RESEARCH ARTICLE

2024, vol. 11, issue 1, 141 - 151
https://doi.org/10.5281/zenodo.15258153

THE CAUSES, EXTENT AND EFFECTS OF MEDICO-LEGAL CLAIMS ON HEALTHCARE DELIVERY IN SOUTH AFRICA

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Abstract

South Africa's healthcare system is on the cusp of a perfect storm that has the potential to paralyze service delivery, due to the increasing costs of providing healthcare services and the increase in medical malpractice litigations. Thus, the paper investigates the extent and effects of medico-legal claims on healthcare service delivery and the underlying factors causing the increase in the health sector. This paper relied on an in-depth review of relevant literature relating to the SA health system, medical malpractice, and healthcare service expenditure. The paper revealed that staff shortages, decline in professionalism, poor record-keeping, poor health systems are among the factors contributing to high medical malpractice litigations. The paper concluded that for the benefit of healthcare providers and patients, medical malpractice grievances should be settled in a non-adversarial manner outside of the courts it poses a serious threat to the survival of both the public and private health system.

Keywords: health, healthcare, malpractice, service, medico, claims

Introduction

South Africa's healthcare system is on the cusp of a perfect storm that has the potential to paralyze healthcare service delivery, due to the increasing costs of providing healthcare services and the increase in medical malpractice litigations. In recent years, the South African health department has seen a sharp increase in medical malpractice litigations. The rising number of medical negligence claims affects both the private and public sectors (Oosthuizen and Carstens, 2015). The country experiences a high number of medico-legal cases due to the complex nature of medical decisions, poor communication between healthcare providers and patients, inadequate documentation, and poor accountability. These cases have significant financial implications for the Department of Health, which has to pay out compensation claims and legal fees, negatively affecting the goal of reducing healthcare expenditure.

This translates to an increasing number of claims against the department and amounts of money awarded over the years relating to medicolegal cases. Several factors have been sighted as contributing to this increase such as scarce resources, staff shortages, poor infrastructures, high levels of disease burden and archaic record keeping. The large pay-outs by the Department of Health in medical negligence litigations have put a further strain on the health budget. Over the years, budget allocation for the health department has increased dramatically. Howarth and Hallinan (2016) reveal that since 2008, the number of medicolegal claims brought against both private and public healthcare providers have accelerated.

Not only has there been an increase in the frequency of claims, but the amounts that have been awarded have also risen significantly. Several factors have contributed to this increase and doctors as well as other healthcare providers have been profoundly affected thereby. It is near impossible to find any empirical data on medical malpractice in South Africa (Coetzee and Carstens, 2011) in (Oosthuizen & Carstens, 2015). In June 2013, the then Minister of Health, in response to a parliamentary question on the number of claims instituted against the department, declined to give exact figures of medical malpractice cases and costs amount awarded in terms of claims. The Minister did indicate that the escalation of medicolegal claims and associated legal costs is a top

priority of the Department and that it poses a serious threat to the survival of both the public and private health systems.

Against this backdrop of the increasing number of litigations claims against the health sector, this article aims to answer these two fundamental questions: firstly, what factors contribute to the increase in the litigation claims and expenditure in the health sector, and secondly, how provincial and national healthcare departments can curtail this problem.

In the paper various scholarly, governmental, civic society and public sector writings are reviewed in an attempt to answer the two questions above. The paper therefore takes a general literature review style followed by a commentary approach.

Laws and regulations governing medical negligence

The contribution submits that the increase in medical negligence claims should not come as a surprise, considering the high regard that our courts had for patient autonomy even before the enactment of the 1996 Constitution. The Constitution of the Republic of South Africa, 1996 contains specific rights that patients, including child patients, can enforce. Section 9 of the Constitution states that everyone has the right to equality, including access to health care services. This means that individuals should not be unfairly excluded in the provision of health care. People also have the right to access information if it is required for the exercise or protection of a right. Furthermore, this may arise in relation to accessing one's medical records from a health facility to lodge a complaint or for giving consent for medical treatment; this right also enables people to exercise their autonomy in decisions related to their health, an important part of the right to human dignity and bodily integrity in terms of sections 9 and 12 of the Constitutions respectively. The National Health Act of 2003 also establishes regulations to ensure good quality healthcare services, which includes the prevention of medical negligence. The act also creates a framework for addressing medical malpractice claims and provides for punitive damages in cases of gross negligence. Regardless of the above, the South African Law Review Commission (2023) reports that medico-legal claims are not governed under any specific Act of Parliament but are litigated using common law.

