LAW SOCIETY
OF SOUTH AFRICA

COMMENTS BY THE LAW SOCIETY OF SOUTH AFRICA
ON THE ROAD ACCIDENT FUND MEDICAL TARIFF
PUBLISHED FOR COMMENT ON 10 MARCH 2021 IN TERMS OF SECTION 26 OF THE ROAD ACCCIDENT FUND ACT 56 OF 1996, AS AMENDED

INTRODUCTION

Tariffs were introduced into the Road Accident Fund Act 56 of 1996 (the Act) by way of the amendment effected to Section 17 by the Road Accident Fund Amendment Act, 2005, and now reads as follows:

"17 (4B)(a) The liability of the Fund or an agent regarding any tariff contemplated in sub-sections (4)(a), (5) and (6) shall be based on the tariff for health services provided by public health establishments contemplated in the National Health Act, 2003 (Act No 61 of 2003), and shall be prescribed after consultation with the Minister of Health.

(b) The tariff for emergency medical treatment provided by a healthcare provider contemplated in the National Health Act, 2003 –

(i) shall be negotiated between the Fund and such healthcare providers; and

(ii) shall be reasonable taking into account factors such as the costs of such treatment and the ability of the Fund to pay.

(c) In the absence of a tariff for emergency medical treatment the tariffs contemplated in paragraph (a) shall apply".

In terms of Section 17B the limitation of liability of the Road Accident Fund (the RAF) to prescribed tariffs is in respect of claims made in terms of "*sub-sections (4)(a), (5) and (6)*" of Section 17 only. Thus, liability in respect of claims for future medical costs, claims for interim payments of incurred medical costs and claims direct from suppliers can be limited to *"the tariff for health services provided by public health establishments contemplated in the National Health Act, 2003 (Act No 61 of 2003".*

The proposed tariff is promulgated in terms of Section 26 of the Act, which grants the Minister of Transport the power to "*make regulations regarding any matter that shall or may be prescribed in terms of this Act or which it is necessary or expedient to prescribe in order to promote or achieve the object of this Act*".

THE TARIFF PROMULGATED IN REGULATION 5

The first tariff (UPFS) prescribed for non-emergency treatment was articulated in the Regulations as follows:

(1) The liability of the Fund or Agent contemplated in Section 17(4B)(a) of the Act shall be determined in accordance with the uniform patient fee schedule for fees payable to Public Health Establishments by full paying patients, prescribed under Section 90(1)(B) of the National Health Act, 2003 (Act No 61 of 2003), as revised from time to time."

The rationality and legitimacy of this tariff was successfully challenged in the case of *Law Society of South Africa and Others v Minister for Transport and Another (CCT 38/10) [2010] ZACC 25; 2011 (1) SA 400 (CC); 2011 (2) BCLR 150 (CC) (25 November 2010).*

The Constitutional Court found that a tariff that denies a road accident victim treatment in the private health sector is "*not rationally related to the objectives sought to be achieved".*

At page 55 [91] of the judgement the court had the following to say:

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. This simply means that all road

accident victims who cannot afford private medical treatment will have no option but to submit to treatment at public health establishments.

And at page 59 [99]:

I am satisfied that the UPFS tariff is incapable of achieving the purpose which the Minister was supposed to achieve, namely a tariff which would enable innocent victims of road accidents to obtain the treatment they require. UPFS is not a tariff at which private health care services are available; it does not cover all services which road accident victims require with particular reference to spinal cord injuries which lead to paraplegia and quadriplegia. The public sector is not able to provide adequate services in a material respect. It must follow that the means selected are not rationally related to the objectives sought to be achieved. That objective is to provide reasonable healthcare to seriously injured victims of motor accidents.

THE PROPOSED ROAD ACCIDENT FUND TARIFF 2020/2021 (THE RAF TARIFF)

In the limited time available for comment, the Law Society of South Africa (LSSA) has been able to determine that the RAF tariff falls far short of the actual cost of treatment and services in the private health sector. Below are a few examples:

Procedure codes by medical specialists

The RAF proposed tariffs are between 33% and 50% lower than the average rate currently charged by medical specialists.

Radiology codes

The RAF proposed tariff for black and white x-rays are on average 25.7% lower than current private radiology charges.

Physiotherapist codes

The RAF in hospital physiotherapy tariffs are on average 46% lower than those currently charged.

Hospital tariff codes

The RAF proposed hospital tariffs are between 55% and 70% lower than the current private hospital charges.

There is also a concern that the new coding system may not accommodate accounts submitted by suppliers and therefore conversion of their accounts so as to process payment may not be possible.

CONCLUSION

If afforded more time, the LSSA will produce a more detailed analysis of the proposed tariff as against the current costs in the private health sector. However, what is immediately apparent is that if these tariffs are adopted, road accident victims who are not able to afford to fund their treatment will have no option but to seek treatment in the public sector.

If anything, the public health system has deteriorated since 2010. Conditions in the Eastern Cape, in particular, are dire. It is submitted, that, on this ground, alone, this tariff will also not withstand a constitutional challenge.