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SUBMISSIONS TO THE PORTFOLIO COMMITTEE ON JUSTICE AND CORRECTIONAL SERVICES IN RESPECT OF THE STATE LIABILITY AMENDMENT BILL [B16-2018]

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INTRODUCTION

1. We refer to the call for comment relating to the State Liability Amendment Bill, B16-2018 ('the Bill'). We welcome the opportunity to make these submissions and to engage with issues related to the Bill. **We also take this opportunity to note that we will avail ourselves to make oral representation on the submissions made herein should we be called upon to do so.**

2. As was stated by the Department of Justice and Constitutional Development in Parliament during the introduction of the Bill, the main motivation for amending the State Liability Act 20 of 1957 is the financial strain caused by medical claims against the Department of Health particularly from cerebral palsy which is as a result of complications and negligence during childbirth.[1] It is our submission that focusing on only the fiscal impact of these claims completely ignores the root cause of the problem i.e. the harm, injury and violence suffered by women especially in accessing public health due to negligence, poor quality among others. This approach has the serious effect of devaluing women's bodies, women's suffering and consequently women's rights especially the rights to equality, dignity, health including sexual and reproductive health and bodily autonomy.

3. Our submission is focused on the gendered nature of this harm.

   3.1. We will focus on the plight of women in South Africa who experience serious human rights violations, in their various forms, when accessing public hospitals in order to give birth, or access pre-natal healthcare services.

   3.2. We centre our submissions and recommendations on the disproportionate effect that poor public health care services has on women in South Africa, and note the absence of concrete positive steps taken currently to address the root problem causing many women to suffer such injustices and resorting to courts for relief.

   3.3. We emphasise that holding the state liable therefore remains the main source of recourse available to women in this position to vindicate their rights and allow them to live in equality and dignity as envisaged by the Constitution of the Republic of South Africa, 1996 ('the Constitution'). The bill frustrates this option for women.

4. Our submission is divided into three parts:

   4.1. **In Part A** we introduce the organisations making this submission;

   4.2. In **Part B** provides the general framework relevant for the Bill which must borne in mind including an overview of the right to healthcare services in South Africa and the experiences of women giving birth in public facilities;

   4.3. **In Part C** we make specific submissions relating to some provisions of the Bill.

A. INTRODUCTION TO THE AUTHORS

5. The **Legal Resources Centre ('LRC')** is a public interest, non-profit law clinic in South Africa that was founded in 1979. The LRC uses the law as an instrument of justice to facilitate the ability of vulnerable and marginalized persons and communities to assert and develop their rights; promote gender and racial equality and oppose all forms of unfair discrimination; as well as contribute to the development of human rights jurisprudence and to the social and economic transformation of society. The LRC

[1] https://pmg.org.za/committee-meeting/26832/.

operates throughout South Africa with offices situated in Johannesburg, Cape Town, Durban and Grahamstown. Through strategic litigation, advocacy, education and training, the LRC has played a pivotal role in developing a robust jurisprudence in the promotion and protection of equality and non-discrimination, and other constitutional rights. A significant proportion of the LRC's work has been in the sphere of gender equality, non-discrimination and addressing the disproportionate burden faced by women in poor service delivery. Within the arena of equality and non-discrimination, the LRC has viewed the rights of vulnerable and marginalised persons including refugees, children and women, among others, as being integral to the advancement of society and achieving equality in justice for all.

6. The **Women's Legal Centre** ("The Centre") is an African feminist legal centre that advances women's rights and equality through strategic litigation, advocacy and education and training. We aim to develop feminist jurisprudence that recognises and advances women's rights. The Centre drives a feminist agenda that appreciates the impact that discrimination has on women within their different classes, race, ethnicity, sexual orientation, gender identity and disability. The Centre does its work across five programmatic areas including the right to be free from violence, women's rights in relationships, and women's rights to land, housing property and tenure security, women's sexual and reproductive health rights and women's rights to work and at conditions of work.

