COMMENTS BY THE SOUTH AFRICAN ORTHOPAEDIC ASSOCIATION
AND THE SA SPINE SOCIETY

(hereinafter “the societies”)

on

THE DRAFT ROAD FUND BENEFIT SCHEME BILL, 2014
(NOTICE NO 337 OF 2014)

1. INTRODUCTION

1.1. The societies welcome the opportunity to comment on the RAFBS Bill, a bill drafted to substitute the Road Accident Fund Act, No 56 of 1996.

1.2. The societies also uses this opportunity to request a face-to-face meeting with the Department of Transport, as per the invitation extended to the attendees at the National Workshop, 19 June 2014. The societies look forward to take share the responsibility for this important piece

1.3. The societies welcome an approach that gives effect to the rights of patients (road accident victims) to social security and access to healthcare, both of which are rights entrenched in the South African Constitution. It also welcomes the no-fault system when addressing the needs of road accident victims to obtain appropriate healthcare, irrespective of the duration thereof.

1.4. Ensuring that patients access appropriate care is a key constitutional aspect of the social security- and access to healthcare rights of victims. This is intrinsically related to the reimbursement to healthcare professionals and healthcare establishments when treating and caring for victims of road accidents.

1.5. The RAFBS Bill is a remedial piece of legislation, and the societies urge firm steps from the Department of Transport to address the causes of road accidents. It cannot be denied that the extent of the financial difficulties of the RAF relates to the high incidence of motor-vehicle accidents in South Africa. Although the RAFBS may address the funding of healthcare, the mere fact that an accident occurs place an unnecessary burden on the health sector, and resources which could have been used elsewhere, have to be channeled to addressing the effects of such road accidents. According to StatSA, violence in South Africa caused 9% of all deaths in 2010, more than cancer, endocrine diseases (it must be noted that many sources, including that of the Road Traffic Management Corporation, estimates the actual number of fatalities at more than 10 000):

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1 This was submission is made with the assistance with Elsabe Klinck Consulting CC.
Therefore the best way to address this, is better preventative action. The societies urges the implementation of various initiatives to address this serious challenge.

1.6. Soos wet nou is, as hofsaak afgehandel is, sal betaal vir x, y and z, maar niemand (HCPs) aanvaar dit nie… gaan na prokureur toe en dan sale k kan opereer… [NOTE: I think I missed the point here – we said it is meaningless – why is that? Can we elaborate?]

1.7. The matter of the reimbursement level for healthcare professionals was addressed in the 2010-ruling of the Constitutional Court in the matter between the Law Society of SA and others v the Minister of Transport and the RAF (CCT38/2010). The Court found as follows, and the societies recommends that this principal be adopted within the proposed scheme:

[88] The prescription of UPFS makes it impossible for road accident victims to obtain treatment in a private health care centre. … The tariff is so low that road accident victims will not be able to obtain treatment from private health care institutions

[91] I have no hesitation in finding that the UPFS tariff is a tariff that is wholly inadequate and unsuited for paying compensation for medical treatment of road accident victims in the private health care sector. The evidence shows that virtually no competent medical practitioner in the private sector with the requisite degree of experience would consistently treat victims at UPFS rates.

[NOTE TO CLIENT: DO WE SAY ANYTHING HERE ON LEVEL OF REIMBURSEMENT? ARE THE SOCIETIES HAPPY WITH 2008 REGULATIONS THAT SET TARIFFS?]

1.8. A further principle emerges from the Constitutional Court case, which should be considered in the Bill, on the right of access to healthcare is to ensure that all road accident victims can obtain appropriate care, if needed, for life:
It emerges from the evidence that the UPFS\(^2\) tariff does not cover material services which road accident victims require and which are provided by the private health care sector. Dr Edeling\(^3\) draws specific attention to quadriplegic needs. He lists services which do not appear on the UPFS tariff which relate to home visits by a psychiatrist, counselling by a psychologist, home nursing services and home-based physiotherapy. The evidence suggests that for victims rendered quadriplegic or paraplegic living in informal settlements or living far away from hospitals or clinics, home visits can mean the difference between life and death. It is clear, that the UPFS tariff is inadequate for paying compensation for medical treatment for road accident victims and in particular in relation to victims rendered quadriplegic or paraplegic.

