**COMMENTARY ON THE STATE LIABILITY AMENDMENT BILL**

**1. Introduction**

* 1. Algorithm Consultants & Actuaries submits the following comments on the State Liability Amendment Bill (“SLAB”).

1.2 The intention of SLAB is:

To amend the State Liability Act, 1957, so as to provide for structured settlements for the satisfaction of claims against the State as a result of wrongful medical treatment of persons by servants of the State; and to provide for matters connected therewith.

**2. Documentation**

2.1 In formulating our comments we consulted the following documents:

2.1.1 State Liability Amendment Bill (2018).

2.1.2 National Health System Litigation Authority Annual Report and Accounts 2017/2018 (United Kingdom).

2.1.3 Office of Health Standards Compliance Annual Inspection Report 2016/2017.

2.1.4 Eastern Cape Department of Health Annual Report for 2015/2016 and 2016/2017.

2.1.5 Gauteng Department of Health Annual Report for 2015/2016 and 2016/2017.

2.1.6 KwaZulu Natal Department of Health Annual Report for 2015/2016 and 2016/2017.

2.1.7 A paper entitled *Periodic Payment Orders* compiled by the General Insurance Research Organizing Committee of the Institute and Faculty of Actuaries 2010.

2.1.8 South African Law Reform Commission Issue Paper 33 on Medico-Legal Claims (2017).

2.1.9 Submission of Section 27 on the State Liability Amendment Bill dated 24 August 2018.

2.1.10 A paper compiled by the Structured Settlements Working Party of the Institute and Faculty of Actuaries 2000.

2.1.11 **Report of the Working Group on Legislation on Periodic Payment Orders dated 22 April 2015 (Ireland).**

2.1.12 American Congress of Obstetricians and Gynaecologists (ACOG) 2015 Professional Liability Survey Results.

2.1.13 Brakenridge, R.D.C. et. al. (2006). *Medical selection of life risks, 6th edition*. New York: Palgrave Macmillan.

2.1.14 Baergen, R. (2007). The Placenta as Witness. Clinics in perinatology. 34. 393-407.

2.1.15 Hwang, Chi-Yuan & Wu, Chien-Hung & Cheng, Fu-Cheng & Yen, Yung-Lin & Wu, Kuan-Han. (2018). A 12-year analysis of closed medical malpractice claims of the Taiwan civil court: A retrospective study. Medicine. 97.

2.1.16 Kos, Marina. (2012). Placenta: A silent witness: Clinical and forensic importance of placental examination. Materia Medica. 28. 533-539.

2.1.17 Bateman, C. (2014). Discard the placenta at your peril, pathologist warns doctors. South African Medical Journal. 104(11): 729-730.

2.1.18 Roescher, Annemiek & Timmer, Albert & Erwich, Jan Jaap & Bos, Arend. (2014). Placental Pathology, Perinatal Death, Neonatal Outcome, and Neurological Development:
A Systematic Review. PloS one. 9.

**3. Areas of commentary**

3.1 We have provided commentary on the following broad aspects:

3.1.1 Medical negligence litigation against the State covered in Section 4.

3.1.2 The global childbirth litigation industry covered in Section 5.

3.1.3 Structured settlements covered in Section 6.

3.1.4 Comparing lump sum settlements and structured settlements covered in Section 7.

3.1.5 Caregiving covered in Section 8.

3.1.6 Placental pathology covered in Section 9.

3.1.7 Life expectancy covered in Section 10.

3.1.8 Conclusions covered in Section 11.

**4. Medical negligence litigation against the State in South Africa**

4.1 The Financial Mail (19 July 2018 to 25 July 2018 edition) provides the following situation concerning medical negligence claims against the State in South Africa:

4.1.1 Contingent liabilities

 Table 1: Contingent liabilities (R’ million)

|  |  |  |  |
| --- | --- | --- | --- |
| Province | 2014/2015 | 2015/2016 | 2016/2017 |
| Eastern Cape | 8,211 | 13,421 | 16,773 |
| Free State | 540 | 941 | 1,307 |
| Gauteng | 10,079 | 13,452 | 17,844 |
| Kwa-Zulu Natal | 6,725 | 9,957 | 10,292 |
| Limpopo | 1,197 | 1,607 | 2,116 |
| Mpumalanga | 1,459 | 2,366 | 5,243 |
| Northern Cape | 174 | 343 | 1,221 |
| North West | 34 | 856 | 1,285 |
| Western Cape | 193 | 182 | 32 |
| Total | 28,612 | 43,125 | 56,113 |
| Claims lodged  | 1,562 | 1,732 | 1,934 |

