**Medical negligence litigation as a mechanism for understanding gaps in health system responsiveness in the South African Public health system.**

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**Supervised By: Associate Professor Jill Olivier**

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**Abstract**

Medical negligence claims in South Africa have seen a significant rise in recent years. The reasons given for this rise have ranged from accusations of predatory legal practitioners taking advantage of patients to an ever-increasing quantum of damages been awarded by the courts. The impact of this rise in cases has particularly been felt by public health systems, who are having to dedicate considerable resources to defending the claims made against their workers and facilities, as well as make the pay-outs for damages awarded against them. The increase in medical negligence cases has been viewed as an unwelcome and expensive hinderance to the proper functioning of these public health systems, leading to calls by health system leadership for an overhaul of the laws governing medical negligence claims and possible legal remedies including damages. While procedural interventions may be helpful in reducing the cost of medico-legal claims for the public health system, they do not address the underlying challenge of untoward health outcomes that are the basis of subsequent negligence claims. However, health systems leaders rarely give countenance to the possibility that the increase of medical negligence claims is a *response* to weak health systems, lacking in their ability to meet their obligations to health users. While these obligations include quality health care delivery with favourable biomedical outcomes, they also entail appropriate response to legitimate citizen expectations (health system responsiveness). An exploratory qualitative interdisciplinary study, using case law analysis was carried out to analyse medical negligence case law in South Africa and to identify possible health system responsiveness lapses. Five aspects of responsiveness emerged in the findings from the analysis of the case law, with dignity being the health system responsiveness category most often breached, as recalled by health users in their medical negligence claims. This exploratory study raises the possibility of viewing medical negligence cases as a mechanism for informing lapses in health system responsiveness. Such a responsiveness-minded analysis of health user claims can help in an understanding of patient dissatisfaction as being as much about desires for a more responsive health system as it is about seeking recompense for untoward health outcomes.

## Acronyms and abbreviations

| | |
|---|---|
| DOH | Department of Health |
| HIC | High- Income Country |
| HPSR | Health policy and systems research |
| HSL | Health systems leadership |
| HSR | Health system responsiveness |
| LMIC | Low-and Middle-Income Country |
| MEC | Member of Executive Council |
| MPH | Master of Public Health |
| MOH | Minister of Health |
| NHA | National Health Act |
| SAFLII | Southern African Legal Information Institute |
| WHO | World Health Organization |

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# Part A: Study Protocol

## Introduction

Litigation has increasingly been used to air out grievances and seek recompense for health concerns in South Africa (Coetzee and Carstens, 2011; Oosthuizen and Carstens, 2015). With the constitutional recognition of the right to health and the attendant duties on the South African State to provide affordable, accessible, and quality care, there is an increase in the legitimate expectations of the populace to enjoy this benefit from the now democratic South Africa (Mæstad *et al*., 2011; Flood and Gross, 2014; Forman and Singh, 2014). This phenomenon of increasing health related claims is keeping in line with research that shows that judicialization of health claims is higher in countries with a clear legal framework on health rights (Dittrich *et al*., 2016).

However, in South Africa, as with many other developing countries, there are still gaps in the aspirational goals of the laws that provide for the existence of health rights and the delivery of the health goods that accrue from those rights to the populace (Forman and Singh, 2014). The result of the mismatch between citizens' legitimate claim to quality health care and the ability of States to meet them has resulted in litigation to compel State action (Forman and Singh, 2014). As an extension of this phenomenon, in the quest for accountability and recompense, health users are making claims against their health care providers when the services they have received are seen as suboptimal and, in some cases, with adverse health effects (Pienaar, 2016). This in turn has led to more claims against health system leadership (HSL) and the health systems they lead for lapses in the standard and quality of care provided to health users (Pepper and Slabbert, 2011; Pienaar, 2016).

While the phenomenon of increased medico-legal litigation in South Africa has been seen by the State and its agents as an ever-increasing attempt to misuse the courts to extract from an already struggling health system (Mosime *et al.,* 2016), some human rights activists and scholars see it as a welcome development for the advancement of health rights and the delivery of better health care (Gloppen, 2008; Heywood, 2009; Flood and Thomas, 2020). However, a major ripple effect of increased judicialization of health claims against the State is that more resources from the public health system's budget is having to be allocated to the litigation and settlement of the claims against it. There is thus the legitimate fear that 'over litigation' may lead to a weaker health system (Mæstad *et al*., 2011).

In response to the need to resolve the resource allocation concerns raised by increased litigation against the South African public health care system, effort has been made by HSL to limit State liability and curtail the ability of health users to litigate. These attempts are laid out in the robust report by Kollapen *et al.,* (2017), where they lay out the state of medical negligence in South Africa and the steps taken by HSL to address it. They note that drawing from a viewpoint that blames increased litigation on a desire of litigants to benefit from ever-increasing damages awarded, legal practitioner instigated greed and an abuse of the spirit of the law, the response of public health leadership in South Africa has been viewed as being adversarial and combative (Joubert, 2016). While many of the identified reasons for the increase in medico-legal action in South Africa may be true, it is pertinent to note that for those actions regardless of intent to be successful in court, they must be grounded in factual evidence and proven on a balance of probability, being the required

burden of proof in law for medical negligence cases (Khan, 1984). As such, the increase in the pay-outs being made for damages claims are an indicator of increased volume of successful claims against the health system. There is therefore room for an exploration of possible lapses in public health system health service delivery that have led to the uptake of successful medico-legal claims against it. Such an approach can assist the South African health system address the identified factors and mitigate the increase in medico-legal cases and subsequent payments of damages when successful. Considerable work has been done to identify factors responsible for increased medico-legal cases (Pienaar, 2016), as well as the challenges of health care delivery that often result in poor health outcomes (Maphumulo and Bhengu, 2019). Legislation to stem the tide of medico-legal claims has been proposed as an important intervention to address the ever-growing challenge. However, such an intervention would likely only be dealing with the symptoms of a larger problem in the health system. As Kollapen *et al.* (2017) note,

> "As is often said, there is no claim without negligence. Legislation can address procedure, establish bodies to deal with some issues, create interventions that do not currently exist, alter the method and timing of compensation and so forth; but legislation cannot address systemic problems with leadership, governance, management, budgeting and procurement, quality of care, lack of skills, personnel shortages, training, attitudes of staff and maintenance of facilities and equipment."

While interventions to stem biomedical mishaps are also an important area of exploration in a bid to reduce the incidence of medical negligence claims, such steps are unfortunately not infallible, as they cannot guarantee the complete mitigation of human error, nor do they cover the full range of variables that lead to health user dissatisfaction and ultimately, claims against the health care provider (Oosthuizen and Carstens, 2015).

An exploration of other factors not directly tied to the success of biomedical interventions, ought to be considered. One important way to explore the framing and system wide context of "declining standard of health care and a decline in professionalism among health care workers" (Malherbe, 2013), would be through an evaluation of the 'responsiveness' of the health system. This is because the concept of health system responsiveness (HSR) is concerned with the identification and understanding of factors that are important for a satisfactory interaction of the health user with the health system, outside of the ambit of the specific biomedical intervention they are seeking (Murray *et al.,*1999).

This study seeks to explore how lapses in HSR are factored into medico-legal cases against the public health system in South Africa. It is intended that through a better understanding of the desire of health users for more responsive systems, gaps in meeting this legitimate desire of health users may be identified and highlighted in medico-legal cases. A more robust understanding of the challenges of public health care delivery and the role that HSR plays in the provision of optimal care, can provide a contextual understanding necessary for the South African health system to be more deliberate in providing more reflexive and empathetic interactions (Valentine et al., 2008) with its health users at all levels. However, for this kind of contextual approach to understanding the non-biomedical factors that cause health user dissatisfaction and litigation, there is need for a grounding of these factors in the larger existing scholarship on HSR. To this end, a preliminary scoping review has been carried out on the nature of HSR, its relevance to understanding of medico-legal litigation and the way said litigation is carried out in the South African context.

**Literature review**

A scoping literature review was conducted with materials relating to medical negligence and HSR in both peer-reviewed and grey literature. The review began with a global focus, for an understanding of macro-level interventions in various country contexts, and then narrowed into specific attention on low- and middle-income country (LMIC) settings, particularly where health rights are recognized, ending with an examination of the South African context (See methods below).

The focus of this study as with other HSR and scholarship, has been to better understand the challenges of health care delivery at a systemic level, and adequately respond to those challenges through interventions that ultimately serve to strengthen the health system (World Health Organization, 2000). The scoping of this research agenda has thus been reliant on the existing literature that provides an adequate framing of the scope and nature of the unmet expectations of health users from the health system and how these in turn lead to unfavourable levels of satisfaction with the care received. Significant work in this regard has been done by the World Health Organization (WHO) to understand and contextualize health user concerns in their interactions with health systems (World Health Organization, 2000). The WHO has noted that there are factors outside of biomedical care that affect the quality of health user interaction with the health system, and has proposed that these factors be continually observed, and the compliance with their fulfilment monitored and assessed, with subsequent necessary changes made to improve on their delivery, by the health system (World Health Organization, 2000). This feedback loop has been observed to be integral to responsiveness efforts towards improved health systems performance (Veillard *et al.,* 2010).

**The nature of health system's responsiveness**

The World Health Organization (WHO) has stated that HSR is an integral part of health system performance (World Health Organization, 2000). In the WHO's framing, HSR is one of three main goals, alongside good health, and fair financing (Murray *et al.,*1999). According to the WHO, HSR is defined as

> "The ability of the health system to meet the population's legitimate expectations regarding their interaction with the health system, apart from expectations for improvements in health or wealth." (World Health Organization, 2000).

The population's legitimate expectations in this instance are defined in terms of international human rights norms and professional ethics (Murray *et al.,*1999).

Accordingly, HSR can be understood as the proposed outcome of an institutional relationship with health users, where that relationship is based on the understanding that it is important to meet the demands of these users (Murray and Frenk, 2000). In this manner, responsiveness is both about meeting the needs of health users who are consumers of the health system, as well as ensuring the protection and fulfilment of the rights of the patients to a timely and adequate range of care (De Silva and Valentine, 2000). The reasoning for HSR is that, as with all other systems, the health system would need to meet certain goals and there is need for a method to constantly check to see if it was meeting those goals (World Health Organization, 2000). It is thus premised on an understanding that in determining what the goals of the health system are, and if they are being met, the expectations of the people for whom it is intended will be taken into consideration and will form part of a continuous feedback loop (World Health Organization, 2000).

Based on this understanding of the nature and intent of HSR, the WHO states that the task requires developing and implementing technical tools to monitor and raise awareness on how people are treated as well as the environment in which they are treated (World Health Organization, 2000). In measuring responsiveness, there are two broad areas of consideration which are further divided into seven key elements. They are: (i) respect of persons: which entails the elements of dignity, autonomy, and confidentiality, and (ii) client orientation, which consists of the four other elements, which are prompt attention to the patient, quality of the amenities, access to familial and social support networks, and having the choice of provider (Mirzoev and Kane, 2017).

In a bid to realise the barometers of HSR, Liao identifies two models of responsiveness (Liao, 2018). They are a citizen-driven model where responsiveness is largely driven and shaped by the expectations and demands of health users and the expertise/administrator-driven model where administrators use their discretion and expertise to decide what expectations require a response and which are to remain unaddressed (Liao, 2018). While people may be indifferent or not adequately attentive to the workings of the health system and how it affects the nature of healthcare they receive, often enough, when there are interactions that involve some form of confirmation of their active expectations (such as accessibility of services) or violation of their passive expectations (such as lack of privacy), they tend to take notice and, in some instances, voice out those expectations (Liao, 2018). When there is need for action to address the concerns of the health system, Liao identifies three groups of actors that are relevant to the process: policy makers, managers, and service providers. How these actors respond to calls to be more responsive to the needs of health users will often be dependent on how they perceive their users - whether as patients, recipients, beneficiaries, clients, consumers, citizens, or holders of rights (Lodenstein, *et al.,* 2017). Their response in this regard is itself intrinsically linked to the first set of considerations for measuring HSR which are about the dignity, confidentiality, and autonomy of the health user. Where the emphasis of HSR is on meeting the demands of health users, the health system is better poised to be patient-centred.

Despite responsiveness being a key objective of national health systems, it is still significantly understudied, and is the least understood health system objective (Mirzoev and Kane, 2017). As Murray *et al.,* (1999) point out, much of the debate on health system design is couched in claims and counterclaims about what works and what does not work. However, because of how important responsiveness is to the work being done by the health system, there is a pressing need to be better able to measure it and deliver on it for health users. As De Silva and Valentine state, institutions ought to be designed in a manner that makes them more cognisant of the legitimate expectations of their health care users, so that they are better able to respond to these legitimate expectations and better able to safeguard their relevant fundamental rights (De Silva and Valentine, 2000). Responsive health systems ought to anticipate and adapt to changing needs, harness the opportunities presented to promote access to effective interventions and improve the quality of health services. This is all to help build towards the goal of better health system (Mirzoev and Kane, 2017; Khan *et al.,* 2021).

As such, various mechanisms for gathering the information necessary for informing responsiveness have been adopted over time. They include household surveys, patient exit interviews, focus groups, and rapid appraisals (World Health Organization, 2000). Satisfaction questionnaires often tend to look at the system from the provider's perspective and try to measure responsiveness from the point of view of the health system's own stated objectives. As such, it has been criticized as being susceptible to giving misleading results that do not adequately reflect the true feeling of the health users (Williams *et al.,* 1998). Health users are constrained to

responding to a prejudged notion of what the duties of health care providers are. Furthermore, it makes it more difficult to compare satisfaction survey results across health systems, as they often do not have the same objectives or barometers for measuring those objectives (Williams *et al.,* 1998). There is thus need for more citizen-driven models (Liao, 2018) for understanding health user expectations and subsequently responding to their needs. To do this, outlets that health users use to register their displeasure must be increasingly utilised for framing the understanding of the lapses in health service provision that require necessary attention.

**Litigation as a sign of dissatisfaction with the health system**

Studies have been conducted to better understand when and why litigants go to court in civil cases for redress and what they aim to get from the courts (Lind *et al.,* 1989; Gloppen, 2008). Similar studies have been conducted in the specific instance of medico-legal claims, in a bid to better understand what motivates health users to sue health care providers (Pienaar, 2016). In one study, patients emphasized a desire to receive an apology after a medical error and identified the failure of the health service provider to provide one as a motivation for seeking legal redress (Gallagher *et al.,* 2003). Another study found that health users were often prompted to institute legal action when they realised that their health care providers had failed to be fully honest with them and either directly misled them or allowed them to believe the wrong things (Hickson *et al.,* 1992). In another study, up to 37% of patients stated they would not have gone on to sue if they had gotten an explanation and apology, while 14% stated that they would not have sued if there had been an admission of negligence (Vincent *et al*., 1994).

As these studies show, patients often take legal action where they perceive that their health care provider failed to treat them with dignity and/or failed to accord them the respect and agency that they felt was due, either before, during, or after receiving care. Beyond any specific medical mishap, how the health user is treated goes a long way in determining how they perceive the care they have received as well as any subsequent steps they take in response to that care (Valentine *et al*., 2008). Where there is a power imbalance, as is usually the case with health care providers and their patients (Murray and Frenk, 2000), actions to redress the weakened position of the patient may be taken, especially where there is sufficient legal justification for such action.

As a result of the significance of patient perceptions in the assessment of care received and any subsequent decisions to seek redress, there is need for a better understanding of the factors that increase the chance of litigation from patient dissatisfaction. While there is no gainsaying that more action is needed to mitigate medical mishaps on both the personal and systemic level, the odds of 100% perfection 100% of the time is next to impossible to guarantee. As such, understanding the ancillary concerns layered over untoward biomedical outcomes can be a useful way to contextualize the mismanagement of patient interactions with the health system as whole.

Therefore, litigation might be understood as not just the act of trying to right a medical wrong but as a process of getting vindication for a perceived affront of the health user's legitimate expectation of dignified and empathetic care, especially where there are no internal mechanisms for acknowledging any harm caused and making amends where possible. This kind of understanding of health user motivations is in line with Murray and Frenk's (2000) position that responsiveness should be understood as a continuous process of responding

to the legitimate needs of health users and not just as a one-off outcome. To this end, to achieve a more responsive system, institutional relationships must be created to be deliberate and conscious about recognising and adequately responding to the legitimate expectations of its patients (Murray and Frenk, 2000). Guaranteeing the satisfaction of health users, however, must transcend a consumerist approach to health care delivery that seeks to ensure customer satisfaction and continued patronage (Murray *et al.,*1999). The desire of a health system to be more responsive must rather be fundamentally rooted in an understanding that health care is primarily a human right, which means that users are owed a range of obligations which they can reasonably expect to enjoy (Murray *et al.,*1999). Healthcare is as much a commodity as it is a right. Both interpretations place an onus on the satisfaction and well-being of the user as its primary goal. In this regard, adopting a stance that seeks to either limit litigation as an outlet for registering displeasure and seeking redress (Oyebode*,* 2013; Zondo, 2020), without a similar interest in understanding the issues that resulted in that perception of poor health care and service would be one that seeks to sweep the problem away or in the extreme, muzzle discontent. Such an approach by HSL would be counterproductive in a patient-centred health system (Veillard *et al.,* 2010). Ultimately, with a better understanding of medical litigation and its use as an avenue for registering displeasure with health care delivery, the possibility of using it as a data point for a more robust and contextual understanding of systemic lapses in health care delivery is made more possible. In this sense, litigation in the context of health care and health systems strengthening can be reframed as a tool for rights promotion which is necessary for health system accountability (Gloppen, 2008). It can importantly also be used as part of the feedback loop for health managers on the needs and expectations of their health users.

However, due to the procedural nature of many of the possible ways of registering displeasure, function often must conform to form. In the case of medico-legal litigation, the types of action possible are determined by both procedure as well as possible causes of action in law (Pienaar, 2016). This is even more specific, depending on the country where the litigation is carried out, and is based on that country's system of law as well as its legal principles for access to justice. These are geography-specific issues that must be taken into consideration for a better understanding of any setting where litigation is used as a chosen outlet for registering displeasure and seeking some form of recompense. In health policy and systems research (HPSR), it is widely acknowledged that health systems are all context-specific and need to be researched as such (Murray and Evans, 2003). In the South African context, medical negligence litigation is an increasingly used way to register displeasure with the care provided by the health system. It is therefore important to understand when and how litigation is an outlet for registering displeasure with health care delivery in a specific context, in this case, South Africa.