Lastly and perhaps more importantly, the evidence shows that in certain material respects the public health institutions are not able to provide adequate services crucial to the rehabilitation of accident victims who are permanently disabled. ... He or she requires immediate and long-term medical and rehabilitative care. Many require specialised care for life, without which they have to face life-threatening complications.

In the Constitutional Court, it was argued that it is hoped that the level of care in the public health sector would develop and become more appropriate for all patients. This is, however, in the experience of the societies' members, not the case and unlikely to be a reality for the short- and medium term. The RAFBS should therefore ensure both appropriate compensation, and access to appropriate care. Such compensation would require to be adapted frequently, so as to keep pace with inflation and other costs that might outstrip inflationary pressures (e.g. equipment that is vulnerable to exchange rate volatility).

It must also be borne in mind that, given the shortage of various types of healthcare professionals (see for example the Department of Health’s HRH Strategy for the Health Sector, 2012 which points to shortage of orthopaedic surgeons of 525 in its base year), the right of access to healthcare could be seriously jeopardized for these victims if a system of designated providers (similar to those in place for medical schemes) are put into effect. Delaying access to healthcare (i.e. availability) is as much of an injustice than access not being affordable. This was also confirmed by the Constitutional Court in the NewClicks case on the pharmacists’ dispensing fees.\(^4\)

With more than 800 000 accidents per year\(^5\), many involving more than one person, at a cost of R300 billion\(^6\), the implication of road accidents on the health care sector, and healthcare professionals, is massive. The lack of data on accidents, and the current emphasis on fatal accidents also serves as a warning signal that managed care systems, currently implemented by

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\(^2\) Uniform Patient Fee Schedule.  
\(^3\) An expert witness in this court case.  
\(^4\) Minister of Health and Another v New Clicks and Others, Case CCT 59/04, decided on 30 September 2005, at par 315.  
individual medical scheme administrators, are nowhere near the magnitude
and life-long support that would be required under the RAFBS, which is
proposing various managed care tools in managing the medical expenses
associated with road accidents. Managed care systems require sophisticated
clinical- and financial software, expert staff, etc.

1.12. Given the objective to ensure an efficient, cost-saving system, the societies
submit that a new system be subjected to a regulatory impact assessment
(RIA). This is as the system appears to be modeled on a large medical
scheme administrator, encompassing controls over the provision of
healthcare, the contracting and management of such contracts, as well as
complex systems and timeframes which could be expensive, time-consuming
and intensive, such as pre-authorisation systems. Such a RIA study7 must be
undertaken as to the cost of the RAFBS system, including the cost of
undertaking managed care as proposed in Chapter 6 of the Bill. Any system
that creates potentially large amounts of administrative work should be worth
it in terms of the benefits it creates.

1.13. It is understood that the Bill, once law, will operate in conjunction with the
Road Accident Fund (RAF) Act, 1996, but that the liabilities of the RAF would
be limited to that described in the Bill.

1.14. A further implication of the co-existence of the RAF Act and the RAFBS Bill,
once law, would be that the 2008-regulations and all the references in the
RAF Act to benefits, will have to be re-evaluated (most notably sections 17
and section 26). For medical practitioners having to work across two sets of
legislation and regulations issued thereunder is cumbersome and legal
issues are bound to arise. The societies therefore proposes clarity on the
regulations – those published with the current RAFBS Bill does not provide
the requisite details on reimbursement and the likes, and the societies is of
the view that the 2008 regulations just require adaptation, so as to ensure a
streamlined system.

