ACTUARIAL SOCIETY
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MEDICAL COMPENSATION FOR ROAD ACCIDENT VICTIMS:

RAF, RABS, CTPI and the limits of Judicial Reform

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ROAD TRAFFIC CRASHES – KEY FACTS

1.19m
people died as a result of road traffic crashes in 2021.

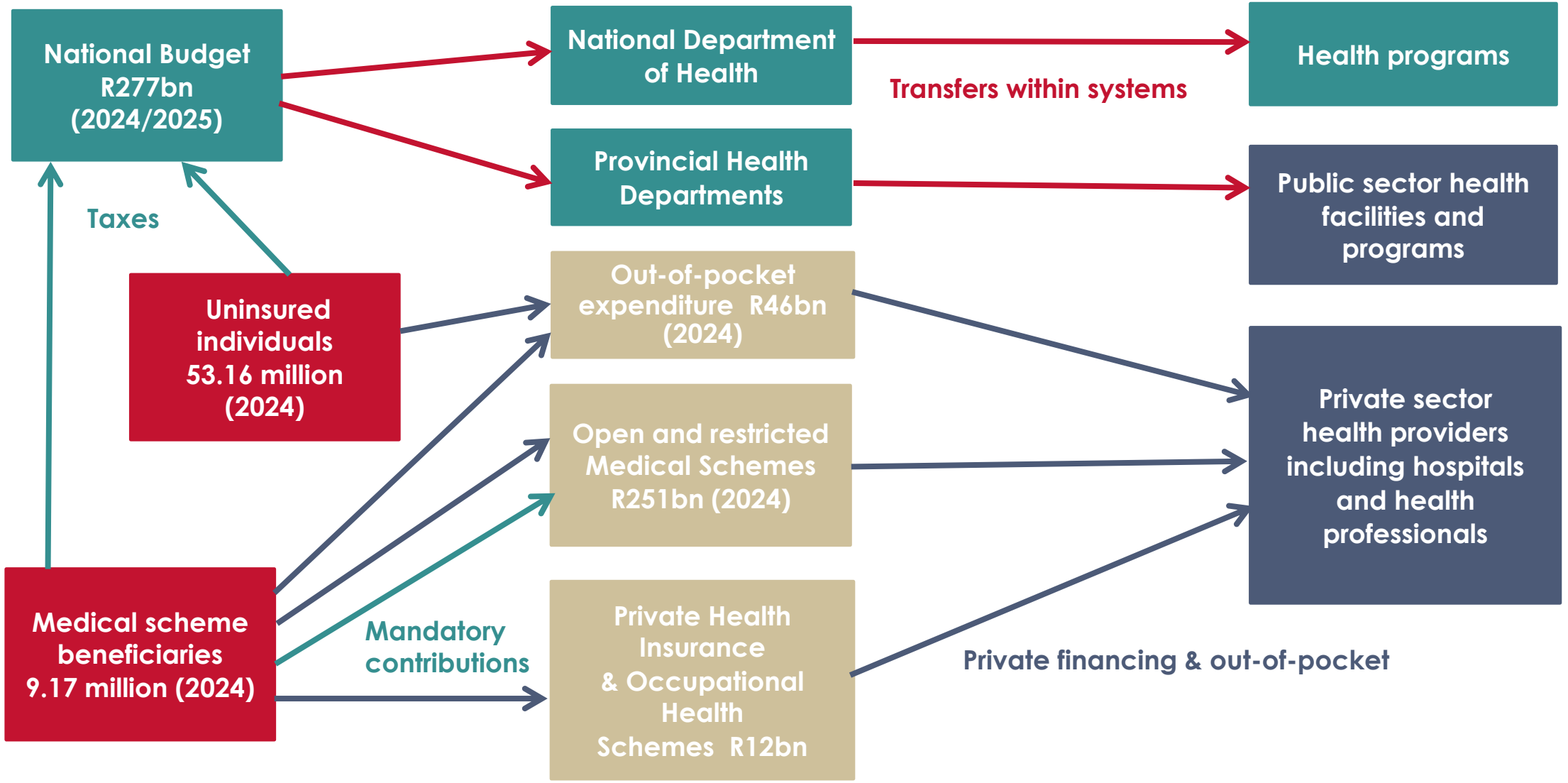
#1 cause
of death for children and young adults aged 5-29 years globally.

92%
of road fatalities occur in low- and middle-income countries, which have ~60% of the world's vehicles.