**The nature of medico-legal litigation under South African law**

The foundation of South Africa's legal regime is rooted in its constitution which both provides for the existence of the judiciary as well as importantly, the human rights that South Africans are entitled to enjoy. Human dignity is provided for in Section 10 of the constitution, which states that "Everyone has inherent dignity and the right to have their dignity respected and protected" (Constitution of South Africa, 1996). It is the foundational right upon which all other subsequent rights, including the right to health is based. The right to health for its own part is clearly provided for in Section 27 which provides that,

"(1) Everyone has the right to have access to ….

(a) health care services, including reproductive health care.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

(3) No one may be refused emergency medical treatment."

In addition to the right to health and dignity that are foundational to the privileges to be enjoyed in the use of the health system, the right to seek legal redress is also enshrined in the constitution. Section 34 grants the right to access the courts, while Section 38 provides for the right to seek appropriate relief from the courts when a right that is provided for in the constitution's Bill of rights is infringed upon.

The National Health Act (NHA) of 2003 provides the structure of the South African health system and the various pillars of the health system as well as the role of officers within that health system. Where action is taken against the health system, the head of the relevant health system, like the provincial Member of the Executive Council (MEC), is the party against whom legal action is sought, although they are not sued in their personal capacity. This is in accordance with the principle of 'vicarious liability' which holds an organization and its nominal leadership responsible for the actions of its agents and officers, which were carried out in the normal course of their official duties and responsibilities (Gittler and Goldstein, 1996; Southwick, 1961). In some instances, other relevant parties that played a role in the events that resulted in the breach of the health user's rights may be joined as defendants in the suit. However, in most instances, even where a specific health care officer is sued specifically, the health system within which they offered their services and the MEC at the head of that health system are still liable parties based on this principle (Gittler and Goldstein, 1996; Southwick, 1961).

In deliberating on the matters brought before them, the South African courts are empowered to apply all relevant laws and legal principles where applicable, to grant appropriate reliefs to claimants (Maimela, 2022). A key relief is the granting of damages. This often is a monetary sum that the court reaches as an estimation of the adequate recompense for loss suffered because of the actions or inactions of the defendant (Coetzee and Carstens, 2013).

In South African law, to make a successful case proving medical negligence, five elements must be shown to have occurred and proven on a balance of probabilities (Khan, 1984). They are, that the conduct that formed the basis of the legal action was wrong, that the wrongful action breached the rights of the person against whom it was done, that the wrongful action caused damage to the person against whom it was done, that the damage suffered was a direct consequence of the wrongful action and that the person who committed the wrongful action is the one being held accountable as being at fault (Maimela, 2022). To successfully prove medical negligence, it is important to show that the medical personnel have failed to exercise the standard of skill and care that is reasonably expected of competent medical personnel in their field of medical practice. This is a reasonableness test that the courts apply in their consideration of the facts of the matter. The more complicated a medical issue is, the higher the degree of skill and care required and the courts in making their determination, decide whether a reasonable practitioner in the same type of medical practice would have made such an error (McQuoid-Mason, 2010). This is different from trying to prove that malintent was at the

heart of the untoward action or inaction (McQuoid-Mason, 2010). It is thus important to note that the focus in medical negligence claims is the failure to act in a matter that is up to the accepted standard of action in the dispensing of care, and less about whether or not harm was intended by the actions or omissions. Here, the focus is on establishing that harm was committed to the health user, that said harm should not have occurred if the medical personnel responsible for their care acted to the standard of care, they owed the health user and that as such, the medical personnel (and by extension their employer) is responsible for the harm suffered by the health user.

In claims of medical negligence, either the medical personnel involved in the medical procedure is sued in their individual capacity or their employer is sued because said employer has vicarious liability for the actions of its staff in the course of carrying out their official duties (McQuoid-Mason, 2010).

Medical negligence is thus a civil claim against the health system *and* the health care provider under it, after due consideration that the wrong suffered is tangible and can be proven according to the requirements for making a valid case of negligence.

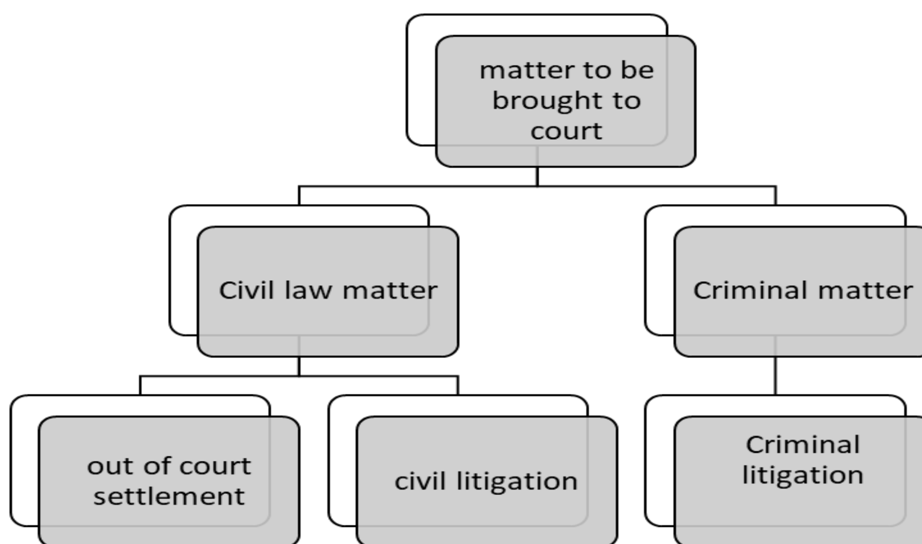


**Figure 1**: How medical negligence cases are handled in court (Source: author)

As with criminal matters, where one of the parties is not satisfied with the decision of the court where the matter was initially brought (court of first instance), they may appeal the decision. However, it is important to note that appeals end at the Constitutional Court in South Africa and their decisions are the final outcome on a matter. It is also important to note that while the Constitutional Court addresses issues of constitutional clarity, interpretation and enforcement brought before it, it also acts as a court of final appeal. This distinction is important when factoring that health claims may sometimes be framed as constitutional issues in accordance with the right to health. However, these claims are different from medical negligence claims which are about a breach of duty of care.

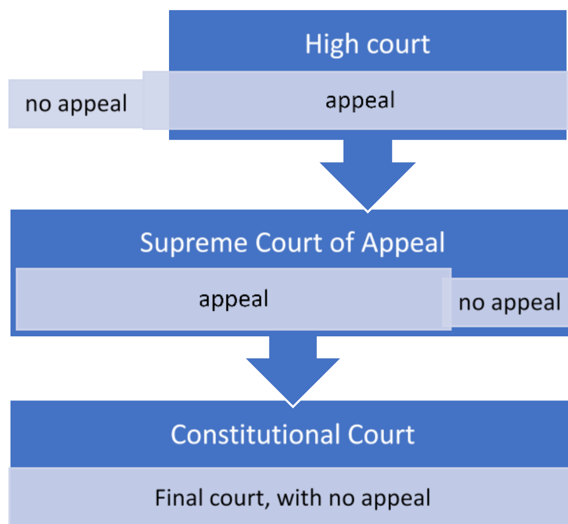


**Figure 2**: How medical negligence litigation can proceed through the South African judicial system (source: author)

**The scope and impact of medico-legal litigation in South Africa and the health system's response to it**

In March 2015, the South African Department of Health (DOH) held a medico-legal summit to discuss the growing 'crisis' of medico-legal claims in South Africa (Maphumulo and Bhengu, 2019). The summit was attended by several key actors in the country's health governance structure at the national and provincial level. These included the National Minister of Health (MOH), Provincial MECs for health, representatives from the World Health Organization (WHO), representatives from various statutory organizations including the Office of Health Standards Compliance, Health Professions Council of South Africa, professional bodies like the Medical Association of South Africa, the Hospital Association of South Africa, the Medical Protection Society and the South African Medico-Legal Society as well as various health managers, legal practitioners and academics. At the summit, the MOH stated that there were concerns that the 'lawsuit crisis' in South Africa could lead to collapse of the health system.

This rise in legal claims against the health system and its personnel is premised on the rules of common law in the absence of any specific legislation to regulate the issue. This common law that is the product of received English legal tradition forms a significant portion of the legal norms of the country, which is also heavily influenced by Roman Dutch law and principles (Roederer, 2009). In line with these legal traditions, most of the medico-legal cases against the health system are crafted as medical negligence cases, with ever-increasing damages being sought and granted by the courts. The increase in medical negligence cases is evidenced in the large numbers found in the law reports and South African case law databases.[1] Cases related to medical

[1] Case law databases and reports are a repository of decided cases, laying out the facts of the cases as well as the decisions of the courts and their reasoning. Examples of such databases in South Africa are SAFLII (www.saflii.org), Jutastat (juta.co.za) and LexisNexis (lexisnexis.co.za).

negligence in South Africa from 1994 till the time of conducting this study, number 1232, spread across various provinces and reaching the highest courts in the country.

| **Court** | **Number of cases of medical negligence (1994 to 2022)** |
|---|---|
| Constitutional Court | 37 |
| Supreme Court of Appeal | 172 |
| Eastern Cape Province<br>• Bhisho<br>• East London Local Court<br>• Grahamstown<br>• Eastern Cape<br>• Mthatha<br>• Port Elizabeth | <br>22<br>8<br>38<br>27<br>33<br>46 |
| Free State<br>• Bloemfontein | <br>106 |
| Gauteng<br>• Gauteng<br>• Johannesburg<br>• Pretoria | <br>34<br>175<br>296 |
| Kwazulu Natal<br>• Durban<br>• Kwazulu Natal<br>• Pietermaritzburg | <br>25<br>5<br>25 |
| Western Cape<br>• Western Cape High Court | <br>111 |
| Northwest<br>• Mafikeng | <br>39 |
| Nothern cape<br>• Kimberley | <br>20 |
| Limpopo<br>• Polokwane<br>• Thohoyandou | <br>6<br>1 |
| Mpumalanga<br>• Mbombela<br>• Middelburg | <br>5<br>1 |

**Figure 3:** Provincial spread of medical negligence cases from 1994 to 2022 (Source: author)

While cases of medical negligence are often initiated in the provincial high courts where the health care services were provided and fall under the auspices of the provincial health system, they can sometimes go up to the higher courts where parties are appealing against the decision of the court of first instance (where the matter was first initiated). These matters can go as high as the Constitutional Court which is South Africa's highest court and whose decision is final and binding (Dugard, 2006).

There is a recognition by scholars and members of the health governance structure that the South African health system requires more strengthening to meet its obligations to its health users (Coovadia *et al.,* 2009; Gilson *et al*., 2017; Malakoane *et al.,* 2020). The increase in medical litigation cases has so far been seen as one of the challenges to health systems strengthening efforts (Maphumulo and Bhengu, 2019). Based on this problematization of the phenomenon of increasing medical negligence litigation, the legal rules that make negligence claims possible, and the amount awarded as damages where those claims are successful, have been questioned (Coetzee and Carstens, 2011). Based on this framing of medico-legal cases as inherently problematic, interventions on how to address the increase of such cases in South Africa have focused on limiting the instances where legal action can be taken, as well as placing a cap on amounts that may be awarded as damages (Mosime *et al.,* 2016). While efforts to stem frivolous claims are a worthwhile endeavour, they run the risk of losing sight of the needs of health users and litigation as a legitimate outlet to register displeasure with the failure of the health system to meet those needs.

This approach to the problem is, however, not fully in tune with what should be the true aims of any patient-centred health system (Veillard *et al.,* 2010). A large part of the health system's ability to adequately fulfil its duties is dependent on its ability to appropriately respond to the expectations and needs of its users (Veillard *et al.,* 2010). It therefore important to ground medico-legal challenges, and responses to such in health system's responsiveness.

**Research purpose and question**

With the ever-increasing cases of medico-legal litigation against the South African public health system at various levels and geographical locations, there is a need for a better understanding of how unfavourable treatment of health users adversely affects their perceptions of the health system and informs the choices they make to seek redress; to incorporate such understanding into the efforts at making the health system more responsive. This exploratory study is aimed at considering the possibilities for incorporating medico-legal litigation as a relevant communication or feedback channel that informs HSR.

Therefore, the study seeks to explore: *What health systems responsiveness lapses are reflected in medical negligence claims in South Africa?* To answer this question, medico-legal cases across the country from 1994 to 2022 will be examined. The selection of 1994 is due to it being the time of the transition to democratic constitutionalism and the recognition of health rights for all, which is the premise upon which the public health system functions. Instances where there was a failure to meet a responsiveness aim will be highlighted to identify the areas of lapses of the health system to meet the needs and expectations of health users. This study will contribute to the first phase of a broader HSR study, mapping the feedback mechanisms in the Western Cape, while exploring how they fit into the national health system. The student project supervisor is also the PI of the larger multi-country study – and this sub-study will comply with all broader project ethical and data management strategies (see below).

**Methodology**

To answer this question, an exploratory qualitative interdisciplinary study, using case law analysis of the existing case law on medical negligence in South Africa will be undertaken in four phases, to examine any instances of judicial intervention in the cases which could and ought to have an impact on the responsiveness of the health systems.[2]

The first phase which has been conducted and already reported above is the scoping review of the relevant literature on medico-legal litigation and the factors that influence it. In the next phase, data will be gathered, entailing finding relevant cases across the country that deal with medical negligence claims against the State and its public health care system, including its health management and leadership as well as staff, where the health system and its agents were found liable. The third phase of the research will entail an examination of the selected cases that meet the identified criteria. Here, the facts of the cases as well as the pronouncement of the courts will be examined to highlight where and when they speak to the nature of treatment given to the patients. Importantly also, the pronouncement of the court as an impartial judge on these matters will also be analysed, especially in the instances where they pronounce judgements that speak to not just the specific cases where they are adjudicating on, but also speak to what they identify as far reaching and systemic challenges that have led to the circumstances in the cases before them. This exercise will lead directly to the fourth stage which is to analyse how the reviewed cases speak to challenges in HSR in the public health care system across South Africa.

It is important to note that this study is not primarily about medical negligence in and of itself. Rather it is about using cases where medical negligence has been established and the fault of the health care provider is clear, to understand broader issues with how health systems in South Africa respond to the needs and expectations of health care users. It also examines how officers of these health systems act in ways that exacerbate the untoward health outcomes and leave health users feeling dissatisfied and unfairly treated by the health system. This study seeks to It builds on the work of scholars like London (2008; 2015), Malumba (2018), Ooms *et al.,* (2022), Forman (2005; 2013), and Durojaye (2016), who do interdisciplinary work engaging in the law and its effects in shaping public health interventions and practices, particularly in Africa. Thus, the study situates itself between legal research and practice and HPSR. While HPSR is itself an interdisciplinary field (Sheikh et al., 2011; Gilson, 2013; Olivier, 2014), there is a need for more work that connects legal scholarship with health system research. This is especially where the two disciplines understand the same set of issues as a problem but currently only utilize their own disciplinary tools to engage with the same problem. In this vein, the study seeks to bring both fields of scholarship together, in framing the challenge of increased medico-legal litigation and exploring interventions to solve the problem at a systemic level.

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[2] While the term 'case' is used, as is common in legal discourse to describe an issue litigated before the law courts, this study approach is not a 'case study' as termed a particular approach in HPSR.

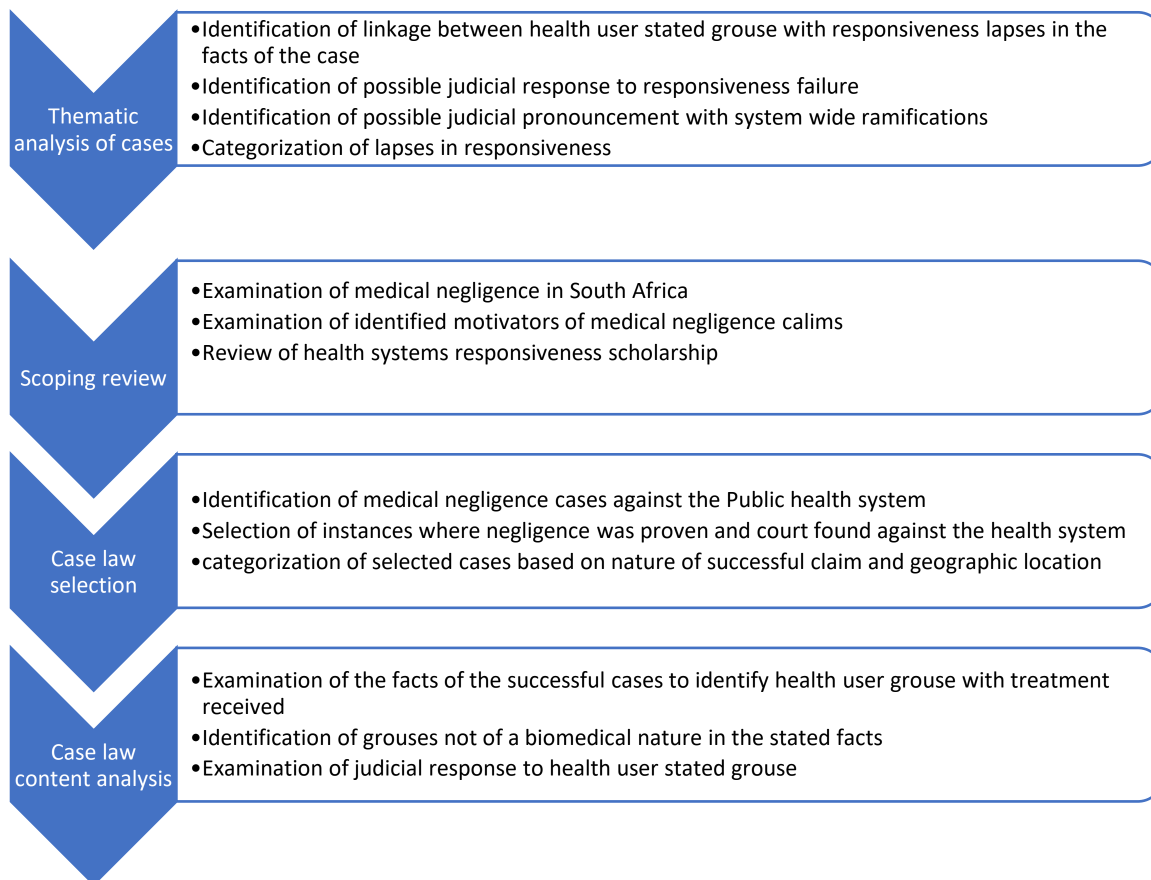


**Figure 4:** Methodology phases and actions to be taken (Source: author).

**Phase 1: Scoping review**

According to Tricco *et al*., (2018) a scoping review is defined as "A systematic approach to map evidence on a topic and identify main concepts, theories, sources, and knowledge gaps." It is an effective approach to initiating interdisciplinary research such as this. In this study, the usual steps in a rapid scoping review have been carried out.[3] These included identifying the research question, studies that are relevant to the research question, selecting the area and subject of study relevant to the research question, as well as charting the data required for answering the research question (Arksey and O'Malley, 2005).