B. PREVAILING CONTEXT OF ACCESS TO HEALT CARE IN SOUTH AFRICA: THE UNENDING STRUGGLE FOR WOMEN

a. Gendered Burden of Poverty

7. Women in South African are more impoverished than men, with a poverty headcount of 58,6% as compared to 54,9% for men according to Statistics South Africa.[2] Approximately 83% of the population in South Africa rely on public facilities for healthcare and therefore more than 46 million people will be affected by this amendment to the State Liability Act, the majority of whom are women.[3]

b. Racial divide in accessing healthcare services in South Africa

8. As was noted by the Health Department, prior to the 1994 democratic breakthrough, South Africa had a fragmented health system designed along racial lines. One system was highly resourced and benefited the white minority while the other was systematically under-resourced and was for the black majority.[4] It was further noted that, "*post-1994 attempts to transform the healthcare system and introduce healthcare financing reforms were thwarted. This has entrenched a two-tiered health system, public and private, based on socioeconomic status and this system continues to perpetuate inequalities in the current health system*."[5]

9. While there has been some progress in trying to bridge the poverty and racial gap in accessing health care services, "*the health system's effectiveness and efficiency still remains a huge challenge. These challenges are more pronounced in relation to the inequitable financing of the health care system whereby the poor are still largely marginalised and many other South Africans are at risk of*

[2] Statistics South Africa "Poverty in South Africa". Available at: http://www.statssa.gov.za/?page_id=739&id=1.
[3] The Council for Medical Schemes. Annual report 2014/15. Council for Medical Schemes; 2015 Available at: https://www.medicalschemes.com/files/Annual% 20Reports/AR2014_2015.pdf.
[4] Republic of South Africa Department of Health. National health insurance for South Africa: towards universal health coverage. Republic of South Africa Department of Health; 2015 Available at: https://www.health-e.org.za/wpcontent/uploads/2015/12/National-Health-Insurance-for-South-AfricaWhite-Paper.pdf.
[5] Ibid.

catastrophic health expenditure."[6] Catastrophic health care expenditure: health care expenditure resulting from severe illness/injury that usually requires prolonged hospitalisation and involves high costs for hospitals, doctors and medicines leading to impoverishment or total financial collapse of the household.[7] In simple terms, those injured or harmed through negligence potentially could be pushed deeper into poverty because of the medical needs required as a result of the injury.

c. Experiences of Women in accessing Women Specific Services in Public Health: The perpetuation of Gender Discrimination

10. We emphasise that childbirth is a women-specific experience. As a result of the direct link between gender, poverty and racial discrimination from apartheid, indigent women continue to be marginalised in their ability to access basic services, such as healthcare. The Constitutional Court in South Africa is committed to the transformative values of the Constitution and has reiterated the importance of providing adequate services to marginalised, vulnerable persons. An example of the Court's commitment is the case of *The Government of the Republic of South Africa and others v Grootboom and others*[8] in which Mrs Irene Grootboom and other respondents were left homeless after an eviction from their informal homes. The Court confirmed that rights entrenched in the Bill of Rights cannot only be understood in their textual setting, but rights must be understood in their social and historical context.[9]

11. As already mentioned, health care services in South Africa have historically been skewed in terms of race, gender and socio-economic status. The institutional mechanisms established to deliver health care services have historically reflected and continue to reflect a disproportionate bias in favour of dominant groupings in society, with specific services for women continuing to lag behind other services.[10]

    11.1. Childbirth in South Africa continues to be divided along racial lines with black and coloured women giving birth primarily in public facilities and white women giving birth with specialist physicians in private hospitals.[11]

    11.2. Increasingly women are being encouraged to give birth in a health facility.[12] It has been reported that 90% of women are giving birth in healthcare facilities.

    11.3. The public sector is providing care for 83% of the South African population.[13] Therefore it is imperative for the state to inspect the status of obstetric care provided in public health facilities in hopes of putting measure in place to address the burdens and vulnerabilities mentioned above.

    11.4. We submit that when the state allow poor services to continue to be rendered in women for women specific health care services like child birth the state discriminates against women on the basis of race, pregnancy, sex, gender among others. Section 9 of the Constitution prohibits unfair discrimination. The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 ('**PEPUDA')** gives effect to section 9 of the Constitution and also prohibits

[6] Ibid.
[7] Ibid.
[8] [2000] ZACC 19.
[9] Paragraph 22.
[10] K Moyo "Realising the right to health in South Africa" (2016) Foundation for Human Rights page 5.
[11] M Hasting-Tolma, A Tolte & A Temane "Birth Stories From South Africa: Voices Unheard" (2018) *Women and Birth* 31 p43.
[12] Ibid.
[13] Ibid.

discrimination on the basis of sex, gender, and pregnancy. Section 8 of PEPUDA specifically prohibits unfair discrimination on the ground of gender including gender-based violence; any practice which impairs the dignity of women and undermines equality between women and men; discrimination based on the ground of pregnancy and systematic inequality of access to opportunities by women as a result of the sexual division of labour. This is the case with childbirth.