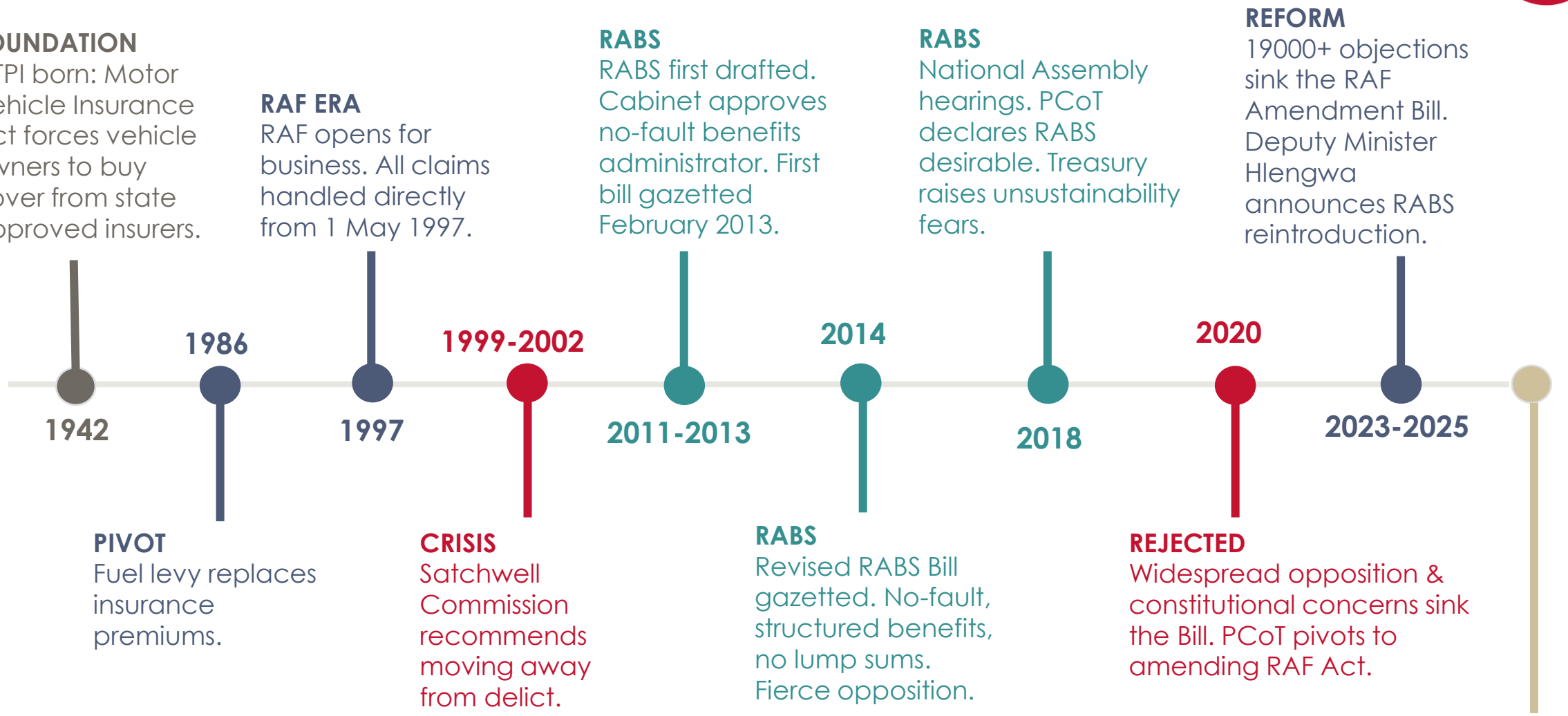
>50%
of deaths are vulnerable road users – pedestrians, cyclists and motorcyclists.

3% GDP Road traffic crashes cost most countries approximately 3% of their GDP each year.

SOUTH AFRICAN HEALTH SYSTEM



80 YEARS IN SEARCH OF A BETTER ROAD



RAF OVERVIEW

RAF provides cover to all users of South African roads for loss or damage caused by the negligent driving of motor vehicles within the borders of the Republic.

The RAF provides **two types of cover**, namely:

1. Personal cover to motor vehicle accident victims or their families.
2. Indemnity cover to wrongdoers.

Damages paid by the RAF are categorised as special damages and general damages. **Special damages** are paid for pecuniary losses, and include:

- **Past and future hospital, medical and related expenses.**
- Past and future loss of earnings.
- Past and future loss of support.
- Funeral expenses.

General damages (non-pecuniary loss) are paid as compensation for loss of amenities of life, pain and suffering, disability and disfigurement.

