LAW SOCIETY
OF SOUTH AFRICA

**SUPPLEMENTARY 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**

## SECTION 17 OF THE ACT

The relevant portion of Section 17 of the Act 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."*

There is an obvious anomaly in that Section 4B(a) refers, specifically, to "*sub-sections (4) (a), (5) and (6)*" of Section 17 only. The excludes the Fund's liability for past hospital, medical and other costs incurred following an injury and forming part of a claim made by the injured party. It is unlikely that it was intended to restrict the application of a prescribed tariff only to costs covered by undertakings, direct claims and interim claims. However, this appears to be the literal interpretation of the amended section and may need to be addressed by way of an appropriate amendment to the Act.

In terms of the definitions and Section 26 of the Act, the Minister of Transport is charged with the responsibility of prescribing tariffs and before doing so shall consult with the Minister of Health.

The Minister of Health's views on the proposed tariff will doubtless provide insight into the impact that the proposed tariff will have on the operations of the Department of Health. Currently it is understood that the Fund pays the full paying patient fee when reimbursing provincial hospitals for services rendered to road accident victims. It is also understood that the proposed tariff falls far short of this. The proposed tariff also fails to provide for certain essential services, for example certain theatre personnel whose attendances are necessary during surgery.

Road accident victims form a large part of the case load of provincial hospitals. A significant reduction in the reimbursement paid by the Fund to the provincial hospitals may further hamper the operations and efficiency of those hospitals to the detriment of all patients, not just road accident victims.

The imposition of any tariff which precludes road accident victims from accessing private health care will have a ripple effect on the efficient operation of provincial hospitals to the detriment of all public health care users.

The requirement "*after consultation with the Minister of Health*" permits the Minister of Health to be satisfied with the remuneration and/or the ability of the national health system to accommodate accident victims at this tariff, which, being a subsidised tariff, may not permit the development of better or more facilities (out of revenue generated) to cope with the influx of additional patients, unable to access private health care by virtue of restrictive tariff.

Chapter 11 of the National Health Act 2003, in Section 90, enables the Minister of Health, after consultation with the National Health Council, to make regulations regarding:

*"(1)(b) the fees to be paid to public health establishments for health services rendered*"

A further question may therefore be asked, namely whom does the RAF Act contemplate would be prescribing the tariff as far as services rendered by public health institutions go? Is it the Minister of Transport, or is it the Minister of Health?

In this regard it is interesting to note that, whilst Section 26 of the RAF Act specifically empowers the Minister of Transport to make regulations relative to an assessment method, in respect of injuries which are not serious and dispute resolution, no specific power is given him regarding the prescribing tariffs. No doubt the very wide power in Section 26 to make regulations on "*any matter...or which it is necessary*

*or expedient to prescribe in order to promote or achieve the object of this Act*" would confer on him the necessary power to do so.

In the interests of transparency and for meaningful consultation, details of consultations between the respective Ministers of Health and Transport should be published and the views of the Minister of Health made public.

**DENIAL OF PRIVATE HEALTH CARE**

The effect of the proposed tariff will be to deny many road accident victims access to private health care. Currently there is still a significant body of persons injured in road accidents who are able to access private health care even though they do not have medical aid and do not have the private means to cover the costs. This is possible as the services and treatment are rendered to those persons in the knowledge that the costs will be reimbursed at a reasonable tariff by way of direct claims on the Fund by the suppliers and service providers. The proposed tariff will put an end to this as the suppliers and service providers cannot render treatment or provide services at this cost.

The shortfall in reimbursement to medical aids will result in increased membership fees, which in turn will inevitably result in more persons being unable to afford any form of medical cover and thus have to rely on public health care.

In our initial submission, the LSSA outlined the shortfall in the proposed tariff to current private costs. However, the LSSA failed to point out that that comparison was as against medical aid tariffs. For private patients the shortfall will be even more significant.

Currently persons with an undertaking are entitled to access private health care treatment. This means that persons requiring prosthetics, wheelchairs, carers, surgery, post operative care and other essential services are able to access this in the private sector. The proposed tariff will put an end to this.

The point has already been made that the Constitutional Court has already found that the imposition of a tariff which will deny seriously injured road accident victims private health care thus denying them certain modalities of treatment and materially increasing their risk of death, will, on that ground alone, be struck down.

**PURPOSE OF THE TARIFF**

The introduction of the tariff is aimed at reducing costs in line with the Funds overall strategy. However, the percentage savings that will be achieved by drastically reducing the cost of treatment and services will not make a material difference to the expenditure of the Fund, as medical and related expenses account for less than 10% of its expenditure. However, for the road accident victim the cost will be significant and could prove fatal. It is submitted that there are other ways of reducing expenditure rather than at the expense of those very people the Fund is mandated to serve.

Therefore, the introduction of any restrictive tariff that has the effect of denying proper health care to injured road accident victims is not rationally connected to the purpose for which the Fund was established.

**THE PUBLISHED TARIFF**

The LSSA relies on the advice of experts in relation to the detail of the published tariff. It has been advised that the tariff is inadequate and also does not provide for many essential services which are required in order to provide proper health care.

In this regard, the LSSA associates itself with the submission made on behalf of the Health Funders Association and in particular paragraph 7 thereof.