11.5. In determining whether discrimination is fair or unfair, section 14 of PEPUDA states that some of the factors taken into account include whether the discrimination impairs or is likely to impair the dignity of a person; the impact of the discrimination; position of a person in society and whether they have suffered patterns of disadvantage; extent of the discrimination; and whether it is systematic, among others.

12. Some of the specific examples of poor birthing experiencing that women have undergone in South Africa which indicates poor, unequal, inefficient medical care which has led to medical negligence claims include (these are examples taken from court cases or judgments):

i. <u>High Perinatal Mortality Rates</u>

13. The perinatal mortality rate is not only an indicator of maternal health but also a vital indicator of quality of obstetric care offered. According to Statistics South Africa, the perinatal mortality rate in South Africa in 2016 was 21 deaths per 1000 live births. The vast majority of perinatal deaths are preventable with proper maternal care.[14] A report compiled for the Perinatal Problem Identification Program found that almost half of the deaths that occur due to asphyxia – a complication that can cause cerebral palsy as well – were preventable with better foetal monitoring.[15] The report further notes that in a third of babies dying with hypertension, the hypertension was detected but the medical staff failed to act on the matter.

14. The World Health Organization (WHO) defines the perinatal mortality rate as the number of stillbirths and deaths in the first week of life per 1000 births. The Birth and Death Registration Act 51 of 1992 defines stillborn as "at least 26 weeks of intra-uterine existence but showed no signs of life after complete birth".

ii. <u>Worsening Maternal Mortality Rates</u>

15. South Africa's maternal mortality rate has increased from 85 deaths per 100 000 live births in 2005 to 138 deaths per 100 000 live births in 2015 according to the WHO.[16] We noted that in 1990 WHO reports this to have 108 deaths per 100 000 births. Therefore, South Africa is experiencing an increase in maternal mortality whereas the global trend is a sharp decrease. This is an indication of regression of quality of obstetric care offered by public health facilities in South Africa.

iii. <u>High Incidences of Obstetric Medical Negligence</u>

16. Although substandard care has been recognised as a serious problem in South Africa, there is very limited research on the quality of care during childbirth.[17] A study done by Silal et al[18] highlights the low standard of quality of care experienced by women in public health facilities during antenatal care and delivery. The empirical research showed that out of the sample size of 300 women, all but one

[14] http://www.statssa.gov.za/publications/P03094/P030942014.pdf
[15] Report available at: https://www.ppip.co.za/wp-content/uploads/Saving-Babies-2012-2013.pdf
[16] http://apps.who.int/gho/data/node.main.15?lang=en
[17] M Hasting-Tolma, A Tolte & A Temane "Birth Stories From South Africa: Voices Unheard" (2018) *Women and Birth* 31 p43.
[18] S Silal, L Penn-Kekana, B Harris, S Birch & D McIntrye "Exploring inequalities in access to and use of maternal health services in South Africa" (2012) 12 *BMC Health Services Research.*

woman were generally dissatisfied with the quality of care their received in the public health facility. Four of the 300 women experienced stillbirths and explained that after the stillbirth they were placed in maternity wards with mothers and new born babies. Another study done by Chadwick et al[19] highlighted four central themes in women's narrative of distress in health facilities:

16.1. **(1) Negative interpersonal relations with caregivers:** women receive hostile and punitive treatment; humiliation; they are being told to 'clean up their mess' after giving birth and screamed at.

16.2. **(2) Lack of information:** nurses and midwives withheld information from women even after they request the specific information and birth complications were not explained to women. Consequently, they could not actively participate in their own birth experience and have a say about their own bodies.

16.3. **(3) Neglect and abandonment:** women are being left alone for hours and nurses tell patients 'they forget about them'.

16.4. **(4) Absence of labour companion:** women giving birth in public facilities are often denied the presence of labour companions.

17. These studies indicate serious levels of poor service delivery in public health facilities. We highlight a few cases that have been litigated as a result of the poor services:

17.1. **Still birth caused by medical negligence**:

17.1.1. ***Hoffman v Member of the Executive Council Department of Health, Eastern Cape 2011 JDR 1081 (ECP):*** Plaintiff was ignored when she informed the hospital staff that she is a high-risk patient and must give birth by caesarean section. After the hospital staff informed the plaintiff that she must monitor the foetal heart rate with a machine, the plaintiff informed the staff that the heart rate was low. The caesarean section was only performed hours later, and the infant was still born. The court held that the defendants acted negligently and is liable to pay damages to the plaintiff.