In exploring the practice of health rights litigation and medical negligence claims more specifically, the study first began with a global focus, drawing on international human rights law and practice, as well as domestication and litigation at the macro level. It then narrowed down to litigation in the context of developing countries with legal recognition of health rights but having limited commensurate resources to fulfil its obligations (Gloppen, 2008; Mæstad *et al*., 2011; Flood and Gross, 2014;). Subsequently, a narrower

[3] In this MPH minor dissertation style, this section of the Methods is written in the past tense, as it has already been conducted at this stage, and has been reported earlier in the Literature Review section of the protocol.

focus was placed on the South African experience and the nature of health claims against the state, and the use of litigation as a form of State accountability (Gloppen, 2005; Heywood, 2009; Forman and Singh, 2014).

The outcome of this preliminary scoping review was that non-biomedical motivations for litigation were explored. Research into litigation as an expression of dissatisfaction revealed that medico-legal claims are not only due to untoward health outcomes, nor are they driven merely by pecuniary interest. This in turn led to an examination and mapping of HSR research as an area of scholarship that maps out and measures non-biomedical factors that affect health user satisfaction. This has been reflected in the literature review, which has examined the nature of HSR and the need to measure it and have a contextual understanding of its importance to health user satisfaction. In carrying out this preliminary framing of the issues and exploring the linkage between medical negligence litigation and HSR failure, various sources of data and scholarly input were used, drawing from traditional legal research and health system's research. The various bodies of scholarship were drawn from Southern African Legal Information Institute (SAFLII), Lexis Nexis, Juta, PubMed, EBSCOhost, and Google scholar. The scoping review drew from research HIC and LMIC contexts with an eventual particular focus on research from 1994 onwards, when South Africa moved to democratic constitutionalism and the desire for universal human rights for all (Dubow, 2012).

**Phase 2: Case law data gathering, sorting and categorization**

For the cases that will serve as the data source for this study, relevant case law will be sourced from several public legal databases that are publicly accessible as legal judgements are in the public record. In addition, there has been a preference in using SAFLII and its case reports of relevant cases as it is an open access database of legal cases.[4] Jutastat and Lexis Nexis, will also be used as complementary data base sources for cases that may not be reported on SAFLII. The documented case law in these databases adequately lay out the facts of the cases, the arguments of the parties as well as the judgment of the court and the reasoning for the judgment.

For this stage of case law data gathering, *medical negligence* will be the key search term, as it is cases where claims of medical negligence have been made that are the intended demographic as explained above. The use of this term in searching the case law databases is because medical negligence is not simply a term for describing untoward health outcomes, or a descriptor of unfair treatment in a health setting. Rather, it is in fact a specific cause of action in law under the law of delict as explained above. It is the nature of claim that can be made in law which would cover the aspects of health user dissatisfaction relevant to HSR and strengthening research. Only cases that are of a civil nature and occur within South Africa will be selected, as that is the geographical scope of the study. Upon identifying cases of medical negligence, they will be narrowed down to cases involving the public health system, this will be done by identifying that one of the parties in the case is a representative of a public health system. This will often mean that the MEC for Health of the specific province is a party to the suit. As mentioned, in these instances, the MEC is sued not in their personal capacity but in an official and representative capacity as head of the health system in question.

[4] See footnote 1.

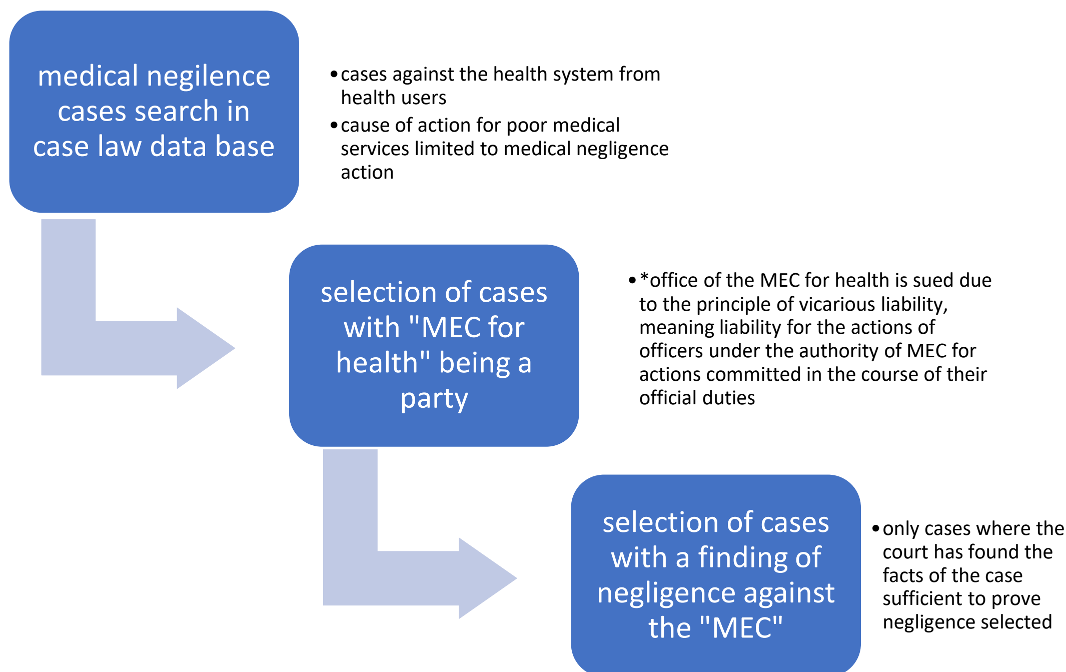


**Figure 5:** Process of case law gathering and selection (Source: author)

After pruning out cases not involving the public health care system and its agents, the identified cases will be analysed and categorized based on nature of subject matter/context of medical negligence claim. However, in this categorization, the focus will only be on instances where the claim of medical negligence was upheld, this is because they serve as instances where the negligence or misstep of the health system and its agents have been impartially found to be present by a competent court of law. While the need for medical negligence to be found to be existent is necessary for streamlining the cases analysed to one where fault is clear, the elements of negligence and how they are manifested in the biomedical procedure are not the focus of this study. Rather, the focus is on analysing the facts of the cases leading up to and after the medical procedures that resulted in/or exacerbated the adverse outcomes for the health user.

**Phase 3 Case law content analysis**

At this stage, the focus of the research will be on the analysis of the thematic issues that arise from the relevant case law reports that have met all the criteria listed above. In this phase, the facts of the cases as well as the judgment of the courts will be the primary focus of examination in the case law reports. They will be examined to find the non-biomedical issues raised by health users as areas of dissatisfaction in the care they received or during their interaction with the health system. Here, the findings and reasoning of the court in arriving at its verdict of guilt against the health system will also be analysed to understand how the treatment of the health user was seen by the judge in those cases. Instances where the courts make specific value judgments on the practices of the health systems will also be noted and included in the analysis of emerging factors and trends in how health users are treated. The focus in this phase of the study will be to identify how often non-biomedical factors play a role in the dissatisfaction of health users, if in the estimation of the health users said treatment had an impact on the eventual untoward health outcome and if the court in its judgment agrees with the health users' perception of treatment received and its impact. If and where patterns of types of

conduct or omissions in the treatment of health users emerge, those types of conduct will be noted, and categorized based on nature of the treatment and where it occurred. Any allusions to geographical concentration of a particular type of conduct that is made by the judiciary, based on their observation of the kind of matters brought before it, will importantly also be noted and cross referenced with any observed patterns during case gathering and case law content analysis. The possibility of such judicial pronouncements and interventions is in line with the South African judiciary's practice of outlining the reasoning of the courts based on the immediate facts before them and in view of the larger context in which the claim has been made. This is something the courts have done in the past in socio-economic rights litigation brought before them (Mbazira, 2009).

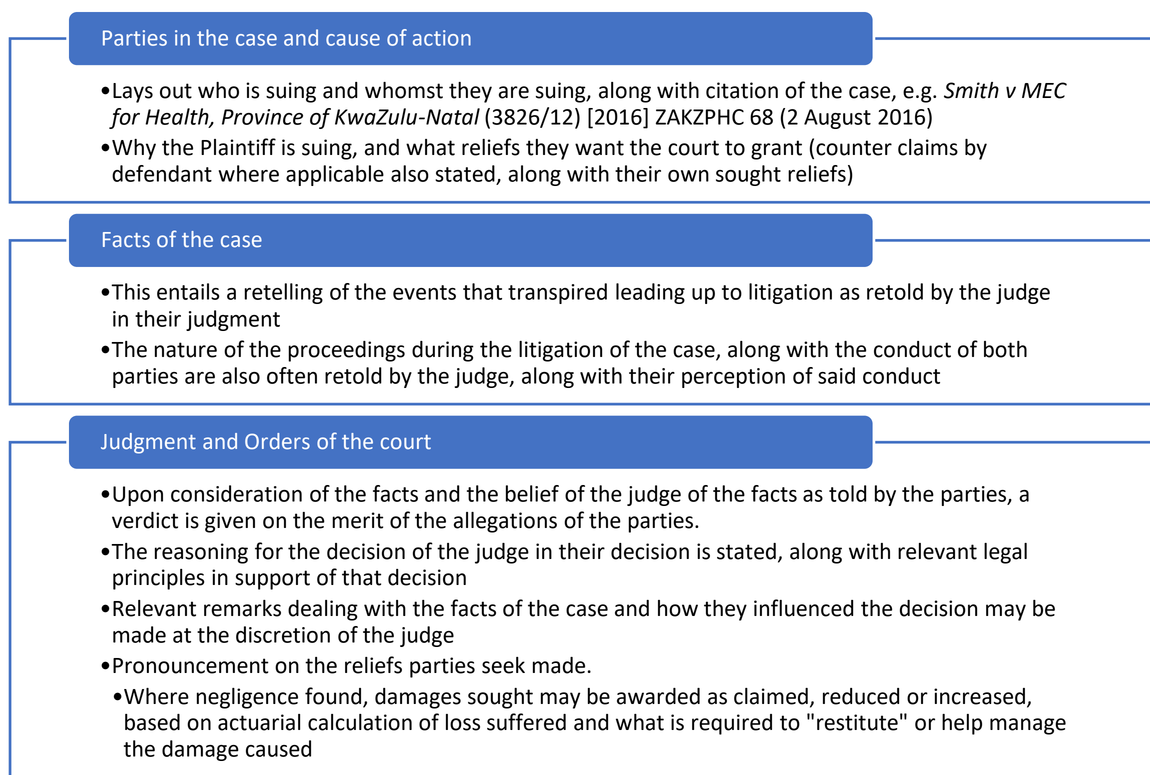


**Figure 6**: Outline of a typical case law report from a publicly accessible law data base like SAFLII (source: author)

**Phase 4: Thematic analysis of case law to identify lapses in health system responsiveness**

Following the identification and categorization of the types of non-biomedical treatment that health users identify in the claims, the nature of these various types of treatment will be further examined to determine those that align with any HSR categories and tabulated as such. These categories will be dependent on the themes that emerge from the cases, which may include verbal altercations/rude remarks, nonchalant conduct, poor case management, undue delay in responding to health user needs, or poor case file management. These instances will then be analysed to see if and where they speak to any of the aspects of HSR. The relevant

instances of responsiveness failures will then be tabulated and analysed to identify any possible thematic patterns or peculiarities of geographical concentration, which will in turn be further investigated and presented in the research output. The aim is to observe what types of untoward non-biomedical treatment emerge from the large volume of medical negligence claims, examine how relevant those non-biomedical lapses are to aspects of HSR and report on the frequency of these lapses in the health system, along with any peculiarities of intensity and seriousness. In addition, any assertions by the court on systemic lapses will be drawn into the thematic analysis in the exploration HSR lapses in medical negligence cases in South Africa.

**Possible limitations and challenges to the study**

The study relies on cases from events that have already occurred and have been adjudicated on. To this end, the study does not look to revert the events in those cases or provide any remedies to wrong parties. Rather, by showing if and how there is a pattern of mistreatment of health users, the study looks to show the areas that can be improved on in the interactions with health users and the management of potential conflict by the health system and its managers. While the aim of the study is to better understand medical negligence litigation as an outlet for registering displeasure with responsiveness failings, due to the nature of medical negligence claims and the legal requirements for establishing and subsequently adjudicating such claims, there is no expectation to find instances where the courts make express pronouncements using specific health systems language. This is because legal officers predominantly lack the training or tools to frame legal claims in that manner. However, the interdisciplinary nature of this study, grounded in an understanding of both health systems scholarship and legal practice makes it possible to gather from the facts and judgments, issues that speak to a desire for better health care and more specifically, more responsive treatment from interactions with health systems.

Yet another possible challenge is the fact that it will be impossible to make a generalizable claim from an individual case. And so, even where a court has expressly pointed out a flaw in the way a health user was treated, such a statement may not be extrapolated to mean that it is a systemic flaw of the health system as opposed to being an indictment in that specific matter. This is because for the most part, the nature of litigation in South Africa is adversarial and individualising. While progressive judges may make assertions with a systemic focus, many others abstain from indicting the State agency sued and making recommendations on how to address what the court perceives as a case of a larger systemic problem (Bilchitz, 2003). Consequently, the approach of the study will be to point out relevant instances of failures of responsiveness from several cases from the various data bases, compile the list of thematic issues that were at the heart of health user's grouses with the health system and to point out if and where certain issues were recurring themes in the legal cases.[5] By doing this, the study seeks to test whether the approach of compiling information and feedback across various individual litigated cases is a useful approach to understand responsiveness of the health system. This will also be done to show what issues are of concern in the various provinces to the various health users. The focus will thus be on an aggregation of the case law as well as the principles laid out in those cases to show key areas in need of closer attention and understanding.

Regarding whether the data is an accurate enough representation of the state of medical negligence, there is a recognition that not all cases that go to the various courts are reported. However, the use of three different

[5] See footnote 2.

publicly accessible case law databases will provide a substantial sample of the scope of medico-legal litigation in South Africa. Also, although litigation is an increasingly used route for registering displeasure with health care provision, it is cost-prohibitive and often time consuming. This in turn means that there may be a significant attrition rate of cases, with many instances of health user dissatisfaction not going to court or not being prosecuted to a full conclusion. While there is increasing specialisation of legal practice in medical negligence claims, the provision of pro-bono services to the indigent or legal representation on conditions of post judgment success settlement do not mean that would-be litigants will take legal action. Instead, some litigants may choose alternative dispute resolution mechanisms to reach a settlement with the health system or may choose to abstain all together from registering their concerns through formal legal processes due to a fear of the courts and its processes, which is an issue that has been identified in other studies that examine access to justice barriers (Rhode, 2013; Bamgbose, 2015;). Therefore, there may be many more relevant instances and cases that this study may not be able to capture.

**Ethical considerations**

Case law will be the primary data source, the legal cases are matters of public record, and the databases used to search for the relevant case law are also public legal databases. Therefore, this study is 'low risk' as it constitutes the secondary analysis of publicly available information.

In many of these cases, the reportage has already taken relevant steps to anonymize minors and dependants, and this approach will be carried over into the study. The study draws on multiple forms of evidence but does not include any human subjects, and therefore does not pose significant ethical risks. Any sensitive or personal information, even if sourced in public documentation, will be considered carefully before inclusion.

While broad-based observations may be made about short comings in health care provision, specific health care providers will not be indicated by name, even where they form part of the public record of the reported cases. This is because this research is more concerned with identifying and establishing patterns as opposed to individual infractions. The purpose is to understand if patterns emerge in the types of cases that end up being litigated for medical negligence and if these patterns can inform more responsive systems. As such, adequate measures will be taken swiftly to adapt the study if risks to the health system arise. All data will be collected from open access case law data bases with reported cases forming the basis of materials used for the analysis. These cases when analysed will be stored on a password protected private computer.

As this study forms a part of a larger study examining health responsiveness,[6] the primary investigator will also help to ensure that the study keeps in line with parameters of the larger study.

**Timeline**

This exploratory study is estimated to span across ten months from the initial scoping review which has been conducted to the editing of the research output with necessary edits done. Throughout the research, as in the earlier stages of the research, there will be routine communication with the dissertation supervisor.