4.1.2 Payments made

 Table 2: Payments made (R’ million)

|  |  |  |  |
| --- | --- | --- | --- |
| Province | 2014/2015 | 2015/2016 | 2016/2017 |
| Eastern Cape | 74.9 | 255.6 | 208.5 |
| Free State | 0.2 | 1.7 | 1.6 |
| Gauteng | 241.1 | 572.8 | 531.3 |
| Kwa-Zulu Natal | 103.5 | 90.4 | 251.3 |
| Limpopo | 35.6 | 9.6 | 74.8 |
| Mpumalanga | 7.6 | 15.2 | 34.4 |
| Northern Cape | 3.8 | 4.8 | 0.8 |
| North West | 13.2 | 6.4 | 29.5 |
| Western Cape | 19.3 | 28.1 | 38.4 |
| Total | 499.2 | 984.6 | 1,170.6 |

4.1.3 The value reported in respect of contingent liabilities is misleading as it merely reflects the value of summonses received. An analysis must be made linking final settlement values to original summons amounts. In certain matters merits fail and claims are nil. In other matters claimants die before the commencement of litigation and claim values are a fraction of the summons value.

4.1.4 By way of example, in the Western Cape, the contingent liability decreased by R 150 million from 2015/2016 to 2016/2017 and payments for 2016/2017 amounted to R 38.4 million.

4.1.5 An audit must also be conducted to rule out aspects such as double counting (for example, recording an amended summons amount as 2 claims).

**5. The global childbirth litigation industry**

5.1 The American Congress of Obstetricians and Gynaecologists (ACOG) 2015 Survey on Professional Liability revealed the following:

5.1.1 At least one professional liability claim was filed against 73.6% of respondents during their professional careers, with an average of 2.59 claims per ob-gyn.

5.1.2 Neurologically impaired infant claims were more likely to be the primary allegation of an obstetric claim (27.4%).

5.1.3 Of neurologically impaired infant claims; 55.2% were delivered by caesaren section, 40.5% were delivered vaginally, and 2.0% were delivered by VBAC.

5.2 In the United Kingdom, the National Health Service paid out approximately £ 2.2 billion in medical negligence claims in 2017/2018. Of that amount, approximately £ 595 million was paid in claimant and defence legal costs – claimant legal costs amounted to approximately 3.6 times defence legal costs.

5.2.1 In the United Kingdom, the National Health Service has experienced the following in respect of cerebral palsy claims:

5.2.2 Over the past 14 years, the number of claims has been between 179 to 255 a year. The total claim value has increased significantly from £ 359 million in 2004/2005 to £ 1.861 billion in 2017/2018.

5.3 Hwang et al. note that with respect to a 12-year analysis of closed medical malpractice claims of the Taiwan civil court that:

 The most common single specialty involved was obstetrics (10.7%)

Increased public education to prevent unrealistic expectations among patients is recommended to decrease frivolous lawsuits. Further investigation to improve the lengthy judicial process is also necessary to relieve the stress of medical malpractice claims on clinicians and practitioners, as well as on the judicial system and rightful claimants.

**6. Structured settlements**

6.1 A Structured Settlement is defined as follows by the National Structured Settlement Trade Association of the United States:

 *“A structured settlement is the payment of money for a personal injury claim where at least part of the settlement calls for future payment. The payments may be scheduled for any length of time – usually as long as the claimant’s life – and may consist of instalment payments and/or future lump sums. Payments can be in fixed amounts or they can vary. The schedule is structured to meet the financial needs of the claimant.”*

**6.2 Under SLAB compensation for medical negligence against the State** can either be in the form of a single lump sum or, alternatively, as a series of regular payments over the remainder of the claimant’s lifetime. The latter is known as a structured settlement, or a periodic payment order.

6.3 SLAB makes provision for payments to be made once a year and are linked to the consumer price index. Linking payments to the consumer price index may be challenged. In the United Kingdom in the case of *Thompstone v Tameside & Glossop Acute Services NHS Trust*; the Courts ruled that a higher earnings index could be used instead of the consumer price index. This resulted in a substantial increase in the value of periodic payments.

