POLICY BRIEF 5

Impact of medicolegal claims on service delivery access and quality

August 2023

By Dr Jodi Wishnia, Michelle Flowers and Suhavna Khalawan

The authors all have experience with children with disabilities either through actuarial quantum calculations of medico-legal claims (SK), or their clinical background and research (MF and JW).

The authors work at or are affiliated with Percept, a transdisciplinary collective that aims to provide high quality research and analysis for some of the world's most pressing problems.

Table of Contents

List of Figures

List of Tables

Foreword

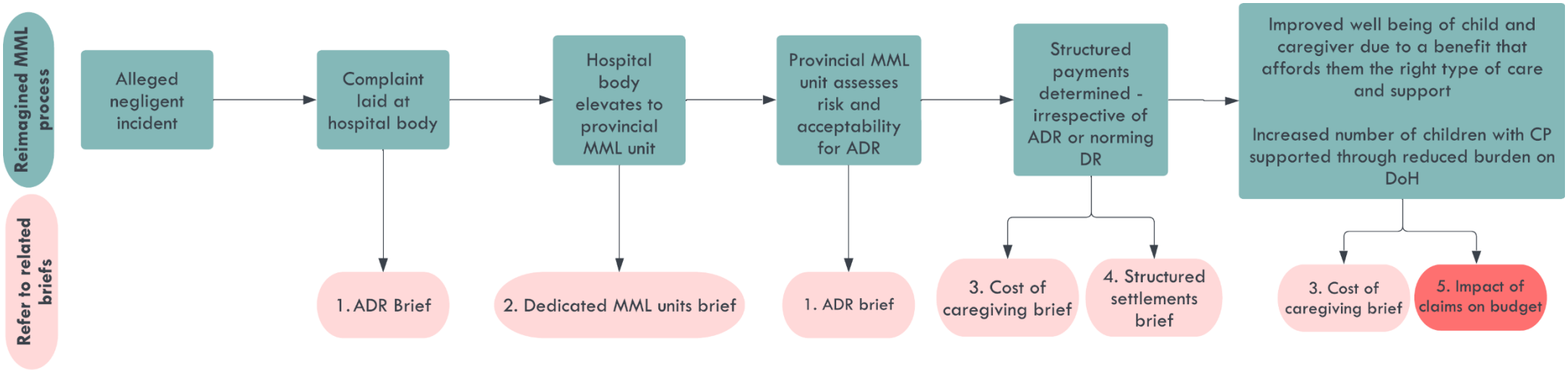
The Public Interest function was created by the Actuarial Society of South Africa (ASSA) to enable the organisation to pro-actively participate in public policy discussions. ASSA seeks to inform debate on matters of public interest in South Africa, especially when it is deemed that actuarial expertise can add value. ASSA can provide facts, figures, comments, and analyses of consequences on a wide range of topics where the actuarial skillset can provide unique insights.

There is no specialised legislation governing the medical malpractice (medico-legal) space in South Africa.[1,2] Claims are therefore dealt with by way of the common law. This increases the risk of exploitation and abuse. The South African Law Reform Commission (SALRC) seeks to reform the law to address the risks inherent in using common law for medico-legal claims. In collaboration with other experts in this space, such as ASSA, the SALRC aims to draft legislation that will best serve the citizens of South Africa.

ASSA aims to provide feedback, research, and commentary throughout the process to help shape the SA medico-legal legislation space. A series of work and policy briefs were commissioned to research the recommendations of the SALRC, of which this forms one of the briefs in the series. It is envisaged that the findings from this research would equip the SALRC with the evidence needed to tighten legislation and provide outcomes that are fair to all involved parties. It is our view that by linking these policy briefs together, one can understand the policy levers available to the SALRC to reimagine or shape the future of the medico-legal space.

Figure 1 below illustrates our reimagining of this space, based on the research and content of the policy briefs in this series. Figure 1 shows the flow of the research briefs Percept was commissioned to write. The briefs follow the same order as a medico-legal claim and thereby paint a story of the necessary reform along the medico-legal journey. The brief herein is the fifth brief in the series and discusses the impact of medico-legal claim pay-outs on the public health service delivery budget and availability.

