SOARING MEDICAL MALPRACTICE LITIGATION IN SOUTH AFRICA AND ITS IMPLICATIONS FOR THE IMPLEMENTATION OF THE PROPOSED NATIONAL HEALTH INSURANCE SCHEME

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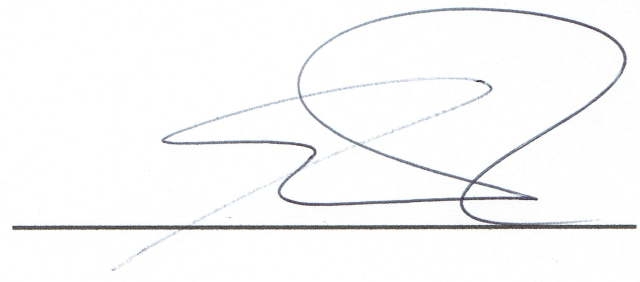
DECLARATION

I, the above student, hereby declare that the submission contained herein is my own original work and that all my sources have been properly acknowledged.

Student's Signature



ABSTRACT

South Africa (SA) is a new democracy since 1994 with a new constitution that outlaws all forms of discrimination and affords equality to all men and women who live in it. The previous regime had entrenched discrimination based on race where the majority non-white population was denied privileges afforded their white counterparts. This arrangement ran for a period longer than 300 years and has resulted in abject poverty and lack of education for the majority black population. Poverty and lack of education are significant hindrances to development and when compounded by a burden of disease will further stymie development.

Provision of free healthcare and education would assist the previously disadvantaged communities as it will ensure that the little resources they may have, can better be utilised on other needs such as food and clothing. This study will focus on the provision of free healthcare and not free education.

South Africa has inherited two systems of healthcare, one public and the other private, which are seemingly in competition with each other. The public healthcare looks after most of the poor population whereas the private services few individuals with affluence as it is fee-based. Perhaps it would be ideal to have the two systems of healthcare functioning synergistically rather than antagonistically. The proposed National Health Insurance scheme (NHI) for South Africa, with pilot sites already running is an attempt by the government to achieve the goal of universal healthcare which is in line with the United Nation's Millennium Development Goals (MDG) targeted at poverty reduction, but is perceived as a threat to private healthcare because of the position adopted by government in the NHI white paper, which states that the role of private healthcare will be only complimentary to the NHI and provide those services which the NHI will not be providing. This is a clear threat to the existence of private healthcare.

Implementation of the NHI scheme is not without challenges such as infrastructure, personnel and financial resources like the soaring medical malpractice litigation. There are numerous factors which are contributing to the soaring medical malpractice claims worldwide and South Africa is not exempted, as recorded that in the past four years the Department of Health (DOH) had incurred R1.2 billion in legal costs related

to medical malpractice claims. Therefore, soaring medical malpractice claims threaten the survival of the present healthcare systems and will further hinder the implementation of the NHI scheme as it ravages the financial resources allocated for healthcare provision and threatens the existence of the high-risk medical specialities (like obstetrics and gynaecology, neuro-surgeons and orthopaedic surgeons). This trend is likely to worsen in South Africa as medical malpractice claims continue to devour financial resources intended for the provision and improvement of healthcare services.

The National Health Service (NHS) in the United Kingdom (UK) celebrated its 70th birthday recently, was a response by the government to provide universal access to quality healthcare for all the citizens as a response to the devastation of World War II. The experience of the NHS provides insights into the challenges of implementing a universal healthcare service in an inequitable society.

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Without my supervisor, Prof DJ McQuoid-Mason's guidance and patience this could not have happened. My immense gratitude and admiration to him. To Dr Caroline Goodier for her encouragement and lessons, thank you profusely.

This one is for all *Bahlakoana ba Mmapholo wa Disema*, *maila ngwathela ha a je sengwathana sa maobane*. if you really put your mind to achieving something, nothing will stop you, be it age or location, thank you all for your love and support.

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CHAPTER 1 INTRODUCTION

1.1 Access to Medicine

Access to basic health care is a human right and is guaranteed in the Constitution[1] of the Republic of South Africa according to the Bill of Rights.[2] This right was motivated by the economic and social inequalities of the apartheid system where the majority of South Africans were excluded from accessing adequate basic healthcare.[3] Constitutional imperatives prompted the design of the Policy of the National Health Insurance (NHI) scheme.[4] The adoption and implementation of the NHI scheme attests to the commitment of the South African government to take 'reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to have access to health care services including reproductive health care.'[5]

In addition, South Africa is a signatory to the International Covenant on Economic Social and Cultural Rights [6] which it ratified on the 18th January 2015, suggesting that the right of access to basic health care by all who live in South Africa is a domestic and international right as enshrined in the Constitution[7] and international conventions.[8] The proposed NHI scheme is South Africa's response to fulfil this obligation.

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[1] The Constitution of the Republic of South Africa, 1996.

[2] The Constitution s 27 (2).

[3] H. Coovadia, R. Jewkes, P. Baron, D. Sanders, D. McIntyre, 'Health in South Africa Part 1: The health and health system of South Africa: historical roots of current public health challenges.' (2009) 374 *The Lancet* 817, 818.

[4] Republic of South Africa, Department of Health (Green paper). *National Health Insurance in South Africa: Introduction.* Pretoria: Government Printer 2011.

[5] The Constitution s 27 (2).

[6] UN General Assembly. *International Covenant on Economic, Social and Cultural rights (ICESR),* 2200 (XX1) of 16 December 1966.

[7] The Constitution s 27 (2).

[8] UN World Health Assembly Resolution 58.33 2005 139. Sustainable health financing, universal coverage and social health Insurance.

While South Africa has made a commitment to implement the NHI scheme, there are many reasons to anticipate that its implementation will be faced with numerous challenges, ranging from inefficient management of the entire system of health, poor allocation of financial resources, inadequate human resources, poor infrastructure, the high burden of disease and the escalating medical malpractice claims.[9] It has been suggested that medical malpractice claims may be a hindrance to the implementation of the NHI scheme,[10] as millions of Rands are spent towards settling medical malpractice claims[11] rather than going to the implementation of the NHI scheme's pilot programs. In 2016, all provinces faced claims totalling R37 billion.[12]

It is against this backdrop that the study seeks to identify and analyse the contribution of the South African laws and other factors to the medical malpractice claims trajectory and the possible impact that this will have on the implementation of the proposed National Health Insurance (NHI) scheme.

National Health Service (NHS) in the United Kingdom will provide lessons from which South Africa can benefit in the implementation of the proposed NHI scheme, because the NHS is a universal healthcare system introduced to provide access to healthcare for all UK citizens after World War II. The aftermath of which necessitated a policy shift towards improved access to healthcare. Similarly, South Africa is undertaking to provide healthcare to all South Africans left destitute by the system of apartheid. The NHS' experience of 70 years will provide valuable insights, taking into consideration

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[9] I. Carrim 'Can the National Health Insurance (NHI) succeed in the current medical malpractice climate in South Africa?' (2016). *http://www.camargueum.co.za/article/21012016/can-national-health-insurance-nhi-succeed-current-medical-malpractice-climate-south.* (Accessed on 04 April 2016).

[10] S. Mahomed, '*Discussion Document compiled by the Steve Biko Centre for Bioethics prepared for the Minister of Health for the Medico-legal Summit.* (2015) (Pretoria) Unpublished.

[11] I. Carrim 'Can the National Health Insurance (NHI) succeed in the current medical malpractice climate in South Africa?' (2016). *http://www.camargueum.co.za/article/21012016/can-national-health-insurance-nhi-succeed-current-medical-malpractice-climate-south.* (Accessed on 04 April 2016).

[12] K. Masweneng 'Medical Lawsuits Posing a Financial Risk to Healthcare in Gauteng (2017') https://www.timeslive.co.za/news/south-africa/2017-08-13-medical-lawsuits-posing-a-financial-risk-to-healthcare-in-gauteng-ramokgopa/ (Accessed on 07 Sept 2017).

that it had faced similar challenges during its implementation and continues to be beleaguered by on-going challenges to providing universal access.

1.2. Background to the Subject

1.2.1 The South African legal framework

The Constitution[13] and the National Health Act[14] require the government to provide healthcare for residents and through the Bill of Rights[15] obligates it to deliver access to healthcare for all within its available resources[16] and basic healthcare for children.[17] In addition to the right of access to healthcare for all, the Constitution[18], the National Health Act[19], the Children's Act[20], the Consumer Protection Act [21] and the Contingency Fees Act [22]have changed the practice of medicine from a paternalistic, where the doctor knew all, to a patient-centred service.[23]

In the author's experience the changes seem not to have affected the training of medical professionals as the prevalence of paternalistic tendencies are still rife. Consent obtained is usually inadequate, as patients are made to consent for procedures that they do not understand, and are therefore unable to attach value to

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[13] The Constitution 1996 s 27 (2).

[14] National Health Act 61 of 2003 s 1 (1).

[15]The Constitution 1996 s 27 (1) (a), (2), (3).

[16] The Constitution 1996 s 27 (1) (a), (2).

[17] The Constitution 1996 s 28 (1) (c), (2).

[18] The Constitution 1996 s 9 (1) (2) (3)(4) (5) s10 s 11 s 12 (2) s 14 (d) s24 (a) (b).

[19] National Health Act 61 of 2003 s 1 (1).

[20] The Children's Act 38 of 2005 s 129.

[21] The Consumer Protection Act.

[22] The Contingency Fees Act.

[23] DJ. McQuoid-Mason 'Michael Jackson and the limits of patient autonomy' (2012) 5 (1) *SAJBL* 11, 12.

the outcome with no opportunity to decline.[24] The consequence is an increased risk of medical malpractice claims based on insufficient consent and invasion of privacy or patient assault. An example is *C v Minister of Correctional Services*[25] where an inadequate consent was obtained because the patient had consented to a venesection and not the HIV test that was done and resulted in a claim for invasion of privacy.

The principle of 'the best interest of the child'[26] further complicates the practice of medicine because any parent who takes their child to a medical professional for consultation, expects an explanation from the healthcare professional regarding the problems afflicting the child. However, if the child's age is 12 years or older and the child is of enough maturity and refuses to consent to the disclosure of information to the parent, the healthcare professional is expected to respect the provisions in the law about confidentiality.[27] This means that the child must consent to their parent being informed about their condition.

The Contingency Fees Act[28] provides a legitimate channel to facilitate access to justice for those who cannot afford a lawyer. Most South Africans are poor, and this has afforded them access to justice. However contingency fees can have unintended consequences in the healthcare sector, where the canvassing of disgruntled patients by the legal fraternity leads to increases in the number and magnitude of malpractice claims.[29] The Minister of Health has requested lawyers to get out of hospitals.[30]

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[24] The author is a General Practitioner with an experience of 30 years in private practice.

[25] *C v Minister of Correctional Services* 1996 (4) SA 292 (T).

[26] The Constitution 1996 s 28 (2).

[27] The Children's Act 38 of 2005 s 129.

[28] The Contingency Fee Act No 66 0f 1997 s 2 (1) (2).

[29] The ANC Legal Research Group. *Medical Negligence and the bleeding of the public purse* Meeting held at Hogan Lovells, Sandton. (Accessed 02 April 2016) Live stream on SABC News DSTV Channel 404.

[30] A. Motsoaledi 'Doctors call for lawyers to get out of hospitals' (2015) 8 (1) *SAJBL* 4,6.

The *Batho Pele* Principles were introduced [31] by the Government as policy and were intended to improve the quality of service delivery in all public institutions. However, they are seldom applied in practice. Complimentary to the *Batho Pele* Principles, the introduction of the Consumer Protection Act (CPA)[32] has safeguarded patients' rights when accessing healthcare and extended their ability to litigate.[33] The nature of medical services in the private sector has changed from being a social good to a business practice. In the past a patient would report to the HPCSA if unhappy with the quality of service received or seek justice under other relevant acts such as the Criminal Procedure Act.[34] Now medical services have become business transaction where litigation is an option.[35] Healthcare professionals are expected to adhere to ethical principles and not to adopt business practices. Defensive medical practice results from healthcare professionals pre-empting litigation, ironically resulting in increased cost of healthcare. Defensive medicine is estimated to contribute up to one third of the total cost of healthcare.[36]

Amendments to the Road Accident Fund Act[37] have removed the incentive for personal injury legal practitioners to pursue Road Accident Fund claims. Medical malpractice claims provide an alternative to such practitioners.[38] Advertising by

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[31] Republic of South Africa, Department of Public Service Administration *White Paper on Transforming Public Service Delivery* 18th Dec 1997. The 8 *Batho Pele* Principles are as follows: *Consultation; service standards; access; courtesy; information; openness and transparency; redress and value for money.*

[32] The Consumer Protection Act 66 of 2008.

[33] L. Pienaar 'Investigating the reasons behind the increase in Medical Negligence Claims' (2016) *PELJ / PER* 1,3.

[34] The Criminal Procedure Act 51 of 1977.

[35] R. Rowe & K. Moodley 'Patients as consumers of health care in South Africa: the ethical and legal implications' (2013) 14:15 *BMC Medical Ethics* 1,9.

[36] M Pepper & M Nothling Slabbert 'Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4 (1) *SAJBL* 29, 34.

[37] The Road Accident Fund Amendment Act 19 of 2005.

[38] T. Kahn, 'It's sickening: The alarming rise of medical malpractice claims' https://www.businesslive.co.za/fm/features/2018-07-19-its-sickening-the-alarming-rise-of-medical-malpractice-claims/ (Accessed on 20 Aug 2018).

personal injury lawyers targeted at disgruntled patients has increased awareness. and led to an increase in medical malpractice claims.[39] This has been compounded by the Contingency Fees Act.[40] However, the contribution by the healthcare professionals cannot be underplayed, as no claims will exist without medical malpractice.

1.2.2 The planned health policy shift

The proposed National Health Insurance scheme is a response by the SA government to honour its obligation of delivering healthcare to all as required under the new public healthcare system. The NHI Green Paper[41] was released in 2011 and the White paper[42] was released in December 2015 followed by the gazetting of the bill in June 2018.[43] The NHI scheme is considered as a policy shift that will contribute towards the reduction of poverty resulting from healthcare costs as espoused by the United Nations Millennium Development Goals (MDG's).[44]

There are two distinct and parallel providers of healthcare in South Africa: the public and the private sectors.[45] The public healthcare system may not deny any person medical services.[46] On the other hand, the private healthcare system may deny any member of a medical scheme their services if the premium has not been paid or if their needs exceed the limits imposed and agreed to beforehand.[47] However, emergency

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[39] P. van den Heever 'Medical Malpractice: The Other Side' (2016) 10 *De Rebus* 49.

[40] The Contingency Fees Act 66 of 1997 s 2.

[41] Department of Health (DOH). National Health Insurance in South Africa: Policy Paper (2011).

[42] The White Paper National Health Insurance: Towards Universal Health Coverage (2015).

[43] *SA Government Gazette* 21 June (2018) No 635 4.

[44] UN Millennium Development Goals. There are 17 specified MDG's; Goal 1 is poverty alleviation and Goal 3 is health. All these goals should be pursued in order to achieve development and improve quality life for the entire human race.

[45] Coovadia *op cit.* (2009) 374 *The Lancet* 826.

[46] The Constitution 1996 s 27 1 (a) 2.

[47] The Medical Schemes Act 131 of 1998 ss 33 & 34.

medical care may not be denied anyone either by the public or the private sector, regardless of their inability to pay.[48] Likewise the private sector can refuse services to non-scheme members who cannot afford their services.

Profit instead of the provision of healthcare seems to be the focus of the private sector. By law, medical schemes are not supposed to make profit. But by outsourcing their administration to entities that are not prohibited from making profit, has opened an opportunity for profit making. Profit is accumulated in the administrator and not in the medical scheme.[49] Running a profitable business is not against the law, however, administrators of medical schemes circumvent the intention of not for profit conditions of registered medical schemes.

There are similarities and differences between the private and public healthcare systems. Similarities exist in their provision of healthcare to all residents of South Africa and their proneness to escalating medical malpractice claims.[50] The difference comes in the funding and the fact that public-sector looks after more people with low or no incomes and the private sector services fewer individuals who have larger incomes.[51]

Total expenditure on healthcare services in South Africa is reported to be 8.8% of the gross domestic product (GDP).[52] This is higher than the recommended level of 5.8% for developing countries, according to the NHI policy paper.[53] The private sector

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[48] The Constitution 1996 s 27 (3).

[49] A Hassim, M Heywood, J Berger. 'Chapter 6: The Private Health Care Sector' (2007) *Health and Democracy* 162, 167.

[50] I. Carrim 'Can the National Health Insurance (NHI) succeed in the current medical malpractice climate in South Africa?' (2016). *http://www.camargueum.co.za/article/21012016/can-national-health-insurance-nhi-succeed-current-medical-malpractice-climate-south.* (Accessed on 04 April 2016).

[51] A, van den Heever, '*Review of Competition in the South African Health System*.' Produced for the Competition Commission. (2012) 1,45.

[52] L. Bidzha, T. Greyling & J. Mahabir, 'Has South Africa's investment in public health care improved health outcomes?' (2017) *Economic Research Southern Africa.* 3.

[53] Department of Health (DOH). National Health Insurance in South Africa: Policy Paper (2011).

spends 4.1% of this GDP looking after 16.2% of the population, while the public sector spends the rest on the remaining 84 %.[54]

Despite the greater spending on healthcare by SA than other developing countries as demonstrated by the 8.8% of the GDP, the health outcomes are poor[55] rendering healthcare in SA as much more expensive or inefficient than in peer BRICS[56] countries with comparable levels of GDP.[57] [58] Table 1 compares South Africa's health expenditure and health outcomes with other BRICS countries.

Table 1: Total health expenditure of BRICS countries as a percentage of GDP and health outcomes.[59]

Country	**Total expenditure on health (% GDP)**	**Life expectancy (years) (m / f)**	**Probability of dying under 5 per 1000 live births**	**Probability if dying between ages 15 & 60 (per 1000 population) (m / f)**
Brazil	8.3	71 / 79	15	194 / 91
Russia	7.1	66 / 77	8	294 / 111
India	4.7	67 / 70	39	214 / 138
China	5.5	75 / 78	9	93 / 67
South Africa	8.8	60 / 67	37	359 / 246

[54] Bidzha *op cit* (2017) 7.