1.15. The Bill refers to “rules” in various places and it is submitted that not
requiring key criteria and administrative arrangements to be set in
regulations avoid the democratic scrutiny and public input that would be
applied to rules being made in regulations. Such actions may also be
deemed to be an unauthorized delegation of powers. The societies propose
that reference to “rules” be substituted with reference to “regulations”.

2. COMMENTS ON CHAPTER 1: DEFINITIONS & OBJECTIVES

“Emergency health care service” - should be defined in line with the Constitutional
interpretation thereof, viz. “the sudden and, at the time, unexpected onset of a health

condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s life in serious jeopardy”. It must also be noted that a emergency care may need to be, for medical reasons, delayed, and that does not make such care less of part of the emergency care needed to save life or limb.

“Health care service provider” should be defined as a provider “and/or” a health establishment, as services may be rendered by both in connection with victims of a road accident (e.g. a private hospital will provide a theatre and theatre staff, whilst an anaesthetist and an orthopaedic surgeon will also be providing services).

“Occupational therapist” (OT) – is it unclear why this specific health service provider is defined separately, whereas OT’s, physiotherapists, medical practitioners (GPs and specialists), etc. are all defined under the Health Professions Act, 1974, as healthcare professionals and fall under the definition of a provider earlier in the Bill.

“Spouse” – the definition of a domestic partnership as necessarily being undertaken in a “contractual” format could lead to persons being denied rights under the Act if interpreted as a written, formalized contract.

“vocational training” – it is unclear why only one type of training is being proposed, which could hamper the prospects and not fit with the injuries and/or previous occupation of victims of road accidents.

3. COMMENTS ON CHAPTER 2: ADMINISTRATOR

3.1. On section 3(2): It must be clear whether the RAFB Administrator is a public entity under the Public Finance Management Act, 1999, as the manner in which allocations are made, procurement is undertaken, and so forth, should be subject to the PFMA and the control of National Treasury. The Administrator will still be an organ of state in constitutional terms, even though it is a juristic person. It should also be subject to the oversight of Parliament.

3.2. On section 5(e): The Administrator must facilitate access to “early, effective and appropriate health care and medical and vocational rehabilitation...”. Appropriateness in all healthcare interventions is key, and protects persons from their healthcare rights being limited by rationing of care in a way that constitutes sub-optimal care. Section 5(e) should refer to healthcare, and not only to rehabilitation.

3.3. Section 6(j): the duty to investigate the causes of accidents sit with the South African Police Service and entities such as the Road Traffic Management Corporation, in terms of Act 20 of 1999. It is submitted that the RAFB Administrator not duplicate efforts in this regard.

4. COMMENTS ON CHAPTER 3: GOVERNANCE
4.1. Given the focus on benefits of a medical nature, and the fact that this aspect of the RAFBS will be the most onerous and important, the composition of the Board should reflect persons knowledgeable and experience in healthcare provision.

4.2. Section 7(b) would, in effect, mean that only one person could be from the medical field, which would be wholly inadequate to ensure appropriate measures and realistic administrative and clinical criteria are set. The societies proposes that section 7(b) be amended to reflect the following – “(b) Ten … in one or more fields, of which at least four persons have to be from the following categories each:
(i) orthopaedic surgery, nominated by the SAOA;
(ii) an orthopaedic- or neurosurgeon, nominated by SA Spine;
(iii) occupational therapy;
(iv) another field of medicine involved in the healthcare management of road accident victims;
and the remaining seven persons from the field of disability management, medical insurance ....”.

4.3. It is unclear what “medical insurance” means. Social security measures, which the RAFBS will be, is markedly different from the principles that underpin “ordinary” insurance law. The societies propose that an expert in medical scheme management or managed care (which is such a system) rather be included in the list.

4.4. Section 8 means that, should there be mass resignations from the Board, a Board could be in existence that have had no public input or participation in the process. The Minister can also not appoint “any competent person”, the person appointed must be from the same or a similar field as stipulated in section 7. The societies propose that a vacancy per se should not give the Minister to not abide by the provisions of section 7(2), (3) and (6). Only in extraordinary circumstances should the Minister be allowed, in order to ensure the smooth continuation of the business of the RAFBS Administrator, be permitted to appoint interim Board members.