6.4 SLAB is silent as to whether there can be a provision for step changes in the regular payment amount to be written into a structured settlement. These are known as stepped structured settlements and apply at fixed points in time to situations where a specific change in circumstance has already been foreseen at the time of settlement. For example, care giving costs typically increase after a child attains 18. It is preferable to make provision for stepped structured settlements so that Section 2A(4) is not relied upon unnecessarily.

6.5 SLAB makes provision for variability orders, whereby the case can return to court in specific circumstances, such as a deterioration in the claimant’s medical condition. For both the stepped and variability orders, the terms under which the increase in payments will be triggered have to be defined clearly at the time of the settlement.

**7. Comparing lump sum settlements and structured settlements**

7.1 Flexibility

From the claimant’s perspective the main advantage of a lump sum settlement is that it provides an immediate cash benefit for the estimated total loss. This provides the claimant with maximum flexibility. Under a structured settlement this advantage is lost.

7.2 Dissipation risk

Dissipation risk relates to the risk that the claimant dissipates the award well in advance of needs. Alternatively, the claimant could under-spend and unnecessarily compromise quality of life. In the event of dissipation, the State will end up bearing the additional costs arising from the misjudgment or choice of the claimant. A structured settlement reduces this risk substantially.

7.3 Adequacy risk

This is the risk that the compensation paid may be more or less than the claimant’s actual needs. The only way to eliminate this risk is through a structured settlement.

7.4 Mortality risk

This is the risk that the claimant may live for a longer or shorter duration than the basis of the award. For a structured settlement the risk would stay with the State. Another aspect of the mortality risk is the return of capital in the event of early death. This has been adequately addressed in the matter of *AD and Another v MEC for Health and Social Development, Western Cape Provincial Government* (27428/10) [2016] ZAWCHC 116.

7.5 Investment risk

This is the risk that the investment return achieved by the claimant falls below the anticipated basis of the award. Currently a Trustee can invest in riskier securities than a Curator.

7.6 Inflation risk

This is the risk that the escalation of costs may exceed the basis of the award. The structured settlement under SLAB provides for increases in line with the consumer price index. However, this does not eliminate the risk for the State since actual costs, such as care in a State Institution may inflate at a higher rate.

7.7 Default risk

It is unclear if the regulatory regime for structured settlements would afford good default risk protection. This must be viewed against the decline in South Africa’s credit rating.

7.8 In summary

Even though claimants have historically tended to prefer a settlement in the form of a lump sum, it is widely argued that it is in the claimant’s best interest to receive compensation in the form of regular payments instead. The primary reason for this (other than the possibility that a claimant may choose to spend most of the money up front) is that a structured settlement takes away most of the risks that are inherent in a lump sum. For example, should the claimant live longer than was anticipated at the time of the settlement, there is the potential for the funds from a lump sum to run out, whereas, by definition, a structured settlement will continue to pay out for the remainder of the claimant’s lifetime. Changes in the economic environment can also affect the value of a lump sum; for example, if inflation proves to be higher than was expected at the time of settlement then the value of the lump sum will be eroded. Similarly, 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.

**8. Caregiving**

8.1 The largest cost driver of medical negligence claims in birth injuries is the cost of future caregiving. SLAB does not address this.

8.2 With respect to the total claim for future medical and related expenses, the cost of future care giving and assistance (including the cost of training care givers, domestic assistance and the costs of an *au pair*) constituted the following proportion of the total claim for future medical and related expenses in various matters:

8.2.1 36.7% in *Singh and Another v Ebrahim* (413/09) [2010] ZASCA 145.

8.2.2 53.5% in *Lochner v MEC for Health and Social Development, Mpumalanga* (2012/25934) [2013] ZAGPPHC 388.

8.2.3 48.3% in *AD and Another v MEC for Health and Social Development, Western Cape Provincial Government* (27428/10) [2016] ZAWCHC 116.

8.3 Set out in the graph below is a comparison of a lump sum, periodic payments that have not been discounted and periodic payments that have been discounted.