[55] H. Coovadia *op cit.* (2009) 374 *The Lancet* 817.

[56] BRICS an acronym for the five fastest emerging economies which forms an economical bloc since 2011. (Brazil, Russia, India, China and South Africa).

[57] R Burger & C Christian, 'Access to health care in post-apartheid South Africa: availability, affordability, acceptability. (2018) *Health Economics, Policy and Law* 1.

[58] World Health Organization. Global Health Expenditure Atlas. Geneva: World Health Organization, 2010. http://www.who.int/nha/atlas.pdf (accessed 17 June 2019).

[59] *Ibid.*

'Spending through medical schemes in South Africa is the highest in the world and is six times higher than in Organisation for Economic Cooperation and Development (OECD) countries.'[60] [61]

Private healthcare is accessible to those who can afford to pay for it.[62] In the case of medical schemes, should the member's needs exceed the pre-agreed level of service, the individual is denied the service unless he or she pays in the difference. The inability of members to pay in the additional amount may leave them with no choice but to go to the public service as illustrated by the case of *Soobramoney*.[63] He was a member of a medical scheme that paid for him to receive renal dialysis. In the process his medical aid benefits were exhausted and he was denied further care which led him to seek assistance from the public health facility. However, he did not qualify for renal dialysis in the state hospital according to the policy on renal dialysis exclusion criteria[64] His condition was not an emergency and the hospital did not have adequate resources. The Constitutional Court upheld this decision.

Private healthcare members who are currently employed will retire from active employment due to age. After retirement the employer no longer contributes towards the medical aid, therefore they are more likely to stop paying the medical insurance premiums and their cover may cease, unless their scheme no longer requires them to pay. Thereafter they may have to revert to state care resulting in the increase in numbers of patients under state care without a proportionate increase in funds. This trend is likely to continue. Consequently, the level of care in the public health sector is likely to decline and more medical malpractice claims will be lodged.[65]

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[60] R Burger & C Christian, 'Access to health care in post-apartheid South Africa: availability, affordability, acceptability. (2018) *Health Economics, Policy and Law* 1.

[61] L. Lorenzoni & T. Roubal, 'International comparison of South African private hospital price levels.' (2016) *OECD Health Working Paper No. 85.* 9.

[62] Medical Schemes Act 131 of 1998 s 29 (n).

[63] *Soobramoney v Minister of Health, KwaZulu*-Natal 1998 (1) SA 765 (CC).

[64] National Department of Health (2009) Guideline for chronic renal dialysis.

[65] The ANC Legal Research Group. *Medical Negligence and the bleeding of the public purse.* Meeting

At present the state health care sector is only funded by taxes and does not have insurance cover against medical malpractice claims.[66] Part of its budget is used to settle these claims,[67] which depletes the funds allocated for the provision and improvement of healthcare, resulting in a deterioration in the quality of care, thus spiralling to further malpractice claims.[68] The result is that a vicious cycle is established with possible negative consequences for the implementation of the proposed NHI scheme.[69] 'The White Paper does not address medical malpractice and this is a huge concern.'[70] Empirical data on the causes and extent is erratic and often unobtainable and complicates the efforts to address it.[71] Regardless of the existing setbacks such as medical malpractice claims, South Africa must fulfil its obligation to provide healthcare for all as required by the Constitution and international covenants.

The private health care system is not spared from medical malpractice claims, as seen by its mandatory requirement for all private healthcare providers to have indemnity insurance against medical malpractice claims.[72] The present trend of increasing medical malpractice claims in number and value has impacted negatively on healthcare provision in South Africa.[73] Firstly, the increase in professional indemnity

held at Hogan Lovells, Sandton. (Accessed 02nd April 2016) Live stream on SABC News DSTV Channel 404.

[66] National Department of Health Budget http://www.treasury.gov.za/documents/national%20budget/2017/review/FullBR.pdf (Accessed on 08 April 2016).

[67] The ANC Legal Research Group. *Medical Negligence and the bleeding of the public purse.* Meeting held at Hogan Lovells, Sandton. (Accessed 02nd April 2016) Live stream on SABC News DSTV Channel 404.

[68] Judge J Kollapen; 'Project 141 Medico-Legal Claims' (2017) *Issue Paper 33* 1,7.

[69] Judge J. Kollapen; *op cit.* (2017)14.

[70] I. Carrim 'Can the National Health Insurance (NHI) succeed in the current medical malpractice climate in South Africa?' (2016). *http://www.camargueum.co.za/article/21012016/can-national-health-insurance-nhi-succeed-current-medical-malpractice-climate-south.* (Accessed on 04 April 2016).

[71] W. T. Oosthuizen, & P.A. Carstens, 'Medical malpractice: The extent, consequences and causes of the problem' (2015) 78 *THRHR* 269 ,273.

[72] National Health Act 61 of 2003 s 46.

insurance premiums has led to further increasing the cost of healthcare; secondly the reduction in the number of high risk specialties (obstetrics, neurosurgery and orthopaedic practice) influencing the quality of care received; and finally, the decline in the number of insurance companies providing medical malpractice cover.[74]

The increasing number of medical malpractice claims is a global phenomenon, beginning in the United States of America (USA).[75] Available documentation shows that there was a rapid increase in medical malpractice claims in the USA in the early 1970's. It stabilized in the late 1970's, and then there was a resurgence in the 1980's with an increase of about 10% a year.[76] Unlike in the United States of America, the United Kingdom, Canada and Australia did not experience the increase in the 1970's.[77] Nonetheless, they did experience a comparable increase in the 1980's to that seen in the United States of America.[78] Could South Africa be catching up with this global trend? Are there other contributory factors such as (a) South Africa's progressive Constitution; (b) poor quality of the management of public healthcare services; particularly corruption of the officials; (c) poverty; (d) ignorance; (e) desperation by the patients to make money by making false claims; (f) poor standard of care by the healthcare professionals; and (g) opportunity for the legal fraternity to make money?

Pepper and Nothling-Slabbert state that there has been an increase of 550% in the past 17 years in medical malpractice claims in the private sector and claims of more than R5 million in value have increased by 900% since 2005.[79] The public healthcare

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[73] D Roytowski, T R Smith, AG Fieggen, & A Taylor. 'Impressions of defensive medical practice and medical litigation among South African neurosurgeons (2014) 104 (11) *SAMJ* 736, 737.

[74] GR Howarth, B. Goolab, RN Dunn &AG Fieggen 'Public somnambulism: A general lack of awareness of the consequences of increasing medical negligence litigation' (2014) 104 (11) *SAMJ* 752.

[75] Oosthuizen *op cit.* (2015) 78 *THRHR* 280.

[76] *Ibid* 278.

[77] *Ibid* 278.

[78] *Ibid* 279.

[79] M Pepper & M Nothling-Slabbert' Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4 (1) *SAJBL* 29, 32.

caters for 86% of the population and is likely to have a much higher rate of claims by virtue of the numbers and the deficiencies in healthcare provision.

A discussion document prepared by the Steve Biko Centre for Bioethics for a Medico-legal summit which was held by the Minister of Health[80] on the 9th and 10th of March 2015, explored how medico-legal claims have escalated in both the public and private sectors. The document made comparisons and indicated what the international approach to medical malpractice claims has been. The document mentioned that the causes for the increase in medical malpractice litigation has been the result of poor record generation and keeping; (b) inadequate security for patient records; (c) low staff morale and unprofessional behaviour; (d) lack of equipment and human resources; and (e) the defence of cases without merit, such as in the case of *Lushaba*[81] where the MEC for health was trying to defend an indefensible case.

The Government is examining the possibility of law reform to mitigate the escalation in medical malpractice claims. Among the topics discussed is the fact that the amounts paid in settlement of claims have progressively increased at a rate of approximately 14% a year between 2009 and 2015.[82] The Minister of Health Dr Aaron Motsoaledi has established the Office of the Health Ombudsman to promptly address complaints about medical malpractice which it is hoped will minimize the number of cases that will be decided in the courts. This should ease the burden of the backlog experienced by the courts and save on the associated legal costs.[83]

This study will identify the risks posed by increasing medical malpractice claims to the implementation of the NHI scheme.

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[80] S. Mahomed *Discussion Document compiled by the Steve Biko Center for Bioethics in preparation for the Medico-legal Summit to be held by the Minister of Health* (2013) Pretoria Unpublished.

[81] *Lushaba v MEC for Health*, Gauteng 2015 (3) SA 616 (GJ).

[82] Judge J Kollapen *op cit.* 16.

[83] A. Motsoaledi 'Health Department Budget Vote 2016/2017' (2016) available at http://allafrica.com/stories/201605101404.html (Accessed on 11 May 2016).

1.3. The Purpose of the Study

The increasing number and value of claims, amounting to billions of Rands paid in the settlement of malpractice claims for individuals are threatening the provision of healthcare to many people in need of healthcare in South Africa.[84],[85] The right of one individual should not enjoy priority over the larger public good. It has been submitted that an individual's rights should only be respected to a point where they begin to impact negatively on the rights of others.[86] The intellectual property rights (IPRs) of pharmaceutical companies has been shown to have had a negative impact on the public's right of access to medicines because of monopolies afforded to them by their IPRs.[87]

Present and future spending on large malpractice claims will have a negative impact on the implementation and success of the NHI unless it is controlled. In the financial year 2016/2017 The Department of Health was confronted by a contingent liability of R56.1 billion which is equivalent to one third of the total health budget for the same period.[88] There is no doubt medical malpractice is a reality and that victims should be compensated where they have been wronged.[89] However, the values of the settlements need not be so high as to deny the others access to healthcare.[90]

This is a desktop study attempting to answer the following questions:

1. What impact does the SA laws (Constitution, National Health Act, Children's Act, Consumer Protection Act and Contingency Fees Act) on informed

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[84] C. Bateman "'Wing and a prayer' days over for SA's health system" (2011) 101 (12) *SAMJ* 859.

[85] A. Dhai 'Medical Negligence: Alternative Claims Resolution an Answer to the Epidemic' (2016) 9 (1) *SAJBL* 2.

[86] YA. Vawda, & B.K. Baker 'Achieving social justice in the human rights/intellectual property debate: Realising the goal of access to medicines' (2013) 13 *African Human Rights Law Journal* 55, 57.

[87] Vawda *op cit.* (2013) 13 *African Human Rights Law Journal* 64.

[88] Medium Term budget Policy Statement (2016) National Treasury Annexure A 53.

[89] Pepper *op cit.*(2011) *SAJBL* 4 (1) 34.

[90] GR Howarth, *op cit.*(2014) 104 (11) *SAMJ* 752.

consent, privacy, as well as government policies (Batho Pele Principles) have on the escalating medical malpractice claims?

2. What risks do medical malpractice claims present to the implementation of the proposed National Health Insurance scheme?
3. What lessons can be learned from other countries such as the UK, which is the most experienced, that has implemented universal healthcare in the face of increasing medical malpractice claims?
4. What suggestions have been made to effectively implement the NHI scheme in South Africa, in the face of the increasing number of medical malpractice claims?

1.4 Conclusion

As mentioned, the introduction of the Constitution,[91] the National Health Act,[92] the Children's Act,[93] the Consumer Protection Act,[94] the Contingency Fees Act,[95] and the Road Accident Fund Amendment Act,[96] have partly led to an escalation of medical malpractice litigation in South Africa.[97] When it was established, public healthcare was not originally designed to cater for the majority of the population. Their geographical location, infrastructure and human resources were planned mainly for a select few, namely the white community.[98] With the implementation of the Constitution, the number of South Africans who are dependent on public healthcare services has increased significantly and the upgrading of the public healthcare facilities has not kept pace with the increased utilization. Amongst the myriad of problems that this imbalance presents, is the boom in medical malpractice litigation in

[91] The Constitution 1996.

[92] The National Health Act 61 of 2003.

[93] The Children's Act 38 of 2005.

[94] The Consumer Protection Act 66 of 2008.

[95] The Contingency Fees Act 66 of 1997.

[96] The Road Accident Fund Amendment Act 19 of 2005.

[97] Pienaar *op cit.*(2016) *PELJ / PER* 1,11.

[98] Coovadia *op cit*.(2009) 374 *The Lancet* 817.

the public health sector that we are witnessing today. However, this is just one of the problems that are facing the delivery of quality healthcare.

The National Health Act[99] provides grounds for the patient to litigate when their autonomy, confidentiality and bodily integrity are violated by healthcare professionals without proper informed consent. Proper informed consent is sometimes difficult to secure, where communication fails due to language barriers. For instance, the language used is English in a country with 11 official languages. In some instance this necessitates the use of interpreters but with an inherent risk of distortion of information. There is a need for the use of simplified language.

The principle of 'the best interest of the child'[100] tends to challenge the rights of the parents to know about matters affecting their child's health. Where the child who is 12 years and older, and of sufficient maturity,[101] refuses to consent to the disclosure of its medical information to its parent, the healthcare professional is expected to respect this provision. The parents justifiably expect to be informed about the child's condition, so that they can provide support and guidance to the child effectively. The parents see this as the healthcare professional withholding important information and may result in conflict between the two parties. Conversely, the law imposes a duty on the healthcare professionals to report any untoward incidences which may affect the health and wellbeing of the child, such as child abuse or neglect[102]- but not to the parent.

The current and future projections of medical malpractice litigation paint a gloomy picture for healthcare in SA. The consequential depletion of financial resources threatens the maintenance, improvement of healthcare services and the introduction of the NHI scheme. This has a circular effect of reducing the quality of healthcare services provided and causing even more claims for medical malpractice.

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[99] The National Health Act ss 6, 7, 8, 14 and 17.

[100] The Constitution 1996 s 28 (2).

[101] The Children's Act 38 of 2005 s 129.

[102] DJ. McQuoid-Mason, 'Decriminalisation of consensual sexual conduct between children: What should doctors do regarding the reporting of sexual offences under the Sexual Offences Act until the Constitutional Court confirms the judgement of the Teddy Bear Clinic case?' (2013) 6 (1) *SAJBL* 10,11.

CHAPTER 2 THE PROPOSED (NHI) SCHEME FOR SA

2.1 Background to the NHI policy for SA

Access to healthcare is a human right and government must ensure the progressive realization of this right within its available resources as stipulated in the Bill of Rights.[103] It is essential that the right be met by creating the necessary conditions for people to access healthcare, by providing positive assistance, benefits and actual quality healthcare services.[104] Universal access to a quality healthcare service is a basic human right - hence the worldwide attempts to provide sustainable healthcare to the public.[105] Free quality healthcare will ensure that people are not exposed to the excessive cost of healthcare, which can be catastrophic at the going private healthcare prices. SA as a developing country, with limited resources and a poor economic outlook, faces a worst risk to healthcare provision than that experienced by the UK after the Second World War with a developed economy. Regardless, SA is going ahead with the implementation of the NHI scheme, because it is key to preventing poor health and catastrophic healthcare costs, which are major factors in retarding development.[106]

The NHS in the UK has been running for 70 years and is a model of publicly funded universal healthcare (Chapter 3). South Africa launched the NHI Green Paper in 2011 which is said to provide an innovative and sustainable system for the financing of healthcare, as well as offering quality services to citizens.[107] It was followed by the publication of the NHI Bill on the 21st June 2018 in the *Government Gazette*.[108]

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[103] The Constitution 1996 s 27 (2).

[104] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights (ICESCR),* 2200 (XXI) of 16 Dec 1996.

[105] Human Rights and Health (2017) http://www.who.int/mediacentre/factsheets/fs323/es/ (Accessed on 02 Aug 2018).

[106] *Ibid*.

[107] The Green paper Republic of South Africa, Department of Health (2011). *National Health Insurance in South Africa: Introduction.* Pretoria.

[108] *SA Government Gazette* 21 June (2018) No 635 4.

The current South African healthcare system is inequitable and undermines the rights of many citizens, especially those in the low-income brackets and the unemployed.[109] Therefore, the implementation of a system such as the proposed NHI scheme is designed to change and improve healthcare delivery to everyone in the country.[110]

The NHI objectives are to advance access to quality health services for all who live in South Africa, irrespective of their employment status.[111] Private healthcare is very expensive and unaffordable even to the employed, as seen by the increases in member's contributions to medical schemes with shrinking benefits packages. The proposed NHI scheme aims to pool financial resources and secure healthcare services on behalf of the entire population.[112]

As stated by the National Department of Health (NDoH), the NHI scheme plans to procure services efficiently on behalf of the entire population.[113] This system would strengthen the under-resourced and strained public sector to improve delivery of healthcare.[114] However, challenges such as opposition from the private healthcare providers, corruption in the healthcare sector, legislative challenges, insufficient human resources, lack of professionalism from the healthcare providers and the public's mistrust of the government, need to be addressed.[115]

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[109] D. McIntyre, M. Thiede, M. Nkosi, V. Mutyambizi, M. Castillo-Riquelme L Gilson, E. Erasmus, J Gouldge, 'A Critical Analysis of the Current South African Health System' (2007) *Shield Work Package 1 Report'* 10.

[110] A Gray & Y Vawda. Health Policy and Legislation. In: Padarath A, King J, Mackie E, Casciola J, (eds). *South African Health Review (*2016*)*. *Health Systems* Trust 4.

[111] Department of Health *National Health Insurance White Paper* 'National Health Insurance for South Africa: Towards Universal Health coverage' December 2015.

[112] NHI White Paper *op cit.* 11 261.

[113] D McIntyre, B. Garshong, G. Mtei, F. Meheus, M. Thiede, J. Akazili, M. Ally, M. Aikins, J. Mulligan & J Goudge 'Beyond Fragmentation and Towards Universal Coverage: Insights from Ghana, South Africa and United Republic of Tanzania (2008) 86 (11) *Bulletin of the World Health Organization* 871,876.

[114] PR, Sekhejane 'South African National Health Insurance (NHI) Policy: Prospects and Challenges for its Efficient Implementation' (2013) 102 *Africa Institute of South Africa Policy Brief* 1,3.