4.5. Section 9: The societies recommend that the Board be empowered to establish advisory and/or consultative bodies, such as with practicing healthcare providers, so as to ensure that the rules it would apply in, for example, pre-authorisation, are technically sound and in the interest of patients. These committees will not be Board Committees, but advisory Committees separate from the board, which would perform ad hoc advisory, expert and technical services. This will also avoid conflicts of interests, as set by section 16, whilst allowing expert and practical input into Board processes and decisions.

4.6. Section 13(1): It is suggested that the Board meets at least twice per annum, so as to (a) recommend and approve budgets to be put to the National
Treasury and as part of the Parliamentary budget vote; and (b) review and approve the Annual Report to be submitted to the Parliament annually.

4.7. Section 13(2)(a) refers to the members of the Board entitled to vote. Voting rights are, however, not described. For example, CEOs would normally not have a voting right, but it may be the intention to do so in the case of the RAFBS Administrator?

4.8. Section 14 should consider the involvement of professionals who has to be adequately remunerated for time out of their practices and the cost of securing locums.

4.9. Section 15 must include duties on the Board to –
   4.9.1. Approve and submit an annual budget and performance plan as is required from all organs of state to the Minister and National Treasury;
   4.9.2. Approve and submit an annual report to the Minister and to Parliament.

4.10. Part B, chapter 3 raises issues as the term of office of the CEO is 5 years, whereas the term of office of a Board is 3 years. As the CEO will be appointed to the Board (or is the position ex officio) – corporate governance issues may arise. It is recommended that section 7(1)(a) be amended to state “CEO, ex officio, as a non-voting member of the Board”. This would also solve the possible contradictions in the CEO being accountable to the Board, but being a Board member at the same time.

4.11. Section 24 speaks about “executive management”, but it is unclear how that level will be determined. It could also raise corporate governance issues if executive managers deem themselves accountable to the Board, and not to the CEO.

5. COMMENTS ON CHAPTER 4: FINANCE

5.1. It must be clear that the SAFBS Administrator is a body under the applicable schedules of the PFMA, so as to ensure the level of independence that would be required in order to not fall into the funding predicament of entities such as the Medicines Control Council, where income cannot be retained and reverts into National Treasury, and where the Administrator would be dependent on allocations from the National Treasury as budgets annually. The societies suggest that the RAFBS be listed, as is the case with the Compensation Commission, as a schedule 3 “National Public Entity” under the PFMA.

5.2. Section 27(2)(b) refers to monies apportioned by government under the RAF Act – as the Act is phased out, it is unclear whether this source of funding would also cease to exist. It is suggested that Parliament still be endowed with the power to make allocations to the RAFBS, i.e. the section 27(2)(b) must not be limited to RAF Act functions.
6. COMMENTS ON CHAPTER 5: LIABILITY OF ADMINISTRATOR

6.1. Section 28(4) appears to relate to motor vehicle accidents not on South African soil. The phrase “legally present” is unclear and should be clarified. If the intention is to limit compensation to persons who are South African citizens or South African residents, such limitation would need to be constitutionally defensible, as well as the limitation on the rights of such persons to take civil action against a person who caused such accident.

6.2. The societies believe that the exclusion of civil liability under section 29 could make medical practitioners a target of aggrieved patients / road accident victims, in an attempt to place such persons in their status quo ante. The societies’ members are already facing increase instances of litigation and/or complaints at the HPCSA, with a resultant effect on professional indemnity cover / insurance premiums. The societies believe that this matter should be considered by the drafters of the Bill, in conjunction with the Minister and Department of Health, as provincial health departments have also already experienced claims to the millions of Rand in all provinces.