In South Africa, medical negligence falls under the jurisdiction of the Department of Health. The Health Professions Council of South Africa (HPCSA) is responsible for policing the actions of healthcare workers and looking into allegations of malpractice. It is responsible for establishing regulations and guidelines for the professional behaviour of doctors. According to the HPCSA's code of ethics, healthcare professionals to act in their patient's best interests and provide treatment that meets accepted professional standards of excellence

Contextualizing medical negligence

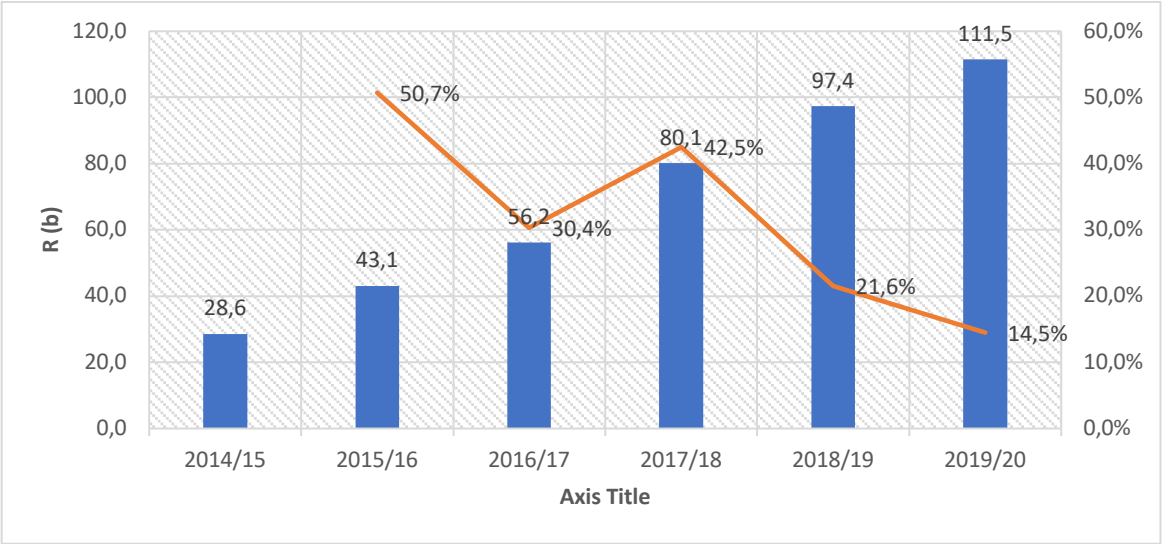
The concept "medical negligence" has a complex connotation that must be unpacked before it can be understood in the medical setting. There is no universally accepted definition of "medical negligence" among published works. Kumar and Bastia (2011) for instance, define medical negligence as an act or omission by a healthcare provider which deviates from accepted standards of practice in the medical community, and which causes injury to the patient. In the medical profession, there are set standards of practice which medical practitioners are expected to meet when performing their duties. Furthermore, negligence is defined as the omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do (Denning, 1993). Professional negligence refers to an act or a lack thereof considered inconsistent with the professional standard maintained by reasonable, similarly trained representatives of that profession. Malpractice is the term that has evolved in civil law and has become synonymous with professional negligence. The above definitions provided by Kumar and Bastia (2011) and Denning (1993) deduce that there are legislative imperatives that prescribe accepted practices by healthcare practitioners to patients. Medical malpractice is defined as a lack of reasonable care and skills or negligence on the part of a medical practitioner in the treatment of a patient whereby the health or life of a patient is endangered.