RAF MEDICAL COVERAGE

https://raf.co.za/Product-and-Services/Pages/Medical-expenses.aspx

A **third party** may claim his or her proven **past and future medical expenses** from the RAF.

The medical expenses must be reasonable, necessary, and directly related to the injuries sustained in the motor vehicle accident.

Medical Expenses can be divided into two different categories:

1. Past medical expenses already incurred up to the time of settlement.
2. Future medical expenses that may be incurred after settlement.

Important to note that it is a **fault-based system**: Apportionment of Damages Act, 1956 (Act No. 34 of 1956), so medical expenses are apportioned by claimant's degree of blame.

RAF TARIFFS

https://raf.co.za/Legislation/Pages/Legal-Framework.aspx

In respect of accidents occurring on or after 1 August 2008, the liability of the RAF is limited as follows:

- Hospital, medical and related expenses are now paid on the basis of two tariffs. The first relates to emergency medical treatment and the applicable tariff is based on the National Health Reference Price List. The second relates to non-emergency medical treatment and the tariff applicable for such treatment is the Uniform Patient Fee Structure for fees payable by full-paying patients prescribed by the National Health Act, 2003 (Act No. 61 of 2003), as revised from time to time.

TWO RAF TARIFFS

EMERGENCY TREATMENT

Tariff basis:

National Health Reference Price List (NHRPL).

Statutory basis:

Section 17 of RAF Amendment Act.

Key problem

NHRPL is a guideline, not an enforceable rate. Private practitioners typically charge 200% to 300% above NHRPL.

Also applies to:

Section 17(5) supplier claims from private hospitals.

NON-EMERGENCY TREATMENT

Tariff basis:

Uniform Patient Fee Schedule (UPFS) for full-paying patients.

Statutory basis:

National Health Act, 2003 (as revised).

Key problem

UPFS is a public hospital patient fee – not a private sector rate. Covers only a fraction of private treatment costs.

Also covers:

Section 17(4)(a) future medical expense undertakings.

LEGAL CHALLENGE TO NON-EMERGENCY TARIFF

STRUCK DOWN

UPFS Tariff for Non-Emergency Treatment

Case: Law Society of South Africa & Others v Minister for Transport & Another [2010] ZACC25

Outcome: Regulation 5(1) declared unconstitutional and invalid.

The Constitutional Court found that UPFS rates are wholly inadequate for private sector treatment – virtually no competent private practitioner would treat patients at those rates. The UPFS tariff was found irrational and incapable of achieving the RAF Act's purpose of enabling victims to obtain the care they require.

LEGAL CHALLENGE TO EMERGENCY TARIFF

SUSPENDED

2022 Revised Emergency Tariffs (GN R2395)

Case: NCPD & LSSA v Minister of Transport & Others [2023] ZAGPPHC 348

Outcome: Interim interdict granted. RAF's appeal was refused.

The 2022 tariffs covered only ~60% of previously reimbursed treatments and excluded critical services (e.g. helicopter ambulances). RAF was ordered to disclose decision-making documents it repeatedly withheld – earning punitive costs orders. The tariffs remain under court interdict pending the full review application. RAF's leave to appeal was refused.

THE CURRENT POSITION

PRIVATE SECTOR NON-EMERGENCY

The UPFS cap is constitutionally dead since 2011. Actual reasonable private rates are claimable.

The RAF must pay what was actually and reasonably charged, though it will scrutinise every line item.

Claimant bears onus to prove reasonableness.

PRIVATE SECTOR EMERGENCY

The 2022 NHRPL-based tariffs cannot be applied (court interdict).

The default pre-2022 position applies: NHRPL as reference only. Since NHRPL is a guideline, not a cap, actual private rates remain arguable.

RAF disputes quantum in practice.

PUBLIC SECTOR

Primary care clinics:
free (no RAF claim on that cost).

Hospital treatment:
billed via UPFS means-test. Claim according to H1/H2/H3.

Invoices & proof of payment to be submitted.

PAST MEDICAL EXPENSES DISPUTE

CORE LEGAL QUESTION: Is the RAF liable to pay a claimant's past medical expenses when those expenses were already paid by the claimant's medical aid scheme?

RAF POSITION

NO.

Where a medical scheme paid the expenses, the claimant suffered no loss. Without loss, the RAF owes nothing.

DISCOVERY POSITION

YES.

Medical aid payments are collateral benefits (*res inter alios acta*). The RAF cannot benefit from a private contract between a member and their scheme.