17.1.2. ***Mbhele v MEC for Health (355/15) [2016] ZASCA 166:*** The foetus was in distress and despite the woman requiring urgent medical treatment, the hospital staff did not attend to her during labour and the child was stillborn. The plaintiff was also placed in a ward the with mothers and their new-born babies and compelled to identify the body of her baby at the mortuary. The defendant was held liable and ordered to pay damages for the pain and suffering caused by negligence.

17.2. **Child born with cerebral palsy caused by birth implications**:

17.2.1. ***Makgomarela v Premier of Gauteng and another [2012] ZAGPJHC 217:*** The plaintiff was given Prostin during labour, which is against hospital regulations and placed the baby in distress. The negligence caused hypoxia which resulted in cerebral palsy. The court held that the hospital, and by vicarious liability the two defendants, was negligent and liable to pay the plaintiff damages.

17.2.2. ***Sifumba v Member of the Executive Council for Health Eastern Cape 2015 JDR 1597 (ECM):*** The plaintiff sought and was denied emergency medical treatment, that the defendant's employees failed to monitor the foetal heart rate at 30minute intervals, failed to take

[19] R Chadwick, D Cooper & J Harris "Narratives of distress about birth in South African public maternity settings: A qualitative study" (2014) 30 *Midwifery*.

precautions against foetal distress, failed to detect foetal distress, failed to transfer the plaintiff to another hospital and failed to perform a caesarean section timeously. The child's brain injury resulted in cerebral palsy and the court held that the defendant was negligent.

17.2.3. ***Tsita v MEC for Health and Social Development Gauteng 2015 JDR 1539 (GJ):*** Plaintiff was in prolonged labour and the hospital should have opted for a caesarean section. Instead they waited for normal birth. The long labour resulted in the baby being born with cerebral palsy.

17.2.4. See also: ***Xolile v MEC for Health and Social Development Gauteng 2016 JDR 2004 (GJ); Smith v MEC for Health Gauteng 2015 JDR 1819 (GJ); Paia v MEC for Health and Social Development 2017 JDR 0735 (GJ).***

17.3. **Surgical negligence during birth**:

17.3.1. ***Nzimande v Member of the Executive Council for Health, Gauteng 2015 (6) SA 192 (GP):*** During the caesarean section the surgeon cut the baby on its arm and the child later required further surgery as the wound became infected. The hospital waited 9 days to clean to the wounds of the baby. The court held that the hospital was negligent and ordered the defendant to pay damages for patrimonial and non-patrimonial losses.

18. These systemic problem and the lack of address was raised in the case of *M v Member of the Executive Council for Health, KwaZulu-Natal*[20] in which the court said the following:

> *"Although they represent as a bipolar dispute between a plaintiff and a defendant with the remedy being findings on liability, compensation and costs* ***the problem of malpractice remains institutional.*** *Malpractice suits are retroactive in the sense that they seek to remedy past wrongs. The litigation resolves the dispute but not the institutional problems****. Remedies that are forward-looking, that seek to resolve problems for the future should be considered for long-term sustainable solutions. The court cannot initiate such remedies without the co-operation of the litigants.***[21]"

19. Because of the poor services received, by mid-2017, contingent liabilities for alleged medical negligence in the public sector reached R55 billion, excluding legal expenses.[22] As stated in the Issue Paper 33 on Project 141 Medico-Legal Claims by the South African Law Reform Commission ('the Issue Paper') not all claims of medical negligence go as far at the court and the majority of claims are settled before proceeding to court.[23] Some claims do not reach the courts at all as they are settled beforehand after the responsible facility admits negligence. This indicates that the magnitude of the problem exceeds far beyond what has been reported or been made accessible through reports. More worryingly, there is a continued violation of women's bodies, there positions in society marginalised, and women continue to be invisible or blatantly ignored when key steps are taken to budget and plan for their empowerment, equality and affirmation of their place in society.

20. In further assessing the fairness or unfairness of the discrimination, one of the factors that are considered is whether and to what extent reasonable steps have been taken to address the disadvantage which arises from or is related to one or more of the prohibited grounds. We do not believe that reasonable or any steps have been taken to systematically overhaul the structural failures

[20] Unreported case no 14275/2014.
[21] Para 79.
[22] B Taylor, J van Waart, S Ranchod & A Taylor "Medicolegal storm threatening maternal and child healthcare services" (2018) 108 *South African Medial Journal* 149-150.
[23] Paragraph 2.30

and abuses faced by women when approaching public facilities to improve the experiences of women during childbirth.