6.3. Although it is understood that the RABS Administrator do not want to pay legal fees, such legal representation may be necessary for patients who are unable to explain the impact of their losses on their lives, either due to their incapacity / disability and/or due to absence of financial means to secure expert legal services. This might have the exact opposite effect to what the Bill intends – indigent patients would not have any person act on their behalf, whereas victims with more financial means would have such access and possibly more successful claims under the RAFBS Act.

7. COMMENTS ON CHAPTER 6: BENEFITS

7.1. The societies urge that the drafters of the legislation investigate the challenges currently being experienced by the Compensation Commission system, and take steps to avoid this. It should also be noted that many providers are no longer seeing occupational injuries, due to the administrative inefficiencies, as well as the non- or late payment of accounts. The RAFBS should avoid these, as if it were to occur, road accident victims’ access to healthcare would be seriously hampered.

7.2. Section 31(1) does not list medical care and other healthcare rendered by healthcare professionals registered at the HPCSA and Pharmacy Council (although it might be implied in section 31(1)(d) as “outpatient services” and (c) – “emergency and acute care”). Furthermore, the inclusion of healthcare professional services into “hospitalization” cannot be assumed as, in the private hospital setting from a billing and service delivery perspective, the services and billing are separate (HPCSA rules prohibits the employment of practitioners by private hospitals). In the public hospital setting from a practical point of view, the services of the hospital (nursing and such
ancillary care) are different from the healthcare rendered by medical practitioners and those registered at the HPCSA. Pharmaceutical care (medicine and dispensing fees) are also not listed in section 31(1).

7.3. Section 31(1)(k) refers to medical reports. Practitioners have been traditionally, not been funded or funded inadequately for such reports, which are often the crux of claims against the specific funder. The societies propose that any benefit schedule published under the RAFBS Act addresses this aspect and ensure appropriate fee levels based on the hourly input and level of complexity required for these reports.

7.4. A further element that is absent from the list in section 31(1) and which may be implied by the medical report, is instances where, due to the accident, a patient would, later in life, need a revision of previous surgery provided, or would need, later in life, as a result of the accident, for example a hip replacement. The societies therefore suggest the addition of section 31(1)(l) “Further healthcare as may be required pursuant to such needs anticipated in the medical report or, where not anticipated, causally related to the accident”. The need for this is already recognized in section 31(1)(h) – “long-term personal care”.

7.5. Section 31(2) refers to the criteria to be applied when evaluating whether to reimburse a health service or not. The determination of what is “reasonably required” and “reasonably necessary”, as well as “appropriate” has to be determined with reference to evidence-based medicine. This concept is defined and applied within the other social security system where pre-authorisations and the likes are applied, viz. the Medical Schemes Act. It states that limitations must be based on “evidence-based medicine”, defined in the law as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research.”

7.6. Any limitation to the rights of access to healthcare have to pass the limitation clause test set in section 36 of the Constitution, 1996. This means that the limitation must be clearly mandated by the RAFBS and comply with the section 36 factors. The societies therefore propose that clear criteria be set so as to ensure that patients / victims can access evidence-based care, and that any limitation is justifiable on that basis.

7.7. Both sections 32(1)(f) and 33(1)(2)(a) states that pre-authorisation may be required for pre-appointed (contracted) service providers and for those not contracted. Pre-authorisation systems are resource-intense and require fairly sophisticated systems built on clinical protocols, financial models. It must be applied, managed and adjudicated by persons who are clinical peers to the professionals requesting particular treatments or interventions, and cannot be adjudicated by persons who do not understand the scope and extent of the injury and/or proposed treatment.
7.8. The societies suggest that the RAFBS undertakes a regulatory impact assessment as to the extent of this undertaking, given the monthly numbers of road accidents in South Africa. THE SOCIETIES suggests that, prior to implementation, the system of pre-authorisation be tested as pilot projects, so as to ensure its applicability and appropriateness. [NOTE: do we have any data as to the % of RAF claims that are medical / treatment related?]