[115] L Amado, N Christofides, R Pieters, & J Rusch. 'National Health Insurance: A lofty ideal in need of cautious, planned implementation' (2012) 5(1): *SAJBL* 4,7.

The history of public healthcare provision can be traced as far back as 1918, when legislation about public health was first introduced.[116] BJ Pienaar chaired a Commission on Old Age Pensions and National Insurance in 1928, which supported the free coverage of medical, maternity and funeral benefits for low-income employees in the formal sector in urban areas.[117] The National Health Service Commission (1942-1944)[118] chaired by Henry Gluckman, recommended that healthcare services be provided free of charge at the point of service for all who lived in SA without discrimination. The similarities between this proposal and the NHI are evident. However, it was short-lived with the election of the National Party in 1948 with DF Malan at the helm.[119]

From then onwards, public health provision was segregated and favoured the white minority population and provided an inferior service for the majority black population. During this period the white population enjoyed world-class services, with the achievement of the world's first heart transplant by Dr Christiaan Barnard.[120] under public healthcare service. Private healthcare was available to those who could afford it.

Private health insurance in SA was pioneered by mining companies to provide healthcare for their white employees and membership was voluntary.[121] In the 1960's 80% of white people had access to private healthcare in contrast to the 90% of the black population, that had to rely on the substandard public health sector.[122] The

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[116] S. Horwitz 'Health and Healthcare under Apartheid' (2009) Unpublished University of Witswatersrand 3.

[117] D. McIntyre, 'National Health Insurance: Providing a Vocabulary for Public Engagement'. In: S. Fonn, A, Padarath, (eds). South African Health Review (2010). *Health Systems Trust*;145, 147.

[118] Coovadia, *op cit.* (2009) 374 *The Lancet* 826.

[119] H. van Rensburg & D. Harrison 'History of Policy' In D Harrison & M Nielson (eds) South African Health Review (1995) *Health Systems Trust* 95, 101.

[120] van Rensburg *op cit. (1995) Health System Trust* 99.

[121] Coovadia, *op cit.* (2009) 374 *The Lancet* 820.

[122] D. McIntyre & R.E. Dorrington. 'Trends in the Distribution of South African Health care Expenditure' (1990) 70 *SAMJ* 127.

Medical Schemes Act (MSA)[123] was introduced in 1967 to regulate private healthcare, and to protect white users from the private health providers and prescribe minimum benefits (pmb's).[124] In 1989 and 1994 reforms were introduced which allowed medical insurers to run their own services.[125] The introduction of the MSA resulted in a migration of healthcare providers from the public to the private sector, attracted by better income, as they could charge for their services, and not depend on state salaries.[126] The migration of healthcare professionals from the public to the private sector led to the deterioration of the public sector, and exposed the government to the high levels of medical malpractice litigation that is seen today.[127] This has escalated since SA's first democratic elections with an increased number of beneficiaries and insufficient resources.[128] Healthcare reform was inevitable and various commissions were established to address the healthcare needs of the entire population of SA.[129]

The Health Care Finance Committee in 1994 recommended that all formally employed individuals, together with their immediate dependents, should mandatorily subscribe to health insurance known as the Social Health Insurance (SHI).[130] Moreover, in 1995 then Health Minister, Nkosazana Dlamini-Zuma, appointed a Committee of Inquiry on National Health chaired by Drs. J Broomberg and O Shisana, to establish the role that

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[123] The Medical Schemes Act 72 of 1967.

[124] Hassim *op cit.* (2007) *Health and Democracy* 167.

[125] Hassim *op cit.*(2007) *Health and Democracy*168.

[126] Coovadia, *op cit*.(2009) 374 *The Lancet* 826.

[127] LC Coetzee & Carstens PA 'Medical Malpractice and Compensation in South Africa' (2011) 86 (3) *Chicago Kent Review 1263,* 1299.

[128] P. Mahlathi & J Dlamini 'Understanding and managing the movement of medical doctors in the South African health system' (2017) *African Institute for Health and Leadership Development 10.*

[129] H. Mcleod 'National Health Insurance Background Brief (2009)' *Innovative Medicine South Africa* 1,3. 1994 Health Care Finance Committee; 1995 Committee of Inquiry into National Health Insurance; 1997 Department of Health SHI Working Group; 2002 Taylor Committee of Inquiry into Social Security 2004/5 Ministerial Task Team for Implementing SHI.

[130] African National Congress. 'A National Health Plan for South Africa' (1994) http://www.anc.org.za/content/national-health-plan-south-africa (Accessed on 06 June 2017).

the medical schemes could play in the SHI scheme.[131] The proposal, however was inadequate as it only catered for the needs of the few employed, and not the entire population, reminiscent of healthcare provision prior to democracy.[132]

Despite the proposed SHI shortcomings, the idea was still pursued and the Social Health Insurance Working Group in1997 devised a framework that defined the role of private healthcare financing.[133] In 2002 the Committee of Inquiry into Comprehensive Social Security for South Africa chaired by Professor V Taylor, recommended a dedicated tax for health that would finance compulsory cover for those who were in the formal sector and earning above a stipulated tax threshold.[134] To implement the recommendations made by the Taylor Committee, the Ministerial Task Team on Social Health Insurance was convened in 2002 to draft the implementation plan. However, like previous other proposed models, Taylor's social health insurance recommendations failed, as it only catered for the working members of the population and would have left out the non-working population.

It is during this time the HIV-AIDS epidemic was gaining momentum and the public health sector was failing to cope. This was aggravated when ex-president Thabo Mbeki's government failed to provide a rational response to the epidemic, and this compounded the situation.

2.2 The NHI Scheme proposal

The ANC Polokowane conference of 2007,[135] resolved to implement a universal healthcare system for SA. This was followed by the formation of the Advisory Committee on National Health Insurance in 2009 to develop and accelerate

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[131] H McLeod & S. Ramjee 'Medical Schemes'. In: Harrison S, Bhana R, Ntuli A, (editors). (2007) *South African Health Review Health Systems Trust 48.*

[132] Hassim *op cit.*(2007) *Health and Democracy* 171.

[133] D. McIntyre *op cit.* (2010) *South African Health Review* 78, 80.

[134] Reports of the Taylor Committee into a social security system for South Africa Committee Report No.6 *Various Social Security Aspects of the South African Health System* (2002) 189.

[135] African National Congress. ANC 52nd National conference resolution. 2007 Dec 16 – 20, Polokwane.

implementation of the NHI scheme. The NHI Green Paper[136] was published on the 12th August 2011 and it outlined the following four clear objectives:

1. To provide improved access to quality health services for all South Africans irrespective of whether they are employed or not.
2. To pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund.
3. To procure services on behalf of the entire population and efficiently mobilize and control key financial resources. This will obviate the weak purchasing power that has been demonstrated to have been a major limitation of the medical schemes resulting in spiralling costs.
4. To strengthen the under-resourced and strained public sector to improve the health systems performance.

The NHI would be implemented in three phases over a 14-year period, starting in 2012 with 11 pilot sites.[137]

2.2.1 The First Phase 2012 – 2017

The period encompassed policy and legislative reforms to strengthen the public health system and to improve the service delivery platform. This will be done by selecting districts for piloting various components of the scheme and establishing the transitional NHI fund. In 2015 the White Paper on NHI was released and the objectives set out in the Green Paper were then modified so that they could be carried into the Bill.[138]

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[136] Department of Health (DOH). National Health Insurance in South Africa: Policy Paper (2011).

[137] MP. Matsoso & R. Fryatt 'National Health Insurance: The first 18 months' (2013) *SAMJ* 103 (3): 156,158. The Pilot sites are as follows:

SITE		POPULATION COVER	PROVINCE
1.	OR Tambo	1 754 499	Eastern Cape
2.	Thabo Mofutsanyane	771 610	Free State
3.	City of Tshwane	2 520 425	Gauteng
4.	Amajuba	517 279	KZN
5.	uMgungundlovu	1.071 606	KZN
6.	uMzinyathi	517.806	KZN
7.	Vhembe	1 312 197	Limpopo
8.	Gert Sibande	946 719	Mpumalanga
9.	Pixley ka Seme	192 572	Northern Cape
10.	Dr. Kenneth Kaunda	902 675	North West
11.	Eden	567 993	Western Cape

[138] The White Paper National Health Insurance: Towards Universal Health Coverage (2015) *http://www.gov.za/sites/www/gov.za/files/National_Health_Insurance_White_Paper_10 Dec2015.pdf* (Accessed on 06 June 2017).

2.2.2 The Second Phase 2018 - 2021

The second phase will deal with the registering of the population and issuing of patient beneficiary cards, with priority being given to vulnerable groups - the elderly, children and people with disabilities. It would include redirection of the funds from the Workman's Compensation Fund and the Road Accident Fund to the NHI Fund. The fund will begin to buy health services from providers.[139]

2.2.3 The Third Phase 2022 - 2026

The third phase will encompass the integration of the public and private healthcare systems.

2.2.4 Other possible sources of funding

As much as job creation is critical for the South African economy, the negative impact to health by some industries should not be overlooked. The introduction of the sugar tax, tax on plastic packaging, sin tax (alcohol and tobacco) are positive development towards making industries contribute to the negative impact they have on health.
Road traffic offences including speeding fines, failure to comply with regulations should also be redirected towards the NHI fund as they too impact on increasing the burden on healthcare services. Non-resident visitors to South Africa should be charged for services rendered under the NHI.

The marketing of health products which are not registered as medicine and sold as supplements should be subjected to tax like alcohol, tobacco and sugar, because they can contribute negatively towards healthcare by portraying the impression that they are preventive to diseases and thus misleading and discouraging the population from appreciating the value of primary healthcare.

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[139] *Ibid.*

2.3 The NHI White Paper

The White Paper estimates that the total cost for implementing the NHI scheme from 2010 to 2025 will be R256 billion in 2010 terms.[140] The funding of the NHI scheme will be tax-based whereby all employed persons will contribute according to their income, and the services will be rendered to all according to their health needs, free of charge at the point of service.[141] The argument that SA cannot afford the cost of implementing the proposed NHI scheme comes largely from the private sector, as they perceive the NHI scheme as a threat to their continuing existence.[142]

There were 17 million people dependent on social grants (29.7% of the population) in 2016[143] and the grants cannot cover the cost of medical services for the poor. The unemployment rate of 27.7% in 2017,[144] means that many South Africans are reliant on public healthcare. The low-income bracket individuals with the low levels of skills also depend on the public healthcare services. The unaccounted-for illegal immigrants and asylum seekers also add to the burden on the public healthcare services. This is further aggravated by private patients who have exhausted their medical scheme benefits. Private healthcare can only be attained by the working few, who are also at risk from escalating high healthcare expenses with limited cover.[145] In line with the UN's Millennium Development Goals (MDG) and SA's own National Development Plan (NDP),[146] increasing healthcare costs may aggravate poverty, and it is argued

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[140] The White Paper *op cit.* 252.

[141] *Ibid*.

[142] D. McIntyre, 'Can South Africa afford not to have NHI?' (2011) The South African Health News Service https://www.health-e.org.za/2011/08/22/can-south-africa-afford-not-to-have-a-nhi. Section 27 (Accessed on 06 June 2017).

[143] Statssa General Household Survey PO318 (2016) s 7 http://beta2.statssa.gov.za (Accessed on 07th June 2017).

[144] Statssa (2016).

[145] DJ Ncayiyana 'The self-destructing private sector is no less a blot on our health system than the crumbling public health system' (2012) 102 (10) *SAMJ* 772.

[146] Brand South Africa 'The National Development Plan: A Vision for 2030' (2017) https://www.brandsouthafrica.com/governance/ndp/the-national-development-plan-a-vision-for-2030 (Accessed on 12 Aug 2018).

that NHI would help to address such poverty.[147] There are, however, realistic threats to the implementation of the NHI scheme which will be explored below.

The SA health outlook is bleak as the country is already spending 8.8% of its GDP on healthcare with unsatisfactory outcomes as compared to other developing countries.[148] It is hoped that the introduction of the NHI scheme which will be primary healthcare-driven, thereby reducing the burden of diseases and will result in the reduction of demand for secondary healthcare services.[149] The NHI will command purchasing power as a single purchaser of healthcare services for the entire population.[150] The monopoly which will be enjoyed by the NHI is necessary as it will be for the benefit of the entire population in pursuit of social solidarity. All medical records will be electronic and centralized with password protection, to eliminate duplication of services and improve on patient care while saving costs.[151]

The inherited dysfunctional healthcare system is depriving most of the population of quality healthcare. Successful implementation of the NHI scheme will improve the healthcare of the population, and it is believed that it will increase productivity and development of the population will result.[152]

2.4. Threats to the successful implementation of the NHI scheme in SA

The provision of healthcare has three distinct spheres namely: -

a) Management of the healthcare department.
b) Resources available to deliver healthcare (human and financial resources).
c) Recipients who must find the services, accessible, affordable and acceptable.

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[147] Human Rights and Health (2017) http://www.who.int/mediacentre/factsheets/fs323/es/ (Accessed on 02 Aug 2018).

[148] MMI Health 'Funding for National Health Insurance' (2016) *Submission to Davis Tax Committee* 16.

[149] Section 3 The White Paper 48.

[150] Chapter 8 The White Paper 275.

[151] Chapter 7 The White Paper 264.

[152] McIntyre *op cit*.(2010) 152.

Failure in any of the above spheres can lead to medical malpractice claims with negative impact on the implementation of the proposed NHI scheme.

McIntyre emphasizes the need to engage with the public, as well as front-line healthcare workers, to achieve a successful implementation of the NHI scheme.[153] There needs to be a clear understanding by the public, (who are the recipients of the NHI scheme), of what the scheme sets out to achieve. There also needs to be a better understanding by front-line healthcare workers of what is expected of them in order to achieve their positive involvement and patient satisfaction.

The NHI policy focuses predominantly on the creation of a universal health-care system. However, it does not address distribution of efficient, skilled and professional healthcare workers in the public sector clearly.[154] The total number of medical practitioners registered in SA in 2015 was 42 323 of which only13 656 were working in the public sector.[155] This suggests that around 28 500 are either working in the private sector, or they could be working abroad whilst retaining their registration in South Africa. The best scenario, (where all the registered doctors in the country would be evenly distributed throughout the population), would give the doctor per population ratio of 1:1 299 based on a population estimate of 55 million.[156] Eighty percent of the population rely on the public health sector served by only 13 656 medical practitioners. This means that there is a doctor per population ratio of 1: 3 244 in the public sector, as compared to the 1:1 000 recommended by the WHO.[157]

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[153] McIntyre *op cit*.(2010)149.

[154] C. Day & A Gray 'Health and related indicators'. In: Padarath A, Barron P, (eds). South African Health Review 2017 *Health Systems Trust*; 341.

[155] Health Professions Council of South Africa (HPCSA) Statistics. (2016) http://hpcsa.co.za/ (Accessed on 06th June 2018).

[156] Statssa Mid-year Population Estimates PO 302 (2018) https://www.statssa.gov.za/publications/P0302/P03022017.pdf *(A*ccessed on 06 June 2018).

[157] S T Ntuli & E Maboya. 'Geographical distribution and profile of medical doctors in public sector hospitals of the Limpopo Province, South Africa.' (2017) 9 (1) *African Journal of Primary Health Care & Family Medicine.* 3.

To address the distorted distribution of medical practitioners, SA government introduced a 'certificate of need' for healthcare professionals. This attempt by NDoH failed because it was unconstitutional, as it implied that all healthcare professionals in practice without the certificate of need would be practicing against the law.[158]

The case of *President of the Republic of South Africa and Others v South African Dental Association and Another* [159] confirmed the unconstitutionality of the 'certificate of need'. Moreover, it was incorrect to curtail people's freedom of trade, occupation or profession.[160]

SA is not short of medical practitioners, the distribution of medical practitioners between the private and public healthcare sectors is inappropriate. It would be a sacrifice for a healthcare professional to select to work in challenging rural areas, therefore the government should consider remuneration that is comparatively higher than that of a similar professional in urban areas in order to attract and retain such professionals in those settings.[161]

The recruitment of foreign doctors from Cuba was introduced to address the rural medical practitioners' shortages.[162] The deployment of foreign doctors in remote and rural areas might have impacted positively[163] on the situation, and only time will tell if it will be sustainable.

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[158] The Constitution s 21 (1) (3) s 22.

[159] *President of the Republic of South Africa and Others v South African Dental Association and Another* (CCT 201/14) [2015] ZACC 2; 2015 (4) BCLR 388 (CC) (27 January 2015).

[160] *Ibid*.

[161] JL. Haskins, SA. Phakathi, M. Grant & CM. Horwood. 'Factors influencing recruitment and retention of professional nurses, doctors and allied health professionals in rural hospitals in Kwazulu-Natal' (2017) 22 *Health SA Gesondheid* 174 183.

[162] Ntuli *op cit.* (2017) 9 (1) *African Journal of Primary Health Care & Family Medicine* 3.

[163] *Ibid*.

2.4.1 NHI pilot projects

Recruitment of general practitioners for the NHI pilot sites has failed to achieve the targeted number of GP's needed to run the NHI pilot sites due to the following factors:[164]

1. Remuneration: The government is offering NHI GP recruits a basic rate of ZAR 381 per hour, whereas in the private practice a GP can earn more than ZAR 2000.00 per hour. At this rate the government is unlikely to attract and retain experienced GP's for the NHI. A different model of remunerating healthcare providers may attract many healthcare providers. Capitation model, where a healthcare provider is paid upfront for looking after a certain number of patients is far more attractive than the current payment model employed by government at present.
2. Reluctance of GP's to forgo their independence: The NHI pilot sites are run by nurses and therefore the GP's are unlikely to take instructions from such nurse, as the GP's have a higher level of training.[165] From the author's experience, patients at primary care clinics are poorly managed and not referred to the hospital in good time, resulting in patients either deciding to consult private general practitioners or their condition worsening, which will result in an unnecessary burden on the hospitals.
3. Pilot sites are inadequately equipped: The pilot sites lack basic monitoring and procedural equipment such as foetal monitoring systems resulting in unnecessary referrals of patients to hospitals for conditions that could have been managed at the clinics.[166]
4. Stock-outs of medicines: The stock-outs and the limited Essential Drug List (EDL) lead to patients being referred to hospitals due to lack of medicines in the clinics.[167]

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[164] R. Surender, R. van Niekerk & L Alfers. 'Is South Africa Advancing Towards National Health Insurance? The Perspectives of General Practitioners in One Pilot Site' (2016) 106(11) *SAMJ* 1092.