21. The redress sought in medical malpractice cases therefore is a way for these women to restore their dignity and vindicate their marginalisation in health care. Accordingly, the judiciary in South Africa plays an important role to ensure that a person harmed or whose rights were violated has access to justice as envisaged by the Constitution of South Africa.

d. Violations of the Right to Health including Sexual and Reproductive Healthcare

22. The right to health care is not only guaranteed in the Constitution but is also a well-established right in international law. Section 27 of the Constitution provides for the right to healthcare for *everyone*, which explicitly includes access to reproductive health care. Section 12(2) of the Constitution confirms that everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction and to control over their body.

23. The International Covenant on Economic, Social and Cultural Rights ("ICESCR") provides for the right to health in article 12 by enjoining states to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Committee on Economic, Social and Cultural rights (CESCR), in its General Comment No. 14, has elaborated on the normative content of the right to health by recognising the right to health to include equal access for all, on the principle of non-discrimination, to health care facilities, goods and services.

24. Article 12 of the Convention on the Elimination of all forms of Discrimination against Women ("CEDAW") encourages states to take appropriate measures to eliminate discrimination against women in the field of health care. Additionally, states are compelled to ensure to women specific services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

25. On a regional front, Article 14(1) of The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa provides that states parties shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted.

26. All the above clearly establish that the state has an obligation to act and improve the experiences of women in childbirth including guaranteeing the right to equality, dignity, health care, bodily autonomy among others. Section 7(1) of the Constitution is clear in its statement that the state must respect, protect, promote and fulfil the rights in the Bill of Rights, with the state including the Legislature. We will now discuss what this obligation means.

RECOMMENDATIONS:

TAKE URGENT AND IMMEDIATE STEPS TO ADDRESS THE SYSTEMIC FAILURES AND SHORTFALLS IN THE PUBLIC HEALTH SECTOR FACILITIES PROVIDING SERVICES TO WOMEN FOR CHILD BIRTH IN ORDER TO GURANTEE THE RIGHTS OF WOMEN

27. We note from the offset that we are aware that the State Liability Amendment Bill is intended to be an interim mechanism while the larger investigation into medico-legal claims by the South African Law Reform Commission is being done. However, we submit that this step of amending the State Liability Act sends an unfortunate fundamental message – that the state will only care about women-specific struggles enough to take steps when women's needs to vindicate their rights are affecting their budgets, and the first step to solving this problem is limiting the manner in which such persons can receive financial redress from court. This is apparent from the fact that the first step taken or even the

long term steps by the SALRC will not address the root problem – namely the existence of poor, violent and inadequate services for child birth in public healthcare facilities. We humbly submit that at this stage the immediate and urgent step taken by the state must be to improve the quality of care given in these facilities and reduce the number of women with poor experiences of birth.

28. It is our submission that the issue at hand is not a legal one, but rather an issue of lack of training, administering and accountability in the respective health facilities providing child birth services and care. Amending the legislation that governs the payment of damages *ex post facto* medical negligence does not provide a durable solution in our opinion; rather, it explains that there is no willingness to put women first.

29. Section 27(2) confirms that the state must take reasonable legislative *and other measures,* within its available resources, to achieve the progressive realisation of each right. Other measures must, amongst others, include inquiry into the service delivery at public health facilities. There has not been sufficient systematic inquiry into women's birthing experiences in healthcare facilities and therefore the state is failing in part its obligation confirmed in section 27(2) of the Constitution.[24]

30. The court in *Grootboom* case noted the following regarding reasonable measures to realise rights entrenched in the Bill of Rights:

"The state is required to take reasonable legislative and other measures. Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The state is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programmes implemented by the executive. These policies and programmes must be reasonable both in their conception and their implementation. The formulation of a programme is only the first stage in meeting the state's obligations. The programme must also be reasonably implemented. An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the state's obligations."[25]

31. We concur with the Chairperson of the Portfolio Committee for Justice and Correctional Services, Mr Mulaudzi, that this problem is not just caused by a few events, but that there is a much bigger problem.[26]

a. Need to provide positive experiences in accessing state hospitals

32. The current dire state of health care in South Africa necessitates the need to reform health service delivery. The state has an obligation to provide women who approaches a public healthcare facility with positive experiences.