7.9. Section 32(1)(b) refers to the certification that an injury was caused by or arose from an accident. This would be impossible to adjudicate and it could mean that access to healthcare.

7.10. The societies propose that, in setting tariffs either in terms of section 32, 33 or 55, the SAOA coding system be used. This Coding system sets out all the interventions and actions that may be undertaken by orthopaedic surgeons, and therefore provide an authoritative view of the professional activities, as well as the weightings between various activities.

7.11. Section 32 creates a system akin to the “preferred provider” and “designated service provider” systems used by medical schemes. This limits patients’ rights to freedom of choice of provider as entrenched in the Patient Charter and the Consumer Protection Act. This could also have implications for the right of access to healthcare, which does not only involve the affordability of services, but also the availability thereof.

7.12. In medical schemes, DSP arrangements are not applicable in the following circumstances, which The societies suggest should also apply to the RAFBS:

7.12.1. The contracted service provider is - or enablers for services are - not available (e.g. there is not appropriate healthcare professional to render the requisite services, or there is no bed to admit the victim, or there is no professional trained or experienced in, for example, complex spinal surgery required etc.); and/or

7.12.2. The contracted service provider is too far from the victim’s home or work (i.e. the cost of transportation to and from the facility for the victim and/or his or her family just becomes a cost-shifting exercise); and/or

7.12.3. Immediate healthcare (i.e. healthcare of an extent less than what is required as emergency care) or emergency healthcare is required.

7.13. In addition, provision must be made for choices. Victims may want to choose a non-contracted provider, which provider may know their medical history, is trusted by the patient/victim, is known the render quality care in a particular field, etc. The rule in the medical schemes environment in these circumstances is that schemes will pay up to the amount contracted, and the patient picks up the tab for the difference. As the claim becomes a right awarded by the RAFBS, such an approach would be fair, as the quantum of the benefit remains the same, but it allows patients their freedom of choice.
This could also assist in alleviating the burden on already over-burdened public health facilities.

7.14. [NOTE: should we say something here about orthopaedic services in the public sector? I.e. is it available, waiting lists, numbers of orthopods, etc.?

7.15. Section 32(2)(b) is unclear in its meaning and intent. The societies require confirmation that the intent is that a medical scheme DSP / contracted provider would automatically be deemed to be a RAFBS contracted-in provider. It may also be that the intention of this subsection is that the RAFBS will not reimburse healthcare that falls within the scope of a medical scheme’s benefits, but that the RAFBS will then reimburse the medical scheme, and not the provider. This, in turn, could leave practitioners out of pocket, in particular where scheme rates paid to practitioners are lower than those reimbursed by- or contracted by the RABFS.

7.16. Section 33 (1)(b) and (c) refers to either a published tariff, or to the “reasonable cost” of a service. In this, the societies draw attention to the fact that the Uniform Patient Fee Schedule cannot be regarded as such a tariff reflecting the “reasonable cost” of a service, it is not based on the actual cost of the services rendered by the public sector and merely reflects what the public sector deems as affordable to patients who are able to make some contribution to their healthcare. Provincial health accounts show that monies earned via this source is minimal. It is also, in fact, heavily subsidized by money from the general fiscus allocated to healthcare facilities.

7.17. Section 33(2)(a) refers to “rules” and it is unclear what rules this refer to. This section might have been borrowed from a medical scheme administrator agreement, and if so, the societies would caution against the adoption of phrases which may not be totally applicable as (a) the number of potential beneficiaries vastly outstrip those of an average medical scheme administrator, and (b) medical scheme administrators have sophisticated software and resources to fulfill the detailed managed care criteria set in the regulations to the Medical Schemes Act.