[165] The author.

[166] Surender *op cit.*(2016) 106 (11) *SAMJ* 1093.

[167] *Ibid*.

5. Very high workload: The GP's must service huge numbers of patients within a limited time, meaning that the consultation times will be insufficient to provide quality care.[168]
6. GP's end up assisting the nurses: GP's must assist nurses because of the large numbers of patients in need of service and the shortage of nurses. This is often due to misappropriation of resources.[169]

Most users are dissatisfied with the quality of service they receive from the public-sector facilities, mainly due to the uncaring attitude of the staff, long waiting times, and poor management of facilities.[170] In an attempt to address the shortcomings of public servants and the negative perceptions about public health, the Batho-Pele Principles[171] as well as the National Patient's Charter [172] were launched. The impact of these policies is yet to be fully realized.

2.4.2 NHI issues to be addressed

It is anticipated that there will be changes, if not the NHI scheme ideals will never be realized and this will further amplify other weaknesses in the public healthcare sector such as increasing medical malpractice claims.[173] Matsoso and Fryatt[174] report that the implementation is progressing positively in many areas.

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[168] *Ibid*.

[169] *Ibid*.

[170] E Scheffler, S Visagie & M. Schneider. 'The impact of health service variables on healthcare access in a low resourced urban setting in the Western Cape, South Africa' (2015) 7 (1) *Afr J. Prm Health Care Fam Med* 6.

[171] The *Batho Pele* Principle' South Africa. Department of Public Service and Administration. *Batho Pele* handbook: http://www.dpsa.gov.za/batho-pele/docs/BP_HB_optimised. pdf. (Accessed on 08 May 2017).

[172] Booklet 3: National Patients' Charter. Health Professions Council of South Africa. (2008) http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules (Accessed on 21 Aug 2018).

[173] S. Benatar. 'The challenges of health disparities in South Africa' (2013) 103 (3) *SAMJ* 154.

[174] Matsoso *op cit*.(2013) 103 (3) *SAMJ* 157.

The public health sector also has some self-destructive tendencies which pose a risk to the successful implementation of the NHI scheme. The attitudes of many of the personnel are unprofessional and counterproductive. The fact that many are medical aid members using private facilities has a negative impact on their motivation to improve the quality of care delivered to the public.[175] The negative attitude of healthcare providers and workers needs to be addressed to improve the interaction between the care giver and the recipient. If the communication between the patient and the care giver is respectful and earnest, it will enhance the resolution of problems should harm occur. It has been estimated, that the full implementation of the NHI scheme will have a total cost of approximately R336 billion by 2025.[176] The case of *Sony and Another v Premier of KwaZulu Natal and another* illustrates the responsibility of the healthcare provider to its patient as opposed to advice given by other junior personnel in the healthcare provision.[177] Budgeting for training and support may result in further costs, but will save costs in the long term, as it may reduce the incidence of malpractice claims in the public sector.[178]

Adequately trained healthcare providers and workers, (as they are the face of the NHI), will improve the experience of the patients about public healthcare. With improved perceptions and positive engagement, health outcomes are likely to improve resulting in increased productivity that could raise the GDP by 0.5%.[179]

Patients who are referred to the public health sector from private providers are shabbily treated by the public healthcare employees.[180] For instance, a patient who

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[175] The author.

[176] D. McIntyre, 'Can South Africa afford not to have a NHI?' (2011) *The South African Health News Service* https://www.health-e.org.za/2011/08/22/can-south-africa-afford-not-to-have-a-nhi. (Accessed on 06 June 2017).

[177] *Sonny and Another v Premier KwaZulu Natal and another* 2010 (1) SA427 KZP.

[178] Sekhejane *op cit*.(2013) 102 *Africa Institute of South Africa Policy Brief* 3.

[179] *Ibid*.

[180] The author.

was referred to hospital by the author for an ankle fracture that required internal fixation accompanied with an x- ray reported by a registered radiologist, was made to undergo another x-ray examination before they could be assisted. This is an indication of duplication and wasteful expenditure and discourages patients from continuing to seek care from public hospitals and further reinforces the stereotype of uncaring public healthcare providers.[181]

The NHI scheme has resulted from the ANC policy adopted at the Polokwane ANC conference in 2007.[182] The opposition parties' position on the NHI scheme is unclear regarding its the adoption and implementation. A change in government by a different political party poses a potential risk to the implementation of the NHI scheme, as has happened in the past.[183] The new government may have a different program to address the healthcare needs of all South Africans.[184] It is submitted that the next general election in 2019 may usher in a policy change relating to the proposed NHI scheme.

Biased contributions by the print, radio and television media can mislead the public who lack the capacity to analyse and criticize such content - the majority of whom are the intended beneficiaries of the scheme.

2.6 Conclusion

It is going to be challenging to provide adequate access to people in rural areas, given that 43% of the population resides there, while healthcare professionals are reluctant to live in the rural areas.[185] The implementation of the NHI scheme needs to address

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[181] The author.

[182] 'Resolutions by ANC, 20 December 2007, 52nd National Conference, Polokwane' https://www.sahistory.org.za/archive/resolutions-anc-20-december-2007-52nd-national-conference-polokwane (Accessed on 24 Oct 2018).

[183] Coovadia, *op cit.* (2009) 374 *The Lancet* 826.

[184] S. Thomas & L Gilson 'Actor Management in the development of health financing reform health insurance in South Africa 1994 - 1999' (2004) 19 (5) *Health Policy Plan* 279.

[185] Human Resources for Health South Africa 'HRH strategy for the health sector 2012/ 2013 – 2016/ 2017' (2011) *National Department of Health* 30.

this challenge and this will require innovative thinking. If healthcare professionals initially migrated from public to private healthcare because of the remuneration, then government can reverse that by offering remuneration that is better than that offered in private. It is submitted that private healthcare will be stifled as a result, provided the public sector becomes effective and efficient.

The culture of poor service delivery compounded by corruption across the entire government departments, especially healthcare delivery, is largely instrumental in the negative public outlook towards government's ability to implement the NHI scheme successfully. The high levels of medical malpractice claims experienced by the NDoH is but a symptom of hopeless healthcare delivery. Unless medical malpractice is addressed one cannot justify the decision to implement the NHI scheme in this hostile environment.

CHAPTER 3 THE EXTENT OF MEDICAL MALPRACTICE IN SA

3.1 Medical malpractice litigation in SA

Medical malpractice is a broad term which includes professional negligence as a subset and not a synonym.[186] It is complex and difficult to understand, because it has different implications for different people. To a patient it could be any harm that occurs regardless of the presence or absence of negligence. To a healthcare professional it could be perceived as a vindictive action against their professional integrity. To the government it is an unpleasant and wasteful expense. To society it could mean depletion of scarce resources. Finally, to the lawyers it could be a risky but rewarding exercise. Carstens states that medical negligence forms the larger part of medical malpractice in SA, whether committed by omission or commission.[187] As medical malpractice claims are more likely to be decided in a court of law, it is intended to deal with the legal principles involved.

3.1.1 Professional negligence

Professional negligence occurs when a healthcare professional harms a patient because of a failure to act, or having acted in a way that a reasonable practitioner in his or her field of practice ought not to have acted in a comparable situation.[188] This describes the level of skill that is expected from the professional in question. For instance, a specialist is expected to have a higher level of skill than a general practitioner.[189] A general practitioner who attempts to perform a procedure on a patient that requires specialist expertise and harms the patient, will be found negligent for practicing outside his/ her scope of expertise.[190] The shortage of skilled

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[186] DJ. McQuoid-Mason, 'What constitutes medical negligence? A current perspective on negligence versus malpractice' (2010) 7 *SA Heart* 249.

[187] P. Carstens & D Pearmain *Foundational Principles of South African Medical Law* (2007) 599.

[188] MA Dada & DJ McQuoid Mason (eds) *Introduction to Medico-Legal Practice* (2001) 339.

[189] McQuoid-Mason *op cit.* (2010) 7 *SA Heart* 249.

[190] DJ McQuoid-Mason 'The Medical Professions and Medical Practice. In WA Joubert & JA Faris (eds). *The Law of South Africa vol 17* part 2 2nd ed (2008): paras 39 and 45.

professionals in the public sector contribute to escalating medical negligence claims. For example, junior doctors are sometimes faced with situations where they attempt to do procedures that require a higher level of skill than they possess.[191] In *Nyathi v MEC, Department of Health, Gauteng and Others* [192] a central venous line[193] was inserted into his carotid artery at Pretoria Academic Hospital, then he was transferred to Kalafong hospital. Insertion of a central venous line into a carotid artery would result in oxygenated blood forced under pressure to escape through the tube instead of medicines flowing into the artery. To a trained junior health professional, this would raise alarm because the high pressure and the bright red blood which will go into the tube. The professional who inserted the line was grossly incompetent to carry out the procedure. The second hospital failed to identify and correct the mistake. Again, this is grossly incompetent. One can only conclude that the person who inserted the central venous line did not have the requisite skill to do so and the professionals at the second hospital were negligent.

In a court of law, the presence of harm alone does not establish negligence. For negligence to have occurred the harm should have been foreseeable and there must have been a failure to take adequate measures to mitigate it.[194] When obtaining an informed consent, the patient needs to have been warned against the likelihood of harm occurring and have attached significance to it.[195] Furthermore, failure to cure does not constitute negligence, unless an undertaking was given that a cure is guaranteed.[196] Various professional negligence acts include disclosure of confidential medical information without consent as happened in the case of *Jansen van Vuuren* v

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[191] Pepper (2011) 4 (1) *SAJBL* 29, 28.

[192] *Nyathi v MEC, Department of Health, Gauteng and Others* (2008) ZACC.

[193] A thin tube (drip) inserted into a neck vein, in order to facilitate administration of medicines directly into the vein during a resuscitation procedure. If the central venous line is inserted into an artery, because of high pressure in the arteries blood will flow out and medicines will not flow in.

[194] SA Strauss, *Doctor, Patient and the Law* 3 ed. (1991) 284.

[195] Dada & McQuoid-Mason *op cit. 8.*

[196] McQuoid-Mason *op cit.* (2010) 7 *SA Heart* 248.

Kruger.[197] For example, in *Friedman v Glicksman,*[198] the doctor failed to warn the patient about the risks of having a child with deformities due to her age and the parents were able to recover damages. Only the courts will decide on whether professional negligence occurred or not, it is not the expert witnesses nor professional bodies that take this decision.[199]

Liability for professional negligence in medical practice can extend to the employer where the offender is employed and acting within the scope of his / her employment.[200] This amounts to vicarious liability and both the perpetrator and the employer will be liable.[201] It is worth noting that vicarious liability does not extend to the employer who enters into contracts with independent contractors, as the brief of the latter will be limited to the work they have to do and the employer does not tell them how to do it.[202] In the case of the proposed NHI scheme, the NDoH will be liable vicariously, as contracted medical practitioners will be expected to comply with the employer's protocols. The liability will extend to the employer, as is the case in the UK, under the NHS with the Clinical Negligence Scheme for Trusts (CNST).[203]

3.1.2 The cost of medical malpractice claims

Bateman[204] states that there has been a steep rise in medical malpractice claims in South Africa. An important question to consider is what effect this increase is having

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[197] Cf *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A). The Constitution 1996 s 14 (d).

[198] *Friedman v Glicksman* 1996 (1) SA 1134 (W).

[199] Dada & McQuoid-Mason *op cit.* 22.

[200] McQuoid-Mason *op cit.* (2010) 7 *SA Heart* 248.

[201] *Ibid.*

[202] Dada & McQuoid-Mason *op cit.* 25.

[203] NHS Indemnity 'Arrangements for Clinical Negligence in the NHS' http://www.unitetheunion.org/uploaded/documents/PLINHSEmpEng11-4005.pdf NHS Trusts Constitution (Accessed on 07 May 2018).

[204] C. Bateman 'Medical Negligence Pay-outs Soar by 132% Subs Follow' (2011) 101 (4) *SAMJ* 216,217.

on the provision of healthcare in South Africa generally. The Medical Protection Society (MPS)[205] has reported that the cost of reported claims has more than doubled over a recent 2-year period in private healthcare. Claims exceeding R1 million have increased by nearly 550 % compared to those of 10 years ago, while claims of over R5 million have increased by 900 % in the past 5 years.[206] In 2016, the Gauteng Departments of Health and Social Development reportedly faced medical malpractice claims totalling R13,8 billion, and nationally all provinces faced claims of R37 billion.[207] Media reports of high damages awarded for malpractice claims in public health institutions are common-place, and becoming more frequent with each passing year.[208]

Malherbe states that the Health Professions Council of South Africa (HPCSA) received 2,403 complaints about health care professionals between April 2011 and March 2012.[209] Many of these related to claims of insufficient care, incompetence, lack of consent, fraud and theft.[210] Thus it is clear that there has been a significant increase in medical malpractice in recent years, and both the size and frequency of medical malpractice claims has escalated, affecting both the public and private sectors.

In March 2012, the Acting Registrar of the HPCSA, Dr TKS Letlape was reported as saying that a decline in the levels of professionalism among practitioners was one of the reasons for the launch of a national radio awareness campaign, aimed at educating the public on the role of the HPCSA. This was to create awareness of

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[205] G. Howarth & E. Hallinan 'Challenging the Cost of Clinical Negligence' (2016) 106 (2) *SAMJ* 141.

[206] Judge N Classen, 'Mediation as an Alternative Solution to Medical Malpractice Court Claims' (2016) 9 (1) *SAJBL* 7,10.

[207] K. Masweneng 'Medical Lawsuits Posing a Financial Risk to Healthcare in Gauteng (2017') https://www.timeslive.co.za/news/south-africa/2017-08-13-medical-lawsuits-posing-a-financial-risk-to-healthcare-in-gauteng-ramokgopa/ (Accessed on 07 Sept 2017).

[208] Judge J Kollapen *op cit*.17.

[209] J. Malherbe, 'Counting the cost: The consequences of increased medical malpractice litigation in South Africa'. (2013) 103 (2) *SAMJ* 83.

[210] Health Professions Council of South Africa (2016) Annual Report 2015/2016 114.

patients' rights and responsibilities when accessing healthcare.[211] However other professional bodies tend to disagree, and suggest that patient awareness of their rights will add impetus to the increasing numbers of medical negligence claims.[212] The constitutional right to bodily and mind integrity[213] assists patients to hold their healthcare practitioners accountable.

3.1.3 The effect of medical negligence claims

Advances in science have improved the life expectancy of babies born with mental defects because of problems in pregnancy or during birth.[214] When the courts decide on the amount of claim to be paid, they take life expectancy of the victim into consideration. This has resulted in ever increasing amounts of settlements for these cases as demonstrated by *B and Other v MEC Health and Social Development*[215] where a minor was born with encephalopathy and cerebral palsy because of negligence and the courts awarded damages of ZAR 20 million.

Judge Claasen[216] argues that an increase in medical malpractice claims has both direct and indirect effects on the cost of healthcare. In a direct manner, increased malpractice litigation causes the indemnity premiums of healthcare practitioners to increase, thereby resulting in a hike in fees payable by patients for professional services.[217] The indirect effect is seen in smaller urban areas and rural settings, where practitioners working in high-risk specialties (e.g. obstetrics, neurosurgery and orthopaedic surgery) may not be able to perform enough treatments or operations to

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[211] M Mahlangu 'HPCSA embarks on a public road show' (2015) https://www.health-e.org.za/2015/10/23/hpcsa-embarks-on-public-road-show/ (Accessed on 07 June 2017).

[213] The Constitution 1996 s12 (2)(a)(b)(c).

[214] Statssa Release PO302 Mid-year Population estimates 2016 https://www.statssa.gov.za/publications/P0302/ *(A*ccessed on 05 June 2017).

[215] *B and Another v MEC Health and Social Development Gauteng Provincial Government* 16233/13 2017 ZAGPPHC 152.

[216]Judge N Classen, 'Mediation as an alternative solution to medical malpractice court claims' (2016) 9 (1) *SAJBL* 7.

[217] Howarth *op cit*. (2014) 104 (11) *SAMJ* 752.

justify paying increased indemnity insurance premiums.[218] As a result they may decide to move their practices or stop practicing altogether, resulting in dwindling of specialists in those areas, so depriving communities of access to specialist care and expertise in the public sector.[219]

In addition, an increased risk of ligation may indirectly prompt practitioners to perform additional, often unnecessary, diagnostic and screening tests.[220] Performance of unnecessary investigations aggravates the costs of care to patients and exposure to risks without material benefit.[221] This practice is encouraged by fear of litigation.[222]

Public healthcare is already strained, as there are more patients to look after, and less resources to do so with, leading to the high numbers of negligence claims. The continued use of money budgeted for healthcare provision to settle ever increasing medical claims, can only lead to catastrophe. Some of the claims (e.g. those approaching and exceeding R20 million) are an indication of the impact negligence claims have on the money budgeted for healthcare provision, if they are multiplied by the numbers of similar claims. The contingency liability of R25 billion by the National Department of Health out of a national budget of R187.5 billion, translates to 13.3% of the budget going towards contingency for medical negligence claims.[223] This is a great loss to public healthcare services.

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[218] J. Seggie, 'The 'boom' in medical malpractice claims-patients could be the losers' (2013) 104 (7) *SAMJ* 433.

[219] G. Howarth, 'The Threat of Litigation: Private Obstetric Care – *Quo Vadis?'* (2011) 4 (2) *SAJBL* 85,86.

[220] D Roytowski *op cit*. (2014) 104 (11) *SAMJ* 736.

[221] D Roytowski, *op cit.* (2014) 104 (11) *SAMJ* 737.

[222] G. Howarth, *op cit*. (2011) 4 (2) *SAJBL* 85,86.

[223] MO. Phahlane Office of the Chief Litigation Officer Untitled Department of Health Medical Negligence Summit (2015) 8.

3.2 The volume of medical negligence claims in South Africa

In South Africa, while medical malpractice has always existed in the medical profession, it was usually considered as a professional ethical issue rather than a legal matter.[224] As a result in most cases disciplinary processes based on breaches of professional ethical codes were followed if a medical practitioner was found guilty of any medical wrongdoing.[225]

There are many reasons for believing that the explosion in medical malpractice litigation in South Africa is of real concern for both practitioners and the government. This is evident in the following statement by Health Minster Dr Aaron Motsoaledi:

> 'The nature of the crisis that our country is experiencing is a very sharp increase – actually an explosion in medical malpractice litigation, which is not in keeping with generally known trends of negligence or malpractice. The cost of medical malpractice claims has sky-rocketed and the number of claims increased substantially.'[226]

Table 2 shows the total amounts of medical malpractice claims accumulated in a 4-year period.[227]

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[224] Health Professions Act 56 of 1974 s 3 (m) (n).

[225] Health Professions Act 56 of 1974 s 3 (n).

[226] Anon 'Medical Litigation Crisis – Motsoaledi' (2015*)* https://citizen.co.za/news/south-africa/340687/medical-litigation-crisis-motsoaledi/ (Accessed on 05 June 2017).

[227] M.O. Phahlane Untitled Office of the Chief Litigation Office. The figures for Gauteng and Northern Cape Provinces are not provided in this report.

Table 2 Provincial claims for medical malpractice for the period from 2011 – 2015[228]

PROVINCE	AMOUNT CLAIMED	AMOUNT PAID OUT
Western Cape	R277 923 389,00	R61 996 027.00
Eastern Cape	R8 051 060 166.00	R341 182 935.00
KwaZulu Natal	R7 417 797 805.00	R496 347 078.00
Mpumalanga	R1 012 855 397.00	R62 343 129.00
Free State	R1 204 009 676.00	R36 897 433.00
Limpopo	R1 247 505 948.00	R68 906 854.00
North West	R995 268 683.00	R48 372 947.00
Gauteng*	not provided	not provided
Northern Cape*	not provided	not provided
Total	R20 206 421 064.00	R1 116 047 403.00

Obtaining reliable data about the extent of medical malpractice in SA is difficult. The information about medical malpractice is not easy to collate. Some cases end up in court, while others are settled out of court. It is reported that 70% of the cases are settled out of court and some cases get reported to the HPCSA.[229] Collating of medical malpractice information is therefore challenging.[230] Stratifying the causes of medical malpractice, and adopting effective strategies to be implemented, becomes an intricate task. If the NHI scheme is to be implemented successfully, addressing the causes of medical malpractice needs to be a priority.

A report in the *Sunday Times* highlights the alleged corruption of state attorneys colluding with private firms to loot public funds.[231] The figures of corruption (reported

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[228] *Ibid.*

[229] SA Strauss 'Doctor, patient and the law: A delicate triangle' (2008) *Spring SA Orthopaedic Journal* 10.

[230] Oosthuizen *op cit.* (2015) (78) *THRHR* 270.

[231] Q. Hunter 'Government Lawyers, private firms "collude to loot public purse https://www.pressreader.com/south-africa/sunday-times/20180812/281505047049755 (Accessed on 12 Aug 2018).

as R80 billion) which translates to almost half of the R187 billion total budget for health in 2017/18 period, is catastrophic. [232]

3.3 SA Laws affecting medical malpractice claims

The introduction of following laws has contributed to the increasing malpractice claims.

(a) The Constitution;[233]

(b) The National Health Act;[234]

(c) The Consumer Protection Act;[235]

(d) The Contingency Fees Act;[236] and

(e) The Children's Act.[237]

3.3.1 The Constitution

Before the enactment of the Constitution, paternalism in healthcare was the order of the day, where the doctor knew best and would not be questioned even if gross negligence had occurred.[238] As Frank Lloyd Wright, the famous architect, once said 'doctors are the only ones who bury their mistakes, but an architect can only advise his clients to plant vines.'[239] The times when the doctors could do as they please with their patients, as though their patients were objects, are over. This means that

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[232] *Ibid.*

[233] The Constitution 1996.

[234] The National Health Act 61 of 2003.

[235] The Consumer Protection Act 66 of 2008.

[236] The Contingency Fees Act 66 of 1997.

[237] The Children's Act 38 of 2005.

[238] HK Nevhutalu '*Patients' rights in South Africa public health system; Moral-critical Perspectives'* (2016) Unpublished PhD Dissertation, University of Stellenbosch 78.

[239] B. Hubbard '10 Frank Lloyd Wright Quotes That Will Make You Proud To Be An Architect' https://www.thearchitectsguide.com/blog/10-frank-lloyd-wright-quotes-that-will-make-you-proud-to-be-an-architectFrank Lloyd Wright (Accessed on 09 Aug 2018).

healthcare provision now takes a patient-centered approach and doctors are held accountable by their patients.

Section 1 (a) is a founding principle in the Constitution, and affords dignity and equality to all.[240] It is submitted that in a situation where a person's dignity is violated, antagonism will result which could be subtle or overt, and this may lead to medical malpractice claims, due to a failure to resolve issues timely. Many malpractice claims arise from a communication failure between the patient and the healthcare provider.[241] Problems that arise in doctor-patient relationships can be resolved, provided that mutual respect is maintained, and communication is optimal. This implies that paternalistic dominance by the healthcare provider impinges on the dignity of the patient. Patient-centered care enhances mutual respect and improves communication.

3.3.1.1. The Constitution and informed consent

Section 10 of the Constitution further emphasizes the right to dignity, by guaranteeing respect and protection of this right,[242] while section 12 (1) (e) prohibits treating anyone in an inhumane or degrading way.[243] Furthermore, section 12 (2) addresses issues of informed consent and prohibits interference with body and mind.[244] Section 14 (d) prohibits disclosure of confidential medical information without a written consent.[245] Failure to observe the above mentioned sections of the law will result in the healthcare provider being found negligent, and is in any event disrespectful of their patient.

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[240] The Constitution 1996 s (1) (a).

[241] Medical Protection Society 'Advice Booklets' Communicating with patients (2017). https://www.medicalprotection.org/southafrica/advice-booklets/common-problems-managing-the-risks-in-hospital-practice-in-south-africa/communicating-with-patients (Accessed on 09 Nov 2018).

[242] The Constitution 1996 s 10.

[243] *Ibid* s12 (1) (2).

[244] *Ibid* s14 (d).

[245] *Ibid s27* (1)(a) (2) (3).

In the case of *McDonald v Wroe*[246] the court concluded that there was insufficient consent, where the defendant failed to warn the plaintiff (patient), of the likelihood of nerve damage resulting from a tooth extraction. Judge Fourie decided that consent was lacking, and as a result, the extraction constituted assault. A further complication is that fluency in all 11 official languages is impractical, healthcare providers may find it challenging to secure informed consent as required by the law. Not only is fluency of language the challenge, the low levels of comprehension of medical and legal terms by the majority of South Africans is also a factor.

3.3.1.2 The Constitution and access to healthcare

Section 27 (1)(a)(2) and (3) of the Constitution obliges the state to provide access to healthcare for all within its available resources.[247] Delayed access to healthcare can translate into access denied. The hypothetical scenario of a situation that occurred, where an MEC for health refused to renew a service contract for the maintenance of oncology equipment is an example of this.[248] According to the scenario, the MEC appointed an ex-employee of the department to repair and maintain the equipment at a higher price than the initial contract instead. This resulted in delayed access for cancer patients, which resulted in a waiting period of 9 months that could have been provided in two weeks.[249] This led the patients' conditions worsening from curable to terminal. Resources were available, but the patients were denied access to specialized healthcare. Based on the above scenario, the management of the hospital in question could be held liable for the premature deaths of oncology patients.[250]

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[246] *McDonald v Wroe* (2006) 3 All SA 565 (C).

[247] The Constitution 1996 s 28 (2).

[248] A. Dhai, 'A health system that violates patients' rights to access health care.' (2012) 5 (1) *SAJBL* 3.

[249] DJ. McQuoid-Mason 'Public health officials and MEC 's for health should be held criminally liable for causing the death of cancer patients through their Intentional or negligent conduct that results in oncology equipment not working in hospitals' (2017) 10 (2) *SAJBL* 83.

[250] *Ibid.*

The extent of corruption and fraud committed by management of NDoH is depleting financial resources already allocated for the provision of healthcare. This should be urgently addressed, as provision of extra funds is unlikely to improve the performance of healthcare delivery.

3.3.1.3 The Constitution and children's rights to healthcare

Section 28(2) provides that any decision taken by a court of law in all matters pertaining to children, must always be in the best interests of the child.[251] The high awards paid out for children born with mental defects due to medical malpractice are a result of the desire to ensure the welfare of the child who are likely to live longer than adults. Section 28 (1)(c) affords children the right to basic healthcare services, unlike Section 27 which affords access to healthcare for adults.[252]

3.3.2 The National Health Act (NHA)[253]

The NHA replaced the Health Act of 1977,[254] with the following objectives of regulating the healthcare system and aligning it with the Constitution[255] directives. In a way the NHA is instrumental in reforming healthcare delivery because:

1. It fulfils the constitutional right of access to healthcare;
2. It empowers patients' rights in healthcare delivery by clearly recognizing the rights to autonomy[256] and confidentiality.[257]

Therefore, the NHA enables patients to litigate when their rights have been violated. Such patients may use the breach of a provision in the NHA as evidence of

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[251] The Constitution s 28 (2).

[252] The Constitution s 27 (1) (a).

[253] The National Health Act 61 of 2003.

[254] The Health Act 63 of 1977.

[255] The National Health Act 61 of 2003 The Preamble.

[256] *C v Minister of Correctional Services* 1996 (4) SA 292 (T).

[257] *Jansen van Vuuren v Kruger* 1993 (4) SA 842 (A).

negligence.[258] *Patz v Greene*[259] illustrates that establishment of negligence can be construed from transgression of a specific provision of the law.

3.3.3 The Consumer Protection Act[260]

The Consumer Protection Act is designed to protect and develop the rights of all consumers. Section 1 gives a broad definition of 'consumers.' Patients are not excluded from this classification.[261] The Act therefore protects patients as consumers and gives them the right to litigate if they are unhappy with the quality of healthcare received.[262] The Act further offers protection by prohibiting the use of unfair exclusion clauses in the transactions between the patient as the consumer and the healthcare provider as the 'supplier'.[263] According to Pepper and Slabbert, patients can now claim for damages against the supplier who in this case is the doctor, of a faulty device (e.g. a faulty pacemaker), without establishing negligence on the part of the supplier,[264] unless the healthcare practitioner has indemnified himself / herself from the manufacturer. However, according to section 61 of the Consumer Protection Act [265] nobody in the supply chain can indemnify themselves against the consumer.

3.3.4 The Contingency Fees Act[266]

The Contingency Fees Act applies to situations where a legal practitioner agrees to represent a client, who otherwise could not afford the legal fees, on the basis of not

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[258] The National Health Act ss (6) (7) (8) (15) and (16).

[259] *Patz v Greene* 1907 TS 427.

[260] The Consumer Protection Act 68 of 2008.

[261] Section (1)(a) and (b).

[262] The Consumer Protection Act 68 of 2008 s (69).

[263] L. Pienaar 'Investigating the Reasons behind the Increase in Medical Negligence Claims' (2016) *PELJ/PER* 19.

[264] Pepper *op cit.*(2011) 4 (1) *SAJBL* 30.

[265] The Consumer Protection Act 68 of 2008 s61 (1)(a)(b)(c).

[266] The Contingency Fees Act 66 of 1997.

charging a fee if the client loses the case.[267] Sections 3 (1) to 3 (3) of the Contingency Fees Act[268] provide that a legal practitioner and his/her client can conclude a contingency fees agreement. In terms of such agreement both attorneys and advocates are permitted to accept litigation work on the condition that no fee will be charged if the supposed litigation is unsuccessful.[269] If the case is successful then, the lawyer is entitled to double his /her normal fee for the work, but not in an amount exceeding 25% of the settlement amount.[270] The bigger the claim, the more attractive it will be to the legal professional. In the case of a claim for R20 million, 25% is R5 million which is attractive money for the claimants as well as the lawyer should the claim be successful.[271] It has been suggested that touting for disgruntled patients by the lawyers at public hospitals has increased the number of malpractice claims.[272]

3.3.5 The Children's Act[273]

Children who are 12 years or older and sufficiently mature, may consent independent of their parents, to medical treatment. [274] For surgical treatment the child is expected to be assisted by their parents in consenting.[275] If a health professional administers treatment to a child entitled to consent by law, without such child's consent, he or she would contravene the Children's Act. The consent of the parent or guardian in this situation is not required, and the Children's Act would have been violated. The 'best interest of the child' provision[276] protects a child in all matters affecting its health and

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[267] Section 2 (1)(*a*) and (*b*) of the Contingency Fees Act 66 of 1997.

[268] The Contingency Fees Act 66 of 1997.

[269] *Ibid.*

[270] *Ibid*.

[271] Howarth *op cit.* (2014) 104 (11) SAMJ 752.

[272] Motsoaledi *op cit*.(2015) 8 (1) *SAJBL* 4.

[273] The Children's Act 38 of 2005.

[274] The Children's Act 38 of 2005 ss129 (2) (a) (b) (3) (a) (b).

[275] The Children's Act s 129.

[276] The Constitution s 28 (2).

wellbeing. If the child wishes their medical information not be disclosed to its parent by the healthcare professional, it may not be disclosed regardless of the parent being responsible for the medical expenses.[277] If such a child is a dependent on a medical scheme he or she must be told that the parent as guardian may learn about the treatment from the medical scheme account, because the claims carry an International Classification of Disease (ICD 10) code.[278]

3.4 Other factors influencing medical malpractice claims in SA

There are several other factors that influence the rise of medical malpractice claims, such as working conditions, that are subject to shortages of staff, unmanageable workloads and operational failures by medical management. These and other factors influencing medical malpractice have been well documented by Chamisa[279] who observes that:

> 'Due to this disproportional ratio, doctors and nurses are over-strained and left exhausted. Workload and differential allocation of resources in public hospitals are the primary causes of stress.'[280]

The challenges facing the public healthcare system in South Africa cannot be overstated. The shortage of medical staff compounded by the growing level of medical malpractice claims, raises numerous challenges for the successful implementation of the National Health Insurance scheme and calls for immediate and carefully executed interventions.

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[277] L. Pienaar *op cit.* (2016) *PEL/PER* 19.

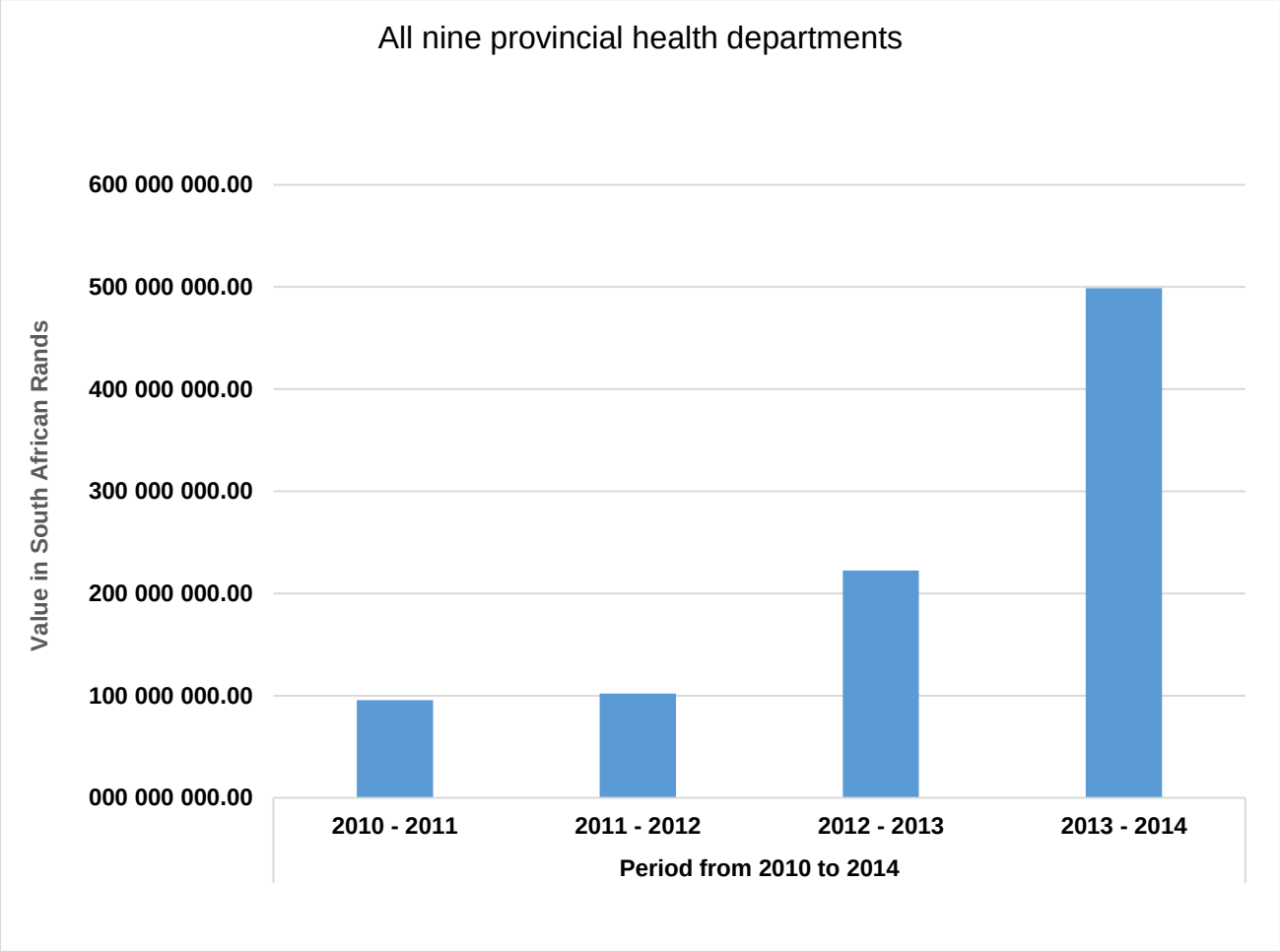
[278] ICD-10 stands for International Classification of Diseases and Related Health Problems (10th revision). It is a coding system developed by the World Health Organisation (WHO), that translates the written description of medical and health information into standard codes.

