPF; SASA; SASOG. Life Healthcare is supportive of the idea of a certificate of merit, but registers concern over the cost of an expert opinion at such an early stage of proceedings and by whom it would be paid [Life Healthcare 4].

⁶¹ Mayibongwe Maqhina “Health considers fund to deal with medical claims” *IOL* (2 May 2021). IP 33 respondents: Larsen supports a no-fault compensation system for South Africa [Larsen 5–6]. SAMA express the view that “a no-fault system could be effective in dealing with medical malpractice matters”, but caution that “this would have to be carefully considered, and claims must be adequately and timeously attended to” [SAMA 7].

⁶² Bateman quotes Prof Mark Doepel, an associate professor at the School of Law of the University of Notre Dame, on no-fault compensation systems: “Doepel was highly critical of ‘no-fault’ compensation schemes, saying they would almost certainly fail for financial reasons and had almost bankrupted the New Zealand healthcare system.” [Bateman 11]. Howarth & Carstens express some doubts about the efficacy of no-fault compensation systems to improve patient safety due to a lack of evidence [Howarth & Carstens 72]. MPS refer to the reasons why the UK decided against implementing a no-fault compensation system, one of the main reasons being an estimation that no-fault compensation schemes could increase the costs of settling claims against the NHS by between 20% and 80%. MPS opine that the principles are transferable to South Africa. [MPS *Clinical Negligence* 26.] IP 33 respondents who are not in support of no-fault compensation: National Treasury; Western Cape DOH; State Attorney, Pretoria; GMG; Life Healthcare; MPS; Netcare; Paul du Plessis Attorneys; OTASA; SAMLA; SAPPF; SASA; SASOG; SASS. National Treasury states that introducing a no-fault system would entail major reform that would require much more work before a decision to implement such a system could be made [National Treasury par 32]. The State Attorney, Pretoria argue that a no-fault compensation system will be expensive, patients will be compensated who would not otherwise have qualified, and deserving patients harmed by negligence will receive smaller awards [State Attorney, Pretoria 22]. The Gynaecology Management Group question whether a no-fault compensation system would be sustainable, whether it would advance a patient-centred approach by making patients safer, whether those who are wronged would be better-off in the long run and whether it would be properly administered [GMG 7]. Life Healthcare provided an exposition of the advantages and disadvantages of the no-fault compensation system and the reasons why such a system would not work in South Africa, which is in main the failure of the RAF [Life Healthcare 2–3]. MPS reiterated their previous concerns in their response to IP 33, adding a reference to the Scottish proposals for possible no-fault

successfully implemented systems for no-fault compensation. These countries, however, have certain characteristics in common, which South Africa does not share.⁶³ Despite the much-lauded advantages of no-fault compensation systems, South Africa lacks the prerequisites for a successful no-fault system:

- 1) South Africa is not a high-income country, has a very small tax base in relation to the size of the population and an extremely high unemployment rate.⁶⁴
- 2) South Africa does not have a comprehensive, well-functioning national social welfare / social insurance system in place.
- 3) South Africa does not have a good, well-managed, properly resourced and adequately staffed public health system.

(b) Redress system

9.48 **The Commission propose that South Africa adopt an administrative compensation system, based on the Welsh redress system, for smaller medical negligence claims.** The Welsh redress system is discussed in Chapter 7. Since both a no-fault system as well as a redress system are administrative compensation systems, either system will require the establishment of a new component to deal with the claims that will be received. Either system will necessitate creating posts on organisational establishments of provincial DOHs in order to appoint staff with the necessary skills and experience to manage, investigate and consider the expected compensation claims.

compensation [MPS IP 33 Response 7]. Netcare indicate that a no-fault system would simply move the problems experienced currently out of the legal system into the financial and administrative field, where it will continue to harass the public and private health sectors [Netcare par 6.8.2]. Paul du Plessis Attorneys express disquiet about the possibility of a huge increase in claims if a no-fault system is introduced [Paul du Plessis Attorneys 5]. SAMLA believe a no-fault compensation system is not suitable in view of the current socio-economic factors in South Africa, will lead to an increase in claims and might not pass constitutional muster [SAMLA 39 & 40]. SASA is of the view that a no-fault system would not be workable in South Africa, especially in light of the problems with other statutory funds, ie RAF and the Compensation Fund. [SASA item 4 question 8]. As pointed out by a number of respondents, South Africa does not have a very good track record with regard to these types of statutory fund considering the current state of affairs at the Road Accident Fund and the Compensation Fund.

⁶³ See Chapter 7 for a discussion of the compensation systems of various countries.

⁶⁴ New Zealand and Sweden are usually cited in discussions about no-fault compensation. Comparing some very basic information delivers the following results:

South Africa:	population: 60.14 million	unemployment: 34.4%	GDP for 2021: 4.7%
New Zealand:	population: 5.12 million	unemployment: 4%	GDP for 2021: 5.1%
Sweden:	population: 10.44 million	unemployment: 8.8%	GDP for 2021: 9.7%
Sources:	Statistics South Africa accessed 18 October 2021 www.statssa.gov.za/		
	Statistics New Zealand accessed 18 October 2021 www.stats.govt.nz/		
	Statistics Sweden accessed 18 October 2021 www.scb.se/en/		

(c) *Difference between redress and no-fault compensation*

9.49 The difference between a no-fault system and a redress system is that negligence need not be proved in a no-fault system, while proving negligence (fault) is still a requirement for compensation in terms of a redress system. Both systems require proof of causality. Because a no-fault system only requires proof of causality, not negligence, the introduction of a no-fault system will almost certainly lead to a huge increase in claims.⁶⁵ If South Africa is intent upon introducing and implementing an administrative compensation system, the Commission is of the view that a redress system is preferred over a no-fault system.

9.50 The advantage of a redress system is that it provides for an administrative compensation system broadly similar to a no-fault system. However, because proving fault is still a requirement for compensation through a redress system, the system should not attract a deluge of claims to the same extent as a no-fault system. Although a redress system will require similar resources (additional posts, skilled staff, an administrative support system) to a no-fault system, negligence is still a requirement for compensation under a redress system, which should cut down on the number of claims received and, most importantly, the number of claims that will qualify for the payment of compensation.

(d) *Redress and pre-action protocol*

9.51 It is important to note that a plaintiff cannot pursue a claim under the redress system and the pre-action protocol simultaneously. The plaintiff may start with the redress process and, if not satisfied, can switch to the pre-action protocol. Alternatively, a plaintiff may start with the pre-action protocol and then switch to the redress process if appropriate. The idea is that redress should be applied for smaller claims and the pre-action protocol be used for higher value claims. A limit could be set for smaller claims that should be adjusted from time to time, possibly starting with a limit of R1 million.

(e) *Redress and litigation*

9.52 **The Commission propose that, once a plaintiff formally accepts an offer for redress under a redress system, the plaintiff cannot pursue a medical negligence**

⁶⁵ Refer to discussion in Chapter 7 of the UK and Scottish processes to investigate the possibility of introducing no-fault compensation systems and the reasons why these two countries eventually decided against it. The envisaged huge increase in the number of claims and the overall rise in claims expected to be paid out is one of the biggest reasons why the UK and Scotland decided against the no-fault compensation route.

claim in court anymore. A plaintiff may change his or her mind at any time during the course of the redress proceedings in order to pursue a claim by means of litigation. However, taking a second bite at the cherry after an offer for redress has been accepted would defeat the objective of quick administrative resolution. In addition, it would lead to legal uncertainty to apply various resolution methods to one claim. The whole aim of a redress system is the quick and easy administrative resolution of claims.

(f) Redress and patient complaints system

9.53 A proper redress system goes hand-in and with a patient complaints system. The national DOH published the *National Guideline to Manage Complaints, Compliments and Suggestions in the Public Health Sector of South Africa* in April 2017. The national DOH published additional guidelines to assist health establishments to develop standard operating procedures during the same month. These guidelines are the following:

- Guideline to Develop a Sub-District/District Specific Standard Operating Procedure to Manage Complaints, Compliments and Suggestions
- Guideline to Develop a Hospital Specific Standard Operating Procedure to Manage Complaints, Compliments and Suggestions.

9.54 The Commission have no information about the successes or deficiencies of the complaints, compliments and suggestions system. There is also no information available on whether and how the system improves service delivery. A patient complaints system should be linked to measures to investigate complaints and take steps to address issues raised. It is hoped that the system is functional and not just another paper exercise.

8 Pre-action protocol

(a) UK pre-action protocol

9.55 In the UK pre-action protocols must be followed before formal court proceedings may be instituted. Following a pre-action protocol does not deny access to court, but introduces additional steps to the civil process. The court may impose sanctions for failure to comply with the *Pre-Action Protocol for the Resolution of Clinical Disputes*.⁶⁶

⁶⁶ *Pre-Action Protocol for the Resolution of Clinical Disputes* (PAP CD) par 1.7.

The PAP CD applies to all claims against hospitals and other health care providers in both the public and private sectors.⁶⁷ The general aims of the PAP CD are to:⁶⁸

- (a) maintain and/or restore the patient/ healthcare provider relationship in an open and transparent way;
- (b) reduce delay and ensure that costs are proportionate; and
- (c) resolve as many disputes as possible without litigation.

9.56 The specific objectives of the PAP CD are:⁶⁹

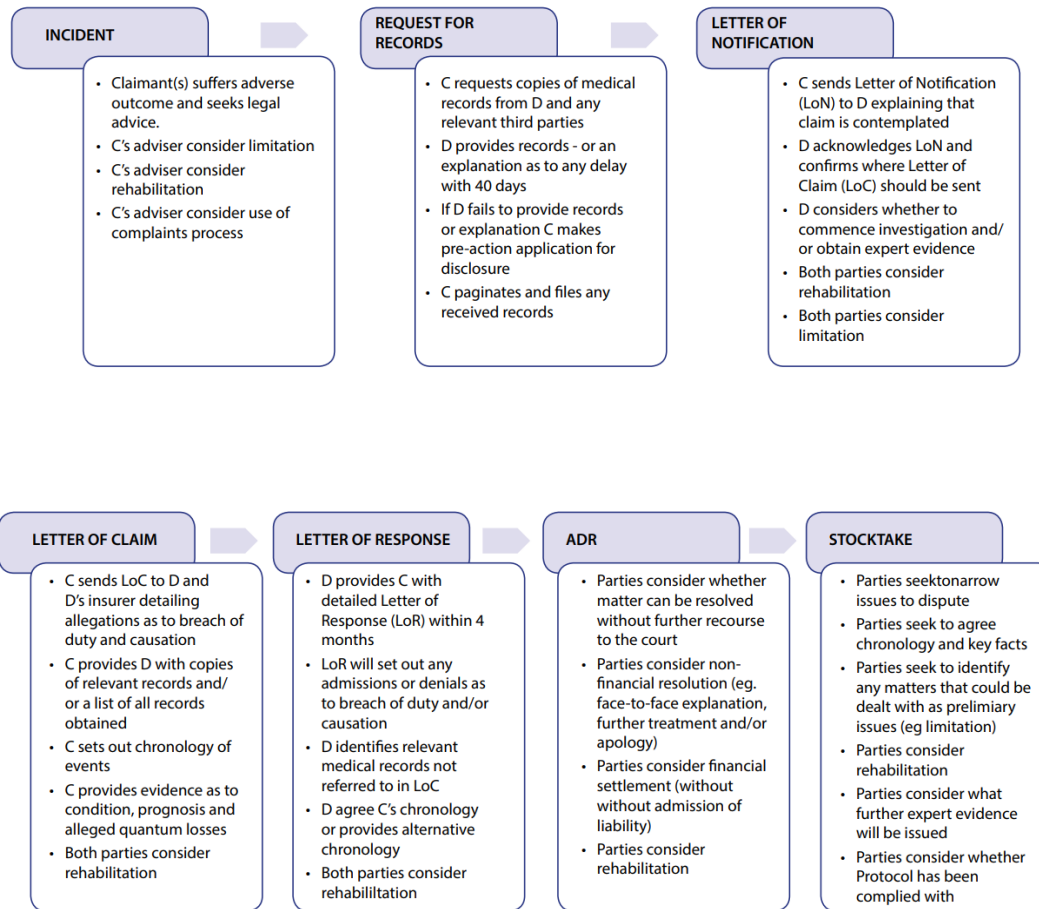
- (a) to encourage openness, transparency and early communication of the perceived problem between patients and healthcare providers;
- (b) to provide an opportunity for healthcare providers to identify whether notification of a notifiable safety incident has been, or should be, sent to the claimant in accordance with the duty of candour imposed by section 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;
- (c) to ensure that sufficient medical and other information is disclosed promptly by both parties to enable each to understand the other's perspective and case, and to encourage early resolution or a narrowing of the issues in dispute;
- (d) to provide an early opportunity for healthcare providers to identify cases where an investigation is required and to carry out that investigation promptly;
- (e) to encourage healthcare providers to involve the National Health Service Litigation Authority (NHSLA) or their defence organisations or insurers at an early stage;
- (f) to enable the parties to avoid litigation by agreeing a resolution of the dispute;
- (g) to enable the parties to explore the use of mediation or to narrow the issues in dispute before proceedings are commenced;
- (h) to enable parties to identify any issues that may require a separate or preliminary hearing, such as a dispute as to limitation;
- (i) to support the efficient management of proceedings where litigation cannot be avoided;
- (j) to discourage the prolonged pursuit of unmeritorious claims and the prolonged defence of meritorious claims;
- (k) to promote the provision of medical or rehabilitation treatment to address the needs of the claimant at the earliest opportunity; and
- (l) to encourage the defendant to make an early apology to the claimant if appropriate.

⁶⁷ PAP CD par 1.1.

⁶⁸ PAP CD par 2.1.

⁶⁹ PAP CD par 2.2.

9.57 The UK pre-action protocol process is illustrated in the flowchart below:⁷⁰



9.58 The process would mostly commence with the plaintiff requesting the health records. The request must contain sufficient information about the claim, the seriousness of the event, the information required from the defendant and so forth. The defendant must respond within a particular time and identify a person to liaise with. If the records are not provided, the plaintiff may bring an application for disclosure of the records. This process is followed by a letter of notification from the plaintiff about a possible claim.

9.59 The letter of notification allows the defendant to inform medical indemnity insurers where appropriate and to consider options such as commencing an investigation or obtaining expert opinions. In addition, it allows parties the opportunity to start with rehabilitation or other treatment where appropriate at an early stage. After considering the records obtained from the defendant and other information, the plaintiff may decide

⁷⁰ PAP CD Annexure A.

to send a letter of claim. The letter of claim must contain prescribed details, such as information about all records, relevant reports, prognosis, alleged quantum of losses and so forth. This information must accompany the letter of claim. The letter of claim may propose an offer for settlement.

9.60 The defendant must reply with a letter of response in which the defendant admits, partially admits, specifies, or denies with defendant's own version of events. Information about the discipline of the expert evidence is required. The letter of reply must also respond to plaintiff's offer to settle if applicable. The defendant may offer to settle with sufficient evidence to allow for proper consideration. The defendant may obtain expert opinions. If no there is no agreement at this stage mediation or conciliation must be attempted. If it is not successful the parties must be able to provide reasons to court for the failure to mediate/conciliate. Parties at this time consider their options, such as an apology and explanation, further treatment, or financial settlement (without admission of liability).

9.61 If the dispute has not been resolved after mediation, parties should still review their positions, seek agreement on particular issues if possible and consider the need for further expert evidence. Once all these requirements have been complied with, the parties may decide to proceed with litigation.⁷¹ A pre-action protocol will add another step to the civil litigation process, but by adding this step it is hoped that going to court might be avoided altogether.

(b) Pre-action protocol proposal

9.62 As indicated in paragraph 9.48, the Commission's proposal to introduce a redress system as applied in Wales is aimed at dealing with smaller claims by means of an administrative procedure. If the size of a claim exceeds the limit of compensation that may be awarded via the redress system, or if a plaintiff chooses not to apply for redress, or if the dispute could not be resolved via the redress system, a plaintiff may always still institute litigation. **The Commission propose introducing a pre-action protocol similar to the *Pre-Action Protocol for the Resolution of Clinical Disputes (PAP CD)* of the UK as part of the litigation process.**

⁷¹ PAP CD par 6.1.