8.3.1 The **lump sum** is indicated in **green**. It has been calculated on the basis that a caregiver would be required at a cost of R 240,000 per annum for life. The injury party is assumed to be a male child aged 10 years old with a life expectancy of an additional 20 years. Future caregiving costs have been inflated at an assumed 6% per annum compound and have been discounted at 8.65% per annum compound (a net discount rate of 2.5% per annum compound is therefore assumed). The underlying mortality table is taken as the same as used for the cases in paragraph 8.2.1 to 8.2.3 above; adjusted so as to allow for a future life expectancy of 20 additional years.

8.3.2 The **blue** bars illustrate the cumulative total **undiscounted structured settlement claim** should the claimant survive a further 0, 1, 2, 3,…,25 years. Although life expectancy is estimated at 20 years the claimant could die sooner or live longer. The graph illustrates this by indicating the amount payable should the claimant die 0 to 25 years after the date of trial (though it could be longer).

8.3.3 The cost of care giving is taken as R 240,000 initially. It is assumed that this will be paid at the beginning of each year and escalate at 6% per annum compound.

8.3.4 The total estimated amount paid is materially larger under a structured settlement award since structured settlement payments are undiscounted whilst the lump sum award already includes an allowance for discounting.

8.3.5 The **red** bars show the effect of **discounting the structured settlement** cash flows at a net discount rate of 2.5% per annum compound. The difference between the values at each age is less pronounced than on an undiscounted basis.

**9. Placental pathology**

9.1 As noted by Roescher, et al.:

It is thought that the pathogenesis of neurological impairment has an antenatal as well as an intra-partum component. An event weeks before delivery can result in a non-optimal fetal environment. This might result in lowering the threshold required for more recent events to cause brain injury. Placental lesions can be such an antenatal event.

In summary, despite the difficulties in studying the relation between placental lesions and neurological morbidity, and the inconsistent results, some conclusions can be drawn. For those studies finding a relation with poor neurological outcome, the placental lesion is ascending intrauterine infection with a fetal response. Furthermore, in term infants a larger variety of placental lesions seem to be associated with poor neurological outcome compared to preterm infants. Knowledge on the pathophysiological mechanisms leading to long-term neurological deficits may lead to possible interventions to improve outcome. The fact that the placenta is available for histological examination immediately after birth and that it may reveal valuable information for pediatricians, leads to an early opportunity to intervene to the benefit, hopefully, of ill neonates.

9.2 As noted by Baergen:

The placenta not only "records" and reflects the intrauterine environment, it also provides valuable information on the cause and timing of many adverse events and conditions. The placenta may be useful in several ways. It may be the cause of injury due to an inherent abnormality, it may "malfunction" because of disease processes that are not primarily placental in origin, or it may merely reflect an abnormal intrauterine environment. Not only may the etiology of the injury be ascertained from placental examination, but also a time frame during which the abnormal condition has been operating. Acute lesions may be associated with sudden catastrophic events, whereas other, more chronic lesions lead to decreased placental reserves. Markedly depleted reserves will render the infant susceptible to other, sometimes more acute, events and thus are also associated with significant injury or even death.

9.3 As noted by Kos:

In all the surveys, neurological impair is the leading cause of the reasons for liability claim, with the cerebral palsy being the most serious damage. The possible etiologies have been discussed for years, and although the damage to neural tissue is undebatable, there is still no agreement upon the timing of the damage. Some authors think that 90% of the cases of cerebral palsy are not due to intrapartum events, while in the opinion of others most of the devastating events occurred in the perinatal period. It is still impossible to firmly determine in each single case whether the hypoxic insult has developed during delivery, in the first few hours after birth, or was already present before the labor began, as a consequence of long lasting hypoxia during pregnancy.

The basis of litigation claims against obstetricians, anesthesiologists and neonatologists is the notion that fetal death or neurological disabilities are the result of failure or delay in intervention or inappropriate management of injuries believed to have occurred during the process of delivery. The intense fetal monitoring and changes in methods of delivery have decreased the incidence of cerebral palsy, but not substantially.

The placenta is an easily available specimen and the costs of a routine pathological examination are moderate, so in all doubtful cases, the clinicians should not hesitate to ask for a pathological analysis and opinion.