33. **Only five out of 649 health facilities across South Africa are found to be compliant with the Department of Health's norms and standards according to the Office of Health Standards Compliance.[27] All available resources and time should first be spent on fixing the hospitals to improve the experiences of those accessing such services before legislative amendments are considered that prescribes the way in which redress can be sought. We believe that this approach puts women first and sends a clear message about their position and value in society.**

[24] M Hastings-Tolsma, A Nolte & A Temane "Birth Stories from South Africa: Voices Unheard" (2018) 31 *Women and Birth* p42-50.
[25] Paragraph 42.
[26] https://pmg.org.za/committee-meeting/26832/.
[27] https://www.news24.com/SouthAfrica/News/the-dire-state-of-healthcare-20180610-2

b. Address discrimination in health

34. As indicated above, the absence of adequate health care services has a disproportionate effect on women in South Africa. Women are subjected to maltreatment, abuse and violence in public health facilities.

35. Amending the State Liability Act without first addressing the state of health care sends out the message that the state is only concerned about the financial impact medical malpractice has on the health budget and not on the violation of human rights specifically faced by women. The state, in being reactive, is not concerned about dealing with the causes of this women-specific issue, but rather willing to deal with one of its symptoms, which occurs only when women approach the courts to seek redress.

36. We remind the Portfolio Committee of Chapter 5 of PEPUDA that emphasises that the state has a duty and responsibility to promote and achieve equality. Section 25 provides that the state must, where necessary, take steps to develop and implement programmes in order to promote equality, develop action plans to address any unfair discrimination and develop appropriate internal mechanisms to deal with complaints of unfair discrimination. Further, section 25(4) specifically states that:

> *All Ministers must implement measures within the available resources which are aimed at the achievement of equality in their areas of responsibility by—*
>
> *(a) eliminating any form of unfair discrimination or the perpetuation of inequality in any law, policy or practice for which those Ministers are responsible; and*
>
> *(b) preparing and implementing equality plans in the prescribed manner, the contents of which must include a time frame for implementation of such plans, formulated in consultation with the Minister of Finance.*

37. **We submit that the fact that Portfolio Committee has been informed that the spike in the medical legal claims relates to women giving birth indicates that there is a clear understanding of the shortfalls in the services offered to women. It is therefore perplexing that there is no urgent desire to look at the shortfalls causing litigation and take steps to ensure that women access services at a more equal footing as envisaged by the Constitution, which are safe, give proper effect to and respect their rights.**

38. **The state must therefore immediately investigate the failures and shortfalls and immediately develop and implement a plan to improve the state of these facilities and their services, to improve access and quality as a way to realise the rights of women as explained above.**

PART C: SPECIFIC RESPONSES AND RECOMMENDATIONS TO THE PROVISIONS OF THE BILL

a. Section 1 (relating to section 2A(1) – Separation Of Powers

39. Under the separation of power doctrine there are three spheres of governance in South Africa, namely the legislative sphere, the executive sphere and the judicial sphere. The legislative authority vests in the Parliament of South Africa, as confirmed in section 43 of the Constitution and the judicial authority of the Republic is vested solely in the courts.[28] Importantly, section 165(3) of the Constitution states that "(n)o person or organ of state may interfere with the functioning of the courts".

40. The Constitutional Court has made the following remarks regarding the importance of the independence of the judiciary:

[28] Section 165 of the Constitution.

"The separation required by the Constitution between the legislature and executive on the one hand, and the courts on the other, must be upheld otherwise the role of the courts as an independent arbiter of issues involving the division of powers between the various spheres of government, and the legality of legislative and executive action measured against the Bill of Rights, and other provisions of the Constitution, will be undermined. The Constitution recognises this and imposes a positive obligation on the state to ensure that this is done. It provides that courts are independent and subject only to the Constitution and the law which they must apply impartially without fear, favour or prejudice. No organ of state or other person may interfere with the functioning of the courts, and all organs of state, through legislative and other measures, must assist and protect the courts to ensure their independence, impartiality, dignity, accessibility and effectiveness."[29] (footnotes omitted)

41. We submit that section 2A of the State Liability Amendment Bill infringes on the important doctrine of separation of powers as the section states that a court of law ***must*** order that compensation be paid in structured payments if the claim exceeds R1million. The court, as custodian of law and redress, is removed of its judicial discretion to make appropriate orders for relief.

42. As stated in the Issue Paper, other jurisdictions such as the United States of America, United Kingdom, Australia, New Zealand, Finland, France, Germany, Luxembourg, Portugal, Spain and Sweden empower their courts to make an order where damages are either paid in structured payments **or** in lump sums.[30] We note that in the above mentioned jurisdictions, the discretion to decide on the method of payment of damages is vested in the courts.

43. The Issue Paper suggested that any amendments to the State Liability Act should include a clause where the court can deviate from periodic payments for future damages in special circumstances.[31] Such a clause is omitted from the State Liability Amendment Bill.

