EXPLORING POTENTIAL REFORMS TO ADDRESS THE HIGH COSTS OF MEDICAL MALPRACTICE LITIGATION IN SOUTH AFRICA

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ABSTRACT

For many years, medical malpractice claims have threatened the effective governance of health care sectors the world over. South Africa is not exempt from the effects of this phenomenon. The effects of increasing medical malpractice claims and their associated costs threaten the effective governance of the private and public health care sectors, which results in a vicious cycle of resource depletion, poor service delivery and constantly increasing rates of medical malpractice incidents. This research aims to add to the body of work in South Africa concerning the adverse effects of medical malpractice claims. This dissertation provides a theoretical discussion on whether periodic payments and alternative dispute resolution are satisfactory responses to combat both the rising cost of damages and the procedural backlogs present within the law of delict and medical malpractice litigation in South Africa to achieve comprehensive reform in the law of delict. Ultimately, this dissertation examines the practical legal issues that have led to the current medical malpractice crisis in South Africa. The dissertation examines the role of aspirational health care policies, goals and agendas (specifically section 27 of the Constitution of the Republic of South Africa) that have been implemented on a national level, and it also examines the ability to implement comprehensive reform to address the medical malpractice crisis to hopefully break the vicious cycle that is keeping South Africa from achieving its national and constitutional health care goals.

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1 CHAPTER 1: INTRODUCTION

South Africa is currently battling a widescale ‘passive’ infringement of the right to healthcare services.[1] Most South African hospitals are under-resourced and overburdened, and medical personnel find themselves working in dilapidated and outdated medical facilities.[2] The South African Law Reform Commission Issue Paper 33 (Project 141) Medico-Legal Claims (“Issue Paper 33”) states that the undue pressure in their workplace often leads to a lower quality of service provision, especially in overpopulated public hospitals, and devastating cases of medical negligence often ensue.[3] As a result, injured parties are entitled to compensation.[4] Unfortunately, both the injured party and the defendant are left to resolve their dispute through an expensive and protracted litigation procedure that few can afford.[5] If the injured party is successful in their claim, the damages pay-out that they receive can be burdensome on the defendant, who might not be able to pay these fees.[6] The financial burden is particularly worrisome when one understands that the government, as a public defendant, is also affected by these damages pay-outs.[7] However, whether the defendant is a private practitioner or the government, the entire South African health care sector is adversely affected by this current medico-legal “crisis”.[8] The current vicious and expensive cycle of medical negligence litigation has increased tremendously over the last few years, and it continues to grow at an alarming rate.[9] However, when one accounts for the attention that medical malpractice issues have received not only in South Africa but in foreign jurisdictions[10] as well, it becomes evident that the entire South African medical malpractice procedure requires reform.[11]

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[1] South African Law Reform Commission Issue Paper 33 (Project 141) *Medico-Legal Claims* (2017) at 2–8; Section 27(1)(a) and 27(2) of The Constitution of the Republic of South Africa, 1996: Effective reforms must be taken to provide systemic relief to address the medical malpractice crisis, as there is both a positive and negative obligation on the state to ensure that the right to health care is not infringed.

[2] Ibid Issue Paper 33.

[3] Ibid.

[4] Ibid at 15–8.

[5] Ibid.

[6] Ibid at 44–5.

[7] Ibid at 4.

[8] Ibid at 3, “Minister for Health, Aaron Motsoaledi, is actively confronting this issue due to his concerns about the escalating ‘crisis’”.

[9] Ibid.

[10] Ibid 38–46.

[11] Ibid at 6–8.

Several seminars have been held in recent years that have brought interested parties together to discuss the matter.[12] As a result, more research has been conducted on the topic, which has led to a considerable amount of empirical information becoming available on the subject.[13] The elements that lead to excessive medico-legal fees can be broken down into two categories.[14] The first is that the cost of litigation not only includes attorney fees for the length of the disputes, but litigation costs also include fees for medical experts and actuarial scientists who assist with the calculation for damages (e.g. future expenses). The second element of medico-legal costs is the damages that are awarded to claimants, and the cumulative amount of medical malpractice costs can extend into the billions,[15] considering the devastating injuries they may have suffered.[16] The tables below detail the growth in the cost of medico-legal claims over the past few years in South Africa.[17]

In the 2009/2010 financial year, the estimated provincial medico-legal liability statistics for 7 of the 9 South African provinces were as follows:[18]

Province	2009/2010 Bill (In ZAR)
KwaZulu-Natal	R547 million
Mpumalanga	R19 million
Gauteng	R10 million
Western Cape	R6 million

[12] Ibid at 1–5.

[13] Ibid.

[14] Ibid at 2–8.

[15] WT Oosthuizen & Pieter A Carstens 'Medical Malpractice: The extent, consequences and causes of the problem' (2015) 78 *THRHR* 269 at 273.

[16] Ibid at 272–75.

[17] Medical Protection Society 'Challenging the Cost of Clinical Negligence: The Case for Reform' available at *www.medicalprotection.org/southafrica/home* at 5, "There is growing recognition of the need for legal reform in regards to clinical negligence in South Africa. Not only to reduce mounting costs that are becoming a burden for the public purse, but also to create a system that both ensures reasonable compensation for patients allows for a fair and robust defence where necessary."

[18] Oosthuizen & Carstens op cit note 15 at 272–75.

North West Province	R1.7 million
Free State	R577 000 (thousand)
Eastern Cape	Over R8 million
Total from the 7 Provinces	R592 277 000.00

The statistics above refer to a collection of medico-legal related bills in that year, not only relating to damages or litigation fees.

The following statistics show an increase in the national total for principle amounts paid out for litigation for all nine provinces:[19]

Financial Year	National Total (in ZAR)
2010/2011	R95 531 132.44
2011/2012	R102 046 645.02
2012/2013	R222 448 608.19
2013/2014	R498 964 916. 72

From these litigation fees alone, one observes that the national total increased by almost double from the 2011/2012 year. The costs appear to be increasing at an exponential rate, as the South African Law Reform Commission ("SALRC") notes that in the 2015/2016 financial year the national total for contingent liabilities for medical malpractice amounted to R40 923 535 000.[20] The statistics above refer to the public health sector, which is where the bulk of medico-legal claims have arisen. However, this increase is not limited to the public health sector.[21] The Medical Protection Society reported that between 2009 and 2015, the amount claimed for clinical negligence in South Africa has increased by a mean rate of 14%.[22] The most recent

[19] Issue Paper 33 op cit note 1 at 16.

[20] Ibid at 17.

[21] Ibid.

[22] Medical Protection Society op cit note 17 at 10.

statistics reported show that R80.4 billion has been spent on medico-legal litigation and its associated costs at the end of March 2018.[23] The damages fees are not the only problem – the current claims process by way of adversarial litigation is equally concerning,[24] even if many cases are settled out of court.[25]

Knowing that billions of rands are coming from the government-appointed funds for health care, it cannot be denied that the cost of medico-legal litigation and damages in South Africa raises broader questions than those typically considered within the context of the law of delict. Instead, questions of constitutional law and structural transformation are raised, within the spheres of both health care and the operation of the legal system itself. That is because every cent spent on litigation is a cent lost in the endeavour to meet the constitutional right of access to health care and to avoid a 'passive' breach of that right. With the advent of international and national agendas and instruments focusing on human rights, it has become more pressing to implement practical solutions to protect and fulfil such rights in the realm of medico-legal litigation. It is time for South Africa to deal with the deep structural issues that have been made evident through the rising costs of medical malpractice litigation. As a response to the crisis, the National Department of Health (" the NDoH") launched sub-programmes to implement alternative dispute resolution ("ADR") measures and structured settlements to address the issues faced by the entire South African health care sector.[26] Furthermore, the NDoH's sub-programme was tasked with assisting with the amendment to the State Liability Act 20 of 1957 (resulting in the State Liability Amendment Bill 16 of 2018 (the "SLAB"/ "the Bill"))[27]. This amendment seeks to implement structured settlements and treatment in lieu of monetary

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[23] '#BudgetSpeech2019: How govt plans to curb medico-legal claims' in Medical Law News South Africa 21 Feb 2019 available at *https://www.bizcommunity.com/Article/196/716/187656.html* accessed on 13 October 2020: "Between 2015 and 2018, the review said, claims against health departments had risen from R28.6 billion in March 2015 to R80.4 billion in March 2018. During this period, claim payments increased to R2.8 billion from R498.7 million"; National Department of Health Annual Report 2017/2018 at 21.

[24] Medical Protection Society op cit note 17 at 11.

[25] Oosthuizen & Carstens op cit note 15 at 276.

[26] National Department of Health Annual Report 2017/2018 at 21.

[27] State Liability Amendment Bill 16 of 2018; Wiers R 'The State Liability Amendment Bill | A Missed Opportunity for Change' available at *https://www.adams.africa/insights/state-liability-amendment-bill-missed-opportunity-change/* accessed on 14 October 2020.

compensation to address the ballooning future care costs of medical malpractice claims to meet the needs of plaintiffs as well as public and private defendants.[28]

In Chapter 2, this dissertation explores the challenges of the healthcare crisis in South Africa alongside the South African Law Reform Commission's ("SALRC") Issue Paper 33 and additional academic commentary. In Chapter 3, the dissertation examines the current commentary on the SLAB to determine whether it is an effective tool to realise the healthcare reform it attempts to achieve. Chapter 3 also examines the curial developments that have allowed structured settlements and other cost reforms (such as treatment in kind) to enter into the delictual process. Chapter 4 examines whether an ADR system comparable to New Zealand's healthcare disputes system would bring a more fundamental change to the healthcare crisis. Chapter 4 also examines the role of the Office of the Health Ombud to determine whether it can take on an alternative dispute resolution (ADR) function to achieve fundamental reform to the medico-legal crisis. Finally, Chapter 5 concludes with the suggestion that an ADR system may be able to achieve necessary reform alongside the cost reforms of structured settlements.

[28] Bill 16 of 2018; Chapter 6: Questions for Consideration in Issue Paper 33 op cit note 1 para D at 54–5.

2 CHAPTER 2: OVERVIEW OF THE CHALLENGES AND POTENTIAL REFORMS

It is widely suspected that the decline in health care standards in South Africa has adversely affected the provision of adequate health care services, particularly in public health care facilities.[29] This has unfortunately resulted in greater incidences of expensive medical malpractice lawsuits.[30] Consequently, there has been an expansion of liability concerning medical malpractice claims which may, given its financial impact, have led to a further decline in health care standards.[31] As previously mentioned, this expansion of liability comes as a result of the increase in the number of medical malpractice claims, the size of the awards ordered and the litigation procedure. While many issues have resulted in the decline of public health care standards (such as instances of insufficient care, maladministration, and even corruption),[32] the expansion of medical malpractice liability has almost certainly exacerbated this decline.

One opinion expressed during public debate on this issue is that the crisis should be dealt with on a service delivery and management level only.[33] That is to say, issues of corruption and poor service treatment and medical attention must be focused upon instead of reforms to the law of delict.[34] While it is undoubtedly true that the former matters must be addressed, the *legal* issues surrounding the medical malpractice crisis must equally be addressed. That is because these matters interrelate and are mutually reinforcing.[35] They are somewhat symbiotic in the results that they ultimately produce: i.e. poor health care standards. Therefore, addressing the decline in health care standards must be accompanied by an attempt to address current litigious medical malpractice trends.[36] Unsurprisingly, most academics have cited the failure of the current law

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[29] Bernard Wessels 'The Expansion of the State's Liability for Harm Arising from Medical Malpractice: Underlying Reasons, Deleterious Consequences and Potential Reform' 2019 (1) *TSAR* 1 at 5.

[30] Ibid.

[31] Ibid.

[32] SECTION27 submission 'State Liability Amendment Bill 16 of 2018' (2018) para 25 at 11.

[33] Amnesty International South Africa 'Submission to the Portfolio Committee on Justice and Correctional Services' (2018) at 4–8.

[34] DSC Attorneys 'Written Submissions Regarding the State Liability Amendment Bill, B16 – 2018'

para 5.

[35] Bernard Wessels and James Wewege, "The State Liability Amendment Bill – further evaluation and commentary" (2019) 3 *TSAR* 484 at 491.

[36] Issue Paper 33 op cit note 1 note 7 para E at 55.

of delict and the litigation procedure to deliver sufficient recompense to injured parties.[37] They also agree that the protracted process leads to amplified costs concerned with medico-legal litigation.[38] Another important voice is that of the South African Law Reform Commission, which is a public body that contributes to the nation's pursuit of equality, fairness and constitutionality. The Commission has often been at the forefront of change in our legal practices by championing reform various legal spheres.[39] The Commission has published Issue Paper 33, entitled *Medico-Legal Claims*, which examines the state of South Africa's medical malpractice crisis and its associated legal issues. In its work on the medico-legal crisis, the SALRC identifies possible causes for the crisis and possible remedies for the issues surrounding the medico-legal claims, such as reforming the calculations of delictual orders and finding a more affordable litigation process.[40]

This chapter provides an overview of the challenges faced by the South African health care system by reference to the work of the SALRC's paper and relevant academic scholarship. The chapter then turns to an overview of the range of potential reforms proposed in the literature, by the courts, and by way of the State Liability Amendment Bill. The option of structured settlements is introduced, which stands out as particularly popular among the multiplicity of possible reforms – both conventional and fundamental. The chapter concludes by justifying the focus of the remainder of the dissertation, namely, the possibility of a combination of structured settlements with the introduction of a novel system of administratively efficient alternative dispute resolution.

2.1 The Challenges to the Health Care System as Explained in the SALRC Paper and Academic Literature

The Commission begins its observation of these issues by briefly acknowledging that the current financial struggles faced by both the private and public health care sectors have worsened due to the increase in the amount of money that is spent on medical malpractice

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[37] Ibid Issue Paper 33 at 8–10.

[38] Ibid at 13–6, and 20–2.

[39] See *https://www.justice.gov.za/salrc/* accessed on 14 October 2020.

[40] Chapter 6: Questions for Consideration in Issue Paper 33 op cit note 1 paras B-F at 51–7.

litigation and the costs of the associated damages.[41] The first response that the Commission considers is whether there should be an abolition of the common law with regards to the lump-sum rule that requires a judgment debtor to pay the ordered amount in full to the judgment creditor.[42] The aim of abolishing the lump-sum rule would be to compensate the injured party fairly while finding new methods of buffering the defendant's cash flow by implementing a payment plan to stagger the financial recompense for injured parties.[43] By tackling this one delictual principle, public and private medical defendants may be able to contain and possibly limit the undue financial strain that affects their day-to-day delivery of health care services. The Commission draws comparisons between South Africa's unfolding medico-legal crisis and the collapsed systems of the United States.[44] They note that South Africa cannot afford to undergo a similar collapse, as it would not be in the interest of anyone's constitutional right of access to burden the healthcare system.[45] However, according to the Commission, the recent explosion is unusual compared to international examples because, in only a few years, there has been an increase in legal touting, a lower level of medical care and expertise, as well as an increasingly anxious medical workforce.[46]

Chapter 2 of the SALRC paper states that private health care is increasing in cost and is gradually becoming unaffordable.[47] In turn, this places a burden on the public health care sector, as it lacks the financial and human resources to deal with the increased demand for health services.[48] However, in Issue Paper 33, the Commission discusses aspirational goals that have been set for the health care sector to improve the health of the nation and improve access to health care. In a concerted effort to set things in motion by many interested groups, a Medical Malpractice Workshop was held in March 2017 with a panel of interested parties including the Minister of Health, the SALRC, the Road Accident Fund, legal professionals, actuaries, academics, and medical professionals. In this Workshop, members addressed methods of

[41] Issue Paper 33 op cit note 1 para C sub-para 1.6 at 2.
[42] Ibid at 2.
[43] Ibid at 2 para C and at 16–8.
[44] Ibid at 8.
[45] Ibid at 8; 36–7.
[46] Ibid at 1–2.
[47] Ibid para 2.29 at 18.
[48] Ibid at 6–22.

improving the medico-legal litigation procedure and culture to promote efficacy and better health care governance.[49] Another aspirational health care guide is the National Development Plan ("NDP") that is hoped to be achieved by 2030.[50] This 2030 NDP presents a long-term perspective that deals with broader themes of promoting health in South Africa through six main points:[51] Point one deals with the need for inter-sectoral and inter-ministerial collaboration to meet the health goals and health care goals of the public.[52] Points one to three outline the general objective of the NDP to develop a healthier society and for health consciousness to become engrained in South Africa's cultural behaviour.[53] Point four discusses the human capacity that is vital to securing a healthy and health-conscious South Africa.[54] Point five continues to discuss the importance of improving governance and eliminating the infrastructure backlogs of the health care system.[55]

Finally, the Commission discusses how the Negotiated Service Delivery Agreement ("NSDA") is in favour of balanced measures to improve the general health of South Africans as well as improving health care facilities available to them through their Ten Point Plan.[56] This plan seeks to address South Africa's health care issues by: "improving the quality of health services provided to South Africa citizens by establishing an independent National Quality Accreditation Body; overhauling key components of the management systems and structures in the public health sector; better planning and management of human resources for health; the strategic implementation of infrastructure development and maintenance initiatives; and mass mobilisation of communities and key stakeholders to promote better health outcomes."[57]

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[49] Ibid at 3.

[50] Ibid.

[51] Ibid at 23–6; National Planning Commission '*National Development Plan 2030: Our Future – make it work*' (2012) available at https://www.poa.gov.za/news/Documents/NPC%20National%20Development%20Plan%20Vision%202030%20-lo-res.pdf accessed on 14 October 2020 at 330.

[52] Issue Paper 33 op cit note 1 at 4–5; Ibid Chapter 10 of the National Development Plan.

[53] Ibid Chapter 10 of the National Development Plan.

[54] Ibid.

[55] Ibid.

[56] Ibid.

[57] Ibid at 330–41.

The SALRC paper highlighted the need for broader government policy on health care in order for any legislative reform to be effective.[58] These policies and goals allude to a greater good that South Africa must aspire to as a nation with regards to our health care – a greater good that balances the needs of the ailing and injured with the issues faced by those offering health care services. The Commission reiterates the need for legal reform to occur in both the public and private health care sectors because the lack of legislation dealing with medical negligence claims and the previous failure to implement the necessary legal reforms are still an ongoing administrative threat.[59] Thus, on the one hand, the nation is full of aspirational socio-economic and legal goals as well as service delivery plans to help better the nation's health and access to health care. On the other hand, the medical malpractice crisis that has been building for years needs to be addressed as soon as possible, or it may derail the goal of a healthier South Africa with a better approach to health care service provision.

The current national movement towards better health care coincides with the global conversation on health care. In a recent statement, the UN Secretary-General remarked that the easiest way to determine the success of a country is to look at the state of health care.[60] In fact, as of 2019, every single United Nations ("UN") member state agreed to establish universal health care in their respective countries after the UN and the World Health Organisation issued a report on the state of health care around the world.[61] An efficient health care system has many benefits for the rest of the country, and it is essential to remember that any reform must align with sustainably offering quality health care to all and ensuring that health care facilities function effectively. In South Africa, providing access to health care is a socio-economic right that not only requires the state to stop activities that infringe upon/ result in the regression of this right (this is known as the negative obligation); [62]but to also promote measures to advance

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[58] Issue Paper 33 at 22–7, 36–47 and 49–50.

[59] Ibid at 4.

[60] A Merelli, *'The US just promised to adopt universal health care'* in Quartz 23 September 2019, available at https://www.google.co.za/amp/s/qz.com/1711520/the-us-just-promised-to-adopt-universal-health-care/amp/accessed on 14 October 2020; An Overview of the Consultation Paper on Periodical Payments for Future Pecuniary Loss in Personal Injury Cases in Hong Kong Lawyer July 2018, available at http://hk-lawyer.org/content/overview-consultation-paper-periodical-payments-future-pecuniary-loss-personal-injury-cases accessed on 14 October 2020.

[61] Ibid.

[62] Section 27(1)*(a)* of the Constitution of the Republic of South Africa, 1996; Iain Currie, Johan De Waal Jason Brickhill *et al.* 'Socio-Economic Rights' in Iain Currie and Johan De Waal (ed) *The Bill of Rights Handbook* 6 ed (2015) at 568–70.

the right to health care and to improve the content of this right (this is known as the positive obligation).[63]

Meeting the *positive* obligation of the state to improve access to socio-economic rights is not a straightforward exercise. This is detailed in the case of *Government of the Republic of South Africa and Others v Grootboom and Others* ("*Grootboom*").[64] Within section 26 (as with section 27), there exists an internal mechanism to deliver appropriate relief using available resources progressively and reasonably.[65] *Grootboom* is a landmark decision as it provided principles for reviewing the reasonable and progressive attainment of socio-economic rights.[66] The reasonableness review from *Grootboom* can be imputed to other socio-economic exercises, such as section 27 of the Constitution.[67] It was further developed in the *Minister of Health v Treatment Action Campaign* (2) ("*Treatment Action Campaign*") to be transparent to be reasonable.[68] The socio-economic reasonableness test was summarised by Liebenberg.[69] A reasonable government programme "must be capable of facilitating the realisation of the right;[70] it must be comprehensive, coherent and co-ordinated;[71] appropriate financial and human resources must be made available for the programme;[72] it must be balanced and flexible;[73] it must make appropriate provision for short-, medium- and long-term needs;[74] it must be reasonably conceived and implemented;[75] it must be transparent, and its contents must be made known effectively to the public,[76] and it must make short-term provision for those

[63] Section 27(2) of the Constitution; ibid *The Bill of Rights Handbook* at 570–84.

[64] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC).

[65] Ibid paras 41–2 and 95–6.

[66] Sandra Liebenberg 'South Africa's Evolving Jurisprudence on Socio-Economic Rights: An Effective Tool to Challenging Poverty' in *Law, Democracy and Development* (2002) 6 159 at 171.

[67] Ibid at 177–80 para 4.2.3.

[68] Ibid at 180–84 para 5.2.4; *Minister of Health v Treatment Action Campaign* (2) 2002 (5) SA 721 (CC) para 123.

[69] *The Bill of Rights Handbook* op cit note 62 at 578.

[70] *Grootboom* supra note 64 para 41.

[71] Ibid paras 39–40.

[72] Ibid para 39.

[73] Ibid para 68, 78 and 95.

[74] Ibid paras 43.

[75] Ibid para 40–3.

[76] *Treatment Action Campaign* supra note 68 para 123.

whose needs are most urgent."[77] Socio-economic rights should be achieved progressively within the state's available means.[78] However, the qualification of availability of resources does not exempt the state from working to progressively budget, plan and realise socio-economic rights – not even when resources are scarce. [79] Therefore, it can be said that whatever is reasonable in socio-economic rights issues should be socially responsive. It is incumbent upon spheres of government to provide a reasonable, clear and comprehensive pathway to address the medical malpractice crisis. The contextual background of the medical malpractice crisis and the various national plans that focus on improving health care and access to health care on a large social level suggest that the comprehensive reform needed should be socially responsive and uplift the right of access to healthcare holistically. Thus, one could categorise socially responsive reform as reform that targets the social, financial and legal issues that are prevalent in a socio-economic crisis while upholding the normative values of dignity, fairness and equality found in the Constitution.

The effect of the increase in medico-legal claims is not only economical - it is also personal. On a human resource level, South Africa's healthcare system faces grave difficulties as many medical professionals leave the profession in a bid to avoid the stress of working in a chronically under-resourced environment with ballooning indemnity costs.[80] In fact, staying in the profession may become unfeasible when one calculates the professional indemnity costs associated with being a specialist physician in South Africa to avoid personal financial ruin if one faces a medical malpractice lawsuit.[81] Furthermore, practitioners experience heightened anxiety when their professional standing is questioned in a medical malpractice claim, which affects their subsequent work.[82] This leads to a heightened risk that medical practitioners are practicing what is called defensive medicine to avoid claims of negligence.[83] In short, defensive

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[77] *Grootboom* supra note 64 paras 44, 64, 68 and 99; *Treatment Action Campaign* supra note 68 para 78.

[78] *The Bill of Rights Handbook* op cit note 62 at 58–84.

[79] Ibid at 582; *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd* 2012 (2) SA 104 (CC) para 74.

[80] 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 *SAMJ* at 752–53.

[81] Ibid Howarth *et al.* at 752–53; C Archer 'Medical malpractice crisis deepens: New approach' (2016) vol 106 No.6 *SAMJ* at 8.

[82] Oosthuizen & Carstens op cit note 15 at 279–80.

[83] Ibid at 278–79.

medicine occurs when a medical practitioner over-treats a patient by ordering further medical tests and the like in order to diagnose a patient accurately.[84] Although the extra care is somewhat prudent, practicing defensive medicine naturally leads to more costly medical bills and is therefore only a temporary solution to a more significant problem.[85] Short-term solutions such as these are impractical and potentially counter-productive. Therefore, South Africa requires a set of long-term and comprehensive solutions to combat the adverse effects of the current medico-legal crisis on all fronts.[86]

While remarking on the poor standard of health care available to South Africans, especially in the public health care sector, Oosthuizen and Carstens advanced the debate[87] by showing that most claimants have not brought claims forward because of a lack of awareness or inability to institute claims formally owing to the arduous legal process.[88] Furthermore, Oosthuizen and Carstens emphasised the misfortune of uncompensated patients who must still live with the emotional and physical pain of their injuries as well as all the physical impairments following on from such injuries.[89] Coetzee and Carstens explain that there is no social insurance or compensation scheme that covers medical events which means that injured parties derive their compensation from private practitioners or the overall health care budget, and this exacerbates the unkempt state of South Africa's public health care sector.[90] Currently, patients are expected to spend more on expensive health care services, because of increasing practitioner insurance fees,[91] and where they cannot afford these fees, they are forced to turn to under-resourced public hospitals, because of the lack of private specialising doctors available in South Africa.[92] In such instances, patients are more susceptible to incidents of medical malpractice.[93] Coetzee and Carstens comment that injured claimants need robust legal assistance because hospitals

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[84] Ibid.

[85] Ibid.

[86] Issue Paper 33 op cit note 1 at 8–9.

[87] WT Oosthuizen & PA Carstens 'Re-Evaluating Medical Malpractice: A Patient Safety Approach' (2015) 78 *THRHR* 380.

[88] Ibid at 386.

[89] Ibid at 381–82.

[90] LC Coetzee & PA Carstens 'Medical Malpractice And Compensation In South Africa' (2011) 86:3 *Chicago-Kent Law Review* 1263 at 1263–65; Issue Paper 33 op cit note 1 at 4–8.

[91] Coetzee & Carstens op cit note 90 at 1298–301.

[92] Ibid.