9.63 Introducing pre-action protocols will require amendments to civil procedure and court rules.⁷² The Commission propose that the two processes cannot be followed simultaneously, however, if either system is attempted without resolving the dispute, the other system may be used. The redress system is not a prerequisite to instituting action, but first attempting to resolve a dispute by means of the pre-action protocol is a prerequisite for instituting formal court proceedings. As is the case with the introduction of a redress system, the provincial DOHs will require adequate and qualified staff in provinces to provide support for the application of a pre-action protocol, but the division dealing with redress applications could probably also deal with pre-action protocols. Several commentators and respondents to *Issue Paper 33* are in support of improved pre-trial measures. The majority of respondents support pre-trial processes.⁷³

9 Litigation

(a) *Introduce civil process changes to limit delays*

9.64 **The Commission propose that civil process changes be introduced to limit delays and expedite proceedings.** The amendments to civil procedure should ensure that requirements such as filing a certificate of merit, seeking redress where appropriate or complying with the pre-action protocol must take place before a case can proceed to a court hearing. First, if no certificate of merit affidavit was provided during the pre-action protocol process or the redress process, a certificate of merit affidavit must be submitted before action can be instituted. Second, if it seems that the size of the claim falls within the ambit of the redress process, seeking redress must first be attempted. Third, if a

⁷² Although the South African pre-action protocol will use the British pre-action protocol as a model, it will be adapted to South African circumstances. Another good example of pre-litigation processes is the measures applied by the state of Utah, USA. A possible extra step could be peer review of expert opinions if requested by either of the parties. A number of respondents have proposed peer review of expert opinions: on the one hand to counteract the “hired gun” type expert that favour a specific party; on the other hand to determine whether a case has merit or not. Apparently some professional medical organisations already conduct peer review informally, but the sentiment seems to be in favour of a more formal peer review system. Peer review would also have the effect of screening claims. IP 33 respondents in favour of peer review: Dalmeyer; GMG; Joseph’s Inc; SAMLA; SAPPF.

⁷³ Lerm (2017) 334 & 335; MPS *Clinical Negligence 20* refer to the UK Pre-Action Protocol for the Resolution of Clinical Disputes (2015). IP 33 respondents: Clinix; Friedman & Associates; Gary Austin Attorneys; Joseph’s Inc; General Council of the Bar; Life Healthcare; MPS *IP 33 Response*; Netcare; OTASA; SAMA; SAMLA; SAPPF; SASA. The General Council of the Bar also referred to the UK pre-action protocols in particular [GCB 21–23].

claim was instituted without the pre-action protocol having been complied with, the matter must be diverted to the pre-action protocol process before proceeding to court.

(b) Proceed with action timeously after issuing summons

9.65 The Clinix Health Group suggested an amendment of the High Court Rules so that a summons becomes stale after a particular period: for example, plaintiff is barred from proceeding with a claim after a year of inaction – similar to the situation in the magistrate’s courts. As a further safeguard the Clinix Health Group proposes that the court be given a discretion to extend the period on good cause shown, keeping the interests of both parties in mind.⁷⁴ **The Commission support the proposal that a plaintiff is barred from proceeding with a claim after a period of inaction, with the possibility of having the period extended by the court on good cause shown.**

(c) Improve pre-trial procedures

9.66 Apart from the pre-action protocol, which is aimed at simplifying and shortening the claims process and keeping matters out of court, proposals in line with suggestions made by MPS,⁷⁵ commentators on the topic and respondents to IP 33 can also be introduced.⁷⁶ The exchange of factual witness statements, early exchange of expert evidence, early expert meetings, fast-track procedures for medical negligence claims and sanctions to penalise non-performing parties were canvassed in submissions received.⁷⁷ According to MPS, in their experience “the more open the parties can be early in proceedings, the greater the chance that the claim can be resolved early to the benefit of both the patient and defendant.”⁷⁸ **The Commission propose amendments to civil procedure to improve pre-trial procedures and court case flow and management**

⁷⁴ Clinix and Mediclinic described their experience of expending huge amounts to prepare a defence for claims that later turn out to be unsubstantiated or meritless, or are simply abandoned. Summons are issued precipitously to interrupt prescription; issued in a “catch-all” manner citing various co-defendants; or issued to test a defendant’s appetite for possibly settling a claim. Both respondents complain that these claims are then withdrawn or left to become dormant. The plaintiff is usually indigent, leaving the defendant to cover the costs. Contingent liability for claims reflects negatively on the insurance portfolio of the insured (health practitioner/ hospital). [Clinix par 1.6 to 2.13; Mediclinic 6–7].

⁷⁵ MPS *Clinical Negligence* 7, 12 & 21.

⁷⁶ IP 33 respondents: Clinix; Friedman & Associates; Gary Austin Attorneys; General Council of the Bar; Joseph’s Inc; MPS *IP 33 Response*; Netcare; SAMLA; SAPPF. SAPPF suggest mandatory pre-trial conferences and early exchange of materials and documents [SAPPF 5], while SAMLA moot mandatory expert meetings [SAMLA 44].

⁷⁷ IP 33 respondents: Joseph’s; Life Healthcare; MPS *IP 33 Response*; Netcare; OTASA.

⁷⁸ MPS *Clinical Negligence* 14.

to expedite and simplify the finalisation of claims. Examples of such amendments are earlier exchange of information, expert notices, summaries and witness statements; as well as early expert meetings and pre-trial conferences.

(d) *Adversarial system and inquisitorial system*

9.67 Another matter that the Commission specifically sought comments about in Issue Paper 33 pertains to the adversarial system and the inquisitorial system. Respondents were requested to consider whether:

- The adversarial system is the best option for dealing with this particular area of the law.
- Applying the inquisitorial system or aspects of the inquisitorial system to medical negligence claims would be beneficial.

9.68 Some respondents were of the view that introducing the inquisitorial system in some instances or introducing elements of the inquisitorial system might be beneficial.⁷⁹ National Treasury for example express the opinion that the adversarial system “incentivises healthcare providers to be protective rather than cooperative when it comes to sharing information on adverse events”.⁸⁰ The adversarial system is firmly entrenched in South African law and cannot be ousted for one type of claim. However, the Criminal Procedure Act 51 of 1977 introduced some inquisitorial elements into criminal proceedings.⁸¹ **The Commission propose that inquisitorial elements be introduced into civil proceedings to allow parties to agree on certain facts or events before the formal court hearing commences.** This will allow narrowing of the issues before the court to the matters that are truly in dispute and that have to be resolved by the court.

(e) *Expert witnesses*

9.69 One of the biggest cost drivers in medical negligence litigation is the cost of expert witnesses. An expert witness is ultimately responsible to the court to assist the court to reach a decision. An expert witness should provide objective evidence and his or her expert opinion is not supposed to be biased in favour of the party requesting the

⁷⁹ Lerm (2017) 336. IP 33 respondents: National Treasury 25; Larsen 4–5; SAMA; SAMLA; SAPPF; SASS.

⁸⁰ IP 33 respondent: National Treasury 25.

⁸¹ Sections 112(1)(b) and 115(2) of the Criminal Procedure Act 51 of 1977.

expert witness to testify.⁸² In view of the duties of an expert and the obligation on an expert witness to give objective evidence, there seems to be no real reason why each party should have a separate set of witnesses to testify on the same matter.⁸³ **The Commission thus propose that the parties use joint expert witnesses.** Although the

⁸² IP 33 respondent: SASA advise as follows with regard to experts testifying on contingency: "SASA is firmly of the view that no expert should be testifying on a contingency basis. All experts must be paid according to fee scheduled set [sic] by the Department of Justice, so as to curb the hired guns phenomenon." [SASA item 4 question 23]. This sentiment is echoed by Jon Driver-Hewitt (consultant orthopaedic surgeon) in a letter to *De Rebus*, where he stated that witnesses who charge on a contingency basis (ie only for successful outcomes) discredit their objectivity. Counsel or the presiding judge should ask a witness whether he/she will only be paid if the case is decided in favour of the litigant who called the witness. If the answer is "yes" the witness should be classified as biased [Jon Driver-Hewitt "Letters to the Editor – Contingency" *De Rebus* (September 2020)].

⁸³ Van den Heever & Lawrenson cite the English judgment in the case of *National Justice Compania Naviera SA v Prudential Assurance Co Ltd (The 'Ikarian Reefer')* [1993] 2 *Lloyd's Rep* 68 at 81, where Cresswell J set out the duties of an expert:

- 1) Expert evidence presented to the court should be, and should be seen to be, the independent product of the expert, uninfluenced as to form or content by the exigencies of litigation.
- 2) An expert witness should provide independent assistance to the court by way of objective, unbiased opinion in relation to matters within his expertise ... An expert witness in the High Court should never assume the role of an advocate.
- 3) An expert witness should state the facts or assumptions upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion.
- 4) An expert witness should make it clear when a particular question or issue falls outside his expertise.
- 5) If an expert's opinion is not properly researched because he considers that insufficient data is available then this must be stated with an indication that the opinion is no more than a provisional one.
- 6) If after exchange of reports, an expert witness changes his view on a material matter ... such change of view should be communicated ... to the other side without delay and when appropriate to the Court.
- 7) Where expert evidence refers to photographs, plans, calculations ... survey reports or other similar documents [these] must be provided to the opposite party at the same time as the exchange of reports.

The duties of an expert witness (items 1 to 5) as set out above were endorsed by Davis J in *Schneider NO and Others v AA Another* 2010 (5) SA 203 (WCC) 212F–213B; by Mokgoatlheng J in *Ntsele v MEC for Health, Gauteng Provincial Government* (2009/52394) [2012] ZAGPJHC 208; [2013] 2 All SA 356 (GSJ) (24 October 2012) par 89–90. See also S Grobler "The role of the expert witness: Excerpts of a presentation to the XIth Controversies and Problems in Surgery Symposium, Pretoria" (20 October 2006) *The South African Gastroenterology Review* (March 2007) 11–14 at 11:

The expert witness is ethically and legally obligated to tell the truth. Transcripts of depositions and courtroom testimony are public records and subject to independent peer reviews. Moreover, the expert witness should willingly provide transcripts and other documents pertaining to the expert testimony to independent peer review. The expert witness should be aware that failure to provide truthful testimony exposes the expert witness to criminal prosecution for perjury, civil suits for negligence and revocation or suspension of his or her professional license.

[Patrick van den Heever and Natalie Lawrenson *Expert Evidence in Clinical Negligence: A Practitioner's Guide* (Juta 2015) fn 19 at 18.]

notion of joint expert witnesses appears to be a foreign concept for some, there are respondents who are supportive of this proposal.⁸⁴

9.70 MPS raised concerns about single expert witnesses, which concerns are understood and shared.⁸⁵ In line with a proposal by SASOG [implemented by SASOG by mandating the Expert Opinion and Mediation Committee (EOMC)]⁸⁶ **the Commission propose that, for specialised technical medical evidence, a panel of three joint expert witnesses from the discipline concerned be appointed from an official list compiled by the court in cooperation with the relevant medical professional body.** This proposal received support from Dalmeyer as well.⁸⁷ There is one condition: the expert who provided the certificate of merit affidavit at the start of the matter should not be one of panel members for the same case.

(f) Appointment of assessors

9.71 Lerm and other respondents suggest specialised courts or specialised judges for medical negligence cases.⁸⁸ This is not a feasible option. Establishing new or specialised separate courts is an expensive exercise and takes scarce resources away from other areas. In addition, there are neither enough judges to allow for this type of specialisation nor are medical negligence cases numerous enough to justify appointing specialist judges just to hear these cases. There is, however, another possibility that can be considered, namely the appointment of assessors to assist judges in complex medical negligence matters. In South Africa assessors are mostly appointed for complex criminal cases. Assessors may be appointed in civil matters in terms of section 34 of the Magistrates' Court Act 32 of 1944 "upon the application of either party".⁸⁹ The Superior Courts Act 10 of 2013 does not specifically provide for the appointment of assessors in civil proceedings. Because it has inherent powers to determine its rules and procedures,

⁸⁴ IP 33 respondents: KZN Treasury; GunnClark; SAMA; SAMLA. The notion of joint expert witnesses is strongly supported by Western Cape DOH. Van der Merwe asks whether the need for two teams of expert witnesses – one for the plaintiff and one for the defendant – implies that expert witnesses are not objective [Van der Merwe 1].

⁸⁵ IP 33 respondent: MPS *IP 33 Response 5*.

⁸⁶ Prof Ismail Borat "MPS/Ethiqaal Co-operation and Collaboration Meeting" message sent by electronic mail to MPS, EthiQal and the researcher (27 March 2018).

⁸⁷ IP 33 respondent: Dalmeyer.

⁸⁸ Lerm (2017) 332. IP 33 respondents: Joseph's Inc; Mediclinic; Netcare; SAMA; SAMLA; SAPPF.

⁸⁹ Rule 59 of the Magistrates' Courts Rules deals further with the appointment of assessors in magistrates' courts.

it is contended that the High Court could decide to appoint assessors if considered necessary.⁹⁰

9.72 To ensure that the procedure for the appointment of assessors in High Court cases is on a sure footing, **the Commission propose that the Superior Courts Act 10 of 2013 and the Uniform Rules of Court should be amended to provide for the appointment of assessors on application of either of the parties, or if the court is of the view that it would be in the interests of justice, or specifically when the case is of a complex nature involving highly technical expert evidence.** In this manner the court will have access to expert and specialised assistance when hearing highly technical or complicated medical negligence cases, without the cost and complications of establishing specialist courts or appointing specialist judges only for medical negligence cases.

9.73 SAMLA proposed the establishments of specialist medical courts, but support the appointment of skilled assessors “to assist judges and magistrates in complex medical negligence matters” where it would not be viable to establish specialist medical courts.⁹¹ This sentiment is mirrored by Lerm⁹² and some IP 33 respondents.⁹³

10 Compensation

(a) Diverse views

9.74 There were noticeable divisions among the respondents about compensation options. The aspect of compensation that causes the most problems is the future medical care component in cases where a patient requires ongoing care after suffering a serious and permanent personal injury. Dr Zweli Mkhize, the Minister of Health at the time, was

⁹⁰ Henry Lerm “Two heads are better than one” *De Rebus* (October 2012) 22–24 [Lerm (2012)].

⁹¹ IP 33 respondent: SAMLA 37.

⁹² Lerm (2017) 333.

⁹³ IP 33 respondents: Joseph’s Inc refer to “dedicated courts, assisted by medical assessors, to determine disputes of a medical nature” [Joseph’s 17 par 1.2.8]. Ric Martin Incorporated Attorneys express the view that “the time has arrived for the Courts to appoint at least one medical expert to sit as assessor with the presiding judge in complex matters involving breach of mandate and/or negligence in medical cases” [Ric Martin Inc 1]. SAMA support the appointment of medical assessors [SAMA 4].

quoted in the media for mooted a no-fault system for medical negligence compensation for South Africa (see also par 9.47).⁹⁴

9.75 It is clear from the discussion in Chapter 7 that a no-fault compensation system is not a viable solution to South Africa's medico-legal claims crisis.⁹⁵ Despite the much-lauded advantages of no-fault compensation systems, South Africa lacks the prerequisites for a successful no-fault system:

- South Africa is not a high-income country.
- South Africa does not have a comprehensive, well-functioning national social welfare / social insurance system in place.
- South Africa does not have a good, well-managed, properly resourced and adequately staffed public health system.
- South Africa has a fairly low income per capita and a much narrower tax base compared to the developed countries where no-fault compensation systems are applied.⁹⁶

9.76 The proposal at the opposite end of the spectrum of proposed changes to SA law, is that the current litigation and compensation system should remain in place with a few tweaks to procedural issues.⁹⁷ This is not feasible either. Apart from the fact that the current system has become unaffordable, the people of South Africa should no longer tolerate the situation since it is impacting on their constitutional right of access to health care services. The current medico-legal situation in the public health sector is seriously affecting the delivery of health care services to the broader population for the benefit of the lucky few who won the "litigation lottery ticket".⁹⁸ In addition, it is taking money out of the under-resourced public health system into the well-resourced private health sector.⁹⁹

⁹⁴ Mayibongwe Maqhina "Health considers fund to deal with medical claims" *IOL* (2 May 2021).

⁹⁵ The Free State DOH agrees, indicating that a no-fault system would not work until systemic issues are dealt with, as South Africa has too many cases [Free State DOH 2].

⁹⁶ See statistics cited in Chapter 9 fn 64.

⁹⁷ IP 33 respondents: Friedman; General Council of the Bar; Josephs Inc; Mullins.

⁹⁸ SAMLA confirms this concern: "A compelling argument can also be put up that paying out large amounts to individuals, have the effect that it impairs services to the greater populace. Any savings could be utilized for improving health care services. The lack of adequate facilities poses a risk to the well-being of many patients." [SAMLA 51].