44. The court is entrusted with the power to determine appropriate relief in cases where negligence is established. When determining what constitutes an appropriate remedy, the Constitutional Court has noted the following:

*"**In our context an appropriate remedy must mean an effective remedy, for without effective remedies for breach, the values underlying and the rights entrenched in the Constitution cannot properly be upheld or enhanced.** Particularly in a country where so few have the means to enforce their rights through the courts, it is essential that on those occasions when the legal process does establish that an infringement of an entrenched right has occurred, it be effectively vindicated. **The courts have a particular responsibility in this regard and are obliged to "forge new tools" and shape innovative remedies, if needs be, to achieve this goal.**[32]**"** (footnotes omitted) (own emphasis added)*

"Courts have a duty to mould an order that will provide effective relief to those affected by a constitutional breach."[33]

[29] South African Association of Personal Injury Lawyers v Heath and Others 2001 (1) BCLR 77 (CC); 2001 (1) SA 883 (CC) paragraph 26.
[30] Paragraph 4.5, page 39 of the Issue Paper.
[31] Paragraph 6.7, page 54 of the Issue Paper.
[32] *Fose v Minister of Safety and Security 1997 (3) SA 786 (CC)* para 69.
[33] *Modder East Squatters and Another v Modderklip Boerdery (Pty) Ltd, President of the Republic of South Africa and Others v Modderklip Boerdery (Pty) Ltd [2004] ZASCA 47* para 42.

45. By prescribing the form of the remedy without providing the court with discretion to deviate from the periodic payments, the court is being stripped of its power to effectively determine the most appropriate remedy for the particular case in front of the court.

Recommendations:

46. **Ensure that the Bill does not limit the discretion and independence of the judiciary as envisaged by the Constitution. We suggest that the word "must" in this proposed section for the Bill must be removed.**
47. **The section should rather make this an option that the court could consider if the court deemed it to be just and equitable in the circumstances to depart from giving full and final settlement. We suggest that it must be left to those who represent the state in such cases to motivate why periodic payments should be made as envisaged by the Bill and for the Applicants argue why the periodic payment model is not adequate which then allows a court to make a finding on the issue and decide on a case to case basis to avoid encroaching on the powers of courts.**
48. **A blanket approach proposed by the Bill unfortunately falls short of the constitutional imperatives relating to the judiciary.**

b. Access to Justice – Limiting "once and for all rule"

49. The memorandum to the Bill states that, *since the proposed new section 2A will exclude medico-legal claims insofar as future medical expenses are concerned from the ''once and for all'' rule, it is necessary to amend section 4, the savings provision, of the principal Act*[34].

50. The 'once and for all' rule states that when a plaintiff brings a claim for damages, and in this case for medical negligence, then they must claim for all damages (current and future) that arise out of the specific set of facts, and they can only do so once. So, if a woman was to experience medical negligence and instituted a claim for compensation, then she cannot later return to court to claim again for an issue that arose later but as a result of the same medical negligence. The new section 2A does not allow for the injured person to include a claim for future medical expenses resulting from the medical negligence.

51. We submit that by amending the State Liability Act by removing the 'once and for all rule' and disallowing lump sum payments, the right to access to justice is affected. Injured persons, either in their personal capacity or representative capacity, who do not have the financial ability to afford a private attorney rely on contingency fees as a method to access a court of law. Generally, law clinics are unable to conduct personal injury litigation, therefore attorneys who finance these cases become a lifeline for indigent, incapacitated clients.[35] Further, according to the Regulations of the Legal Aid South Africa Act 39 of 2014, legal aid may not be granted for personal injury claims.[36] The only exception to this is granting legal aid to children in cases of personal injury.[37] Therefore persons seeking to institute legal proceedings against the state for medical wrongfulness rely on private practitioners. Contingency fees are therefore used as an incentive for private attorneys to represent women and other clients who have a potential claim for medical negligence against the state but are unable to afford to pay for these legal services.

[34] Paragraph 2.3
[35] D Millard & Y Joubert "Bitter and Twisted? On Personal Injury Claims, Predatory Fees and Access to Justice" (2015) *Obiter* 36 558.
[36] Regulation 11(10).
[37] Regulation 23(4).

52. The proposal to remove the payment of a lump sum by providing for structured settlements has the consequential effect that the contingency fee will be based on a smaller quantum – the quantum for past and immediate expenses, but not future medical expenses and loss of future income. This may make contingency agreement less attractive for attorneys in medical negligence claims.