The extent of medical-legal claims in South Africa

In South Africa, medical practitioners do not only have to contend with civil claims, they are also held accountable for unprofessional conduct by the HPCSA. The objective of a disciplinary inquiry of this nature differs from that of a civil claim, in that the focus is not on compensation for damages suffered by the patient, but rather on upholding the standards of the profession and protecting the interests of the public. This fact is also reflected in the disciplinary powers of the professional boards and the penalties that may be imposed by them.

Data from the National Department of Treasury (2023) was used to comment on the extent of medico-legal claims across the provinces. Figure 1 below shows that a graphical com pilation from this data showing the annual growth medico-legal claims in South Africa for the period between 2015 and 2020.

Figure 1: Medico-Legal claims against provinces (Treasury, 2021)



Source: National Department of Treasury (2023)

In the 2019/20 financial year, a total of R111.5 billion medico-legal claims were made against South Africa's provincial health departments. In nominal terms this was an increase from R97.4 bn and R80.1bn claims made in the previous 2018/19 and 2017/18 financial years respectively. Using the 2014/15 financial year as the base year, the chart shows that medico-legal claims against the provinces, in total rose from R28.6bn to R43.1bn, a 50.7% annual leap. The claims growth rate subsided temporarily to 30.4% per annum in 2017/16 financial year before rising again to 42.5% in the 2017/18 period. The data shows that consistent increase in medico-legal claims in monetary claims albeit there is a general decline in the annual increase of these claims.

Table 1 below looks at the provincial level data on medico-legal claims, this date also coming from the National Treasury Report.

Table 1: Medico-legal claims by province (National Treasury, 2021)

R thousand	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	%
Eastern Cape	8 210 838	13 421 136	16 772 732	24 193 619	32 864 497	36 751 207	33,0%
Free State	540 365	940 545	1 306 928	1 842 917	2 874 754	3 429 585	3,1%
Gauteng	10 079 281	13 452 064	17 844 047	21 701 514	19 625 835	21 038 799	18,9%
KwaZulu-Natal	6 724 865	9 957 126	10 292 463	16 638 734	20 110 314	23 440 969	21,0%
Limpopo	1 196 787	1 606 657	2 115 529	4 874 800	8 265 440	10 327 987	9,3%
Mpumalanga	1 459 497	2 366 010	5 242 757	7 472 985	9 451 927	9 457 321	8,5%
Northern Cape	174 111	342 829	1 220 527	1 605 291	2 104 584	1 629 962	1,5%
North West	33 881	855 737	1 285 126	1 697 205	1 982 272	5 395 624	4,8%
Western Cape	193 395	182 025	135 700	90 350	110 599	33 155	0,03%
Total	**28 613 020**	**43 124 129**	**56 215 809**	**80 117 415**	**97 390 222**	**111 504 609**	**100%**

Source: National Treasury (2021)

Out of the R111.5bn medico-legal claims burden, 33% thereof came from the Eastern Cape, 21% from KwaZulu-Natal, 18.9% from Gauteng and 9.3% from, Limpopo. Other provinces each contributed less than 9% each to the burden. In all the provinces except the Western Cape, medico-legal claims show a positive growth trend in nominal terms. The Western Cape further contributed the least to this burden this being 0.03%.

The Treasury reports further notes that the provinces total contingent liability from medico-legal issues was R1.72 billion and this represented claims that whose outcomes and therefore payments were still outstanding. According to Low (2022), R6.5bn was paid out as awarded claims in the 2020/2021 financial year.

Factors contributing to high medical-legal claims

Malpractice liability encompasses a wide range of causes. Patients can institute claims against healthcare providers if they have suffered damages due to the conduct of the medical practitioners or hospital staff involved in their treatment.

As Coetzee and Carstens (2013) postulate, the increase in medical negligence claims cannot be ascribed to one single reason. It is rather a combination of developments in the medical industry and the law that creates fertile ground for making such claims. Rowland and Adefuye (2022) notes that these causes can also be classified into

individual healthcare professional factors and healthcare systems factors. These latter relate to wider factors that include infrastructural and administrative challenges in the healthcare system (Prinsen, 2023). Such a system could be a single medical facility or the broad national healthcare system.

