SUPPLEMENTARY SUBMISSION ON BEHALF OF

THE SOUTH AFRICAN MEDICAL MALPRACTICE LAWYERS' ASSOCIATION

INTRODUCTION

1. At the public hearings on 31 October 2018, a number of questions were raised by members of the Committee. The presenters were afforded the opportunity to supplement their written submission by way of a further note. We do so hereunder.

2. However, prior to doing so, we are constrained to place on record:

   2.1. First, our grave concerns as regards the public participation process that has been followed to date. In our view, that process did not (and does not) accord with the prescripts of section 59 of the Constitution. We emphasise that a deficient process has the effect of tainting any resultant legislation. We recorded our clients concerns in respect of the process in correspondence dated 6 November 2018, a copy of which we attach as "**A**" hereto. The submission of these supplementary representations should in no way be construed as an acceptance by our clients of the fairness or properness of the process followed.

   2.2. Second, the particular skill and insight of our members, all of whom are medical malpractice lawyers and uniquely placed to provide a perspective on: (a) the causes of medical malpractice claims; (b) the process of obtaining justice on behalf of victims of medical malpractice at the hands of the State in our courts; (c) the conduct of obstruction and delay and/or dilatory conduct by the State Attorney and provincial health departments in dealing with medical malpractice litigation; (d) the practical application of the current **State Liability Act, No 20 of 1957**; (e) the litigation finance needs of victims of medical malpractice seeking redress in our Courts against the State; (f) the medical, educational, vocational and financial needs of victims of medical

malpractice; (g) the public versus private medical market place; (h) general quantification of claims of victims of medical malpractice and principles applicable thereto; and (i) consumer price inflation versus medical inflation. Each of these issues bear fundamentally on the Bill and therefore this submission ought to be afforded careful consideration, together with the original submission.

3. In what follows and emanating from the questions raised, we address the following issues in turn hereunder:

3.1. First, the interest sought to be protected by our representations.

3.2. Second, why an amendment to the legal aid regime ought not to be pursued instead of objecting to the Bill.

3.3. Third, the inaccessibility of the private health care system.

3.4. Fourth, the impact of the structured settlement arrangement on future budgeting and section 66 of the Public Finance Management Act No 1 of 1999 ("**the PFMA**").

3.5. Fifth, alternative measures to address the underlying mischief targeted by the Bill.

3.6. Sixth, the mechanisms presented by the Bill in respect of accessing health care and quantifying claims for damages.

3.7. Finally. the timing of the Bill and the South African Law Reform Commission process and in particular outstanding information required to assess aspects of the proposed Bill.

ON WHOSE BEHALF THIS SUBMISSION IS MADE AND THE INTERESTS SOUGHT TO BE ADVANCED?

4. As indicated in our initial submission, the Submission is made on behalf of the South African Medical Malpractice Lawyers' Association.

5. As regards the interest sought to be advanced, we say the following:

5.1. First, the interests of Medical Malpractice Lawyers' Association clearly underlies the submission. That interest, however does not lie in seeking to immunise lawyers against challenges to charging excessive legal fees; it is rather to protect lawyers who have extant valid contingency fee agreements entered into in terms of the law as it currently applies. Variation of the terms of such valid agreements will substantially impact the administration of justice. It is trite law that retrospective application of the law under these circumstances will not pass constitutional muster.

5.2. Second, the impact on poor people cannot be divorced from the services rendered by lawyers. Simply put, if the Bill presents a deterrent to attorneys accepting matters on a contingency basis, it results in access to justice being frustrated for poor and marginalised persons.

5.3 Third, the primary motivation underpinning the submission is to ensure that the Committee is aware of the risks in respect of a challenge to the constitutionality the Bill (if adopted). The Association seeks to engage constructively and comprehensively with the committee on the complexities related to the proposed Bill.

SUPPLEMENTING THE LEGAL AID SYSTEM

6. In the course of the hearing, a member of the Committee raised the issue of whether the concerns we had raised would not be better served by an amelioration of the legal aid system so that legal aid may be provided to victims of medical negligence.