7.18. The provision of a treatment plan in section 34(1), which plan is “determined” by the Administrator, creates the impression that the Administrator would request, evaluate and approve of such individual treatment plans. As is the case with pre-authorization, this would require skilled and experienced resources in the employ of the RAFBS Administrator, as well as compliance with evidence-based medicine and treatment protocols set from time to time. In terms of the Health Professions Act, 1974, and the regulations and ethical rules published thereunder, healthcare can only be determined by persons who have qualified and are registered to advise on such treatment, and can only be provided on the basis of an examination by a healthcare professional. It is therefore unclear on what basis the Administrator will determine the treatment plan.
7.19. Section 34(1)(b) involves a number of persons or entities in the treatment plan for future healthcare services. It must be noted that the National Health Act, 2003 leaves the decision as to the care to be provided to the patient (section 6). This decision is, and cannot be made by the employer or even the healthcare provider and would leave patients disempowered of their right to freedom and security of the person as set in section 12 of the SA Constitution, 1996. It also constitutes a violation of a beneficiary’s right to privacy as entrenched in the Constitution, the National Health Act and the 2013 Protection of Personal Information Act. Subsections 33(1)(b)(ii) and (iii) must therefore both be preceded by the phrase “when agreed to by the beneficiary in writing…”. Healthcare providers found to act in contravention of the National Health Act and/or their ethical and legal duties to obtain informed consent to treatment and written consent to disclosure of information.

7.20. Section 36(1), in contrast to section 33(1)(d), is interpreted to mean that foreign nationals who are not South African residents could not claim for income benefit support, whilst such persons would be able to claim for healthcare service, provided that it is rendered in South Africa. The application of the RAFBS to persons who are legally, and those who are illegally, in South Africa, should be confirmed.

7.21. The societies, whose members themselves may become the victims of accidents, wishes to highlight a particular concern facing smaller employers. Where professionals employ staff, and where such staff are dependent for their income on the income of the professional, the limitations on the income support benefits in section 35 could cause considerable hardship for such employees in the short-term, if such caps are placed a the level proposed. The non-adjustment of temporary income support benefits on inflation would have a similar effect on the beneficiary and his or her staff.

7.22. Long-term income support benefits (section 37(1)(c)) depends on, amongst others on “further specialist medical reports” that may be called for by the Administrator. The societies submit that the standard form currently used by orthopaedic surgeons could be used as a template to develop a form to be used by the RABFS Administrator to ensure a consistent application of certain criteria to all cases.

7.23. AMA Training where does it fit in, great discomfort and one would then …

7.24. Section 37(3) refers to the HPCSA as the body to set guidelines for assessments. It must be noted that, by registering professionals, the HPCSA already approves of the professional training and competence of a professional, and cannot delineate such competencies ex post facto by setting the said guidelines. This power is also not afforded to the HPCSA in the Health Professions Act, 1974. The societies submit that section 37(3) be reworded to states that such reports be undertaken in accordance with the
scope of practice, training and experience of the specific assessor, who should be duly registered at the HPCSA.

7.25. Section 38’s provision of vocational training programme may be required should not be an add-on or a nice to have, but a necessary component of the victim’s rehabilitation.

7.26. Section 40 sets a monetary limit. Given the changes in inflation, etc., it is submitted that no monetary values be set in the Bill itself, and that it rather refers to monetary values as set by the Minister from time to time.

8. COMMENTS ON CHAPTER 7: CLAIMS PROCEDURE

8.1. Section 43(2) refers to a claim not being payable unless it is submitted in a format prescribed in the rules (the societies supports these to be set rather as “prescribed in regulations”). The societies urge that the RAFBS Bill includes criteria related to such claims, and also prescribes timelines for the submission, consideration and payment of such claims.

8.2. Making a claim for healthcare services dependent on the co-operation of a victim under section 44 could leave health service provider exposed. The societies proposes that the claims of healthcare professionals not be linked to performance of actions by any third party, including the victim, over whose actions they would have limited or not control.