Poor health systems also contribute to medical negligence claims. Inadequate resources, poorly designed processes, and inadequate training and education contribute to medical errors and negligence. A robust health system ensures that appropriate training, resources, and processes are in place to ensure that care is delivered safely and effectively. Malakoane et al. (2020) highlight several factors adversely affecting public healthcare system efficiency in South Africa. These include poor structural organisation and coordination across healthcare facilities leading to fragmented services, funding shortages, lack of modern facilities and technologies and poor information management among others. These in solo or in tandem create a system that fails to cope with services quantity and et al. demand (Malakoane et al. ,2020).

This section of the paper examines the role of staff shortages, the decline in professionalism among medical practitioners, poor record-keeping practices, the increased value of claims, poor health systems, poor leadership and management and patient communication breakdowns in contributing to high medical negligence claims.

The decline in the level of professionalism among medical practitioners

A major issue for the health sector in recent years has been the general deterioration in medical practitioners' professionalism. The HPCSA began its public awareness campaign in March 2012 to inform both patients and doctors about their rights and responsibilities.

This initiative was launched in response to some of the developments. Dr Letlape the acting CEO of the HPCSA, postulated that a decline in levels of professionalism among healthcare practitioners and the increasing costs of medical negligence necessitated the need for greater public awareness of patient's rights and responsibilities when accessing healthcare.

Medical practitioners are expected to follow strict ethical and professional codes but the rise of unprofessional behaviour such as misconduct, negligence and lack of care has led to increased medical negligence claims (Desmond & Dierickx, 2021). In some cases, lack of knowledge of proper medical procedures among practitioners' compromises patient outcomes. Under such scenarios focus moves on to differentiating between negligence and ignorance (Desmond & Dierickx, 2021). A study by Sayers, et al. (2021) found that "unprofessional and disrespectful behaviour creates tension, mistrust and leads to communication breakdowns which in turn can result in medical errors, lack of accountability and transparency, and increased medical negligence claims" (Sayers et al, 2021). One of the significant policy failures attributed to medico-legal cases is the lack of standardization in the training and qualification of healthcare professionals.

Patient-to-practitioners relationships and communication

Patient communication breakdowns also contribute to medical negligence claims (Humphrey et al., 2022). Patients must be able to communicate effectively and openly with healthcare providers to ensure that their care is tailored to their individual needs. The breakdown of communication can lead to diagnostic errors, treatment errors, and the failure to provide appropriate care (Humphrey et al., 2022). Communication issues between healthcare practitioners and patients can arise as a result of mistrust between the two groups (Madawala et al., 2023). Graham and Kelly (2020) and Madawala et al. (2023) note that it is not uncommon for patients to hold a general anger towards healthcare professionals mainly as the latter group is often perceived as less caring. Such adversities make it easy for patients to commit to sue healthcare practitioners even in cases when there is no factual or legal basis for this (Graham & Kelly, 2020). Mutumba et al. (2021) also believe that extremely positive expectations that doctors were competent enough to resolve any patient problem created sever anger when the desired health outcome was not achieved. In this case, even when a doctor is not negligent a disappointed stakeholder may feel the need to sue as a way of reconciling with that feeling of anger. At the same time, healthcare practitioners got angry over perceived patients' negligence of own health – this creating a work burden on them. This is exemplified in a Cape Two study Nhemachena and Spath (2023).

A study by the National Center for Biotechnology Information found that "effective communication is essential to reducing medical errors, increasing patient satisfaction, and reducing the risk of liability" (National Center for Biotechnology Information, 2018). Thus, addressing patient communication breakdowns is essential to reducing medical negligence claims. Douglas et al. (2021) also found poor communication between medical staff working on similar patient as a significant cause of surgical errors and their consequential damages lawsuits (Liberman et al., 2020). There is also a potential burden that comes in when a patients is put in scenarios that demands them to communicate with more than one practitioner especially when they are not fully capacitated.

Administrative or internal causes

The management of unsatisfactory outcomes in a healthcare facility plays a role in the extent of institutional level medico-legal claims. Lim et al. (2022) discuss a proactive way of managing these claims these being effective, patient centred and accountable systems. Reactively, however, professional engagement with aggrieved parties decreases medico-legal claims rates. This included through effective communication a negotiations, apologies and payment waivers among others (Lim et al., 2022). Buchanan and Crosbie (2019) discuss case management as a proactive medico-legal claims management option that could work for South Africa. This involved looking at every patient wholistically, including the patient's and their family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes." p1. However, this demand coordinated administrative and operational processes (Buchanan & Crosbie, 2019) and these are not readily available in the South African public healthcare sector (Malakoane et al., 2020).