⁹⁹ The dilemma facing the public health sector is highlighted by the Auditor-General reports for the years 2017-18, 2018-19 and 2019-20 discussed in Chapter 5. IP 33 respondent: Oosthuizen. SLA Bill 2018 submissions: ASSA.

(b) Retain public sector funds in public health system

9.77 It is important to retain public health services funds within the public health sector as far as possible. Funds expended to provide public health care users (who had suffered harm and are being compensated by means of service delivery in public health facilities) with proper medical care, rehabilitation and therapy is retained in the public health system to the benefit of all public health care users. If these funds were paid out for use in the private health sector, only the patient harmed would benefit from that expenditure.

9.78 The private health sector delivers services to less than 20% of the population, but spends almost the same portion of the GDP on that number of people that the public health sector spends on the 80% of the population that utilises public health services.¹⁰⁰ Using public health funds for specialised private health services for a lucky few means that a sizable chunk of the public health sector's funds is going to the private sector as well. Expenditure on public health services to the advantage of all public health services users will go much further to improve access to quality health care to all, rather than benefiting a tiny minority of users with massive pay-outs.

9.79 Fortunately the Constitutional Court has already developed the common law to some extent and opened the way with its decisions in the cases of *MEC, Health and Social Development, Gauteng v DZ obo WZ*¹⁰¹ (DZ case) and *MEC for Health, Gauteng Provincial Government v PN*¹⁰² (PN case). The cases and the case law preceding these matters are discussed in Chapter 4. **The Commission propose that the decisions in the DZ and PN court cases should be confirmed and expanded in legislation.**

(c) Structured settlements

9.80 With regard to the nature of compensation, **the Commission propose that structured settlements should be the norm for compensation awarded for damages suffered due to medical negligence by state employees.** The components of a structured settlement would be the following:

- 1) Lump sum awards should only be paid for past expenditure and damages, and immediate and necessary expenses (eg rehabilitation costs, assistive devices, adjustments to living environment and so forth).

¹⁰⁰ Section 27 Fact sheet: *Funding the Right to Health* (2019) 1.

¹⁰¹ *MEC, Health and Social Development, Gauteng v DZ obo WZ* [2017] ZACC 37.

¹⁰² *MEC for Health, Gauteng Provincial Government v PN* [2021] ZACC 6.

- 2) Future health care services must be provided in state hospitals as far as possible.¹⁰³ Where state health services cannot provide the full range of services required, where some of the state services are inadequate or where services are not of an acceptable standard, monetary compensation should be paid for private health care only to the extent that the services offered by the state are insufficient. The monetary award for private health care should be included and paid as part of the periodic payment as calculated per annum.
- 3) Periodic payments in the nature of an annuity (not down payments on a lump sum amount) must be awarded for future maintenance, loss of earnings and the portion of future medical care, treatment, rehabilitation and therapy that the court is not satisfied the state would be able to deliver or where the health service delivered by the state is not of an acceptable standard.

9.81 Depending on the nature of the case and the damages suffered, the **Commission propose that compensation should be awarded in the form of a structured settlement – with part of the compensation paid in a lump sum, part of the compensation paid as periodic payments, and part of the compensation provided as payments “in kind” by means of the delivery of services – allowing a combination of these methods and determining the ratio of one aspect in comparison to another aspect by considering the circumstances of each particular case.** Structured settlements when awarding compensation is especially important in matters where a significant portion of the compensation is required for future medical care, future loss of earnings and future maintenance, particularly when the person harmed is still a young child. Several commentators and respondents support alternative compensation methods (such as providing services) and structured settlements.¹⁰⁴

¹⁰³ Several authors and respondents support rendering of health care services at public health establishments as a viable or even preferred method of compensation. Pauw (2017) states: “The object of an award of damages is to compensate a plaintiff for loss suffered. Leaving aside the non-pecuniary aspects of the action for pain and suffering ... and the *actio iniuriarum*[.] such award is to compensate the plaintiff for diminution in his/her patrimony. An award in damages sounding in money can never compensate a plaintiff in full for his/her patrimonial loss. An award in the form of an analogy to restitution can be more compensatory in effect. It accords with section 173 of the constitution: the interests of justice. It takes into account fairness to both plaintiff and defendant. A monetary award may be inappropriate in certain cases.” [Pieter Pauw “Alternative relief in delictual claims?” 2017 (4) *TSAR* 846–856 at 850 and 853.]

¹⁰⁴ Pauw (2017) support the notion of compensation by other means than lump sum payments: “Compensate the minor child in so far as it is possible, but do not limit compensation to the payment of money as a lump-sum award. Promote the interests of the provincial health departments by directing the rendering of services.” [Pauw (2017) 850.] IP 33 respondents on structured settlements and delivering services: National Treasury; KwaZulu-Natal DOH;

(d) Future loss of income

9.82 **The Commission further propose changing the underlying principle for the calculation of future loss of income.** At present a variety of factors, some of which are very speculative or at best an educated guess, are taken into consideration when considering possible future loss of income. These include for example the social situation, background, level of education and careers of the parents of young children. **The Commission propose that calculations of future loss of income be premised on a structured format or guideline based on the average national income, or the average income of the area where the claimant lives.** This notion is supported by comments received from KwaZulu-Natal Treasury and other respondents.¹⁰⁵

(e) Capping certain categories of damages

9.83 Another factor pertaining to compensation that the Commission raised in Issue Paper 33 was the possibility of capping general damages. Comments received from the State Attorney, Pretoria does not consider the limiting or capping of general damages as a concern, because “[a]wards with regard to general damages are generally on the low side compared to future medicals”.¹⁰⁶ This view is supported in the response received from the office of the State Attorney, Bloemfontein, which states that “[g]eneral damages on the overall constitute approximately 10% of the total amount awarded or settled.”¹⁰⁷

9.84 Pauw however disagrees: “It is notorious that awards of general damages have gone through the roof.”¹⁰⁸ He refers to the case of *NK obo ZK v MEC for Health, Gauteng*¹⁰⁹ by way of example, where the SCA increased the amount of R200 000 awarded as general damages by the court a quo to R1 800 000. Willis JA referred to a

KZN Treasury; NW Treasury; Eastern Cape DOH; Western Cape DOH; State Attorney, Pretoria; Dalmeyer; GMG; GunnClark; Netcare; SAMA; SAMLA; SAPPF; SASOG. SLA Bill 2018 submission: ASSA suggest the creation of care centres for specialised medical treatment.

¹⁰⁵ IP 33 respondents: KZN Treasury; EthiQal; GMG; MPS *IP 33 Response*; Netcare; SASA; SASOG; SASS; Scharf.

¹⁰⁶ IP 33 respondent: State Attorney, Pretoria 23.

¹⁰⁷ IP 33 respondent: State Attorney, Bloemfontein 5.

¹⁰⁸ Pieter Pauw “Alternative relief in medical malpractice claims – further developments” 2019 (1) *TSAR* 91–97 at 95.

¹⁰⁹ *NK obo ZK v MEC for Health, Gauteng Province* (216/17) [2018] ZASCA 13 (15 March 2018) par 13.

number of cases relied upon by the appellant to arrive at the amount claimed.¹¹⁰ Wessels shares Pauw’s disquiet about general damages: “Taking into account that the amounts awarded [for general damages] in the medical malpractice context have increased significantly, it may be worthwhile to consider placing a cap on these amounts.”¹¹¹ There are a number of respondents who share these sentiments.¹¹² Some respondents register concern over the size of the claims of foreign nationals.¹¹³

9.85 South Africa does not recognise the concept of punitive damages, which is damages awarded to the defendant as a deterrent or “punishment” in addition to compensatory damages (for actual losses suffered). Over the past few years the courts have in a number of instances awarded “constitutional damages” to a defendant. The issue of constitutional damages is discussed in more detail in Chapter 2. The Constitution makes provision for an award of this nature¹¹⁴ and the courts have awarded fairly high constitutional damages in some instances. **The Commission propose that it has become necessary to cap any damages other than special damages – such as constitutional damages and general damages (non-pecuniary damages).** This will also ensure that it does not become punitive damages in disguise.

¹¹⁰ *S obo S v MEC for Health, Gauteng Province* (2009/27452) [2015] ZAGPPHC 605: Louw J awarded R1 800 000; *Matlakala v MEC for Health, Gauteng Province* (2011/11642) [2015] ZAGPJHC 223 (2 October 2015): Keightley J awarded R1 500 000; *Mbhalate v MEC for Health, Gauteng Province* (2012/45017/12) (17 February 2016): Campbell AJ awarded R1 800 000; *PM obo TM v MEC for Health, Gauteng Province* [2017] ZAGPJHC 346 (7 March 2017): Meyer, Weiner and Monama JJ awarded R1 800 000; *AD & IB v MEC for Health and Social Development, Western Cape Province* (27428/10) [2016] ZAWCHC 116 (7 September 2016): Rogers J awarded R1 800 000; *Hlubi v MEC for Health, Gauteng Province* (57301/15) [2021] ZAGPPHC 214 (8 February 2021): Wanless AJ awarded a total amount of R1 000 000 (R400 000 for the mother and R600 000 for the deceased child).

¹¹¹ Wessels 21.

¹¹² *MPS Clinical Negligence* 22 & 23. IP 33 respondents: Eastern Cape Treasury; KZN DOH; KZN Treasury; National Treasury; Camargue; EthiQal; Life Healthcare; Mediclinic; MPS *IP 33 Response*; Netcare; OTASA; Riskhouse Actuaries; SAPPF; SASOG; SASS; Scarf. Oosthuizen suggests the creation of an efficient, prompt and easily accessible system to administer undertakings to pay for the costs of future healthcare and assistive devices if and when they arise [Oosthuizen 4]. SLA Bill 2018 submissions: ASSA.

¹¹³ IP 33 respondents: Mediclinic suggest that capping of damages should be considered for foreign claimants where such claimants will be favoured by the exchange rate [Mediclinic 11]. Mullins opines that it seems unfair to cap the claims of South African citizens, but not claims of foreign citizens [Mullins 8].

¹¹⁴ Section 38 of the Constitution: “Anyone listed in this section has the right to approach a competent court, alleging that a right in the Bill of Rights has been infringed or threatened, and the court may grant appropriate relief, including a declaration of rights.”

(f) Periodic payments

9.86 **The Commission propose that periodic payments calculated on an annual basis should be the default compensation option for all future compensation not delivered as services.** Any monetary award, whether in the form of a lump sum or by means of periodic payments, must be underpinned by proper medical, statistical and actuarial evidence. Periodic payments in particular should be calculated with the assistance of an actuarial scientist and the annual award should include the portion for private health services. If actuarial scientists can calculate future expenses for a child with a life expectancy of 50 years, including the cost of a variety of private medical services and therapeutic treatments, surely they can calculate an average payment on an annual basis that would still include the cost of the necessary services. These calculations should also consider “step changes”,¹¹⁵ which means that there could be increases above the normal CPI rate in some years to accommodate expected changes in the beneficiary’s circumstances, such as a child starting school. Although the periodic payments should be calculated on an annual basis, it can be paid monthly or quarterly. Many respondents are supportive of the notion of periodic payments.¹¹⁶

(g) Administration of periodic payments

9.87 **To administer periodic payments, the Commission propose that the functions of SASSA be expanded to also deal with these payments, alternatively that a division be created within each province to deal with periodic payments.** Free State, KwaZulu-Natal and the Northern Cape were optimistic about their capacity to administer such a system, while Gauteng and Western Cape believe a new division will have to be established. These responses appear from the representations made to the Portfolio Committee on Health during the public hearings in Parliament on the State Liability Amendment Bill 2018.¹¹⁷ The Commission propose that a uniform operational

¹¹⁵ Department of Justice and Constitutional Development “Summary of comments on State Liability Amendment Bill, 2018” presented to the Portfolio Committee on Justice and Correctional Services (October 2018) [SLA Bill comments (2018)]: Algorithm Consultants and Actuaries [SLA Bill comments (2018) at 20].

¹¹⁶ Pauw (2017) 855. IP 33 respondents on periodic payments: EC Treasury; KZN DOH; KZN Treasury; NW Treasury; National Treasury; State Attorney, Pretoria; Camargue; EthiQal; Netcare; OTASA; SAMA; SAMLA; SAPPF; SASOG; SASS. Western Cape DOH support periodic payments, but state that it should only be applied to higher value claims due to the administrative burden it will impose [WC DOH re par 4.24]. GMG support periodic payments paid on a monthly basis [GMG 9]. Riskhouse Actuaries consider the system of periodic payments as too expensive [Riskhouse 1].

¹¹⁷ SLA Bill 2018 submissions 3 & 7.

and monitoring system be designed for administering periodic payments, involving National Treasury. Proper implementation of the system and monitoring of its operation is critical and should be built into the system design. In addition, the system should include some method of alerting a province when a beneficiary dies, so that the periodic payments can be stopped.

9.88 The Commission is of the view that the option of including the cost of private medical services as part of the annually calculated periodic payments is preferred over a system where the state undertakes to pay for private health services on receipt of quotations. The state often mooted this system of giving an undertaking to pay for private medical services, on receipt of quotations, in cases involving a significant future medical care component. The administrative burden of such a system is immense and will cause long delays and huge bottlenecks. It is therefore not supported. **The Commission further propose that a schedule of benefits for specific injuries or conditions be compiled that can be adjusted annually or that could be linked to an index of average values for automatic adjustment every year.** The amount of the periodic payments should also be increased annually in the same manner, by linking payments to an index of average values (eg the CPI) for automatic adjustment every year.¹¹⁸

(h) Adjusting periodic payments in exceptional circumstances

9.89 The common law “once and for all rule” traditionally does not allow a matter based on the same facts to be referred back to court. **The Commission propose that a deviation from the “once and for all” rule should be possible for adjusting periodic payments in exceptional circumstances.** Examples of exceptional circumstances would be a drastic change in the circumstances or health of the person who suffered harm, or the availability of new and improved public health services or new treatment options that were previously lacking or inadequate.

(i) Arguments against lump sum payments

9.90 Another reason why the Commission propose periodic payments over lump sum payments is to reduce the possibility of money paid for compensation falling short, or the recipient of the money being over-compensated; the money being squandered or not properly invested; or the recipient “double-dipping” by utilising public health services in

¹¹⁸ IP 33 respondent: As pointed out by SAMA, a discount rate for future care will be irrelevant if periodic payments are introduced [SAMA 8].

spite of receiving money for private health care. Few people who suddenly receive a large sum of money have the expertise to invest the money properly or wisely. There has also been instances of state attorneys and private attorneys colluding to settle medical negligence claims for large amounts. If no more huge lump sum payments are going to be made, the incentive to commit corruption in this regard will at least be removed.¹¹⁹

9.91 Patients often continue using public healthcare, either by choice or because no private health services or only limited private health services are available in the area. If the patient dies sooner than the predicted life expectancy, the money is lost. If the patient lives longer than expected, the provision made for the patient is inadequate. A very important consideration, which is seldom raised during court proceedings, is the actual availability of specialised private health care services where the patient lives. Expert evidence about specialised private health care, therapy and rehabilitation usually fail to mention that these services are mostly only available in metropolitan areas, not small towns and rural communities.

9.92 The unfortunate event of a beneficiary of a huge pay-out passing away at a young age, with the unused millions in his estate devolving upon his mother and grandmother after lengthy and expensive court proceedings, came to light in the case of *Wilsnach NO v TM and others*.¹²⁰ Although one does not begrudge the family inheriting from the deceased child's estate, the money that was intended for his future care is now enriching two persons while being lost to the state. There is a lot of anecdotal evidence of huge compensation awards paid out, only for the money to be squandered by the family of an intended beneficiary, with the intended beneficiary returning to the public health system for services and even receiving a disability grant. This can also happen when the compensation award is placed in trust, partly because there is very little oversight of trusts by government.

¹¹⁹ "SIU uncovers corruption in state attorney's office" *eNCA* (30 June 2020); Kgaugelo Masweneng "Former acting head of state attorney's office and Eastern Cape lawyer in court on fraud charge" *Sowetan Live* (10 April 2021); "SIU welcomes prosecution of Umthatha State Attorney official, lawyer" *South African Government News Agency* (12 April 2021); Lubabalo Ngcukana "SIU closes in on lawyers, health workers and officials over dodgy medical claims" *City Press* (16 May 2021).

¹²⁰ *Wilsnach NO v TM and others* [2020] JOL 49017 (GP).