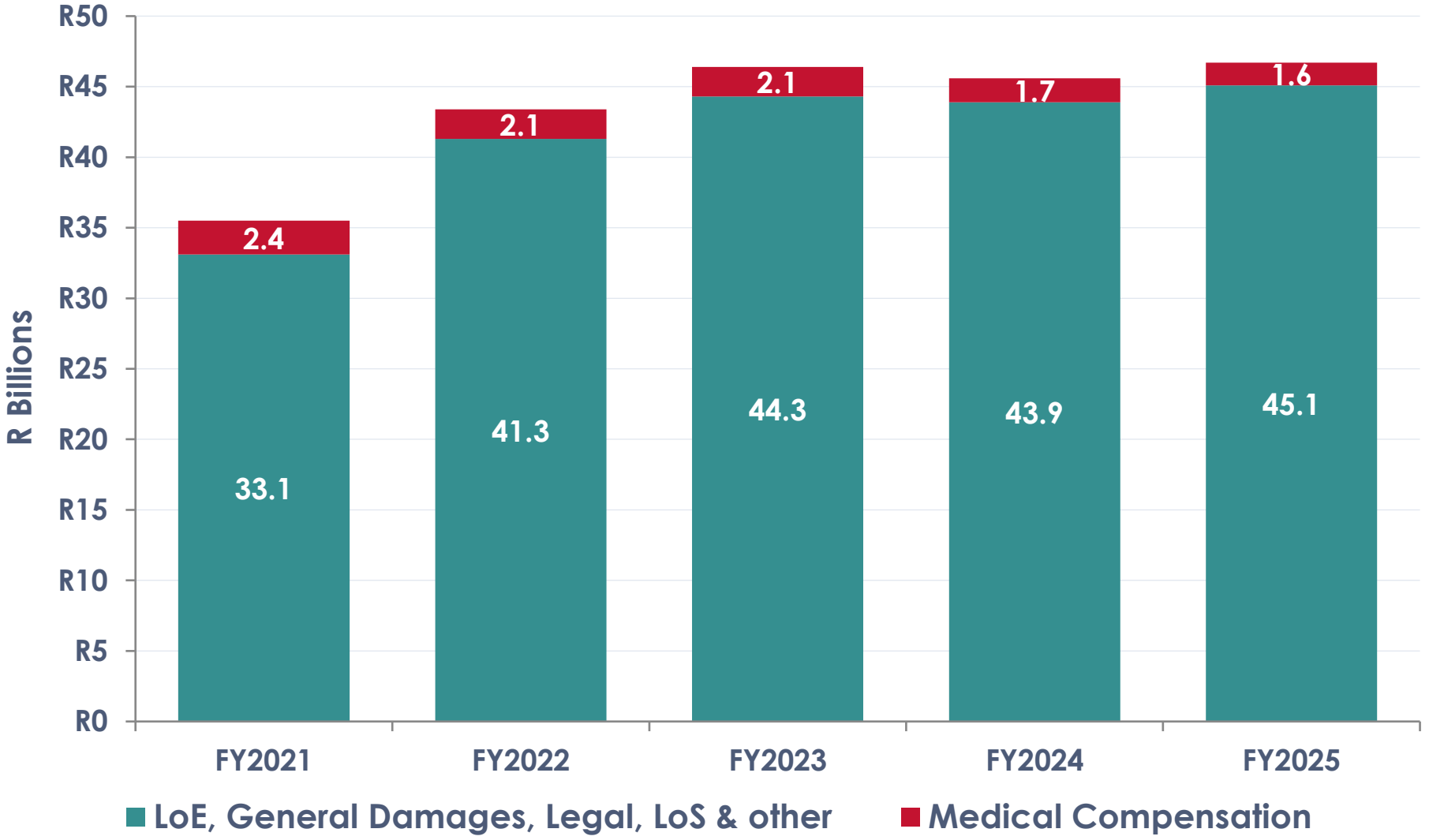
AWAITING JUDGMENT: Discovery Health (Pty) Ltd v Road Accident Fund and Chief Executive Officer of the Road Accident Fund: Collins Phutjhane Letsoalo (372/2025)
(heard by the Supreme Court of Appeal on 16 February 2026)

HOW IT WORKED IN PRACTICE

Principle of subrogation (scheme steps into the member's shoes)

DISCOVERY: Once the scheme pays, it is entitled to be reimbursed when the RAF settles. Discovery's scheme rules require members to repay the scheme from RAF proceeds. **RAF:** RAF is not an insurer; neither is a medical scheme. The subrogation principle (requiring insurer status on both sides) cannot apply to compel RAF repayment to schemes.