Poor record-keeping practices are another factor that contributes to medical negligence claims (Causey & Marley, 2022). Medical negligence claims can be attributed to the failure to document appropriately, misinterpretation of documentation and incomplete documentation (Krauss et al., 2021). Also, lack of properly trained staff including poor and non-compliant hiring practices can increase medical malpractice risks leading to medico-legal claims increases. Leappe (2015) points to the absence of effective risk management systems in medical facilities as a cause of malpractice increases that eventually result in claims.

Organisational cultures also play a role in the challenge. Lack of continuous improvement and development focused as well as patient focused cultures could both result in increases in malpractices (Thirumoorthy, 2019). Leappe (2015) believes that patient centric cultures are of significance important inc the curbing of the problem. Poor internal accountability within a medical facility can breed negligent and irresponsible behaviour (Rucell, 2019). Rucell (2019) further argues that institutional power dynamics.i.e. too powerful and hierarchical unreachable institutional leadership versus poor and discriminated masses creates an environment where marginalised groups, including women suffer the brunt of medical malpractice more than other groups. This argument is primarily based on the author's observations that women, as primary child-bearers suffered structurally imposed medical neglect. This view connects with the poor leadership and management cause of medico-legal claims rises discussed further below.

Staff shortages

The healthcare system is grappling with a shortage of workers, including doctors, nurses and other healthcare workers. This has been exacerbated by the COVID-19 pandemic, with many frontline workers getting infected or succumbing to the virus. Findings from a study by Ndebele (2021) revealed that 20% of the respondents believed the moratoria had increased mistakes among practitioners, due to increased work pressure which is a result of staff shortages. The interviewees corroborate this view, pointing out that the risks of delivering erroneous services to patients had increased in frequency, alongside the risks of litigation for negligence, also referred to as medico-legal cases. Notably, one respondent refuted that the staffing moratoria increased the number of patient incidents and litigations for negligent service, as healthcare workers overstretch themselves to provide the necessary care. Furthermore, Rawat (2015) and (Ndebele et al. 2021) explains that even outside moratoria, South Africa generally has health staffing gaps, emanating from the low training capacity of medical professionals versus the high demand for such professionals (Rawat, 2015) and (Ndebele et al. 2021).

Furthermore, a study by Barnard & Breeze (2022) found that "shortages also cause burnout among existing staff, resulting in more errors and safety incidents" and that "recruiting experienced and skilled staff is essential to prevent harm to patients and to reduce the risks of litigation" (Barnard & Breeze 2022). Therefore, addressing the issue of staff shortages is essential to reduce medical negligence claims. The shortages of healthcare workers have led to increased workloads for those remaining, leading to burnout and fatigue, which can lead to medical errors (Stehman et al., 2019). Stehman et al. (2019) further assert that failure to address the systemic factors behind staff burnouts, depression and substance abuse among others are behind the persistence of medical malpractices. In a systemic review of articles from 1974 to 2019, they found the medical and healthcare systems have been putting their emphasis on addressing these problems on an individual-to-individual basis without looking at them systemically.

Poor leadership and management

Poor leadership and management practices also contribute to medical negligence claims (Yau, 2020). The leader's ability to provide direction, manage resources effectively, and create a culture of safety and accountability is essential in reducing medical errors and negligence. Poor leadership and management can also contribute to staff shortages, inadequate training and education, and poor communication (Yau, 2020).