7. We say the following in response:

7.1. First, our submission is premised on the present legal framework. In terms of that framework:

7.1.1. No legal aid is presently available to victims of medical malpractice.

7.1.2. There is no alternative state measure that is aimed at allowing persons to litigate medical negligence claims.

7.1.3. Legal services are excessively expensive and out of the reach of the poor.

7.1.4. Contingency fee agreements are the only way by which poor people are able to go to Court in order to vindicate their rights when they have suffered negligence at the hands of the State.

7.2. Second, our Submission should not be construed as an acceptance of the ambit of legal aid as presently provided; those are however separate issues that do not form the subject of these public hearings.

7.3. Thirdly, in the course of the LRC's Submission, one of the Committee member's suggested that Legal Aid does provide assistance for civil claims, including medical negligence claims. This is manifestly not correct. The Legal Aid Board is unable to provide assistance in medical malpractice matters, inter alia, for the following reasons:

7.3.1 The practice of medical malpractice law is a specialist field requiring specialist knowledge.

7.3.2 The Legal Aid Board does not have the funding and/or specialist skills required to:

7.3.2.1 Obtain all medical, employment and other records.

7.3.2.2 Obtain independent medico-legal reports by independent experts, over a range of medical and other disciplines, in order to provide the court with expert evidence (often at a cost in excess of R1 million rands per case).

7.3.2.3 Obtain the services of counsel with specialised knowledge to conduct the litigation.

The Contingency Fees Act 93 of 1996 was specifically designed to provide a mechanism to obtain the funding of such litigation by specialist attorneys with the required skills.

7.4. Fourth, in the course of the hearings it was suggested by a Committee member that attorneys were "unpatriotic" because they do not provide gratuitous assistance to persons seeking to litigate medical negligence matters. The question is, with respect, misguided (and regrettable) in that: (a) private lawyers bear no obligation to provide gratuitous services; such an argument could never pass constitutional muster given that the State itself does not provide access to gratuitous legal services for persons seeking to pursue medical malpractice claims against the State; (b) attorneys are in any event bound to act within the confines of the Contingency Fees Act.

7.5. Finally, contingency fee arrangements are not tantamount to "playing the lotto" (as suggested by one of the Committee members); they are a real and important way of ensuring access to justice for poor people within the confines of the legislatively prescribed framework.

THE INACCESSIBILITY OF THE PRIVATE HEALTH CARE SYSTEM

8. In the course of the hearing, the somewhat surprising statement was made by one of the Committee members that public health care services are superior to those at private health facilities. There is no basis for such a claim. According to the most recent research, only 0.7% of public health establishments comply with

the Norms and Standards determined by the Office of Health Standards Compliance. This statistic plainly speaks to the dire state of the public health system.

9. A further point raised during our presentation was that private health care services are in any event inaccessible to the majority of the poor because they do not have access to medical aid. This point, in our view, misses the point:

9.1. First, the Constitutional Court has already held as follows[1]:

> "[96] It is indisputable that imposing public health tariffs on road accident victims amounts to restricting them to treatment at public health institutions, if they cannot fund the health care themselves. In some instances, that restriction will be perfectly reasonable and adequate. However, the overwhelming and undisputed evidence demonstrates that road accident victims who are rendered quadriplegic or paraplegic, require specialised care for life, without which there can be life-threatening complications which, if unattended, lead to their inevitable demise.
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> [97] To this charge, the respondents have no effective answer. They acknowledge the vast disparity between private and public health care establishments and explain how they propose to improve public health care establishments. What they do not do, is to meet head-on the complaint that quadriplegic or paraplegic road accident victims would not easily survive the health care services at public hospitals."

9.2. Second, in relation to a claim for damages arising from negligent conduct, the threshold for a claim for damages is not based on whether the individual can (or prior to the injury could) afford services from the private sector; the issue is rather an award of damages that will suffice to address the harm that an individual sustained on account of the negligent failures of the public health system. The legal principle that apply is: to place the victim in the position he/she would have been, but for the negligence of the State.

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[1] Law Society of SA v Minister for Transport 2011 (1) SA 400 (CC) at par 96 to 100.