Figure 1: Reimagining of the SA medico-legal space



Abbreviations

ADR - Alternative dispute resolution
DR - Dispute resolution
MML - Medical malpractice litigation
CP - Cerebral palsy
DoH - Department of Health

Introduction

South Africa is experiencing a substantial rise in the number and quantum of medical negligence claims in its public health sector.[1] If claims are successful, the funding to pay claimants is derived from the public health budget, meaning that claims actively reduce available public health funds for service delivery.[2]

This research brief aims to articulate the impact of this redirection of funds on access to healthcare. We do this by looking at the opportunity cost or what else could have been "bought" with the funding that was paid to claimants. This work brings to life the trade-offs in place within a medical negligence claims environment that has high associated legal fees and no payment ceilings for claims of similar types.

We believe and support the right to justice and compensation for those who have experienced negligent care. This right should be accessed through sustainable legal processes that do not further jeopardise healthcare access and quality for the claimants themselves, as well as future public sector healthcare users. Similarly, the health system has a responsibility to render quality health services that its users can trust and part of this responsibility requires transparent data on the quality of services provided. The system and its users' needs are deeply intertwined. This research brief aims to clarify the impact of claims payments from the systems perspective.

Access ≠ Quality

Whilst interpreting this brief, it is critical that the reader is cognisant of the difference between access and quality. For many years, many lower- and middle-income countries (LMICs) struggled with healthcare access - where it was difficult for patients to get to facilities or facilities were so in demand that waiting times tangibly impacted on access to services. More recently, the problems of access have been largely solved but the quality of care received remains a substantial challenge.[3] The Lancet Global Commission on Quality Health Systems found that more people are dying from poor quality than a lack of access in LMICs (i.e. facilities are available but are inadequately resourced to provide quality care), making clear the need for more attention on not just access but the quality of the services accessed.[3]

Defining quality

The definition of a high-quality health system in South Africa, which was finalised in 2019 by the South African Lancet National Commission, is one that achieves equitable health outcomes and a long and healthy life for all. Donabedian's 1996 framework for quality is still widely used today.[4] It uses three factors to evaluate quality, namely; structure, process, and outcomes. Structures are defined as the infrastructure, equipment and attributes of healthcare providers through which care is provided. Process relates to the standardisation of healthcare through clinical protocols. Outcomes refer to the impact on patients. Outcomes, such as reduced rates of morbidity or mortality are helpful examples of impactful outcomes for a health system to measure and monitor.

While South Africa does collect mortality data, morbidity data are not yet routinely

collected. This makes it difficult to regularly assess the outcomes of health system interactions which do not result in death and to determine whether the system is providing high quality care. This is pertinent for the medical negligence space which predominantly deals with cases where a patient was injured or disabled as a result of the care received (i.e. it would show up as morbidity not mortality).

In the absence of morbidity data, we have to use "output" data which provides information on the utilisation of services (i.e. access) but not necessarily on the quality of the services provided. This lack of data makes it hard for citizens to hold their public health system to account and, it makes it difficult in judgments to know whether the health system did all it should and could have done to prevent the negative patient outcome. Therefore, critical to reforming the medicolegal environment is the roll out and use of electronic health records (EHR) systems that use clinical coding (like ICD10 codes) which can assist providers to deliver quality care and can assist the system to better measure and uphold quality.

Understanding the quantum of claim pay-outs

As mentioned, there has been a dramatic rise in the number of medical negligence claims in South Africa. Birth injury claims account for a large proportion.[2] In addition to the direct health and financial burden on children and families, cerebral palsy (CP) caused by alleged medical malpractice during delivery has significant consequences for provincial health budgets, accounting for around half of medical negligence claims (in terms of cost[1]) against the government.[5]

Table 1 shows the claims paid in 2019/2020 against total Provincial Department of Health (PDoH) expenditure and hospital-based expenditure for the same period. The public health budgets provide a breakdown of expenditure for only hospital services. These claims are the ones that were paid but are not necessarily an indication of all claims owing as what is paid is often a function of available cashflow rather than what is due.[5] While the proportions appear relatively low, the next section will illustrate the impact of this outflow of service delivery funds on access to available services. The data in red represents the worst affected provinces.