Furthermore, effective leadership and management practices, including communication, support, and accountability, create a culture of safety, can reduce medical errors and negligence. Therefore, strong leadership and management practices must be implemented to reduce medical negligence claims. Maphumulo and Bhengu (2019) assert that the South African public healthcare system in general is heavily disadvantaged by poor leadership systems that breed mismanagement and maladministration. They further link this to the politico-administrative system that fails to implement measures that optimally address identified healthcare system challenges. Subscribing to this view, Ndebele et al (2021) assets that Politicians have attempted to attribute the decline in the public sector to a myriad of ills, none of their making. Furthermore, Kirsten and Maharaj (2022) link leadership issues to the dominant politico-administrative cadre deployment and public sector corruption narratives. In their argument leaders fail to exercise guidance to politically compromised professionals who include medical doctors. At the same time, some appointed leaders are neither experienced or qualified to run public healthcare facilities (Kirsten & Maharaj, 2022). Both scenarios, nonetheless link the wider political system with the individual and institutional level malpractices that eventual turn into medico-legal claims. Close associated with this is the wider healthcare challenges issues behind medico-legal claims challenges.

The legal systems and environment as causes

Some scholars argue that both positive and negative developments in the legal system have resulted in an increase in medico-legal claims. Prinsen (2023) reviews Acts that include the National Healthcare Act 61 of 2003 and the Consumer Protection Act 68 of 2005. These laws have emancipated health seekers firstly to demand adequate professional assistance from healthcare and in the absence of this to seek appropriate litigatory action. Thus medico-legal claims increase could be a signifier of an awakening society that better understands healthcare workers obligations in service delivery. Pienaar (2016) asserts that a pro-patient legal system exhibited by the courts that look more favourably at the infringements of patients' rights are also at the centre of the claims increase conundrum. Graham and Kelly (2020) also point out that generally, the global health-seeking public has greater access to legal assistance include through legal practitioners. This implies that in the past, medico-legal claims might have been low simply because of restrictions to legal help. The Contingency Fee Act No. 66 of 1997 increases people's access to legal assistance as they only pay lawyers a percentage from proceeds of successful litigation. This legislation despite its noble apple to increase equality in the access to justice could also explain increases in medico-legal claims, including non-deserving ones (Prinsen, 2023).

At the same time, the general legal awakening could have come with an element of legal and litigation systems abuses as health seekers direct their knowledge at attempting to rent-seek form the healthcare system (Pienaar, 2016). Hanganu and Ioan (2020) argue that financial motives were one of the causes of increasing medico-legal claims albeit this is intertwined with a myriad off external factors. The financial motive does explain only a fragment of the problem. Koch (2017) asserts that there is a need to balance between the justice and fairness and speed of settlement and quality aspects of medico-legal claims to both the litigant and the defendants

Wessels (2021) comments that rent-seeking behaviour point to the need to reform medical malpractice law in South Africa. This behaviour, at its extreme includes a fraud component albeit there is a need to separate between fraudulent claims and non-fraudulent financially motivated claims. South Africa currently has a State Liability Amendment Bill of 2018 under consideration. This is intended to reduce state liability and stagger payments for awarded claims. Pitt (2022) asserts that the fact that celebral palsy which is the most well-paying malpractice outcome accounts for 50% or more of all claims point to the existence of fraudulent claims made in cahoots with lawyers.

The rise in the value of claims

The value of claims is a significant factor contributing to medical negligence claims. As the cost of medical services continues to rise, so does the value of claims. Medical negligence claims have become more frequent and more expensive over time, with the pay outs being a substantial burden on the healthcare system. The increasing value of claims is partially due to the lengthening of life expectancy, increasing medical care costs and higher compensation awarded by courts. This argument is also discussed by Prinsen (2023) who states that as life expectancy, and therefore the number of future years one has to leave with the effects of malpractice increases so does the compensation they get to cover future costs of living. Using the above findings an argument of interest to the researcher is therefore whether this cause can be classified as a bad thing. Society cannot be punished for staying longer – the process of reducing medico-legal costs would need to focus on the root causes rather than the peripheral outcomes such as claim increases due to life expectancy increases.

The above factors, as noted can be reclassified into individual, institutional and wider systemic factors. Systemic factors are factors affecting the whole provincial and national medical system. The existence of such factors is evidenced by different claims statistics from the provinces.

The effects of medico-legal claims on the healthcare system

Several sources discuss the effects of medico-legal claims on the healthcare sector. This section discusses some of these sources. The costs of medical negligence are becoming more expensive in South Africa, with the government shelling out millions to compensate victims. This amount to a significant financial burden on the South African health department, which is already facing numerous financial challenges.