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[6] This research has been funded through the Health Systems Research Initiative (HSRI) in the UK, a collaboration between the UK MRC, ERSC, DFID and the Wellcome Trust. Grant number: MR/P004725/.

| | | Timeline | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Research Phase | Key Activities | June 2022 | July 2022 | Aug 2022 | Sept 2022 | Oct 2022 | Nov 2022 | Dec 2022 | Jan 2023 | Feb 2023 | Mar 2023 |
| Scoping review | Medical negligence scoping review | | | | | | | | | | |
| | Responsiveness Global scoping review | | | | | | | | | | |
| | Responsiveness Regional, and domestic scoping | | | | | | | | | | |
| | Review protocol development | | | | | | | | | | |
| | Submission of review protocol to HREC | | | | | | | | | | |
| Case law data gathering | | | | | | | | | | | |
| Case law content analysis | | | | | | | | | | | |
| Thematic analysis | | | | | | | | | | | |
| Write up. | | | | | | | | | | | |
| Submission of thesis for examination | | | | | | | | | | | |

Figure 7: Estimated timeline for the study

**Anticipated Budget**

This research project is being undertaken in South Africa (the primary author's country of residence) and is being conducted in partial fulfilment of the requirements for a Master's in Public Health. This research project is partially funded by larger responsiveness project which this research forms a part of. All cases are publicly accessible, while research and scholarship used are accessible to the researcher by virtue of institutional access to libraries and databases. The research will also be carried out on the researcher's personal computer and data saved on the researcher's secure hard drive. There are no direct costs associated with conducting research activities, save for the final printing of a hard copy of the dissertation for submission. The primary author declares no conflict of interests.

| **Item** | **Total cost** |
|---|---|
| printing including a final hard copy of dissertation | R 1000.00 |

**Communication strategy**

The findings from this study will be shared in thesis format and in the format of a journal manuscript. The thesis format will be shared with the University of Cape Town's open access research database. Additionally, the findings will be communicated in the format of a journal manuscript intended for publication in a relevant journal read by key public health professionals, researchers, and health system stakeholders. Lastly, findings from this study will be disseminated on the primary author's social media accounts which have some relevant health system related followers.

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**Part B: Journal Article**

Target journal: Target journal: Health Policy and Planning[1]

**Medical negligence litigation as a mechanism for understanding gaps in health system responsiveness in the South African Public health system: a mixed methods case analysis.**

Omowamiwa Kolawole[2]

**Abstract**

South Africa has experienced a significant spike in medico-legal litigation against national and provincial health systems. The increase in medical negligence cases has been viewed as a crisis for the health system, and an unwelcome and expensive hinderance to the proper functioning of the public health systems, enabled by predatory legal practitioners and permissive courts. However, health systems leadership has given little consideration to the possibility that the increase of medical negligence claims is in response to weaker health systems, lacking in their ability to meet their obligations to health users. While these obligations include quality health care delivery with favourable biomedical outcomes, they also entail legitimate expectations for a more responsive health system. An exploratory qualitative interdisciplinary study, using case law analysis was carried out to analyse medical negligence case law in South Africa to identify health system responsiveness failures in the interactions of health users with public health facilities and the health system. In the twenty three legal cases, five aspects of responsiveness emerged from the analysis of the case law, with dignity being the health system responsiveness category most often breached, as recalled by health users in their medical negligence claims. This exploratory study raises the possibility of viewing medical negligence cases as a mechanism for informing lapses in health system responsiveness. Such a responsiveness-minded analysis of health user claims can help in an understanding of patient dissatisfaction as being as much about desires for a more responsive health system as it is about seeking recompense for untoward health outcomes – and therefore the increase in litigation can be seen as an opportunity for increased feedback seeking a systemic response. A systemic response that uses the understanding of its lapses in responsiveness to improve its health care delivery would be helpful in the reduction of medical negligence claims by addressing the non-biomedical factors that lead to patient dissatisfaction.

Keywords
Health system responsiveness, South Africa, medical negligence

Key Messages

- There is an increase in medical negligence claims in South Africa, which has largely been framed by health system leadership as problematic for systems functioning. However, the trend of increasing medico-legal litigation in South Africa provides an important opportunity to explore the role of the health system responsiveness domains in health user dissatisfaction.
- Analysing individual litigated cases is a useful approach for understanding lapses in health system responsiveness, as it provides contextual depth on the gravity of responsiveness lapses and its subsequent effects on health users satisfaction as well as patient health outcomes. The richness

[1] Instructions for the authors are included in Appendix 3.
[2] For minor dissertation examination purposes, the student is the first and sole author.

of data that arises from this analysis provides key insights on the linkages between responsiveness and the quality of health care provision received by health users.

- Incorporating legal case law analysis can be a useful tool for health policy and systems research, and health systems strengthening if it is used as part of the feedback loop on health user dissatisfaction and feedback on health system lapses. Further research may be carried out to explore the utility of this approach in other health systems where there is a legal enabling environment of the recognition of health rights and there is robust medico-legal litigation.

**Introduction**

South Africa has seen a significant rise in medico-legal litigation against the public health care system with cases of medical negligence against national and provincial health systems increasing exponentially (Coetzee and Carstens, 2011; Malherbe, 2013; Seggie, 2013; Matumba *et al.,* 2021). Several reasons have been given for this rise, ranging from an influx of predatory legal practitioners to overindulgence by the courts who issue high amounts to litigants in damages (Kollapen *et al.,* 2017). More charitable interpretations have explained that the phenomenon is due to an increase in human rights awareness and the normalization of the notion of the right to health in the country (Pienaar, 2016). However, on the part of the public health system, led by the Members of Executive Council (MEC) in charge of health, the increase in litigation is viewed primarily as a problem to be addressed (Maphumulo and Bhengu, 2019). This is because limited resources available to provide health goods to the public are spent on defending cases and paying damages (Malherbe, 2013). This fear was fully articulated when in 2015, the South African Department of Health (DOH) held a medico-legal summit to discuss the growing 'crises' of medico-legal claims in South Africa with several key actors in the country's health system leadership. There, the MOH stated that there were concerns that the 'lawsuit crises' in South Africa could lead to the collapse of the health system (Claassen, 2016). The fears of a collapse of the health system also resonate with studies that have shown an increase in the running cost of practicing medical care, through the increase of health practitioners' insurance premiums as well as an increase in the practice of ordering often unnecessary extra diagnostic tests, in order to be seen to be doing everything to prove that the standard of care has been met (Malherbe, 2013).

The South African public health system's response to increased medico-legal action has been one of externalizing the reasons for increased litigation against it. However, a reconsideration of the nature and substance of the medical negligence cases can be a useful exercise for better understanding why they occur and the steps that can be taken to mitigate them. Much of the focus has been on the biomedical challenges of health care provision, assuming them to be the major driver of medical negligence litigation, with interventions looking to engage with how to better protect health practitioners from liability (Bovbjerg *et al.,* 2001; Mateo and Williams*,* 2020). However, as studies in other settings have shown, the decision of health users to sue in the event of an adverse health outcome is driven by more than just the nature of the biomedical care they received (Hickson *et al.,* 1992; Vincent *et al*., 1994; Gallagher *et al.,* 2003). Studies have shown that while an adverse health outcome may be an issue of concern, the decision to seek legal redress is often in response to the failure to acknowledge wrongdoing and a lack of apology (Lind *et al.,* 1989; Robbennolt, 2003). Where the legitimate expectations of health users to receive empathy and have their concerns addressed is ignored or dismissed, it exacerbates the untoward experience from receiving care from the health system. Litigants have stated that their reasons for suing also include perceptions that their health

care provider had not been fully honest with them, had misled them or neglected to properly inform them about vital information related to their care(Hickson, *et al.,* 1992). What these studies show is that claims of medical negligence are influenced by multiple factors other than the untoward biomedical care alleged. These studies support the health system responsiveness scholarship that indicates that in the provision health care services, the legitimate expectations of the population being served in their interactions with the health system must be met (World Health Organization, 2000). The work on health system responsiveness has therefore been on better categorizing and measuring these legitimate expectations in a bid to better meet them (Khan et al., 2021).

**Background**

There is a recognition that patients hold certain values as integral to the health care they receive and expect their observance, in their interaction with the health system (Valentine *et al.,* 2008). Patients are concerned not only with the direct outcomes relating to their care but are also invested in the process of health care delivery, such as the reassurance and guidance that they receive, how long they must wait for treatment and importantly whether they are treated with dignity and respect (Murray and Frenk, 2000; Valentine *et al.,* 2008, Mirzoev and Kane, 2017). In recognition of this need, the World Health Organization (WHO) formulated the notion of health system responsiveness (World Health Organization, 2000), which entails the characteristics of health system encounters that are valued by people and the measurement of these characteristics from the point of view of the health user. Eight key domains have been identified as integral to the experience of the health user in their interactions with the health system and they are dignity, autonomy, confidentiality, communication, prompt attention, social support, quality of basic amenities and choice (De Silva, 2000; Valentine, *et al.* 2003).

**Table 1.** Health system responsiveness domains and their meanings (source: De Silva and Valentine, 2000; *Valentine, *et al*., 2003).

| **Health system responsiveness domain** | **Definition and examples of manifestation in health user interaction** |
|---|---|
| Dignity | Recognition of health user's personhood.<br>• Treating patient with respect.<br>• Acknowledging the human rights of the patient.<br>• Allowing the patient ask questions and providing necessary information to the patient. |
| Autonomy | Freedom of the health user to act independently.<br>• Allowing patient make decision on course of treatment.<br>• Ensuring that patient is in a sound mind when making decisions. |
| Confidentiality | Recognizing and protecting the health user's privacy.<br>• Conducting consultations with the patient in a way to that protects their privacy.<br>• Protecting patient records and information and not disclosing said information without prior consent from the patient. |
| Prompt attention | Attendance to the needs of the health user in reasonable time.<br>• Prompt provision of emergency care.<br>• Ensuring ease of access to health facilities.<br>• Ensuring short waiting times for patients before being seen. |
| *Communication | Properly informing the health user of vital information throughout their interaction with the health system.<br>• Providing patient with the necessary information to make an informed choice. |

| | |
|---|---|
| | • Providing all relevant information to the patient in a manner that they understand and comprehend. |
| Quality of basic amenities | The provision of the necessary physical infrastructure to ensure a conducive environment for the provision of health care.<br>• Clean and tidy health facility environment.<br>• Regular maintenance of health facility premises.<br>• Clean water, toilets, linen and instruments. |
| Access to social support networks during care | Allowing communication and support for the health user from their familial and social networks.<br>• Allowing regular visits of the patient by relatives and friends.<br>• Allowing patient receive food and consumables brought by family and friends. |
| Choice of care provider | Giving health user viable options between and within health care units.<br>• Allowing patient exercise preference for where they want to be cared for, and by who. |

The focus of defining and measuring responsiveness, is to have a better understanding of the non-biomedical factors that lead to health user dissatisfaction with their interaction with the health system. Subsequent measurement is focused on having a better sense of the frequency of the non-biomedical factors that cause health users to be dissatisfied with their care and their interaction with the health system. Medico-legal litigation is an increasingly used outlet for health users to register displeasure with the nature of their care (Matumba *et al.,* 2021). In the wake of the trend of increased use of medico-legal litigation in South Africa, there is an opportunity to explore if and how lapses in responsiveness play a role in the dissatisfaction of health users and their eventual litigation. Such an exploration would serve to add further context to the reasons given thus far, for the upward trend of health user litigation which include an abuse of judicial processes (Seggie, 2013), attorney instigation (Malherbe, 2013), the rise in the value of claims (Pienaar, 2016), and the wider application of consumer protection laws to the health care provision context (Pepper and Slabbert, 2011). However, as Malherbe (2013) and Pienaar (2016) point out, along with the external factors that create an enabling legal and judicial environment for seeking redress in the form of medical negligence litigation, there also a legitimate concern that the increase in medical negligence claims is in response to a decline in health service provision and decline in health care worker professionalism.

In consideration of the role of poor health care delivery in increasing medico-legal litigation in South Africa, there is an important opportunity to explore the role of these eight domains in the dissatisfaction health users experience with the South African public health system. Such an exploration into the self-reported areas of dissatisfaction with the care health users receive can serve as an additional data point for better understanding lapses in health care provision especially as it concerns the non-medical aspects of interaction with health users. As such, this study explores the instances where failure to address an aspect of health system responsiveness has been raised as a grouse of the health issue in their legal action against the public health system in South Africa.

While the South African courts have recognized that there is a concern around the "flood of medical negligence litigation", (*Member of the Executive Council for Health, Gauteng v Lushaba*, 2016), they also recognize that there is a ripple effect on claimants, as litigation costs mount and cases become unduly prolonged, due to delays and overwhelmed courts (*Member of the Executive Council for Health, Gauteng v Lushaba*, 2016). However, beyond the immediate inconvenience litigants experience, Malherbe (2013) notes that health users are at an increased risk of more far reaching consequences, due to a reduction in the capacity of health systems to provide quality care on already

limited and stretched resources. It is thus important to understand as many of the factors that play a role in increased litigation and address them where possible, to both rectify the immediate challenges caused by the practice of medico-legal litigation as well as the long term effect on the capacity of health systems to meet their obligations to the populace.

The aim of this study is to better understand medical negligence litigation through the lens of the health system responsiveness issues that arise, as well as their frequency and the contexts in which they occur. This way, a nuanced and holistic examination of the existing body of case law on medical negligence in South can be an important data point on systemic failure instead of been viewed as an exacerbation of an “increasingly hostile, pressurized and uncertain,” climate for the provision of health care (Howarth et al., 2013).

**Methods**

An exploratory qualitative study, using mixed method case law analysis was conducted during 2020-2023. The research process was conducted in four phases which consisted of a scoping review, case law selection, case law content analysis and a thematic analysis of the cases. To understand the nature, context, and content of medico-legal cases against the public health system, case law in South Africa was used as the primary data source for the study. Following the initial scoping review, relevant cases[3] of health users suing the public health system for subpar health care provision were selected, categorized, and analysed, to identify the relevant domains of health system responsiveness raised by health users as been intrinsic to their feeling of not been cared for adequately during the interaction with the health system. Then, the cases that were selected as being relevant to the study were systematically analysed and categorized with the intent of identifying all relevant instances of allegations of breaches of the responsiveness categories, as acceded to by the courts in their decisions and findings.

For the case selection, the strategy adopted was a combination of the transparent and replicable approach common in the medical and social sciences along with the use of expert judgment common in conventional legal scholarship. (Hall and Wright, 2008; Hall, 2013; Baude *et al.,* 2017). In the process of case selection, the knowledge of legal precedence and a familiarity with law reports was used to identify relevant case law where health users sued the public health system for medical negligence; being the most common legal cause of action recognized by South African law to convey displeasure with the health services provided (Zondo, 2020).

Thus, the relevant text for searching for cases was “medical negligence”. The following search strings were used to capture cases that included cases against the public health system in any part of the country; ‘health care,’ ‘Member of Council’, ‘MEC for health.’ The reasoning for limiting cases to those involving the MEC as a party to the suit are two-fold. For one, the subject of consideration is around health system responsiveness in the public health system. This in turn warrants consideration of only those cases where public health system is being held to account. In such instances, the MEC is often the main party being sued in their nominal capacity as being at the top of the system’s leadership and governance structure. In this instance, the office of the MEC for health has vicarious liability for the actions of its agents. The principle of vicarious liability holds an organization and its nominal leadership responsible for the actions of its agents and officers, which were carried out in the normal course of

[3] Cases in this instance refer to litigated matters, decided by the South African courts.

their official duties and responsibilities (Gittler and Goldstein, 1996; Southwick, 1961). As noted in *Nzimande v The MEC for Health, Gauteng* (2015),

> "The Member of the Executive Council for Health bears the political responsibility. The MEC has clearly been cited in his official capacity."

The first search was conducted in September 2019 on the Southern African Legal Information Institute (SAFLII) case law database. This search covered the years from 1994 to 2019 and was limited to South African cases. A subsequent search was conducted in March 2022 to find any new cases from 2019. This resulted in 89 cases determined to be relevant, meeting the criteria set out from the initial result of 1232 results produced by the database.

To determine relevance, only instances where guilt had been established against a public health facility and by extension its health system leadership were selected. Of the cases where guilt was established, instances where the negligence was determined by the courts to be a product of a lapse in biomedical technical skill in the care provided, leading to an untoward biomedical outcome were eliminated. Subsequently, cases where other facts were raised by plaintiffs in support of their primary claim of medical negligence were then examined. Of these instances, concerns raised by patients about the circumstances under which their untoward health outcome occurred were further categorised into responsiveness related issues and non-responsiveness related issues. The responsiveness related issues were then further examined and categorised.

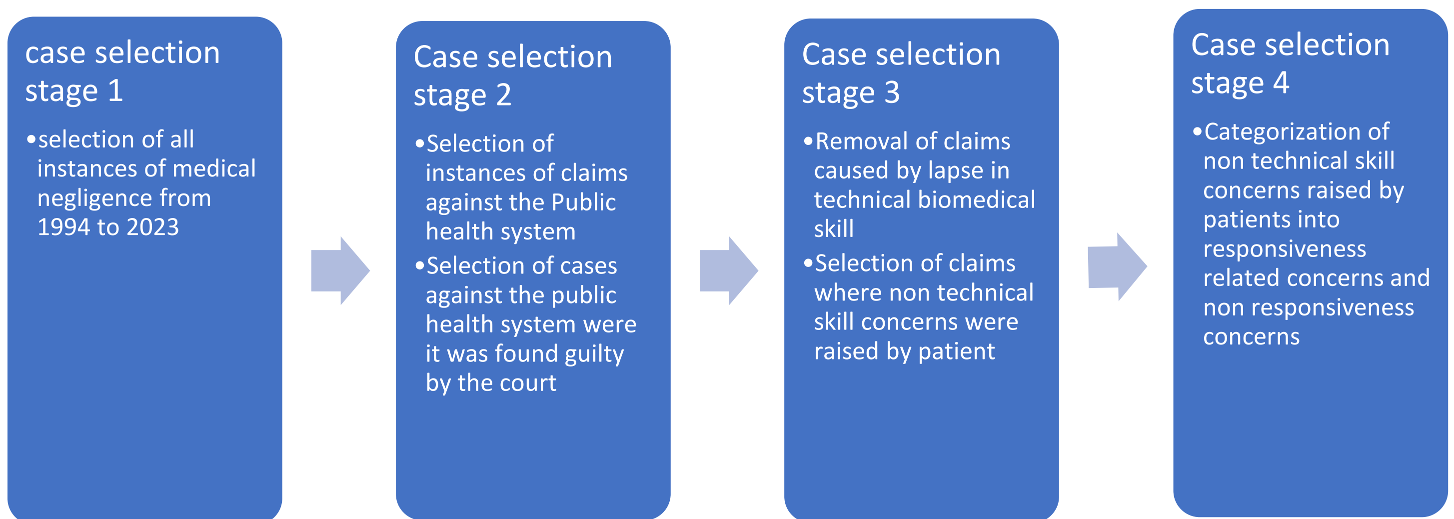


**Figure 1.** Process of case selection of relevant medical negligence claims against the public health system, in South Africa from 1994 to 2022 (source: author)

In the analysis of the relevant case law, descriptive legal analysis as opposed to more traditional doctrinal research that is focused on normative analysis more common in legal research was used. This is because the research is more concerned with the facts and the courts' reactions to those facts, as opposed to the legal principles and reasoning in the court's decisions. Therefore, instances of health

user displeasure recalled in the facts of the relevant cases were studied, analyzed, and categorized into responsiveness categories. Instances where a non-biomedical concern was raised that did not directly fall under a responsiveness category were noted and subsequently excluded.