RAF TOTAL vs MEDICAL COMPENSATION



FUTURE MEDICAL EXPENSES UNDERTAKING & COVERAGE

What is the Section 17(4)(a) Undertaking?

- A written promise by the RAF to reimburse a claimant for all future costs of hospital or nursing-home accommodation, treatment, services and goods arising from their accident injuries – for the remainder of the claimant's life.
- Payment is made after costs are incurred, on submission of proof. The RAF CEO has issued a blanket election: courts may take judicial notice that the RAF will issue such an undertaking in every valid claim.

What is Covered

- Hospital, nursing-home and rehabilitation accommodation.
- All treatment, surgery and specialist services.
- Prosthetics, wheelchairs, orthotics, assistive devices.
- Vehicle modifications and home adaptations.
- Reasonable domestic assistance where injury requires it.

FUTURE MEDICAL EXPENSES PROCESS & ACCESS TO CARE

How It Works: 5-Step Process

1. Claim lodged – liability established.
2. RAF tenders undertaking (or court orders it).
3. Claimant incurs treatment cost and pays provider.
4. Claimant submits proof of payment to RAF.
5. RAF reimburses (uncertainty around tariffs).

Access to Care Concerns

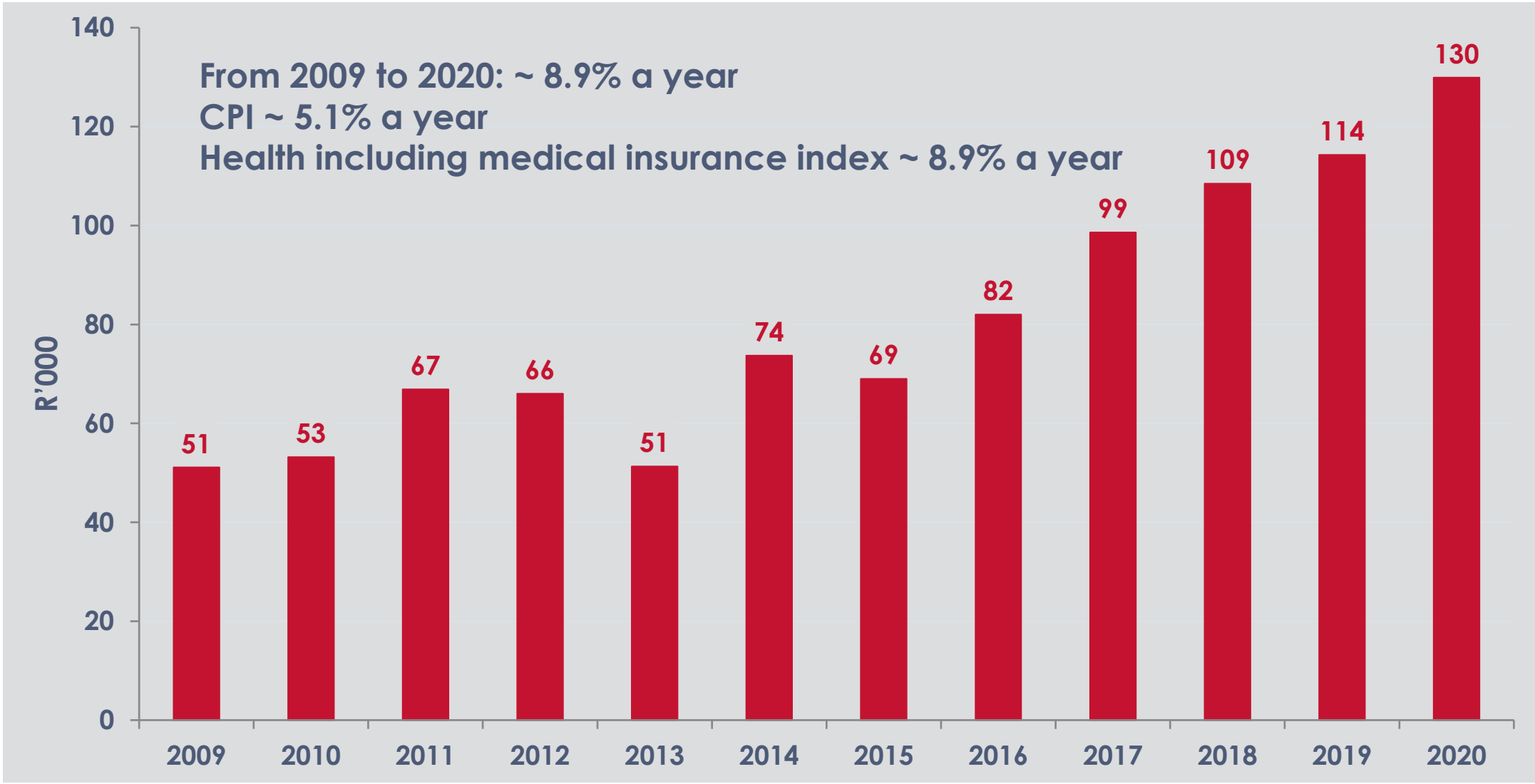
- Reimbursement model: claimant must fund care first.
- Uninsured claimants effectively restricted to public facilities.
- RAF frequently delays payment – courts award interest at the prescribed rate of interest.
- No prescription period: new invoices can be submitted indefinitely under a valid undertaking.