The cost of medico-legal cases on the economy

The effects of medical negligence are not only felt in the healthcare sector but also in the broader economy. Medico-legal cases can have various economic implications, including lost productivity, decreased foreign investment, and an increase in insurance premiums. A study conducted by Muntingh et al. (2019) estimated that the total cost of medico-legal claims on the South African economy was approximately R1.4 billion per annum. This cost was attributed to various factors, including the high legal costs associated with these cases and the impact they have on the healthcare sector's funding. Costs of individual medical care also rise in response to increasing medico-legal claims (Pienaar, 2016). This happens as medical indemnity costs are eventually passed on to the patient inf the form of higher medical bills (Kapoor et al.,2022). From an economic perspective this adds on to society's economic burdens and contributes to lowered standards of living – all factors held constant.

Effects on patient care quality

While the general expectation is that increasing medico-legal claims can motivate medical practitioners to be more prudent and professional in their work and conduct, this might not happen as expected. As Pienaar (2016) reviews, medical professional can become more self-centred rather than patient centred in their approach. In other words, they would value their professional and monetary loss protection than the loss of patients' lives (Miziara et al., 2022). Katz (2019) sees defensive medicine as a constrained choice that medical practitioners take out of the fear of personal consequences. Thus, it puts the treatment focus on the healthcare provider rather than on the patient, overall to the latter's disadvantage. The dilemma is that it is difficult to blame them for taking such an approach or to draw a clear line on ethical versus unethical defensive medicine (Miziara et al., 2022). Katz (2019) add that the solution for this practice is even harder to find as it may imply reversing some of the patients' rights. This argument is reinforced by Ndebele and Ndlovu (2023) who posits that in South Africa where the quality of healthcare is already reported to be poor, such an approach will most likely harm the majority of health seekers than benefit them.

Effects on marginalisation and equality debates

An interesting argument by Rucell (2019) is that medico-legal claims are one of the few ways that marginalised persons, specifically women can get redress from an overbearing structurally discriminative and male-dominated healthcare sector. At the same time however, narrative around these claims overshadow the need for improved accountability specifically in women's obstetrical healthcare issues. Thus, as far as Fucell is concerned, these claims fail to positively transform the obstetrics healthcare environment. As argued the consequences felt by the government, as a defendant have not been phenomenal enough to force a rapid healthcare system transformation.

Mitigating medical malpractice litigations

The South African Law Review Commission (2023) recommended "prerequisites" for the containment of medico-legal claims increases that included:

- National medico-legal management strategy
- Fully committed medico-legal management professional provincial teams
- State-led record management and reporting systems that support effective data sharing
- Budgeting for medico-legal litigation
- Committed alternative dispute resolution team in each province.
- Introduction of patient safety measures in all provinces.
- State bodies monitoring the enforcement new and old healthcare legislation

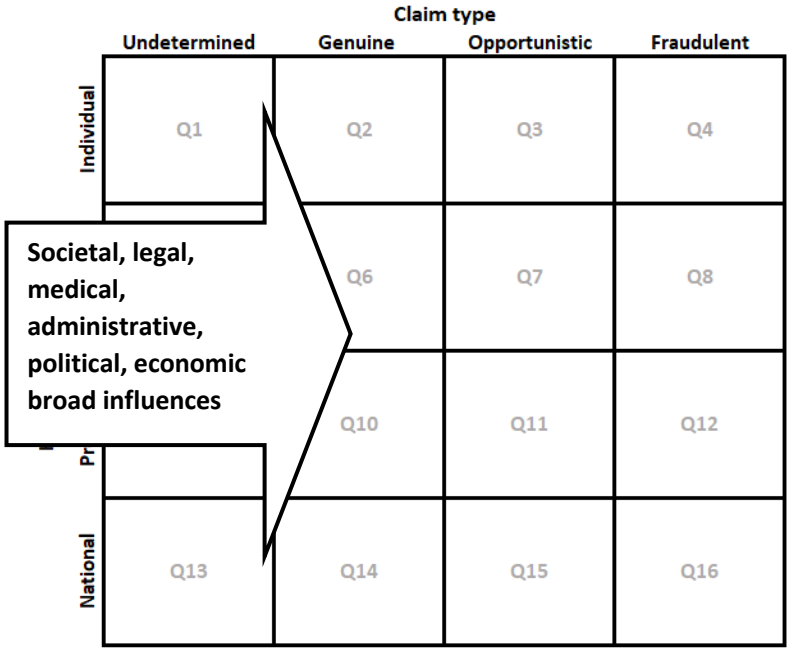
The South African Medical Association (SAMA, 2023) believes that specialised medical courts could curtail the medico-legal challenge more effectively than the current general courts. This stemmed from views that the