IMPACT ON FUTURE BUDGETING

10. The effect of structured settlements is that the Courts effectively prescribe to government the extent to which their future budgets should cater for medical malpractice payments (which may extend to in excess of 30 years). Yet:

    10.1. There is no mechanism under the current statutory framework that allows for budgeting beyond the Medium Term Expenditure Framework.

    10.2. There is a specific prohibition against making future financial commitments as contemplated by section 66 of the PFMA.

    10.3. The Bill will result in the Courts prescribing to Government the extent of future commitments in respect of future budgets; these decisions are being made in a vacuum and in the absence of the Courts being aware of the competing demands on the fiscus in any given year. To this end, it, in our view, the concept of structured settlements infringe the doctrine of separation of powers.

ALTERNATIVE MEASURES TO ADDRESS THE UNDERLYING MISCHIEF

11. There is presently a process underway before the South African Law Reform process. That process has thus far, objected to peremptory structured payments, yet, the Bill adopts a model in direct contraction to the SALRC process.

12. We are of the view that:

    12.1. The process before the South African Law Reform Commission ought to be permitted to run its course.

    12.2. In the interim, misappropriation of damages awards and "windfalls" by the heirs of victims of medical malpractice that are unable to manage their own affairs, may be addressed via the construct developed in the matter of **AD and IB v MEC for Health and Social Development, Western Cape Provincial Government, Case Number 27428/10, Western Cape**

Division, Cape Town in the High Court of South Africa, which, *inter alia*, established that:

12.2.1 Development of the common law and/or amendment of the once-and-for-all rule is not necessary in order to protect an award, ensure that all the funds are utilised for its intended purpose and/or to allow for a reversion to the State of any unused medical expenses and/or equipment.

12.2.2 Where a victim, that is unable to manage his/her own affairs, receives an award, same may be protected by establishment of a trust to manage the award.

12.2.3 Provisions in the trust deed may provide that:

12.2.3.1 Damages awarded in respect of future medical expenses should be ring-fenced, netto of litigation costs.

12.2.3.2 Damages for future medical expenses may only be applied for the purpose for which same was awarded, subject to a monitoring process by a trust appointed case manager and in consultation with trustees.

12.2.3.3 Annual auditing and reporting mechanisms to both the Master of the High Court and Defendant (State) in respect of the application of the award for future medical expenses.

12.2.3.4 A right of reversion of all funds held in the medical expenses account of the trust on the death of the victim, to the Defendant (State), netto of the trust administration costs.

12.2.3.5 A right to top-up the damages in the event that the victim exhausts the damages awarded in respect of the future medical expenses in his lifetime, subject to a prescribed method.

12.2.3.6 Awards for past expenses, loss of earnings and general damages be excluded from the abovementioned construct, whilst still being managed by the trust.

12.3. Alternative methods of providing compensation to victims of medical malpractice such as e.g. provision of services by a state hospital, negate the certainty, individual freedoms, fairness and justice associated with the once-and-for-all rule. It is important to highlight the fact that:

12.3.1. The multiplicity of disputes that may arise over a victim's lifetime in respect of the necessity for services and/or failure of the state to render such services, and the associated increased dispute-resolution costs.

12.3.2. The loss of freedom of a victim of medical malpractice that is bound to receive treatment from one institution only, neglecting to take note of the right of the individual to move freely anywhere in the world, choose treatment modalities and the like. Not only does the victim suffer from an unfortunate, often catastrophic event, he/she is thereby bound to the wrongdoer for the balance of his/her lifetime and at the mercy of the wrongdoer to be compensated.

12.3.3. The failure/inability of victims to be able to access treatment, where they are provided with an apportioned undertaking (due to a liability and causation finding) in respect of the future medical expenses to be incurred.

12.3.4. Various services and treatment modalities are not rendered by the state and/or available at the required frequency.

12.3.5. The introduction of thresholds for the ability to claim are often accompanied by tailoring of evidence and fraud, as dealt with extensively in the Satchwell Commissions' enquiries relating to the Road Accident Fund.

THE MECHANISMS PRESENTED BY THE BILL

13. The Bill presents three mechanisms by which to address its intended objectives:

13.1. First, it makes structured settlements peremptory. There is no precedent for this. Such a proposal has two very serious consequences: (a) it eliminates any judicial discretion on the part of the Courts; and (b) it prevents the parties from agreeing to a single lump-sum settlement, even if such a model may best serve the interests of the Plaintiff and be the most cost effective option for the State. Periodic payments, in the jurisdictions where they apply, are not peremptory, but based on choice and/or evidence as to the most appropriate payment-method in each individual matter.

13.2. Second, it allows for the Courts to order the State to provide future medical treatment at a public health establishment that is compliant with the norms and standards as determined by the Office of Health Standards Compliance. As stated, there are only 0.7% of public health establishments that meet this threshold. The provision is therefore unlikely to yield any benefit in relation to the stated objectives of the Bill given that it is largely incapable of practical implementation.

13.3. Third, the Bill refers to limiting the liability of the State, where future medical treatment is to be delivered at private health facilities, to "the potential costs that would be incurred if such care was to be provided in a public health establishment". This provision is problematic because: (a) the public health system cannot be used as a comparator for

determining the cost of private health care when the public health system in on the brink of collapse – simply put, a system which is failing on account of resource constraints cannot be used to benchmark costs at a private health facility; (b) it will result in a shortfall if a private health facility is accessed which will have to be self-funded – where such self-funding cannot take place, individuals will not be able to utilise private services.

14. The result of the aforegoing is that if the Bill is to be adopted in its present form, the vast majority of poor persons will be forced to return to the State system; this despite having been subjected to negligent conduct at the hands of the State. The further, very serious consequence of the Bill is that despite the shortcomings and profound under-resourcing of the State health which, this becomes the only option to the Plaintiff.

15. In addition, it must be emphasised that the effect of the Bill is that Plaintiffs will not be able to meet a short fall in costs of future health care services from the damages claimed under other heads due to same being paid periodically. This is particularly pertinent in cases where the victim only receives an apportioned claim e.g. 50% of his/her damages due to a liability finding and the principle of causality.

THE TIMING OF THE BILL AND OUTSTANDING INFORMATION

16. The South African Law Reform Commission:

16.1 First, is currently seized with a review of all issues relating to the practice of medical malpractice law and, specifically, a review of the **State Liability Act, No 20 of 1957**, in terms of **Issue Paper 33** on **Project 141**. The commission is due to report its findings during **2019**. To our knowledge a wide range of submissions from a diverse group of interested parties, have been made. The South African Law Reform Commission has been established, specifically, to do research in order to make recommendations to Government for the development, improvement, modernisation or reform of the law. The Commission's programme is

approved by the Minister of Justice. We submit that it is a matter for concern that the input, or as a minimum, an interim report on the issues relating to the **State Liability Act, No 20 of 1957** from the commission is not available to inform the process relating to the amendment of the Act.

16.2 Second, actuarial modelling of the financial implications of the introduction of periodic payments need to inform the process relating to the amendment of the Bill. To our knowledge no such model exists at the instance of the State. Our own modelling in this regard, supported in the submission made by the Actuarial Society of South Africa, demonstrate an alarming quadruple multiplication of the liability of the State, once the actuarial benefit of "capitalisation" and the removal of contingency deductions (that are generally applied by our courts in respect of future damages) are removed. Considering, that the proposed legislation has the main aim of saving of money for the State, we submit that the legislation as proposed woefully falls short on this account.

16.3 Third, actuarial costing of the system to:

16.3.1 Review periodic payments in the courts;

16.3.2 Pay periodic payments;

need to be made.

No financial benefit will accrue to the State, if the costs of delivery of periodic payments is similar to, example, the Workman's Compensation Commissioner's delivery costs, namely, 17% of all amounts paid periodically, and where such delivery costs are, **in addition,** to the State's current liability for damages in medical malpractice cases. If anything, the State's huge contingent liability for such damages will balloon exponentially.

We submit that no proper evaluation of the proposed legislation may be made, prior to the abovementioned documentation/information becoming available.

We thus conclude that considering the information contained in this submission, read with our previous written submission, the proposed legislation will not pass constitutional muster.