[93] Ibid.

are, regrettably in many cases, mismanaged and understaffed, which, in turn, increases incidents of medical negligence in South Africa.[94] Additionally, the authors note that there is a so-called "conspiracy of silence" when negligence occurs, which stops these claims from being reported; and unfortunately, the incidences that are reported meet many roadblocks as there is no formal claims process outside of the traditional and tedious litigation route.[95]

Another pressing issue arising from these claims alludes to a South Africa *sans* doctors. In a country where quality health care is hard to come by, Howarth, Goolab, Dunn and Fieggen warn against apathy and "public somnambulism" and call upon those affected to find solutions for the problems arising from the expansion of medical malpractice liability.[96] These authors have commented on the increased costs associated with the practice of defensive medicine while also highlighting the negative mental and emotional burdens facing medical practitioners in their high-pressure profession.[97] Their research shows how practitioners are facing increases in stress disorders, causing them to consider early retirement, or in some instances, these increased stressors discourage some practitioners from fully entering the medical profession at all.[98] Oosthuizen, Coetzee and Cartsens share critical remarks on supposed reluctance by medical practitioners to share their erroneous work in a bid to avoid litigation.[99] They believe that this reluctance leads to more adversarial litigation, and they fear that this may impact the subsequent judgments.[100] They also argue that a healthy patient-doctor relationship may lead to better litigation and, as they put it: be "beneficial to the safety of the health system as a whole".[101] Howarth *et al* warn South Africa of a possible dystopian future where in-demand and high-risk specialist doctors become extinct in South Africa's health care system.[102] The shift from private to public health care can occur easily as private medical professionals faced with the threat to their personal and professional lives opt to work in the public health care

[94] Ibid.

[95] Coetzee & Carstens op cit note 90 at 1285–287 and 1301.

[96] Howarth & Goolab *et al.* op cit note 80 at 752.

[97] Ibid.

[98] Ibid at 752–53.

[99] Oosthuizen and Carstens op cit note 87 at 387-88; Coetzee & Carstens op cit note 90 at 1294–95.

[100] Ibid.

[101] Coetzee & Carstens op cit note 90 at 1299-301; Howarth *et al.* op cit note 83 at 752–53.

[102] Howarth *et al.* op cit note 80 at 752–53.

sector.[103] In this way, they will find professional and personal financial cover from the health department through vicarious liability. They claim that increased indemnity insurance for medical doctors has led to increased medical costs owing to the growing practice of defensive medicine.[104] In short, they detail a pattern where practitioners and patients from the private sector opt to work and seek medical treatment in the public health sector.[105]

Consequently, patients will naturally seek medical care from the public health care sector if more practitioners choose to leave private health care, thus creating a further burden on the strained resources of the public health care sector.[106] Added to this, patients are also turning to public health care because of the rising costs of private medical assistance.[107] The cumulative increased burden on the public health care sector places a further burden on public resources which leads to more opportunities for medical negligence to occur.[108] These issues depict how an ill-managed medical malpractice system and the expansion of medico-legal costs inch South Africa further away from achieving its constitutional and national health care goals and equitable redress. The resounding thought is that these issues cannot continue indefinitely and that the crisis needs to be correctly managed or rooted out in order to contain and possibly limit the cost of medical malpractice litigation in South Africa.[109]

Pienaar attempts to diagnose the cause or causes that have led to an increase in medico-legal claims and the financial issues associated with this increase.[110] The author explores various possibilities that have contributed to the crisis, and these possibilities range from an increase in consumer awareness regarding better service delivery to a decrease in practitioner standards.[111] She identifies the legal tools and bodies that govern the medical practice within

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[103] 'Re-Evaluating Medical Malpractice: A Patient Safety Approach' at 379–80.

[104] Coetzee & Carstens op cit note 90 at 1289; Oosthuizen & Carstens op cit note 87 at 390–91.

[105] Issue Paper 33 op cit note 1 paras 2.1–2.3 at 6.

[106] Howarth *et al.* op cit note 80 at 752–53.

[107] Ibid at 753.

[108] Ibid at 752–53.

[109] Wessels & Wewege op cit note 35 at 486.

[110] L Pienaar 'Investigating the Reasons Behind the Increase in Medical Negligence Claims' (2016) 19 *PELJ/PER* 2 at 2–3.

[111] Ibid at 5–8.

South Africa; she also investigates the professional conduct of medical practitioners and legal practitioners alike; she identifies the adverse effects of the increase in the claims but ultimately, the author declines to pinpoint a single factor responsible for the rise in medico-legal claims and their associated costs.[112] She recognises that there are a multiplicity of factors that have led to this health care crisis and suggests that enacting legislation may be the best route to tackle it.[113]

Essentially, the expansion of liability continues to grow alongside the decline in health care standards. As previously mentioned, the reasons for the expansion of liability are not limited to medical malpractice claims; however, no writer has proven that medical malpractice claims have not caused a decline in health care standards. Thus, the issue is not whether medical malpractice reform should take place. Rather, the seriousness of the crisis presents another question: *how* should medical malpractice reform take place? The content of this reform should be socially responsive and advance the right to health care.

2.2 Structured Settlements

In recent years both the courts and the legislature have engaged in discourse about the effectiveness of structured settlements in South Africa as a way to implement a short-term cost-saving measure by way of a reform of the lump sum and once-and-for-all rules at common law. This is, in effect, a positive attempt to address the medical malpractice crisis and improve health care, by focusing on the remedial stage of the application of the law of delict. Given the prominence and apparent popularity of this suggested reform, it is important at the outset of this dissertation to explain the background of this proposed alteration to fundamental common-law remedial principles in the law of delict.

In South African law, claims for compensation for harm occasioned by medical negligence are regulated by the law of delict, which comprises common-law principles and is applied by the courts on a case-by-case basis employing traditional common-law methodology.[114] It is trite

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[112] Ibid at 8–12.

[113] Ibid at 17–8.

[114] Max Loubser & Rob Midgley *The Law of Delict in South Africa* 3 ed (2017) 327–31; Neethling & Potgieter *Law of Delict* (2015) at 17 – 22.

that five elements must be present to determine whether a delict has taken place. There must be a positive act or an omission that is both wrongful and negligent, which factually and legally causes harm or damage.[115] In the context of claims for medical negligence, the application of the principles of the law of delict typically occurs as follows. Firstly, a relevant act or omission by the medical defendant is identified.[116] Second, the court must determine whether that conduct was wrongful in the circumstances, which is sometimes described as an evaluation of whether the medical practitioner acted in a legally reprehensible manner.[117] Third, the court must determine whether the medical defendant's conduct fell short of the standard of the reasonable medical practitioner in the circumstances.[118] Finally, the defendant's negligent and wrongful conduct must be shown, on a balance of probabilities, to be both a factual and legal cause of the plaintiff's harm, which in turn must be quantified.[119] The overarching principle of quantification (otherwise known as the sum formula rule) is that loss is calculated by determining "the difference between the value of the plaintiff's estate after the commission of the delict and the value it would have had if the delict had not been committed".[120] The purpose is to restore the plaintiff (as far as possible) to the patrimonial position that he or she would have occupied had the delict not been committed, and thereby to redress the diminution of his or her patrimony caused by the defendant's delict.[121]

Once damages are quantified, South African law dictates that a lump sum of the determined damages must be paid in full to the plaintiff to remedy the harm caused, and therefore the full quantum of the damages is ordered to be paid in full and at once.[122] Lump-sum payments guarantee that injured parties will receive their court-ordered compensation in full which brings

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[115] Ibid Loubser & Midgley at 110–11 and 125–32; Francois du Bois *Wille's Principles of South African Law* 9 ed (2011) 1091–93.

[116] Ibid Loubser & Midgley at 99; ibid *Wille's Principles* at 1096.

[117] Ibid Loubser & Midgley at 180 and 183; ibid Wille's Principles at 1096.

[118] *Kruger v Coetzee* 1966 (2) SA 428 (A) at 430; *Esterhuizen v Administrator, Transvaal* 1957 (3) SA 710 (T) at 723H.

[119] Loubser & Midgley op cit note 114 at 80–5

[120] *Dippenaar v Shield Insurance Co Ltd* 1979 (2) SA 904 (A) at 917B; *Standard Chartered Bank of Canada v Nerperm Bank Ltd* 1994 (4) SA (A) at 776E; *Transnet Limited v Sechaba Photoscan (Pty) Ltd* [2004] ZASCA 24 paras 16 – 7; Potgieter, Steynberg & Floyd *Visser & Potgieter Law of Damages* (2012) at 71 – 91.

[121] *Standard General Insurance Co v Dugmore* 1997 (1) SA 33 (A) at 41C-D.

[122] Issue Paper 33 op cit note 1 at 43–5.

finality and closure to the disputing parties, allowing them to part ways financially, emotionally and relationally.[123] Moreover, according to the once-and-for-all rule, which is closely related to the lump-sum rule, the plaintiff must claim delictual damages for all of the harm flowing from a single alleged incident of medical negligence in a single action, rather than in a series of distinct actions.[124] The once-and-for-all rule is closely connected to the Roman-Dutch *res judicata* principle that promotes curial finality.[125] It is a common-law rule which ensures that once a case is adjudicated, it cannot be re-opened or re-adjudicated, as the matter must reach finality.[126]

Although the goal of compensation, all at once and by way of a single payment, attempts to protect the injured party's interests, dignity and bodily integrity, by seeking to return the aggrieved party to his or her patrimonial state prior to the delictual event, this method of distributing delictual damages has been questioned in light of the circumstances facing South Africa's health care sector.[127] Both the lump-sum and once-and-for-all rules have been argued to be unfair and unfeasible in medical malpractice claims in South Africa, as they create undue financial burdens on the defendants who are expected to pay the totality of the expensive damages costs all at once.[128] In fact, both the lump-sum rule and the once-and-for-all rule have been the cause for personal injury law reform in various foreign jurisdictions.[129]

The SALRC has joined in this debate and questioned the effectiveness and feasibility of these common-law rules.[130] For example, the SALRC's paper depicts how in the United Kingdom, periodic payments are favoured in place of both the once-and-for-all rule and lump sum awards in order to provide the defendant with financial security to meet the plaintiff's needs as well as

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[123] The Ministry of Justice & the Scottish Government and the Department of Justice, Northern Ireland 'Damages Act 1996: The Discount Rate Review of the Legal Framework' (2013) para 87 at 29.

[124] *Member of the Executive Council for Health and Social Development, Gauteng v DZ obo WZ [2017] ZACC 37* paras 15–6 and 78.

[125] Ibid.

[126] Ibid paras 56–9; Issue Paper 33 op cit note 1 at 32–5.

[127] Issue Paper 33 at 3, "Minister for Health, Aaron Motsoaledi, is actively confronting this issue due to his concerns about the escalating 'crisis'"; C Bateman 'High-risk specialties threatened by runaway legal costs (2016) vol 106 no. 1 *South African Medical Journal* 9–16.

[128] Issue Paper 33 at 2.

[129] *DZ obo WZ* supra note 124 para 32, and paras 56–9.

[130] Issue Paper op cit note 1 at 2.

its healthcare duties.[131] A significant drawback of favouring periodic payments over lump-sum damage awards is the question of whether the order will decrease the financial burden caused by medical negligence claims, or whether periodic payments would prolong the significant and compounded damages award over several years, possibly resulting in overcompensation.[132] The suggestion of structured settlements will be discussed in greater detail below in chapter three to provide further context to this strategy's potential effectiveness in South Africa.

The reforms proposed by way of the SLAB would do away with the lump sum and once-and-for-all rules.[133] However, the Medical Malpractice Lawyers Association ("MMA") assumes that the bill would demote state accountability. Wessels and Wewege argue that MMA's statement means that the converse is true: i.e. that lump-sum payments promote state accountability.[134] These notions are unsubstantiated and incorrect as lump-sum payments have not resulted in greater state accountability.[135] However, the MMA did not provide sufficient proof of its claim nor did they prove the converse of its claim – i.e. that the implementation of structured settlements will decrease state accountability.[136] The MMA determined that the abolition of the once-and-for-all rule in favour of structured settlements envisioned by the SLAB results from the lack of clarity concerning the structure of contingency fee arrangements when structured settlements are ordered.[137] However, this link is tenuous and fails to address the necessary issue concerning state accountability in medical malpractice cases. The SLAB should not be curtailed for this reason. However, abolishing the lump-sum and once-and-for-all rules completely may be a drastic approach and the legislature should proceed with caution. This dissertation returns to the topic below in chapter three.

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[131] Ibid Issue Paper 33 at 43–5, Peter Barrie 'Periodical Payments after Thompstone' (2008) *Guildhall Chambers*; Section 2 of the Damages Act 48 of 1996; GIRO Working Party 'Periodic Payment Orders' (2010).

[132] Ibid Peter Barrie; Ibid GIRO Working Party.

[133] Memorandum of the Objects of the State Liability Amendment Bill 2018.

[134] State Liability Amendment Bill (B16-2018) Submission on Behalf of Medical Malpractice Lawyers Association paras 27.5–27.6.

[135] AB Wessels & James Wewege op cit note 35 at 495–96.

[136] Medical Malpractice Lawyers Association op cit note 134 para 27.6

[137] Ibid Submission on Behalf of Medical Malpractice Lawyers Association paras 27.5–27.6.

2.3 The Parallel Role of the Office of the Health Ombudsman

Those embarking on the reform of the traditional delictual procedure should pay close attention to the possible role that these existing bodies and laws can play in the reformation project. For they too may have to undergo various changes in order to engage effectively with any alternative dispute resolution systems and alternative payment solutions that may be adopted in the future. For example, the Office of the Health Ombud ("the OHO") was appointed in 2016 to expedite medical malpractice claims fairly and to address the malpractice crisis.[138] The OHO is perfectly situated to assist with dispute resolution and healthcare improvement because of its close proximity to the Office of Health Standards and Compliance ("the OHSC") [139]and its success with the resolution of the Life Esidimeni arbitration (which will be discussed in Chapter 4 below). Unfortunately, the OHO's power is curtailed by a lack of funding and legislative power to enforce its recommendations on a wider scale.[140] Thus, it can be said that the OHO is not being leveraged to its fullest capacity to achieve its goal of alleviating the burdens of poor service delivery and the medical malpractice crisis in general.[141] The OHO is discussed in greater detail in Chapter 4 below. Given the current climate, it is crucial to ensure the alignment of health care bodies and the medico-legal fraternity's practices with section 27 of the Constitution and the national health agendas that are ultimately informed by that same constitutional imperative. As things currently stand, the struggles of the OHO add to the problems faced by the health care sector, as the OHO's function is being curtailed, when it should instead, form part of the solution for medico-legal reform and effective health care provision.

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[138] Ebenezer Durojaye and Daphine Kabagambe Agaba 'Perspective Contribution of the Health Ombud to Accountability: The Life Esidimeni Tragedy in South Africa' *Health and Human Rights Journal*, December (20) No.2 161 at 162 *https://pilot.uwc.ac.za/xmlui/bitstream/handle/10566/5030/Durojaye.pdf?sequence=1&isAllowed=yaccessed* 14 October 2020

[139] Office of the Health Ombud Annual Report 2018/2019 at 8.

[140] Ibid at 3 and 8.

[141] Ibid.

2.4 A Multiplicity of Proposed Reforms

For a crisis as multi-faceted as the medical malpractice crisis, it seems likely that there should exist a multi-layered response or, at the least, a multiplicity of workable suggestions to address the crisis. Proposals put forward in the academic literature range from structured settlements introduced above, to systems of alternative dispute resolution, to no-fault compensation schemes. The different types of reform may be classified according to the element of delict that they appear to address. Oosthuizen and Cartsens mention two categories of reforms that are of use to this dissertation, namely, conventional and fundamental reforms.[142] Conventional reforms include the following: (*i*) reforms that limit access to court, (*ii*) reforms that alter specific liability rules (e.g. the doctrine of *res ipsa loquitur*) and (*iii*) reforms that directly address the size of damages payable.[143] Fundamental reforms include (*iv*) alternative dispute resolution mechanisms, (*v*) no-fault compensation schemes, and (*vi*) systems of enterprise liability (e.g. vicarious liability) that address the adjudication procedure and patient care.[144] Oosthuizen and Carstens argue that fundamental reforms are the best way "to align the objective of the health care system with those of the malpractice system".[145] They also believe that patient-centred reforms are required, given the need to avoid focussing purely on the position of defendants.[146]

The expansion of medical negligence liability and its consequent negative effects on the public health care sector has inspired academics, politicians and practitioners to find the best possible methods to reform medical malpractice litigation in South Africa. The list of suggestions to combat the situation at hand is varied, but one recurring thought is that delictual reform may need to occur on a legislative level.[147] The SALRC listed over twenty legislative reforms in chapter 6 of Issue Paper 33.[148] Each of the reforms mentioned focuses on different aspects of the system of delictual liability as well as public service management which shows that this

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[142] Oosthuizen & Carstens op cit note 87 at 391–94.

[143] Ibid at 391–92.

[144] Ibid at 391–94.

[145] Ibid at 393–94 and 396; section 27 of the Constitution; the National Health Act; Coetzee & Carstens op cit note 90 at 1284–285; Oosthuizen & Carstens op cit note 87 at 396.

[146] Ibid Oosthuizen & Carstens at 391–92.

[147] Issue Paper 33 at 51–7.

[148] Ibid.

crisis involves socio-economic failures: financial, administrative and legal. It is a multi-faceted crisis that exists in a multi-faceted conversation on reform.

The landmark judgment in *DZ* shifted the public conversation on medical malpractice litigation by suggesting that the common law be developed to allow for structured settlements.[149] This case, alongside the SALRC report, has encouraged the SLAB's proposition for the once-and-for-all rule to be abolished by allowing for structured settlements that are subject to variation.[150]Additionally, the SLAB makes provision for compensation to be paid in kind instead of compensation sounding in money.[151] The SLAB in itself is intended to operate as an interim measure while the SALRC continues to investigate a more permanent solution to the medical malpractice crisis. The more recent *MSM obo KBM v The Member of the Executive Committee for Health, Gauteng Provincial Government* (*"MSM"*) judgment has possibly developed the common law to allow for compensation to be paid in kind.[152] Furthermore, the proposed National Health Insurance system ("NHI"), if implemented, would run concurrently with the common law development, statutory intervention, and further investigations by the SALRC.

With each pathway to reform, the right to health care is paramount. The goal to compensate claimants fairly and to provide them with better health care treatment is balanced against the national goal to improve the declining standards of health care by limiting the adverse effects of medical malpractice litigation. Though differences of implementation exist in each pathway, the reform sought calls for socially responsive medical malpractice practices that uphold the individual's rights alongside the rights of the general public and healthcare providers. Currently, much-needed reform is taking place, almost on an interim basis, by way of curial, common-law development alongside the legislative proposals contained in the SLAB. However, permanent and long-lasting change is still required to create sustainable reform.

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[149] Memorandum op cit note 133; *DZ obo WZ* supra note 124.

[150] Section 2A(1) – (2)(b) of the Bill 16 of 2018 op cit note 27

[151] Section 2A(2)(b) of the Bill 16 of 2018 op cit note 27.

[152] *MSM obo KBM v The Member of the executive Committee for Health, Gauteng Provincial Government* (4314/15) [2019] ZAGPJHC 504 at 50–1.

The current reforms of the SLAB and the common law development taking place veer towards conventional reform as opposed to fundamental reform. The application of structured settlements alters the application of the once-and-for-all rule as a singular element, while compensation in kind introduces a greater element of remedial discretion into the application of the Aquilian action.[153] Ultimately, conventional reform tends to limit the application of a particular delictual element, while fundamental reform changes how personal injury claims are adjudicated or managed altogether.[154]

When embracing fundamental reforms, governments tend to look to no-fault compensation schemes or large-scale alternative dispute resolution schemes.[155] The effect that vicarious liability has on the public health care sector is also significant.[156] Placing liability on the sector itself diminishes its ability to operate effectively and provide adequate health care to South African citizens, potentially benefitting the few at the expense of the many.[157] To abandon vicarious liability, applied via the existing common-law delictual paradigm, would be financially beneficial for the public health care sector as this too echoes the calls for a socially responsive medical malpractice procedure, namely one that is focused on promoting rights on a larger scale rather than the individual whose single claim may prejudice wider national efforts.[158] Fundamental reforms allow for socially responsive reform.[159] However, it must be admitted that fundamental reforms do not necessarily result in better personal injury reform. For example, the Road Accident Fund ("RAF") is a statutory scheme that is still plagued by issues of financial shortfalls, mismanagement, and alleged corruption and is undergoing further reform.[160]

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[153] *https://www.businesslive.co.za/bd/national/health/2018-10-31-bill-to-replace-lump-sum-settlements-for-negligence-claims-with-periodic-payments-draws-ire/* accessed on 23 August 2020; Memorandum op cit note 133; Pieter Pauw 'Alternative Relief in Delictual Claims' 2017 (4) *TSAR* 846 at 852–56.

[154] Oosthuizen & Carstens op cit note 87 at 393–94.

[155] Ibid at 394.

[156] Bernard Wessels 'Reconsidering The State's Liability For Harm Arising From Crime: The Potential Development Of The Law Of Delict' (2019) 30 *Stellenbosch Law Review* 361 at 388.

[157] Ibid at 372.

[158] Ibid at 388.

[159] Ibid.

[160] Loubser, Midgley & Jabavu *et al*. 'Road Accident Fund Act 56 of 1996' in *Law of Delict* op cit note 114.

2.5 The Focus of This Dissertation

Due to spatial constraints, the remainder of this dissertation focuses only on a few of the above-mentioned proposed reforms. Although a no-fault compensation scheme, or comparable statutory schemes like the RAF or the compensation fund established in terms of the Compensation for Occupational Injuries and Diseases Act 130 of 1993, may be attractive in principle, the question of the financial viability of such systems, particularly in the context of the ongoing controversy surrounding the NHI and the general state of public financing, looms large.[161] It seems more practical, therefore, to focus on less cost-intensive reforms which bear prospects of success.

For this reason, the dissertation focuses its attention on the possibility of implementing an alternative dispute resolution process in parallel with the existing and ongoing reforms introducing structured settlements, and with it, treatment in kind. Moreover, the SLAB presents various administrative issues that require an administrative answer. Ultimately, this dissertation assesses whether a socially responsive medical malpractice culture can be achieved through the combination of structured settlements proposed by the SLAB and the courts together with a new administrative process to examine claims.

South Africans need solutions that recognise the vulnerability of patients – indigent or not – while reasonably tempering their expectations of doctors. Doctors and medical practitioners possess concurrent vulnerabilities such as emotional and professional stress, unbearable workloads that leave them exhausted and prone to making more accidents; the possibility of no longer practicing; and financial constraints arising from paying the damage awards.[162] These realities cannot be ignored either, and one should not discredit the practical issues that are threatening the financial and human resources of the public health care sector. The SALRC points out that the lack of co-operation from all interested parties in this matter has hindered the response time to this issue and any other possibilities of progress and reform.[163] The

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[161] J Larkan 'What's wrong with the NHI Bill? Let us count the ways' *Business Day* 11 September 2019 available at https://www.businesslive.co.za/bd/opinion/2019-09-11-whats-wrong-with-the-nhi-bill-let-us-count-the-ways/ accessed on 14 November 2020.

[162] Ibid at 381 and 392–93.

[163] Issue Paper 33 op cit note 1 at 6–8.

Commission also points out that most approaches concerning medical negligence seem to be in disarray in both the public and private health care sectors in South Africa.[164] This can only have been exacerbated by the extraordinary challenge of the COVID-19 pandemic which broke out in March 2020.[165]

With this knowledge, one must inquire whether the suggestions of structured settlements will achieve the desired medical malpractice reform to meet the needs of the plaintiffs and assist defendants with cost-saving measures. Structured settlements, as a cost-focused reform, fall into the category of conventional reforms;[166] and while Oosthuizen and Carstens lean towards fundamental reforms,[167] the benefits of using both fundamental and conventional reforms concurrently may result in comprehensive reform that addresses the litigation procedure and cost of damages simultaneously. This is discussed in greater detail in Chapter 4 below.

Solutions must be established that do not favour one group over another in a way that will entrench the vicious cycle that is already at play. Organs of state and reformers alike need to understand and embrace the symbiotic relationship that exists between the participants on both sides of the medical relationship. So, in other words, the solution required is one that ensures a safer health care environment for patients as well as a more helpful delictual process for both the plaintiffs and the defendants. To truly solve this crisis, South Africa must go beyond the many symptoms of the crisis and find an argument that services the greater good. In this debate, the greater good is enshrined in the constitutional right of access to health care services, and it can only be achieved through meeting the needs of claimants while simultaneously safeguarding the health care sector and its resources. Additionally, the time-consuming and emotionally draining court procedure is not helpful for either the patient-plaintiff or the defendant in the health care sector. Furthermore, while the common law has been developed to some extent, there needs to be a structural and legislative change that attempts to achieve the greater good in terms of service delivery in health care and South Africa's medical malpractice

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[164] Ibid.

[165] *https://sacoronavirus.co.za/* accessed on 14 October 2020; 'South Africa' Recession Worsens as Economy Shrinks 51%' *https://www.aljazeera.com/economy/2020/09/08/south-africas-recession-worsens-as-economy-shrinks-51-in-q2/?gb=true* accessed on 14 October 2020.

[166] Oosthuizen and Carstens at 392.

[167] Ibid at 391.

practices. It is the job of the State, through its various organs and bodies, to implement reform that includes both fundamental and conventional aspects working concurrently to achieve comprehensive delictual reform that aligns the national health agenda with the medical malpractice procedure in South Africa.[168]

[168] Issue Paper 33 op cit note 1 at 1.

3 CHAPTER 3: STATUTORY AND COMMON LAW REFORMS OF MEDICAL MALPRACTICE LIABILITY IN SOUTH AFRICA TO DATE

The need for medico-legal reform in South Africa is apparent and undisputed, but the conversation on how to achieve satisfactory reform while upholding constitutional values is varied. The research has established that the current medical malpractice crisis is a liability for the South African healthcare system. Furthermore, having established that the country requires a comprehensive approach to solve the crisis, the research can now turn to the specific reform that was presented in 2018: The State Liability Amendment Bill of 2018 (hereafter referred to as "the SLAB"/ "the Bill"). This dissertation aims to determine whether comprehensive reform can occur through conventional and fundamental reform in South Africa; thus, this section will explore whether the suggested SLAB could offer the comprehensive reform that is required to solve the crisis.

Towards the end of 2018, the Department of Justice and Correctional Services published an amendment to the State Liability Act of 1957. This proposed amendment would provide for structured settlements as a form of compensation for medical malpractice claims in lieu of a traditional lump-sum payment.[169] The State hopes to achieve financial relief through this amendment by managing the cash flow of the healthcare sector: provincial and national; private and public. Structured settlements can be classified as conventional reforms as they supposedly provide a short-term financial solution to the issue of personal injury law.[170] The Department of Justice and Correctional Services called for responses to the Bill.[171] This chapter examines the provisions of the proposed Amendment Bill alongside the relevant responses.

There are many methodologies with which to compensate the plaintiff and determining which one is better, all things considered, may be a philosophical question. Through the SLAB, the legislature is attempting to implement some form of conventional reform. The legislature has thereby proposed a multi-faceted response to address multiple aspects of the current medico-

[169] Memorandum op cit note 133 para 1 at 4.

[170] Oosthuizen & Carstens op cit note 87 at 392–93.