53. Attorneys providing legal representation on a contingency basis play an important role in ensuring access to justice in cases where the client might not have been able to afford a private attorney. This essentially enables persons who are unable to afford a lawyer, like indigent women who access public services realise their rights to access to justice – consequently their other constitutional rights including equality, dignity, health and bodily integrity.

54. Contingency fees of legal practitioners are governed by the Contingency Fee Act 66 of 1997. According to section 2(1)(a) and (b) of the Contingency Fee Act contingency can take one of two forms, namely:

    54.1. On an 'all or nothing' basis where the legal practitioner shall not be entitled to any fees for services rendered unless the client is successful in the proceedings or;

    54.2. On the basis that the legal practitioner shall be entitled to fees equal or higher than his or her normal fee if the client is successful.

55. In the matter of *Mfengwana v Road Accident Fund* 2017 (5) SA 445 (ECG) the court stated:

    'The basic idea behind a contingency fee agreement is that the attorney takes on the risk of financing his or her client's litigation in the hope – or anticipation – of succeeding. If the litigation is not successful, the attorney will not be paid. If the litigation is successful, the attorney will be entitled to a success fee that is higher than his or her normal fee' and further stated at para 11: 'Section 2 of the Act is the core of the Act. It makes provision for contingency fee agreements and for the higher than normal fee that an attorney may charge to "offset" the risk of earning no fee in the event of him or her not concluding a case successfully'.[38]

56. The State Liability Amendment Bill is an indirect barrier to justice and access to legal services with a disproportionate effect on indigent persons, especially vulnerable women. This cause is two-fold:

    56.1. Indigent women are reliant on state health care services as private medical services are not within their financial reach and;

    56.2. Indigent women might not be able to afford private attorneys to represent their claim of medical negligence without the incentive of a contingency fee.

57. During the introduction of the State Liability Amendment Bill to the Portfolio Committee on Justice and Correctional Services on 15 August 2018, the issue of contingency fees was mentioned by the Department of Justice. The Department noted that attorneys would get less money if they were working on a contingency basis as the total amount of damages would not be determined until the injured person has passed away. However, this issue was merely noted without sufficient scrutiny.

Recommendations

58. **Ensure that the Bill makes provision for contingency for the full quantum to be paid. The estimated quantum would have to be adjudicated in the court in any case – either as part of the primary case or later if the quantum and merit is spilt. Therefore, the Bill can make provision for contingency to be paid on the full amount even if future payments will be made periodically.**

[38] Paragraph 6.

59. **<u>If no provision for contingency can be made, we submit that the State must ensure that the Bill in its current form is not passed.</u>**

c. Limiting choice of facilities for further treatment

60. The Bill empowers the state to order a person who has sued the state for medical negligence and requires treatment to be treated at a public health establishment. It is unreasonable to request a woman and/or family to return to the institution that caused damages in the first instance as a result of malpractice to be provided with redress, especially when most facilities found by OHSC to be non-compliant as mentioned above. This again forces poor women to access service where the quality is not guaranteed, and which continue to discriminate against them because the state has not addressed the cause of the medical negligence.

<u>Recommendation</u>

61. **<u>We suggest that section 2A(2)(c) be removed from the Bill. Alternatively, at most, this must only be made as a potential remedy that the court can order if and when it is deemed as just and equitable relief by Court once the parties have argued for and against it, respectively.</u>**

d. <u>Limiting state liability should services be sought in private care</u>

62. The Bill further provides that "*[i]n circumstances where future medical treatment has to be delivered in a private health establishment, the liability of the State shall be limited to the potential costs that would be incurred if such care was provided in a public health establishment*".[39] It is our submission that this is unreasonable and punitive towards those who take steps to vindicate their rights. Should the state have fixed the shortfalls and poor service delivery in facilities, as explained above, then their liability would have been limited.
63. The state cannot only want to purportedly limit their financial responsibility at this level. Effective services and quality services will significantly reduce the number of instances of medical negligence in our opinion. This is central to promoting and realising rights at a systematic level.

<u>Recommendation;</u>

64. **<u>This clause must be removed.</u>**

CONCLUSION AND RECOMMENDATIONS

65. The State Liability Amendment Bill in its current form should not pass. We submit that it specifically denies limits women access to reproductive justice as explained above.
66. We trust that you will find this submission made by the LRC and WLC in this document useful. Should you have any comments or questions please do not hesitate to contact Ms Mudarikwa at mandy@lrc.org.za.

*****ENDS*****

[39] Section 2A(2)(d).