UNDERTAKINGS DEVELOPMENT

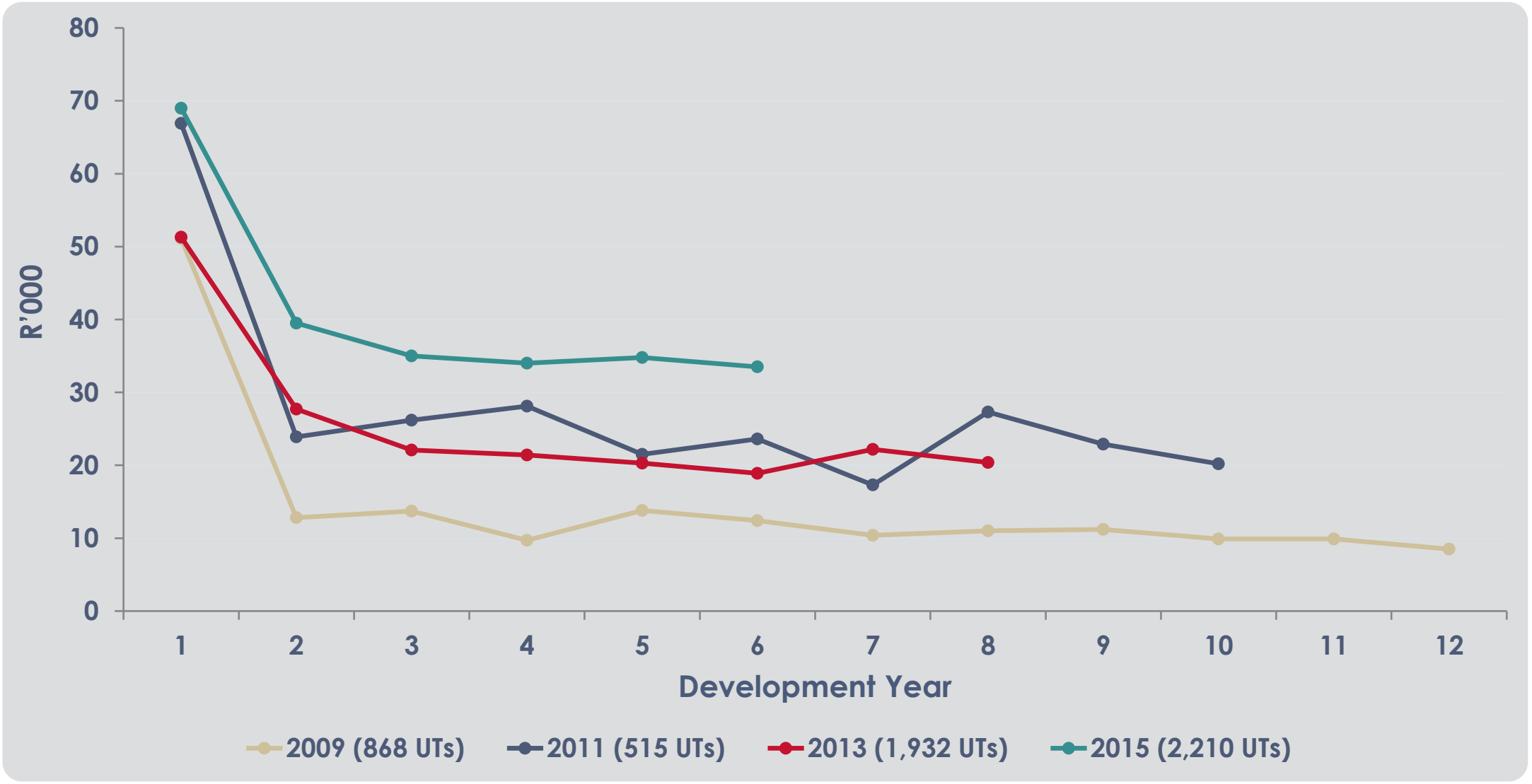
==========Average costs per annum (R'000) by development year==========