Also, instances where the court importantly made a judgment with respect to not just the individual case but to a systemic flaw in the health system were also noted and analysed to identify issues that the courts as an independent arbiter observed to be of an area of concern in the nature and quality of care provided by that health system. The various relevant cases that were analysed and compared allowed for contextual inter and intra-case analysis that would not have been possible if only one landmark case law on medical negligence was used as a single case to better understand patient dissatisfaction at lapses in HSR. According to Baxter and Jack (2008), this also makes the evidence generated stronger and more reliable. Decided legal cases, which are matters of public record and are available on public access databases were the primary data source of the study, making it 'low risk'. In addition, names of parties in the cases were removed where possible. This is because the study was concerned with identifying and understanding patterns as opposed to individual infractions.

**Table 2**. Research procedure (source: author)

| **Methodology step** | **Phase of research** | **Action taken** | **Justification for decision** |
|---|---|---|---|
| 1. Scoping review | Research design | Conducting literature review on medical negligence claims, its causes, and effects | To better understand the causes of medical negligence claims and why there is an increase of such claims in South Africa |
| | | Conducting literature review on health system responsiveness scholarship | To better understand the categories of responsiveness and how so defined |
| 2. Case law selection | Data collection | Identifying medical negligence cases against the public health system | To identify scope of negligence claims across South Africa |
| | | Selecting cases where negligence was successfully proven against the health system | To exclude instances where the courts have found no merit in the claims against the health system |
| | | Categorizing relevant cases based on nature of the claim and geographical location | To better identify possible patterns in geographical spread and subject matter reoccurrence |
| | | Categorizing relevant cases based on the nature of non-biomedical lapses raised | To better distinguish where the claims were due to technical biomedical failure and when non biomedical issues were raised as contributing to the untoward health outcome |
| 3. Case law content analysis | Data analysis | Analysing the facts of selected cases | To identify the nature and frequency of non-biomedical lapses that play a role in health user dissatisfaction with care received |
| | | Identifying non-biomedical lapses raised in litigation | |
| 4. Thematic analysis of cases | Data analysis | Identifying possible linkage in health user complaints and responsiveness categories | To identify and make links between legal issues raised in court to prove negligence and health systems framing of responsiveness |
| | | Identifying judicial response to the non-biomedical lapses raised and any pronouncements made on them | |

| | | | |
|---|---|---|---|
| | | Categorizing the non-biomedical lapses in terms of responsiveness categories | |

**Results**

From the initial search of the case law database,[4] 1232 cases of medical negligence claims were found to be made against the public health system in South Africa. These represent the volume of claims against the public health system, whether legitimate or eventually successful in the courts. This number buttresses the claims of the MOH on the 'explosion' of medical negligence claims (Kollapen, 2017). Of the claims made against the public health system, 37 went up to the Constitutional Court,[5] being the highest court in the country, while the Supreme Court of Appeal had 172 cases brought before it. There were 174 cases brought before courts in the Eastern Cape, while 106 cases were in the Free State. In the Gauteng province, there were 505 cases dealing with medical negligence claims. Kwazulu-natal province had 55 cases, while the Western Cape courts had 111 cases brought before it. The provinces with lesser numbers of cases brought before their courts included North West (n=39), Nothern Cape (n=20), Limpopo (n=7) and Mpumalanga (n=6).

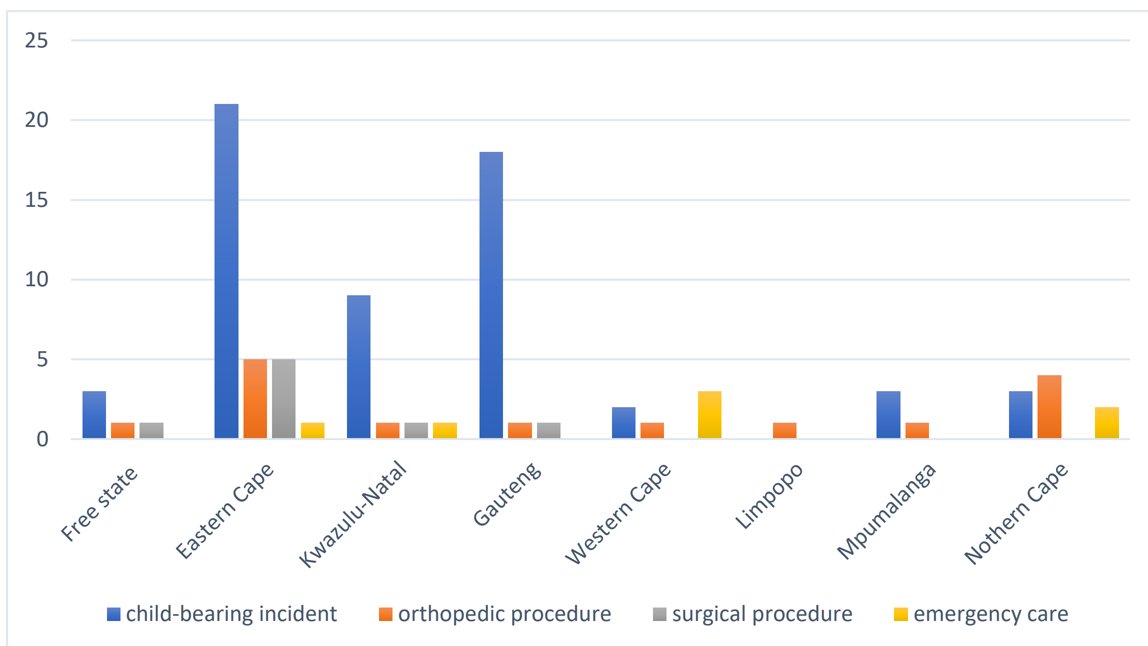


**Figure 2.** Spread of 83 cases of medical negligence claims against the public health system, in South Africa arranged by province and nature of medical intervention from 1994 to 2022 (source: author)

[4] Case law databases and reports are a repository of decided cases, laying out the facts of the cases as well as the decisions of the courts and their reasoning. Examples of such databases in South Africa are SAFLII (www.saflii.org), Jutastat (juta.co.za) and LexisNexis (lexisnexis.co.za).
[5] In South Africa, cases begin at the Magistrate Court, to the High Court and then the Supreme Court of Appeal and finally up to the Constitutional Court, which is the highest court in the Country.

Regarding relevance to the focus of the study on lapses of health system responsiveness in public health care medical negligence claims, cases of medical negligence in time period (n=1232) were streamlined to cases where a non-biomedical concern was raised in support of the claim of negligence (n=89). Of these cases, those assessed to have an element of lack of health system responsiveness identified by health user (n=23)

Of the eventual 89 cases (See Appendix 1) found to be relevant to this research, cases involving childbearing related procedures were the highest number of instances at 59/89. 15/89 cases consisted of claims arising from orthopaedic procedures, while 9/89 instances had to do with surgical procedures or postoperative care. Cases relating to emergency care were the lowest at 7/89 cases. Of these 89 cases, those assessed to have an element of lack of health system responsiveness identified by health user (n=23)

On the responsiveness issues raised, 23/89 (25.5%) cases were found to have health user complaints that had a direct bearing on responsiveness. These cases had a category of responsiveness raised by the health user as being intrinsic to their dissatisfaction with their care and linked to their claim of medical negligence. In the 23 instances, 5 of the 8 categories were raised, with no concerns raised on the issues of choice, confidentiality, and access to social support networks. Of the 5 categories featured, complaints of affronts to dignity had the highest occurrence, happening 10 times followed by lack of proper communication with 6 times with one of those instances also being a case of a breach of autonomy. Issues around prompt attention were raised the second to last with concerns raised 5 times. Issues around patient autonomy occur 2 times, with the quality of basic amenities being the least, occurring only once. The case where concerns on autonomy were raised was only one where poor communication was an issue.

Of the cases where a category was in issue, the courts made an assertion in the judgment that directly alluded to a systemic failure of the health system 9 times. In these instances, the courts stated that the cases before them were emblematic of what they perceived as a systemic failure of the health system in that regard.

Of all the 23 cases where a responsiveness category was identified, cases where a childbearing procedure was at the heart of the medical intervention were the highest, occurring in 17 cases, followed by orthopaedic procedures which occurred 3 times. Emergency care occurred 2 times, while Surgical procedure occurred only once. Importantly also, instances where a lapse in responsiveness contributed to the eventual untoward health outcome occurred 15/23 times, meaning that 65% of the time, the failure to be responsive impacted the eventual poor health outcome.

**Table 3:** Thematic organisation of 23 cases into responsiveness lapses raised in litigation (source: author)

| **Dignity** | **Communication** | **Autonomy** | **Prompt attention** | **Quality of basic amenities** |
|---|---|---|---|---|
| Gura v MEC for Health, Free State Province | NM obo[6] NM v MEC for Health, Eastern Cape | Links v Member of the Executive Council, Department | Ndisane v MEC, Department of | M v Member of the Executive Council for |

[6] The term 'obo' is used in the reporting of case law to mean: 'on behalf of' and is often used when a parent or guardian is suing on behalf of their child or ward.

| | | of Health, Northern Cape Province | Health Eastern Cape Province | Health: Eastern Cape Province |
|---|---|---|---|---|
| Y M v MEC Department of Health Free State and Another | Marr v MEC Department of Health Eastern Cape Provincial Government and Another | Mene v Member of the Executive Council for Health in the Province of the Eastern Cape | Hoffmann v MEC for Department of Health, Eastern Cape, and Another | |
| Zonele v MEC of Health of the Eastern Cape Government | R v MEC for Health | | Mbhele v MEC for Health for the Gauteng Province | |
| S v Member of the Executive Counsel for the Department | M v Member of the Executive Council for Health KwaZulu-Natal | | Maphosa v MEC for Health, Limpopo | |
| N. M. obo S. M. v MEC for the Department of Health, Eastern Cape Province | M obo M v MEC for Health of the Mpumalanga Provincial Government | | Goliath obo O v MEC Department of Health Northwest Provincial Government | |
| B.M v MEC for the Department of Health, Eastern Cape Province | Links v Member of the Executive Council, Department of Health, Northern Cape Province | | | |
| Buys v MEC for Health and Social Development of the Gauteng Provincial Government | | | | |
| V v MEC for Health: Gauteng Province and Others | | | | |
| B and Another v MEC for Health and Social Development of the Gauteng Provincial Province Government | | | | |
| S v Member of the Executive Counsel for the Department of Health, Eastern Cape | | | | |

**Links v Member of the Executive Council, Department of Health, Northern Cape Province is a case with two health system responsiveness categories emerging.*

**Dignity**

Instances of undignified treatment of health users emerge as the most recurring complaint and concern of health users. In these 10 instances (see Table 3 above), the displeasure of the health users on the nature of the treatment they received was apparent, with litigants in all 10 cases raising the undignified treatment in their claim of poor treatment during their interaction with the health system. There are (8/10) cases where health workers were reported as making dismissive and rude remarks

to patients. These rude remarks tend to have a long term effect on health users, as they vividly remember actions or words said to them, even after significant time has passed. As one health user stated,

> *"Your honour, if I may just say, I mean I was the one that was in labour, I was the one that was there and if words like that were said to me it is very difficult or very unlikely that I would forget in a day or two, that type of words that were uttered to me, I will not forget it.* (*Buys v MEC,* 2015).*"*

In other instances, the undignified treatment was exacerbated by a further infantilizing of the health user where their legitimate concerns were dismissed as them being "childish'' (*V v MEC for Health: Gauteng Province and Others*, 2020). In one case, a health user in labour desperate for medical attention was told; "Lady, still walk around!"(*S v Member of the Executive Counsel for the Department of Health, Eastern Cape,* 2017). When she continued to approach the nurses during the remainder of that day and night due to her discomfort, the nurses became visibly annoyed. In yet another case, the judge noted the depth of the undignified treatment, where a patient was told to "stop being childish" when she complained to the nursing staff about her symptoms (*V v MEC for Health: Gauteng Province and Others,* 2020). This type of crude and unfeeling commentary with the effect of affronting the health user's dignity was again noted by the court where it recalled the events, in *B and Another v MEC for Health and Social Development of the Gauteng Provincial Province Government* (2017), where after just giving birth, "one of the nurses even lifted the leg of the baby and dropped it saying 'this is a lifeless baby,'" and threw the baby in the bin, where it was later discovered crying by one of the cleaning staff.

**Communication**

Closely linked to affronts to dignity are the issues around lack of proper communication. Leaving patients in the dark about what is happening to them as well as the steps being taken to address their health concerns can be a disorienting feeling, leaving the health user unduly apprehensive, and agitated (Andorno, 2013). A lack of proper communication also affects the ability of the health user to exercise their autonomy and to make an informed choice about their health, as was the case where the health user asserted that he was never told of the decision to amputate his thumb, nor was he told the reason why it was done (*Links v Member of the Executive Council, Department of Health, Northern Cape Province,* 2016). Lack of communication is especially disorienting for a health user in the course of childbirth who is unsure of the state of their new born and is left without any guidance, a situation that happened in 5/7 cases dealing with communication or even worse, deliberately left in the dark as to the condition of their child in a bid to avoid taking responsibility for the unfavourable health outcome that the health user is unaware of. As the mother in, *M obo M v Member of the Executive Council for Health, Eastern Cape Province* (2017) put it,

> "I was not advised by the doctor, nor did I consider the possibility that what occurred as a matter of fact could be as a result of the hospital staff's negligence during the birth process."

Also, as another case showed, with poor communication, comes poor or little to no necessary advice to the health user about the right course of action and viable next steps. This is turn exacerbates an

already tense experience with the health system, especially when the health user has limited education and literacy.

**Prompt attention**

The courts also noted that in the 5 cases where lack of prompt attention was a cause of dissatisfaction with the care received, the failure further contributed to the adverse health outcome suffered by the health user. Failure to provide prompt attention due to being understaffed occurred in 2 of the 5 cases. In one instance, the court took notice of the understaffed health system and stated that the failure to provide adequate staff, was in fact a dereliction of duty by the MEC for Health (*Ndisane v MEC, Department of Health Eastern Cape Province*, [2019] ZAECMHC 19). In another case, the court took judicial notice of the evidence provided, that the maternity unit that attended to the health user was understaffed, which in turn led to the failure to provide timeous care to the health user. This case was further worsened by the fact that it was the MEC who pleaded inadequate facilities as a justification of the delay to provide care to the health user (*Goliath obo O v MEC Department of Health North West Provincial Government,* [2019] ZANWHC 31).

**Quality of basic amenities**

The one instance where the quality of basic amenities was in issue was one where emergency care was needed and could not be adequately given, serving as a pointer to the ripple effect inadequate basic amenities can have on not just the experience of the health user but also on the actual biomedical care they receive. The case (*M v MEC for the Department of Health, Eastern Cape Province*, 2014), was exacerbated by the action subsequently taken by the MEC which led the court to comment that,

> "It is a salutary lesson to be observed that the defendant must bear the costs on the higher scale in the pursuit of defending a doctor's reputation rather than in keeping an objective mind about how the hospital collectively measured up to the standard expected of it."

There, the court was clear in its reprimand, stating that the ability to not just recognize the condition of the patient but to promptly institute necessary treatment was an intrinsic part of its primary function of providing health care, further making the point that the ability to adequately address the responsiveness issues is central to the ability to be a proper functioning people-centred, health system.

**Discussion**

Our findings point to the use of litigation to express dissatisfaction with care provided to health users. However, beyond dissatisfaction with biomedical outcomes, health users have expressed categorical disapproval with *how* said care was provided to them during their interaction with the health system. This phenomenon therefore means that their feedback includes suggestions for health system strengthening. These findings of displeasure with health user treatment and its role in the perception of an unfavourable experience with the health system, resonates with existing studies that show the link between health user satisfaction and responsiveness (Campbell *et al.,* 2000; Fan *et el.,* 2005; Yakob and Ncama, 2017). As Yakob and Ncama (2017) note, health user satisfaction with the services provided is an integral function of health systems. As seen in our study, even where the issue in contention is primarily the untoward health outcome and the negligence that led to it, health users

often raise events in their interaction with the health system beyond the biomedical intervention that led to the untoward health outcome. This is worthy of note when considering that such assertions by health users were not the norm, occurring only 23/89 times in the instances where the public health system was found to be at fault and as such, liable for medical negligence. This is proof that raising such non-biomedical lapses is not an essential legal element of a valid claim of negligence. Thus, where health users raise their misgivings about responsiveness lapses, they must not be dismissed as a necessary step for proving their claims. As the data from our study shows, health users who are treated in an undignified manner, especially when they are in their most vulnerable state, are acutely aware of the disdain with which they have been treated by the health workers and/or managers subsequently when they seek redress. Matiti and Baillie (2020) have stated that broadly, in many different country contexts, when faced with serious illness or uncertainty about diagnosis, patients tend to lose confidence and feel out of control, which in turn diminishes their sense of dignity. In a different study, in the British context, patients stated that they felt 'so small and so vulnerable' (Bell and Duffy, 2009) Similar findings have been made in the South African context, by Jewkes *et al*., (1998) where they noted that in a bid to show dominance, healthcare workers often left expectant mothers about to give birth, feeling apprehensive and fearful due to 'rude', 'inhumane' and 'not caring' midwives who spoke to them as if 'talking to a child (Jewkes *et al*., 1998). In dealing with the health system, patients are often placed in a situation of special vulnerability where they are deeply dependent on the assistance of others, both for the improvement of their health condition, but often also for the meeting of their most basic needs (Murray and Frenk, 2000). In such a state of susceptibility, patients are exposed to having their self-esteem affected if they see certain attitudes or behaviour by health care providers that appear to be dismissive or outrightly antagonizing of their dignity and self-worth (Andorno, 2013).