Table 1: Claims as a proportion of Department of Health total and hospital budgets (2019/2020)

R'000	Claim payments	PDoH total budget	PDoH hospital budget	% of total PDoH budget	% of hospital budget
EC	766 399	26 200 501	13 677 975	2.9%	5.6%
FS	22 655	11 123 859	5 954 328	0.2%	0.4%
GP	502 148	50 673 663	31 809 762	1.0%	1.6%
KZN	180 444	45 226 576	24 631 874	0.4%	0.7%
LP	83 572	21 011 275	11 712 997	0.4%	0.7%
MP	45 534	14 257 736	6 331 749	0.3%	0.7%
NC	40 735	5 183 451	2 139 750	0.8%	1.9%
NW	18 912	12 435 608	5 345 306	0.2%	0.4%
WC	60 140	24 773 271	14 599 946	0.2%	0.4%
TOTAL	**1 720 539**	**210 885 940**	**116 203 688**	**0.8%**	**1.5%**

We analyse the impact of claims on service delivery for the three provinces with the highest Rand amount in claims pay-outs in 2019: Eastern Cape (R766m), Gauteng (R502m) and KwaZulu-Natal (R180m). While the Northern Cape (NC) shows a greater proportion of their service delivery funding going to claims, the quantum in KZN presents a larger absolute financial burden.

From work conducted in related briefs[6,7] to determine a standardised benefit package for children with CP, we determined that for the first year that a successful claimant (with a demographic profile matching that of the child BN in the recent judgment - i.e. 11 years old with severe cerebral palsy who lives outside a city centre[8]) receives funding, the cost would be approximately R2.9m (Table 2).

Table 2: Illustrative costing of the first year of funding required for a child with CP[6,7]

Overall Grouping	**Annual budget: Year 1**
Caregiving	312 000
Equipment: Assistive devices	135 375
Equipment: Communication devices	12 000
Equipment: Therapy devices	3 500
Medical care	53 430
Support: Education (inclusion in mainstream or special schooling)	72 600
Support: Environmental (adaptations to the house)	600 000
Support: Nutritional (dietician assessments and support and supplements)	120 428
Support: Psychosocial (child and family psychology)	14 400
Support: Transport (vehicle including licence, maintenance, tracking and travel costs)	1 427 450
Therapy: Additional (case management and respiratory physiotherapy)	39 452
Therapy: Block (intensive two-week speech, physio- and occupational therapy sessions)	26 500
Therapy: Regular (regular speech, physio- and occupational therapy sessions)	91 767
Total yearly payment	**2 908 901**

Of the costs listed in Table 2, only some would form part of standard care for all children with disabilities (where the rest arise because of the negligence claim and are not usually provided as the standard package of clinical care offered to patients by the Department of Health). In Table 3, we list those costs which would be the responsibility of the PDoH for all children with CP and use this as a proxy cost for the rehabilitation services children with CP using the public health sector would require.

Table 3: Costs borne by the health system for children with disabilities

Overall Grouping	Annual budget: Year 1	Part of routine CP Care?
Caregiving	312 000	No
Equipment: Assistive devices	135 375	Yes
Equipment: Communication devices	12 000	Yes
Equipment: Therapy devices	3 500	Yes
Medical care	53 430	Yes
Support: Education	72 600	No
Support: Environmental	600 000	No
Support: Nutritional*	107 799 12 629	Yes No
Support: Psychosocial	14 400	Yes
Support: Transport	1 427 450	No
Therapy: Additional	39 452	Yes
Therapy: Block	26 500	Yes
Therapy: Regular	91 767	Yes
Total estimated rehabilitation cost for year 1	**R484 223**	

The rehabilitation cost to the public health system per child with severe CP is estimated at R484k in the first year (breakdown shown in Table 3). Currently, some of these services are throttled due to insufficient budget and some are provided by non-government organisations at no cost to the PDoH. So, while this may very well be the "real cost", it is not the current spend on children with cerebral palsy in PDoHs.

Figure 2 shows the selected package of care graphically.

Figure 2: Public health sector service package for children with disabilities

* Nutritional support included as part of routine CP care relate to dietician assessments and support. Items not included are paediatric supplementary drinks and feeding equipment.

Impact of claims on availability of rehabilitation services for children with CP using the public health sector

Arriving at a fair public sector cost for the package of care if it were to be delivered by the State

The "public health defence" has been successful in several cases recently[2], where the PDoH has been allowed to provide some of the necessary services for medico-legal claimants inside public hospitals, rather than pay for the claimant to access these services outside of the public health service.