(j) *Argument against trusts*

9.93 A number of respondents suggested that lump sum payments should still be the norm for compensation payments, but that a trust should be set up into which the amount of compensation should be paid.¹²¹ The proponents of trusts further suggest that there should be top-up and claw-back provisions to allow for additional payments should there be a shortfall, or reclaiming the money should the trust beneficiary pass away with money left in the trust. Using trusts for compensation payments will still require the state to make huge pay-outs, thus the trust model will not help the state to retain money in the public health sector.

9.94 The success of claw-back provisions is not guaranteed, given that the state might not even know when a beneficiary passes away. Trustees who are family members are just as likely to squander the money as in the instances when money is paid directly to a beneficiary's guardian. Professional persons or legal entities appointed as trustees have to be remunerated for their services. **For these reasons the Commission do not support the creation of trusts for administering large lump sum compensation payments, unless there are truly exceptional circumstances to justify the creation of a trust.**

(k) *Delivery of quality health services*

9.95 A stern word of caution is warranted here: if the state does not get its house in order with regard to the delivery of quality health services, these measures will be challenged and could be overturned. Proposing legislative amendments to make periodic payments and the delivery of health services in public health establishments the norm, does not mean that the state is absolved from the responsibility of taking serious action to address the problems in the public health sector. If the courts are not convinced that the state can deliver services of an acceptable standard, the proposals made in this paper will be challenged and the situation will be worse than before.

¹²¹ IP 33 respondents: EthiQal; Joseph's Inc; Mediclinic; Netcare; RiskHouse Africa. SAMLA support setting up trusts for minors or mentally incapacitated person who are awarded large sums of money as compensation [SAMLA 58].

11 Birth defects and serious permanent injuries

9.96 Dealing with birth defects and serious permanent injuries is one of the biggest challenges in the current climate. Birth defects and serious permanent injuries are often the result of a patient safety incident or an avoidable adverse event. Children born with cerebral palsy is a particular challenge, as CP babies give rise to the highest value claims, make up the bulk of provinces' contingent liability for medico-legal claims and generally form the greater part of the compensation claims paid out by provinces.

9.97 The main reason for the high value of CP compensation claims is the future care component, since provision must be made for care, rehabilitation, treatment, therapy, care givers and so forth for several decades into the future. Other types of permanent serious injury that require long-term future health services are usually of a neurological nature, therefore the underlying principles applicable to long-term future care and treatment of CP babies could also be applied to other patients requiring long-term future care and treatment.

9.98 As discussed in more detail in Chapter 5 above (see pars 5.89–5.106), there is a common misunderstanding that cerebral palsy is mostly caused by birth trauma. Medical negligence claims for babies with CP are often successful on the basis that the baby suffers from CP because the mother was not adequately monitored during labour and delivery by caesarean section was not performed in time, resulting in brain damage to the baby due to insufficient oxygen during the birth process. The reality is that only between 10 and 14% of CP incidences can be ascribed to birth trauma.¹²² The prevalent scientific view is that CP mostly develop during pregnancy as a result of a series of interrelated factors and events.

9.99 The prevalence of CP has also remained stable over the past 50 odd years at about 2 to 2.5 births per 1000, in spite thereof that the rate of caesarean deliveries has increased steadily over time and are now six times higher than in the 1960s.¹²³ When considering the research discussed in Chapter 5, one can only speculate on the number

¹²² Ismail Borat et al "Cerebral palsy and criteria implicating intrapartum hypoxia in neonatal encephalopathy – an obstetric perspective for the South African setting" *SAMJ* (March 2021) 111:3 (Suppl 1278.) 277–279 at 277.

¹²³ Alastair H. MacLennan, Suzanna C. Thompson & Jozef Gecz "Cerebral palsy: causes, pathways, and the role of genetic variants" *American Journal of Obstetrics & Gynecology* (December 2015) 779–788 at 781.

of findings made against provincial DOHs or cases settled because of incomplete evidence placed before the court, incomplete health records or applying the wrong science. The adverse of the state being held liable or settling even when not really at fault, are the many probable instances of CP babies that do not receive proper care, rehabilitation or treatment because they never manage to obtain legal advice, or they did not have a winnable case.

9.100 Many people are opposed to law reform, in particular law reform aimed at doing away with the huge lump sum payments that are depleting the provinces' budgets and increasingly impacting upon their ability to deliver services.¹²⁴ Opponents voice concerns about limiting plaintiffs' constitutional right of access to health services and freedom of choice with regard to choosing a health care provider, and that the delivery of services rather than the payment of money for injuries suffered takes rights away from claimants in medical negligence cases.¹²⁵ The Constitution, however, does not specify private health services or mention anything about choosing a particular health care practitioner.

9.101 It must be emphasized again that the more money is taken from the public health sector to benefit a handful of successful claimants, the less money is available to improve services for the benefit of all users of public health services. It is the members of the poorest communities who have no option but to use public health services that are most affected by deteriorating health services standards due to depleted budgets. The solution to addressing the problems in the public health sector does not reside in making huge lump sum payments to a lucky few claimants. The same principles apply to any patient suffering a permanent injury and requiring long-term care, rehabilitation and treatment.

12 Other matters

9.102 The nearly 50 respondents that made presentations and submitted comments on Issue Paper 33 raised several concerns and made a number of proposals about a range of issues. The parliamentary public hearing process on the State Liability Amendment Bill 2018 also evoked a number of presentations about the state of public health services

¹²⁴ IP 33 respondents opposed to law reform: Friedman & Associates; Joseph's Inc; General Council of the Bar; Mullins.

¹²⁵ "Briefing on State Liability Amendment Bill by DOJ&CD" Minutes of Portfolio Committee on Health (26 January 2021).

in SA. In response to the some of the submissions received, the Commission propose the measures set out below.

(a) Medical practitioners and nurses

9.103 Some respondents express disquiet over the professionalism, attitude, skills and training of health practitioners, but several respondents are particularly apprehensive about the training, qualifications, skills, professionalism and attitude of nurses, as well as shortages of nurses.¹²⁶ **The Commission propose that the training and qualifications of nurses should be reviewed to reconsider the curriculum, practical training, quality of training and so forth.** Adequate nursing numbers should be determined and every effort made to fill posts, supported by campaigns to encourage people to enter the profession. Interventions are urgently required to address nursing attitudes, including monitoring nurses and holding nurses accountable when necessary. Administrative and managerial tasks performed by nurses should be assigned to other staff as far as possible, freeing nurses to focus on the care of patients.¹²⁷

9.104 Another important matter is senior oversight, which is hampered by factors such as the administrative burden on nursing managers, and the historical fact that medical staff are limited in how much authority they can bring to bear on nurses. This is particularly an issue at nurse-run obstetric units where there is virtually no day-to-day nursing or medical oversight. Lastly, the reasons for the closure of state-run nursing colleges were never understood, but it might be useful to consider re-establishing some of these facilities.

(b) Contingency fees

9.105 A substantial number of comments were received about contingency fees. Some support contingency fees as a critical method to allow indigent people access to legal advice and representation;¹²⁸ others are of the view that the promise of a contingency

¹²⁶ Aikman 54; Maphumulo & Bengu (unpaged). IP 33 respondents: GunnClark; Kaseke; Larsen; Mediclinic; Mullins; OTASA.

¹²⁷ See in general: AG Mphephu *Effects of nursing work loads on patients safety in the selected public hospitals in Vhembe District of Limpopo Province, South Africa* (unpublished MCur dissertation, University of Venda 2019).

¹²⁸ IP 33 respondents: EC Treasury; KZN DOH; National Treasury; Bowmans; Dalmeyer; Discovery Health; EthiQal; Friedman & Associates; General Council of the Bar; GunnClark; Mullins; Netcare; OTASA; Paul du Plessis Attorneys; Ric Martin Attorneys; SAMA; SAMLA; SAPPF; Scharf.

fee serves as an incentive for unethical and even illegal conduct by legal practitioners.¹²⁹ Some want to retain contingency fees; some suggest that the Contingency Fees Act 66 of 1997 (CFA) is being abused and that the Act should be reviewed and amended, or that more oversight is required;¹³⁰ others want contingency fees to be banned or disallowed.¹³¹ The new trend of “litigation funding” should also receive attention (see paragraph 5.87).

9.106 The Commission support contingency fees since it serves as a powerful incentive for legal practitioners to represent claimants who would otherwise be unable to afford legal presentation.¹³² It is unfortunately also true that the promise of a potentially huge contingency fee serves to motivate some legal practitioners to unethical and even illegal conduct. There surely is a limit to the work required to prepare for a court case, which should not depend on the size of the compensation award. **The Commission therefore propose an amendment of the CFA to provide for a sliding scale for determining contingency fees in relation to the size of a compensation award.** This suggestion was put forward by the State Attorney, Pretoria in their comments on IP 33.¹³³

(c) Good Samaritan laws

9.107 South Africa does not have a “Good Samaritan” law that obliges a doctor to render assistance in an emergency, while exempting the doctor from liability for negligence. In South African law this type of situation is addressed through the common law, the Constitution, case law and HPCSA guidelines. Following on a suggestion made by the advisory committee for this project, **the Commission proposes the introduction of a “Good Samaritan” law, exempting a medical practitioner acting in an emergency situation from negligence claims as long as the conditions for acting as a “good Samaritan” are complied with.**

¹²⁹ IP 33 respondent: Ric Martin Inc.

¹³⁰ Oosthuizen & Carstens *Malpractice* 283; Wessels 8; IP 33 respondents: EC Treasury; KZN DOH; National Treasury; Bowmans; Dalmeyer; Discovery Health; EthiQal; GunnClark; Netcare; OTASA; Ric Martin Attorneys; SAMA; SAMLA; SAPPF; Scharf.

¹³¹ IP 33 respondent: Mallory. Ric Martin Inc provides detailed explanations of the negative effect of contingency fees, but conclude by proposing amendments to the CFA and a different basis for determining fees.

¹³² The Contingency Fees Act 66 of 1997 was adopted as a result of an investigation conducted by the SALRC as Project 93: Speculative and contingency fees.

¹³³ IP 33 respondent: State Attorney Pretoria 7. SAMLA suggest that contingency fees should be reduced to 12.5% [SAMLA 18].

9.108 In the South African law of delict there generally is no liability for an omission, unless, in the particular circumstances, there is a legal duty to act. This was established by the Appellate Division (now the Supreme Court of Appeal) in the 1975 case of *Minister van Polisie v Ewels*.¹³⁴ It follows therefore that a medical practitioner who fails to act when the circumstances dictate that there is a legal duty upon him or her to do something, is guilty of negligence if he or she then chooses to do nothing. There is general consensus about the current state of the law in South Africa: if a medical professional comes across an emergency, he or she should render assistance, unless there is a likelihood of personal danger or injury; he or she is incapable of assisting; or there is another qualified person at the scene already.¹³⁵ Section 27(3) of the Constitution is another important consideration, stating that nobody may be refused emergency medical treatment.

(d) Amendment of ILPACOS Act 40 of 2002

9.109 The State Attorney Pretoria highlighted the problems encountered by that office:

- 1) No acknowledgement from the health establishment concerned that litigation has been instituted.
- 2) Not getting instructions from the relevant department or hospital.
- 3) Struggling to obtain the health records of the patient.
- 4) Identifying witnesses and ascertaining their availability and whereabouts at an early stage.

9.110 The State Attorney, Pretoria suggested an amendment of the Institution of Legal Proceedings against certain Organs of State Act 40 of 2002 (ILPACOS Act) to make provision for service (apart from service to the head of the provincial DOH) to the CEO of the state health establishment where the cause of action arose. The CEO should then provide the following information to the head of department and the relevant office of the State Attorney:

- 1) whether the incident indeed occurred at the specific hospital;
- 2) whether the hospital records are available;
- 3) regarding the medical practitioners and nursing personnel involved:

¹³⁴ *Minister van Polisie v Ewels* 1975 (3) SA 590 (A).

¹³⁵ Strauss 90; Carstens & Pearmain 173; David McQuoid-Mason "When are doctors legally obliged to stop and render assistance to injured persons at road accidents?" *SA Medical Journal* Vol. 106 6 (June 2016) 575–577 at 576; John Saner *Medical Malpractice in South Africa* (LexisNexis 2018) 4-3; Health Professions Council of South Africa *Guidelines for Good Practice in the Health Care Professions* (undated) par 5.1.13.

- a) identifying the medical practitioners and nursing staff;
- b) indicating whether they are still employed at the health establishment;
- c) if no longer employed at the hospital, to which hospital they have been transferred
- d) their contact information, if known.

9.111 A copy of the hospital record should be furnished to the State Attorney's office together with this report. The intention of such an amendment would be to ensure that the hospital where the cause of action arose and which in any event is the relevant institution to furnish the information required, does so without further avail.

9.112 **The Commission propose that the Legal Proceedings Against Certain Organs of State Act 40 of 2002 be amended where appropriate as proposed by the State Attorney, Pretoria.** However, some of the proposals put forward by the State Attorney, Pretoria might be better placed as part of the national strategy that must be developed and followed for dealing with medico-legal claims.

(e) HPCSA and SANC

9.113 Respondents raised concerns about the HPCSA, indicating that the Council is not functioning optimally and is not always fulfilling their functions with regard to health practitioners, or that their functions should be expanded to improve the quality of care to patients and to deal with patient complaints.¹³⁶ It is unclear whether the matters raised in the 2015 *Report of the Ministerial Task Team (MTT) to Investigate Allegations of Administrative Irregularities, Mismanagement and Poor Governance at the Health Professions Council of South Africa (HPCSA): A Case of Multi-System Failure* (the Mayosi Report) have been fully implemented. The length of time it is taking the South African Nursing Council (SANC) to review the training and qualifications of nurses is also a matter of concern. OTASA suggested that the functions of the HPCSA and other professional boards should be expanded to ensure quality of care to patients.¹³⁷ **The Commission propose that the Minister of Health and the national DOH should ensure that the concerns about the HPCSA and the SANC are addressed.**

¹³⁶ IP 33 respondents: Life Healthcare; OTASA; SAMA; SAPPF.

¹³⁷ IP 33 respondent: OTASA 8.

(f) Collaboration with private health sector

9.114 Several private entities, hospital groups, medical professionals, insurance companies and so forth offered to assist the public health sector. Most of the offers for assistance made by persons and organisations in the private health sector appear to be well-intentioned, intended to aid the public health sector to benefit the health sector as a whole. Many private sector respondents that submitted comments on IP 33 indicated their willingness to assist and detailed how they can help.¹³⁸ Several organisations such as the SA Medical Association (SAMA), SA Medico-Legal Association (SAMLA), SA Society of Obstetricians and Gynaecologists (SASOG) and academic institutions have hosted conferences and workshops at their own expense to come up with solutions to address the medico-legal crisis in South Africa.

9.115 The President hosted a Presidential Health Summit in October 2018, which was followed by a report and eventually culminated in the Presidential Health Summit 2018 Compact, entered into by government and private health organisations, all committing to cooperate to resolve the crisis in the SA health sector. In the executive summary the cooperation envisaged between the public and private sectors is specifically mentioned:¹³⁹

What is exciting is the realisation and acceptance by all the participants of the notion that the health system can never be fixed by the Health Department alone – it requires a focused, practical and collaborative approach. The government and participating stakeholders continue to demonstrate their commitment to improving the health system to bring new dawn with a desire to see not only a halt in the deterioration of the health system but a massive improvement in its functioning for the benefit of all South Africans. The stakeholders are committed to working together for the next five years to improve the health system.

9.116 Yet, like all the numerous reports, policies, guidelines, declarations, proposals and other documents that preceded the Presidential Health Summit Compact, it is not clear what tangible outcomes the summit and declaration have eventually achieved. The Commission therefore proposes – before yet another report is commissioned, another Ministerial Task Team or Ministerial Advisory Committee is appointed, another summit,

¹³⁸ IP 33 respondent: Netcare.

¹³⁹ South African Government *Presidential Health Summit 2018 Compact: Strengthening the South African health system towards an integrated and unified health system* (25 July 2019) 19 [PHS Compact (2019)]

conference or workshop is held – that the work that has been done already be fully implemented. It is not known why proposals made had not been implemented. Despite all that has been said, the goodwill and offers of assistance and cooperation from the private health sector have not been taken up in full. A vast amount of work has been done, but all this work is still mostly on paper – it has not been translated into action. It is unclear why.