The seriousness of dignity affronts to health users is reflected in it being most frequently expressed as a matter of concern, in this study. The study's findings resonate with the notion that the choice of litigation can often be in pursuit of recognition of the harm that has been done, as well as a desire for recompense for affronts to dignity (Hensler, 2003). It also highlights the importance of dignity as a key aspect of health system responsiveness (Mirzoev and Kane, 2017). The focus on dignity, not only reinforces other studies which indicate how important it is to health users during their interaction with the health system (Valentine *et al.,* 2008), but simultaneously shows how an aspect so important to health user is not given enough consideration and prioritization. As Valentine *et al.,* (2008) have pointed out, in many priority lists, patients state the desire for 'humanness' as important to them. Beyond the specific medical interventions that patients are given and their success or failure, the circumstances under which those services are provided are important to the health users and determine how they ultimately feel about being heard and treated humanely (De Silva and Valentine, 2000). The need to recognize and respect the dignity of health users is particularly apparent when considering that there are inherent power imbalances in the relationship between health care provider and health user (Murray and Frenk, 2000). Beyond the duty of care owed to the patient, there is a responsibility to make patients feel as welcome and at ease as is possible in the larger context of the health challenges that warrant their use of the health system in the first place. Dignity in the context of being a barometer for health system's responsiveness relates to the right of the health care user to be treated as a person and not simply as just a patient receiving medical care (Beach *et al.,* 2005). It is key to the transition of perceiving the health user as an 'object' to being a 'subject'

(Andorno, 2013). As such, the recognition of the dignity of health users must remain a foundation to ground all subsequent interactions with health users, to be people centred (De Man *et al.,* 2016). To be people-centred means prioritizing not just the needs of health users but their general sense of wellbeing; which is strongly linked to how they are treated and importantly also; how they *perceive* that they have been treated (Robinson *et al.,* 2008).

Responsiveness lapses are, however, not simply irritations that make the health user experience with the health system unpleasant. They can have a direct bearing on the eventual untoward health outcome (Yakob and Ncama, 2017). As Campbell *et al.* (2000), put it, health outcomes are a consequence of care and how it is provided. As in this study, when responsiveness lapses that ultimately play a role in the delivery of substandard care and eventual poor health outcomes occur 15/23 times, they cannot be dismissed as peripheral inconveniences to the health user. While the desire to ensure as favourable an interaction with the health system is on its own, a laudable goal that must be encouraged, its direct bearing on eventual health outcomes is further reason to better understand it and incorporate it into the delivery of a patient centred health system (Valentine, *et al.* 2003). Paying attention to health system responsiveness importantly means that health workers who have more direct interactions with health users must also be aware that the provision of their services goes beyond the provision of healthcare. While significant work has been done globally (Gallagher, 2004; Pelzang, 2010; Kitson *et al.*, 2013), and in the South African context (Smit, 2005; Delobelle *et al*., 2009; Honikman and Fawcus, 2015), on the importance of training health workers to show empathy in their interactions with health users, a stronger connection must be made to responsiveness and its centrality to the health user experience.

In the South African context, there is considerable focus on situating healthcare provision in human rights discuss. This has meant that healthcare is framed as a right with ancillary patient rights as contained in the National Health Act (NHA) and the Patients Charter. The court in *Rens v MEC for Health, Northern Cape* (2009), noted that the current South African constitutional dispensation is "founded on values such as human dignity and the advancement of human rights and freedom" (Para 41.2) and as such, "one would expect better from a state department" (Para 41.2). In *M v MEC for Health, Eastern Cape* (2014), the court stated that treatment of patients with dignity was not simply necessary for good service provision but was in indeed intrinsic to the protection of human rights as provided for by the South African constitution. These cases further restate the connection the courts make between dignity in the context of health care delivery to dignity as a fundamental principle of the new democratic dispensation upon which the country's constitution and by extension, national ethos is to be built on. Increased human rights awareness has been highlighted as one reason for the increase in medical negligence claims (Pienaar, 2016). As Yakob and Ncama (2017) note; with increased awareness of client rights to respect and autonomy, a more responsive health system is required to meet up with health users' legitimate expectations. As such, the failure of the health system to become more responsive to the heightened awareness of its populace has left it struggling to keep up with the claims against it and must be rectified to avoid its own feared collapse as expressed by health system leaders (Kollapen, 2017; 2021). The need for respecting and promoting the dignity of patients is even more imperative in the context of ever-increasingly bureaucratic, impersonal, and often commercialized health care delivery (Timmermans and Oh, 2010). In the often high-pressure and high-volume nature of health care provision, there is often a tendency to be programmatic and

utilitarian and, in the process, inadvertently overlooking kindness and recognition of patients as individuals (Dyrbye et al., 2017). The ripple effect of such 'cold' treatment is more likely a reduction in patient satisfaction, even if the substantive health care that is provided is satisfactory, with a positive health outcome for the health user (Reader et al., 2014).

To be as effective as possible, the willingness to accept and learn from data that indicate lapses in responsiveness must importantly be championed by health system leadership. As Swanson *et al.*, (2012), point out, the role of health system leaders in health system strengthening includes a willingness to implement feedback loops and learn from them. Our study shows the (previously unexplored) viability of framing medico-legal litigation as a feedback mechanism – particularly suited for understanding lapses in health system responsiveness. With this understanding of medico-legal litigation, health system leadership has an opportunity to reframe its perception around litigation from being an inconvenience driven by 'greedy legal practitioners' (Oosthuizen and Carstens, 2015), to being an increasingly used outlet by health users for registering displeasure with their health outcomes and more broadly, their interaction with the health system. Such a reframing of medico-legal litigation is beneficial for maximizing the utility of available feedback loops, which can now include litigation involving the health system. Importantly also, the reframing can also lead to a rethinking around how claims against the health system are handled. Where complaints around untoward health outcomes are brought by health users, a willingness to understand, empathize and make amends where necessary is important for rectifying harm done, as it is for being more responsive and creating more favourable health user interactions. The observation of the courts in *Zonele v MEC for Health, Eastern Cape* (2014) and in, *S v MEC for Health, Eastern Cape* (2017) that, the matters should never have proceeded to trial, are an indictment of not only the legal processes of the health system but its introspectiveness and willingness to accept blame and make necessary amends. Unfortunately, however, from some of the arguments of the public health system in various provinces in the cases, as well as from the assertions of health governance leadership (Oosthuizen and Carstens, 2015), there is a failure to make the connection between health responsiveness lapses and unfavourable bio-medical outcomes. Such a failure to see the linkage between untoward biomedical outcomes with the non-biomedical aspects of the interaction with health users will ultimately lead to ill equipped interventions that do not effectively mitigate the perceived problem of increasing litigation against the public health system. The challenges faced in the provision of health care cannot however be fully understood without factoring the context in which the care is provided (World Health Organization, 2007).

Making a stronger connection with responsiveness and seeing it as intrinsic to the proper functioning of the health system will be a major step in the right direction of providing truly people centred health care (World Health Organization, 2007; Byrne *et al*., 2020). The admonition of the court in *MEC for Health, Gauteng v Lushaba* (2016), that "bureaucrats seem to get off scot-free, blithely taking no responsibility" (Para 11), bears repeating, especially when considering its further assertion that "the quest to bring accountability… for the tragic proliferation of damages claims… which deserving claimants are sometimes made to suffer, must take a different form" (Para11). Utilization of litigation for informing lapses in responses in responsiveness is one such 'different form' that ought to be explored.

As such, further interdisciplinary work that is grounded in an understanding of legal processes and health systems goals should be done to better understand the use of litigation as an outlet for the registration of health user dissatisfaction. Importantly also, further HPSR with a focus on health system processes should explore if, how and where other mechanisms for the registration of this dissatisfaction have failed, that make it necessary to raise them in litigation. Attitudes of health system managers and various cadres of leadership, including MECs, to conflicts and threats of litigation should also be explored. Such areas of further examination can play a role in improving health system responsiveness measurement, the internal mechanisms for registering health user displeasure, the processes for resolving complaints and ultimately, the formulation and implementation of interventions that result in health system strengthening and better health outcomes for health users. While all these may not guarantee a complete reduction in the incidences of medical negligence and litigation claims to that effect, they can help reduce medical negligence claims because they will improve the provision of health care as well as the resolution of the misgivings that eventually end up in litigation. The reduction in medico-legal claims will in turn make resources that have previously been channelled into the defence and settlement of claims, available for the provision of health care to those most in need of it, which has been a fundamental problem of health system leadership with the ‘crises’ of increased medical negligence claims.

**Conclusion**

When the WHO introduced health system responsiveness as a key measure of health system performance, it was done with the intention to make health systems more people-centred (World Health Organization, 2000). This is important to note for contextualizing what is to be measured when trying to understand health system responsiveness health user priorities in this regard and the failures to meet those expectations (Valentine *et al.,* 2015). If the treatment of health users plays as much of a role in how they perceive the nature of care they have received, as this and other studies show, significant effort must be put into better understanding the phenomenon and using it to inform how the non-medical aspects of health care service are handled. This is especially so, considering that the decision to sue is not driven by purely a desire for financial compensation and often transcends the immediate biomedical failure on which the particular action is grounded (Hensler, 2003). While more action is needed to mitigate medical mishaps on both the personal and systemic level, the odds of 100% infallibility all the time is next to impossible to guarantee. Medico-legal cases are however often not simply about the actual medical error but are also about the mismanagement of the larger patient interaction with the health care system at its various levels and stages (Vincent *et al*., 1994).

The ability to evaluate the performance of public healthcare service is important to users of the service as well as to the providers of the service (De Jager *et al.,* 2010). It is therefore not enough to have a general overview of what health users hold as important to them in their interactions with the health system. It is thus important to have a contextual grasp of where and how these expectations have been met and where they have fallen short, to have better insight as to the reason for this. Using health litigation as a mechanism for measuring HSR provides this dual benefit in that, through an analysis at the macro level, it is possible to map out frequency as well as spatial spread of weaknesses in HSR in the country. However, beyond this is the opportunity to obtain robust qualitative data that contextualizes and provides a sense of intensity of the affront caused to health users. In this sense, an analysis that factors the vivid recollection of the events by the aggrieved health users (in some

instances even many years after) can provide insight that is not flattened by questionnaires. In addition to this, findings of the court in these cases provides the added advantage of being an extra layer of data for analysis on the nature and intensity of the responsiveness failure. This is especially so, when and where the courts go on to make pronouncements in their judgment that allude to a systemic failure of the health system.

However, to effectively use case law as a data point for informing health system responsiveness, the starting point for health system's leadership must be a willingness to learn from previous shortcomings and not to have an unduly combative stance towards cases brought against it. Attempts at addressing increasing litigation must importantly identify the factors and circumstances under which these cases are brought as well as the cadres of health care workers whose actions lead to untoward interactions with health users and ultimately inform their decision to sue the public health system. The courts have noted with concern that in the defence of their position, the MEC and the public health system can be unduly obstructive, even when their fault is seemingly apparent (*Nzimande v The MEC for Health, Gauteng,* 2015). This kind of posturing is antithetical to a patient-centered approach to health care; in which case the health leadership ought to be more driven by a desire to better understand what was done wrong and the best way to rectify the harm done to the patient.

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## Appendices

**Appendix 1**: List of cases analysed

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| Free State | ▪ Molete v MEC for Health, Free State<br>▪ Gura v MEC for Health, Free State Province<br>▪ C P v MEC Health of Provincial Government of the Free State<br>▪ Y M v MEC Department of Health Free State and Another<br>▪ A K obo L K v Member of the Executive Council for Health, Free State Province |
| Eastern Cape | ▪ Matshaya v MEC, Department of Health, Eastern Cape Province, and Another<br>▪ P v MEC for Health, Eastern Cape<br>▪ Goliath v. The Member of The Executive Council for Health in The Province of The Eastern Cape<br>▪ Noxolo Sifumba V MEC For Health Eastern Cape<br>▪ MEC Health, Eastern Cape v Mkhitha<br>▪ NM obo NM v MEC for Health, Eastern Cape<br>▪ NN obo ZN v MEC for Health, Eastern Cape Province<br>▪ Sifuba v MEC for Health, Eastern Cape<br>▪ Mbola obo M v Member of The Executive Council for Health, Eastern Cape<br>▪ Zonele v MEC of Health of the Eastern Cape Government<br>▪ S v Member of the Executive Counsel for the Department of Health, Eastern Cape<br>▪ Saki v Member of the Executive Council of the Department of Health, Eastern Cape Government<br>▪ K v MEC for Health, Eastern Cape<br>▪ Luyanda v Member of the Executive Council for Health, Eastern Cape<br>▪ N. M. obo S. M. v MEC for the Department of Health, Eastern Cape Province<br>▪ B.M v MEC for the Department of Health, Eastern Cape Province<br>▪ ZS obo OS v Member of the Executive Council Responsible for Health in the Eastern Cape<br>▪ M obo M v Member of the Executive Council for Health, Eastern Cape Province<br>▪ Marr v MEC Department of Health Eastern Cape Provincial Government and Another<br>▪ Siwayi v MEC For Health, Eastern Cape Province<br>▪ Ndisane v MEC, Department of Health Eastern Cape Province<br>▪ Member of the Executive Council for Health, Eastern Cape Province v YN obo EN<br>▪ Hoffmann v MEC for Department of Health, Eastern Cape, and Another<br>▪ Ndaliso v MEC of The Department of Health of The Eastern Cape Government, Bhisho<br>▪ Ntaba v MEC of the Eastern Cape Government, Bisho<br>▪ Helmey v MEC, Department of Health Eastern Cape and Another<br>▪ Mene v Member of the Executive Council for Health in the Province of the Eastern Cape<br>▪ M C v MEC for Health, Eastern Cape<br>▪ MM obo EM v MEC for Health Eastern Cape<br>▪ Mtiki v Member of the Executive Council for the Department of Health<br>▪ Meyers v MEC, Department of Health, Eastern Cape<br>▪ AN v MEC for Health, Eastern Cape |
| Kwazulu-Natal | ▪ Smith v MEC for Health, Province of KwaZulu-Natal<br>▪ Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal<br>▪ Mpanza v MEC for Health for the Province of KwaZulu-Natal<br>▪ M v Member of the Executive Council for Health KwaZulu-Natal<br>▪ D v MEC For Health for The Province of KwaZulu-Natal<br>▪ HN v MEC for Health, KZN<br>▪ PS obo AH v MEC for Health for the Province of KwaZulu-Natal<br>▪ Premier of the Province of KwaZulu-Natal v Sonny and Another<br>▪ Franks v MEC for the Department of Health for the Province of Kwazulu-Natal<br>▪ Swardt v Member of the Executive Council for Health, KwaZulu-Natal Province<br>▪ Sonny and Another v Premier of the Province of Kwazulu-Natal and Another<br>▪ P H obo S H v MEC for Health for the Province of KwaZulu-Natal<br>▪ Nzimande v The MEC for Health, Gauteng<br>▪ Khoza v MEC for Health and Social Development of the Gauteng Provincial Government<br>▪ Member of the Executive Council for Health, Gauteng v Lushaba<br>▪ NK obo ZK v Member of the Executive Council for Health of the Gauteng Provincial Government<br>▪ Ntsele v. MEC for Health, Gauteng Provincial Government<br>▪ D.N v. The MEC for Health, Gauteng<br>▪ V v MEC for Health: Gauteng Province and Others<br>▪ MEC, Health and Social Development, Gauteng v DZ<br>▪ M M obo Z M v Member of Executive Council for Health, Gauteng Provincial Government<br>▪ N v MEC for Health, Gauteng<br>▪ B v MEC for Health and Social Development of the Gauteng Provincial Province Government |

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| | ▪ N obo N v MEC for Health and Social Development of the Gauteng Provincial Government<br>▪ P N.O. v Member of the Executive Council for Health and Social Development (Gauteng)<br>▪ T obo T v MEC for Health and Social Development of the Gauteng Provincial Government<br>▪ Makgomarela v Premier of Gauteng and Another<br>▪ F M v Member of the Executive Council for Health Gauteng Provincial Government<br>▪ Carrim v Premier of the Gauteng Province and Another<br>▪ Mbhele v MEC for Health for the Gauteng Province<br>▪ MEC for Health and Social Development of the Gauteng Provincial Government v Zulu obo Zulu<br>▪ H [....] v MEC for Health, Gauteng Province |
| Western Cape | ▪ Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape<br>▪ M and Another v MEC for Health, Western Cape<br>▪ AD and Another v MEC for Health and Social Development, Western Cape Provincial Government<br>▪ Premier of the Western Cape Province and Another v Loots NO<br>▪ van Rhyn v MEC for Health, Western Cape<br>▪ A M and Another v MEC for Health, Western Cape |
| Limpopo | ▪ Maphosa v MEC for Health, Limpopo |
| Mpumalanga | ▪ Lochner v MEC for Health and Social Development, Mpumalanga<br>▪ T[...] NO v Member of the Executive Council for Health, Mpumalanga<br>▪ M obo M v MEC for Health of the Mpumalanga Provincial Government<br>▪ Dludlu v MEC for the Department of Health of the Mpumalanga Provincial Government |
| Northern Cape | ▪ Rens v MEC for Health: Northern Cape Provincial Department of Health<br>▪ Dopp NO v MEC Health, Northern Cape<br>▪ Links v Member of the Executive Council, Department of Health, Northern Cape Province<br>▪ van den Berg v Minister of the Executive Council for The Department of Health, North West<br>▪ Goliath obo O v MEC Department of Health North West Provincial Government<br>▪ NM obo TM v Member of Executive Council, North West Department of Health<br>▪ F [....] v MEC for Health North West Province<br>▪ Kgosiemang v MEC for the Department of Health, North-West Province<br>▪ R v MEC for Health |

**Appendix 2:** Table of relevant cases analysed, and facts used for categorization.

| Case | SUBJECT MATTER | Judicial comment | HSR context | Direct quote for context |
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| Gura v MEC for Health, Free State Province | Childbirth related procedure | No<br><br>Court spoke about the events to make the point around negligence. | Dignity<br><br>Rude remarks | The nurse then came and took the baby without checking if it was alive. The nurse put the baby in a waste plastic bag |
| V v MEC for Health: Gauteng Province and Others | Childbirth related procedure | No<br><br>Court however commented of the rude remarks. | Dignity<br><br>Rude and dismissive remarks. | She confirmed that when she complained to the nursing staff of the symptoms she experienced, she was told to stop being childish |
| B and Another v MEC for Health and Social Development of the Gauteng Provincial Province Government | Childbirth related procedure | No<br><br>Court however commented of the rude remarks. | Dignity<br><br>insensitive comments made and nonchalance. | She states further that one of the nurses even lifted the leg of the baby and dropped it saying, 'this is a lifeless baby'. Mrs Grobler states further that one of the nurses even lifted the leg of the baby and dropped it saying, 'this is a lifeless baby'. |
| M obo M v MEC for Health of the Mpumalanga Provincial Government | Childbirth related procedure | No<br><br>Court however commented of the rude remarks | Communication<br><br>failure to provide full disclosure to the patient. | I was not advised by the doctor, nor did I consider the possibility that what occurred as a matter of fact could be because of the hospital staff's negligence during the birth during the birth process. |
| Links v Member of the Executive Council, Department of Health, Northern Cape Province | Orthopaedic procedure | No<br><br>Court however commented of the rude remarks. | Communication and<br><br>Autonomy<br><br>Failure to inform patient of health decision and allow them to make informed choice. | He claims that he was never told of the decision to amputate his thumb nor was he told the reason for it. |
| R v MEC for Health | Emergency care | No<br><br>Court however commented on the treatment patient received. | Communication<br><br>Failure to explain what was going on in treatment. | She noticed a black spot around the site where the needle had been inserted. She enquired from the nursing staff about the cause of the black spot and did not get an answer. A doctor was called who refused to speak to her. |
| Mbhele v MEC for Health for the Gauteng Province | Childbirth related procedure | No<br><br>Court however commented on the treatment the patient received. | Prompt attention<br><br>Nonchalant treatment before and after delivery. | Despite the results of the CTG scan showing foetal distress, the second plaintiff was not attended to promptly and the doctor who had ordered the scan did not follow up on the CTG scan. The nursing sister |

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| | | | | who did the CTG scan neglected to inform the doctor of the result[s] of the CTG scan. [The] second plaintiff was left alone to progress in labour without her labour being monitored, which resulted in her delivering a fresh still birth. |
| Maphosa v MEC for Health, Limpopo | Surgical procedure | Yes<br><br>Court noted that the case was an example of larger systemic challenges which the MEC had failed to bring the court into its confidence on. | Prompt attention<br><br>Poor and delayed care. | In addition to this, it is clear that the plaintiff was sent from pillar to post, and it was only after about three to four months that surgery was performed on his ankle. |
| Y M v MEC Department of Health Free State and Another | Surgical procedure | No<br><br>Court however commented of the rude remarks. | Dignity<br><br>Disparaging treatment and rude remarks. | The baby was taken out of the waste bag and taken to the Neonatal Intensive Care Unit (NICU). |
| NM obo NM v MEC for Health, Eastern Cape | Childbirth related procedure | No<br><br>Court spoke about the events to make the point around negligence. | Communication<br><br>Withholding material facts from patient. | There is no record that the applicant was advised by the nurses at the clinic or by anyone of the cause of the suspected condition of the child. |
| M v Member of the Executive Council for Health: Eastern Cape Province | Emergency care | Yes<br><br>Court disparaged the MEC.<br><br>It is a salutary lesson to be observed that the defendant must bear the costs on the higher scale in the pursuit of defending a doctor's reputation rather than in keeping an objective mind about how the hospital collectively measured up to the standard expected of it. | Quality of basic amenities | Similarly, a failure to recognize a condition requiring treatment, or to institute medically appropriate treatment, comes under the same broad mantle of management. |
| NN obo ZN v MEC for Health, Eastern Cape Province | Childbirth related procedure | No<br><br>Court spoke about the events to make the point around negligence. | Poor Health record management<br><br>**Not a domain of health system responsiveness** | There was a paucity of records from which the monitoring of the birth process could be gleaned |
| Mbola obo M v Member of The Executive Council for Health, Eastern Cape | Childbirth related procedure | No | Poor Health record management | This case is plagued by incomplete or absence of relevant records to aid the adjudication process. That can only be laid on the |

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| | | Court spoke about the events to make the point around negligence. | **Not a domain of health system responsiveness** | doorstep of the defendant, especially in so far as it bears an evidentiary burden |
| Zonele v MEC of Health of the Eastern Cape Government | Orthopaedic procedure | Yes<br><br>Disparaged the MEC<br><br>This matter should not have proceeded to trial. It must have been clear to the defendant or the relevant official dealing with the claim that the plaintiff's treatment was sub-standard. | Dignity<br><br>Impatience and nonchalant attitude to patient | He felt pain and a woman said he should have pain medication, but the four men said they were in a hurry because there was a strike on and told him to be strong. |
| S v Member of the Executive Counsel for the Department of Health, Eastern Cape | Childbirth related procedure | Yes<br><br>Disparaged the MEC<br><br>It appears therefrom that well before trial the defendant was possessed of his own expert evidence which indicated that the hospital staff was negligent. Despite this the trial has been doggedly and unnecessarily proceeded with. | Dignity<br><br>Rude comments | "Lady, still walk around!"[10] She continued to approach the nurses during the remainder of that day and night to the extent that the nurses became annoyed. |
| N. M. obo S. M. v MEC for the Department of Health, Eastern Cape Province | Childbirth related procedure | Yes<br><br>The defendant should only litigate in the public interest. Any decision of the head of the department relating to litigation should be reasonable and rational. When the defendant does litigate, it should conduct itself in such a manner as to avoid unnecessary delays and cost orders. In my view the mature and timeous consideration of the claim ought to have led the defendant (at minimum) not to contest the allegation of negligence, thereby reducing the issues in dispute. The defendant's persistent denial of negligence raises concerns that it persists in not appreciating its obligation towards the public it is meant to serve. | Dignity<br><br>Rude remarks/lack of care/concern | The nursing staff became angry and abusive when she pointed out that the child was deteriorating and berated her for giving out that she knew better than they did.<br><br>There is no merit in its disregard of the medical evidence to the contrary. Our Constitution and particularly the values enshrined in the Bill of Rights require committed service from the public sector, a commitment eerily absent in this case. |

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| B.M v MEC for the Department of Health, Eastern Cape Province | Childbirth related procedure | No<br><br>Court spoke about the events to make the point around negligence | Dignity<br><br>Rude and insensitive treatment | Under cross-examination she said the nurse who delivered her baby, was harsh to her. |
| Marr v MEC Department of Health Eastern Cape Provincial Government and Another | Childbirth related procedure | Yes<br><br>It is clear from the reported cases and many unreported matters in this division, that the attitude of some senior members of the provincial government of this division towards orders of the High Court is often one of indifference.<br><br>Wholesale non-compliance with court orders is a distressing phenomenon in the Eastern Cape that has caused the courts in that province to try to devise ways of coming to the assistance of social welfare applicants whom the provincial government has failed.” | Communication<br><br>Lack of adequate information and access to case file | |
| Ndisane v MEC, Department of Health Eastern Cape Province | Childbirth related procedure | Yes<br><br>Disparaged the MEC based on inference made.<br><br>She was never seen by a doctor during all of this time because the doctor was busy in theatre. This suggests again a dereliction of duty by the MEC for Health in terms of not providing adequate staff. | Prompt attention<br><br>Not responding to the plaintiff's need timeously. | She was never seen by a doctor during all of this time because the doctor was busy in theatre |
| Hoffmann v MEC for Department of Health, Eastern Cape, and Another | Childbirth related procedure | Yes<br><br>Disparaged the MEC based on inference made.<br><br>It is evidence that Dora Nginza maternity unit is a very busy place and frequently they are under staffed. | Prompt attention<br><br>Failure to provide timeous care | The evidence quoted verbatim reads: “Then she said to me I shall have to wait a little while because I am still far from giving birth, they are under staffed, but I shall have to wait.” |

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| Mene v Member of the Executive Council for Health in the Province of the Eastern Cape | Childbirth related procedure | No | Autonomy<br><br>Failure to allow patient to make informed choice. | Once the doctor arrived, she asked again for an operation, but the doctor said that she was about to give birth and must "try by all means". |
| Madida obo M v Mec for Health for the Province of Kwa-Zulu Natal | Childbirth related procedure | Yes<br><br>This case is a microcosm of a greater social phenomenon. Hence, I directed that the person(s) responsible should depose to affidavits explaining how the records were initially unavailable and then available. The affidavits had to be submitted to the National Minister of Health and the defendant for further action and copied to the registrar for the court's information. My reason for doing so was, in deference to the separation of powers principle, to alert the political heads of a chronic administrative deficit in health services that is also impacting on the efficiency of the courts as time is lost in trial matters being adjourned. | Poor Health record management<br><br>**Not a domain of health system responsiveness** | Ironically it is the plaintiff who gave the defendant's representatives copies of defendant's own records. She did so on no less than on two occasions.<br><br>To plead 'no knowledge' and to put the plaintiff to the proof of facts that should be easily ascertainable was not a plea in good faith. It is hardly the response of a caring health service.<br><br>The problem of medical and hospital records being unavailable timeously or at all is a recurring feature in medical malpractice cases that result in adjournments and extraordinary waste of legal and experts' costs at the expense of the public purse. |
| M v Member of the Executive Council for Health KwaZulu-Natal | Childbirth related procedure | No<br><br>Disparaged the MEC based on inference made. | Poor communication<br><br>Failure to inform mother of the situation and failure to give proper advice on viable next steps | Ms M. testified that when she was discharged from hospital, she was never advised of any appointment that she had to attend after being discharged. She testified that only when she arrived at her home did she discover two letters that were in a packet that had the baby's medication |
| D v MEC For Health for The Province of KwaZulu-Natal | Childbirth related procedure | Yes<br><br>It is a disturbing fact that in more than one of these medical negligence cases that have come before this court, involving the current defendant, incomplete records are produced in respect of a | Poor Health record management<br><br>**Not a domain of health system responsiveness** | At the outset of the trial, it was said that these records had been lost. That is however assuming they ever existed |

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| | | crucial stage of the labour of plaintiffs. | | |
| PS obo AH v MEC for Health for the Province of KwaZulu-Natal | Childbirth related procedure | No<br><br>Disparaged the MEC based on inference made. | Poor Health record management<br><br>**Not a domain of health system responsiveness** | The medical records (all of which emanate from the possession of the defendant) are not models of clarity. Some appear to be incomplete. Some are very difficult to read. Where entries are unclear or cryptic, and open to interpretation. |
| Nzimande v The MEC for Health, Gauteng | Childbirth related procedure | Yes<br><br>The defendant is an organ of State. The sole purpose of its existence is service to the public by providing health care (and possible also education). Such health care should normally be rendered in an efficient manner unless the State's resources do not permit such service: Soobramoney v Minister of Health, Kwazulu Natal [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (CC); pars [11], [31] and [36]. The defendant has only itself to blame that the application of the maxim res ipsa loquitur is justified. | Procedural insensitivity | None of the essential features of the plaintiff s case were disputed or could be disputed, yet the defendant persisted in resisting both merits and quantum on the basis of a bare denial.<br><br>There is no suggestion in the pleadings or the evidence that the defendant did not have the resources available to render effective health care that would seem to have been nothing more than routine. The services of the George Mukhari hospital are intended primarily for those members of our society who cannot afford private medical services. The plaintiff clearly falls into this category. Given the serious allegations against professional individuals, doctors, and nurses, it is surprising that the defendant decided to play possum. |
| Khoza v MEC for Health and Social Development of the Gauteng Provincial Government | Childbirth related procedure | No<br><br>However, court made inference to the position of the law.<br><br>Moreover sections 13 and 17 of the National Health Act 61 of 2003 require not only that the records of hospitals and clinics be maintained and safely stored but also that adequate controls of access are put in place. | Poor Health record management<br><br>**Not a domain of health system responsiveness** | Moreover sections 13 and 17 of the National Health Act 61 of 2003 require not only that the records of hospitals and clinics be maintained and safely stored but also that adequate controls of access are put in place. |

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| Member of the Executive Council for Health, Gauteng v Lushaba | Childbirth related procedure | No<br><br>Blame placed on predatory lawyers | **Not a domain of health system responsiveness** | |
| Buys v MEC for Health and Social Development of the Gauteng Provincial Government | Childbirth related procedure | Yes<br><br>Court took judicial notice of the rude remarks | Dignity<br><br>Dismissive and rude remarks | It was then put to her that the sister or midwife who was in charge did not utter the words "jy sal druk" as alleged by the plaintiff. She gave the following response: "Your honour, if I may just say, I mean I was the one that was in labour, I was the one that was there and if words like that were said to me it is very difficult or very unlikely that I would forget in a day or two, that type of words that were uttered to me it is, I will not forget it." |

**Appendix 3:** Health Policy and Planning Journal Guidelines

"*Health Policy and Planning* improves the design, implementation, and evaluation of health policies in low- and middle-income countries through providing a forum for publishing high quality research and original ideas, for an audience of policy and public health researchers and practitioners. *HPP* is published 10 times a year. *HPP* has a double-blinded peer-review policy. This means the identity of the authors is anonymous to the reviewers and vice-versa. All types of papers are peer reviewed and all article abstracts from each issue are translated into French, Spanish, and Chinese.

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*Only articles in English are considered for publication.*

The journal follows Oxford SCIMED style. Please refer to these requirements when preparing your manuscript. More information on preparing your manuscript is available. Oxford English spelling style should be used consistently throughout your manuscript. (-ize/-ization), except in quotations and in references.

Prepare your manuscript, including tables, using a word processing program and save it as a *.doc, .rtf* or *.ps* file. Use a minimum font size of 11, double-spaced and paginated throughout including references and tables, with margins of at least 2.5 cm. The text should be left justified and not hyphenated.

Authorship: Please note there should be a LMIC (lower-middle-income) named author from the region of the paper included in the paper. If all named authors are from HICs' (high-income countries) please clarify the reason for this on the Title Page. In addition, a contributorship statement is required - please note as follows on the Title Page:

Please clarify how each author has contributed to the paper. You need to create a list assigning a person's name against the following roles or tasks:

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- Data collection
- Data analysis and interpretation
- Drafting the article
- Critical revision of the article
- Final approval of the version to be submitted - all named authors should approve the paper prior to submission.

The Title Page should be uploaded as a separate file type "Title Page" and contain the following information:

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3. Each authors affiliation and qualification (BSc, MA, PhD...)
4. Keywords and an abbreviated running title
5. 2-4 Key messages, detailing the main points made in the paper
6. A word count of the full article: Word Limits do not include Abstract, References, Figure/Table legends.

7. Ethical Approval • if no ethical approval was required for the research, please note the reason: • Example A: Ethical approval for this type of study is not required by our institute.

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Original Articles-word limit 6000 Review Articles- word limit 10000 Commentaries: Word limit 1200 How to do...or not to do - word limit 3000 Methodological Musings-word limit 3000 Innovation and practice reports: word limit 2000.

Funding/Acknowledgements/Conflicts of interest/Ethical approval should be noted on the title page.

In the acknowledgements, all contributors who do not meet the criteria for authorship should be listed. Sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source, and submit written permission from the copyright holder to reproduce the material.

Please be aware that the requirements for online submission and for reproduction in the journal are different: (i) for online submission and peer review, please upload your figures separately as low-resolution images (.jpg, .tif, .gif or. eps); (ii) for reproduction in the journal, you will be required after acceptance to supply high-resolution .tif files. Minimum resolutions are 300 d.p.i. for colour or tone images, and 600 d.p.i. for line drawings. We advise that you create your high-resolution images first as these can be easily converted into low-resolution images for online submission.

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Certain image formats such as .jpg and .gif do not have high resolutions, so you may elect to save your figures and insert them as .tif instead.

For useful information on preparing your figures for publication, go to the Digital Art Support page.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

*Manuscript file must include text body. Title Page, Figures and Tables should be uploaded separately.*

**Prior Publication Policy**

*[Based on a statement developed by a group of editors of journals that publish articles on health, health services, and health policy. Journals currently using this statement include Health Affairs, Health Services Research, Inquiry, Journal of Health Politics, Policy and Law, Journal of Health Services Research & Policy, Medical Care, and the Milbank Quarterly.] Background* The policy of the journals subscribing to this statement is to consider for publication only original work that has not previously

been published. Questions about what constitutes previous publication are arising with increasing frequency because of the growth of electronic publishing and the increasing number of reports and papers being produced by organizations and agencies. This statement provides guidance on this issue.

There are legitimate reasons why research may be disseminated before submission to a journal. Active communication among researchers about preliminary findings or the circulation of draft reports for discussion and critique contributes to the eventual quality of published work. In addition, organizations that support or carry our research have an understandable interest in disseminating their work. From the perspective of journals, these reasons for dissemination must be balanced against two considerations. The first is the value of the peer review process. The rules against prior publication are intended to add some assurance of the credibility of published research.

Papers are often improved during the peer review process, with findings, conclusions, and recommendations sometimes changed in response to reviewers' comments. The public and policymakers might be confused or misled if there were multiple versions of a paper in the public domain. Second, from a more parochial viewpoint, journal space is limited, and much time and expense are involved in the evaluation, publication, and distribution of journal articles. Journals must make difficult choices about what to include there is less value in publishing papers that have already been disseminated to their target audiences.

We discuss here several types of dissemination and provide guidelines with respect to the prior publication question. This discussion is essentially an elaboration of two rules, the first emphasizing previous dissemination of the material, the second stressing disclosure.

- Rule One: If the material in a paper has already been disseminated to a journal's audience, particularly in a format that appears to be a final product, then it is unlikely that a second version will be worth publishing in the journal.
- Rule Two: It is the responsibility of authors to let editors know at the time of submission whether a paper's contents have been previously disseminated in any manner so that the editors can determine whether to proceed with the review process.

*Previous Presentations at Meetings* Presentation of a paper at conferences or seminars usually does not jeopardize the possibility of publication. *Working Papers* Dissemination of "working papers" to a limited audience will not ordinarily jeopardize publication. Working paper series are used by many organizations as a means of enabling researchers to obtain critiques from fellow researchers. Working papers covered by this policy are those that are released by the author or an organization rather than by a publisher, are not advertised to the public, and are marked as drafts that are subject to future revision. HPP will not publish papers for which a similar working paper is already available in the public domain.

*Internet Postings* Release via the Internet may jeopardize journal publication under some circumstances. Presentation of the work as a final report is a marker of an attempt to reach a wide audience, particularly when combined with efforts to direct traffic to the work (e.g., via links on other sites) and efforts to attract attention (e.g., press releases). In contrast, if a document is posted on the Internet only to facilitate communication among colleagues with the aim of getting feedback, and if there has been no attempt to otherwise attract the attention of journalists, the public, or the broader research community to the document, then this is unlikely to preclude journal publication. In general, when posting on the Internet serves similar functions as presentation at professional meetings - facilitating the development of papers and the improvement of the research, influencing future revisions, and not constituting a "finished" product - it would not be considered prior publication. On the other hand, when the Web site posting functions as a virtual version of a conventional publication, which may even be copyrighted by the posting organization, the benefit of an additional publication in the journal will be scrutinized carefully.

In cases where there has been little to no exposure at the time that a paper has been submitted to the journal, but the circumstances surrounding the posting make it likely that a high level of exposure (press coverage, etc.) might occur, then the author should remove a posting as a condition for further consideration of the manuscript. Authors who post papers on a Web site and do not want it to constitute prior publication should also post a disclosure statement such as: "This draft paper is intended for review and comments only. It is not intended for citation, quotation, or other use in any form." This statement should be kept on the Web site throughout the review process and until the paper is actually accepted for publication in a journal. Once accepted, authors should post a message to the effect that: "A revised final version of this paper will appear in (Journal Name), volume, issue." Authors also should include this statement as a header or footer on every page of the paper.

*Formal Reports from Foundations, Academic Institutions, Institutes, Trade Associations, and Government Agencies* The dissemination efforts of foundations, government agencies, research institutes, and other organizations that support or carry out research can complement publication in peer-reviewed journals. If publication in one of our peer-reviewed journals is desired, organizational publications should be timed to coincide with or follow journal publication, with appropriate copyright permissions having been obtained. This sequence ensures that the peer-review process will have an opportunity to correct deficiencies of method or presentation. Formal, published reports that have gone through an editorial process, that have been intended to reach a wide audience, and that are publicized and available to any interested party (whether free or not) usually will not be considered for journal publication. A paper that is based on such a report might be considered for publication if it were sufficiently different in emphasis or intent. In such instances, the author should explain at the time of submission (or before) how the paper differs from the previously released report and why its publication would represent a distinct and important contribution beyond that version.

*Policy briefs* If the findings of a piece of research have been published locally (i.e. in a specific country) with the aim of influencing policy debates in that country then even if the brief is available on the web we may consider publishing an article so long as (i) the brief has not had wide circulation outside the country and (ii) the brief is clearly targeted at policy-making audiences, and hence does not include the detailed discussion of methods and perhaps findings that one might expect in a journal article.

*Media Publicity* If results reported in a working paper have become widely known as a result of media exposure (or even if the potential for widespread exposure remains during review), and that working paper is readily available to interested readers (e.g., through a Web site), an editorial judgment will be made whether journal publication would be appropriate. Authors can help protect their work from unwanted media exposure by making clear on working drafts, copies presented at conferences, and other versions that it is a draft that has not yet undergone peer review for publication and that findings and conclusions are subject to change. Authors also should request that any "stories" derived from interviews with the media be embargoed until the work is published or released by the publisher (see, for example, Fontanarosa, P.B., and C.D. DeAngelis. 2002. The Importance of the Journal Embargo. Journal of the American Medical Association 288: 748-750). Any accepted manuscript released to the media should contain the statement: "A revised final version of this paper will appear in (Journal Name), volume, issue." Journal policies involving author contact with members of the media may vary, depending on the issue or journal. Thus, authors should check with the editor before speaking with or distributing papers to members of the media.

*Importance of Disclosure*

In contrast to the editors' decision whether a certain paper has been disseminated too widely to warrant journal publication, there is very little judgment involved in whether an author should disclose previous dissemination. Prior to, or at the time of, submission of a paper that has been disseminated in any of the ways discussed previously, authors should bring this to the attention of the editor so that a determination can be made before the paper goes into the peer-review process. In so doing, authors should describe in what form and how the work was previously disseminated and how the submitted

manuscript differs from previously disseminated versions. Editors might be receptive to a modified version of a paper that has been widely disseminated if the submitted version has a different focus (e.g., more emphasis on methods, more sophisticated analytic approach, or discussion of developments that have transpired since the initial dissemination). The key point is to let editors know about any dissemination that will have, or is likely to have, occurred before the journal article is published rather than have it discovered during or after the review or editorial process. As part of the submittal, authors should include copies of other related papers that might be seen as covering the same material.

Failure to disclose could preclude publication in the journal or, if already published, could result in a notice in the journal about the failure and may result in a retraction of the article.

**Manuscript Preparation**

Page 1: *Title Page* – as above.

Page 2: *Abstract.* The abstract should be prepared in one paragraph, no headings are required. It should describe the purpose, materials and methods, results, and conclusion in a single paragraph no longer than 300 words without line feeds. Page 3: *Introduction.* The Introduction should state the purpose of the investigation and give a short review of the pertinent literature and be followed by: *Materials and methods.* The Materials and methods section should follow the Introduction and should provide enough information to permit repetition of the experimental work. For particular chemicals or equipment, the name and location of the supplier should be given in parentheses. *Results.* The Results section should describe the outcome of the study. Data should be presented as concisely as possible, if appropriate in the form of tables or figures, although very large tables should be avoided.

*Discussion.* The Discussion should be an interpretation of the results and their significance with reference to work by other authors.

*Abbreviations.* Non-standard abbreviations should be defined at the first occurrence and introduced only where multiple use is made. Authors should not use abbreviations in headings.

All *measures* should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

*References.* References must follow the Harvard system and must be cited as follows: Baker and Watts (1993) found... In an earlier study (Baker and Watts 1993), it... Where works by more than two authors are cited, only the first author is named followed by 'et al.' and the year. The reference list must be typed double-spaced in alphabetical order and include the full title of both paper (or chapter) and journal (or book), thus: Baker S, Watts P. 1993. Paper/chapter title in normal script. Journal/book title in italics *Volume number in bold:* page numbers. Baker S, Watts P. 1993. Chapter title in normal script. In: Smith B (ed). *Book title in italics*. 2nd edn. Place of publication: Publisher's name, page numbers.

*Tables* All tables should be on separate pages and accompanied by a title - and footnotes where necessary. The tables should be numbered consecutively using Arabic numerals. Units in which results are expressed should be given in parentheses at the top of each column and not repeated in each line of the table. Ditto signs are not used. Avoid overcrowding the tables and the excessive use of words. The format of tables should be in keeping with that normally used by the journal; in particular, vertical lines, coloured text and shading should not be used. Please be certain that the data given in tables are correct. Tables should be provided as Word or Excel files.

*Availability of Data and Materials*

Where ethically feasible, *Health Policy and Planning* strongly encourages authors to make all data and software code on which the conclusions of the paper rely available to readers. Authors are required to include a Data Availability Statement in their article.

We suggest that data be presented in the main manuscript or additional supporting files or deposited in a public repository whenever possible. For information on general repositories for all data types, and a list of recommended repositories by subject area, please see Choosing where to archive your data.

*Data Availability Statement* The inclusion of a Data Availability Statement is a requirement for articles published in *Health Policy and Planning*. Data Availability Statements provide a standardised format for readers to understand the availability of data underlying the research results described in the article. The statement may refer to original data generated in the course of the study or to third-party data analysed in the article. The statement should describe and provide means of access, where possible, by linking to the data or providing the required unique identifier.

The Data Availability Statement should be included in the endmatter of your article under the heading 'Data availability'.

More information and examples of Data Availability Statements.

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- [dataset]* Authors, Year, Title, Publisher (repository or archive name), Identifier

*The inclusion of the [dataset] tag at the beginning of the citation helps us to correctly identify and tag the citation. This tag will be removed from the citation published in the reference list.

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**Types of papers**

Health Policy and Planning welcomes submissions of the following article types:

- Original research
- Review articles
- Methodological musings
- Innovation and practice reports
- Commentaries
- 'How to do (or not to do) ...' [for example, see Hutton & Baltussen, HPP, 20(4): 252-9] and
- '10 best resources' [for example, see David & Haberlen, HPP, 20(4): 260-3].

**Original Research**

Manuscripts should preferably be a *maximum* of *6,000* words, excluding tables and figures/diagrams.

The manuscript will generally follow through sections: Title page, Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, Acknowledgements, References. However, it

may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

For the reporting of statistical analyses please consider the following additional points:

- Focus the statistical analysis at the research question.
- Provide information about participation and missing data.
- As much as possible, describe results using meaningful phrases (e.g., do not say "beta" or "regression coefficient", but "mean change in Y per unit of X"). Provide 95% confidence intervals for estimates.
- Report the proportions as *N* (%), not just %.

- Report *P* values with 2 digits after the decimal, 3 if <0.01 or near 0.05 (e.g., 0.54, 0.03, 0.007, <0.001, 0.048). Do not report *P* values greater than 0.05 as "NS".
- Always include a leading zero before the decimal point (e.g., 0.32 not .32).
- Do not report tests statistics (such as chi-2, T, F, etc.)."

For acknowledgements, figures and measures see above.

**Review Articles**

Manuscripts should preferably be a *maximum of 10,000 words*, excluding tables, figures/diagrams, and references.

Reviews may be invited. They generally address recent advances in health policy, health systems and implementation. *Systematic reviews are particularly welcomed but* may not be appropriate for every topic. If authors are submitting a review article that is not a systematic review, then the paper should explain why a systematic review was not feasible/desirable, and the review methods should be described in a way that is as clear and as replicable as possible.

The manuscript will generally follow through sections: Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

Checklists have been developed for a number of study designs, including randomized controlled trials (CONSORT), systematic reviews (PRISMA), observational studies (STROBE), diagnostic accuracy studies (STARD) and qualitative studies (COREQ, RATS). We recommend authors refer to the EQUATOR Network website for further information on the available reporting guidelines for health research, and the MIBBI Portal for prescriptive checklists for reporting biological and biomedical research where applicable. Authors are requested to make use of these when drafting their manuscript and peer reviewers will also be asked to refer to these checklists when evaluating these studies.

**Commentaries**

Short commentaries on topical issues in health systems are welcomed - *please email the editorial office prior to submission*. Most such commentaries are commissioned by the editors, but the journal will also consider unsolicited submissions. Commentaries should of broad interest to readers of *Health Policy and Planning*, and while they are not research papers, they should be well substantiated. Manuscripts should preferably be a *maximum of 1,200 words*, excluding tables, figures/diagrams, and references.

The manuscript will generally contain a short set of key take-home messages. Tables and Figures should not be placed within the text, rather provided in separate file/s.

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This series is meant to explain how to use a particular research or analytical method (e.g., social network analysis, discrete choice experiment etc.). The research or analytical methods discussed should be well accepted and clearly defined: this category of paper is not meant to address methodological debates but rather to help disseminate and promote the use of well-accepted methodologies. Manuscripts should preferably be a *maximum of 3,000 words* excluding tables, figures/diagrams, and references.

- The sections must be arranged as follows: i) Title page, ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.

Tables and Figures should not be placed within the text, rather provided in separate file/s.

**10 Best Resources**

This 10 best is a series of articles that identify and outline the 10 most useful resources from a range of sources to help facilitate a better understanding of a particular issue in global health.

We often commission these articles, but we also hear unsolicited suggestions.

For acknowledgements, figures and measures see Title page.

**Methodological Musings**

This series is meant to address methodological issues in health policy and systems research, where there is currently a lack of clarity about accepted research methods. This series is intended to support the development of the health policy and systems research field, through supporting methodological discussion.

Manuscripts should preferably be a *maximum of 3,000 words*, excluding tables, figures/diagrams, and references.

- The sections must be arranged as follows: i) Title page, ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.
- For acknowledgements, figures and measures see Title page.

**Innovation and Practice Reports**

These short reports are narratives and/or reflections/experiences from the perspective of health leaders, managers and practitioners operating at the national or sub-national level which focus on innovative approaches to strengthen health systems. They do not need to report a completely new activity or practice but could consider an adaptation or modification to an existing one. Papers should highlight the experience of health system practitioners in taking action to strengthen health systems through innovative activities. These activities might address governance or human resource management approaches, for example, rather than having a health care focus. Other relevant activities include practices to build capacity, develop new partnerships, new approaches to management, or restructuring relationships within health systems implemented at scale with the intention of promoting changes in practice. The innovations should preferably have been implemented for sufficient time to allow authors to demonstrate their potential system benefits,

including sustained improvement over time. We encourage authors to think how the experience they report adds to existing work in their own setting, as well as other settings - but this is not essential.

We will not consider clinical and pharmaceutical innovations and practices.

Manuscripts should be a *maximum* of *2,000 words*. The manuscript will generally present the following sections:

- *Key Messages* (2-4 key messages or lessons for consideration in other settings)
- *Abstract* (no more than 300 words) • *Introduction* – outline the background to and context of the activity or practice: what is it and why does it matter in your health system? Please also clarify how you generated the reflections presented in this report: who was involved, what did you do, what forms of evidence are used?
- *Implementation* – how was the activity or practice developed and implemented? was it adapted over time and if so, how, and why? how was it scaled up, and to what level was it scaled?
- *Achievements/Challenges* – what benefits have been seen in the health system? at what scale? What challenges were faced?
- *Enablers/Constraints* – what factors enabled implementation, scale-up and achievements, and what factors constrained them?
- *Conclusions*: what are the key lessons for other health leaders in other settings concerning this activity/practice
- References

If used, Tables and Figures should not be placed within the text, rather provided in separate file/s. In the main body of the paper, sub-headings may be useful to signal key elements of the experience reported.

**Ethics approval**

*Ethics approval is not required for this type of article, which is intended to allow reflections on innovative approaches to strengthen health systems written by health system leaders and managers working at national or sub-national level.*

However, in the introduction, please briefly clarify how you generated the reflections presented in this report including who was involved, what you did and what forms of evidence were used. If you require writing assistance, please do contact us at hpp.editorialoffice@oup.com.

**Submission process**

Pre-submission language editing

Authorship

Originality

Online submission

**Pre-Submission Language Editing**

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**Originality**

Manuscripts containing original material are accepted for consideration with the understanding that neither the article nor any part of its essential substance, tables, or figures has been or will be published or submitted for publication elsewhere. This restriction does not apply to abstracts or short press reports published in connection with scientific meetings. Copies of any closely related manuscripts should be submitted along with the manuscript that is to be considered by HPP. HPP discourages the submission of more than one article dealing with related aspects of the same study. For further information on the prior publication policy see Prior Publication Policy.

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- a statement of financial or other relationships that might lead to a conflict of interest or a statement that the authors do not have any conflict of interest.
- a statement that the manuscript has been read and approved by all authors (see also section on authorship);
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Prior to submission please carefully read instructions on each type of paper and closely follow instructions on word count, abstract, tables and figures and references. This will ensure that the review and publication of your paper is as efficient and quick as possible. The Editorial Office reserve the right to return manuscripts that are not in accordance with these instructions. All material to be considered for publication in Health Policy and Planning should be submitted in electronic form via the journal's online submission system. Once you have prepared your manuscript according to the

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**Conflict of Interest**

Authors must declare any conflicts of interest during the online submissions process. The lead author is responsible for confirming with the co-authors whether they also have any conflicts to declare.

**Ethical Approval**

A requirement of publication is that research involving human subjects was conducted with the ethical approval of the appropriate bodies in the country where the research was conducted and of the ethical approval committees of affiliated research institutions elsewhere. Furthermore, subjects' consent must have been obtained according to the Declaration of Helsinki. A clear statement addressing all these points must be made in any submitted manuscript presenting such research. In original articles, this information must also be included in the methods section of the submitted manuscript. Please note that it is the responsibility of the corresponding author to ensure that the relevant ethical approval described above is provided. The Editors-in-Chief reserve the right to refuse publication where the required ethical approval/patient consent is lacking, or where the approval/consent provided is deemed incomplete or ambiguous.

**Funding**

Details of funding sources should be listed in a separate section entitled "Funding". This should appear before the acknowledgements section.

The following rules should be followed:

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- The full official funding agency name should be given, i.e., 'the National Cancer Institute at the National Institutes of Health' or simply 'National Institutes of Health' not 'NCI' (one of the 27 subinstitutions) or 'NCI at NIH' - see the full RIN-approved list of UK funding agencies for details.
- Grant numbers should be complete and accurate and provided in brackets as follows: '[grant number ABX CDXXXXXX]'
- Multiple grant numbers should be separated by a comma as follows: '[grant numbers ABX CDXXXXXX, EFX GHXXXXXX]'
- Agencies should be separated by a semi-colon (plus 'and' before the last funding agency)
- Where individuals need to be specified for certain sources of funding the following text should be added after the relevant agency or grant number 'to [author initials]'.

An example is given here: 'This work was supported by the National Institutes of Health [P50 CA098252 and CA118790 to R.B.S.R.] and the Alcohol & Education Research Council [HFY GR667789].

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