Year	No. of UTs	1	2	3	4	5	6	7	8	9	10	11	12
2009	868	51.1	12.8	13.7	9.7	13.8	12.4	10.4	11.0	11.2	9.9	9.9	8.5
2010	746	53.2	22.1	21.8	21.1	23.5	17.9	17.3	19.3	19.2	17.2	17.1	
2011	515	66.9	23.9	26.2	28.1	21.5	23.6	17.3	27.3	22.9	20.2		
2012	1,003	66.0	30.7	26.0	21.7	25.2	27.7	24.6	25.2	21.6			
2013	1,932	51.3	27.7	22.1	21.4	20.3	18.9	22.2	20.4				
2014	1,887	73.7	41.7	28.6	27.4	26.8	28.0	28.4					
2015	2,210	69.0	39.5	35.0	34.0	34.8	33.5						
2016	2,012	82.0	49.5	39.0	40.3	37.5							
2017	2,149	98.6	60.9	48.8	45.1								
2018	1,847	108.5	70.3	49.1									
2019	2,110	114.3	66.4										
2020	1,919	129.9											

YEAR 1 AVERAGE COST TREND



COSTS DECLINE OVER DEVELOPMENT YEARS



SOME REASONS FOR THE DECLINE

Injury and clinical factors

1. Most injuries are temporary, not permanent.
2. Surgery, hospitalization, physiotherapy, and specialist consultations are typically front-loaded. Ongoing treatment in later years is limited to follow-up and chronic cases, which is a small subset of claims.
3. Permanent disability (>30% rating) is relatively rare. The bulk of undertakings involve lower-severity injuries, driving rapid natural cost runoff.

International experience

1. The declining cost pattern is a well-established actuarial phenomenon. For example, workers' compensation databases show losses developing downward after the initial accident year across all industries.
2. International experience confirms that only complex claims (spinal injuries, severe burns) sustain elevated multi-year costs. Simple injury cohorts run off rapidly, consistent with the RAF data.

RAF UNDERTAKING vs ONCE-AND-FOR-ALL RULE

RAF Section 17(4)(a) Undertaking

Basis

Parliament deliberately departed from the once-and-for-all rule and created a lifetime reimbursement mechanism specific to motor accident claims.

Payment Structure

Periodic reimbursement: costs incurred → proof submitted → RAF reimburses (tariff uncertainty). No upfront capital sum for future care.

Finality

Open-ended by design. Undertaking runs for the claimant's lifetime. New invoices may be submitted indefinitely as treatment needs arise.

Claimant Risk

Claimant bears cash-flow risk (pay first, claim back) and potential tariff shortfalls.

Provider Choice

Theoretically free – but private specialist care effectively unaffordable for uninsured claimants without a medical aid.

Once-and-for-All Lump Sum

Basis

Settled common law rule: all damages – past and future – from a single cause of action must be claimed once and awarded as a single monetary sum.

Payment Structure

Full actuarially discounted **lump sum** paid upfront at private-sector rates, covering estimated lifetime care costs. Often administered through a trust.

Finality

Total and permanent. Once the order is paid, no further claim may be brought on that cause of action – even if actual future costs exceed the estimate.

Claimant Risk

Defendant pays once. Claimant bears investment and longevity risk. If care costs exceed the actuarial estimate there is no recourse against the wrongdoer.

Provider Choice

Full freedom. Capital in hand immediately – claimant selects provider and controls timing. SCA upheld the right to dignity and choice of provider (Schippers JA).

TN obo BN v MEC FOR HEALTH, EASTERN CAPE (11/02/2026)

Background

- A child born with spastic quadriplegic CP at Cecilia Makiwane Hospital sued for R23 million in damages. The Eastern Cape MEC conceded liability but argued that instead of paying a lump sum, the state could provide future care at its public hospitals.
- The Bhisho HC upheld this "public healthcare remedy" as a justified incremental development of the common law under s 39(2) of the Constitution.

Supreme Court of Appeal rejects the Public Healthcare Remedy

- Judicial replacement of the lump sum rule is not incremental development, it is radical restructuring of the law of damages.
- Reform involves health policy, public finance, equality and dignity – these are legislative, not judicial, questions.
- Courts are ill-equipped for such systemic reform: single-case vehicle cannot accommodate the full range of policy consequences.
- Right to dignity: child left dependent on the very institution whose negligence caused the harm.