13 Ordinary negligence vs gross negligence

9.117 Adv JH de Waal SC put forward a proposal that common law claims for medical negligence should be restricted to grossly negligent medical treatment, “motivated by the crisis in which public health establishments find themselves in”.¹⁴⁰ He refers to the drastic increase in the scale of litigation over the past 10 years and the expectation that it will increase. He expresses concern over the affordability of the current system and the impact of litigation on medical practitioners in the public sector.¹⁴¹

(a) Case law

9.118 Adv De Waal cites the 2011 Constitutional Court judgment in *Law Society of South Africa and Others v Minister for Transport and Another*,¹⁴² which dealt with amendments to the Road Accident Fund Act 56 of 1996 (RAF Act). The appellants (applicants) challenged the constitutional validity of certain provisions of the Road Accident Fund Amendment Act 19 of 2005. The matter pertained to the following legislative provisions:

- Section 17(4)(c) of the RAF Act, which imposes limits on claims for loss of income or support. Section 17 of the RAF Act, dealing with the liability of the RAF and the agents of the RAF, was substituted by section 6 of the RAF Amendment Act, 2005.
- Section 21 of the RAF Act, which abolishes the common law right to a claim for compensation for loss or damage resulting from bodily injury or death due to

¹⁴⁰ JH de Waal *Memorandum: In re: Draft discussion paper: Project 141: Medico-Legal Claims* Comment on draft discussion paper on Project 141: Medico-Legal Claims (30 June 2021). Adv De Waal is a member of the South African Law Reform Commission.

¹⁴¹ De Waal 2.

¹⁴² *Law Society of South Africa and Others v Minister for Transport and Another* 2011 (1) SA 400 (CC).

driving a motor vehicle, except for instances where the fund (or an agent) is unable to pay any compensation.

- Regulation 5(1), as prescribed under section 17(4B)(a), determining tariffs for health services.

9.119 The Court acknowledged assurances put forward by the Minister of Transport and the RAF that the limitations introduced by the RAF Amendment Act are intended to be a temporary measure. Adv De Waal contends that, notwithstanding the supposed transient nature of the scheme introduced by the Amendment Act, the Constitutional Court recognised the principle that a common law delictual claim may be abolished:¹⁴³

[T]he Constitutional Court has accepted that a victim's common law delictual claim against a wrongdoer may be abolished without replacing same with an equivalent statutory claim against the State. ... The important principle that was established though is that a common law claim may be abolished or limited, even one for bodily injury or death of a breadwinner and that there is no duty on the State to replace that claim with a compensation scheme that guarantees an equal compensation or benefit to the victim. The State's duty under s 12 of the Bill of Rights to protect a person's right to bodily and psychological integrity does not necessarily translate into a right to claim damages from the wrongdoer.

9.120 Adv De Waal holds the view that the Constitutional Court accepted the principle that a common law claim may be abolished by legislation. The Court, however, did reiterate the context within which the Court reached this conclusion:¹⁴⁴

We must keep in mind not only the government's intermediate purpose in enacting this legislation, but also its long-term objective. The primary and ultimate mission of the Fund is to render a fair, self-funding, viable and more effective social security service to victims of motor accidents. The new scheme is a significant step in that direction. On all the evidence it is clear, and the Minister and the Fund assure us, that the ideal legislative arrangement should not require fault as a prerequisite for a road accident victim to be entitled to compensation for loss arising from bodily injury or death caused by the driving of a motor vehicle. Therefore, the abolition of the common-law claim is a necessary and rational part of an interim scheme whose primary thrust is to achieve financial viability and a more effective and equitable platform for delivery of social security services.

¹⁴³ De Waal 3.

¹⁴⁴ *Law Society* pars 54 & 55.

On balance, I am satisfied that the abolition of the common-law claim is rationally related to the legitimate government purpose to make the Fund financially viable and its compensation scheme equitable.

9.121 Although the RAF Amendment Act abolished the common law claim against a driver or owner of a motor vehicle, it substituted this particular common law claim with a statutory claim against the RAF. The statutory claim against the RAF is still a delictual claim and proving ordinary negligence, not gross negligence, remains a requirement in terms of section 17(1) of the RAF Act. The ultimate objective is stated to be no-fault compensation for claims, in which case proving negligence will no longer be a requirement as only causality will have to be proved (apart from other statutory conditions that may have to be complied with). Abolishing a common law claim that requires proving ordinary negligence in favour of a system more detrimental to health services users due to the more onerous burden of proving gross negligence might not pass constitutional muster on the grounds applied in the *Law Society* case.

9.122 *Adv De Waal* also discusses the matter of *Afrox Healthcare Bpk v Strydom*,¹⁴⁵ where the Supreme Court of Appeal in 2002 had to consider whether a private hospital could exclude liability for negligence by agreement between the parties. The SCA finds that it is not contrary to public policy to give effect to such an exclusion. Drawing a conclusion from the *Afrox* case, *Adv De Waal* expresses the opinion that:¹⁴⁶

[I]f a private hospital may exclude common law liability for negligent medical treatment by contract, then it should be possible for the legislature to exclude the liability of public health establishment for negligence by way of legislation.

9.123 *Adv De Waal* proposes introducing a general law amendment or amending the National Health Act 2003 to exclude a health care provider in a public health establishment from liability for an act or omission unless gross liability or intentional wrongdoing is proven.

¹⁴⁵ *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA).

¹⁴⁶ *De Waal* 4.

9.124 McQuoid-Mason argues that the Consumer Protection Act of 2008 superseded the effect of the *Afrox* case.¹⁴⁷ The CPA defines the expressions “consumer”, “supplier” and “service”. It is generally accepted that a health services user is included under the definition of “consumer”, that a medical practitioner is included under the definition of “supplier”, and that health services are included under the definition of “service”.¹⁴⁸ Applied to the health services sector, a health services user/ patient (consumer) enters into an agreement with a health establishment/ hospital or health care provider/ medical practitioner (supplier) for the delivery of health services (service). When a consumer and the supplier of a service enters into an agreement, sections 48 and 49 in Part G of the CPA are of particular importance. Part G pertains to the “Right to fair, just and reasonable terms and conditions”. Section 48 deals with unfair, unreasonable or unjust contract terms, while section 49 provides for circumstances when a consumer’s attention must be drawn to terms and conditions in agreements.

9.125 McQuoid-Mason is of the view that the exclusion clause that engaged the court in the *Afrox* case would have been pronounced unfair, unreasonable or unjust in terms of section 48(2)(a), (b) and (d) of the CPA, and that the court would have invalidated the agreement in terms of section 52(3) of the CPA.¹⁴⁹ According to McQuoid-Mason, the provisions in section 48(2) paragraphs (a), (b) and (d) that would be relevant here are the following:

- The term or condition of the agreement is excessively one-sided in favour of someone other than the consumer.
- The terms of the transaction or agreement are so adverse to the consumer as to be inequitable.
- The transaction or agreement was subject to a term, condition or notice that is unfair, unreasonable, unjust or unconscionable, or the fact, nature and effect of that term, condition or notice was not drawn to the attention of the consumer in the manner required by section 48.

¹⁴⁷ David McQuoid-Mason “Hospital exclusion clauses limiting liability for medical malpractice resulting in death or physical or psychological injury: What is the effect of the Consumer Protection Act?” *SAJBL* December 2012 Vol 5:2 65–68 at 67 [McQuoid-Mason (2012)].

¹⁴⁸ Department of Trade and Industry *Consumer Protection Act: Your Guide to Consumer Rights & How to Protect Them* (2011) 6; M Nöthling Slabbert & Michael S Pepper “The Consumer Protection Act: No-fault liability of health care providers” *SAMJ* 2011 Vol 101:11 800-801 at 800; Moore Stephens *Consumer Protection Act Guide* (2018) accessed 21 July 2021 [moorestephens.com/MediaLibsAndFiles/media/southafricaweb.moorestephens.com/Guides-2018/MS-Consumer-Protection-Act-Guide.pdf](https://www.moorestephens.com/MediaLibsAndFiles/media/southafricaweb.moorestephens.com/Guides-2018/MS-Consumer-Protection-Act-Guide.pdf).

¹⁴⁹ McQuoid-Mason (2012) 67.

9.126 McQuoid-Mason further contends that the exclusion clause at issue in the *Afrox* case would have required compliance with section 49 of the CPA in that the consumer's attention would have to be drawn to the provision.¹⁵⁰ Section 49 provides as follows:

- (1) Any notice to consumers or provision of a consumer agreement that purports to –
- (a) limit in any way the risk or liability of the supplier or any other person;
 - (b) constitute an assumption of risk or liability by the consumer;
 - (c) impose an obligation on the consumer to indemnify the supplier or any other person for any cause; or
 - (d) be an acknowledgement of any fact by the consumer,
- must be drawn to the attention of the consumer in a manner and form that satisfies the formal requirements of subsections (3) to (5).

9.127 McQuoid-Mason's view that the CPA has superseded the *Afrox* case is supported. However, Brand JA in *Afrox* recognised inequality of bargaining power as a relevant consideration when parties enter into an agreement.¹⁵¹ The Constitutional Court, in the matter of *Barkhuizen v Napier*, endorsed the principle enunciated in the *Afrox* case:¹⁵²

Although the court found ultimately that on the facts there was no evidence of an inequality of bargaining power, this does not detract from the principle enunciated in that case, namely, that the relative situation of the contracting parties is a relevant consideration in determining whether a contractual term is contrary to public policy. I endorse this principle. This is an important principle in a society as unequal as ours.

9.128 The CPA acknowledges bargaining power as one of the issues that the court must consider when adjudicating a transaction or agreement. Section 52(2)(b) requires the court to consider, among others, "the nature of the parties to that transaction or agreement, their relationship to each other and their relative capacity, education, experience, sophistication and bargaining position".

¹⁵⁰ McQuoid-Mason (2012) 67.

¹⁵¹ *Afrox Healthcare Bpk v Strydom* par 12.

¹⁵² *Barkhuizen v Napier* CCT 72/05 [2007] ZACC 5 par 59.

9.129 Ngcobo J made another important observation in *Barkhuizen* about the validity of contracts:¹⁵³

All law, including the common law of contract, is now subject to constitutional control. The validity of all law depends on their consistency with the provisions of the Constitution and the values that underlie our Constitution. The application of the principle *pacta sunt servanda* [agreements must be kept] is, therefore, subject to constitutional control.

9.130 In view of the effect of the CPA as explained by McQuoid-Mason and the statements made by the Constitutional Court in *Barkhuizen*, it is contended that *Afrox* does not provide justification for introducing legislation that limits the state's liability for medical negligence to gross negligence or intentional wrongdoing. It is doubtful that legislation of this nature will pass constitutional muster in view of constitutional obligations such as the right to dignity, to be free from all forms of violence, the right to freedom and security of the person and the right of access to health care services.

(b) International law

9.131 The researcher conducted research on legal systems relevant to medical liability in other countries. Apart from aspects of medical negligence claims in Italy, there are not any modern systems that limit liability for medical negligence to gross negligence or intentional wrongdoing in delict or in tort. The no-fault compensation systems for medical injury prevalent in New Zealand and the Nordic countries are discussed in Chapter 7, as are the birth injury no-fault compensation systems of Japan and the states of Florida and Virginia in the USA. Apart from legislation in Florida and Virginia for no-fault claims for birth injuries, all other USA states require proof of ordinary negligence for medical malpractice claims.

9.132 The common law systems of Australia, Canada and the United Kingdom all require proof of ordinary negligence for medical injury, while the hybrid civil law/common law system of Scotland has the same requirement. The liability system of Austria (a civil law system) is based on tort, with the exception of regional compensation funds for hospitals that were initiated by a 2001 federal law.¹⁵⁴ The Austrian system requires

¹⁵³ *Barkhuizen v Napier* par 15.

¹⁵⁴ The regional compensation funds in Austria, referred to as *Patientenentschädigungsfonds*, are intended to assist claimants in matters where liability is difficult to establish, for example when it is difficult to prove negligence or causality [Bernhard A Koch "Medical Malpractice in Austria" in Ken Oliphant & Richard W Wright *Medical Malpractice and Compensation in Global Perspective* (De Gruyter, 2013) 7–33 at 31].

ordinary negligence for medical liability.¹⁵⁵ In Poland civil liability for medical malpractice is also based on fault, usually negligence, and ordinary negligence at that.¹⁵⁶ Germany mostly applies contract law to medical negligence claims after amendments to the German civil code, but proof of fault is still required, with ordinary negligence being the norm.¹⁵⁷

9.133 France and Italy (Italy's Civil Code of 1942 was based on the French Napoleonic Code of 1804) were the only countries that required proof of gross negligence for compensation for medical liability.¹⁵⁸ In France this rule applied until 1992, when the gross negligence requirement for finding public health services liable for medical liability was changed to ordinary negligence.¹⁵⁹ Law 2002-203 of 4 March 2002 (the French Patients' Rights Law) completely overhauled the French legal system in respect of medical negligence claims as discussed in Chapter 7.

9.134 Medical negligence claims in Italy is mostly brought on the basis of contractual liability, and gross negligence is the measure in certain instances as stipulated in article 2236 of the Italian Civil Code. The basis for compensation for medical liability is article 2043 c.c, entitled "Compensation for unlawful acts". Article 2043 c.c states that "Any fraudulent, malicious, or negligent act that causes an unjustified injury to others obliges the person who has committed the act to pay damages".¹⁶⁰ Coggiola translates and explains article 2236 c.c, which applies to contractual medical liability:¹⁶¹

"If the professional services involve the resolution of technical problems of particular difficulty, the person who renders such services is not liable in damages, except in case of fraud, malice or gross negligence". This rule, which clearly limits the liability of the party to cases of malice or gross negligence, is aimed at encouraging the undertaking of risky or difficult commitments that have also a social function such as, in our cases, risky

¹⁵⁵ Koch in Oliphant & Wright 17.

¹⁵⁶ Kinga Bączyk-Roswadowska "Medical Malpractice and Compensation in Poland" in Oliphant & Wright 327–375 at 344.

¹⁵⁷ Marc S Stauch "Medical Malpractice and Compensation in Germany" in Oliphant & Wright 179–209 at 184 & 185.

¹⁵⁸ Nadia Coggiola "Medical Liability Law in Italy" [*Journal du Droit de la Santé et de l'Assurance - Maladie \(JDSAM\) 2019/2 \(No 23\)*](#) 45–53 pars 1 & 2.

¹⁵⁹ G'sell Macrez in Oliphant & Wright 136.

¹⁶⁰ Coggiola par 27.

¹⁶¹ Coggiola par 20.

major surgical operations or complex diagnosis, as the liability is excluded in cases of ordinary or slight negligence.

9.135 In some instances judges applied article 2236 c.c (that is applicable to contractual liability) to cases about medical tortious liability, “providing that whenever a professional is required to render a performance involving the solution of technical problems of special difficulty, his liability for non-performance shall be limited to cases where he acted with gross negligence or malice.”¹⁶² Under Italian legislation and case law it is possible to claim for compensation based on contractual and non-contractual liability in the same action. For this reason the contractual rules concerning proof were often applied to contractual and non-contractual sources where both types of source were of relevance in a particular matter.¹⁶³

9.136 The Italian provision and the application thereof in Italian case law from time to time as discussed above, however, is not a system that could be replicated in South Africa.

¹⁶² Coggiola par 31.

¹⁶³ Coggiola par 35. An example of such a scenario would be were a claimant is instituting action against the hospital where an operation was performed on the basis of contractual liability, while instituting action against the independent surgeon (i e not employed by the hospital), who performed the operation, on the basis of tortious liability.

CHAPTER 10: COMMENTS ON ISSUE PAPER 33

The respondents listed below commented on Issue Paper 33. A short synopsis of each respondent's submission is provided.

	Respondent [Sector]	Comment
1.	African Centre for the Constructive Resolution of Disputes (ACCORD) [Alternative Dispute Resolution, Durban]	<ul style="list-style-type: none"> • Mediation, especially the advantages of mediation. • International experience of mediation.
2.	Bowmans Attorneys [Attorneys, Johannesburg (HQ), Cape Town, Durban]	<ul style="list-style-type: none"> • Comments about contingency fees. • No meaningful way to hold legal practitioner to account for assessment of client's prospects. • Possible adverse costs order not really a deterrent. • Measures proposed to prevent abuse of contingency fees.
3.	Camargue [Insurance Risk Management Johannesburg]	<ul style="list-style-type: none"> • Reasons for increased medico-legal litigation: <ul style="list-style-type: none"> ○ increase in consumer awareness; ○ public marketing campaigns by legal fraternity; ○ contingency fees. • Supports considerations and proposals put forward in March 2017 Medical Malpractice Workshop. • Abuse of / non-compliance with CFA. • Propose capping of claims. • Payment of future damages. • Proper construction and storage of medical records.
4.	Clinix Health Group [Health care group (hospitals) Johannesburg (HQ)]	<ul style="list-style-type: none"> • Serves previously disadvantaged communities. • Express serious concerns about abuse of system by legal practitioners instituting legal proceedings for frivolous or unsubstantiated claims, or abandoning claims after a while. Such proceedings have a severe financial impact on defendants, who incur significant expenses to prepare for defending claims that eventually never go to trial. • Criticise some existing Uniform Rules of Courts, specifically rules 36(9)(b) and 37. • Support amendment of court rules and practice directives. • Suggest amendments to Court Rules to compel plaintiffs to furnish defendants with medico-legal and other expert reports that will confirm the allegations of their attorneys from the outset when they present the claim. • Support capping of payments, certificate of merit, review of prescription. • Propose medical reports in support of a certificate of merit. • Suggest treatment of claimants through proposed NHI. • Propose improved monitoring of healthcare providers.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • Does not support mediation. • Highlight problems with indemnity insurance due to high risk – refer to s 46 of National Health Act, 2003. • Highlight concerns about foreign claims values. • Other proposals: Revisit application of <i>res ipsa loquitur</i> concept; consider alternatives to monetary compensation; assist plaintiffs through social justice and the grants system. • Amend High Court Rules so that summons becomes stale after a particular period: for example, plaintiff is barred from proceeding with a claim after a year of inaction – similar to situation in magistrate’s courts. As a safeguard give court the discretion to extend the period on good cause shown, keeping the interests of both parties in mind.
5.	Dalmeyer, Paul Dr [Medical practitioner (obstetrician / gynaecologist) Stellenbosch]	<p><u>Reasons for litigation</u></p> <ul style="list-style-type: none"> • current litigious and biased legal system; • decline in standard of medical training. <p><u>Possible interventions</u></p> <ul style="list-style-type: none"> • parties must “keep talking” and mediate a resolution; • peer review system; • review medical training model to improve the standard of clinicians. <p><u>Comments</u></p> <ul style="list-style-type: none"> • Traditional common law system is outdated and not appropriate for medico-legal disputes. • Strong support for alternative dispute resolution, especially mediation. • Supports peer review, amendment of consent forms, “certificate of need” / certificate of merit. • Criticises contingency fees, system of legal representation, touting, double dipping. • Dissatisfaction with prescription periods. • Refers to SASOG programme (developed over two years), which addresses many of the issues raised in par 6.4 of IP 33. • Propose that a single expert witness report be compiled by three unbiased experts (chosen on merit by the SASOG council). The experts chosen will be by consensus of the opposing parties seeking resolution. Experts may not be chosen by a legal representative or an insurer. • Positive about structured settlements.
6.	Discovery Health [Medical aid scheme]	<ul style="list-style-type: none"> • Support declaration flowing from March 2015 Medico-Legal Summit. • Ensure continuous and systematic improvements in patient care. • Suggest a broad approach to monitoring and measuring care in support of good quality health outcomes. • Further to outcomes, certain processes are also important measures of quality and should be included in assessing quality of care performance.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • Maintain staffing and infrastructure at adequate levels. • Planning is required to ensure training of adequate numbers of healthcare professionals. • Ensure that training of medical professionals is of a high standard and that health professionals are up to date with skills and knowledge. • The use of evidence-based clinical treatment protocols is an important component of quality care and provides a reference point for assessing the care given. • An important principle for sustainable quality improvements initiatives is that monitoring and reporting of health information is not used for punitive purposes, but always to motivate the improvement of quality of care. • It is essential to rationalise all data to be collected so that it can be used for multiple purposes e.g. reporting quality data to an external regulator. • Critical of contingency fees system. • Critical of lump sum payments and attendant assumptions regarding life expectancy, future treatment requirements, income loss and future living expenses. • Suggest engagement with the Law Society to determine ethical guidelines with respect to medico-legal claims. • Suggest a facility or district clinical governance team that regularly reviews adverse events and advise on whether a case has merit. • In favour of compulsory mediation. • Propose the establishment of a National Health Compensation Fund (similar to the Compensation Fund for occupational injury and disease), funded by levies from health professionals and health facilities, that makes periodic payments on a no-fault basis to claimants. • Supports establishment of a National Health Tribunal to adjudicate cases. • Review private sector as well, not only public sector. <p>Refer to the six “aims” for improving the delivery of care developed by the Health Care Quality Initiative of the Institute of Medicine. Respondent is of the view that it is meaningful and comprehensive enough to enable long term sustainability of any healthcare system. The six aims are as follows:</p> <ol style="list-style-type: none"> 1) Safe: Avoiding preventable injuries, reducing medical errors. 2) Effective: Providing services based on scientific knowledge (clinical guidelines). 3) Patient-centred: Care that is respectful and responsive to individuals. 4) Efficient: Avoiding wasting time and other resources. 5) Timely: Reducing wait times, improving the practice flow. 6) Equitable: Consistent care regardless of patient characteristics and demographics.

	Respondent [Sector]	Comment
7.	EthiQal [Medial risk protection insurance Risk management Cape Town (HQ)]	<ul style="list-style-type: none"> • Support mandatory mediation for medical malpractice claims. • Introduce rules relating to mediation in the High Court (similar to the rules in the District and Regional Courts). • Refer to perception that contingency fees lead to an abuse of the litigation process, particularly in medical malpractice claims. This resulted in an increase in the number and size of medical malpractice claims. • Amend the CFA to stop abuse of the Act. • The CFA is lacking in that it makes no provision for criminal sanction or civil liability resulting from non-compliance. • CFA has given rise to the possibility of legal practitioners litigating recklessly and in some instances in a vexatious manner. • Propose that filing of affidavits (in terms of section 4 of the CFA) should take place at outset of proceedings to inform all parties that the plaintiff litigant and legal practitioner have entered into a contingency fee arrangement. • Support a certificate of merit in all cases where contingency fees are charged at commencement of proceedings. • Advertisements with the phrase “no win no fee” borders on irresponsible advertising and should be regulated by the Law Society. Claimants are not always informed that they are liable for costs owed to the defendant if the claim for damages is unsuccessful. An adequately worded disclaimer or caveat should be inserted into the advertisement to inform the unsuspecting consumer of the dangers, for example “should you be unsuccessful you may be liable for the legal costs of the defendant”. • Costs of professional indemnity cover for medical practitioners has increased to the extent that many doctors are opting not to specialise in high risk areas or procure indemnity cover. • Support capping of claims, particularly loss of income and medical expenses. • Support payment of damages awards by way of annuities/ structured payments to alleviate the financial burden placed on the medical fraternity and address the uncertainty regarding life expectancy. • Support structured payments /annuity payments – it would allow more certainty when making damages awards, particularly with regard to life expectancy. • Propose trusts with top-up and claw-back provisions. • Take significant steps to procure reliable South African data in terms of which calculations relating to the quantification of medical malpractice claims in South African can be premised. Use information on medical malpractice claims instituted against the state and Home Affairs information on births and deaths to conduct a mortality study which could be used in medical malpractice matters. • Currently there is no legislation that deals with mandatory professional indemnity cover for healthcare professionals.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • Support mandatory professional indemnity cover for healthcare practitioners. • MPS is not subject to regulations pertaining to the short-term insurance industry, which is unfair and prejudicial to domestic insurers. • Providers of professional indemnity for healthcare practitioners must be registered in the Republic of South Africa. • South Africa is in desperate need of a system which promotes expeditious medical malpractice dispute resolution while minimising expenditure.
8.	Expert Opinion and Mediation Committee (EOMC) mandated by SASOG [Professional organisation – medical]	<ul style="list-style-type: none"> • Comment regarding expert witnesses. • Criticise current “single witness” practice. • Propose panels of experts (3 experts).
9.	Friedman & Associates [Attorneys, Durban]	<ul style="list-style-type: none"> • Improve medical care. • Highlight problems with state attorneys. • Support compulsory mediation and arbitration. • Support early settlement of cases, lump sum awards, contingency fees. • Do not support periodic payments, direct access without legal representation. • Propose that awards for future medical expenses be returned upon death of plaintiff.
10.	Gary Austin Attorneys [Attorneys, Benoni]	<ul style="list-style-type: none"> • Reasons for litigation. • Problems with health service delivery – improve health service. • Highlight gross wastage and mismanagement of monies by state during litigation process. • Proposals to improve state’s handling of litigation.
11.	General Council of the Bar [Legal sector Advocates]	<ul style="list-style-type: none"> • Opposed to amendment of common law. • Critical of law reform proposals other than procedural amendments. • Consider deterioration of provincial health care facilities, problems with service delivery and poor administration in public health sector as the root of the problem. • Reasons for increased medico-legal litigation. • Propose procedural amendments, more research into prevalence of ML claims. • Critical of practice of paying for litigation from budget of health care facility concerned. • Refer to UK pre-action procedures. • Support contingency fees. • Does not support capping of damages awards, periodic payments or undertakings in lieu of monetary awards.
12.	GunnClark, Nicky Ms (HPCA) [Health care Cape Town]	<p><u>Reasons for increase in claims</u> More people using health care.</p> <p><u>Reduce litigation</u></p> <ul style="list-style-type: none"> • Address patients’ need for answers when adverse events occur.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • Put worthy claims through mediation. <p><u>Concerns</u></p> <ul style="list-style-type: none"> • Ratio of doctors and nurses to patients, dwindling numbers of health sector workers. • Reluctance to report errors. • How will shortcoming in medical care be revealed? <p><u>Support</u></p> <ul style="list-style-type: none"> • Make attempt at mediation compulsory, fully implement non-legislative solutions. • Common law system: propose measures to improve addressing potential claims. • Amendment of SL Act to provide for structured settlements and periodic payments. • Doctrine of avoidable consequences. • Current prescription system, contingency fees. <p><u>Law reform</u></p> <ul style="list-style-type: none"> • Support all law reform proposals, except establishment of statutory body or tribunal; capping claims; prescribing guidelines for future care, treatment therapy and assistance devices; reduction in contingency fees. • Support compulsory attempt at mediation. <p><u>Existing measures and short-term solutions</u></p> <ul style="list-style-type: none"> • Support implementation of all existing measures and short-term solutions, except appointment of in-house medical experts in provinces. • Co-operation between state attorneys and province: include relevant health care facility. <p><u>Does not support</u> Inquisitorial system.</p> <p><u>Agree</u> Common law “once and for all” rule is problematic.</p> <p><u>Proposals</u></p> <ul style="list-style-type: none"> • Improve complaints system and offer sufficient redress. • Investigate adverse incidents thoroughly and transparently in-house and institute improvements in practice. • Explain errors/adverse events to patients and link clinical governance to complaints procedures and mediation. • Explain “near misses” as well, not only adverse events, to learn from it. • Support Judge Claassen proposal for database of adverse incidents to be held provincially for the NDOH to collate and issue annual reports on, for circulation to medical faculties for use in teaching. <p><u>Other</u> Included article on law reform in USA states of Michigan and Utah.</p>
13.	Gynaecology Management Group Limited (SASOG)	<ul style="list-style-type: none"> • Support legislative reform. • Common law no longer adequate. • Reasons for increased litigation. • Raise concerns about expert witnesses, rise in cerebral palsy claims, advertising by lawyers, indemnity insurance (s46 of

	Respondent [Sector]	Comment
	[Professional organisation – medical Johannesburg (HQ)]	<p>NHA 2003), regulations under section 90(1)(g) of NHA, double-dipping.</p> <ul style="list-style-type: none"> • Does not support a separate budget for litigation, no-fault system. • Highlight problems with RAF in relation to a compensation fund. • Support mediation, pre-screening, statutory tribunal to adjudicate, certificate of merit, capping of claims, structured settlements, periodic payments, review of compensation, standard of future medical care. • Highlight need to also look at following matters: role of Office of Health Standards Compliance, Health Professions Council and health ombud; standardisation of care, registries and health outcomes measures; and peer review mechanisms.
14.	Health Provincial Eastern Cape [Provincial government, Cape Town]	<ul style="list-style-type: none"> • Support compulsory mediation. • Support periodic payments, but questions whether the state has the capacity to manage periodic payments. • Support a designated budget for structured settlements. • Consider establishing a separate entity to deal with periodic payments. • Suggest a trust fund created by the state to manage future clinical care. • Consider reform of “once and for all” rule to enable state to provide health care services in public hospitals or to give undertakings to pay for reasonable costs of care. • This proposal holds additional advantages: it creates an incentive to improve standards in public health care facilities; allows for the benefit of economies of scale (eg for obtaining medicines, medical supplies, assistive devices etc); optimise allocation of scarce health resources; court order directing provision of public health care services ensures right on the part of disabled child to full range of required services and equipment for the rest of the child’s life. • Such child’s affairs should be included under the Guardian’s Fund. • Amend Contingency Fees Act to prevent abuse, require disclosure of a contingency fee agreement, make it possible to recover costs from attorneys for frivolous litigation. • Amend PFMA to provide for separate budgeting for medico-legal claims. • Amend State Liability Act to provide for general damages up to a certain value to be paid as a lump sum, and for rest to be paid as periodic payments and in kind to reduce future estimated costs. • Propose amendments to State Liability Amendment Bill. • Propose that, in addition to usual clinical notes, a “scribbler” accompany medical teams while doing rounds to take notes, or that medical staff be equipped with encrypted devices linked to a central data base to make recordings. • Reasons for increase in M-L claims: opportunists that abuse the system.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • Legislative reform is required. • Recognise the public health care defence and provide for services and supplies in public health care facilities. • Propose amendment to the NHA with regard to the disclosure of health records / information.
15.	Health Provincial Free State [Provincial government, Bloemfontein]	<ul style="list-style-type: none"> • Recognise patient safety as a priority. • Raise concerns about staff shortages, lack of equipment and medication. • Support compulsory mediation, tribunals to determine liability, periodic payments. • Highlight Treasury regulation 12 regarding claiming against responsible individual. • Propose creation of separate insurance (refer to SASRIA). • Refer to Virginia and Florida legislation (USA).
16.	Health provincial Gauteng [Provincial government, Johannesburg]	<ul style="list-style-type: none"> • Propose payment of future medical expenses by rendering the medical services or paying the service providers who will render such services. • Support establishment of a fund for payments.
17.	Health Provincial KwaZulu-Natal [Provincial government, Pietermaritzburg]	<ul style="list-style-type: none"> • Support legislative reform, periodic payments as an alternative to lump sum payments, allow undertakings to be given. • Support capping of claims (non-economic portion), but full redress for injury in an economical manner – find a balance. • Reasons for increase in ML litigation. • Support legislative reform, mediation when appropriate, separate budget for litigation, review of consent forms, certificate of merit (though does not seem to consider it really necessary), periodic payments, and undertakings for medical expenses. • Introduce hospital certificate (undertaking) to limit future medical costs. • Raise concerns about contingency fees, staff shortages in government, systemic failures in hospitals, indemnity insurance. • Highlight need for specialised medico-legal units in government, combining the legal and medical professions. • Doubtful about joint experts. • Propose fund for minors (like Guardian's Fund).
18.	Health Provincial Western Cape [Provincial government, Cape Town]	<ul style="list-style-type: none"> • Support joint experts, structured settlements / periodic payments, but only for high value claims, common law system, separate budget for litigation, undertakings for services where feasible, amendment of State Liability Act. • Opinion: access to justice no longer a problem (based on number of spurious claims). • Reasons for increase in medico-legal litigation. • Highlight need for improved patient safety, declining capacity in state attorney offices, specialised medico-legal unit. • Caution: mediation is an option, not panacea, should be voluntary. • Express concerns about aspects of implementation of prescription by courts.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> Does not support indemnity cover of state employees.
19.	Hospital Association of South Africa [Health care organisation, Sandton]	Public health angle.
20.	Joseph's Inc [Attorneys, Johannesburg]	<ul style="list-style-type: none"> Express concerns about health care standards in the public and private sectors, problems with getting compensation paid out by state, access to records, absence of sufficient sanctions to penalise non-performing party in litigation process. Highlight problems with state attorney, interest due to late payment of claims and poor record-keeping. Introduce pre-trial measures, fast track procedures, budget for claims. Recommendation re disciplinary action, enforcing standards of care. Support specialised courts, peer review, certificate of merit, trust funds to administer payments (with conditions eg return of money if claimant dies). Review Rules of Court and Practice Manuals. Enable plaintiff to tender a settlement / compromise agreement on a without prejudice basis. Periodic payments difficult to administer.
21.	Joubert, Wihann Mr [Attorney, Pretoria]	MPhil Medical Law dissertation.
22.	Kaseke, Trudy Ms [Attorney, Sandton]	<p><u>A</u></p> <ul style="list-style-type: none"> Comments on the background to the medico legal crisis. Provide practical examples to issues raised for the requirement of law reform. Identifies issues of lack of training, denialism of the failing health care system by the health authorities, an obsession by state law advisors to defend indefensible claims, failure to prioritise solutions by provincial health departments most affected. <p><u>B</u></p> <ul style="list-style-type: none"> Failure of health systems and human failure (eg nurse training). Poor planning around increased patient numbers, finger pointing amongst authorities. <p><u>C</u></p> <ul style="list-style-type: none"> CL offers the plaintiff redress to the outcomes of medical negligence. Any change must consider the best interest of those harmed. Does not support adversarial system. Scope for improvement for future medical but underlying reason must be identified.
23.	Larsen, Jonathan Dr [Medical practitioner (obstetrician / gynaecologist) Howick KZN]	<p><u>Reasons for litigation</u></p> <ul style="list-style-type: none"> Greed, culture of litigation, anger and grief. Inadequate understanding of health issues (exacerbated by conflicts between traditional concepts of health and disease and western practices of health care).

	Respondent [Sector]	Comment
		<p><u>Concerns</u></p> <ul style="list-style-type: none"> • Attitudes among health care workers (loss of concept of calling to selfless caring for others), paternalism and superiority. • Adverse working conditions, burnout, excessive workloads and sleep deprivation, leading to fatigue and exhaustion. • Inadequate staffing levels, incompetent managers, poor management of trained staff, poor support for personnel in the workplace by incompetent managers, who inevitably monitor the bureaucratic paperwork, but not the actual patient care. • Training of nurses (no longer “hands on”), in particular the training of midwives (one year midwifery course was abandoned in favour of an integrated course). • Training of midwives. <p><u>Other</u></p> <p>Included article on New Zealand no-fault system.</p>
24.	Life Healthcare [Health care group (hospitals) Johannesburg]	<ul style="list-style-type: none"> • Raise concerns about state of health care facilities. • Reasons for increase in ML litigation. • Improve quality of public healthcare system. • Do not support no fault system. • Support certificate of merit with expert report, earlier exchange of information. • Improve complaints processes via OHSC and HPCSA. • Support capping of claims. • Caution against <i>res ipsa loquitur</i> doctrine.
25.	Mallory, Louise Ms [Medical malpractice insurance]	<p><u>Reasons for litigation</u></p> <ul style="list-style-type: none"> • Not drop in standards of care. • Society has become more litigious. • Legal professionals trying to make a lucrative living and targeting the poor to claim. <p><u>Concerns</u></p> <ul style="list-style-type: none"> • Raise concern that medical practitioners practice defensive medicine due to fear of being sued. • Patients are treated according to what they can afford / what medical aid is prepared to pay. • Expense and practical considerations of accessing and storing records, especially old records, for an extended period of time. • Concerns about sustainability of private insurers over an extended period of time. <p><u>Support</u></p> <ul style="list-style-type: none"> • Separate budget for litigation. • Shortening prescription period for minors to 3 years. • Tables of quantum allowed for specific treatments, pains and suffering, loss of income etc. <p><u>Proposals</u></p> <ul style="list-style-type: none"> • Problems span public and private sectors, project should not only focus on public sector. • Take stronger action against legal practitioners for touting / illegal conduct and keep data base of such actions. • Allow public the option whether to mediate or litigate.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • Cap fees that can be claimed by legal practitioners and ban contingency fees. • Use retired / semi-retired specialists on mediation panels and allocate junior person to assist and for mentoring. • Investigate claims to determine whether there was negligence, investigate and negotiate quantum accordingly. • Use patient surveys to address problems, keep a data base. • Use insurance companies and law firms to assist patients on a pro-bono basis or train government officials to assist patients to litigate. • Use investment firms to investigate payments made to claimants. • Pay claims directly to service providers, obtain quotations. • Apply certain practices in insurance industry (Losses Occurring policies and Claims Made policies, retroactive cover, run off cover) to medical malpractice. • Adverse incidents should be reported and a central data base kept. • Include information about process for complaints etc in consent forms. • Cap claims as an interim measure while new system is being developed.
26.	Medical Protection Society [Mutual society Risk management]	<ul style="list-style-type: none"> • MPS is a UK mutual aid society that is also active in South Africa. • Reasons for increase in ML litigation. • Express concerns about patient complaints system, legal processes, common law system, unnecessarily adversarial system, use of single joint expert. • Support patient-centred complaints process, procedural reform, certificate of merit, limiting damages awards, alternative dispute resolution, review of contingency fees, introduction of compulsory professional indemnity, establishment of statutory body to deal with ML claims, tariff of general damages. • Caution against no-fault system, net discount rate, periodic payment, annuities / staggered payments. • Refer to international examples. • Support law reform.
27.	Mediclinic SA [Health care group (hospitals) Stellenbosch (HQ)]	<ul style="list-style-type: none"> • Review must also deal with private health care sector. • Reasons for rise in ML litigation, especially rise in quantum. • Highlight need for insurance, rise in premiums and rise in excess payments. • Concern about shortage of medical professionals, especially nurses. Brought Indian nurses to SA. • Highlight own processes and actions to contain claims and costs. • Support certificate of merit and recommend sanction. • Support capping of general damages only. • Support voluntary mediation and arbitration (refer to Namibian experience of compulsory mediation). • Do not support periodic payments in private sector.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • Support trusts. • Investigate and analyse adverse incidents in detail. Resulting reports should not be discoverable. • Concern about access to post mortem reports. • Claims for future medical expenses must be calculated in ZAR. • Take effect of NHI into consideration.
28.	Miller, Neil Mr [Member of public]	<ul style="list-style-type: none"> • Member of public – claim has prescribed. • Raises concerns about alleged abuse of contingency fee agreement where attorney allegedly allowed claim to prescribe without referring claimant to an expert. • Comment raises the aspect of contingency fee agreements and whether claimants have any other right of recourse. • Highlights role/duty of Law society (LPC) to play a more active role.
29.	Mullins SC, John Mr [Litigation – advocate, Pretoria]	<ul style="list-style-type: none"> • Support contingency fees – provides access to justice. • Concerns about apparent lack of training of nurses on basic health care principles and use of equipment. • Propose: focus on training of nurses and implementation of proper systems. • Does not support law reform. • Support “careful” capping”, especially of foreigners’ claims, possibly reducing prescriptions periods for minors (possibly allowing apportionment against parents), common law system. • Support mediation, but express concern about state’s unwillingness to mandate its representatives to enter into settlements. • Identifies that the establishment of causal negligence on the part of the patient is a key determinant in medico legal cases. • Reform should not focus on the public and private health sectors depriving the patients’ rights of being compensated commensurate to the proof of such causal negligence. There has been no real explosion but an increase in patients becoming aware of their rights.
30.	Netcare Ltd [Health care group (hospitals) Sandton (HQ)]	<ul style="list-style-type: none"> • Reasons for litigation. • Support law reform. • Propose that law reform should also cater to private health care, specialised personal injury courts. • Concerns about cases with little or no merit. • Untrained, overworked and poorly motivated medical and nursing staff. • Support common law system, but express view: cannot be further developed. • Support adversarial system, review of common law “once and for all” rule, doctrine of avoidable consequences, review of Contingency Fees Act. • Proposals regarding expert witnesses, specialised medical legal task team for state sector, duplication of own systems in government (internal risk and legal officers). • Improving communication also between fellow medical practitioners and medical practitioners and nursing staff

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • Appointment of private agents to administer payments. • Aggressive advertising and touting by lawyers, illegally obtaining patient information, contingency fees and such agreements. • Support amendment to State Liability Act (express view: should also expand to private sector), certificate of merit, pre-litigation procedures, capping of claims, alternatives to monetary awards (free treatment), net discount rate in conjunction with other remedies. • Guidelines for compensation with caveat, defined benefits, periodic payments, safeguarding of payments and trusts. • Support compulsory mediation or pre-mediation and ADR with some caveats. • Do not support tribunal for screening or adjudication, no-fault system. • Proposal re “double dipping”: state should invoice such patients.
31.	Occupational Therapy Association of South Africa (OTASA) [Professional organisation – medical Pretoria]	<ul style="list-style-type: none"> • Concerns about ratios of nursing staff to patients, training of nurses, especially practical aspect, standards of care, lack of experience, inadequate supervision. • Support separate budget for litigation, compulsory indemnity cover (in public and private sectors). • Propose stricter codes and ethics for attorneys’ conduct, accreditation of experts. • Monthly “pension” in lieu of loss of earnings • Better guidance on compensation and calculation thereof required. • Support ADR and mediation, statutory body for both screening and evaluation, (with conditions), certificate of merit, pre-litigation procedures, capping of general damages, review of Contingency Fees Act. • Opinion that no fault system might increase claims. • Propose: Expand functions of HPCSA and Professional Boards to ensure quality of care to patients. • Provide documents and policies about standards of care and practice, implementation of such policies and for regular review of the policies.
32.	Oosthuizen, André [Litigation – Advocate at Cape Bar, Cape Town]	<ul style="list-style-type: none"> • Recommends fund similar to that of system created under Compulsory Motor Vehicle Insurance Act and its successors, to be managed by insurance companies. • Supports mediation with early exchange of documents.
33.	Paul du Plessis Attorneys [Attorneys Pretoria]	<p><u>Background</u> Attorney specialising in retinopathy of prematurity (ROP).</p> <p><u>Reasons for litigation</u></p> <ul style="list-style-type: none"> • Public awareness leads to more claims. • Backlog of old claims (dating as far back is 1999) currently in the system. <p><u>Concerns</u></p> <ul style="list-style-type: none"> • It transpired in 2012/2013 that standard of care established in mid-1990s and National Guideline for the Prevention of

	Respondent [Sector]	Comment
		<p>Blindness in SA published in 2002 were not being implemented in Neonatal Intensive Care Units.</p> <ul style="list-style-type: none"> • Importance of accountability. • State's capacity to deal with complex medico-legal litigation. <p><u>Proposals</u></p> <ul style="list-style-type: none"> • Improve standard of health care, restructure or limit compensation, provide specifically for administration of payment of M-L claims. • Obligation on health care provider to provide information to patient. • Central fund for damages that is professionally managed. • Proposals re when prescription should start running. <p><u>Support</u></p> <p>Support contingency fees system, certificate of merit.</p> <p><u>Do not support</u></p> <p>Does not support no-fault system – would lead to huge increase in claims.</p> <p><u>Other</u></p> <p>References to international examples.</p>
34.	Ric Martin Inc [Attorneys, Pretoria]	<ul style="list-style-type: none"> • Suggestions on amendment of Contingency Fees. • Recommends appointment of medical assessors to sit with judges. • Cite examples of CP cases where underlying causes not considered by courts and over-reliance of CTG monitoring.
35.	RiskHouse Africa [Actuaries, Sandton]	<ul style="list-style-type: none"> • Reform must look at improving health care to reduce health care costs. • Capping of non-economic claims in some states in the USA have resulted in awards of over 70% of the total claim. • Lump sum or periodic payments require actuarial calculations. • Periodic payments have the added cost of management of the payments which could drive up costs. • Consideration of the state setting up a trust for each claimant and payments being effected over a period of 0-5 years. <p><u>C</u></p> <ul style="list-style-type: none"> • Support recommendations.
36.	Scharf, Georg Dr [Medical practitioner (surgeon), Pretoria]	<ul style="list-style-type: none"> • Reasons for litigation. • Support law reform. • View that proposed NHI will increase claims. • Concerns about underfunding, lack of qualified and experienced staff, deficient management and supervision, foreign “medical immigrants” and “tourists” who are overloading State health facilities. • Concerns about standard of training of some doctors trained abroad, success of mediation, some methods of cross-examination, manner of dealing with lump sum payments, “double dipping” and “double paying”. • Support common law system and adversarial system, with some inquisitorial elements. • Review of “once and for all” rule.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> Support capping of claims, doctrine of avoidable consequences, amendments to contingency fees in the event of unsuccessful claims and future medical costs payable on demand.
37.	South African Medical Association [Professional organisation – medical, Pretoria]	<p><u>A</u></p> <ul style="list-style-type: none"> Unscrupulous contingency fee agreements. Remove reasons for litigation – improve quality and risk management. <p><u>B</u></p> <ul style="list-style-type: none"> CL can remain unchanged but procedural aspects need review. Specialist courts and core group of independent medical assessors to assist judges. Support inquisitorial rather than adversarial system. Support mediation prior to litigation but acknowledge challenges. Support periodic payments, retention of “once for all” rule and prescription periods. Calls for review of Contingency Fee Agreements. <p><u>C</u></p> <p>Support recommendations but do not believe that separate budgets will solve underlying complaint resolution and quality issues.</p> <p><u>D & F</u></p> <ul style="list-style-type: none"> Support recommendations. Support no fault system, mediation and pre-litigation processes. Support separate budget and separate fund for litigation but with proper administrative processes in place. Support establishment of statutory authority on condition that assessors are well trained, with concerns over existing bodies like HPCSA remaining dysfunctional. Support certificate of merit, early pre-trial conferences, early exchange of expert reports, etc as recommended. Do not support capping but support a proper definition of benefits. The issues arising from unethical conduct of attorneys ought to be addressed in LPA. Proposed reforms will do little to mitigate risk of harm against patients – provision of quality care and response to complaints must be operationalized in terms of NHA.
38.	South African Medico-Legal Association [Professional organisation – medical and legal, Johannesburg]	<p><u>A</u></p> <ul style="list-style-type: none"> Decline in professionalism, decline in education and training in standards for medical practitioners. Increased patient awareness – Constitution and CPA. Influx in foreigners leading to an overburdened health care system. Touting by attorneys, influence of contingency fee agreements. Legislation, peer review systems and mandatory mediation. <p><u>B</u></p> <ul style="list-style-type: none"> Develop the CL with legislative measures. Adversarial system not the best for reasons set out. Inquisitorial system preferred with judge being more involved.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • ADR – preference over mediation. • SA legal system is mixed. Not total reform but some reform particularly at provincial level. • Application of international law to be circumspect to unique SA situation. • Support periodic payments. • Support application of doctrine and also hold legal practitioner liable where indicated. • Recommend extension of periods as proposed by Law Reform Paper 126. • No problem with CFA per se, but rather the abuse thereof. • Recommend greater oversight by court post litigation as is done in the EC. • Reduction of contingency fee from 25% to 12.5%. <p><u>C</u></p> <ul style="list-style-type: none"> • Who constitutes in-house? Suggests independent group sourced from different professional associations. • Experts must be accredited. <p><u>D</u></p> <ul style="list-style-type: none"> • Supports amendment to allow for periodic payments as is done in UK, Germany, NZ and Canada (social democratic model) to curb over- or under-compensation. • Recommends that compensation not be taken from service delivery budget. • Awards capping of general damages be further investigated with assistance from APRAV and that Judges Bench Book be consulted for norms. <p><u>E</u></p> <ul style="list-style-type: none"> • Indemnity cover for public health system could be problematic. • This could raise constitutional issues and medical claims are complex in nature. • Recommends ADR and mediation in particular with list of benefits of the mediation process. • Recommends specialist medical courts or appointment of skilled assessors to help judges and magistrates. • Does not support no fault system which will not consider the current socio-economic factors in SA. • No fault system internationally applied but cannot be applied in SA climate. May also not pass constitutional muster and will lead to an increase in claims. • Support for certificate of merit but recommends that the same applies to the defence. Any party pursuing a claim with no merit be penalised with costs <i>de boniis propriis</i>. • Recommend that Rules Board intervenes to look at early exchange of documents and include the witness statements of factual witnesses. • Introduction of a pre litigation phase; a patient-centred complaints centre at departments, expert meetings and drawing up of joint expert minutes – Court rules to be amended to include this.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • Pre-trial and effective case management: focus on tailor-made procedures for medical negligence claims, recommendations are offered on a standard agenda (questions at pre-trial). • Capping of claims must be preceded by a legislative directive and based on the RAF case in the Constitutional Court, with the cogent argument of the Minister of Transport, the CC ruled on the limitation clause and the ability of the RAF to carry out its constitutional mandate. • This could apply to medical negligence claims and it is recommended that the SALRC appoint a panel of experts to formulate tariffs for general damages. • The aspect of periodic payments be further interrogated to determine specifics and the creation of trusts is favoured over the Guardian's Fund.
39.	South African Private Practitioners Forum (SAPPF) [Professional organisation – medical Johannesburg (HQ)]	<ul style="list-style-type: none"> • Raise concerns about cost of litigation, law of delict system, impact of medical scheme requirement, Remunerated Work Outside the Public Service (RWOPS), and the associated lack of control, absence of nationally set standards in relation to record-keeping, indemnity cover, conduct of lawyers, prescription. • Patient responsibilities (s19 of NHA). • Support training of lawyers on health service issues. • Compulsory mediation, pre-trial conferences, compulsory joint minutes by expert witnesses, peer review, screening of claims, specialised courts, certificate of merit, capping of claims. • Review compensation (alternatives to monetary awards) and contingency fees. • Other issues: OHSC, HPCSA, protocols and guidelines.
40.	South African Society of Anaesthesiologists (SASA) Professional organisation – medical Durban	<ul style="list-style-type: none"> • Actions of personal injury lawyers. • Use of professional mediators as soon as a bad outcome is encountered. • Separate budget will not address claims but a dedicated medico legal unit in Departments is recommended as in WC. • Believe that problem will escalate under NHI as private sector practitioners will form part of NHI. • On compulsory indemnity cover: section 46 of NHA only compels the private sector. As is indemnity covers the practice/provider and not the patient. • Law society must address advertising by attorneys. • Support ADR before litigation and propose that a certificate must be issued. • Support mediation bodies and tribunals with trained experts legally and medically to sit in these units. • Training of expert witnesses in compliance with HPCSA guidelines. Experts should not be hired on contingency to overcome “hired gun” phenomenon. • Do not support the no-fault system. Has not worked in RAF. • Compensation must be fair and not compromise the care and any benefit must protect the rights of the complainant. • Consent forms must include mediation.