[171] State Liability Amendment Bill: Public Hearings *https://pmg.org.za/committee-meeting/27412/* accessed on 14 October 2020.

legal crisis. That may be problematic for an interim plan as there will be programs and processes to administrate closely. There is also the direct financial consequence of these decisions and the constitutional effect of the mismanagement of state resources and lack of finances that have created constitutional implications so severe that South Africa now faces a crisis. Many countries experience medical malpractice issues, but this crisis has especially dire consequences on South Africa's vulnerable population.[172]

Thus, in evaluating the SLAB this dissertation attempts to answer two questions. First, what administrative burdens would the SLAB, as it presently stands, impose? Second, as a long-term response to the medical malpractice crisis, is there room to improve or supplement the changes proposed by way of the SLAB by way of a more fundamental reform? The second question becomes the focus of the next chapter.

Very importantly, however, the SLAB is not the only reform currently in motion in South Africa. In recent years, the courts have already developed the common law in order to introduce a variant of a system of structured settlements into South African law. Accordingly, this chapter examines both the SLAB as an interim legislative measure as well as recent developments in the case law, in order to determine whether structured settlements are effective measures to address the medical malpractice crisis.

3.1 The State Liability Amendment Bill

Following below is an examination of the criticisms levelled against each section of the proposed SLAB insofar as they relate to the long-term administrative issues that would follow from the inefficient implementation of this piece of legislation. Section 2 of the SLAB contains two provisions that detail the circumstances where structured settlements will apply to medical malpractice cases in state/public matters.[173] Overall, the structured settlements proposed by the SLAB have divided academic opinion. One school of academic thought is that the SLAB should not be implemented at all because the structured settlements it proposes, will not address the poor standard of health care that is ultimately the cause of increased medical malpractice

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[172] Amnesty International op cit note 33 at 4.

[173] Section 2 of Bill 16 of 2018.

claims. A competing school of thought is that structured settlements should be implemented as an apparent cost-saving measure for the department of health. (As is explained below in chapters four and five, this dissertation ultimately adopts the latter view subject to the complementary adoption of further, more fundamental reforms by way of a system of alternative dispute resolution.) This chapter now turns to examine the effect of structured settlements as they are proposed by the SLAB.

3.1.1 Structured settlements

Wessels and Wewege opined that many submissions failed to address the effectiveness of structured settlements, and as a result, this topic did not receive a lot of detailed attention except for the submission of Algorithm Consultants and Actuaries.[174] Algorithm expressed concerns about structured settlements in terms of the SLAB and determined that a long-term cost-saving benefit of structured settlements is unlikely to be achieved within South Africa.[175] Algorithm determined that structured settlements for individuals may require regular reviews and their study shows that administration costs will accompany structured settlements.[176] Algorithm also stated that the administration costs of structured settlements and their variations could surpass the costs of lump-sum payments, which undermines the apparent financial benefit of implementing structured settlements.[177] This ultimately poses challenges to the goal of diminishing the financial strain that the NDoH and the State are currently facing regarding medical malpractice claims.[178]

Nonetheless, Wessels and Wewege remain firm that structured settlements have the potential to provide at least short-term financial benefits to the state.[179] The authors suggest that in the short term, the state can save money and redirect these finances into solving other issues that

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[174] Wessels & Wewege op cit note 35 at 490.

[175] Algorithm Consultants and Actuaries 'Commentary on the State Liability Amendment Bill' at 10.

[176] Ibid Algorithm para 11.4; Wessels & Wewege op cit note 35 at 491

[177] Ibid Algorithm para 11.4.

[178] Ibid Wessels & Wewege at 491, "Notwithstanding the above, periodic payments could provide a temporary solution that balances the immediate financial well-being of the department of health with the need to compensate deserving victims of medical malpractice. The short-term cash flow benefit for the state could allow additional funds to be redirected towards solving the problems of the failure of service delivery in the public healthcare sector."

[179] Ibid.

the department of health is facing, such as poor health service delivery.[180] This is a widely-held belief concerning structured settlements.[181] Wessels and Wewege believe that the implementation of structured settlements could contribute to the improvement of public healthcare establishments, thereby helping to give effect to the constitutional obligation on the state to progressively realise the rights provided for in section 27 of the Constitution. [182]

Structured settlements ensure that patients do not spend their money recklessly, but that they instead direct the compensation to address the damage that occurred as a result of the injury.[183]

By contrast, if a patient outlives the lump-sum payment, the victim is left without compensation, whereas structured settlements cover the victim's compensation for the length of the victim's life.[184] The value of a lump-sum is subject to change and inflation and it may decrease in value over the years.[185] Wessels and Wewege add that "if investment returns are lower than anticipated at the time of the award then there is a risk that the lump sum will not be sufficient to cover the claimant's costs."[186] Furthermore, it is believed that the lump-sum offers the psychological benefit of a clean break whereas structured settlements as envisaged by the SLAB will force the parties to interact long after the case is settled.[187] However, Wessels and Wewege claim that this understanding of structured settlements in terms of the SLAB is incorrect and hyperbolic as the Bill does not force interactions between the parties.[188] Their interaction is limited to an annuity payment and possible adjustments of the order as time progresses.[189]

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[180] Ibid.
[181] Issue Paper 33 op cit note 1 at 38–9.
[182] Wessels & Wewege op cit note 35 at 491.
[183] Wessels & Wewege op cit note 35 at 492.
[184] Ibid.
[185] Ibid.
[186] Ibid.
[187] Ibid.
[188] Ibid.
[189]Ibid.

Proponents of structured settlements express the view that their advantages may be more beneficial to claimants and their future costs needs.[190] While supporting the implementation of structured settlements, Wessels and Wewege assert that both lump-sum and structured settlements are both constitutionally viable compensation schemes for medical malpractice claims.[191] To support this opinion, Wessels and Wewege reference the *DZ* case[192]: "Although the 'once and for all' rule, with its bias towards individualism and the free market, cannot be said to be in conflict with our constitutional value system, it can also not be said that the periodic payment … system is out of sync with the high value the Constitution ascribes to socio-economic rights."[193] However, it is imperative to conduct an assessment of the ways in which structured settlements may not work within South Africa – which is what Algorithm's submission did.[194]

Algorithm states that it is difficult to establish the long-term benefits or failures that structured settlements may have in South Africa.[195] Thus, structured settlements on their own may not be as lucrative as one would hope them to be. In line with this sobering observation, Algorithm does attempt to justify its belief that structured settlements are an impractical approach to addressing the medical malpractice crisis in South Africa.[196] The actuarial group believes that ordering structured settlements would lead to expensive and time-consuming variation disputes.[197] However, Wessels and Wewege explain that this issue could be remedied by a legislative order to resolve the variation phase through an administrative procedure, rather than through the court process.[198] This would decrease the time and legal fees involved with such a dispute.[199] This is discussed in further detail below in Chapter 4.

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[190] Wessels & Wewege op cit note 35 at 492–93

[191] Ibid at 493.

[192] Ibid.

[193] Ibid; *DZ obo WZ* supra note 124 para 54.

[194] Algorithm op cit note 175 at 10.

[195] Ibid.

[196] Ibid Algorithm; Wessels & Wewege op cit note 35 at 491.

[197] Ibid Algorithm para 11.3.

[198] Wessels & Wewege op cit note 35 at 491–92.

[199] Ibid.

Overall the academic community remains divided on whether structured settlements will be effective enough to improve the crisis. Certain commentary suggests that the SLAB be wholly rejected as the apparent cost-saving benefits of structured settlements are not enough to remedy the poor service delivery in the public health care sector that leads to medical malpractice disputes.[200] DSC Attorneys suggest that further actuarial research is necessary to prove that structured settlements are indeed a successful cost-saving measure before they are implemented.[201] Wessels and Wewege state "that making periodic payments seems to hold definitive short-term financial advantages for the department of health, while the victim continues to receive compensation through a different, arguably more accurate, payment scheme."[202] Given the financial strain that the department is under, the benefit of such a proposal is clear.[203] It will increase the department's financial sustainability and allow it to perform its constitutional duty to provide public healthcare, while ensuring that the victim's harm is repaired."[204] Wessels and Wewege also believe that further research should be done to address the concerns that structured settlements only provide "apparent short-term financial benefits."[205]

The opponents of the SLAB believe it to be insufficient as it does not address the issue of poor health service delivery directly.[206] Opponents of structured settlements also believe it to be inefficient as the SLAB's formulation of structured settlements may leave more room for unforeseen hidden costs that may exacerbate the medico-legal crisis in an entirely new way.[207] However, the possible benefits of structured settlements cannot be overlooked or passed over for non-existent solutions to strengthen the public health care sector. While structured settlements themselves are clearly not a comprehensive plan to address the medical malpractice crisis, the fact that they have been implemented in foreign jurisdictions to assist with the financial management of claims could be a sign that the legislation is going in the right

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[200] SECTION27 op cit note 32 at 1–3 paras 1–7.

[201] DSC Attorneys op cit note 34 at 13-15; Wessels & Wewege op cit note 35 at 492–93.

[202] Wessels & Wewege op cit note 35 at 493.

[203] Ibid.

[204] Ibid.

[205] Ibid.

[206] Amnesty International op cit note 33 at 4–8, Submissions by the Law Society of South Africa at 13; Algorithm op cit note 175 para 11.5

[207] Ibid Algorithm para 11.

direction. The discourse on structured settlements emphasises the limited reach that they have, as a conventional reform method, to achieve comprehensive medical malpractice reform. Furthermore, Algorithm's identification of the administrative burden and costs highlights that an effective administrative procedure is required to process medical malpractice disputes. In order to administer the volume of medical malpractice claims efficiently, a dispute resolution process with strong administrative capacity and foresight would be required. In this sense, the SLAB represents an inadequate reform proposal to the extent that its administrative implementation has not been adequately considered.

Below are further examples of how the administrative burden of implementing SLAB's version of structured settlements has been inadequately considered, set out with reference to particular provisions of the Bill.

3.1.2 Section 2A(2)

Section 2A(2) expands on the circumstances in which structured settlements may be ordered specifically in respect of future costs which include "future care, future medical treatment and future loss of earnings of an injured party".[208] Section 2A(2) provides that structured settlements are to be made at least once a year for the remainder of the injured party's life.[209] It goes on to require that the court may also consider additional circumstances under which periodic payments may be made.[210] Alongside structured settlements, the proposed legislation allows a court to order compensation in kind – that is rendering medical care and services in place of compensation.[211] The SLAB further provides that future medical care must be obtained at a state healthcare facility that is compliant with the OHSC standards of care.[212] Alternatively, if an injured party is to receive this medical care at a private healthcare facility, the state will only be liable to pay state fees for said treatment which leaves the injured party in the unfortunate position of offsetting a cost that they should not necessarily bear.[213] By introducing structured settlements alongside payment in kind, the SLAB is not only providing for a different financial approach, but it is introducing a different compensation model to govern compensation for medical malpractice cases in the future.

3.1.3 Section 2A(2)(a)

The Western Cape Government ("WCG") notes that not enough information has been provided to explain how structured settlement payments would be administered in terms of section 2A2(a).[214] They provide the following three administrative issues presented by this section:[215]

1. "who will the periodic payments be paid to?"[216]

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[208] Section 2A(2) of Bill 16 of 2018.

[209] Ibid subsection (2)*(a)*(i)–(ii).

[210] Ibid subsection (2)*(a)*(iii).

[211] Ibid subsection (2)*(b)*.

[212] Section 2A(2)*(c)*–*(d)*.

[213] Section 2A(2)*(d)* Bill 16 of 2018; Western Cape Government Submission at 5–6.

[214] Ibid Western Cape Government at 3–4.

[215] Ibid at 4.

[216] Ibid.

2. "who decides whether those amounts are reasonable?"[217]
3. "what checks and balances should be in place to ensure that the funds are appropriately spent?"[218]

The WCG poses these questions to ensure that the money paid out is used adequately and managed in such a way that reflects the health care needs of patients, especially the needs of children who are dependent on others to manage their funds and their compensation effectively.[219] The failure to administer funds correctly forces those victims of medical malpractice back into the public health care system regardless of the funds that were made available for their medical treatment.[220] According to WCG, when victims of medical malpractice return to the public health care sector, they are in turn prejudicing others who are in need of public health care services.[221] Therefore, the effective administration of structured settlements is required in order to ensure the sufficient operation of structured settlements.

The SLAB not only envisions structured settlements as an approach to achieve medical malpractice reform, but it also provides for treatment in kind. This additional reform is a fundamental departure from the traditional approach of the Aquilian action, by allowing a defendant to offer treatment to a victim of medical malpractice in lieu of monetary compensation.[222] Since offering treatment in kind addresses a single cost measure in the law of delict, rather than changing a structural element of the law of delict, it can be seen as a conventional reform.[223]

3.1.4 Section 2A(2)(b)

Section 2A(2)(b) provides that the state may order that compensation for future medical treatment be made in kind to injured parties instead of satisfying future medical care payments

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[217] Ibid.

[218] Ibid.

[219] Western Cape Government op cit note 213 at 3.

[220] Ibid.

[221] Ibid.

[222] Pauw op cit note 152 at 852–56.

[223] Oosthuizen and Carsetns op cit note 87 at 392–93.

with the entire or partial monetary award.[224] This section provides no criteria upon which a court may make such an order and how such an order is to be financed, monitored or administrated.[225] This particular section of the Bill does not deal directly with structured settlements, but it is important to note that providing ongoing treatment in kind is not only classified as a conventional reform, thereby limiting its ability to create comprehensive change in medical malpractice litigation.[226] This suggestion further eliminates the application of the once-and-for-all rule by allowing ongoing payment in the form of treatment and care instead of paying the claimant a lump sum to administer accordingly for his or her own treatment.[227] The undertaking to manage where and how a claimant receives treatment requires extensive administrative efficiency and oversight from the government to ensure that claimants are receiving adequate treatment. In that way, if further claims are made by claimants, they can be handled correctly by tracking the treatment plan and movement of the patient.

3.1.5 Section 2A(2)(c)

The SLAB proposes section 2A(2)(c) of the Bill as an answer to ensuring that patients who receive treatment in kind are cared for correctly.[228] This section proposes that victims of medical malpractice can receive treatment at a facility that is approved by The Office of Health Standards Compliance.[229] Academic commentary assumes that a court will send a victim of malpractice to receive from the same institution where she was injured.[230] Wessels and Wewege argue that this understanding of the section goes against the methods of statutory interpretation and they deny that a court will send a victim back to a healthcare facility that caused the malpractice.[231]

Wessels and Wewege emphasise that the goal of the proposed Bill is to change the financial position of the health care department while also supplying the victims with adequate medical

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[224] Section 2A(2)(*b*) of Bill 16 of 2018.
[225] Ibid.
[226] Oosthuizen and Carsetns op cit note 87 at 392–93.
[227] Memorandum op cit note 133 at 4.
[228] Section 2A(2)(*c)* of Bill 16 of 2018.
[229] Ibid.
[230] Wessels & Wewege op cit note 35 at 507.
[231] Ibid.

treatment. Having regard to this goal, they deny that the Bill forces a court to "particularise" where a victim receives treatment, but they ultimately conclude that a court would not place the victim in further danger by exposing a victim of medical malpractice to the same negligent institution while trying to compensate her for her damage.[232] Doing so would constitute bad practice on behalf of the court. This observation by Wessels and Wewege is in line with constitutional practice and administrative standards, as a court cannot act regressively to deny access to healthcare.[233]

The submission of SECTION27 highlights the inadequacy of many public health care facilities in South Africa to provide adequate services in the public sector.[234] Statistics show that most public health care facilities do not meet the required OHSC standards thereby making them unsuitable to care for victims of medical negligence.[235] On the one hand, increasing the involvement of the OHSC in the process of medical assessments may benefit the entire public healthcare system by improving accountability.[236] On the other hand, the failure of many public health care facilities to meet the current OHSC standards leaves possible future victims of medical negligence without an adequate number of facilities to receive their treatment in kind.[237] The lack of adequate medical facilities poses a risk not only to the right to adequate health care, but it threatens other corresponding rights such as the right to movement, the right to work and the right to dignity.[238] Wewege explains that the absence of appropriate facilities leaves these physically impaired patients in a position where they may have to relocate to residences that are close enough to adequate health care facilities.[239]

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[232] Ibid at 508.

[233] Section 27(1)–(2) of the Constitution; Liebenberg op cit note 66 at 173.

[234] SECTION27 op cit note 32 sub-para e, "the most recent OHSC reporting indicates the tiny proportion of facilities that would meet the criteria for OHSC accreditation currently (0,7% of facilities inspected in the 2016/17 financial year)"; SECTION27 op cit note 32 subparas e–f.

[235] Ibid.

[236] Wessels & Wewege op cit note 35 at 490.

[237] Ibid at 489–90.

[238] *https://pmg.org.za/committee-meeting/27412/* last accessed on 23 August 2020: In James Wewege's public oral submission during the public hearings on the SLAB in 2018, he contended that the act of sending a victim to 'a' healthcare establishment would have a negative effect on various "constitutional rights such as freedom of trade, residence, movement and occupation". The reason for this, he claims, is that if a victim receives compensation with only a singular healthcare facility being ordered to provide its services, the claimant's opportunities and rights to move for trade or residence may be unduly affected by the order. Wewege suggests that the Bill be changed to allow for range to address this issue. This dissertation agrees with this point.

[239] Ibid.

According to section 2A(2)(c), the court may only elect to send a victim to an accredited facility, which would exacerbate concerns about the right to freedom of movement.[240] Furthermore, it is must be borne in mind that the victims of medical negligence as well as their caregivers are in an already vulnerable position and should not have their movement or residency options curtailed by this section.[241] The WCG suggests that a strengthening of more health care facilities should occur before the implementation of this section and that using the OHSC standard may curtail the rights available to an injured party.[242] The WCG continues by suggesting that 2A(2)(c) needs to be edited to allow the court to send a medical malpractice victim to any public health care facility that meets or exceeds the standards of a public health care establishment.[243] Section 2A(2)(c) raises concerns regarding the movement of claimants and how the movement of the victims of negligence will be monitored. The lack of administrative clarity and oversight in the SLAB regarding section 2A2(c) compromises the effectiveness of the reform that it is proposing.

3.1.6 Section 2A(4)

Finally, the SLAB provides that the State or the injured party may apply to the court to alter the frequency and/or the amount payable by way of periodic payments where there has been a substantial enough change in the injured party's condition to warrant a variation of the initial order.[244]

The administration of structured settlements requires provincial healthcare facilities to possess the means to successfully administer the structured settlements.[245] DSC Attorneys have expressed concern regarding the ability of these provincial facilities to administer these payments especially in light of a) their failures in implementing past measures, and b) the failure of some facilities to present their capacity to administer structured settlements to the

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[240] Ibid.

[241] Ibid.

[242] Western Cape Government op cit note 213 at 5.

[243] Ibid.

[244] Section 2A(4) of Bill 16 of 2018.

[245] Memorandum op cit note 133, para 4 at 5.

committee.[246] DSC Attorneys added that the wellbeing of patients will still be compromised owing to past inequalities and failures of healthcare facilities.[247] They argue further that there should be checks and balances put in place to demote corruption and fraud that already occur at an alarming rate within the healthcare sector.[248] Wessels and Wewege note these concerns as pressing issues to be dealt with; however, they counterbalance these arguments with "the pressing need"[249] to implement some legal financial measure to change the financial position of the healthcare sector.[250] Wessels and Wewege agree that issues of corruption should be addressed;[251] however, the authors add that corruption and fraud concerns should not be a reason to withhold the implementation of the Bill as a temporary financial measure for the public healthcare department.[252] This dissertation agrees with this position. Corruption should not withhold progress. It should be guarded against, but it should not be feared to the point where no attempt at transformation occurs because of it.

3.1.7 The Role of the Courts as Envisioned by the SLAB

DSC Attorneys claim that the State would be placed in a compromising position where they are called upon to administer a new payment to the victim as the court may not be able to financially approve the claim in order to protect the financial resources of the State.[253] Wessels and Wewege suggest that this claim is over-exaggerated because a court would simply be fulfilling its role in society for the interests of the participants involved.[254] The authors opine further that the SLAB allows for more flexibility to compensate the harm than a lump-sum

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[246] DSC Attorneys op cit note 34 para 5 at 13–4.

[247] Ibid para 5.1 at 13.

[248] Ibid para 5.4 at 14; Amnesty International op cit note 33 at 4–8.

[249] Wessels & Wewege op cit note 35 at 498.

[250] Ibid.

[251] Ibid, "These worries about potential systemic maladministration, corruption and fraud are duly noted and the committee should take it into consideration when evaluating the submissions. Indeed, South Africa's systemic problem with these issues is a major obstacle to progress and requires urgent attention."

[252] Ibid, "In any event, if regard were had to this particular objection, one would struggle to change any existing system in South Africa, because the problem of maladministration and corruption is systemic and pervasive."

[253] DSC Attorneys op cit note 34 at 10, Wessels & Wewege op cit note 35 at 502, "The law firm contended that, once liability is established and the state instructed to make periodic payments under the proposed bill, the state would be "transformed from opponent to benefactor"; Wessels & Wewege op cit note 35 at 503.

[254] Wessels & Wewege op cit note 35 at 503, "All things considered, it is hard to see how the imagined scenario may be described as problematic: all parties involved are simply acting in their interest (like any other litigious matter) and leaving it to a court to make its decision, based on the merits of the application."

payment would and this is to the benefit of the claimant.[255] The authors add that seeing the State as a benefactor does not hold weight, considering the fact that the purpose of this Bill is to curb financial strain on the department of health.[256] They contend further that the Bill allows for flexible measures to assess claims effectively and to ensure that the financial standing of the department is kept in good standing by assessing each claim for additional payments.[257]

But the concern of DSC Attorneys is worth consideration from an administration viewpoint. Through the SLAB, the courts are being called upon to play a more active and recurring role in the decisions of the victims of medical negligence. Therefore, the courts will end up in a constant deliberation process to assess the benefits and reassess the benefits of an initial claim. The constant review of benefits will once again place a burden on the courts. Thus, the variation clause allows claimants and defendants alike to amend provisions to their initial arrangement. In doing so, the state of injured victims would have to be assessed and reassessed, thereby aligning compensation agreements with the condition and needs of the victim.[258] However, reassessing cases would in turn require administrative efficiency and extensive oversight to ensure that claimants are continuing to receive effective compensation and assistance as long as they need to. Therefore, the courts may not necessarily be transformed into a benefactor, but they will have to assume a regular review role which requires an administrative efficiency that the backlogged courts currently do not possess. This entire function may be better achieved if it was handled outside of a traditional court structure, which would, in turn, amplify the benefit of ordering structured settlements and varying structured settlements.

The various administrative issues present in the SLAB run the risk of failing to meet the standard of just administrative action required by section 33(1) of the Constitution, which provides (*inter alia*) that administrative action must be lawful, reasonable and procedurally

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[255] Wessels & Wewege op cit note 35 at 503, "Indeed, there would be no option of approaching a court in an attempt to vary the order to get additional compensation for this treatment. The structured settlements, however, permit such a solution."

[256] Ibid Wessels & Wewege at 503.

[257] Ibid.

[258] *AD and Another v MEC for Health and Social Development, Western Cape Provincial Government ("AD")* (27428/10) [2016] ZAWCHC 116 (7 September 2016) para 185.

fair[259] Depending on how the SLAB is to be implemented if no 'administrative action' is involved (as opposed to 'judicial action') then that implementation cannot be judged in the light of section 33. However, section 33(3) states that the legislature must give effect to administrative action that is lawful, reasonable and procedurally fair by way of curial review or review by an impartial tribunal.[260] Given that the SLAB does not explicitly provide for clear procedures for the administration of structured settlements and compensation in kind, it is unclear whether the requirements of section 33(1) have been met. Although it may be argued that requiring the courts to be repeatedly involved in variation disputes gives effect to section 33(3)(a) of the Constitution, such constant judicial involvement may be imprudent owing to the increase of medical malpractice claims.[261] Furthermore, in accordance with the reasonableness review for socio-economic programmes, it can be said that the SLAB is uncoordinated and under-researched; it lacks clear facilitation and administrative clarity; it is inflexible, and it has failed to account for medium and long-term needs even as an interim measure.[262] The SLAB has also failed to ensure that financial and human resources are effectively made available to alleviate the medico-legal crisis.[263] The SLAB is not transparent in its approach for administering structured settlements, its variations and treatment in kind, and it has failed to properly account for its effect on the indigent and vulnerable who need healthcare and proper compensation.[264] It follows that the comment of Wessels and Wewege of implementing an administrative process to resolve the administrative burden of structured settlements is worthy of further consideration.[265] An administratively efficient alternative dispute resolution process may be one of the ways to strengthen the suggestion of structured settlements especially when one considers the fact that treatment in kind is envisioned as a supportive measure in the SLAB's iteration of structured settlements.

The SLAB not only provides for administratively inefficient implementation of conventional reforms with limited ability to achieve comprehensive reform. It also failed to properly

[259] Section 33(1) of the Constitution.

[260] Section 33(3) of the Constitution.

[261] DSC Attorneys op cit note 34 para 5 at 13–4.

[262] Section 27 of the Constitution; supra note 64; op cit notes 62 and 66.

[263] Ibid.

[264] Ibid; Amnesty International op cit note 33 at 4.

[265] Wessels & Wewege op cit note 35 at 491–92.

consider the effect that its implementation would have on issues such as access to justice or how the proposed monetary compensation would be taxed. Following below is a discussion of what legal aspects the SLAB has failed to give due consideration to.

3.1.8 Section 2A(1)

Section 2A(1) details the first instance where structured settlements must be ordered in lieu of a lump-sum payment in a state medical malpractice case.[266] According to this section, where a claim for damages exceeds one million rands, the damages will be paid to the victim by way of structured settlements.[267] Damages that are included in this determination include both patrimonial and non-patrimonial damages.[268] Past expenses and damages, necessary and immediate expenses, assistive technology, future costs and general damages for pain and suffering are also included in this determination.[269]

SECTION27 criticised the threshold amount for being exclusionary as it is "inflexible and non-responsive to changes in the costs of living".[270] Wessels and Wewege opine that the formulation of this threshold presents an inflexibility that is also non-responsive to future care costs.[271] SECTION27 suggested that the SLAB be amended so that the minister of health provides the threshold amount for medical malpractice claims when necessary.[272] This allows for flexible and responsive compensation to meet the changes in the costs of living and future care costs. This suggestion received support from the academic commentators.[273] However, the Western Cape Government suggested that the amount be reconsidered to allow that a) structured settlements to be made for smaller claim amounts and b) to account for the cases where administration costs may be higher than the actual claim itself.[274]

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[266] Ibid section 2A(1).

[267] Ibid.

[268] Ibid.

[269] Ibid.

[270] Wessels & Wewege op cit note 35 at 496.

[271] Ibid at 497.

[272] Ibid.

[273] Ibid.

[274] Western Cape Government op cit note 213 at 1–3; *https://pmg.org.za/committee-meeting/27412/* accessed on 23 August 2020.

It is further argued that the prescriptive wording of the section precludes the court from using its discretion in awarding structured settlements.[275] Reference is made to section 2(1) of the UK Damages Act and other foreign law jurisdictions illustrate how other jurisdictions allow the court to exercise discretion when awarding either lump-sum payments or structured settlements to victims of medical malpractice.[276] The prescriptive language is also said to be an infringement on the courts' discretionary powers as the section itself does not allow the court to make an order for lump-sum damages.[277] To remedy these concerns, it is suggested that the legislature change the wording of the Bill.[278] However, in the event that the wording remains the same, Wessels and Wewege reference section 2A2(a)(iii) which provides the court with discretionary decision-making ability when ordering structured settlements for loss of earnings and future medical care and treatment costs.[279]

The Law Society suggested that section 2A(1) should be changed to provide more clarity,[280] as the wording of the section suggests that lump-sum payments may still applicable for section 2A(1)(a)-(d); however, it remains unclear.[281] The Law Society further claims that the legislature must clarify whether the one-million-rand threshold applies to a claim or to a judgement.[282] The Law Society suggested an amendment of the section as well.[283] The Western Cape Government ("WCG") further wrote an opinion on the insufficiency of this section.[284] The WCG suggested that the baseline should not be a set figure as there is not enough prior research to support the threshold amount.[285] Instead, the WCG suggests that further research

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[275] DSC Attorneys op cit note 34 at 15–6 para 7.1 – 7.2

[276] Ibid DSC Attorneys; Wessels & Wewege op cit note 35 at 497; sections 116.1(1), (2), (3), (7) and (8) of the Ontario Courts of Justice Act, 1990 (Canadian legislation); section 2 of The Damages Act 1996 (the United Kingdom legislation).

[277] Legal Resources Centre 'Submissions to the Portfolio Committee on Justice and Correctional Services in Respect of The State Liability Amendment Bill [B16-2018]' paras 39 to 48 at 10–2.

[278] SECTION27 op cit note 32 para 23.

[279] Wessels & Wewege op cit note 35 at 497; section 2A(2)*(a)*(iii).

[280] Law Society op cit note 206 at 14.

[281] Ibid.

[282] Ibid.

[283] Ibid.

[284] Western Cape Government op cit note 213 at 1–3.

[285] Ibid at 1.

should be completed to consider a less arbitrary amount and subject that amount to review and change according to the inflation rate.[286] The WCG also opined that structured settlements should be optional for judgments or claims that fall below the threshold amount as this would remedy some of the inflexibility prescribed by the wording of the section.[287] The WCG also suggests that a defendant should be given the right to elect to adhere to the "once and for all" rule if he/she can afford to do so and if the patient agrees to receive a lump-sum payment or a portion of a lump sum payment at once.[288] The WCG also claims that this will allow "a defendant to mitigate against deferring debt and manage its contingent liability which would undoubtedly increase over time as courts order structured payments."[289] Finally, the WCG remarked that parties who reach settlement agreements outside of court may not be able to "negotiate and order"[290] the terms of the compensation as the section does not provide that the same rules apply to settlements made out of court.[291]

Based on the academic submissions above, the legislature should change the wording of this section to clarify that lump-sum payments may still be made where appropriate or mutually agreed upon by the parties to the dispute. The legislature also needs to clarify why it chose the threshold amount of one million rands and provide a mechanism for review of this threshold amount – a mechanism that is fair and based on adequate research. Assuming that the legislature addresses the wording of the section and conducts further research concerning the threshold amount for structured settlements, the legislature will have to provide administrative clarity on how structured settlements should be ordered. The legislature will also have to provide clarity on the review process for claims. The legislature will also have to clarify its position concerning lump-sum payments as there may be defendants who are capable of meeting a lump-sum payment or would prefer to do so for financial reasons.

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[286] Ibid.
[287] Ibid at 3.
[288] Ibid at 2.
[289] Ibid.
[290] Ibid.
[291] Ibid.

Furthermore, the wording of the Bill does not provide clarity on whether the annuities to be paid are subject to taxation according to the Income Tax Act 58 of 1962.[292] Structured settlements can be categorised as repetitive annual repayments.[293] Therefore, the structured settlements envisaged by the SLAB qualify as annuities to be taxed in terms of the Income Tax Act.[294] If the Income Tax Act applies to the structured settlements, the victim will be unduly prejudiced as they will be taxed on finances that are meant for medical costs, loss of earnings, or any other formulation of the structured settlements that the judge has decided upon.[295] It was suggested that the Income Tax Act be amended to exclude the taxation of structured settlements for medical malpractice cases *vis-à-vis* the Road Accident Fund Act.[296]

By determining that the current iteration of structured settlements has tax implications, academics have revealed yet another administrative issue within the SLAB. If the SLAB does not apply a tax exemption to the annuities paid, claimants will be unduly prejudiced by this reduction in their compensation. If the legislature fails to apply a tax exemption to the structured settlements, how would the final repayments be decided to ensure that claimants are receiving their due financial assistance? Thus, the SLAB's inability to provide clarity on the issue of tax repayments reveals an unfair consequence of the lack of this legislative foresight.

The future of contingency fee agreements is also implicated by the proposed SLAB which has a direct effect on the right of access to justice.[297] A standard contingency fee arrangement in South Africa has been formulated to provide greater access to justice for the general public by way of the 'no win, no fee' arrangement prescribed by The Contingency Fees Act 66 of 1997.[298] According to this arrangement, a legal practitioner will only receive a fee for her services where

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[292] Wessels & Wewege op cit note 35 at 506.

[293] Ibid at 507.

[294] Ibid, "Compensation in the form of an annuity results in an amount which would ordinarily be of a capital nature, to be included in a taxpayer's income in terms of paragraph (a) of the definition of gross income. In the absence of an applicable exemption for the particular annuity, it will therefore be included in the taxpayer's income and the latter will be taxed accordingly"

[295] Ibid.

[296] Ibid.

[297] Wessels & Wewege op cit note 35 at 493–95.

[298] The Contingency Fees Act 66 of 1997; Wessels & Wewege op cit note 35 at 494.

she concludes her client's case successfully.[299] In the event that the case is concluded successfully, a practitioner may receive twice as much as the previously agreed settlement, but no more than 25% of the final amount that is awarded to the claimant.[300] Although it is argued that this arrangement allows for greater access to justice, it is also argued that legal practitioners earn large fees for the amounts of money that they receive from medical malpractice cases as these cases already involve large sums of money. This makes medical malpractice law lucrative for lawyers in this field.[301] The Law Society and the Medical Malpractice Lawyers Association argue that the contingency fees for medical malpractice lawyers are necessary considering the highly technical and specialized nature of the work involved in these cases.[302] While there is consensus regarding the adverse effects of the lengthy and extensive legal process, contingency fees are necessary for legal practitioners who deserve to be remunerated fairly for their work in medical malpractice law.

Thus, it is believed that another consequence of implementing the SLAB is that it will do away with contingency fees that assist with providing access to justice while remunerating practitioners as fairly as possible.[303] The Law Society believes that this will lead to a lack of legal representation and, therefore, a diminution of access to justice through the court system as many lawyers will not work without a contingency fee arrangement or without the clarity of how to arrange their fees if structured settlements are ordered.[304] The Law Society claims that this will cause uncertainty for legal practitioner fees.[305] In a similar vein, it is believed that some legal practitioners have not acted in good faith in their medical malpractice practices.[306] This results in defendants needing to defend meritless claims that exacerbate unnecessary expenditure of funds. Legal practitioners have been painted as greedy and willing to take advantage of victims of medical malpractice solely for financial gain.[307] Contrary to this

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[299] Section 2(2) of the Contingency Fees Act.

[300] Section 2(1)–(2) of the Contingency Fees Act.

[301] Wessels & Wewege op cit note 35 at 494.

[302] Law Society op cit note 206 para 3.8; Medical Malpractice Lawyers Association op cit note 134 at 12–4.

[303] Ibid; Wessels & Wewege op cit note 35 at 494.

[304] Medical Malpractice Lawyers Association op cit note 134 at 12–4; Wessels & Wewege op cit note 35 at 494.

[305] Ibid.

[306] Wessels & Wewege op cit note 35 at 494.

[307] Ibid.

rhetoric, Wessels and Wewege refuse to take the position that legal practitioners are greedy and that they care only for the fees that they can earn from medical malpractice claims.[308] The academics adopt a viewpoint that legitimizes the concerns about the arrangement between the practitioner and the possibly successful claimant.[309] They believe that the ethical behaviour of legal practitioners will not be of concern where the claimant is unsuccessful in being awarded damages, as legal practitioners cannot earn from an unsuccessful claim.[310]

Medical malpractice attorneys possess valuable skills and a high level of expertise and knowledge which they use to assist medical malpractice victims.[311] The contingency fee agreements ensure that skilled legal professionals remain in practice to assist claimants when injured.[312] Therefore, the legislature needs to account for the role and the payment structure that applies to legal practitioners. However, it is still paramount that meritless claims are avoided as they can lead to the undue expenditure of funds.

Regarding the issue of access to justice, Wessels and Wewege ultimately disagree with the assumption that the application of the Bill will infringe upon the right of access to justice because there are ways in which to still supply legal assistance to those in need even if certain legal practitioners lose their financial incentive to take on medical malpractice cases.[313] As a remedy, the Legal Resources Centre suggested that a contingency fee be calculated on "the full amount quantum of damages" even though future care costs will be provided periodically and the LRC argued that the Bill should be amended to allow for such.[314] The Western Cape Government argued that the Contingency Fee Act be remedied to "provide for a reduced maximum amount that may be charged as a contingency fee and to determine when and how contingency fees are to be paid in successful medico-legal claims against the state where future periodic payments make up the bulk of a substantial or high-value claim."[315] Wessels and

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[308] Ibid.

[309] Ibid.

[310] Ibid.

[311] Law Society op cit note 206 para 3.8; Medical Malpractice Lawyers Association op cit note 134 at 12–4.

[312] Ibid Law Society para 3.8.

[313] Wessels & Wewege op cit note 35 at 495.

[314] Ibid.

[315] Western Cape Government op cit note 213 at 3.

Wewege also suggested that the Legal Aid Act should be amended to allow law clinics to take on medical malpractice cases.[316] The application of contingency fee agreements is not clear in the case of structured settlements as the aim of structured settlements is to provide ongoing support to patients. Additionally, if legal practitioners are remunerated from structured payments, claimants will once again be forced to take home less than what is necessary to meet their expected needs. Ultimately, the SLAB's failure to consider how it may affect access to justice, the role of lawyers or how contingency fees will be decided going forward highlights the need for proper consideration of how the SLAB's iteration of structured settlements affects other laws in South Africa.

3.1.9 Section 2A(2)(d)

Section 2A(2)(d) allows injured parties to receive treatment in kind at private health care facilities; however, the provision states that the injured party must offset the difference in costs between the public health care facility fees and the services that are administered at the private health care facility.[317] Thus, when injured parties receive private medical care, they will only be financially covered insofar as the public fees related to the care.[318] A common issue among academics is who will pay the difference between the public care costs and the private care costs.[319] This section once again raises issues of whether the SLAB is indeed fair to those indigent and vulnerable members of society who require as much financial assistance that they can receive in the event of a medical malpractice incident.[320] This section is unfair when considering the fact that few public institutions can actually meet the prescribed OHSC standards.[321] This would then force medical malpractice victims to receive treatment in kind from private health care institutions, which will, in turn, exacerbate the financial issues faced by those who should be receiving compensation, instead of paying for a medical mistake that was not their fault. Furthermore, the private institution will still need to be paid for the services that they render outside of personal medical aid or personal financial expense.[322] The WCG

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[316] Wessels & Wewege op cit note 35 at 495.

[317] Section 2A(2)*(d)*.

[318] Ibid.

[319] Western Cape Government op cit note 213 at 6.

[320] Amnesty International op cit note 33 at 4–8.

[321] SECTION27 op cit note 32 subparas e–f.

[322] Western Cape Government op cit note 213 at 6.

suggests that this section should be redrafted after the NHI Bill comes into effect as private healthcare facilities should be remunerated for providing health care services to those who cannot afford private health care fees.[323] Ultimately, this section is unfair for requiring injured persons to pay for injuries that are not their fault.

3.1.10 Section 2A(3)

The SLAB further provides that the structured settlement payments will increase every year according to the consumer price index.[324] Wessels and Wewege observe that the CPI provides a standard measure of inflation that only caters for a "small percentage of medical costs".[325] The CPI does not provide the most reliable approach to calculating inflation on medical costs.[326] Wessels and Wewege suggest that an alternative be used to calculate the inflation of future medical care and treatment costs argue (along with SECTION27)[327] that the CPI is a less satisfactory tool to measure the inflation for medical costs.[328] In making this determination, they conceded that medical costs included future care costs and future medical treatment.[329] It is argued that "the rate of medical inflation is not necessarily equivalent to the Consumer Price Index", which makes it unsuitable when calculating the rate of inflation for compensation that is owed to the patient.[330] Wesssles and Wewege argue that a patient will have to pay the difference of what is owed to her in the event that the CPI does not account for the difference between the interest of general consumer goods and the interest calculated on medical costs.[331] This is manifestly unfair for the claimant. It is suggested that the wording of section 2A(4) provides an opportunity for claimants to vary the amount of their settlements if necessary, as the section states that a "substantial change in the condition or the circumstances of the injured

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[323] Ibid.

[324] Section 2A(3) of Bill 16 of 2018.

[325] Wessels & Wewege op cit note 35 at 504, "it is used as an economic indicator to determine the measure of inflation or deflation within South Africa."

[326] Ibid at 504.

[327] SECTION27 op cit note 32 sub-para g.

[328] Wessels & Wewege op cit note 35 at 504–5

[329] Ibid at 505.

[330] Ibid, "…since 2003 the inflation relating to healthcare has not been equal to annual headline inflation."

[331] Ibid at 505, "The use of the Consumer Price Index to determine future medical costs may prejudice the victim because where the index does not equal medical cost inflation, the annual periodic payment adjustments will not replicate the relative change in the underlying cost that is to be compensated for"; SECTION27 op cit note 32 sub-para g.

party necessitates such a variation".[332] Requiring the claimants to approach the court to adjust the price of inflation will lead to an influx of claims that will cause administrative inefficiencies. Wessels and Wewege argue that interpreting this provision to allow for the correct calculation of inflation would undermine efforts to change the legal culture of medical malpractice litigation in South Africa as these disputes will increase incidents of lengthy and expensive litigation for the state and the victims of malpractice.[333] It has therefore been suggested that the Medical Care Price Index ("MCPI") be used to calculate the requisite medical inflation costs as this index is more accurate.[334] Both SECTION27 and Wessels and Wewege claim that the MCPI is "as cost-effective, reliable, accessible and practical as the Consumer Price Index."[335] Thus, this dissertation agrees that the legislature should not only amend the Bill to reflect the use of the MCPI instead of the CPI,[336] but an alternative review process may be a better vehicle to resolve any variation claims that may arise to avoid overburdening the courts.

3.1.11 Re-adjudication: Applying the bill retrospectively

Section 4 of SLAB implies that the measures of the bill may apply retrospectively "to matters that are already before the court but have not been concluded". This section has not received support from the submissions on the SLAB, as it may undermine the judicial procedure.[337] It is suggested that this section of the proposed Bill be amended to avoid legal uncertainty and that section 4 have no retrospective application.[338] A retrospective application might create a further backlog in the current medical malpractice curial process as cases will have to be re-adjudicated according to different legislative principles.[339] The commentary and the research present no pressing reason to extend the application of this Bill in any retrospective manner.

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[332] Wessels & Wewege op cit note 35 at 506.

[333] Ibid.

[334] Ibid.

[335] Ibid at 506, The MCPI is preferable to the CPI because "it is more accurate in relation to the change in medical costs. If implemented, it will result in the increase in periodic payments replicating, to a greater degree of accuracy, the increase in medical costs that the victim will have to incur."

[336] SECTION27 op cit note 32 sub-para g at 9.

[337] Wessels & Wewege op cit note 35 at 503–4.

[338] Ibid at 504; SECTION27 op cit note 32 sub-para h at 10.

[339] Wessels & Wewege op cit note 35 at 504: It is "contrary to ordinary principles of statutory interpretation and application and may interfere with the administration of justice". Parties will have to "reformulate the relief that they seek." The authors continue that disputing parties "may also be required to lead further factual evidence and

3.2 The Effectiveness of the SLAB as an Interim Measure

Alongside each of the individual problems from each section of the SLAB, the SLAB's operation as an interim measure has been questioned for its ability to address the medical malpractice crisis. As shown above, each section of the proposed SLAB carries its own barriers to success in achieving medical malpractice reform. The financial issues that are facing the public health care sector have a direct effect on the efficacy of the system itself to provide healthcare. This, in turn, compromises the effective administration of the health care system. The SLAB, in attempting to remedy this crisis has unfortunately proposed a system that is riddled with administrative issues and improperly considered reform, as it does not provide effective methods with which to process structured settlement claims and variation of claims that will be brought forward by the victims of medical malpractice.

With this lack of administrative foresight, the SLAB has been criticised for not addressing the deeper structural issue that results in medical malpractice claims.[340] The issue is, according to certain writers, the poor standard of health care service delivery, especially within the public health care sector.[341] Therefore, it is questionable as to whether the SLAB's imposition of structured settlements will provide the necessary reprieve for the public health care sector rather than cause long-term damage through its interim application.[342] By promoting conventional methods of reform, the SLAB would only tackle a portion of the financial concern attached to the crisis as it cannot fundamentally change the deeper systemic health care issues. Thus, questioning whether structured settlements can bring about any effective change – even if it is only in the interim – is not only valid but necessary.

Wessels and Wewege agree with the sentiment that poor service delivery and declining health care standards should be addressed if true transformative change is to occur in the health care

expert evidence, even if this means reopening the process where evidence has already been concluded." It may require the introduction of "additional judicial considerations that the judge may not previously have considered in determining just and equitable relief." "This may undermine the constitutional principle of rule of law, which requires certainty regarding the legal position."

[340] The Legal Resources Centre op cit note 277 at 8–14.

[341] Law Society op cit note 206 at 13; Amnesty International op cit note 33 at 8.

[342] Amnesty International op cit note 33 at 8; Algorithm op cit note 175 at 10.

sector.[343] However, they also agree that the implementation of structured settlements is valuable as it does, at the very least, initiate the process of changing the medical malpractice crisis as an apparent cost-saving measure. They state that structured settlements may help to address the adverse effects of the current once-and-for-all compensation model.[344] They opine that addressing the decline in health care standards alongside the implementation of structured settlements requires a symbiotic response.[345] Thus, they concede that structured settlements cannot exist alone or be successful without addressing the systemic health care crisis issues.[346]

The application of structured settlements has been acknowledged as a starting point to address the medical malpractice crisis. As mentioned above, there is a division in opinion among academics as to whether the once-and-for-all rule should be done away with to allow for structured settlements. However, few submissions provided effective practical alternative methods to challenge the crisis in both the interim and the long-term. Suffice it to say, structured settlements or some iteration thereof has the potential to initiate some positive change in South Africa's health care system right now.

However, the nature of the medical malpractice crisis is multi-faceted, as it is not only a social and structural issue but a legal one as well. Therefore, it goes without saying that the need to address the medical malpractice crisis requires a robust approach that leads to long-lasting transformation and positive reform that benefits all interested parties. Furthermore, structured settlements, being an isolated/conventional method of reform, can only bring about isolated change. Nonetheless, the implementation of this isolated approach to compensation may have long-lasting adverse effects, especially when one considers the lack of administrative foresight that the SLAB presented in its proposed approach to structured settlements.[347] Focusing on whether structured settlements can act as a sufficient method of reform in the interim may be short-sighted, especially where its proper administration has not been provided for.

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[343] Wessels & Wewege op cit note 35 at 486–89.

[344] Ibid.

[345] Ibid.

[346] Ibid.

[347] Ibid.

The Law Society stated that there are other ways to achieve cash flow savings for the department of health that does not involve the implementation of structured settlements.[348] But the Society failed to provide any practical alternative measures. Algorithm claimed that the state should focus on ways to limit the state's liability as the Bill would not achieve this goal through the implementation of structured settlements.[349] The issue of limiting liability is a sensitive one because it may involve an approach whereby a victim of malpractice does not receive full compensation for the damage that they incur, whereas the SLAB still requires that full compensation take place while providing a cash flow saving option to provincial departments of health.[350] SECTION27 presented an alternative method practiced in the Western Cape where the lump-sum is placed in a ring-fenced trust account (for improved administration) that may be payable to the state upon the victim's death.[351] However, this practice does not provide provincial departments of health with a cost-saving option to improve their financial standing. Unfortunately, the use of a ring-fenced trust to administer payments does not remove the financial burden faced by health care facilities and the Department of Health, but it does ensure that payments are made and used appropriately.[352]

According to Weesels and Wewege, as it stands, the structured settlements envisaged by the Bill suggest financial improvement and adequate compensation, which makes the Bill a better option currently in the South African fight against the medical malpractice crisis.[353] At the same time, it should not be overlooked that the comments on the necessity and effectiveness of the SLAB reveal the inadequacy of using only conventional reforms by themselves to achieve the fundamental improvements that are needed. In the absence of a permanent and comprehensive legislative offering, it may be assumed that some reform is better than no reform at all.[354] While this may be true, the critique above shows that the application of the Bill as a temporary response would likely add new frustrations to the growing crisis. Accordingly,

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[348] Law Society op cit note 206 at 1–6.

[349] Algorithm op cit note 175 at 10.

[350] Wessels & Wewege op cit note 35 at 502.

[351] SECTION27 op cit note 32 para 12 at 4.

[352] Wessels & Wewege op cit note 35 at 502, "However, the problem with this solution, as the submission itself admits, is that, while it seeks to ensure "that damages paid in respect of future medical expenses are used appropriately", it does nothing to "alleviate the pressure that lump sum payments impose on health budgets""

[353] Ibid Wessels & Wewege at 502.

[354] Ibid at 509.

if reform should come, it should be more comprehensive possibly comprising of both conventional and fundamental reforms.

3.3 The SLAB: Constitutionally Inadequate or an Administrative Failure?

The Law Society argued that the implementation of the SLAB would result in an infringement of various constitutional rights.[355] It stated that the Bill is irrational as it does not promote equality in terms of section 9, nor dignity in terms of section 10, nor personal freedom and security and protection from all forms of violence in terms of section 12, nor the right not to be deprived of property in terms of section 25, nor the right to access to health care in terms of section 27, nor the right to fair dispute resolution in terms of section 34.[356] The Law Society determined that, given this irrationality, the limitations of the above-mentioned constitutional rights could not be justified in terms of section 36 of the Constitution.[357] Essentially, the Law Society took aim with the ability of the Bill to transform the medical malpractice crisis by stating that the standard of health care should be addressed instead of the legal framework used to compensate those injured in medical malpractice incidents.[358]

The Law Society's claim of irrationality is based on the argument that the implementation of structured settlements will do little to address the real underlying issue, namely, the poor standards of healthcare that result in the incidents that generate medical malpractice claims.[359] However, it is not necessarily irrational to attempt to protect healthcare budgets by way of a system of structured settlements, because those budgets are required to improve the underlying provision of healthcare. So it appears that the SLAB's purposes include an attempt to contribute to addressing the underlying issue.

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[355] Law Society op cit note 206 at 6–13.

[356] Ibid.

[357] Ibid at 13.

[358] Ibid.

[359] Law Society op cit note 206 at 13.

Wessels and Wewege also do not support the Law Society's view.[360] They claim that the link between the purpose of the Bill and the measures chosen to achieve the goal are rational and necessary (even if the Bill is not completely satisfactory in its formulation), regardless of the existence of additional means to contribute to achieving the same goal.[361] Unfortunately, the Law Society did not provide a concrete, alternative solution or a suggestion of how to address the poor standards of health care.[362] They failed to provide their own measure that is "properly related to the public good" that is necessary to bring about reform in the health care sector.[363] The Law Society's claim that Bill should forgo development and implementation[364] is unhelpful in light of the positive obligation imposed by the Constitution to improve delivery of the socio-economic right of access to health care by utilising legislative or other measures to progressively achieve this right.[365] While the SLAB is an imperfect offering and would have to be improved in many respects, it is not wholly irrational. Instead, it should be viewed as a work in progress to be further improved in order to address its apparent administrative inefficiencies so as not to hinder access to healthcare and thereby infringe the negative obligation to provide access to healthcare.[366] Furthermore, the SLAB is the only legal instrument besides the development of the common law (to be examined below) that represents an attempt to remedy the financial issues inherent in the medical malpractice crisis. To deny the effect that medical malpractice claims have on the system smacks of irresponsibility in light of the evidence provided by the South African Law Reform Commission and academic discourse on the subject. One also hopes that the submissions of the Society are not unduly influenced by the interests of legal representatives who profit from the current inefficient system. Even though the SLAB is still under consideration by the National Assembly,[367] it

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[360] Wessels & Wewege op cit note 35 at 500–1, "…the Law Society continued its argument by acknowledging that the bill's purpose (ie to deal with the increasing financial strain on the budgets of provincial hospitals) may be regarded as "legitimate", but then questioned whether "the measure the lawgiver has chosen is properly related to the public good it seeks to realise". It goes on to state that the "most obvious measure to choose would be to reduce the incidents of negligence in Public Hospitals by implementing proper procedures and effective checks and balances and in ensuring a culture of patient safety and medical accountability"

[361] Ibid Wessels & Wewege at 501.

[362] Law Society op cit note 206 at 9.

[363] Ibid.

[364] Ibid.

[365] Section 27(2) of the Constitution.

[366] Section 27 of the Constitution; Liebenberg op cit note 66 at 173.

[367] *https://pmg.org.z/bill/797* accessed on 14 October 2020.

appears likely that the final suggestion of reform will lean towards the cost-saving measure of structured settlements as that is the current trend in the courts as well.

3.4 The Curial Development of the Common Law

To adequately evaluate the potential application of the SLAB, further context is required. The courts have, in recent years, considered the potential development of the common law to introduce judicial discretion to permit structured settlements. Three judgments are considered. First is the *AD* case, decided before the SLAB was proposed, which showcases the development of the common law to allow for structured settlements in South Africa in medical malpractice cases. Second is the *DZ* case, also decided before the SLAB was proposed, which provides a constitutional dimension to the discussion, which in turn likely contributed to the development of structured settlements proposal in the SLAB. The third is the *MSM* case, which was decided after the production of the SLAB. This decision details the administrative issues that prevail when attempting to apply structured settlements and alternative cost-saving measures on a relative basis.

3.4.1 AD and Another v MEC for Health and Social Development, Western Cape Provincial Government ("AD") [368]

In the case of *AD*, the Western Cape High Court provides a detailed description of what a medico-legal periodic payment order looks like in South Africa. In this case, the defendant accepted liability for causing the cerebral palsy of the child (referred to as IDT). The MEC chose to dispute the quantum of certain damages as well as the administration of the top-up/claw-back clauses in the case.[369] Such clauses permit the condition of the injured party to be revisited in order to adjust the payment plan previously agreed in the light of subsequent developments that have occurred after the settlement or court order.[370] The child, who had developed athetoid cerebral palsy, was said to be in a better position than someone who had developed spastic cerebral palsy after birth.[371] The defendant accepted liability but submitted

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[368] *AD* op cit note 258.

[369] Ibid paras 47, 61–2.

[370] Ibid paras 24, 47–62.

[371] Ibid para 2.

arguments on the quantum of damages payable.[372] Additionally, the presence of the claw-back provisions in the independent agreement and their administration by a mutually agreed upon Trust was examined for legality. The court assessed whether revisiting the quantum of damages via the claw-back provision throughout IDT's lifespan would be in contravention of the Public Finance Management Act (which precludes the Department of Health from providing long-term financial security or future payments), but Rogers J held that this would not be an issue as the funds would be administered by way of an independent medical fund instead.[373] The court was also called upon to consider the validity of periodic payments and the development of the common law.[374] Seeing that the litigating parties agreed independently to the use of a structured settlement and its legal administration, the question of developing the common law did not need to be answered in this case.[375] However, the court did consider the benefits and consequences of using structured settlements to compensate injured parties; and ultimately declared that, although the development of the common law could be brought about through incremental changes by relaxing the application of the lump-sum rule,[376] legal reform should instead 'be left to the legislature'.[377] The court ruled in favour of the defendant to apply structured settlements and accepted the calculations put forward by their experts as they were in the interest of fairness.[378] What this case shows is how much empirical evidence and planning is required to apply structured settlements effectively with variation orders. Although the court did not decide to develop the common law, it promoted the ordering of periodic payments in medical malpractice cases.

3.4.2 Minister of the Executive Council for Health and Social Development, Gauteng v DZ obo WZ ("DZ")[379]

For spatial reasons, this dissertation will look at the *DZ* case briefly to reveal how structured settlements and with it, treatment in kind, have been promoted in our law. In this case, a child

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[372] Ibid paras 2–3.

[373] Ibid paras 70–3; sections 65–6 and Schedule 2 of the Public Finance Management Act 1 of 1999.

[374] Ibid paras 46–59.

[375] Ibid.

[376] Ibid paras 57–61; paras 71–4.

[377] Ibid para 74.

[378] Ibid paras 52–60.

[379] *DZ obo WZ* supra note 124.

developed cerebral palsy caused by asphyxia during prolonged labour and vaginal delivery.[380] The liability and the quantum of damages were not argued in this case as the MEC accepted responsibility for the negligent wrongdoing on behalf of its employees, as well as the quantum of damages payable.[381] However, the MEC did approach the courts asking for the quantum of damages allotted to future expenses to be paid periodically in structured settlements as and when the need arose.[382] The MEC also contended that payment be made directly to the relevant service providers instead of the injured party, but ultimately, the MEC asked for the common law to be developed if it did not already allow for this alternative compensation method.[383] First, the MEC argued that compensation be paid "in kind" and need not necessarily sound in money, which was an attempt to offer alternative compensation to injured parties.[384] Secondly, the MEC claimed that the once-and-for-all rule applies to the decision on the merits of the case and not necessarily the quantum of damages payable.[385] If structured settlements were allowed, it would empower the liable party to revisit the annuities payable and adjust them according to the needs of the injured party and the defendant at the time of adjustment.[386]

The majority of the court found that these averments by the MEC were "tenuously linked"[387] and dismissed the appeal with costs. Froneman J, writing for the majority, held that compensation for personal injuries does not necessarily need to sound in money as it does not offend the normative values of the Constitution in providing the right to healthcare.[388] Regarding the second averment, Froneman J assessed the viability of developing the common law in terms of section 39(2) of the Bill of Rights and determined that it was inappropriate as no constitutional right or norm had been infringed.[389] Instead, Froneman J remarked that the MEC should have argued that the common law be developed for the advancement of the

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[380] Ibid paras 1–3

[381] Ibid para 1.

[382] Ibid paras 11–3.

[383] Ibid paras 1–8.

[384] Ibid paras 11–3.

[385] Ibid paras 17–8.

[386] Ibid para 54 and paras 56–7.

[387] Ibid para 12.

[388] Ibid paras 44–6.

[389] Ibid para 32.

interests of justice in terms of section 173 of the Constitution.[390] The majority of the court agreed that developing the common law in this situation would be best achieved through incremental changes and on a case-by-case basis when sufficient and cogent evidence was presented to the court to do so.[391] Froneman also warned that the legislature would be in a better position to develop the common law.[392] The court dismissed the MEC's claims and declined to develop the common law as not enough cogent factual evidence was placed before the court to do so.[393] Nevertheless, the court did not deny the value of structured settlements and treatment in kind.[394] The court stated that structured settlements and treatment in kind were in line with constitutional principles, and in doing so, the court provided a pathway for structured settlements and treatment in kind to form part of the law of delict.[395]

In the minority judgment, Jafta J dismissed the appeal on different grounds. Jafta J disagreed with the decision that structured settlements for personal injury claims are not allowed in the common law.[396] Jafta J argues that periodic payment orders are allowed in South Africa's common law and explains that superior courts can order these periodic payments where it is in the interests of justice.[397] While this minority judgment does not have the same legally binding effect as the majority judgment, this observation and consequent obiter presents litigants with a rare legal opportunity to reframe personal injury compensation in South Africa.[398] Jafta explained that the law does not preclude the use of structured settlements and therefore dismissed the appeal because the appellant did not submit effective legal averments to the court.[399]

Furthermore, understanding the necessity of cost reforms for delict awards, we see the court move to include structured settlements and treatment in kind as viable compensation options

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[390] Ibid paras 32 and 59.
[391] Ibid paras 28 and 55.
[392] Ibid para 34.
[393] Ibid para 57.
[394] Ibid.
[395] Ibid para 58.
[396] Ibid paras 82–7
[397] Ibid paras 88–9.
[398] Ibid paras 83–7.
[399] Ibid.

in the future as they do not offend normative constitutional values.[400] This allows the application of these cost-reforms in South Africa, if not through the SLAB, through the common law.

3.4.3 MSM obo KBM v The Member of the Executive Committee for Health, Gauteng Provincial Government ("MSM")[401]

In 2019, the Gauteng High Court passed judgment on a cerebral palsy case that allowed the defendant to pay structured settlements and offer payment in kind as compensation for the plaintiff's injuries.[402] The facts of the case are as follows: the child (herein referred to as "K") sustained neurological injuries during birth causing the child to develop cerebral palsy.[403] The MEC accepted liability for the injury and asked the court to allow compensation in the form of structured settlements and treatment in kind in place of compensation by way of the once-and-for-all rule.[404] This would require the development of the common law, similar to that considered in the *DZ* case.[405] The plaintiff opposed the development of the common law and asked that the entire sum of future costs be remunerated by way of a lump-sum according to the common law.[406] Based on the defendant's requests to use alternative methods of compensation to satisfy the plaintiff's legal needs, the court identified two points of the case that required consideration: namely, the development of the common law to offer compensation in kind and to compensate a victim using structured settlements.[407] The defendant's request to offer these alternative forms of compensation mirror the efforts of the *DZ* case and the proposed SLAB and thus provide both theoretical and practical insight into the capabilities of the provincial governments to actively apply the proposed compensation reform to incidents of medical malpractice.

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[400] Ibid para 58; Pieter Pauw 'Alternative Relief in Delictual Claims – A Step in the Right Direction' (2018) 1 *TSAR* 176 at 176 and 179; *DZ obo WZ* supra note 124 paras 32 and 54.

[401] *MSM obo KBM* supra note 152.

[402] Ibid para 1–5.

[403] Ibid.

[404] Ibid para 4.

[405] Ibid.

[406] Ibid para 6.

[407] Ibid paras 4.1–4.2.

When discussing the development of the common law, the court turned first to the *DZ* case to solidify the current legal position concerning compensation in medical malpractice cases. The court identified two conclusions reached by the court in *DZ*.[408] Namely, that the Aquilian action must sound in money and that the once-and-for-all rule serves an important purpose of restricting a multiplicity of lawsuits.[409] Ultimately, the court in *DZ* refrained from developing the common law in terms of structured settlements and payment in kind.[410] However, the court in *DZ* left the door open for the development of the common law, according to the court in *MSM*,[411] as the court in *DZ* made an "evaluative" choice to not offer payment in kind.[412] The court in *DZ* also remarked on the migration from the individual nature of compensation in personal injury law to a social-security system that incorporates traditional African values.[413] This amplifies the public health defence (i.e. allowing treatment to serve as compensation)[414] as well as the move toward structured settlements insofar as they support a social agenda promoting a greater good.[415] An argument can be made that this desire for a more socially responsive personal injury compensation model among the legal fraternity can advance the agenda to allow payment in kind alongside structured settlements. However, in what way would this be helpful to the general public? As mentioned above in terms of the SLAB, an interim application of either compensation in kind or structured settlements without administrative efficiency may exacerbate the inabilities of the provincial governments to make good on their promises to compensate injured parties adequately. This tension is showcased in the case of *MSM* as the court questions the Charlotte Maxeke Academic Hospital on its capabilities to properly administer and meet the compensation needs of K.[416]

With regards to the once-and-for-all rule and structured settlements, the court in *MSM* summarised the determination in the *DZ* case in four points.[417] The court in *MSM* reiterated

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[408] Ibid para 22.

[409] Ibid.

[410] Ibid para 39; *DZ obo WZ* supra note 124 at 56.

[411] Ibid para 36.1.

[412] Ibid para 37.3–37.4

[413] Ibid footnote 23 at 16.

[414] Ibid para 19.

[415] Ibid.

[416] Ibid paras 51–91.

[417] Ibid para 38.

that neither structured settlements nor the once-and-for-all rule contravened "the normative constitutional value system".[418] Additionally, the court in *MSM* reiterated that the legislature may not have to be involved in determining the application of structured settlements.[419] Rather, each case could be decided separately and either framework, if reasonable and equitable, could apply.[420] Finally, the court in *MSM* reiterated that developing the common law did not require an abolition of the once-and-for-all rule, but rather, an inclusion of structured settlements subject to top-up/claw-back provisions.[421] This further entrenches the application of structured settlements and treatment in kind in South Africa's medical malpractice jurisprudence.

With the developing common law of the *DZ* case and the newly reported *MSM* case, there appears to be a double-impetus both in the legislature and the common law to implement structured settlements and treatment in kind as conventional cost reforms.[422] However, the implementation and administration of a more socially responsive medical malpractice compensation plan will determine the success of any proposed conventional reform.

The case was decided in the Gauteng High Court and seeing that it involves the development of the common law, it must still be confirmed by the Constitutional Court. Notwithstanding the constitutional confirmation, *MSM* undoubtedly strengthens the arguments that have been made against the sole application of the once-and-for-all rule. This case also reveals the administrative difficulty that is present in administering both treatment in kind as well as structured settlements.[423] Finally, the court in *MSM* reiterated that in the *DZ* case, the court was not called upon to solidify or wholly abolish the once-and-for-all rule; however, the court in *DZ* did praise the value of periodic payments in bringing equity and foresight when compensating an injured party practically for lifelong harm.[424] With structured settlements that

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[418] Ibid para 38.2

[419] Ibid para 38.3

[420] Ibid.

[421] Ibid paras 38.4–39.

[422] Ibid para 38; Bill 16 of 2018.

[423] Ibid paras 43–173 indicate a vast amount of empirical evidence required to facilitate and order compensation in kind; *AD* paras 39–655 the extent of administration and empirical evidence required to succeed in ordering structured settlements.

[424] Para 38.4; *DZ obo WZ* supra note 124 para 54.

are subject to top-up/ claw-back provisions, there is more room for the defendant to plan and save financially which in turn may improve a South African public health care facility's ability to compensate an injured party more effectively while improving its own service delivery.[425] The Constitutional Court in *DZ* also stated that undue dependent claims are "less, if not entirely absent" where structured settlements are ordered subject to top-up/claw-back provisions.[426]

Thus, the court in *MSM* sought to develop the common law in terms of structured settlements and the public health care defence (i.e. ordering treatment in kind).[427] The court embarked on a process to identify whether the Charlotte Maxeke Johannesburg Academic Hospital ("CMJAH") possesses the necessary wherewithal and resources to meet the defence of the government: i.e. to provide reasonable and effective treatment in kind alongside structured settlements for future costs[428] (subject to a non-contested top-up/claw-back provision).[429]

To succeed in its defence to compensate K with treatment, the defendant argued that K would be classified as a special patient who would receive greater attention to address K's healthcare needs.[430] The administrative burden with categorising K as a special patient is evidenced throughout the evidence led by the hospital and its management capabilities.[431] The court examines K's designation as a special patient as well as the issues of administration and addresses the claim that the Gauteng Department of Health is using this case as an example to advance an alternative agenda that circumvents the responsibility attached to compensation by way of the once-and-for-all rule.[432] This is a serious claim which the court addresses through the testimony of Mrs. Bogoshi who explains that CMJAH is undergoing transformation to better its healthcare service delivery to manage the treatment of all patients as well as K.[433] In paragraphs 100 and 101 the judgment further describes how the hospital may manage the day-

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[425] Ibid.
[426] *DZ obo WZ* supra note 124 para 56.
[427] *MSM* supra note 152 Para 39–40.
[428] Ibid para 42.
[429] Ibid paras 9 and 51–91.
[430] Ibid para 55.
[431] Ibid para 55
[432] Ibid para 55; paras 51–91.
[433] Ibid para 114.

to-day administrative issues of special patients.[434] The court recognizes that planning is key[435] to the successful implementation of K's health care plan and highlights that the lack of an effective cost analysis[436] frustrates the hospital's ability to provide effective health care in the future to other special patients.[437] Mrs. Bogoshi (a representative for CMJAH) was also asked to explain why K was identified as a special patient and whether this classification process was sustainable for cases that may arise in the future.[438] While CMJAH has classified patients as "special" prior to K's designation, the hospital's representative admitted that no analysis had been done to ensure that the management of K's case could be scaled to include other special patients who may require the same assistance.[439] In essence, this comment belies the failures of the common law development efforts and the SLAB to properly introduce structured settlements into the law, as the comment reveals the amount of research, empirical data, administrative efficiency and hidden costs that accompany the implementation of structured settlements and compensation in kind.[440] When considering the extent of treatment that is required to compensate one special patient and the financial consequence therein, it is worrisome that the hospital and the provincial government offered such a defence without considering its ability to effectively manage and afford the costs of more special patients.[441] Without a fundamental shift on a management level, the implementation of these conventional reforms will remain an aspirational goal: a goal that is stated yet incomplete and thus, rendered largely ineffective. The court acknowledged the efforts of CMJAH to address the administrative and service delivery failures.[442]

The court was satisfied that CMJAH could offer adequate treatment to the patient; however, the court did not develop the common law regarding structured settlements.[443] The court ultimately developed the common law in terms of section 173 in terms of the MEC's public

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[434] Ibid paras 100–1.
[435] Ibid para 68.
[436] Ibid para 69.
[437] Ibid paras 68–9.
[438] Ibid paras 71–3.
[439] Ibid.
[440] Ibid.
[441] Ibid.
[442] Ibid para 114.
[443] Ibid paras 207–8.

health care defence.[444] However, the court limited this application to cerebral palsy medical malpractice cases that develop in public health care facilities.[445] Therefore, this application does not extend to private health care cases or other state cases.[446]

[444] Ibid para 194.
[445] Ibid.
[446] Ibid.

3.5 Conclusions Regarding the Development of the Common Law

If, according to the courts in *DZ* and *MSM*, the structure of medical malpractice damages awards can be determined on a case-by-case basis, where does that leave the legislative development or any further SALRC suggestion? Are comprehensive reform efforts necessary if conventional reforms such as structured settlements or payment in kind can exist as part of the common law when enough information is made available?[447] Or is legislative intervention still necessary?

With regards to the case law, the application of the envisaged conventional reforms would, as *MSM, AD* and *DZ* indicate, require additional information upon which to make a determination.[448] In both *DZ* and now *MSM,* structured settlements are recognised for their practicality, but not allowed in the specific circumstance because they lacked sufficient evidence to make those decisions.[449] The court in *MSM* addresses the practical questions that make structured settlements cumbersome to the legal profession, the defendant and the injured party alike, including the uncertainty regarding the amount that is to be paid and in what intervals payment is to occur.[450]

Ultimately, the deliberations and implementation of structured settlements in both the case law and the SLAB reveal that structured settlements require extensive administrative clarity before they can form part of a compensation order.[451] In the interim, the *MSM* case reveals that government facilities may not be ready to fully implement the conventional reforms of structured settlements or treatment in kind. This failure is directly linked to the lack of

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[447] Ibid paras 203–6.

[448] Ibid paras 43–173 indicate a vast amount of empirical evidence required to facilitate and order compensation in kind; *AD* paras 39–655 the extent of administration and empirical evidence required to succeed in ordering structured settlements.

[449] Ibid *MSM* at 204.

[450] Ibid. The court in *AD* applied structured settlements and upheld constitutional values; the court in *DZ*: did not denounce the application of structured settlements on the basis that structured settlements do not contravene normative constitutional values; the court in *MSM* reinforces the trend supporting the application of structured settlements. In paragraph 203, the court states that there is no reason to not develop the common law to allow for structured settlements as it does not contravene constitutional principles. However, because insufficient evidence was adduced to reasonably provide for the structured settlements in *MSM*.

[451] DSC Attorneys op cit note 34 para 5; *MSM* supra note 152 paras 43–173; *AD* supra note 368 paras 39–655; Pieter Pauw op cit note 400 at 176.

administrative ability of the provincial governments to meet the needs of the SLAB. However, as the law leans towards socially responsive personal injury compensation schemes, how can the current suggestion of structured settlements, in particular, be properly strengthened to allow for a long-term and legally certain future that upholds the constitutional right to health care while still adequately compensating victims of medical malpractice? In the absence of a minimum core obligation, but with the rise of a socially responsive personal injury law in the medical malpractice arena, reasonableness is the only standard left to govern the successful implementation of a more permanent iteration of the SLAB. Although the SLAB is not envisioned as a long-term plan, the value of its short-term impact is questionable. Bear in mind that the aim of the legislature and the common law development is to transform the medical malpractice crisis without negative constitutional implications. In the case of structured settlements, this transformation presents itself in the form of a minimal financial benefit with various administrative issues.

While the law waits for the Constitutional Court to confirm or deny the *MSM* judgment, and while the legal fraternity waits for the SALRC to present a formal suggestion on the way forward for medical malpractice litigation, it is still necessary to seek more comprehensive measures of reform. As it stands, the SLAB (although an aspirational and necessary step), still presents itself as a flawed legislative proposal that calls for strengthening through additional research and deliberation, especially as it relates to the poor and vulnerable within South Africa.[452] By itself, the SLAB is insufficiently comprehensive and inflexible to remedy the socio-economic or legal concerns of the current medical malpractice crisis. However, recent court developments reveal that structured settlements and with it, treatment in kind, are constitutionally acceptable cost-reforms and they are ultimately here to stay.

While resources are being poured into strengthening the SLAB amidst ongoing SALRC research and the current common law development, surely a more permanent solution can be arrived at to support the cost-reforms. Ultimately, the trend within South Africa and abroad has been to adopt, at the very least, structured settlements as an answer to the adverse effects of the once-and-for-all rule. Understanding that this approach has far-reaching consequences in that

[452] Amnesty International op cit note 33 at 4–8.

it binds claimants and defendants alike to an agreement that may not bring the financial benefit hoped for. However, is it possible that the suggestion of structured settlements, with their few benefits, can be strengthened rather than be discarded? Can structured settlements, along with their variations and treatment in kind concerns be properly administered to achieve their desired effect? Surely, interested parties can sift through the discourse to salvage this approach instead of throwing it out with the bath water.

4 CHAPTER 4: COMPREHENSIVE REFORM: ADMINISTRATIVE STRUCTURES AND ALTERNATIVE DISPUTE RESOLUTION AND REVIEW MECHANISMS

It has been argued above that the SLAB is an administratively flawed response to the medical malpractice crisis. The Bill positions itself as a socially responsive legal instrument by attempting to remedy the medical malpractice crisis through the implementation of structured settlements. Unfortunately, as a result of the SLAB's administrative inefficiencies, its status as an interim measure undermines its effectiveness as a socially responsive measure. However, structured settlements and treatment in kind are still in line with the normative values of the Constitution; therefore, they cannot be wholly discarded. Instead, further reform should occur to operate alongside these cost-focused measures.

Where the administration of the proposed measure fails, its benefit will be lost thereby adding more trouble to the medical malpractice crisis and the poor standard of health care service delivery. The Bill only proposes structured settlements and treatment in kind which can be viewed as conventional reforms. Both of these suggestions address one element of the financial burden of medical malpractice cases: the once-and-for-all rule. By contrast, fundamental reforms, by their nature, seek to overhaul major elements of the system of litigation to create long-lasting reform that changes the entire practice to promote better financial and cultural habits throughout.

Such a comprehensive approach is necessary for South Africa. No-fault compensation schemes and alternative dispute resolution fall into the category of fundamental reform. However, as was explained above in chapter two, the remainder of this dissertation will focus on the latter category of fundamental reforms. Although no-fault compensation schemes may be attractive in principle, their financial viability is highly questionable in the present economic climate.[453] It, therefore, seems more practical to focus on supposedly less cost-intensive reforms which

[453] Op cit note 165.

bear prospects of success. Accordingly, this chapter discusses alternative dispute resolution and the administrative foresight that is necessary to achieve comprehensive reform.

The current iteration of structured settlements in the SLAB requires extensive and continuous deliberation from the courts. Such deliberations may instead be better located within an alternative dispute resolution process. However, large-scale alternative dispute resolution processes naturally require administratively efficient procedures.

Administratively efficient ADR methods have been employed by foreign jurisdictions to work alongside structured settlements to reduce the financial impact of medical malpractice claims. In New Zealand, for example, alternative dispute resolution methods are used to resolve medical malpractice cases, while also employing structured settlements to compensate their victims. Both structured settlements and ADR procedures work hand-in-hand to address the financial concerns that were caused by their own medical malpractice crisis to achieve comprehensive reform. This will be discussed in greater detail below.

This chapter is structured as follows. First, the notion of alternative dispute resolution ('ADR') in general is introduced, followed by an account of existing ADR mechanisms in South African law. Second, the chapter turns to consider two prominent ADR models in the context of medical malpractice liability in foreign legal jurisdictions, namely the United States and New Zealand. The latter system is explored in some detail before lessons are extracted for potential comprehensive reform in South Africa to accompany the existing introduction of structured settlements and with it, treatment in kind.

4.1 Alternative Dispute Resolution in General

Alternative dispute resolution is the practice of settling disputes outside of a traditional litigation procedure. ADR can be practiced through different methods (such as mediation or arbitration) in various industries, and the main benefit of ADR practices is that they are more expedient and cost-effective when compared with traditional litigation procedures.[454] There are

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[454] Mohamed A Chicktay & E Patelia *Appropriate Dispute Resolution* (2015) at 5–13.

many benefits of alternative dispute resolution that make it attractive for settling legal disputes. ADR is beneficial as it encourages self-determination within legal disputes; access to justice; and healthier relationships between the disputing parties, which creates space for a more amicable resolution that benefits all the parties involved.[455] Another benefit of alternative dispute resolution is that it offers a cost-effective and expedient resolution of disputes[456]. This is because it supposedly minimises the financial burden faced by claimants by avoiding the costs associated with waiting for a case to be heard due to the backlog of cases in the current litigious system. However, some disadvantages come with ADR practices, such as the inability to set a legal precedent; it is unwise if there is an imbalance of power between disputing parties, and certain parties may be implicated in a subsequent trial with an adversary if privileged information is divulged in the alternative dispute proceedings.[457] This inability threatens the legal certainty and finality that comes with resolving disputes in court. Thus, it is not guaranteed that ADR techniques will always be in the best interests of the disputing parties.[458] Ultimately, ADR provides for the efficient and cost-effective administration and resolution of disputes, which is helpful when there is an over-reliance on the courts.[459] In the case of medical malpractice reform, ADR measures will be able to assist parties with the resolution of their disputes without having to wait too long for their dispute to be heard by the overburdened courts.

4.2 Examples of Alternative Dispute Resolution in South African Law

This section will discuss ADR practices in South Africa within the specific context of medico-legal disputes through the lens of the Life Esidimeni arbitration and the Office of the Health

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[455] Laurence Boulle 'Promoting Rights Through Court-Based ADR?' (2012) 28 *SAJHR* at 2–3 and 16.

[456] Ibid at 3.

[457] Ibid at 1; Stella Vettori 'Mandatory mediation: An obstacle to access to justice' (2015) 15 *African Human Rights Law Journal* 355–57 and 360–64.

[458] Ibid at 355–57 at 360–63.

[459] Labour Relations Act No. 66 of 1995; John Grogan 'Dispute Resolution' in *Workplace Law* at 3, "Statutory intrusion into the common law of employment was inspired by a general realization that the law had lagged behind conditions in modern commerce and industry and, more recently, by recognition of fundamental human rights and their entrenchment in national constitutions"; Rules for the Conduct of Proceedings Before the CCMA; Andre van Niekerk, Nicola Smit & Marylyn Christianson, *et al*. 'Dispute Resolution' in *Law @ Work* 3 ed (2014) at 455-68; Chicktay & Patelia op cit note 454 at 5–6; Amos Tshabalala 'Media Statement on the CCMA 2018/2019 Annual Report Briefing' 14 October 2019 *https://www.ccma.org.za/Media/ArticleID/310/MEDIA-STATEMENT-ON-THE-CCMA-2018-19-ANNUAL-REPORT-BRIEFING* accessed on 14 October 2020.

Ombud. This is to illustrate the potential success of using ADR methods to resolve disputes outside the formal state litigation procedure.

Mediation refers to the process whereby a neutral third party assists disputing parties to achieve the resolution of their conflict outside of a traditional court structure.[460] The power of mediation is that the third party does not decide the matter for the disputing parties but assists them to settle the matter on the basis that neither party can 'win' the dispute and all of the disputing parties must agree to the final solution.[461] As mentioned above, mediation is a cost-effective and expedient alternative to the traditional civil litigation procedure, and it is seen as a beneficial method to adjudicate the relational conflicts of individuals. Unfortunately, precedent cannot be set in mediation proceedings, and this can be a disadvantage for future disputes that could rely on the decision-making of the proceedings.[462]

In 2020, the new Rule 41A was introduced into the Uniform Rules of Court implementing pre-trial mediation.[463] The objective of this rule is to assist parties in reaching an early settlement of their dispute without the intervention of the courts.[464] The landmark *MB v NB*[465] case illustrated the court's frustrations with lawyers for failing to expedite the resolution of matters through mediation practices.[466] Court rolls throughout the country have only increased in length drawing censure from the courts for the failure of counsel for not referring matters to mediation.[467] As mentioned above, mediation is a facilitated negotiation process that expedites the resolution of disputes outside of the traditional litigious structure.[468]

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[460] Vettori op cit note 457 para 2 at 357.

[461] Ibid at 360–63.

[462] Ibid.

[463] Rule 41A Uniform Rules of Court.

[464] Busisiwe Nhlapo, 'Mediate before you litigate' 28 June 2020 accessed https://www.financialinstitutionslegalsnapshot.com/2020/06/mediate-before-you-litigate/#:~:text=The%20new%20Rule%2041A%20requires,or%20opposes%20referral%20of%20the 16 April 2021.

[465] 2010 (3) SA 220 (GSJ).

[466] Ibid paras 48–61.

[467] Op cit Busisiwe Nhlapo note 464.

[468] Eugene Bester 'Mediation and arbitration – the way to resolve commercial disputes' 5 September 2012 accessed https://www.cliffedekkerhofmeyr.com/en/news/press-releases/2012/dispute/mediation-and-arbitration--the-way-to-resolve-commercial-disputes.html 16 April 2021.

Mediation is often a contracted process as it requires fewer formal steps than traditional litigation – sometimes even arbitration – to resolve disputes.[469] The expeditious nature of mediation makes it more affordable and thus more attractive to disputing parties – as well as the courts who have rebuked counsel for prolonging litigation often at the financial and personal cost of disputing parties.[470]

Regarding medico-legal litigation, the introduction of Rule 41A at this crucial time may serve as a beneficial reprieve, as it may indeed lessen the burden associated with the number of cases wound up in lengthy and costly litigation procedures. However, the implementation of this rule cannot act as a saving grace as certain issues accompany this rule. First, any agreement determined by mediation is non-binding, which means that it does not carry the same force as a court order.[471] Secondly, under Rule 41A, mediation itself is not compulsory.[472] The parties must only satisfy the court that they have attempted to refer the matter to mediation.[473] The parties must thus satisfy the court alongside their initial pleadings why they believe that the dispute should or should not be mediated.[474] Essentially, Rule 41A is a compulsory legal *suggestion* to mediate disputes. As mentioned above, in practice, where mediation does occur, the agreement is often confidential.[475] Thus, no education nor jurisprudential growth through precedent can extend from a concluded mediation agreement which may not benefit the learning efforts necessary in the medico-legal sector. Finally, the information divulged by all the parties in mediation proceedings is privileged.[476] Thus, if litigation ensues after a failed mediation, parties may not be able to plead vital evidence in traditional court proceedings.[477] Therefore, it may be better not to rely solely on Rule 41A mediation or alternative mediation proceedings to meet the concerns of the current medico-legal crisis.

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[469] Ibid.

[470] Op cit Busisiwe Nhlapo note 464.

[471] Op cit Laurence Boulle note 464 at 3, 9 (see footnote 18) and 14.

[472] Op cit Busisiwe Nhlapo note 464.

[473] Rule 41A(2)(a) – (b) of the Uniform Rules of Court; op cit Busisiwe Nhlapo note 464.

[474] Rule 41A(2)(c) of the Uniform Rules of Court.

[475] Op cit Busisiwe Nhlapo note 464.

[476] Op cit Busisiwe Nhlapo note 464.

[477] Ibid.

Arbitration differs from mediation as an alternative dispute resolution method. In arbitration proceedings, a skilled and independent arbitrator hears evidence on a particular matter and is empowered to make a final decision, based on a mutually agreed arbitration agreement.[478] Arbitration goes a step beyond the legal uncertainty of mediation by producing an independent and legally binding award in favour of one party based on the evidence presented.[479] This process may have more steps than mediation; however, it also operates as a flexible alternative for resolving disputes outside of traditional civil litigation proceedings, making it an expedient and cost-effective alternative to court litigation.[480]

4.2.1 The Office of the Health Ombudsman

This section discusses the current work of the Office of the Health Ombudsman ("the Ombudsman/ the OHO") to assist with the resolution of medical malpractice claims in South Africa.

The OHO is empowered by the National Health Act of 2013 to resolve medical malpractice complaints in an "economical, fair and expeditious manner" in response to the health care crisis and expansion of health care liability.[481] The OHO can recommend the use of ADR measures to achieve adequate resolution of cases.[482] The functions of the Ombud exists within the function of the Office of Health Standards Compliance and it is empowered to make recommendations to the CEO of the OHSC who is then required to ensure the implementation of these recommendations.[483] This is done to improve the health care standards and protect the public's right to access to health care.[484] The first Ombudsman was appointed in 2016 and it

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[478] Vettori op cit note 457; Boulle op cit note 455.

[479] 'Difference Between Arbitration and Mediation' available at http://bcicac.com/about/what-is-mediationarbitration/difference-between-arbitration-and-mediation/ accessed on 14 October 2020.

[480] Chicktay and Patelia op cit note 454 at 5–6; John Grogan op cit note 459 at 443–44 and 445–68 Eugene bester op cit note 468.

1 [481] Durojaye & Agaba op cit note 138 at 162.

[482] Ames Dhai 'The Life Esidimeni tragedy Arbitration award: A step in the direction of justice' *South African Journal Bioethics Law* 2018 11 (1) 3 at 3 "The Arbitration was established as a result of a recommendation by the health ombud, in his report that investigated the circumstances leading to the death of these patients."

[483] Ebenezer Durojaye & Daphine Kabagambe Agaba op cit note 138 at 162.

[484] Ibid.

assisted in the fair and expeditious resolution of the Life Esidimeni arbitration by recommending that alternative dispute resolution be used to address the issue of compensation after determining the gross violation of the right to health care.[485] However, Durojaye and Agaba argue that the Ombud's reach is limited as its powers of recommendation are limited to whether the CEO of the OHSC or - in serious cases - the Minister of Health prioritise the implementation of the recommendations.[486] This makes litigation more attractive in its application as results regarding compensation are guaranteed and not dependant on the priorities of the Minister or the CEO of the OHSC.[487]

The Ombudsman lacks its own central piece of legislation detailing the extent of its powers.[488] As a result, its function relies directly on the provisions of supporting legislation such as the National Health Act 61 of 2003 and the Constitution and this limits its enforcement powers.[489] However, the OHO has taken steps to improve its function by implementing a system of resolving disputes that is similar to the UK's Parliamentary Health Service Ombudsman to enforce claims and improve healthcare service delivery. [490] The programme is inspiring as it is taking clear and active steps to perform its function of expediting malpractice claims fairly and improving healthcare service delivery simultaneously.[491] The programme envisioned by the OHO is comprehensive and clearly co-ordinated as it accounts for its financial and staffing shortages to ensure that the Ombudsman's powers extend to all South Africans – privileged and underprivileged. Since the Ombud's inception, it has sought to progressively realise the right to healthcare by challenging the medical malpractice crisis through increased monitoring[492] and expediting and resolving claims fairly between the parties involved and also recommending health care improvements in dire cases.[493] However, the OHO's powers are limited by a lack of legislative foresight and enforcement capabilities.[494] In attempting to improve its function, the OHO has determined that it requires an estimated R64 million to be

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[485] Ibid.
[486] Ibid.
[487] Ibid.
[488] Durojaye & Agabe op cit note 138 at 165; OHO Annual Report op cit note 139 at 17.
[489] Ibid OHO Annual Report at 14.
[490] Ibid at 9.
[491] Ibid at 14, 23 and 26–9.
[492] Ibid at 13.
[493] Ibid at 15–6.
[494] Ibid at 17.

fully funded:[495] that is to improve its enforcement function and to address its current staff shortages to increase its ability to resolve claims.[496]

The Ombudsman, after receiving a complaint will investigate a claim and will make recommendations as to how the claim should proceed; however, it is not clear whether the OHO will *always* recommend ADR mechanisms to resolve disputes, as it did in the Life Esidimeni arbitration.[497] Thus, the OHO's powers will not always result in the swifter conclusion of cases.[498] In the Life Esidimeni arbitration, where the OHO made a recommendation to improve the healthcare facility and resolve the claim swiftly with the use of ADR, it was public interest that drove those calls for the swift resolution of those cases.[499] This calls into question the motivations of the OHO as not all cases can be politically motivated especially considering the volume of cases that the OHO could help to expedite.[500]

Nevertheless, the OHO's function should be extended through clear legislative provisions, not only to increase its enforcement powers as it hopes to do, but also to assist with the growing cost-reforms that are on the horizon as it cannot hope to achieve its aim of alleviating the medico-legal crisis without extending to manage the administration of new cost-reforms. If the OHO aims to address the medical malpractice crisis through expediting claims fairly, one would imagine that, with the new cost-reforms, complaints will come to the OHO regarding the administration of structured settlements, their variations and issues pertaining to treatment in kind. By extending the OHO's ADR functions to include more express and effective mediation or arbitration procedures to expedite claims that may arise. Additionally, express provision must be made to ensure that the judgments of serious cases are available to further the growth of the jurisprudence, like the Life Esidimeni arbitration below. In the Commission for Conciliation Mediation and Arbitration ("the CCMA")[501] we see express ADR provisions

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[495] Ibid at 3.

[496] Ibid at 14.

[497] Ibid at 11.

[498] Ibid at 16.

[499] Durojaye & Agaba op cit note 138 at 165–66.

[500] Ibid at 164–65.

[501] Rules for the Conduct of Proceedings Before the CCMA; Andre van Niekerk, Nicola Smit, Marylyn Christianson *et al*. 'Dispute Resolution' in *Law @ Work* 5 ed (2019) at 479–506.

(informed by the independent legislation Labour Relations Act 66 of 1995)[502] and ADR structures provided to resolve labour disputes outside of a traditional court procedure. The CCMA helps to expedite labour disputes on a wide scale by filtering out simpler claims through conciliation, mediation, and where necessary, arbitration.[503] Where claims are not settled through these ADR processes, claimants have access to review decisions in the Labour Appeals Court,[504] and the Constitutional Court, where necessary.[505] Thus, while formal ADR processes are not clearly envisaged through the OHO, they should be as the OHO is in the best position administratively and functionally to address the administrative inefficiencies that may arise when ordering structured settlements, structured settlement variations and treatment in kind on a larger scale. To date, the Ombudsman has not impeded the ordering of damages. It has only helped to facilitate and expedite the resolution of such claims. This is evidenced in the Life Esidimeni arbitration (discussed below). However, with the advent of structured settlements, structured settlement variations and with them, treatment in kind concerns, the OHO's functions should be extended through clearer legislative provisions (similarly to the CCMA) to process variation claims and treatment in kind issues, as its adjoining office, the OHSC, is already implicated in the SLAB's recommendation for ordering treatment in kind.[506] In this way, South Africa can promote comprehensive reform by marrying a more available fundamental reform procedure (i.e. the OHO's limited but existing administrative capabilities)[507] with the conventional cost reforms that have entered into the discourse on delictual cost reform.

4.2.2 The Arbitration in Life Esidimeni

The OHO, upon receiving a complaint about the Life Esidimeni irregularities sought to investigate the claims and made recommendations to improve the standard of healthcare.[508]

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[502] The Labour Relations Act.

[503] Chicktay op cit note 454, Grogan op cit note 459.

[504] "The Labour Court has the same status as a high court. The Labour Court adjudicates matters relating to labour disputes. Appeals are made to the Labour Appeal Court" *https://www.justice.gov.za/labourcourt/* accessed on 14 October 2020.

[505] Section 167 of the Constitution.

[506] Section 2A(2)*(c)* Bill 16 of 2018.

[507] OHO Annual Report op cit note 139 at 11.

[508] Malegapuru W Makgoba 'The Report Into the 'Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province' No Guns: 94+ Silent Deaths And Still Counting' para 10 at 54.

While the OHO does not provide express ADR practices, one of its recommendations was that the Life Esidimeni matter be arbitrated which saw to the expedited conclusion of the case alongside the ordering of normal compensation cost procedures.[509] Furthermore, access to the arbitration award was made readily available for further legal use, which circumvents the issues of precedent that usually impede the use of ADR practices.[510]

The Life Esidimeni saga is an example of how arbitration proceedings can be imputed to medico-legal cases in order to achieve the expedient resolution of a medico-legal case to meet the needs of the affected parties and uphold their various constitutional rights.[511] The arbitration of this case was overseen by the former Deputy Chief Justice of South Africa Dikgang Moseneke. In his report, he details the events of the case by illustrating the suffering of the various individuals who were unfairly subjected to inhumane health care conditions by members of the Department of Health.[512]

During 2017, certain mental health patients from various NGOs were moved from their care facilities (without informing their families) to less favourable facilities by order of the Department of Health as the NGOs in question could no longer afford to take care of their patients.[513] This process of relocating these patients was known amongst officials as 'The Marathon Project' ("the Project").[514] As a result of the inhumane removals that took place, multiple deaths occurred, and various patients were reported missing, revealing the grim nature of gross medical negligence: culpable homicide, murder, assault and kidnapping. From this explanation, the "treacherous"[515] and inhumane levels of clinical and departmental negligence

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[509] Ibid.

[510] In the Arbitration Between: Families of Mental Health Care Users Affected by The Gauteng Mental Marathon Project and The National Minister of Health of The Republic Of South Africa, The Government of The Province of Gauteng Premier of The Province Of Gauteng, and The Member of The Executive Council Of Health: Province of Gauteng (2018) ("Life Esidimeni Arbitration Award") *http://www.saflii.org/images/LifeEsidimeniArbitrationAward.pdf* accessed on 14 October 2020; Ron Paterson 'The Patients' Complaints System In New Zealand' *Health Affairs* (21) No.3 at 75 and 78; Durojaye & Agaba op cit note 138 at 165.

[511] Ibid paras 1–4.

[512] Ibid.

[513] Ibid.

[514] Ibid para 4.

[515] Ibid paras 42, 60 and 220.

are embarrassingly evident.[516] Steps to subsidise these struggling NGOs were hampered, and it is clear that mass corruption ensued leading to the blatant disregard of patient safety.[517]

The Life Esidimeni saga shows how various constitutional rights can be infringed upon in medico-legal incidences, such as the right to bodily integrity, the right to dignity, the right to equality and ultimately, the right of access to health care.[518] There are many accounts of the painful experience of the patients in the arbitration report, which led the honourable judge to question what the government's obligations are toward mental health patients in South Africa. Moseneke writes that the interpretation of the domestic constitutional or human rights obligations should be in line with international law.[519] He first references the preamble of the United Declaration of Human Rights ("UDHR") which asserts the inherent dignity of all human beings and states that the failure to safeguard this inalienable right is inhumane as it creates room for "barbarous acts" against humanity.[520] He then references various other international declarations, proclamations and enactments such as the African Charter on Human and Peoples' Rights;[521] the Convention on the Rights of Persons with Disabilities;[522] the 1991 United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care;[523] and finally South Africa's own Constitution.[524] He does this to explain that the de-institutionalisation of mental health care facilities is expensive and therefore should not have been undertaken carelessly without having regard to the constitutional rights of the patients whose lives and rights may be affected by an ill-strategised plan.

The lack of accountability during The Marathon Project led to the perpetration of these heartbreaking events, and it was speculated that the Project was a corruption scheme that sought to siphon government funds meant for health care facilities, which resulted in gross

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[516] Ibid paras 80 and 199–201.

[517] Ibid para 76.

[518] Ibid paras 75–80 and 143; ibid footnote 15 at 3.

[519] Ibid paras 142–48.

[520] Ibid para 143.

[521] Ibid paras 143–45.

[522] Ibid paras 146–47.

[523] Ibid paras 148–54.

[524] Ibid paras 154–59.

human rights violations in the form of medical negligence, as the intention of the Project was still being misrepresented by the officials involved.[525] This discussion showcases the significance of the social justice and human rights considerations that can be impugned by the defendants in medico-legal cases. The subsequent order that was given attempted to address these constitutional concerns.

The award was as follows: a lump sum payment was awarded along with various orders relating to the different classes of applicants.[526] Along with damages awards sounding in money, Moseneke also ordered the Gauteng MEC for Health to institute a recovery plan to promote better service provision for mental health patients. Moseneke states that this plan aims "to achieve systemic change" for those who rely on the government's mental health care facilities.[527] This case carries further significance because it gave a directive to the state to improve its service provision for future mental health care users.[528] Through this judgment, Moseneke rooted out corrupt and negligent governmental behaviour while also addressing the constitutional issues that are evident in the health care system today. Furthermore, using arbitration as an alternative dispute resolution method allowed the case to be settled more promptly as opposed to a case that would have had to go through the High Court (with possible appeals) before it could reach the Constitutional Court to discuss the constitutional issues that were prevalent within the case. The parties were able to receive an order for compensation sooner than they would have if they relied upon the turnover time of the current litigation procedure available to adjudicate medico-legal claims because following the Ombud's reports, the arbitration proceedings started on the 9th of October 2017 and were finalised on the 19th of March 2018, which shows that the proceedings took less than one year to settle.[529] This success pales in comparison to the fact that it takes a substantial amount of time to settle medical

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[525] Ibid paras 201–8.

[526] Ibid para 226.

[527] Ibid para 226, "7. (a) Pursuant to the undertaking, by the member of the Executive Council for Health, Gauteng Province, Dr Gwen Ramokgopa, the Government is ordered to provide to the Health Ombud (appointed in terms of section 81 of the National Health Act 61 of 2003) and the claimants listed in Annexures A, B and C or their representatives the recovery plan whose purpose is to achieve systemic change and improvement in the provision and delivery of mental health care by Department of Health in the Province of Gauteng. The parties to these proceedings are permitted to share the recovery plan with interested members of the public. (b) The Government is ordered to report to the Health Ombud and to the claimants within 6 (six) months of the publication of this this Award, and thereafter every six months until the conclusion of the recovery plan."

[528] Ibid.

[529] Life Esidimeni Arbitration Award op cit note 510 paras 2–4.

malpractice cases.[530] The honourable judge gave a directive to the Department of Health to improve its services and compensate the claimants without the time-consuming and financial burden of the traditional court procedure to hamper the prompt settlement of a widely denounced and constitutionally relevant medical negligence case. [531]

Ultimately, the existence of ADR and the apparent efficiency of the Life Esidimeni process with the help of the OHO, indicate that an ADR system with effective administrative oversight can eliminate court expenses; promote expedient resolution of claims; provide real compensation to those injured parties and recommend improved health care provision. This is a patient-centered approach that uplifts those in need and the health care sector while promoting true accountability in medical malpractice cases. Ultimately, the use of ADR methods would promote expedient and cost-effective administration of medico-legal claims in terms of section 34 of the Constitution.[532] Furthermore, since the ADR methods discussed above deal directly with the adjudication procedure, they can act as companions to structured settlements and treatment in kind as they tackle the weaknesses of the civil litigation procedure as well as the costs associated therein.[533]

4.3 Alternative Dispute Resolution in Foreign Law

This chapter now turns to consider two prominent informal ADR models which ultimately amount to more comprehensive reforms of medical malpractice liability that have been adopted by certain states in the United States of America and New Zealand. The following discussion aims to showcase how alternative dispute resolution can be actively incorporated into medical malpractice disputes to promote the efficient and socially responsive resolution of medical malpractice claims.

4.3.1 The United States of America ("USA")

[530] Issue Paper 33 op cit note 1 para 2.31–2.32 at 21–2.
[531] Life Esidimeni op cit note 510 para 226.
[532] Section 34 of the Constitution.
[533] Malegapuru op cit note 508 at 54.

In certain American states, there is an example of a medical malpractice mediation system known as the Communication and Resolution Programme ("CRPs") which is designed specifically to deal with personal injury claims resulting from medical malpractice incidents.[534] CRPs incorporate less formal alternative dispute resolution measures alongside apology laws and in certain instances, no-fault compensation measures or caps on damages. The benefit of exploring CRPs in this dissertation is that they showcase how alternative dispute resolution works alongside other reform methods, such as no-fault compensation or limitation on damages. Alternative dispute resolution in the form of CRPs assists the participants in medical malpractice disputes in seeking a healthier resolution of malpractice claims. An essential aspect of CRPs, in general, is that they promote apology laws in the United States because they prohibit undue findings of fault on behalf of the defendant, which allows defendants to continue their medical practice more responsibly going forward.[535] They are also effective because they are, in a way, specific campaigns that promote the healthy and effective resolution of personal injury claims, so long as they keep on track with the main themes of open disclosure and equitable bargaining for compensation.[536]

Certain hospitals have implemented CRPs as an innovative approach to combat the emotional and logistical issues of a normal litigation process. The real success of this system lies in its expediency and its ability to promote open and honest communication between the opposing parties. The ensuing discussion will evidence that alternative dispute resolution methods in the form of CRPs s are beneficial to all parties involved.[537] CRPs were first tested in 1987 in

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[534] Ibid; Joseph Kass & Rachel Rose 'Medical Malpractice Reform: Historical Approaches, Alternative Models, and Communication and Resolution Programs' *https://journalofethics.ama-assn.org/article/medical-malpractice-reform-historical-approaches-alternative-models-and-communication-and-resolution/2016-03* accessed 14 October 2020.

[535] Ibid.

[536] Ibid "CRPs are one innovative approach to medical malpractice reform that address both patient and institutional needs. CRPs require, however, a culture shift in the medical community and a management of expectations on the part of injured patients who may be anticipating larger payouts than they are offered in this type of system. CRPs also require a favorable legal environment; they work best if "apology laws" explicitly protect clinicians and health institutions from penalty for discussing adverse events openly and honestly with patients and their families."

[537] Ibid, "A number of health care institutions have experimented with a unique twist on ADR by developing communication and resolution programs (CRPs), novel approaches to addressing medical error that have paid off in terms of the costs associated with malpractice litigation [31-34]. These programs encourage open communication and transparency with patients and their families and facilitate restitution for injured parties when appropriate. They also support physicians in disclosure conversations with patients; "American Medical Association Journal of Ethics available at https://journalofethics.ama-assn.org/article/medical-malpractice-

Virginia, USA at Lexington VA hospital. Through the implementation of this process, the hospital managed to reduce its clinical negligence pay-outs by approximately 15%[538] in comparison to other health care institutions in Virginia at the time. The duration of the cases also decreased considerably to less than half of the average litigation period.[539] The implementation of a healthier claims process led to a decrease in the time and money that would usually be spent on these cases. Thus, the implementation of these alternative dispute resolution methods allowed this hospital to manage and address the main issues that are prevalent within medico-legal litigation, which are: the efficacy of the process, the cost of the litigation process and the quantum of damages for medical malpractice claims.

Following on from the successful implementation of these CRPs, other institutions began to implement CRPs outside of Virginia, which resulted in two approaches to practicing and implementing CRPs. According to the American Medical Association, a CRP can be implemented as an early settlement model, or in the form of a limited reimbursement.[540] The early settlement model is divided into the following four components: the first is "acknowledging when patients are injured due to medical error."[541] The second component is "compensating fairly (commensurate with the degree of harm) and quickly when there is a deviation from the standard of care.[542] The third is "aggressively defending against meritless cases," and the final component consists of "studying all adverse events to determine how health care delivery can be improved."[543] Thus CRPs provide a comprehensive and fair approach that attempts to engage with medical malpractice disputes without creating a system riddled with issues of unbalanced bargaining power.

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reform-historical-approaches-alternative-models-and-communication-and-resolution/2016-03, accessed on 30 August 2019.

[538] Ibid, "With the implementation of this program, the Lexington VA became the VA hospital with the lowest payouts. Between 1990 and 1996, the average settlement per claim in Lexington was approximately $15,622 [33], whereas in other VA institutions it was $98,000. Additionally, the average duration of cases decreased from 2-4 years to 2-4 months."

[539] Ibid.

[540] Ibid.

[541] Ibid.

[542] Ibid.

[543] Ibid.

This early settlement CRP model was implemented at the University of Michigan Health System ("UMHS") in the United States.[544] This university hospital provides insurance for all of their physicians, which means that the university defends the medico-legal cases instead of the physicians in their private capacity.[545] Payments are made on behalf of the institution as well.[546] The value of the hospital defending their physicians ensures that the information of the negligent practitioner is retained by the institution instead of being recorded in the National Practitioner Database Bank ("NPDB").[547] Consequently, this safeguards the practitioner's reputation, and in turn, it promotes professional security which encourages practitioners to stay in practice.[548] While this early settlement CRP model encourages practitioners to stay in practice, it does not do so at the expense of good service delivery. This is because the early settlement model studies all adverse events in order to improve health care delivery.[549] By adopting this CRP model, the UMHS also saw a decrease in the procedure time and the quantum of damages associated with their medical malpractice claims, which is a goal for the South African health care sector as well.[550] Thus, the early settlement CRP model promotes accountability, improved health care and improved dispute resolution, which are key factors in reforming medical malpractice litigation in line with the values of dignity and access to socio-economic rights.

An example of the second model of a CRP is a limited reimbursement programme which was first implemented by the COPIC Insurance Company in Colorado.[551] The COPIC Insurance Company operates as a medical liability insurer in the United States. The COPIC Insurance

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[544] Ibid.

[545] Ibid, "Because the payments are made on behalf of the institution only, they are not reported to the National Practitioner Data Bank (NPDB). This operational detail is significant because the NPDB, which was created by Congress, "contains information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers, and suppliers." It is publicly available information that may affect a physician's reputation and follows a physician throughout his or her career. By not reporting this information to the NPDB, UMHS reduces an important barrier to physician participation in this CRP."

[546] Ibid.

[547] Ibid; Michelle M Mello, Richard C Boothman & Timothy McDonald *et al.* 'Communication-And-Resolution Programs: The Challenges and Lessons Learned from Six Early Adopters', Health Affairs 33, No. 1 (2014) at 21—2 and 28. Mello MM *et al*. describe the practice where practitioner's payments are still reported to the NPDB; however, as J Kass *et al*. explains (note 531), this report is only in the institutions name.

[548] Ibid.

[549] Mello MM op cit note 547 at 23–4.

[550] J Kass op cit note 534.

[551] Ibid.

Company's limited reimbursement programme addresses two main points of medico-legal litigation, namely the compensation of the basic needs of the injured party and a more efficient claims process based on three pillars to "recognise, respond and resolve" conflict.[552] The "recognise, respond and resolve" is also known as the 3Rs campaign.[553] Additionally, this CRP model includes elements of a cap system (which is a conventional reform method), because once the negligent event is reported, the injured party will receive compensation to cover their "out-of-pocket expenses" which cannot exceed 25 000 dollars, in addition to open disclosure of how the damage occurred.[554] Like the early settlement CRP model, the defendant does not receive a judgment of fault in his/her individual capacity, which means that these cases are not required to be recorded with NPDB.[555] This adds another layer of professional indemnity for the physician.[556] The implementation of this limited reimbursement programme CRP model has led to a significant decrease in litigious proceedings and a decrease in the quantum of damages payable.[557] This CRP model also encourages and trains (but does not force) disclosure on the part of physicians, and the result of this is that the human relationship between patients and doctors has remained mostly intact.[558] However, injured parties do reserve the right to sue the physician in their personal capacity if they so desire, which promotes fairness for the injured party as well as greater access to justice if they so desire it.[559] This CRP model implements an ADR process alongside the option to approach courts and a cap on the damages payable. This is done to achieve fair compensation; resolve conflicts outside of a formal court procedure

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[552] Ibid.

[553] Ibid, "The model employed by COPIC Insurance Company, a large medical liability insurer in Colorado, is an example of a limited-reimbursement model, the second type of CRP. In 2000 COPIC developed its 3Rs program—Recognize, Respond, and Resolve—to address situations in which their enrollees' patients were unsatisfied with their health outcomes."

[554] Ibid, "When patients suffer adverse outcomes they receive a disclosure of what occurred and compensation for out-of-pocket expenses not covered by insurance (up to $25,000) and for lost time (up to $5,000)."

[555] Mello MM *et al.* 'Communication-And-Resolution Programs' op cit note 547 at 24.

[556] Ibid.

[557] J Kass op cit note 534, "From October 2000 to October 2007, there were 4,800 qualified events, with 1,026 patients receiving payments averaging $5,286. Seven paid cases were litigated, and only two resulted in tort compensation. Sixteen unpaid cases were litigated, and six resulted in tort compensation. Anecdotal evidence and survey data suggest to the COPIC leadership that the system is successful. The majority of physicians and patients find the system effective and only a small fraction of cases that go through the 3R system evolve into litigated and compensated claims. Because of the open disclosure and compensation, the animosity between the injured patient and the physician appears to be reduced, and many patients maintain their therapeutic relationship with their physician. "

[558] Ibid.

[559] Ibid.

where possible; protect the financial standing of the medical workforce as well as improve the provision of health care going forward.

The practice of CRPs has extended to various states since its implementation in Virginia and Michigan, but the results have been varied especially among institutions who failed to properly support the initiative.[560] It was further reported that certain institutions felt that this alternative resolution measure could operate without tort reform measures such as caps on damages.[561] This further illustrates that fundamental reform, if implemented successfully can limit the expansion of liability and improve health care provision. Nevertheless, institutions that applied CRPs were encouraged to apply metrics to improve the system over a long period of time as the system has proved beneficial in certain instances and there is a willingness to improve upon the programmes.[562] Thus, the ability to create and implement policy that accounts for systemic and ethical considerations present within medical malpractice disputes and the standard of health care can be achieved on a fundamental level through the application of administratively efficient ADR procedures.

Ultimately, CRPs allow for restorative dispute resolution that has not only contained the costs of medical malpractice, but they have also led to a decrease in medical malpractice claims. By addressing the negative litigation culture associated with medical malpractice disputes, these hospitals were able to address the costs associated with the medical malpractice claims as well, thereby allowing them to achieve their health care mandate. The example of CRPs shows that patient care and patient autonomy remained at the centre of the measures used by the hospitals to limit or manage financial crises stemming from the traditional litigation approach. Additionally, the choice to pursue legal recourse was not taken away from patients in CRPs, and furthermore, the measures implemented assisted the injured party to resolve her case fairly without unduly affecting the hospital's ability to provide adequate healthcare.[563] CRPs

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[560] Michelle M Mello, Stephanie Roche & Yelena Greenberg *et al.* 'Ensuring successful implementation of communication-and-resolution programmes', BMJ Qual Saf 2020 at 4–6.

[561] Mello MM *et al.* op cit note 547 at 26.

[562] Thomas H. Gallagher, Michelle M Mello & William M. Sage *et al.* 'Can Communication-And-Resolution Programs Achieve Their Potential? Five Key Questions' Health Affairs 37, No. 11 (2018) 1845 at 1846–48 and 1850.

[563] Ibid 'Abstract' at 1845.

showcase that a comprehensive response should be implemented according to the needs and the means of the health care institution. Thus, when addressing the legal elements of a medical malpractice crisis, the well-being of the participants must be at the centre of the decisions. Furthermore, CRPs showcase that ADR measures allow for systemic change that is based on values that mirror the normative values of South Africa's Constitution. CRPs illustrate the ability for philosophical and social values to be quantified and applied effectively. However, their reach is limited as they are not practiced on a national scale or with uniform support across the USA.[564] Similarly, the OHO encumbered by financial constraints and staff shortages and minimal legislative power has limited reach and cannot extend its powers to assist with the greater expedition of managing claims and easing the current medical malpractice health care crisis.

[564] Ibid at 1850.

4.3.2 New Zealand

Following below is a discussion of the benefits of the different alternative dispute resolution mechanisms and administrative structures adopted in New Zealand on a national scale. New Zealand, faced with a similar medical malpractice crisis (within a larger personal injury crisis), embarked on a process to deconstruct the common law procedure altogether and dismantled their personal injury law system altogether. New Zealand created a claims and compensation network that operates on a mixture of conventional and fundamental reform, thereby creating comprehensive reform. New Zealand has managed to implement an extensive administration and alternative dispute resolution structure alongside structured settlements, lump-sum payments and a no-fault compensation scheme in order to provide their citizens with a socially responsive and comprehensive personal injury claims system.

Legislative reform around personal injury claims began in New Zealand in the 1970s with an attempt to significantly change the application of tort law principles to their personal injury claims within the country.[565] The legislature implemented a comprehensive compensation structure consisting of structured settlements and a no-fault compensation scheme to handle personal injury claims.[566] The Accident Compensation Commission ("the ACC") established by the Accident Compensation Act 43 of 1972 empowers this no-fault regime to provide both structured settlements and lump-sum payments.[567] The Accident Compensation Corporation that processes all personal injury compensation complaints, and all practices governing compensation is now governed by the Accident Compensation Act 49 of 2001 ("the ACA").[568] This comprehensive system marries the benefits of no-fault compensation schemes with structured settlements and alternative dispute resolution to achieve fair compensation for injured parties while protecting the defendant's financial cash flow.[569] The lawmakers at the time believed that the law of delict was an unsatisfactory tool to manage the personal injury claims process.

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[565] Geoffrey Palmer 'Compensation for Incapacity: A Study of Law and Social Change in New Zealand and Australia' at 23–32.

[566] The Accident Compensation Act No. 43 of 1972 was amended by the Accident Compensations Act of No. 49 of 2001.

[567] Ibid.

[568] Ibid.

[569] J.A Henderson Jr, 'The New Zealand Accident Compensation Reform' at 787–94.

In the 1960s, the Royal Commission put forward its suggestions to deal with all personal injury claims that consisted of a comprehensive system whereby fault did not need to be proven to claim for compensation resulting from a personal injury claim (including medico-legal claims), and where structured settlements can be ordered to compensate the injured party for the damage that they have suffered.[570] The Royal Commission at the time laid out that funding for structured settlements and future expenses would be covered by collecting tax to cover the compensation fees for the public health care sector – thereby implementing a no-fault compensation scheme.[571] This was to ensure that defendants were not left with the burden of paying damages to injured parties that they could not afford. The lawmakers and the Royal Commission aimed to offer compensation to injured parties of the general public through a community-centred approach that protects the dignity and well-being of New Zealanders.[572] However, with consideration to the high volume of medico-legal claims over the years, New Zealand had to establish an additional dispute resolution system (known as the Health and Disability Commissioner ("the HDC")) to specifically process medical malpractice claims that breach the standard of care owed to patients.[573] This system was established to improve the resolution of medical malpractice injury claims.[574] Nevertheless, even with all of these reforms and the years that New Zealand has had to address any political, administrative and financial difficulties presented by these reforms, medical malpractice claims have not necessarily decreased.[575]

Personal injury law reform came to New Zealand through the Royal Commission's Inquiry into the failures of the common law process to properly compensate victims of personal injury accidents. As a response to the Royal Commission's report, Sir Owen Woodhouse published a

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[570] Personal Injury: A Comment on the Report of the Royal Commission of Inquiry (1969) at 9, 13–17 and 45.

[571] Ibid at 38–41.

[572] Ibid at 45; Preamble of the Constitution.

[573] Health and Disability Commissioner accessed from *https://www.govt.nz/organisations/health-and-disability-commissioner/* on 14 October 2020.

[574] Donna Chisholm, 'New Zealand's bitter pill: No justice for medical negligence': "Patients and their families harmed by substandard health care can't sue and aren't getting justice through the country's complaints system", available at noted.co.nz accessed 14 October 2020.

[575] Katherine Wallis & Susan Dovey, 'Under a system of no-fault compensation for medical injury, is fear as a driver of overdiagnosis diminished?', available at https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=232013 accessed 14 October 2020.

report that promoted a socially responsive approach to personal injury law.[576] This report is now referred to as The Woodhouse Report.[577] In short, the Woodhouse Report provided a social contract between the government and the public whereby the public forfeit their right to sue for personal injury (including medical malpractice injuries) accidents in favour of a socially responsive no-fault compensation personal injury scheme that is focused on improving the well-being of New Zealanders.[578] The Woodhouse Report can be categorised into the following five core principles:[579]

1. community responsibility;
2. comprehensive entitlement;
3. complete rehabilitation;
4. real compensation;
5. and administrative efficiency.

What these principles illustrate is that effective personal injury reform should support greater community values, and effective administration must be successfully envisioned and grafted into that reform. These principles from the Woodhouse Report are fully compatible with the normative values of dignity and equality that enshrine the South African Constitution, as well as the right to health care as it pertains to both the positive and negative obligation to provide the right to health care by implementing effective reforms and guarding against regressive healthcare and malpractice practices.[580] Following the publication of the Woodhouse Report, New Zealand has gone on to implement a personal injury review process and compensation scheme, abandoning their traditional tort procedure.[581] For this reason, New Zealand's approach to personal injury law provides an effective framework for the comparative assessment of the benefits of comprehensive medical malpractice reform through efficient

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[576] Richard Gaskins 'Reading Woodhouse for the Twenty-First Century' (2008) 11 *New Zealand Law Review* at 12, "The Woodhouse Report states several times, in clear language, that it is not trying to solve a legal problem, but rather a social problem."

[577] Ross Wilson, 'The Woodhouse Vision - 40 Years in Practice' (2008) 3 *New Zealand Law Review* at 3.

[578] Ibid Wilson at 3.

[579] Accident Compensation Symposium, 'Accident Compensation 40 Years On - A Celebration of the Woodhouse Report (Compensation for Personal Injury in New Zealand, Report of the Royal Commission of Inquiry)', *New Zealand Law Review* (2008) at 1.

[580] Preamble of the Constitution; sections 2 and 27 of the Constitution.

[581] 'Accident Compensation Symposium' op cit note 565 at 1–2.

administrative action and alternative dispute resolution. What New Zealand's injury reform showcases is that achieving the high ideals of community responsibility, comprehensive entitlement, complete rehabilitation, real compensation and administrative efficiency require an incredible amount of comprehensive administrative power and foresight to enable any fundamental reform such as alternative disputes resolution,[582] which the OHO lacks. The ACC and the HDC are the two main agencies created to process medical malpractice disputes in New Zealand.[583] Within these two structures, there are different claims processes, review methods, legal involvements and approaches to damages.[584] Both agencies and their approaches have been developed in accordance with the Woodhouse Principles.[585]

The ACC itself aims to compensate victims of personal injury without finding fault, thereby reducing the length of the common law process and offering compensation to victims through a tax-funded scheme.[586] This scheme not only seeks to compensate victims, but it seeks to assist them in returning to an independent way of living through social and vocational rehabilitation.[587] However, while the ACC was formed and developed over the years to

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[582] Ibid. Following the enactment of the ACA, the Accident Compensation Corporation was established. After which, the Health and Disability Commissioner was established; Margaret McClure, "A Decade of Confusion: The Differing Directions of Social Security and Accident Compensation 1969 – 1979" (2003) 34 *Victoria University Wellington Law Review* 269 at 269.

[583] Refer to the HDC section and the ACC section at 88–98 below.

[584] Ibid.

[585] Joanna Manning 'Access to Justice for New Zealand Health Consumers' at the HDC Medico-Legal Conference: A Decade of Change (2010), Wellington at 1 and at 16–8.

[586] Ross Wilson op cit note 577 at 7.

[587] Section 70 of the ACA, "Claimant's and Corporation's obligations in relation to rehabilitation

A claimant who has suffered personal injury for which he or she has cover—

(a) is entitled to be provided by the Corporation with rehabilitation, to the extent provided by this Act, to assist in restoring the claimant's health, independence, and participation to the maximum extent practicable.

Section 79, "Purpose of social rehabilitation: The purpose of social rehabilitation is to assist in restoring a claimant's independence to the maximum extent practicable."

Section 80, "Purpose of vocational rehabilitation

(1) The purpose of vocational rehabilitation is to help a claimant to, as appropriate,—

(a) maintain employment; or

(b) obtain employment; or

(c) regain or acquire vocational independence.

(2) Without limiting subsection (1), the provision of vocational rehabilitation includes the provision of activities for the purpose of maintaining or obtaining employment that is—

(a) suitable for the claimant; and

(b) appropriate for the claimant's levels of training and experience."

compensate victims of all personal injury accidents, it was still encumbered by a large number of medical malpractice claims.[588] Unfortunately, the process of reviewing and resolving the large number of medical malpractice claims slowed the ACC's goal to settle all personal injury claims with administrative efficiency.[589] These growing concerns led the New Zealand government to create the HDC whose goals are linked to the ACC and the Woodhouse Principles.[590] In fact, the HDC's "statutory injunction is to achieve fair, as well as simple, speedy, and efficient resolution"; however, it does not compensate injured or aggrieved individuals for their harm.[591] While these two institutions have very separate agendas and processes, they operate in tandem to achieve comprehensive reform by marrying several ADR systems with cost-reforms to offer fair compensation and improve health care and disability services. Both the HDC and ACC processes are discussed below in more detail.

4.3.3 New Zealand continued: The Health and Disability Commissioner

The administrative nature of the HDC shows how medical malpractice incidents can be dealt with outside of a traditional court procedure.

Breach of the Code: "Dignity, Respect, Communication"[592]

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[588] Op cit "Access to Justice for New Zealand Health Consumers" at 15–7.

[589] Ross Wilson op cit note 577 at 6.

[590] Joanna Manning op cit note 585 at 17–21.

[591] Joanna Manning op cit note 585 at 5.

[592] Right 4 of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) 1996 ("The Code of Rights"):

Right to services of an appropriate standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

In place of an action for finding fault, a Code of Rights provides a standard of care for all health and disability practitioners and facilities to uphold.[593] In instances where the Code is breached, a claimant or an aggrieved person may institute a claim with the HDC to remedy the breach.[594]

In comparison, the OHO does not have a central piece of legislation code for claimants to determine whether their health care rights have been breached. Instead, the OHO relies on claimants to contact them if there is a belief of wrongdoing. However, this is not the worst-case scenario as the OHO's standards for health care are determined by the Constitution and the National Health Act. The common law also determines the involvement of the OHO as showcased in the Life Esidimeni arbitration.

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[593] Ibid.

[594] Para 1.2 "Assessment of Your Complaint" from Health and Disability Commissioner at *https://www.hdc.org.nz/making-a-complaint/complaint-process/* last accessed on August 23, 2020.

4.3.3.1 Assessment of claims:

A Complaints Assessor will be assigned to a complainant's case and will be in contact with the complainant regarding their case.[595] Another Complaints Assessor can contact a complainant or aggrieved person about their case.[596] Likewise, an Administrative Assistant, or a Legal Advisor, the Commissioner or the Director of Proceedings can contact a complainant about their case.[597]

4.3.3.2 The review process

The HDC will assess claims by using one or more of the following methods:[598]

1. A determination will be made on whether the Commissioner has jurisdiction to assess a claim.[599]
2. A copy of the complaint will be sent to the health or disability services provider who the claimant believes has breached the Code and the complaint is sent to obtain a response from the health care and disability service provider.[600]
3. The HDC will request further information about a complainant's health from the complainant or relevant health bodies. [601]
4. An independent expert will review a complainant's case and provide the Commissioner with expert clinical advice concerning a claim.[602]

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[595] Ibid.

[596] Ibid

[597] Ibid.

[598] Ibid para 1.3 "Complaints assessment process".

[599] Ibid, "Assess your complaint to determine whether it is something that the Commissioner can look at (that is, whether the Commissioner has jurisdiction)."

[600] Ibid, "Send a copy of your complaint to the provider of the health or disability service (the person and/or organisation you are complaining about), and ask the provider for a response."

[601] Ibid, "Ask you and/or other relevant people and/or organisations for additional information, for example we may ask the relevant District Health Board for a copy of your medical records. Sometimes a number of requests for additional information are necessary."

[602] Ibid, "Ask an independent expert to review your care and advise the Commissioner about clinical aspects of the services you received."

The assessment/review process of a claim can last from a few days to approximately six months depending on the complexity of a claim.[603]

4.3.3.3 Outcomes arising from the claims assessment process[604]

Various outcomes are reached either during or following the assessment of a claim.

1. An advocate can assist a claimant by concluding their claim with the service provider who was in breach of the Code of Rights.[605] The results of this outcome will then be reported to the HDC.[606]
2. The complaint can be resolved between the claimant and the health and disability services provider.[607] The results of this outcome will then be reported to the HDC.[608]
3. An apology may be given to the claimant. [609]
4. A claim can be sent to a relevant governing body.[610]
5. A claim may be formally investigated.[611]
6. No action may be taken if the Commissioner deems it unnecessary to do so.[612]
7. The Commissioner is also empowered to make any other decision that applies to the relevant claim.[613]

This process operates independently of a formal legal process to ensure the efficient resolution of a breach of the Code.[614]

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[603] Ibid, "The complaints assessment process may take anywhere from a few days to several months, depending on the complexity of your complaint (such as whether it is about several different providers) and the issues that arise during our assessment. In most cases, this part of our process will be completed within six months."

[604] Ibid para 1.4 "Possible Outcomes".

[605] Ibid, "Send the complaint to an independent advocate to assist you with resolving your complaint directly with the provider of the service (the outcome of these referrals will be reported back to HDC)."

[606] Ibid.

[607] Ibid, "Send the complaint to the provider of the health or disability service for resolution between yourself and the provider (the outcome of these referrals will be reported back to HDC)."

[608] Ibid.

[609] Ibid, "Take an educational approach, and ask for an apology or recommend action."

[610] Ibid, "Send the complaint to another agency, such as the Ministry of Health, a registration authority (such as the Medical Council of NZ), the Privacy Commissioner, or a Mental Health District Inspector.

[611] Ibid, "Formally investigate your complaint."

[612] Ibid, 'Take no further action on your complaint (if, for example, the provider has already addressed the issues, the events occurred a long time ago, or someone else could deal with it better)."

[613] Ibid, "The Commissioner may also suggest to you other things you could do to try to resolve your complaint (for example, going to the Disputes Tribunal to recover money you may be owed)."

[614] Right 4 of the HDC Code of Rights.

The OHO's process of conflict resolution is not as clearly stipulated as that of the HDC. Rather, the OHO assists the claimants with resolving cases between the claimant and the health care provider. The OHO, like the HDC can recommend that the health care provider improve their service provision in the future, which is paramount to providing safe and effective health care to South Africans.

4.3.3.4 Compensation[615]

The Commissioner cannot order compensation for personal injury claims as that function remains with the ACC.[616] Claimants are therefore encouraged to seek compensation directly from the ACC.[617] However, if at any point, a Commissioner determines that compensation is the desired outcome, the claim will be forwarded to the ACC to allow the claimant or the aggrieved person the opportunity to receive compensation.[618] The OHO does not have compensatory powers either; however, the OHO's system is designed to make recommendations that allow for compensation to take place according to the common law.[619]

4.3.3.5 Formal Investigation[620]

The Commissioner will require a formal investigation of a claim in limited instances to promote the efficient and fast resolution of claims.[621] Where a formal investigation is required, all relevant parties will be informed, and the Commissioner will allow a health and disability services provider to respond to the content of the claim.[622] The Commissioner will then assign

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[615] Ibid para 1.5 "Financial Compensation."

[616] Ibid, "The Commissioner does not have any power to award compensation or require a provider to give you a refund. However, some people who have suffered a personal injury as a result of their treatment may be entitled to ACC compensation. If you think you are entitled to accident compensation, please raise this directly with ACC."

[617] Ibid.

[618] Ibid.

[619] Malegapuru op cit note 508.

[620] Health and Disability Commissioner op cit note 573 para 1.6, "Formal Investigation".

[621] Ibid.

[622] Ibid, "Before commencing an investigation, HDC will inform the consumer/complainant and the provider (ie. the person and/or the organisation you are complaining about) of the intention to investigate, and will advise the provider of the details of the complaint. HDC must also let the provider know of the right to submit a written response to the complaint."

an Investigator to liaise with the claimant or the aggrieved person.[623] The Investigator will also obtain oral, written and any other relevant evidence, including expert evidence, that is related to the claim.[624] After the Investigator completes the investigation, the Commissioner or the Deputy Commissioner will decide whether the conduct in question has indeed breached the Code of Rights in a provisional report.[625] The claimant or the aggrieved person is provided an opportunity to review and respond to the information from the provisional report."[626] Further responses and expert evidence may be considered and reviewed by the Commissioner, following which, the Commissioner forms a final report.[627]

4.3.3.6 Investigation Results:[628]

The outcome of an investigation produces results that include a written apology to the aggrieved person or claimant; "undertaking specific training, and implementing and reviewing systems to prevent further breaches of the Code".[629] The HDC may also recommend a review of a practitioner's competence.[630] Where the HDC makes a recommendation concerning health

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[623] Ibid, "If your complaint is to be investigated formally, it will be assigned to an Investigator, who will become your primary point of contact."

[624] Ibid, The Investigator will identify the facts to be proved (such as what happened, when, where, and so on), collate relevant evidence, and present it to the Commissioner or Deputy Commissioner who has been delegated the investigation for his or her consideration.

During an investigation, HDC may consider oral evidence obtained during interviews with witnesses and parties, and documentary evidence such as correspondence, clinical notes, policy and practice manuals, and any other relevant evidence such as labelled medication containers.

Where the quality of care is an issue, HDC will obtain independent expert advice from a peer of the provider with knowledge of, and experience in, the matters under investigation."

[625] Ibid, "After an investigation, the Commissioner or Deputy Commissioner forms an opinion on whether the provider has breached the Code of Rights, and notifies the parties of his or her provisional findings. If the provisional finding is adverse to any provider, the provider will be given an opportunity to make a written submission."

[626] Ibid, "The consumer/complainant will usually be given an opportunity to review and comment on the "information gathered" section of the provisional report."

[627] Ibid, "The Commissioner or Deputy Commissioner forms and reports his or her final opinion after consideration of any responses to the provisional report and any further expert advice that has been obtained."

[628] Health and Disability Commissioner op cit note 573 para 1.7 "Learning from an investigation'; Para 1.8 "Outcome of an investigation".

[629] Ibid para 1.8.

[630] Ibid, "Where an investigation suggests that there may be concerns about the competence of a registered health practitioner, HDC may recommend to the registration authority (for example, the Medical Council for a doctor) that it consider whether a review of the practitioner's competence is warranted."

care services, the HDC will follow up to ensure that the recommendations were implemented.[631]

The results of an investigation allow the HDC to "promote change" in the health care sector by recommending improvements to a specific health and disability services provider, a government agency, consumer groups or professional groups.[632] By doing so, the HDC affirms the value of the Code and promotes a better health care sector: one that respects and upholds the Code as well.[633]

The OHO has acted similarly to promote change within the health care sector, as is evidenced by the Life Esidimeni arbitration. However, as mentioned above, the OHO's powers are limited by not having its own clear legislative provisions unattached to the National Health Act. Furthermore, the OHO's powers are limited by the lack of funding and staff shortages present.

4.3.3.7 Director of Proceedings:[634]

In a limited number of cases, the Commissioner may refer a claim to the Director of Proceedings to determine whether disciplinary action against a health or disability services provider should take place.[635]

4.3.3.8 Human Rights Review Tribunal:[636]

Where the Director of Proceedings fails to resolve the alleged breach of the code, the claim may progress to the Human Rights Review Tribunal (the "HRRT"), which is a separate court

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[631] Ibid, "When any recommendations are made, HDC follows up to confirm that they have been implemented."

[632] Health and Disability Commissioner op cit note 573 para 1.7.

[633] Section 6 of the Health and Disability Commissioner Act 88 of 1994 ("the HDCA"), "The purpose of this Act is to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights."

[634] Health and Disability Commissioner op cit note 573 para 1.9

[635] Ibid.

[636] Ibid Section 51, "Aggrieved person may bring proceedings before Tribunal

Notwithstanding section 50(2) but subject to section 53, the aggrieved person (whether personally or by any person authorised to act on his or her behalf) may bring proceedings before the Tribunal against a person to whom section 50 applies if he or she wishes to do so, and—

structure designed to deal with healthcare code violations, privacy violations and human rights violations.[637] The Director of Proceedings allows a claim to progress to the HRRT to determine that the conduct in question breached the Code of Rights[638] based on a balance of probabilities and without a defence against unintentional or negligent behaviour.[639] The HRRT can order pecuniary damages or punitive damages to be paid to the claimant or an aggrieved party.[640]

(a) the Commissioner, having found a breach of the Code on the part of the person to whom that section applies, has not referred the person to the Director of Proceedings under section 45(2)(f); or

(b) the Director of Proceedings declines or fails to take proceedings."

[637] *https://www.justice.govt.nz/tribunals/human-rights/* accessed on 14 October 2020.

[638] Section 54 of the Health and Disability Commissioner Act: Powers of Human Rights Review Tribunal

(1) If, in any proceedings under section 50 or section 51, the Tribunal is satisfied on the balance of probabilities that any action of the defendant is in breach of the Code, it may grant 1 or more of the following remedies:

(a) a declaration that the action of the defendant is in breach of the Code:

(b)an order restraining the defendant from continuing or repeating the breach, or from engaging in, or causing or permitting others to engage in, conduct of the same kind as that constituting the breach, or conduct of any similar kind specified in the order:

(c)damages in accordance with section 57:

(d)an order that the defendant perform any acts specified in the order with a view to redressing any loss or damage suffered by the aggrieved person as a result of the breach:

(e)such other relief as the Tribunal thinks fit.

[639] Ibid Section 54(4) of the Health and Disability Commissioner Act , "(4) It shall not be a defence to proceedings under section 50 or section 51 that the breach was unintentional or without negligence on the part of the defendant or any officer or employee or member of the defendant, but the Tribunal shall take the conduct of the defendant or, as the case may require, of any officer or employee or member of the defendant into account in deciding what, if any, remedy to grant.

[640] Ibid Section 52(2) If any person has suffered personal injury (within the meaning of the Accident Compensation Act 2001) covered by that Act, no damages (other than punitive damages in accordance with section 57(1)(d)) arising directly or indirectly out of that personal injury—

(a) may be sought by or on behalf of that person in any proceedings under section 50 or section 51:

(b) may be awarded to or for the benefit of that person in any such proceedings.

Section 54(2) of the HDCA, "In any proceedings under section 50 or section 51, the Tribunal may award such costs against the defendant as it thinks fit, whether or not it makes any other order, or may award costs against the plaintiff, or may decline to award costs against either party.

(3)Where the Director of Proceedings is the plaintiff, any costs awarded against him or her shall be paid by the Commissioner, and the Commissioner shall not be entitled to be indemnified by the complainant or, as the case may be, the aggrieved person.

(5) In any proceedings under section 50 or section 51 in respect of any action of a health practitioner, the Tribunal shall, where that action has been the subject of disciplinary proceedings, have regard to the findings of the body before which those disciplinary proceedings were heard and to any penalty imposed on that health practitioner in those proceedings."

Section 57 of the HDCA, "Damages

(1) Subject to section 52(2), in any proceedings under section 50 or section 51, the Tribunal may award damages against the defendant for a breach of any of the provisions of the Code in respect of any 1 or more of the following:

(a) pecuniary loss suffered as a result of, and expenses reasonably incurred by the aggrieved person for the purpose of, the transaction or activity out of which the breach arose:

Bear in mind that claimants or aggrieved persons may also access the free legal advocacy service at any time for assistance with their claim.[641]

The HDC's process allows for the efficient deliberation and resolution of disputes outside of a formal court process to promote efficiency, healthy dispute resolution and to improve the health care sector for the benefit of the New Zealand community at large.

4.3.4 New Zealand continued: Accident Compensation Corporation

As mentioned above, the ACC is a national compensation claims system whereby those injured in medical malpractice accidents (and other personal injury accidents) may receive compensation for the harm that they have suffered as a result of the medical accident. The ADR system of the HDC just described, works alongside a no-fault compensation scheme providing for, inter alia, structured settlements. For reasons of completeness, this aspect of New Zealand's comprehensively reformed medical malpractice system is considered below.

4.3.4.1 Making and Processing a Claim with the ACC

If a claimant or an aggrieved person believes that they have suffered from a personal injury accident as determined by the ACC, they should visit a health care practitioner who will assess the accident and make the claim on their behalf.[642] The wording of the directive to visit a health practitioner does not require a claimant or an aggrieved person required to visit the practitioner who injured them before sending a claim.[643] They are only required to visit a practitioner who

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(b) loss of any benefit, whether or not of a monetary kind, which the aggrieved person might reasonably have been expected to obtain but for the breach:

(c) humiliation, loss of dignity, and injury to the feelings of the aggrieved person:

(d)any action of the defendant that was in flagrant disregard of the rights of the aggrieved person.

(2) Subject to subsections (3) to (5), the Commissioner shall pay damages recovered by the Director of Proceedings under this section to the aggrieved person on whose behalf the proceedings were brought.

(3) If the aggrieved person is a minor who is not married or in a civil union, the Commissioner may, in his or her discretion, pay the damages to Public Trust or to any person or trustee corporation acting as the manager of any property of that person."

[641] Section 24 of the HDCA; Section 25 of the HDCA.

[642] Section 25 of the ACA.

[643]*https://www.acc.co.nz/im-injured/what-to-do/?smooth-scroll=content-after*-navs accessed from the official website of the ACC on 23 August 2020.

will assist the injured person or the aggrieved person in making their claim.[644] The ACC then conducts an assessment of whether the injury was an accident that can be covered.[645] This assessment is made by focusing on whether the accident was caused by the actions of the health care provider.[646] Essentially, the ACC determines causation without applying a fault enquiry to determine whether compensation should be paid.[647] Where the ACC determines that an accident worthy of compensation has not occurred, claimants and aggrieved persons may ask for a review of the claim.[648] In such instances, claimants may make use of lawyers if they can afford the legal fees.[649] The review process is conducted by Fairway Resolutions (an agency that acts on behalf of the ACC) by means of dispute resolution to resolve claims.[650] In all assessments, the element of causation is the deciding factor as to whether the accident should lead to compensation.[651] Thus, where the medical injury is a natural cause of a procedure, the element of causation will not be met.[652] Conversely, if the injury arose outside of the natural cause of the procedure, causation will be satisfied.[653] By removing the fault enquiry, the ACC is able to determine that an injury took place and thereafter compensate the injured person adequately.

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[644] Ibid.

[645]*https://www.acc.co.nz/assets/im-injured/69cb9b0d31/treatment-injury-cover-decisions.pdf* accessed on 23 August 2020.

[646] Ibid.

[647] Ibid.

[648] Section 63 of the ACA.

[649] "Facilitation: Improves communication between you and ACC by clarifying the issues at dispute. Mediation: Seeks to find an agreement between you and ACC. The Mediator acts as a conduit through which the parties can raise their views without providing advice. Conciliation: Searches for a negotiated solution. The Conciliator plays an active role that might include suggestions on possible solutions and ways to settle the dispute. Review: This is the statutory dispute resolution process that consists of a hearing followed by a legally binding decision." *https://www.fairwayresolution.com/got-a-dispute/acc-dispute-resolution/acc-review* accessed on 23 August 2020 ; *https://thespinoff.co.nz/parenting/29-09-2018/the-no-fault-fallacy-looking-back-at-our-18-months-of-acc-hell/* accessed on 23 August 2020: while this source contains a personal story pertaining to the ACC, it does provide information on the ACC's decision-making structure and process which precludes a fault enquiry. *https://www.acc.co.nz/assets/im-injured/69cb9b0d31/treatment-injury-cover-decisions.pdf* accessed on 23 August 2020.

[650] *https://www.fairwayresolution.com/got-a-dispute/acc-dispute-resolution* accessed on 23 August 2020.

[651]*https://www.acc.co.nz/assets/im-injured/69cb9b0d31/treatment-injury-cover-decisions.pdf* accessed on 23 August 2020.

[652] Ibid.

[653]Ibid;*https://thespinoff.co.nz/parenting/29-09-2018/the-no-fault-fallacy-looking-back-at-our-18-months-of-acc-hell/* accessed on 23 August 2020.

4.3.4.2 Compensation

Where a claim is deemed an accident and meets the causality requirement in terms of the ACA, the claimant is entitled to compensation.[654] Compensation can be paid in a lump sum for permanent injury or it can be paid as an ongoing payment.[655] A victim's injury is subject to assessments and reassessments in order to make sure that the claimant is always compensated fairly and fully.[656] The goal of compensation is to provide "real compensation" that allows victims to be fully rehabilitated both socially and vocationally in order to gain independence in society.[657] If the recipient of compensation is under the age of sixteen or a dependent in any way, their funds will be paid into an independently administered trust.[658] In cases of lifelong

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[654] Section 3 of The Accident Compensation Act.

[655] *https://www.acc.co.nz/im-injured/financial-support/financial-support-permanent-injury/#receiving-your-one-off-or-ongoing-payments* accessed from the official website of the ACC on 23 August 2020.

[656] Ibid.

[657] Section 3 of the ACA, "Purpose

The purpose of this Act is to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable scheme for managing personal injury that has, as its overriding goals, minimising both the overall incidence of injury in the community, and the impact of injury on the community (including economic, social, and personal costs)," through—

(a) establishing as a primary function of the Corporation the promotion of measures to reduce the incidence and severity of personal injury:

(b) providing for a framework for the collection, co-ordination, and analysis of injury-related information:

(c) ensuring that, where injuries occur, the Corporation's primary focus should be on rehabilitation with the goal of achieving an appropriate quality of life through the provision of entitlements that restores to the maximum practicable extent a claimant's health, independence and participation:

(d) ensuring that, during their rehabilitation, claimants receive fair compensation for loss from injury, including fair determination of weekly compensation and, where appropriate, lump sums for permanent impairment:

(e) ensuring positive claimant interactions with the Corporation through the development and operation of a Code of ACC Claimants' Rights:

(f) ensuring that persons who suffered personal injuries before the commencement of this Act continue to receive entitlements where appropriate.

[658] Section 125 of the ACA, "Corporation to pay amount for child to caregiver or financially responsible person

(1) This section applies if an entitlement (other than weekly compensation payable under clause 32 of Schedule 1) provided to a claimant who is not yet 16 years old is solely a payment of money.

(2) The Corporation must make the payment—

(a) to a person who is caring for the claimant; or

(b) if the Corporation considers that it would not be appropriate to make the payment to such a person, to another person or to trustees who, in either case, the Corporation considers will apply the payment as required by subsection (3).

(3) A person to whom a payment is made under subsection (2) must apply it for the maintenance, education, advancement, or benefit of the claimant.

(4) The Corporation is not under an obligation to see to the application of any money paid under this section, and is not liable to the claimant in respect of any such payment."

injuries, a claimant or aggrieved person may be compensated in a lump-sum or by way of ongoing payments.[659] Interestingly, the use of the terms "structured settlements" or "periodical payments" do not feature within the ACC or the HDC.[660] Furthermore, if one looks closely at New Zealand's implementation of structured settlements, one would find a system of rehabilitation that consists of ongoing payments and independence allowances.[661] So, what does it mean to receive ongoing payments or an independence allowance for medical malpractice cases and how does that translate to the everyday lives of New Zealanders who have suffered personal injury accidents? To understand these approaches to payments, the concept of rehabilitation must be fully understood. In line with the principle of complete rehabilitation, the legislature compensates injured persons with the intention of returning them to a state of independence both socially and vocationally so that they may limit their reliance on the state. As such, the ACC uses terms such as "ongoing payments"[662] and "independence allowance"[663] to gradually assist injured persons to return to society. This could also be termed as structured settlements or periodic payments. However, where permanent care is required, the ACC compensates claimants by way of lump-sum or ongoing payments (i.e. structured settlements) from the ACC's tax-funded scheme.[664] In this way, the public health sector and public health facilities are not implicated in long-lasting settlement agreements, nor are they required to compensate an injured person by way of lump-sum at their own expense.

The ACC claims system incorporates methods of alternative dispute resolution, legal representation, no-fault compensation, lump-sum compensation and a form of structured settlements. By implementing administrative structures and comprehensive reform through the ACC's alternative dispute resolution and claims process, New Zealand's legislature was able to apply the benefits of structured settlements while avoiding an over-reliance on the conventional reform itself.

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[659] *https://www.acc.co.nz/im-injured/financial-support/financial-support-permanent-injury/#receiving-your-one-off-or-ongoing-payments* accessed on 23 August 2020, "If we cover your life-long injury, we may be able to give you financial support as a one-off or an ongoing payment."

[660] The Accident Compensation Act; The Health and Disability Commissioner Act.

[661] Sections 70, 79, 80, 81 and 125 of The Accident Compensation Act.

[662] Ibid.

[663] Ibid.

[664] Ross Wilson op cit note 577 at 7.

New Zealand's personal injury nexus is robust and effective. Various institutions and pieces of legislation have been created to enhance the administrative efficiency of resolving medical malpractice claims. A review of the ACC, the ACA, the HDC, the Health and Disability Commissioner Act 88 of 1994 (" the HDCA"), the Code of Rights and Fairway Resolution shows that comprehensive reform is required to achieve reform that incorporates conventional cost-saving methods such as structured settlements into its personal injury claims process. However, implementing these procedures and different reform methods took some time as it was years before New Zealand implemented the ACC and then the HDC in line with The Woodhouse Report.[665]

In these two institutions, one observes that New Zealand's approach to medical malpractice claims is two-fold: to compensate through the ACC for medical malpractice accidents and to improve the state of the health care system through the HDC by efficiently assessing claims of breaches of the Code of Rights outside of a traditional litigation procedure.[666] Both the HDC and ACC meet two concerns raised by academics on this path to socially responsive medical malpractice reform: improving health care services through the HDC and providing adequate compensation through the ACC. Both require extensive procedural and administrative capabilities to manage medical malpractice injury claims.[667] The HDC and the HDCA meet the need to hold those health professionals and health and disability services accountable for their breaches of the Code while promoting better health care services without attaching these individuals and institutions to the financially damaging process of paying for future expenses.[668] However, when a victim of medical malpractice is seeking full compensation, the ACC is the responsible institution.[669] The ACC also employs ADR procedures to process disputes arising from compensation through the government-funded Fairway Resolutions, which helps to expedite compensation disputes.[670] Thus, while these two institutions have separate processes and agendas, they do ultimately influence one another and feed into each

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[665] Margaret McClure op cit note 582.

[666] The Accident Compensation Act; the Health and Disability Commissioner Act.

[667] Ibid.

[668] Refer to the HDC section and the ACC section on page 90 – 100 above.

[669] Ibid.

[670] Fairway Resolutions op cit note 650.

other's processes to provide full compensation and resolution of medical malpractice claims in order to uplift those injured individuals and to improve health care services for all.[671] Alas, neither the HDC nor the ACC are perfect systems, as they have not necessarily led to a decrease in the number of claims brought forward.[672] Notwithstanding these shortcomings, the systems have ultimately been successful in redirecting medical expenditure away from healthcare budgets, processing claims; implementing cost-saving measures and holding healthcare providers accountable.

4.4 Socially Responsive and Comprehensive Reform in South Africa

In the case of South Africa, the option of structured settlements can be categorised as a conventional reform. However, the current South African approach to structured settlements is incomplete because – as proposed in the SLAB and as foreshadowed by the development of the common law by the courts – it lacks administrative clarity and efficiency. To achieve comprehensive reform, South Africa may benefit from implementing a mixture of conventional reforms such as structured settlements and treatment in kind alongside administratively clear alternative dispute resolution systems to achieve comprehensive and long-lasting personal injury law reform. While a no-fault compensation scheme such as the ACC could form part of a comprehensive reform package in South Africa, the financial barriers faced by the NHI and RAF systems, and by the government more broadly particularly in the wake of the COVID-19 pandemic, suggest that it may not be realistic to implement this particular option for the immediately foreseeable future.[673]

South Africa's legal landscape has reaped the benefits of alternative dispute resolution on a large scale through the CCMA as well as on a more limited scale through the example of the Life Esidimeni arbitration.[674] It was shown above that in order to achieve an element of socially responsive medical malpractice reform, some form of fundamental change is required to

[671] Joanna Manning op cit note 585 at 20.
[672] Chisholm op cit note 574; Wallis op cit note 575; Ron Paterson op cit note 510 at 70 and 77–8.
[673] Op cite notes 160, 161 and 165.
[674] Amos Tshabalala op cit note 459.

enhance the current suggestion of structured settlements and treatment in kind in South Africa. The form of fundamental reform suggested by this dissertation is an ADR mechanism comparable to that of New Zealand's HDC and Fairway Resolutions, potentially as a compulsory prerequisite to the institution of a damages claim and to potentially manage compensation disputes. Furthermore, an express ADR mechanism attached to the OHO may assist to further expedite claims and process complaints regarding compensation as seen in the dual role of the HDC and Fairway Resolutions (by way of the ACC). Such reform has the potential to ease the burden on the courts and naturally would require a robust and efficient administrative procedure to resolve medical malpractice disputes alongside the suggestion of structured settlements. Another indirect benefit of implementing an ADR system is that it can incorporate the function of legal representation into it. For example, neither the HDC, Fairway Resolutions nor the OHO precludes the assistance of lawyers.[675] Rather, both the HDC and Fairway Resolutions provide free legal advocacy to those who need it and where a claimant wishes to make use of their own legal aid, the claimant is required to pay those fees.[676] The OHO, likewise, did not prohibit the assistance of legal aid in the resolution of the Life Esidimeni arbitration.[677] Similarly, with the CCMA, the role of lawyers is not rendered redundant – instead, the role of lawyers is regulated.[678] In this way, the measures for reform remain focused on patients' safety while ensuring better healthcare service delivery alongside an expeditious and fair resolution of claims. Therefore, incorporating a healthy legal network into an improved OHO to ensure adequate legal assistance for those in need would be envisaged through legislative developments, as greater empirical information is required to formulate a robust programme.

The healthcare crisis in South Africa is varied and systemic with many ethical considerations to bear in mind. Therefore, an effective health care improvement requires systemic change that can most likely be achieved with the fundamental reform of a focused medical malpractice ADR system. Structured settlements and treatment in kind are not offensive to the normative values of the Constitution, which means their application will become more frequent even if

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[675] Section 25 of the HDCA; "ACC covers the cost of FairWay's services, but you will need to cover your own additional expenses" *https://www.fairwayresolution.com/got-a-dispute/acc-dispute-resolution* accessed on 14 October 2020.

[676] Ibid.

[677] Malekgapuru W Makgoba op cit note 508 para 10 at 54.

[678] *https://www.ccma.org.za/Advice/CCMA-Processes/Arbitration* accessed on 14 October 2020.

the SLAB never passes muster. In other words, the exact clauses of the SLAB may not be implemented in their current specific form. They may be altered or removed altogether depending on the submissions and suggestions that have been made to the Department of Justice. However, as the SLAB is debated, structured settlements and treatment-in-kind are currently finding their place in South African medico-legal practice outside of the propositions of the SLAB. Therefore, these conventional cost-reforms should be managed and supported by fundamental reform to act alongside them. ADR systems could assist the OHO's function of investigating, recommending and enforcing not only cost-orders but improved health care service delivery. What the HDC shows is a system for dispute resolution that allows for a pathway to compensation. Additionally, the use of the Fairway Resolutions ADR systems to process issues relating to compensation decisions by the ACC works concurrently with the HDC system. Thus, while the OHO is calling for funding to improve its enforcement function and its own legislative powers, this dissertation is suggesting that the OHO's powers be extended to allow for greater ADR functions to administrate the cumbersome decisions such as structured settlements, variation orders and issues regarding treatment in kind.

Algorithm determined that administering the costs of structured settlements, variations and treatment in kind may lead to more expensive cases.[679] However, with the application of cost reforms, a system working alongside cost practices is paramount to avoid unnecessary expenditure in courts. However, there is still the issue of increased spending. For example, it was reported that the CCMA received an increase of R93 million for the next three years to improve some of its dispute resolution function.[680] Furthermore, it is estimated that between 2019 and 2022, the Commission's costs will increase by R3.1 billion — of which R1.3 billion has been estimated for administrative purposes.[681] The OHO itself predicted that its funding would need to increase by R64 million in the next few years to be fully realised, improve its enforcement function and rectify its staff shortages.[682] Therefore, it can be assumed that a large

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[679] Algorithm op cit note 175 at 11.4.

[680] Lameez Omarjee 'CCMA will have enough funds to manage its complaints – labour minister' in *Fin24* 14 March 2019 *https://www.news24.com/fin24/economy/ccma-will-have-enough-funds-to-manage-more-complaints-labour-minister-20190314* accessed on 14 October 2020..

[681] Department of National Treasury '2019 Budget Estimates of National Expenditure' at 24, *http://www.treasury.gov.za/documents/national%20budget/2019/enebooklets/Vote%2028%20Labour.pdf* accessed on 14 October 2020.

[682] OHO Annual Report op cit note 139 at 3.

amount of finances would be needed to create, enforce and administer an ADR function through the OHO or independently of the OHO. The amount spent on administratively efficient ADR processes is steep and it could be said that the funding needed for a more effective OHO may just be a redirection of funds spent on medical malpractice court cases. However, the difference between losing money to medical malpractice disputes, and spending money on improving the OHO, is that the OHO — if its powers are properly extended through legislation — will filter out meritless claims and improve the standard of healthcare through improved monitoring, enforcement and education. This should, at least in theory, minimise incidents of malpractice claims and therefore, it should act alongside the cost-saving measures of structured settlements and treatment in kind to safeguard necessary healthcare funds. Therefore, it may be necessary for the OHO to extend its function to manage growing cost reforms to meet its goal of expediting and resolving claims more effectively. Additionally, it may be cheaper for the government to extend an existing function than to create entirely new systems, considering the current economic crisis created by corruption and the COVID-19 crisis. Another indirect benefit of creating an ADR system is the possibility of saving costs through avoiding meritless claims and avoiding further incidents of malpractice by enforcing remedial action amongst health care providers. This, in turn, improves healthcare service delivery. Ultimately, it seems that there is no large cost-saving measure to address the malpractice crisis. Any suggested measure will cost a substantial amount of money to achieve healthcare reform; however, the benefits attached to an ADR system that can process the administration and the deliberation required with new cost-reforms does provide further relief and improves healthcare service delivery which indirectly limits cases of malpractice. This, in theory, should allow the NDoH to spend its finances on areas other than litigation and liability claims. The expenses attached to extending or creating any ADR function will naturally be high; therefore, it is further suggested that while the OHO has budgeted to improve its enforcement function, it should also budget for a more express ADR process that can help to filter out meritless claims and assist possible future claimants with issues arising from the administration of cost reforms. In this way, the OHO does not become redundant, ineffective or a solely politically motivated office. This would naturally take a large amount of time and require further empirical research, but it would be worth it if it could alleviate the healthcare crisis in the long term. Thus, by conducting further research and implementing express legislative and other provisions, the OHO would improve its already progressive steps to realise its aim of being the '"public protector" for

health."[683] This would ultimately help the OHO to achieve the right to healthcare enshrined in the Constitution.

In theory, ADR systems like those described above provide relief and are flexible enough to allow for cost-reforms to take place. However, people run programs and the effectiveness of an improved OHO through more intense ADR may fall victim to corruption or general failure owing to the lack of co-operation as evidenced by the struggles of CRPs and the HDC and the prevailing corruption issues in South Africa. Notwithstanding these concerns, the OHO, if properly invested in, possesses the administrative capacity to manage the administrative difficulties that are present in the current cost-reforms of structured settlements and ordering of treatment in kind. The OHO, being attached to the OHSC is in the perfect position to ensure improved health care enforcement and assist with deliberations and handling of claims; as the SLAB itself envisions the role of the OHSC to ensure its efficacy. Although the OHO hopes to function completely independently of the OHSC,[684] it is suggested that the function of the OHO should remain in close contact with the OHSC to ensure that its recommendations are being implemented to improve the standard of healthcare.

The OHO is a secret weapon in this crisis and it is often overlooked in the discourse. However, considering its goals, functions and influential position, it has the potential to address various issues in the healthcare crisis. Thus, its function should be expressly improved through legislation, and it should be properly invested in to assist with administration and oversight of the current cost reforms, as it could indirectly and directly alleviate some financial pressure and address the ethical concerns of the healthcare crisis if it is leveraged correctly. The OHO is a new office exercising a new function in South Africa, and the office has done relatively well considering the budgetary constraints and staff shortages that it faces. It has shown through the Life Esidimeni arbitration and its handling of smaller cases that it can help to expedite the resolution of medical malpractice claims. This, in turn, decreases the funds spent by the government in lengthy court battles. Furthermore, the OHO has shown that its function can exist alongside and support the cost measures applied in normal medical malpractice

[683] Durojaye & Agaba op cit note 138 at 162.
[684] OHO Annual Report op cit note 139 at 3.

claims, which means that it can hopefully assist with the administration of new delictual cost-reforms. The benefit of such a system lies not only in the faster and hopefully less expensive resolution of claims, but it also assists with the improvement of health care facilities and it filters out meritless claims. This can save costs for the government while assisting claimants with their claims effectively and improving the healthcare system simultaneously. In this way, the vicious cycle at play can be inverted through many cost-saving measures and the added benefit of healthcare. This paper supports the argument that the OHO requires greater funding and power through legislative provisions to assist with the settling of claims, as the courts cannot be relied upon more than they already are, as that will only exacerbate the current medical malpractice crisis. If the OHO's function cannot be extended, it is still suggested that an ADR system be implemented in South Africa to resolve any disputes that may arise with the administrative difficulties of structured settlements, structured settlement variations and treatment in kind.

5 CHAPTER 5: CONCLUSION AND FINAL RECOMMENDATION

A medical malpractice crisis has emerged from the expansion of medical malpractice liability in South Africa. The emergence of this crisis requires an approach that is aligned with the normative values of the Constitution to improve access to the section 27 socio-economic right to health care. This dissertation discussed the most recent developments in medical malpractice reform in South Africa, namely the ordering of structured settlements in the SLAB and the ongoing development of the common law to allow for structured settlements and, to some degree, payments in kind.

Critiques of the SLAB suggests that reform may occur in such a way that would unduly prejudice indigent victims of medical malpractice accidents. Ultimately, the SLAB as it stands is an incomplete legislative offering that misses the mark by attempting to implement very serious measures on an interim basis without effective administrative foresight or a fundamental reform structure to strengthen the suggestion of structured settlements. It is understood that the SALRC is continuing its research to form more comprehensive recommendations to improve the medical malpractice crisis, and as it does so, it may find answers in a multiplicity of reform measures. While the SALRC continues its research, it is of utmost importance that the legislature remains cognizant of the need to provide for fundamental reform measures alongside an extensive administrative process that can support the limited cost-saving benefits of structured settlements or any other established cost-saving method. It was ultimately determined that the SLAB, if implemented as drafted, is an administratively deficient tool that cannot achieve its desired effect. However, if South Africa's legislature implements medical malpractice reform, it would do well to learn from New Zealand's personal injury law structure regarding the implementation of fundamental reform alongside effective administrative structures and alternative dispute resolution structures to promote fair compensation and improve the health care sector. More fundamental reforms that only legislation can achieve will ultimately be required. Comprehensive, permanent change is needed on both a legal level and on a social level.

This dissertation has proposed that the creation of an ADR system allows for oversight and improved handling of issues in a proportionate manner. The South African medical negligence

system is flawed in many respects, including the costs of compensation and litigation. The expansion of liability alongside the poor standard of healthcare are systemic concerns that require systemic solutions. ADR has the potential to serve as a more financially viable fundamental reform measure to work alongside the possibility of structured settlements emerging in the common law or, if enacted, in terms of legislation such as the SLAB.

There are various ethical considerations to consider in the medical malpractice crisis. Beyond the expansion of liability, the poor standard of health care jeopardises the safety of many patients especially those patients who rely on the public health care system. Therefore, an ethical approach is required that can address this concern as reasonably and proportionately as possible, given that a perfect system is impossible to create.

The results of decreased incidents of malpractice and reduced liability fees in CRPs show that an ADR system based on principles that mirror the normative constitutional values may bring success indirectly to medical malpractice cost awards. Having a system that is administratively efficient and proportional to remedy the problems faced in the health care system solves the problem of avoiding costly litigation. Although in New Zealand the issue of costs is dealt with by the ACC, the HDC plays a role in resolving and managing the ethical concerns of health care disputes without unduly implicating the finances of the health care system at large. Furthermore, Fairway Resolutions assists to resolve claims disputes through ADR practices. The benefit of ADR systems is that they foster reviews of inadequate services, while both supporting deserving claims for compensation and attempting to filter out undeserving claims. The same occurs even in the instance of the Ombudsman. Unfortunately, the lack of compulsory involvement or extended reach of the Ombudsman in South Africa mirrors the shortfalls of CRPs. The application of the CRPs is not mandated on a larger scale and thus their potential has not been fully realised. Therefore, the role of the OHO should be extended through express legislative provisions to allow for greater enforcement powers and ADR systems to operate alongside its monitoring and investigation function.

To conclude, it may be unwise to disregard the suggestion of structured settlements or treatment in kind as an active response to the medical malpractice crisis in South Africa, as they have been deemed constitutionally viable compensation tools. However, if they are to be implemented, they would need, at the least, to be complemented by one form of additional

fundamental reform to create comprehensive legal reform in the medical malpractice arena. This dissertation suggested that a form of alternative dispute resolution should be a starting point as it naturally induces an administrative response which is sorely lacking in the current South African medical malpractice discourse. Similar measures already exist and have been proven to work in South Africa through the Ombud's role in the Life Esidimeni arbitration and within the labour law context. Therefore, an extension of ADR processes provides a reasonable and measured approach that aims both to achieve fair compensation in deserving cases and to improve the standard of health care generally. In this way, South Africa can take further steps to achieve socially responsive and comprehensive medical malpractice reform that upholds the normative values of the Constitution and advances the right to health care.

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