[279] D. Chamisa '*The Potential of Alternative Dispute Resolution Mechanisms in Tackling the Increase of Lawsuits due to Medical Negligence in Public Hospitals'* (2013) Unpublished Masters Dissertation. University of Cape Town 11.

[280] *Ibid.*

Having outlined the factors influencing medical malpractice in South Africa, it is worth noting the impact of medical malpractice claims. It is evident that such claims are a critical problem because they divert the millions of Rands required for service delivery of public health. They have resulted in limiting the capacity of the Department of Health to deliver health services to the public, because a significant percentage of its financial resources is diverted to settle medical negligence claims.[281]

Figure 1 The total amounts paid out for medical malpractice claims by all provinces for the period from 2010 – 2014.[282]



[281] Bateman *op cit.* (2011) 101 (4) *SAMJ* 216.

[282] MO Phahlane, Untitled 'Office of the Chief Litigation Officer: Department of Health Medical Negligence Summit' (2015) Paper Prepared for the Minister of Health for the Medico-Legal Summit held 9 – 10 March 2015 10.

From the report by the Office of the Chief Litigation Officer for the National Department of Health there is a significant increase in the total amounts paid during the period of 2010 to 2014 by all provincial departments of health.[283] For the same period the total legal costs paid amounted to R226 019 092.00. This is only what was paid and is not an indication of the total value of the claims. The upsurge of medical malpractice claims has not only placed a burden on the health sector, but also the judiciary.[284] The appointment of the Health Ombudsman is an attempt to reduce the number of cases that end up in the courts. In Gauteng the 92 deaths of psychiatric patients which had increased to 143 at the end of January 2018, were investigated by the Health Ombudsman's office and recommendations were made.[285] This was an attempt by the National Department of Health to respond promptly to the disaster[286] and safe on legal fees.

The introduction of 'MomConnect'[287] by the NDOH has increased the number of pre-natal clinic visits by expectant mothers from four to eight, in an attempt to identify problems early in pregnancy, so that appropriate interventions can be instituted. 'MomConnect' is expected to reduce the number of poor pregnancy outcomes, and minimize the astronomical claims associated with negligence occurring in children born with cerebral palsy.[288] It is commendable, and we hope the human resources buy-in was secured.

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[283] *Ibid.*

[284] *Ibid.*

[285] DJ. McQuoid-Mason' Life Esidimeni deaths: 'Can the former MEC for health and public health officials escape liability for the deaths of the mental-health patients on the basis of obedience to 'superior orders' or because the officials under them were negligent?' 2018 11 (1) *SAJBL* 5.

[286] Minister Aaron Motsoaledi: Address on Life Esidimeni mental health patients tragedy in Parliament. https://www.gov.za/speeches/minister-aaron-motsoaledi-address-life-esidimeni-mental-health-patients-tragedy-parliament (Accessed on 25 Oct 2018).

[287] National Department of Health 'momconnect' http://www.health.gov.za/index.php/mom-connect?id=206 (Accessed on 09 Aug 2018).

[288] *Ibid.*

Considering the amount of money paid in settling medical malpractice claims in the public sector, the question arises whether the NHI scheme can be effectively implemented. The public health sector is already over-stretched and is facing numerous financial challenges. For instance, 'the accumulated losses to South Africa (SA)'s gross domestic product between 2006 and 2015 from the burden of disease such as, diabetes, stroke and coronary heart disease alone are estimated to have cost the country US$1.88 billion' which translates to R28,2 billion.[289] Successful implementation of the NHI scheme, with a strong focus on primary health care will reduce the burden of diseases and curtail the expenses. HIV-AIDS continues to be a challenge to SA, with 10.3% population of people living with HIV-AIDS.[290] Provision of antiretroviral (ARV's) medication and sex education especially targeted at high risk populations, remains an essential component of primary healthcare. The National Department of Health's drive for free male medical circumcision will assist in reducing the incidence of HIV infections as shown by the Orange Farm Study, where there was a 76% decrease in new HIV infections amongst circumcised males.[291] The study confirmed the overwhelming benefits of male medical circumcision towards reducing the incidence of new infections of HIV.

Medical malpractice claims are a threat to the existence of the Department of Health in South Africa and requires special attention if the public healthcare sector is to be effective and sustainable, and able to deliver affordable quality healthcare to all citizens irrespective of their social or economic situation.

In the previous section, the extent of medical malpractice claims in South Africa was highlighted. In this section, the factors that influence medical malpractice claims will

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[289] K Hofman. 'Non-communicable diseases in South Africa: A challenge to economic development' (2014) 104 (10) *SAMJ* 647.

[290] Statssa 'Mid-year Population Estimates' (2015) Statistical Release P0302 https://www.statssa.gov.za/publications/P0302/P03022015.pdf (Accessed on 08 June 2016).

[291] B Auvert, D Taljaard, D Rech, P Lissouba, B Singh, J Bouscaillou, G Peytavin, S G Mahiane, R, Sitta, A Puren & D Lewis. 'Association of the ANRS-12126 male circumcision project with HIV levels among men in a South African township: Evaluation of effectiveness using Cross-sectional Surveys' (2013) 10 (9) *PLOS Medicine* 10.

be discussed. Two key factors have been identified as the driving force of medical malpractice claims and litigation: (a) legal practitioners identifying medical malpractice as a lucrative opportunity for legal work; and (b) patients or the public becoming aware of their rights as consumers.[292]

Given the excessive cost of legal representation, which in most case is out of reach of the poor when it comes to medical malpractice litigation, most attorneys now litigate medical negligence cases on a contingency-fee basis.[293] Another factor that influences medical malpractice claims is that the public has become aware of their rights. Pepper and Nothling-Slabbert [294] state that: 'South Africa is witnessing a severe increase in medical malpractice litigation because patients are increasingly becoming aware of their rights.'

The HPCSA radio campaign to educate patients about their rights and its role is believed to have resulted in a 35% increase in the number of complaints between 2011 and 2016.[295] HPCSA by addressing the complaints and instituting disciplinary measures against its members may have satisfied several complainants resulting in resolution of the matter and avoiding going to court.

3.5 Risks posed by medical malpractice claims for the NHI scheme

The number of medical malpractices claims, the factors which influence medical malpractice claims, and the medical malpractice damage awards discussed above, indicate that the health care system in South Africa is facing profound challenges which need special attention. This is necessary if healthcare is to be sustainable and the implementation of the NHI scheme made possible.

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[292] L. Pienaar *op cit.* (2016) *PELJ/PER* 5.

[293] The Contingency Fees Act 66 0f 1997.

[294] Pepper *op cit.* (2011) 4 (1) *SAJBL* 30.

[295] L. Kelbrick 'The Cost of Rising Claims & Complaints' (2017) 25 (1) *Medical Protection Casebook 7.*

Medical malpractice is of critical concern in South Africa's healthcare sector, and it is brought about by a combination of many factors including the working conditions under which medical practitioners work. The adverse working conditions are compounded by malpractice claims that put medical practitioners under severe pressure, which in turn reduces their morale in performing their duties.[296]

Increasingly medical practitioners with high risk special skills like, obstetricians, neurosurgeons and orthopaedic surgeons are leaving public health sector and moving to private sector work, because of poor salaries and heavy workloads.[297] The NDoH's desire to abolish Remuneration for Work Outside Public Service (RWOPS) and curtailment of overtime pay has aggravated the migration.[298] The remaining specialists in the public service are exposed to increased numbers of patients, resulting in increased medical malpractice risks. The less skilled professionals are faced with having to attempt work beyond their scope.

With increasing medical malpractice litigation, the high-risk specialties will be unattractive to new registrars, and those skills will be under-serviced. The implementation of the NHI scheme will be placed at risk because one of the pillars of the implementation of the NHI scheme is a pool of skilled and committed medical human resources.[299]

It has been said that the increases in litigation will further 'deter talented individuals from entering the medical profession and thus deprive the South African public of essential skills.'[300] The low morale of public healthcare providers has a negative

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[296] S. Moosa 'A Path to Full-Service Contracting with The General Practitioners Under The National Health Insurance' (2014) 104 (3) *SAMJ* 155.

[297] G, George, M Atujuna & J Gow 'Migration of South African health workers: the extent to which financial considerations influence internal flows and external movements' (2013) 13 *BMC Health Services Research* 2.

[298] J. A. Shipley 'Private Practice (RWOPS) and Overtime for State-Employed Specialist' (2015) 14 (1) *SA Orthopaedic Journal* 18.

[299] M. Botes, 'Mediation: A perfect solution to healthcare disputes' (2015) *De Rebus* 29.

impact and is a threat to the successful implementation to the NHI scheme.[301] This calls for strong administrative and managerial support for healthcare providers in the public sector.[302] The Constitution[303] obliges government to provide access to quality healthcare for all and the NHI scheme would achieve this if properly implemented. The time taken to resolve the medical malpractice cases can range from a year to 16 years, and the process is very costly.[304] Delays may be caused by the number of cases on the court roll, the litigating parties' issues, such as exchange of information and loss of patients' records. Legal costs form a significant percentage of the amounts awarded medical malpractice claims. Alternative dispute resolution mechanisms such as mediation can assist in saving legal costs, thereby saving the time it takes to resolve disputes. However, contingency fees arrangements are used because of the benefits to claimants as there is no financial risk on their part, whereas in mediation both parties contribute equally to the mediator's fees. The court-annexed mediation law[305] should be made a pre-requisite to proceeding with a medical malpractice court case. Presumably many of the cases that end up in the courts will be resolved timely, and this will free up the courts to address other matters. Presently the contingency fee arrangement is more attractive to a litigant who cannot afford to contribute towards mediation but, if the litigant can waiver their contribution towards mediation perhaps more people will be encouraged to use mediation. This will also reduce the Department of Health's legal bill and ultimately enable it to redirect the financial resources to the NHI scheme.

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[300] GR Howarth 'Obstetric Risk Avoidance: Will Anyone be Offering Obstetrics in Private Practice by the End of the Decade?' (2013) 103 (8) *SAMJ* 513.

[301] A. Fusheini, J Eyles & J Goudge. 'The social determinants of health and the role of healthcare system: A case study for governance in public hospitals in South Africa' (2016) *Scientific Research Publishing* 1290.

[302] Judge Claasen *op cit.*10.

[303] The Constitution 1996 section 27 (2).

[304] Judge J Kollapen *op cit.* 21.

[305] Magistrate Courts Act 32 of 1944 Rule 72 & 73.

As previously stated by the Minster of Health, Dr Aaron Motsoaledi, one of the biggest challenges to decent healthcare for all, is that at present it is still enjoyed by only 16% of the population who mainly rely on medical aid membership. The remaining 84% rely on public healthcare which is plagued by numerous challenges including increasing medical malpractice claims.[306] He believes that the implementation of the National Health Insurance scheme must be a priority if an equal and just society in South Africa is to be built. While affordable health care for all is a noble goal, the current number of medical malpractice claims poses a serious challenge to the implementation of the National Health Insurance scheme.

3.6 Conclusion

The autonomy of healthcare professionals 'to play god' ceased to exist when the new Constitution[307] was adopted and signed. It resulted in changing the delivery of healthcare to a more equitable relationship of joint decision-making between patients and healthcare providers. This is what the British Medical Association feared when the NHS was introduced in the UK. However, UK healthcare professionals ended up adapting to the new rules of the game. One of the challenges faced by SA healthcare professionals is the diversity of patients and the different levels of education which impact on the ability of patients to understand and attach value to the medical and legal information communicated to them in the healthcare sector. With 11 official languages in SA, it is sometimes necessary to use interpreters which may lead to distortion of the information provided to patients and the healthcare provider. A possible avenue to circumvent the problems involved in obtaining informed consent might be for GP's to obtain the consent prior to referring such patients for tertiary care. As the referring practice can communicate adequately with the patient, informed consent would be easier to secure.

To curtail medical malpractice claims, maladministration and corruption needs to be rooted out. Adequate human and financial resources need to be provided in the public healthcare sector. Furthermore, public sector healthcare workers need to be retrained

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[306] Department of Health National Health Insurance White Paper 'National Health Insurance for South Africa: Towards Universal Health Coverage' December (2015).
[307] The Constitution 1996 ss (10) (12) (1)(e). (2) (a)(b)(c).

in the spirit of the *Batho Pele* principles so that they can treat all their patients with respect regardless of their education level.

The introduction of 'MomConnect'[308] has improved maternity care and addresses issues of the catastrophic levels in obstetrics and gynaecology claims by encouraging pregnant women to attend ante-natal clinics frequently with the hope of identifying problem pregnancies early and instituting appropriate interventions. However, the deficiency in numbers of obstetricians and gynaecologists in the public sector is counter-productive to this initiative as more obstetricians will be required to service the demand created by the increase in the number of ante-natal visits.

Cadre deployment is an Achilles heel of healthcare delivery and undermines accountability and defeats the bigger purpose. The lack of accountability feeds directly into problems experienced downstream such as soaring medical malpractice claims.

The United Kingdom has implemented universal healthcare services in their National Health Service (NHS) which has been running for seven decades, despite increasing medical malpractice litigation since the 1980's. The experience of the NHS in the UK, which is like SA's proposed NHI scheme, as an attempt to achieve universal healthcare will be explored in chapter four with the view to extracting valuable lessons for SA.

[308] National Department of Health 'momconnect' http://www.health.gov.za/index.php/mom-connect?id=206 (Accessed on 09 Aug 2018).

CHAPTER 4 THE NATIONAL HEALTH SERVICE (NHS) IN THE UK

This chapter aims to explore the National Health Service (NHS) in the (UK) which is the longest running universal healthcare service.[309] Both the proposed NHI scheme in South Africa and the NHS in the UK are examples of universal healthcare. Universal healthcare is defined as quality healthcare funded by the state, accessible to all, and provided free of charge at the point of service, to protect individuals who could otherwise not afford healthcare.[310] World War II left the UK with a need for reconstruction and a huge demand for healthcare provision. The society was highly polarized by the class system, and only the rich could afford to purchase healthcare. The solidarity resulting from the War enabled the Labour government to introduce a more equitable healthcare system for all, which is socialist in nature, in a capitalist system. South Africa has a similar predicament of a polarized society, and a need for a healthcare system that is socialist, as many of its citizens cannot afford private healthcare due to the past system of government. The solidarity of the citizens of the UK to see a universal healthcare is lacking in SA, as the previously privileged will not accept erosion of their privilege in order to accommodate the under privileged masses. Moreover, the ideology of apartheid which has relegated the entire non - white population to be subservient to the white minority has left the black majority with poor education and a low self-esteem hence the poor work culture that is predominant in all public departments.

NHS will provide lessons that could assist South Africa (SA) in its implementation of the proposed National Health Insurance (NHI) scheme, by reviewing the existing literature, especially the historical background and the legislative framework. Furthermore, the UK is an English-speaking country and information about the NHS is easily accessible.

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[309] J. Herring. *Medical law and ethics (*3rd edition) (2010) 40.

[310] Universal Health Coverage (UHC) Fact Sheet *The World Health Report WHO Geneva* (2017)http://www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-(uhc) (Accessed on 08 July 2017).

4.1. History and background of the UK Healthcare System

The UK National Health Service has been described as 'Britain's best loved institution.'[311] The World Health Organization (WHO) regards it as 'one of the best healthcare systems in the whole world.'[312] Gordon Brown, the former prime minister said:

> 'the National Health Service is not just a great institution but a unique and very British expression of an ideal -the healthcare is not a privilege to be purchased but a moral right secured for all.'[313]

The appreciation and value of the NHS in the UK and the rest of the world is outstanding. SA is determined to provide a similar system of universal healthcare for all.

The National Health Service (NHS) was launched in 1948 on 5th July at Park Hospital in Manchester, by the Labour government,[314] as part of the post-War reconstruction program. Its establishment was informed by 'slaying the Five Giants'[315] mentioned in the Beveridge report.[316] Mr Aneurin Bevan, the then Minister of Health had the task of implementing the NHS.[317] It remains the main healthcare provider in the UK. Prior

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[311] Herring *op cit.* (2010) 42.

[312] *Ibid*.

[313] *Ibid*.

[314] D. Hands 'Inspiration, Ideology, Evidence and the National Health Service' 9 March 2010 https://www.sochealth.co.uk/national-health-service/healthcare-generally/history-of-healthcare/inspiration-ideology-evidence-and-the-national-health-service/ (Accessed on 08 July 2017).

[315] W. William 'Social Insurance and Allied Services' (1942) HM Stationery Office. https://www.histoire-politique.fr/documents/24/dossier/pdf/HP_Dossier_Noel_Whiteside_def.pdf (Accessed on 10 July 2017). The 'Five Giants' known as (want, disease, squalor, ignorance, idleness) formed part of the Beveridge Report published in 1942 informing the government hon how best to help low income people, effectively by introducing the Welfare State.