	Respondent [Sector]	Comment
41.	South African Spine Society [Professional organisation – medical]	<p><u>A</u></p> <ul style="list-style-type: none"> • Increase in number of personal injury lawyers, capping of RAF claims, touting. • Advertising by HPCSA to report medical practitioners. • Prefer lump sum payments to periodic payments. <p><u>B</u></p> <ul style="list-style-type: none"> • Change adversarial to inquisitorial system. • Pre-mediation and mediation must be part of consent forms. <p><u>E</u></p> <ul style="list-style-type: none"> • Do not support no fault – there could be unforeseen circumstances (eg surgical misadventure vs negligence). <p><u>F</u></p> <ul style="list-style-type: none"> • Lack of communication; promises by attorneys, lack of statistics in the private sector, practice of defensive medicine.
42.	State Attorney Bloemfontein [National government, Bloemfontein] (Ian Gough)	<p><u>Liability</u></p> <p>Doctor/state liable for medical negligence on delictual principles and s27 and 28(1) & (2) of Constitution. Only a few people who suffered damages due to medical negligence will institute claim.</p> <p><u>Fund</u></p> <p>If a fund is established, the fund can request medical assessments at their expense to consider nature and extent of the loss. Examples: Finland, Sweden, New-Zealand, Norway and Vermont, USA.</p> <p><u>Panel</u></p> <p>If a panel is established for medico-legal claims, funding, composition, qualifications, appointment, functions, training, appeal procedures, general processes and procedures should be prescribed.</p> <p><u>Mediation</u></p> <p>Scope of mediation (quantum/merit/both), procedure, information to be exchanged should be prescribed. Deal with procedure after failed mediation eg arbitration, adjudication or appeal. Even if main dispute is not mediated, parties could agree on certain issues, which would not have to be adjudicated. Resolution by mediation can provide for broader settlement terms eg an apology. Training of mediators – eg like one year course in construction industry. Training should include mediation methods, handling of disputes, legal principles eg contracts, delict.</p> <p><u>Appointment of expert to preside</u></p> <p>Consider what expert will be appointed in quantum disputes where there are up to 16 experts from various disciplines. Will decisions be based on <i>viva voce</i> evidence, reports only or the outcome of joint minutes of experts? How soon will parties have access to their opponent's reports?</p> <p><u>Constitutional attack</u></p> <p>Possible constitutional attack on various issues, eg by personal injury lawyers whose interests will be affected. Class actions might arise.</p>

	Respondent [Sector]	Comment
		<p><u>Capping</u> Consider whether capping of general damages is feasible/ constitutional. General damages constitute $\pm 10\%$ of total amount awarded/settled.</p> <p><u>Attorneys' fees</u> Contingency fees are prescribed by statute. Should limit to attorneys' fees relate only to medical negligence claims or also other personal injuries (where claims can also be large)?</p> <p><u>Damages in CP cases</u> See no-fault liability in Japan and Virginia, USA.</p> <p><u>Collateral benefits</u> State of flux in our law must be taken into account for collateral benefits.</p> <p><u>Time within which to bring proceedings</u> Large portion of SA population have limited knowledge of their right to claim, which must be considered with regard to time limits for claims.</p> <p><u>Shortened periods of prescription</u> Shortened prescription periods may be attacked regardless of whether it is considered a fair prescription period.</p> <p><u>Costs</u> Consider a scale of party and party costs at a reduced rate – refer to UK costs report by Lord Jackson.</p> <p><u>Trusts</u> Copy of trust instrument should be furnished to court and defendant – the court and the state (defendant) should have a say regarding the trust. This is in line with s27 and 28(1) & (2) of Constitution. Court should have oversight of utilisation of trust funds, especially when young children are involved, as upper guardian of minors. The Master should furnish regular reports. Damages must be used for purposes for which awarded. The defendant or an independent trustee appointed by defendant should be one of the trustees.</p> <p><u>Insurance companies</u> Doctors in private practice are sued often, leading to doctors practicing defensively and rising insurance premiums. Some doctors leave the profession. The state should learn from insurance companies how to deal with claims, eg basis for settlement, determination of liability, etc. There cannot be one system for the state and another system for private healthcare providers. State and private sector should join forces and deal with medical negligence claims together.</p> <p><u>State Attorney</u> State attorneys' offices are usually general practitioners with some specialisation, but they are being overwhelmed by the huge number of medical negligence cases, especially CP matters. There is a shortage of staff, people are leaving, posts are not filled, the</p>

	Respondent [Sector]	Comment
		<p>volume of work per attorney is on the increase, imposing a greater burden on those who remain. State attorneys struggle to get cooperation and assistance from provincial DOHs.</p> <p><u>Private attorneys</u></p> <p>There are 3 classes of private attorneys who institute action:</p> <ol style="list-style-type: none"> 1) The chancers. 2) Generalist attorneys who deal with medical malpractice or personal injury as part of their practice. 3) Attorneys who specialise in personal injury matters and medical malpractice. <p>Private attorneys can take their time before instituting action, obtaining medical records and expert opinions. Defendants on the other hand (including state attorneys) are very time-bound. Defendants should be afforded more time insofar as litigation in the high court is concerned to file a plea and related documents.</p> <p><u>Specialist attorneys</u></p> <ol style="list-style-type: none"> 1) These attorneys are specialists of specialists. Some only deal with cerebral palsy cases. 2) The attorneys can read medical reports as well as medical practitioners. 3) They choose only clients who they know will succeed, limiting their clients to a few per year. 4) They often employ vastly experienced midwives and theatre sisters to screen clients. 5) They employ experts whose practices consist of examining plaintiffs and providing expert opinions. These experts are experts' experts. <p><u>Procedural rules</u></p> <p>Amend procedural rules to allow for early discovery of the plaintiff's documents, early filing of expert reports and appointment of a single expert to examine plaintiff and prepare a report. Support awarding damages in accordance with scale of benefits depending upon gravity of injury.</p> <p><u>Medical records</u></p> <p>Record keeping in provincial hospitals is problematic.</p> <p><u>Reverse structural interdicts</u></p> <p>Only applicants have brought applications for structural interdicts for the progressive realisation of social rights. Section 27(2) of the Constitution (progressive realization) is not confined to legislation. Propose that state as respondent or defendant should be able to apply for a structural interdict for the progressive realisation of the right to health by means eg of periodic payments or other means of paying compensation.</p> <p><u>Court rules</u></p> <p><u>Case management</u></p> <p>Make more use of pre-trial conferences for personal injury and medical negligence claims. In terms of rule 37(8) a judge may call upon parties to hold conference/s before the judge in chambers (pre-trial conference) – immediately after the close of pleadings, or,</p>

	Respondent [Sector]	Comment
		<p>on a wide reading of the rule, a pre-trial conference may be held prior to the filing of a plea. A pre-trial conference brings the parties formally together to discuss issues, which could include mediation.</p> <p><u>Rule 34A interim payments</u> Contends that rule 34A(6) grants a judge the power to order periodic payments. Contends that rule 34A(7) grants a judge the power to order early discovery, early filing of expert witness reports, mediation and other issues. (Court cannot order mediation if the costs thereof will have to be borne by one or all of the parties.) Practice directives could be issued for personal injury or medical malpractice matters. Contends that there is no reason why the court exercising its inherent jurisdiction to regulate its own process cannot make a similar order where the parties agree to an interim payment without an application.</p> <p><u>Appointment of expert assessors</u> Appoint expert assessor to peruse expert reports, advise court or report back prior to trial. Appointment of expert assessor will be at expense of the state.</p>
43.	State Attorney Pretoria [National government, Pretoria]	<p><u>A</u></p> <ul style="list-style-type: none"> • State hospitals – decline in medical professionalism standards of care). • Awareness of Constitutional Rights. • More attorneys entering profession and training in medical malpractice claims, decline in RAF work, more lucrative types of personal injury claims. • Improvement in quality of service by training and adequate staffing. <p><u>B</u></p> <ul style="list-style-type: none"> • Scope limited. Court can on an ad hoc basis and on defendant's pleadings and supporting evidence make provision for future payments. Reference to MEC of Gauteng v Zulu Case No: 1020/2015, SCA. • Parties not bound by mediation. Arbitration seldom followed. • Subject to provisions of Apportionment of Damages Act. • Minors should not be penalised for omission of parent/guardian. • Contingency: success fee must be amended on a sliding scale in relation to size of claim. <p><u>C</u></p> <ul style="list-style-type: none"> • Agree with recommendations as this impacts on the State attorney ultimately. Hospital managers must ensure compliance. • Case of <i>Khoza v MEC for Health & Social Development Gauteng</i> and implications for application of the maxim of “<i>res ipsa loquitur</i>”. • 2 – 18. Agree with practical suggestions. • Important proviso to joint experts. • 20 – 24 agree. <p><u>D</u></p> <ul style="list-style-type: none"> • Agree with 6.5 – 6.8.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • However, important consideration to further amendment of the Institution of Legal Proceedings against Certain Organs of State, Act 40 of 2002. • Consideration was given to the Department of Safety & Security in view of practical problems encountered by the various hierarchical structures. • A draft amendment appears on page 18 of the comment. <p><u>E</u></p> <ul style="list-style-type: none"> • Consider the provisions of the PFMA and Treasury regulations. • Direct access provision exists but medical claims are complex. • Consider certificate but impractical as experts are not available at onset of matter. • In favour of voluntary mediation. • No fault systems would encourage a wider group of patients with greater financial implications and to the prejudice of deserving claimants. • Certificate supporting liability by 2 medical practitioners is recommended. • Cap not necessary as awards for general damages are low. • Guardian's Fund has its own challenges.
44.	Treasury Eastern Cape [Provincial government, Bisho]	<ul style="list-style-type: none"> • Support recommendations of inter alia limiting access to courts, shorter statutes of limitation, elimination of joint and several liability, standards for experts and capping. <p><u>A</u></p> <ul style="list-style-type: none"> • Poor management, lack of adequate health professionals and equipment, unethical practices of attorneys. • Capping and periodic payments. <p><u>B</u></p> <ul style="list-style-type: none"> • Support recommendations without legislative intervention. <p><u>D</u></p> <ul style="list-style-type: none"> • Support amendment of State Liability Act with lump sum payments for past expenses and damages and capped lump sum for special damages. • Periodic payments for future special damages linked to an index of average values and based on proper actuarial evidence. • Strengthen Patients' Charter, health service delivery guidelines, OHSC and provide for greater accountability. • Whilst law reform supported, short term solutions must improve standard of care.
45.	Treasury KwaZulu-Natal [Provincial government, Pietermaritzburg]	<p><u>A</u></p> <ul style="list-style-type: none"> • Poor record keeping, inadequate staffing/funding and opportunistic lawyers. • Capping as was with RAF. <p><u>C</u></p> <ul style="list-style-type: none"> • Agree. • Mostly agree with recommendations.
46.	Treasury National [National government, Pretoria]	<p>Recommend short, medium and long-term solutions.</p> <p><u>A</u></p> <ul style="list-style-type: none"> • Improve patient safety and quality of care – root cause.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • Introduce mandatory mediation or other ADR mechanisms before litigating firstly, and secondly introduce a national medico legal authority/tribunal to hear cases which failed at mediation. • Thereafter if process still fails allow for appeal of ruling of Tribunal and as a last resort refer case to court process. <p><u>D</u></p> <ul style="list-style-type: none"> • Support amendment of State Liability Act to allow for periodic payments. • Capping of claims and standardisation in calculation of awards. • Provinces to improve capacity to provide for future health care and assistive devices instead of paying for future medical costs. <p><u>E</u></p> <ul style="list-style-type: none"> • Capping on contingency fee agreements and reducing touting. • Support shortening the statutes of limitations to reduce loss of records especially in cases involving minors. <p><u>Annexure A</u></p> <ul style="list-style-type: none"> • Provides statistical analysis of claims from the provinces and reporting of contingent liabilities. However Treasury notes that the reporting of contingent liabilities includes other claims against the state and provinces do not necessarily differentiate between medical negligence and other claims; hence figures may not be absolutely accurate. • Treasury has also picked up discrepancies in reporting of the value of claims, thus further highlighting systems issues within departments. <p><u>A</u></p> <ul style="list-style-type: none"> • Poor health service delivery- shortage of human and physical resources. • Poor communication. • Note improvement in health outcomes – increased numbers of positive outcomes. • Poor record management and inadequate legal capacity at provincial departments. • Lump sum payments, contingency fees, behaviour of law firms. • Increase in claims could most likely be attributed to greater patient awareness and behaviour of law firms. • Improve quality of care, mandatory mediation, establishment of health tribunals and final step to litigation. • Periodic payments; establish national expert teams and medico-legal units within departments. • Contract expertise from private sector, capping of contingency agreements, reviewing statute of limitations and consider compensation in the form of certain services rather than monetary payments. <p><u>B – F</u></p> <ul style="list-style-type: none"> • Support recommendations. Suggest short, medium to long-term implementation. • Short term – increase medico-legal capacity at DOH and DOJ. • For medium term periodic payments and standardising payment criteria may assist.

	Respondent [Sector]	Comment
		<ul style="list-style-type: none"> • Long-term: professional indemnity cover for health care providers.
47.	Treasury North West [Provincial government, Mahikeng]	<p><u>A</u></p> <ul style="list-style-type: none"> • Shortage of health care professionals, lack of medical equipment, infrastructure, deficient record keeping and safe keeping, lack of patient safety and care, lack of management and supervision at facilities. • Effective facility management combined with provision of quality services and effective records management. <p><u>B, C, D & E</u></p> <ul style="list-style-type: none"> • Budget separately for claims, appointment of suitably qualified legal staff, use of in-house experts, standardised procedures for dealing with medical negligence cases, training of health care professionals and reform of “once and for all” rule. • Pay out general damages within 30 days but future medical expenses be covered by undertakings and paid directly to provider. Such undertaking not be a part of judgement creditor’s estate. • Costs of devices be paid for or provided by judgement. Costs of care giver be paid annually and not in lump sum. • Past and future income be subject to tax deducted by the judgement debtor and paid over to SARS. Past income be paid within 30 days and future income be paid annually. • Forbid loss of earning capacity and deal with under one head of loss of income. • Alterations to home, purchase of motor vehicle, judgement debtor must have option to provide for these or pay in cash.
48.	Van der Merwe, Sasja Ms [Psychologist, Pretoria]	<ul style="list-style-type: none"> • Reasons for litigation. • Concerns about objectivity of expert witnesses and fees paid to expert witnesses. • Support screening of claims, compulsory mediation and review of common law “once and for all” rule.

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26.	<i>Law Society of South Africa and Others v Minister for Transport and Another</i> 2011 (1) SA 400 (CC)

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28.	<i>Links v Department of Health, Northern [Cape] Province</i> 2016 (4) SA 414 (CC)
29.	<i>Lushaba v MEC Health, Gauteng</i> (17077/2012) [2014] ZAGPJHC 407 (October 2014)
30.	<i>Marine and Trade Insurance Company Ltd v Katz</i> NO 1979 (4) SA 961 (AD)
31.	<i>Matlakala v MEC for Health, Gauteng Province</i> (2011/11642) [2015] ZAGPJHC 223 (2 October 2015)
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