9.4 As noted by Bateman:

Wright said numerous studies had shown that babies who had ‘an event’ during the course of their mother’s pregnancy went into labour already compromised. The placenta was normally ‘relegated to the sink’. Her experience at Tygerberg Hospital in the year 2000 was that she saw just six placentas from an ‘excellent’ and extremely busy neonatal unit that year. Through her advocacy and that of her colleagues, this improved to 848 placentas a year (still just 15% of deliveries) by 2004/5, when there were only 30 cases of clinically suspected intrapartum hypoxia. On examination, the placenta was normal in only one of these 30 cases, the remainder all showing some degree of pathology unsuspected by the attending clinician.

9.5 The State is urged to conduct a cost-benefit analysis of setting up a fully functional placental pathology unit. Thereafter, norms and standards for referral criteria can be established.
As noted in Bateman:

Wright said that the commonest causes of intrapartum hypoxia were placental abruption and cord accidents (i.e. cord prolapse), both sudden and unpredictable events. Where she was now working (Dora Nginza Regional Hospital in Port Elizabeth), nearly every baby delivered with a low Apgar score was labelled as having birth hypoxia. ‘If that’s seen by a lawyer, it’s a field day because you then have to prove it was not,’ she warned.

**10. Life expectancy**

10.1 A key assumption affecting quantum is life expectancy. This key assumption is complicated by the fact that usually there are two sets of experts arguing a different value.

10.2 How accurate are life expectancy assumptions?

10.2.1 There are a number of factors that may lead to over-estimation of the life expectancy. These include plaintiff lawyers pushing up life expectancy, courts wanting to ensure sufficient funds, suicide or drug use by claimants and reducing care to save money.

10.2.2 There are a number of factors that may lead to under-estimation of the life expectancy. These include the impacts of full time care (for example, picking up tumours or medical needs sooner) and the removal of a number of risk factors (driving, extreme sports).

10.3 The State needs to establish a centralized database of cerebral palsy claims and conduct a complete mortality analysis so that claims can be settled on local experience. At present there is no feedback loop.

10.4 We are in the process of analysing around 200 cerebral palsy claims and will report with our first findings in July 2019.

**11. Conclusion**

11.1 Whether or not there will be savings under the structured settlement basis is difficult to establish. The intention is to ease cash flow concerns but the liability still remains.

11.2 The lump sum approach readily accommodates reductions in settlements for contributory negligence. This is potentially impossible under a structured settlement unless for example care costs were to be made exempt and/or damages under other heads of damage could be used to fund the shortfall.

**11.3 We consider structured settlements impractical for the following reasons:**

**11.3.1** The State’s liability is significantly more variable. This would increase the uncertainty affecting the State’s financial position and has implications for its credit rating. It is unclear how the unfunded liability will be accounted for by Treasury.

11.3.2 The physical consequences of an injury suffered may change over time. This suggests that any system based on structured settlements would require regular reviews of individual cases. This will prove costly for both the State and claimants and result in continuing disputes.

11.3.3 The costs of administering a structured settlement would be much higher than a lump-sum settlement. In addition, there are regulation, cost and implementation implications that would have to be overcome. According to the Office of Health Standards Compliance Annual Inspection Report for 2016/2017, South Africa has 3,816 public health establishments (clinics, community health centres and hospitals combined). An inspection of 696 of these establishments revealed that only 5 were compliant with a score of more than 80%. No public health establishments in the Eastern Cape or Kwa-Zulu Natal were fully compliant – these 2 provinces accounting for around 48% of the total contingent liability faced by the State in the entire country. We therefore support Section 27’s contention that:

This state of affairs cannot be fixed by changing the legal framework in which medical negligence claims are adjudicated. Rather, the solution lies in strengthening health systems by investing in more and appropriately trained health care workers, ensuring that health care workers are appropriately equipped and keeping proper records.

11.4 The payments made in respect of structured settlements will build over time. Ultimately annual payments will increase to meaningful levels, many of these payments relating to claims settled many years previously. The burden of administrating these claims will add a significant cost element in addition to the original claim amounts. Before implementing a system such as SLAB, it is critical to obtain a proper estimate of administrative costs. By way of example, the Compensation Fund is administratively expensive at 17.8% of benefit payments. Accounting for the liability arising out of claims is an extremely complex exercise and one that is the subject of ongoing debate among insurance and reinsurance actuaries.

11.5 SLAB does nothing to limit the State’s liability which should be the core focus in the medical negligence arena. We are in agreement with Section 27 that SLAB is not the answer.