The R484k cited earlier is a high-end estimate, particularly because the medico-legal costing the authors conducted includes some private sector costs.[6,7]

Although it is likely that additional Human Resources for Health (HRH) would be required to support the additional patient load, due to a lack of data these costs do not account for any additional HRH costs. Therefore, the additional cost shown in Table 4 is only for equipment (medical, therapy) and medical care (excluding HRH), which amounts to R305k (Table 4). Costs reliant on HRH are excluded given the already pressing shortage of allied health personnel in the public health sector.

We use the R305,454 cost in this section of the report to illustrate how claims impact on availability and access to public health services for children with CP who would also require these same services from the public health service.

Table 4: Estimated cost for non-human resource reliant rehabilitation services for children with CP

Overall Grouping	Annual budget: Year 1	Personnel-based cost	Cost for public sector delivery
Equipment: Assistive devices	135 375	No	135 375
Equipment: Communication devices	12 000	No	12 000
Equipment: Therapy devices	3 500	No	3 500
Medical care	46 780	No	46 780
Support: Nutritional	107 799	No	107 799
Support: Psychosocial	14 400	Yes	-
Therapy: Additional	39 452	Yes	-
Therapy: Block	26 500	Yes	-
Therapy: Regular	91 767	Yes	-
Total cost for year 1	**477 573**		**305 454**

Arriving at an estimate of children with severe disabilities who will enter the public health system each year

For the three target provinces, due to a lack of comprehensive disability data in South Africa, we have used the beneficiaries of the child Care Dependency Grant (CDG), reported in December 2022.[9] The CDG only goes to those who fall within an income threshold, and is for caregivers of children with severe disabilities. The income threshold for the CDG would also make these recipients reliant on public health services. KZN has the highest number of CDG recipients (Figure 3). However, this is likely to be an underestimation of the number of children living with disabilities in South Africa because of: (1) the gaps in how disability is measured and defined, (2) the lack of training for those conducting the assessments, and (3) because of the income threshold requirement for social grants.[10]

Figure 3: Number of child care dependency grants, per province (End December 2022)

Of these CDG recipients, we separate out those who received a new grant in 2022, to get a sense of the number of new recipients per annum. The social grants monitoring report, released by the Social Security Agency (SASSA), shows fairly stable month on month increases for each province, so we use the 2022 data, which was provided for the first three quarters of 2022†, and estimate what the full 2022 financial year new additions for the CDG would be, assuming applications are stable on a month-to-month basis. We arrive at 1,324 new CDG recipients in the Eastern Cape, 1,221 in Gauteng and 1,912 in KwaZulu-Natal.

If these new CDG beneficiaries (the children) were to receive the package of care described above, it would cost the EC PDoH R404m, the GP PDoH R373m and the KZN PDoH R584m per annum (Table 5). A reminder that these costs are only for the first year, so some of these costs would fall away in subsequent years until equipment needed to be replaced. This is therefore not an annual cost, but only the cost for the first year the child makes use of the rehabilitation services offered at the public health establishment.

Table 5: Estimating total new CDG recipients per annum

Province	April-Dec 2022 new CDG recipients	Monthly new recipients average	Annual estimate of new recipients	Cost of package of services for public health users R(m)
EC	993	110	1,324	R 404m
GP	916	102	1,221	R 373m
KZN	1434	159	1,912	R 584m

† The report only had data for the first three quarters of financial year 2022/2023

Calculating the additional children with severe disabilities that claim pay-outs could support

Table 6 shows how the funds paid out to claimants could be used to support more children with disabilities in each province. From Whittaker's (2021) report, we estimate that in the 2019 year, there were 84 successful claimants paid from the R766m in the EC, 93 successful claimants from the R502m in Gauteng and 35 successful claimants from the R180m in KZN, based on the average size of claim.[2]

Based on the estimated cost for year 1 of R305k, the EC and Gauteng PDoH's would be able to support all new CDG recipients with a full package of care for the first year and still have funding left over with the amount paid in claims. KZN's PDoH would be able to support 46% of new CDG recipients.