[316] The Welfare State http://www.nationalarchives.gov.uk/pathways/citizenship/brave_new_world/welfare.htm (Accessed on 10 July 2018).

to the introduction of the NHS, healthcare in UK was generally available only to the wealthy, unless one could obtain free treatment through charity or teaching hospitals.[318] The majority of the citizens of the UK did not have access to healthcare.[319] The aftermath of Second World War which was characterized by the destruction to both property and human life further aggravated the healthcare needs of all who survived it. The Labour Party's promise of free universal healthcare (NHS) helped to secure a landslide victory in the 1945 general elections.[320]

The NHS funding is 100% from taxes and the service is provided free of charge at the point of delivery for all UK citizens and foreigners living there temporarily.[321] The implementation of the NHS continued side-by-side with private healthcare.[322] NHS did not have the required human resources for its implementation and faced huge resistance from the healthcare professionals who were enjoying the privileges afforded to them by their status and good income from their private practices.[323] Consequently, healthcare professionals were reluctant to relinquish their freedom and income to become civil servants, because they believed their autonomy would be eroded.[324]

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[317] D. Hands 'Inspiration, Ideology, Evidence and the National Health Service' 9 March 2010 https://www.sochealth.co.uk/national-health-service/healthcare-generally/history-of-healthcare/inspiration-ideology-evidence-and-the-national-health-service/ (Accessed on 08 July 2017).

[318] GD. Smith, 'The UK National Health Service and the national health 1948' (1999) 98 9:*1 Critical Public Health* 69, 70.

[319] P. Greengross K Grant & E Collini 'The History and Development of The UK National Health Service 1948 – 1999' (Second Edition) (1999) DFID Health Systems Resource Centre 4.

[320] J. Jones. 'The Secret life of the NHS' (2000) 320:7247 *BMJ* 1457.

[321] G. Bevan, N Mays & S Connolly 'Funding and Performance of Healthcare Systems in the Four Countries of the UK' (2010). London Nuffield Trust Available at www.nuffieldtrust.org.uk/publications/funding-and-performance-healthcare-systems. (Accessed on 10 July 2017).

[322] The National Archives 'Origins of the NHS' http://www.nationalarchives.gov.uk/cabinetpapers/alevelstudies/origins-nhs.htm (Accessed on 10 July 2017).

[323] *Ibid.*

[324] *Ibid.*

The British Medical Association (BMA), the representative of the private general practitioners was adamant that NHS would not succeed, even though some of its members were sympathetic to the NHS and did register as service providers for the NHS.[325] Support from the Royal College of Physicians was secured by Aneurin Bevan the Minister of Health (from 1945-1951), by allowing the private consultants to continue with their private practices, while also serving the NHS, so that it matched their income.[326] Members of the public were required to register with the NHS to obtain a beneficiary number, and thereafter to register with their local general practitioners (GP's).[327]

The uptake from the public was overwhelming and the few doctors who had registered with the NHS became very busy, to the extent that some chose not to service private patients anymore. More general practitioners followed suit.[328]
A basic tripartite system was formed by splitting the service into three tiers, led by the Minister of Health:[329]

1. Hospital services: All previous hospitals (charity, church, and municipal) were organized into 14 regional groups and staff were salaried. Teaching hospitals remained as a stand-alone and reported directly to the Minister of Health.
2. Primary care providers: GP's, dentists, opticians and pharmacists were self-employed under a contract for services with an Executive Council. The primary care givers treated patients and made referrals where necessary.

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[325] M. Rintala *Creating the National Health Service: Aneurin Bevan and the Medical Lords* (2003) 78.

[326] M. Rintala *op cit*.79.

[327] G. C Rivett '*From Cradle to Grave – the first 50 (65) years of the NHS. (1998)'* King's Fund, London available at www.nhshistory.co.uk (Accessed on 10 July 2017).

[328] G. Macpherson '1948: A Turbulent Gestation for the NHS' (1998) 316 (6) *BMJ* 124,125.

[329] Webster C,' *National Health Service Reorganisation: Learning from History?'* (1998*)*: Office of Health Economics https://www.sochealth.co.uk/1998/03/16/national-health-service-reorganisation-learning-from-history/ (Accessed 10 May 2018).

3. Local authority health services: Maternity clinics, clinics, public and environmental health remained under the control of local health authorities.

The above separate areas of care raised problems which led to the system being replaced by a single system that allowed local authorities to support all three areas of care.[330] With Prime Minister Margaret Thatcher (1979–1990) the NHS was decentralized with the intention of reducing bureaucracy.[331] The NHS budget was not increased, but the resources were redistributed.[332] Competition was introduced by the ushering in of providers and purchasers, by the National Health Service and Community Care Act 1990.[333] Twenty-eight Strategic Health Authorities (SHA's) were established to set up Trusts in 2002, but later reduced to ten in 2006 with the role of overseeing the Trusts and accounting to the Department of Health.[334] The SHA's were allocated a budget by the Department of Health with which to purchase healthcare services through the Trusts from healthcare service providers.[335] During the Blair government (1997 – 2007) further reorganization led to the devolution of NHS services in the UK, resulting in each of the four countries having different policies, and each country having its own specific priorities.[336] The difference in priorities makes

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[330] G. Bevan, N Mays & S Connolly 'Funding and Performance of Healthcare Systems in the Four Countries of the UK' (2010). London Nuffield Trust Available at www.nuffieldtrust.org.uk/publications/funding-and-performance-healthcare-systems (Accessed on 10 July 2018).

[331] C. Smith & S. Tudor 'National Health Service: 70th Anniversary' (2018) *10 House of Lords Library Briefing* 10.

[332] *Ibid.*

[333] The National Health Service and Community Care Act 1990 section 5 (230).

[334] The National Health Service and Community Care Act 1990 section 3.

[335] Section 1 par (29) and section 2 par (33).

[336] G. Bevan, M. Karanikolos, J. Exley, E. Nolte, S. Connolly & N. Mays 'The Four Health Systems of the United Kingdom: How Do They Compare*?'* (2014) Summary report. Technical Report. *The Health Foundation and Nuffield Trust, London* 24.

comparison of the healthcare outcomes difficult to achieve.[337] England which is the most populous of the four UK countries with a population of 50 million,[338] will be used for this study.

NHS Direct was the resultant of the devolution of the NHS in England with the following objectives (a) to improve healthcare standards; (b) simplify administration; (c) to remove internal markets; (d) to reduce the cost; and (e) to reduce the patient waiting times.[339]

The Health and Social Care Act, 2012[340] introduced Clinical Commissioning Groups (CCG's) which would replace the SHA's and the PCT's, and further committed to dissolve the current management structure by 2020.[341] All the remaining PCT's and Secondary NHS Trusts were required to meet the conditions of the Foundation Trust.[342] It is said that the reform will put 30 000 administrators out of work.[343] Eighty percent of the NHS budget will be allocated to CCG's to secure healthcare services.[344] Primary health will now consume the bulk of the budget. The reform removed bureaucracy and rendered the relationship between the Department of Health and service providers a direct one as the middle players were removed (SHA's and PCT's).

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[337] Bevan *op cit.* (2014) Technical Report The Health Foundation and Nuffield Trust 14.

[338] *Ibid.*

[339] C. Smith *op cit*. (2018) 16 House of Lords Library Briefing 12.

[340] The Health and Social Care Act 2012.

[341] N. Timmins 'The Four UK health systems: Learning from each other' (2013) The King's Fund 6.

[342] Section 1 (1) of the Health and Social Care (Community Health and Standards) Act 2003 (NHS Foundation Trust were created under the provisions of the Health and Social Care The Foundation Trusts were to have more independence from central government).

[343] Smith *op cit.* (2018) 10 *House of Lords Library Briefing16*.

[344] *Ibid.*

4.2. Quality control in the NHS

There are multiple factors which influence the quality of care delivered; (a) financial costs; (b) human resources; (c) management (d) infrastructure; and (e) patient outcomes.[345] Quality assurance involves periodic assessment of all providers, investigations of issues reported to the regulatory body, and recommendation of the best methods of practice.

In 2008 the NHS England formed Care Quality Commission (CQC) by amalgamating the previous three bodies responsible for healthcare quality assurance, namely: (a) The Healthcare Commission; (b) The Commission for Social Care Inspection; and (c) The Mental Health Act Commission.[346] The other bodies that were involved with quality monitoring included the Independent Regulator of Foundation Trusts and NHS Trust Development Authority which were amalgamated to form NHS Improvement.[347]

In 2015 'Monitor' (NHS Improvement) was formed by the amalgamation of the Independent Regulator of Foundation Trusts and the NHS Trust Development Authority.[348] Despite rigorous quality assurance medical malpractice and healthcare fraud continues to consume financial resources.[349]

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[345] Health Care Systems in Eight Countries (2016): Trends and Challenges, European Observatory of Health Care Systems.http://www.revmed.unal.edu.co/red/documentos/varios/8paises.pdf . (Accessed 02 May 2017).

[346] T. Powell 'The Structure of the NHS in England Briefing Paper' (2017) CBP 0726 *House of Commons Library* 20.

[347] Department of Health and Social Care 'The regulation and oversight of NHS trusts and NHS Foundation Trusts' (2013) 10.

[348] R. Harker 'NHS Funding and Expenditure' (2018) CBP 0724 *House of Commons Library Briefing Paper* 11.

[349] Department of Health and Social Care 'The regulation and oversight of NHS trusts and NHS Foundation Trusts' (2013) 7.

4.2.1 Medical malpractice in the NHS

Medical negligence occurs when a patient suffers harm at the hands of a professional healthcare provider whilst receiving healthcare services.[350] The harm could be due to an act or neglecting to act according to expected professional standards.[351] For negligence to exist the adverse event should have been foreseeable and preventable.[352] A patient who has suffered harm because of negligence is at liberty to pursue legal action seeking compensation under the law.[353] Over and above legal action there are numerous other avenues that can be explored to address the dispute between the patient and the healthcare giver, such as lodging a complaint with the care giver, or the professional body, or hospital authority, or the department of health or the health ombudsman.[354]

Clinical negligence claims have increased from 0.4 billion pounds Sterling in 2006 – 2007 to 1.6 billion pounds Sterling in 2016 – 2017.[355] These are only the amounts that were paid out and excluded pending claims. A provision of 60 billion pounds Sterling was made to pay future costs of clinical negligence for the 2016 – 2017 period.[356] This translates into 50% of the 122 billion pounds Sterling budgeted for healthcare. The National Audit Office Report[357] suggests that the cost drivers that increase the value of clinical negligence claims are;

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[350] MA Dada & DJ McQuoid-Mason (eds) *Introduction to Medico-Legal Practice* (2001) 22.

[351] *Ibid.*

[352] *Ibid.*

[353] Dada & McQuoid-Mason *op cit.*23.

[354] LI Thomas 'Triennial Review of the NHS Litigation Authority – Review Report'(2015) *Department of Health* 11,12.

[355] House of Commons Committee of Public Accounts *Managing the costs of clinical negligence in hospital trusts* Fifth Report of Session 2017 – 2019 8.

[356] National Audit Office *Report by Comptroller and Auditor General Managing the costs of clinical negligence in trusts* Session *(2*017*)* 5.

[357] House of Commons Committee of Public Accounts. *Managing the costs of clinical negligence in hospital trusts* Fifth Report of Session 2017 – 2019 8.

1. The increasing numbers of recipients of healthcare under the NHS. The higher numbers require increases in resources.
2. The high value claims especially birth defects such as cerebral palsy, compounded by long life expectancy and improved life extending technologies, accounted for only 8% of all claims in the period, 2016 – 2017, but 83 % of all damages awarded.
3. The increases in legal costs associated with the consultations with experts and the duration of cases in the courts.

The NHS has adopted various regulatory avenues to counter the increasing clinical negligence claims from the onset. In the 1950's all medical practitioners had to belong to a Medical Defence Organisation (MDO) which assisted medical practitioners in paying for claims against them and shared the responsibility with the NHS.[358] Legal Aid provided legal services for clinical negligence claimants who were eligible, subject to a means test.[359] The 1990's saw a steep increase in the clinical negligence claims and the Department of Health instructed all Health Authorities to assume responsibility for all claims with the hope that as the employers, they were better poised to implement effective, preventive protocols, which were regulated by the Care Quality Commission and NHS Improvement.[360]

The NHS Litigation Authority (NHSLA) was set up in 1995[361] to centralize and resolve all claims and provide in-house insurance resulting in the formation of the Clinical Negligence Scheme for Trusts (CNST), and a non-clinical risk pooling scheme for Trusts which is made up of the Liabilities to Third Parties Scheme (LTPS) and the

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[358] *Ibid.*

[359] P. Fenn, A. Gray, N Rickman & D. Vencappa 'Funding clinical negligence cases: Access to justice at reasonable cost?' (2016) https://www.nuffieldfoundation.org/sites/default/files/files/Funding_clinical_negligence_cases_Fenn_v_FINAL.pdf (Accessed on 11 Sept 2018).

[360] NHS Reforms 'NHS Litigation Authority rebranded NHS Resolution ahead of upcoming reform' http://www.nationalhealthexecutive.com/Health-Care-News/nhs-litigation-authority-rebranded-nhs-resolution-ahead-of-upcoming-reform (Accessed on 02 May 2017).

[361] The NHS Act of 1977 Section 11 (9) (5).

Property Expenses Scheme (PES).[362] Those claims which existed prior to 1st of April 1995 were catered for by the Existing Liability Scheme (ELS).[363]

The Courts and Legal Services Act of 1990[364] introduced contingency fee arrangements which allowed the legal practitioners to take on the claimants' cases based on a 'no-win no-fees' arrangement. If the claimants' cases were unsuccessful, they were obliged to refund the defendants' legal costs.[365] The 1999 Access to Justice and the Conditional Fee Agreements Regulation 2000[366] allowed for the recovery of the claimants' legal insurance premium. In 2006 the NHS Redress Act[367], a fault-based system which removed the right to institute civil claims was passed, and was meant to proactively address clinical negligence claims and to reduce the associated legal costs.[368] England's Redress Act[369] is a distinctive mechanism for addressing claims from harmed patients.[370] Under the Act, there are four steps to be followed in addressing a claim:

1. Investigation of the harm and the incident that resulted in it.
2. Explanation to the patient as to how the harm happened and what will be done to prevent recurrence.
3. Provision of remedial treatment.
4. Payment for further care if NHS cannot provide it.

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[362] Thomas *op cit.* 12.

[363] *Ibid.*

[364] The Courts and Legal Services Act of 1990 Section 58.

[365] A. Towse & P Danzon 'Medical Negligence and the NHS: An economic analysis'(1999) 8 *Health Econ*. 96.

[366] Access to Justice Act 1999 The Conditional Fee Agreements Regulations 2000 Section 30.

[367] NHS Redress Act 2006.

[368] NHS Redress Act 2006.

[369] NHS Redress Act 2006.

[370] R Goldberg Medical 'Malpractice and Compensation in the UK' (2011) 87 *Chicago-Kent Law Review* 133,140.

It was believed that the Redress Act would provide a timely response to the claims and minimize legal costs. It would be less costly as compared to the 'no fault system' adopted by Scotland.[371] Under the Redress Act, the volume of claims stabilized for about three years and then started to increase again from 2008.[372] It is thought that the increase was as a result of the availability of Conditional Fee Arrangements (CFA).[373] Wales implemented a similar scheme in 2011.[374] Scotland opted for the no-fault compensation scheme like the one in Sweden.[375] Under no-fault compensation the establishment of avoidability is not required, and all cases of medical harm would be settled except the listed exclusions. Exclusion of avoidability eliminates proof of negligence as the healthcare provider is not expected to account for the resultant harm, thus protecting the healthcare provider and consequently failure to learn from one's mistakes and a risk of recurrence results.[376] The right to institute civil proceedings was retained by the claimant if unhappy with the outcome. However, the no-fault scheme seems to be effective in reducing tension between a healthcare provider and his/her patient, eliminating the risk of defensive medical practice.[377]

The Legal Aid, Sentencing and Punishment of Offenders Act 2012[378] which was introduced in 2013 limited the lawyer's fees to a maximum of 25% of the award under the CFA.[379] In 2017 the NHSLA became the NHS Resolution. Perhaps this indicates

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[371] K.M Norrie and RA Hendry 'No-fault compensation for medical accidents' (2011) 41 *Journal Royal Physicians Edin* 290,291.

[372] NHS Litigation Authority Report and Accounts (2010) London. The Stationery Office 12.

[373] K Dickson, K Hinds, H Burchett, G Brunton, C Stansfield &J Thomas 'No-Fault Compensation Schemes A rapid realist review to develop a context, mechanism, outcomes framework' (2016) Department of Health Reviews Facility 1,5.

[374] K Dickson, *op cit*.5.

[375] Goldberg *op cit.* (2011) 87 *Chicago-Kent Law Review* 140.

[376] Goldberg *op cit.* (2011) 87 *Chicago-Kent Law Review* 133.

[377] Towse *op cit*.(1999) 8 *Health Econ*. 96.

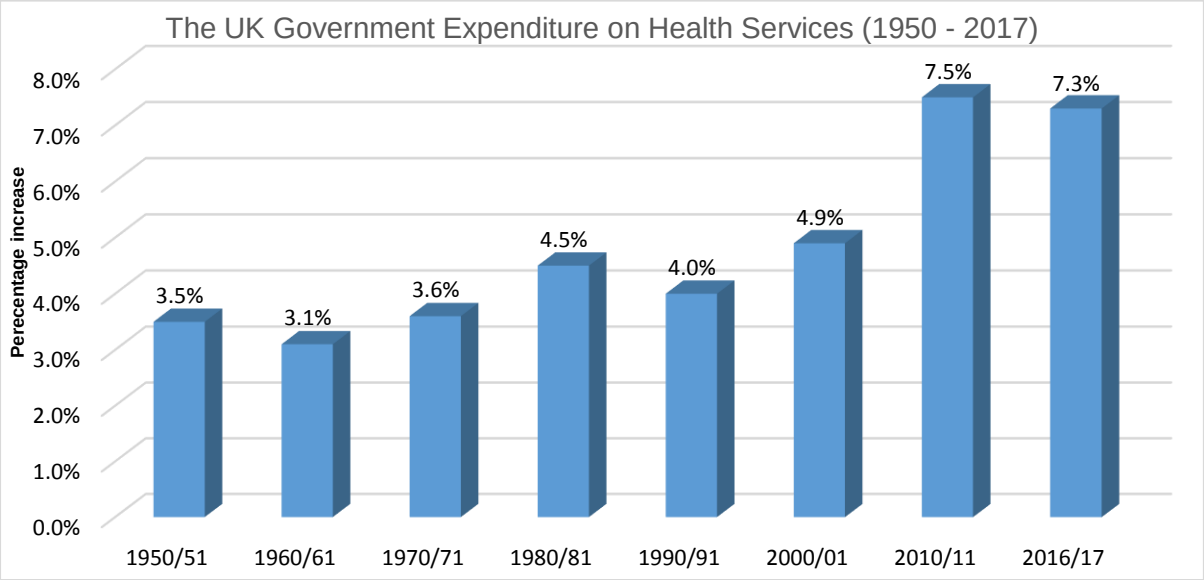
[378] The Legal Aid, Sentencing and Punishment of Offenders Act 2012.