POLICY IMPLICATIONS

Fiscal Context

- EC contingent liability: R22.15 billion (2024/25)
- EC paid R3.46 billion in settlements (2014–2021) – all from unbudgeted funds, classified as unauthorised expenditure.
- EC paid R630 million in 2024/25 financial year alone – approx. 2% of its total health budget.

The Legislative Gap

- The State Liability Amendment Bill (periodic payments + public-sector treatment) was first introduced in 2018. It has never been passed. The SCA has now firmly returned the reform mandate to Parliament.

Current Status

- EC has applied for leave to appeal to the Constitutional Court. Once leave to appeal is filed, the SCA order is suspended and lump-sum payments do not immediately resume.

RABS: MEDICAL AND REHABILITATION BENEFITS

Basis of Liability

- No-fault – benefits paid regardless of who caused the accident.
- Guilty driver and innocent victim receive identical structured benefits.

Medical Expenses

- Defined schedule of benefits; payments made directly to contracted providers.
- Administrator approves a treatment and rehabilitation plan before directing provider.
- No lump sum – all benefits paid periodically.

Rehabilitation

- PRIMARY objective – vocational rehabilitation to return victim to employment.
- Benefits cease on return to work; dependent on NHI infrastructure being operational.
- Flaw: insufficient rehabilitation centres & high disability unemployment rate.

Access to Courts

- Abolished – internal appeal only, then High Court review; no cost recovery for claimant.

COMPULSORY THIRD PARTY INSURANCE (CTPI)

Operation

- Private insurer model – vehicles registered annually pay premium to licensed insurer (could be collected with licence disc or via fuel levy).
- Premium funds a private insurer who is licensed to write CTPI business.
- On a road accident claim, injured party claims against the at-fault driver's CTPI insurer.
- Uninsured or unidentified vehicles covered by a state backstop.

Medical coverage

- Insurer pays necessary and reasonable medical and hospital costs directly.
- Rates negotiated between insurer and provider – private market rates, not a statutory tariff.
- Covers emergency, acute care, surgery, rehabilitation, specialist treatment, assistive devices.
- Private-sector billing rates apply; providers have strong incentive to accept.

KEY SHIFTS OF CTPI vs RAF

Funding model

- RAF: fuel levy tax (universal but fiscus-dependent, deficit-prone).
- CTPI: risk-based premium per vehicle (actuarially priced; insurer bears underwriting risk).

Tariff & provider access

- RAF: access gap for uninsured.
- CTPI: market rates – full private-sector access; no tariff barrier between victim and provider.

Competition & efficiency

- Insurers compete on price, service and claims turnaround.
- Professional fees estimated to fall sharply.
- No state administrative bureaucracy; claims handled commercially.

Fault basis

- CTPI is fault-based like RAF – negligence must still be proved.
- Guilty driver and innocent victim do not receive the same benefit (corrects the RABS anomaly).

CTPI SOUTH AFRICA-SPECIFIC CHALLENGES

Uninsured vehicle problem

- ~60%-70% of SA vehicles currently carry no insurance.
- CTPI requires enforcement at licence renewal – capacity is a real constraint.
- Nominal Defendant backstop must be capitalised for hit-and-run & uninsured claims.

Affordability & equity

- Risk-based premium burdens poorer, higher-risk vehicles disproportionately.
- Low-income motorists may simply not register – increasing uninsured pool.
- RAF fuel levy is invisible and universal; CTPI premium is visible and resistible.

Historical note

- SA had compulsory motor insurance from 1946–1997.
- Switch to fuel-levy RAF in 1997 was driven by enforcement failure and insurer insolvencies.
- Finance Minister Mboweni raised CTPI reintroduction in 2020 Budget Speech – not progressed.

IN CLOSING

01 REAL-WORLD

Behind every tariff gap and undertaking is an injured claimant choosing between under-resourced public care and unaffordable private care – a daily healthcare decision.

Dignity and provider choice are the test of any reform.

02 REGULATION

Courts cannot rewrite the compensation framework.

Reform must come from Parliament.

03 RISK

Lump-sum awards against the state have become a fiscal risk to healthcare itself.

Damages erode health budgets.

REFERENCES

TOWARDS A REASONABLE, AFFORDABLE, EQUITABLE, AND SUSTAINABLE ROAD ACCIDENT COMPENSATION SYSTEM

By GA Whittaker, DF Rodda, JG Schwalb