Table 6: Calculating additional children with disabilities who could be supported in the public health system with the claim payment quantum

Province	Claim pay-out per annum	Number of children who can be supported with claim pay-out	Estimated number of new CDG recipients	Support Coverage
EC	766 399 000	2 509	1 324	All, with surplus
GP	502 148 000	1 644	1 221	All, with surplus
KZN	180 444 000	591	1 912	41%

Summary

Table 7 provides a summary of the impact of medico-legal claims as described in this policy brief. Ultimately, EC and Gauteng could cover all new CDG recipients with surplus funding left over from the annual claim pay-outs that are going to just 84 and 93 claimants, respectively. For KwaZulu-Natal, they could cover 591 of the 1,912 new CDG recipients with the claim pay-out, this is still substantially more than the 35 claimants who received the pay-out in 2019. Ultimately, what this paper has shown is the opportunity cost for newly disabled children in having high and uncontrolled medico-legal claims in a province. Substantial funding is being directed to a few beneficiaries instead of for the greater public good.

That being said, where someone has suffered negligence, they deserve to be compensated adequately. Therefore, this brief is not proposing there is no redress for negligence, only that the systems and processes are strengthened so as to curtail negligence and support better management of medico-legal claims in the South African legal environment for the benefit of all who rely on our public health service.

Table 7: Summary of impact of medico-legal claims

Province	New CDG recipients each year	Cost to provide new CDG recipients with package of care	Medico-legal claim pay-out: 2019	Number of claimants pay-out covered	Number of CDG recipients annual medico-legal claim pay-out could cover
EC	1 324	R 404m	R 766m	84	2 509
GP	1 221	R 373m	R 502m	93	1 644
KZN	1 912	R 584m	R 180m	35	591

Conclusion

From the illustrative analysis provided in this research brief, it becomes clear that the quantum of claim pay-outs going to a few children with cerebral palsy could be used to serve a far greater number of children with disabilities if the funding remained with the PDoH budget. While all health systems are likely to experience negligence claims, and this should be budgeted for, the quantum of claim pay-outs in the South African public health system is no longer financially manageable or sustainable. The quantum of claims pay-outs is negatively impacting on children with disabilities who rely on the public health sector's support for rehabilitation and healthcare.

The public health service must urgently make progress with regards to improving the quality of healthcare and preventing patient safety incidents - this is the primary cause for medicolegal claims in the country. However, the medico-legal environment also requires reform to remove some of the legal flexibility that has prevented the determination of standardised pay-outs, that are based on empirical evidence. Thus, the quality of healthcare and legal reform must go hand in hand to support all South Africa children with disabilities in accessing adequate and high-quality care, to ensure their health, wellbeing, and quality of life for the child and their caregivers.

References

1. South African Law Reform Commission. Project 141: Medico-legal claims [Internet]. 2021 [cited 2022 Aug 30]. Available from: https://www.justice.gov.za/salrc/dpapers/dp154-prj141-Medico-Legal-Claims.pdf

2. Whittaker, Gregory. Medical Malpractice in the South African Public Sector [Internet]. Actuarial Society of South Africa; 2021 [cited 2022 Oct 10]. Available from: https://www.actuarialsociety.org.za/convention/wp-content/uploads/2021/09/Gregory-Whittaker-MedicalMalpracticeInTheSouthAfricanPublicSector-FullReport.pdf

3. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health 2018;6(11):e1196–252.

4. Donabedian A. Evaluating the Quality of Medical Care. Milbank Q 2005;83(4):691–729.

5. Wishnia J, Goudge J. Strengthening public financial management in the health sector: a qualitative case study from South Africa. BMJ Global Health 2021;6(11):e006911.

6. Khalawan S, Flowers M. A structured settlement costing tool for children with CP in SA. 2023;

7. Khalawan S, Ngidi A, Flowers M, Wishnia J. Policy brief on a structured settlements system. South Africa: Actuarial Society of South Africa; 2023.

8. Griffiths J. Judgement: TN obo BN v Member of the Executive Council for Health, Eastern Cape (36/2017) [2023] ZAECBHC 3 (7 February 2023). 2023 [cited 2023 Mar 6];Available from: http://www.saflii.org.za/za/cases/ZAECBHC/2023/3.html

9. South African Social Security Agency. Ninth statistical report: Social Assistance [Internet]. Pretoria: SASSA; [cited 2023 Mar 22]. Available from: https://www.sassa.gov.za/statistical-reports/Documents/December%202022%20%20social%20assistance%20%20report.pdf

10. Kidd S, Wapling L, Bailey-Athias D, Tran A. Social Protection and Disability in South Africa. United Kingdown: Development Pathways;