currently legal systems were biased towards the patient and this encouraged undue litigation against medical practitioners. The University of the Western Cape (2023) believes that educating healthcare practitioners about medical practice law and how it relates with practice could be part of the solution (UWC, 2023). Prinsen (2021) reviews a three-strategy approach. At the first level, it looks at a proactive or preventative stance buttressed in ensuring strict knowledge and compliance of healthcare practice standards including the DoH National Core Standards and Ideal Clinic. The second phase focuses immediate reactionary processes to manage identified medical harm and containing the effects thereof as well as engaging the victim before the matter escalates into a claim. The third of tertiary stage involves efficiently managing medico-legal claims that the above two levels could have failed to contain. This includes measures like quick resolution of claims, further investigation of claim validity, helping victims or litigants manage the effects of the identified malpractices and accountable management of funds advanced to departments for claims settlements. The South African Medico-Legal Association (2022) believes that an improvement in healthcare delivery systems, attraction, employment and retention of adequate skilled staff, putting systems that identify fraudulent versus genuine claims more effectively and empowering healthcare professional to speak out against factors responsible could help to address the challenge.

The above sources identify several factors that attempt to cut across the various domains involved in medico-legal claims, these being the medical, legal, political, public administration and societal areas. Regardless, the problem, as noted from the multiple factors is multifaceted and no single solution could completely curb it in its entirety. Rather policymakers need to enhance the art of optimising among many available feasible solutions and finding the ones that suit certain types of cases.

The paper provides the matric below (Figure 2) as a way of guiding solution-finding and recommendation implementation in medico-legal claims management.

Figure 2: Medico-legal claims scenarios



Source: Author's own (2023)

Guided by the literature reviewed the matrix points out that claims could come from individual related factors like attitude towards work and poor professional acumen that leads to medical malpractices for example. They could also come from problems within a medical facility as a system (e.g. poor leadership, bad care culture, staffing, etc.) or from within the wider provincial or national healthcare systems (e.g. underfunded and overburdened healthcare systems). These claims, also as guided by the literature, could be genuine, opportunistic or completely fraudulent. Policymakers will be able to identify the intersections of various medico-legal claim factors versus the type of claim. Strategies and programmes will be implemented based on the nature and causes of a claim. Thus, fraudulent claims because of individual healthcare professionals' challenges fall in their own strategic quadrant (Q4) that demands specific strategic reactions to address these. False claims because of poor national healthcare systems will also being their own quadrant (Q16) and so on. Overall, the matrix forces the identification of various scenarios surrounding the medico-legal claims issue.

Conclusion

The challenges of medico-legal cases in the Department of Health in South Africa have significant financial implications, undermining the goal of reducing healthcare expenditure. The recommendations provided in this paper offer potential solutions to this issue, enabling the Department of Health to improve its medico-legal practices and minimize financial risk. Policy interventions are necessary if South Africa is to achieve universal health coverage and ensure the well-being of its citizens. The paper finds medico-legal claims as a multifaceted problem emanating from individual, institutional and system level weaknesses and challenges. This suggests that no single solution can be applied to resolve them. Rather multiple approaches that resonate with identified scenarios are required. The paper thus provided a matrix that can guide such scenario-finding exercises. The paper also highlighted that many recommendations have been made on the subject matter. However, what needs to be done is to assess the scenarios they apply in. Finally, the paper recommends the use of the above matrix in finding solutions to various types of medico-legal claims emanating from the individual, institutional and systemic level factors. Scholars in public administration are recommended to interrogate the above matrix with an aim of enhancing its usability.

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