[379] The Conditional Fee Arrangements Order 2013 Article 5 (a) (b).

a desire to resolve matters that can be addressed without litigation and thus save legal costs?[380] The claims for clinical negligence against the NHS continue to increase regardless.[381]

Since inception the NHS has exceeded the budgeted targets by a range from 3.1% to 7.3% of the GDP[382] as shown in Figure 2.

Figure 2 UK government expenditure on health services in excess of the budget[383]



NHS continues to run despite budgetary constraints, because the need for free healthcare services far outweighs other competing interests such as defence,[384] hence there has been no indication of abandoning it. The increase in the budget is due largely to the increase in the number of beneficiaries of the NHS and extended lifespan of its citizens'. This is a positive outcome of a system meant to provide universal

[380] NHS Resolution. 'Delivering fair resolution and learning from harm Our strategy to 2022' https://resolution.nhs.uk/wp-content/uploads/2017/04/NHS-Resolution-Our-strategy-to-2022-1.pdf (Accessed on 10 Sept 2018).

[381] Harker *op cit*.10.

[382] Harker *op cit.* 11.

[383] Harker *op cit.* 14.

[384] Webster *op cit.*

health care, but medical malpractice claims have also increased with the increased number of beneficiaries and further aggravates the financial needs of the NHS.

Various approaches to mitigate the increasing medical negligence claims have been adopted such as the NHS Redress Scheme which has now evolved to NHS Resolution with the hope of minimizing the cost to the already strained NHS.

4.2.2 Healthcare fraud in the NHS

The NHS Counter Fraud Authority (NHS CFA)[385] states that quantifying the extent of healthcare fraud is not accurate because it is an extrapolation from amounts detected. There is a possibility of more fraud not discovered. However, the best data available from the NHS CFA suggests that across the NHS in 2016/17, fraud accounted for about 1.25 billion pounds Sterling[386] lost to patient care. Even before the large-scale contracting out of healthcare services to the private sector, fraud within the NHS was substantial, partly because of the contracts which have been entered with NHS Trusts to deliver healthcare services and products, payment diversion, misrepresentation of qualifications and timesheet fraud by staff.[387]

The regulation of NHS has not been seamless, and problems abound. There have been numerous challenges as seen by the continuous formation, amalgamation and destruction of regulatory bodies, to improve the quality of care and save money.[388] Unfortunately, it has resulted in confusion of reporting lines and duplication of functions. The persistence of fraud, staff shortages and increasing medical malpractice claims are but a few of the challenges facing the NHS going forward.[389]

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[385] R. Hampton 'NHS Counter Fraud Authority Business Plan 2018-19' (2018) https://cfa.nhs.uk/resources/downloads/documents/corporate-publications/NHSCFA_Business_Plan_2018_19-v1.pdf (Accessed on 08 July 2017).

[386] *Ibid.*

[387] Hampton *op cit.*

[388] Webster, *op cit.*

[389] Webster *op cit.*

In the UK the NHS provides public healthcare services and it co-exists with private healthcare.[390] The NHS has contracted private medical practitioners for a fee and has incentives which are voluntary to reward service excellence. The incentives attempt to also retain these professional services and encourage delivery of quality healthcare without removing the individual autonomy, but rather encouraging compliance with the set protocols.[391]

Despite the NHS having run for over seven decades, in a developed economy, there are shortages of some experienced medical specialists as seen by the number of hospitals that have closed paediatric wards due to the shortage of paediatricians.[392] The Royal College of Paediatrics and Child Health reported that 31% of the 195 NHS trusts and health boards had temporarily closed paediatric wards and 41% of neonatal units turn away new patients due to shortage of staff including paediatricians.[393] Healthcare provision is dynamic and there will always be a discrepancy between demand and supply.

4.3 Conclusion

Initially there was significant resistance from politicians and the healthcare providers to the adoption and implementation of the NHS in the UK.[394] However the need for free healthcare services by the public was overwhelming.[395] It took a committed Minister of Health who had a personal experience of the needs of the working class to

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[390] Thorlby *op cit.* 51.

[391] Thorlby *op cit.* 54.

[392] Katie Forster Health Correspondent ' Sick children's wellbeing 'compromised' by shortage of NHS staff' (2017) https://www.independent.co.uk/news/health/nhs-staff-shortages-paediatrics-children-sick-wellbeing-compromised-a7704081.html (Accessed on 02 May 2018).

[393] Royal College of Paediatric and Child Health. 'Facing the Future: Standards for Acute General for Acute General Paediatric Services'. (2015).: http://www.rcpch.ac.uk/facingthefuture .(Accessed on 13 October 2017) 16.

[394] Macpherson *op cit.* (1998) 316 (6) 125.

[395] Macpherson *op cit.* (1998) 316 (6)126.

guide the decision-makers towards adopting and implementing the NHS.[396] The improvement of the quality of life of the British citizens was largely due to free quality healthcare provision through the NHS.[397]

Fraud in the NHS is reported to be a serious threat and cannot be eliminated. However, mechanisms have been put in place to mitigate it.[398] Perfection in healthcare systems is difficult to come by, regardless of the resources employed.[399] Where human beings are entrusted with responsibilities mistakes tend to occur- be they deliberate or otherwise. 'To err is human, to cover up is unforgivable and to fail to learn is inexcusable.'[400]

Healthcare provision is prone to be used as a political lever. The landslide victory of the Labour party in 1997, is reported to have been achieved by promising: 'free speech, openness, impartiality, more democracy and accountability in and around the NHS and elsewhere.'[401] The free flow of honest information can assist in rallying the public to buy into government's good intentions of providing universal healthcare. Public participation is crucial to the processes of change, particularly the healthcare system, as it ensures ownership of the proposed project. The purpose of this reform is to encourage the ongoing privatization of the healthcare industry to give more

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[396] Rivett. *op cit.*

[397] R. Thorlby & S Arora (eds). *The English Health Care System.* E. Mosialos M Wenzl, R. Osborn D. Sarnak 'International Profile of Health Care Systems' (2015) *The Commonwealth Fund* 49.

[398] NHS Counter Fraud Authority 'Leading the fight against NHS fraud Organisational strategy 2017-2020' www.cfa.nhs.uk. (Accessed on 13 Oct 2017).

[399] NHS Resolution 'The environment we work in' https://resolution.nhs.uk/the-environment-we-work-in/ (Accessed on 13 Oct 2017).

[400] R. Horton 'Medical Negligence there are no winners' (2018) 391 *The Lancet* 2079.

[401] J. Jones. *op cit.* (2000) 320:7247 *BMJ* 1459.

choices to patients,[402] to help lower medical costs and to reduce patient waiting times.[403]

The continuous restructuring of the NHS might at first glance look like a knee-jerk response, whereas, it indicates a dynamic responsive organization.[404] The substitution of SHA's and PCT's with CCG's, could indicate the desire of the Department of Health to remove the middleman (NHS Trusts), and deal directly with the healthcare providers and presumably improve efficiencies.

Allocation of 80% of the budget to Clinical Commissioning Groups (CCG's) indicates and emphasis on primary healthcare with the expectation of reducing the burden of disease and improved health outcomes for the population.

[402] NHS 'Five year forward review' (2014) https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf (Accessed on 13 Oct 2017).

[403] Bevan, *op cit.* 24.

[404] Webster *op cit.*

CHAPTER 5 CONCLUSIONS AND RECOMMENDATIONS

5.1 Lessons from the UK

Chapter 4 outlined how UK has gained experience in implementing universal health coverage. The NHS was established as a response to the growing level of inequality and limited access to healthcare by many of its citizens. Since its establishment in 1948 by the then Labour Government, the UK NHS has grown to become the world's largest publicly funded healthcare service. While the NHS is a success story, it is still facing similar challenges of increasing medical malpractice claims to those seen in SA.[405] The money paid for compensation in the UK also comes out of the Department of Health's own budget.[406]

Problems associated with the handling of medical negligence claims by the courts necessitated a review of the Civil Justice System. In 1996 Lord Woolf identified 5 key areas which played a significant role in the handling of medical negligence claims:[407]'(1) The excessive disproportion between costs and damages in medical negligence, especially in lower value claims; (2) the unacceptable delay in resolving cases; (3) the long pursuit of unmeritorious claims and the defence of clear-cut claims; (4) the lower success rate than in other personal injury cases; and (5) the greater suspicion and lack of cooperation between the parties than in many other areas of litigation.'[408] The NHS redress scheme was adopted to minimize the court's work load and to improve on the speedy resolution of claims by classifying claims according to their values and addressing low value claims without the need to engage the courts.[409] The NHS established a facility to assist disgruntled and harmed patients on how to structure their complaints, to guide them on the appropriate lodging of complaints, and

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[405] Goldberg *op cit*. (2012) 87 *Chicago Kent Law Review* 132.

[406] *Ibid.*

[407] L. Woolf. 'Access to justice; Final Report' (1996). *Her Majesty's Stationery Office*.

[408] *Ibid.*

[409] Goldberg *op cit*. 137.

to help them follow up the complaint to its conclusion. This has built trust between the NHS and the patients and has assisted in the resolution of complaints timeously.

Healthcare providers were encouraged to form group practices, and the Department of Health through the CCG's contracted directly with the healthcare providers which reduced bureaucracy and the opportunities for corruption.

At the onset the NHS struggled to attract professionals, out of fear of reduced income and loss of autonomy. However, the arrangement that was adopted whereby the funds were allocated *per capita* to all general practitioners who contracted with the NHS helped to attract more general practitioners. Ultimately the NHS proved to be an attractive option for private practitioners. The fear of losing autonomy was unfounded because of the changes in healthcare practice brought about by patient-centered laws and policies.

The capitation method is effective because group practices have a robust primary healthcare program. This has resulted in reducing the burden of diseases in future, and better health outcomes for the patients, as well as making practices profitable.

In the NHS, the resource allocation continues to be a challenge where the demand for healthcare services will always exceed available resources, but the emphasis on primary healthcare as seen by the allocation of 80% of the budget will reduce the demand for healthcare in the long run. Other funds are raised from diverse sources such as parking fees, telephone fees, charging foreigners, tourists and private patients.[410]

5.2 Recommendations

5.2.1 Reducing soaring medical malpractice costs

As seen at the beginning of Chapter 3, there has been a large increase in medical malpractice claims in South Africa. To reduce these amounts of settlements,

[410] Harker *op cit*. 5.

alternative dispute resolution mechanisms needs to be explored. This can be done through mediation to avoid legal fees and the delays caused by over-burdened court rolls. The establishment of the Health Ombudsman's Office has been a step in the right direction. Staff attitudes of healthcare providers and workers need to be improved and corruption should be decisively dealt with. Politicians and health institution managers should be held personally liable for their failures to implement policies and corrupt behaviour.

There is a need to review the existing laws that govern medical malpractice claims and find alternative ways of settling disputes. As previously mentioned, one solution is to settle disputes out of court using mediation. That would considerably reduce litigation cost.

Low value claims below a stipulated threshold could be resolved through mediation to reduce the burden on the courts and the associated legal costs. Large amounts payable to claimants can be made in periodical payments, as happened with the Road Accident Fund.[411]

5.2.2 Relationship between the NDoH and the healthcare professionals

The more layers in the management structure, such as (the minister of health, the director general, the chief director, and provincial MEC's) creates miscommunication in both directions and further creates opportunity for corruption. The UK NHS systematically abolished the Strategic Health Authorities and Trusts for the above reason. They were replaced with the Clinical Commissioning Groups which forms a direct line of communication between the two parties. Re-organization of healthcare professionals into group practices which can contract directly with the government would also be a useful mechanism for reducing corruption. The responsibility for obtaining informed consent from patients should be the duty of the referring practice or GP as they function as gatekeepers in healthcare provision.

[411] Road Accident Fund Act 56 of 1996 s 4 (b).

Centralized national electronic health records will be essential to reduce the costs associated with the duplication of investigations. Consequentially reducing the risk of patient adverse outcomes associated with polypharmacy[412] given that most of the population is highly mobile and very selective in the information they give to the healthcare provider. This will also assist in monitoring the performance of different practices relative to the recommended protocols. Timely interventions can be also instituted. The records must be password protected for security of personal information. This will also prevent the loss of patient's physical files. In the past lost patient files have resulted in the failure to defend medical malpractice cases that are defensible. Computer literacy should be an integral part of the curriculum of healthcare professionals. Those who qualified before the information revolution should be up-skilled.

5.2.3 Contracts between the NDoH and health professional groups

Attracting healthcare professionals to work for the NHI scheme may be a problem. This is evident from the failure of the NHI pilot projects to attract experienced general practitioners which was largely due to the remuneration offered. Other payment methods must be explored. Capitation offers a win-win situation because it encourages healthcare providers to save costs because their financial performance is dependent on saving costs. Chronic conditions consume more financial and human resources as the patient needs to be monitored and regularly supplied with medicine once a month.

Primary healthcare prevents and delays the onset of chronic conditions as a result less financial and human resources are required. It has been observed that the SA public does not attach value to primary healthcare, as they perceive it as a 'witch-hunt' and rather consult healthcare professionals when the symptoms of ill-health are experienced.[413] The widespread marketing of supplements as medicines misleads

[412] When a patient uses multiple medications and supplements for their illnesses, as a result of consulting different healthcare practitioners, including traditional healers and herbalists where different medications are prescribed without being aware of the other medication the patient is using. Resulting in a risk of drug interactions and over-dosage.

the public into believing that their use prevents disorders instead of promoting primary healthcare. It will be in the best interest of the contracted group to educate the patients especially in the primary healthcare norms because it will assist the practice in becoming financially viable as that will be saving money spent on chronic medication. The other benefit is a healthier patient population. The NDoH needs to assist in controlling the unfounded and misleading marketing of products classified as supplements.

When contracting with healthcare professionals the degree of skill and experience should be taken into consideration when determining the fees, in order to attract the necessary skilled personnel into the service of the NHI scheme. It is the healthcare professional's duty to prevent adverse health conditions in his/ her patients. This implies that primary healthcare will be of paramount importance and if properly applied will reduce the risks of increasing burden of diseases thus saving money for the practice, while ensuring better life outcomes for the patient and value for money for the NDoH.

5.3 Healthcare professionals

Healthcare professionals need to organize themselves into multi-disciplinary group practices and offer a wide range of services, ranging from immunization, health screening of dental problems, visual defects, minor operations and health education. It will reduce the burden of diseases.

Patient education should encompass the training of the public on issues of consent and the meaning of informed consent. The challenge of 11 official languages makes the obtaining of informed consent at tertiary level problematic, because it is unlikely that there are interpreters for all 11 official languages in each tertiary hospital. The practice that is referring the patient for tertiary healthcare is better placed to communicate adequately with the patient. Informed consent secured in this manner

[413] Personal observations by the author are that the public is reluctant to undergo screening test. For instance some of the patients in the author's practice that were encouraged to undergo routine mammogram examination during the October month which is (Breast Cancer Awareness Month), were very reluctant and their reason for their reluctance was 'why look for something that is not present' probably due to fear of being diagnosed with cancer.

is more likely to be effective, because of the knowledge about the patient's circumstances and family, the healthcare provider will communicate at an appropriate level than strangers in the tertiary hospitals. This may reduce the increasing medical malpractice claims in the public.

Proactive measures, such as improving working conditions for medical practitioners and other healthcare professionals, up-skilling them, and creating a conducive healthcare environment should be put in place. Creating a conducive working environment on its own is not enough, it is also important to create more ethical and legal awareness among medical practitioners and other healthcare professionals, so they become more conscientious and aware of their responsibilities.

All healthcare professionals who wish to serve the NHI scheme need to be re-orientated to provide primary healthcare rather than hospital-centric healthcare. The NDoH should assume the role of monitoring the performance of each practice. It should investigate all adverse incidents in order to identify problems early and institute appropriate remedies. Periodic assessments of all healthcare facilities should be instituted and facilities that fail to achieve the desired standards should be put on notice that they may have their contract with the NHI terminated.

5.4 Patient support systems

A dedicated office needs to be set up to assist disgruntled and injured patients in formulating their complaints and to help with follow-up of complaints until their conclusion. This will provide an alternative approach to resolving conflicts that arise. The HPCSA could play this role. The public perception that the HPCSA protects its members needs to be corrected. Patients need to be made aware of their rights and duties when accessing healthcare services. Most of the population has strong cultural and religious beliefs which can be misleading when it comes to matters relating to health. Education of the patient by the healthcare provider, as well as the general education of the population, will help empower people to understand abstract scientific information about nutrition, lifestyle, substance use, the need for physical activity and screening for prevalent medical conditions as informed by epidemiology and ultimately adopt practices that are supportive to good health.

South Africa made history when democracy was introduced, and the atrocities of the apartheid system were acknowledged and unmasked. However, the consequences of apartheid will keep many of the victims of apartheid disempowered. The introduction of the NHI scheme will go a long way towards dealing with the harm suffered by them. This is not an insurmountable objective provided that the commitment of the healthcare practitioners, patients and the public is secured.

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UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

02 June 2016

Dr Manake Athanasius Mokone (813816117)
School of Law
Howard College Campus

Dear Dr Mokone,

Protocol reference number: HSS/0732/016M
Project title: Soaring medical malpractice litigation in South Africa and its implications for the implementation of the proposed National Health Insurance

Full Approval – No Risk / Exempt Application

In response to your application received on 01 June 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Professor David J McQuoid-Mason
Cc Academic Leader Research: Dr Shannon Bosch
Cc School Administrator: Mr Pradeep Ramsewak / Ms Robynne Louw

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