8.3. Section 45(c) and (d) must be aligned with the provisions of the Protection of Personal Information Act, 2013 (“POPI Act”). This Act places severe limitations on the processing (disclosure, sharing, etc.) of health information in particular. It also contains specific provisions relating to information relating to children, and in this regard the provisions of the Children’s Act, 2005 in relation to children’s access to healthcare and confidentiality should also be considered. The societies understand that the POPI Act also applies to state organs. In addition, consideration must be had for the provisions of the Promotion of Access to Information Act, 2000, which sets different standards for requesting information held by the public sector and that held by the private sector.

8.4. Section 47 is supported, but require clarification. It must be clear that the accident and the potential of rights relating to such accident be reported. As currently drafted, the section may be read to mean that only those rights related to a specific medical claim registered within those three years would be valid, whereas it is perfectly possible that a medical issue relating to an accident may arise after three years after the accident. The emphasis is therefore on the registration of the accident, and all rights relating to all claims that flow from it, remains preserved.

8.5. It is unfair to deem a claim to which the Administrator not respond, in terms of section 48, as rejected. To, under section 48(1), require all such claims to
be subject to a lengthy, costly and cumbersome appeal does not make sense. This means that, if the Administrator misplaces a claim, or do not receive a claim, there is no opportunity for follow-up or take any corrective action. Such a mechanism would be in the interest of both the Administrator and the claimant. Furthermore, it would be impossible to appeal in these circumstances, as the grounds for the rejection would not be known.

8.6. The societies recommend a redraft of section 48, in line with the provisions of administrative justice by creating internal follow-up mechanisms, online or similar tracking of claims, acknowledgement of receipts of claims and payment within 90 days of receipt of the claim. The financial risk undertaken through non-payment, and potential rejection due to non-receipt after 6 months appear excessively harsh and inefficient. The societies also suggest that interests must be payable on accounts overdue for longer than 3 months, as the specific practitioner or public sector facility would literally be carrying the financial burden on behalf of the RAFBS.

9. COMMENTS ON CHAPTER 8: DISPUTE RESOLUTION

9.1. The Appeal Committee cannot be constituted of officers of the Administrator, as it would compromise the administrative justice principle of nemo iudex in sua causa (independence of the appeal body from the decision-maker whose decision is being appealed).

9.2. Based on experiences in other such internal appeals processes, the societies proposes that timelines be set for (a) the appointment of an appeal committee, (b) procedural rules for such a committee, which should be uniformly and consistently applied to all appeals, (c) timelines within which the matter must be heard and (d) timelines within which a final ruling must be made. If these processes are not expedient, persons will not use them and the Administrator may face reviews by the High Courts, which will be costly and time-consuming.

9.3. If an appeal takes 180 days to finalise, and the matter has been the non-payment of a claim, it might leave an appellant out of pocket for a year! Taking the matter on review or asking for a declaratory order or interdict would solve the matter much faster and may be an opportunity for lawyers to make up the loss of income brought about by the new RAFBS.

9.4. Members of the societies have experience in these types of appeals (whether at the HPCSA or elsewhere) and would be more than willing to offer their services and support in such appeals processes.

10. COMMENTS ON CHAPTER 9: GENERAL PROVISIONS

10.1. Section 52 limits the liability of staff of the Administrator to intentional wrongdoing only. As with any employee, staff should also be held liable for negligence, and senior managers should be held liable under the Public
15. CONCLUSION

11.1. Many aspects of the RAFBS are still unclear and require amendment.

11.2. The societies also strongly recommend that pilot studies be undertaken to test the application of the new scheme, and its rules on pre-authorisation, payment timelines and contracting before finalizing such aspects.

11.3. A Regulatory Impact Assessment (RIA) is necessary, in order to see if the scheme and its administrative requirements would meet the criteria of efficiency, cost-effectiveness and rationality.

11.4. The societies will gladly engage the Department on any aspect of this submission and reiterates its request for a meeting with Departmental Official prior to the submission of the Bill to Parliament.

11.5. The societies can be contacted through its CEO of SAOA, who will ensure that all communication and information is appropriately disseminated and address. The Executive Committee member tasked with road accident matters is Dr Piet Engelbrecht. The CEO can be contacted as below: