Non-compliant health record-keeping in South Africa: Judicial responses, and progress towards a digital remedy

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Abstract
Numerous South African public health facilities fail to meet their record-keeping obligations as required by law. One of the impacts of this non-compliant medical record-keeping is, as this study found, the undermining of medical negligence claims. The study reviewed numerous South African medical negligence court cases in which an absence of comprehensive, reliable patient records was central to the court's judgment. The research also examined progress towards, and challenges facing, the South African government's efforts to improve medical record-keeping through implementation of a national, digital Health Patient Registration System (HPRS) comprising online electronic medical records (EMRs) linked to unique personal identifiers. Based on the study findings, this article concludes with a call for the South African courts to take steps to compel the state, and public health facilities, to meet the record-keeping requirements contained in the country's applicable legal-regulatory and policy instruments.

Keywords
health care, records, medical negligence claims, court proceedings, judicial decisions, electronic medical records (EMRs), Health Patient Registration System (HPRS), South Africa

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1. Introduction

Proper health record management is an intrinsic aspect of quality health care delivery. Numerous stakeholders and scholars have identified shortcomings in record-keeping by South Africa's public health entities (Malakoane et al., 2020; Marutha & Ngulube, 2012). These shortcomings have numerous potential negative consequences for health care delivery. One such consequence, which is the focus of this study, is that medical negligence claims cannot be accurately assessed in the absence of reliable records. In 2021, the South African Law Reform Commission (SALRC) published a Discussion Paper entitled *Medico-Legal Claims*, which explored "the challenges faced by the public health sector due to the escalation in claims for damages based on medical negligence, the increasing financial implications for the fiscus, and medical negligence case law" (SALRC, 2021, p. 1). This SALRC paper pointed to record-keeping as one of the core deficiencies requiring urgent remedy (SALRC, 2021). According to the paper:

> There are problems with record keeping, information management and filing across the board. The importance of good record-keeping is self-evident, but several respondents [...] and commentators raise concerns about inadequate record keeping at state health establishments […] (SALRC, 2021, p. 165)

This article reports on the findings of my research into South African medical negligence legal cases in which the court's consideration of the facts in question was undermined by lapses in health record management.

In section 2, I set out the methodology followed in conducting the review of the relevant South African case law. In section 3, I set out the South Africa policy and legal-regulatory instruments that require, indirectly or directly, the collection and storage of reliable health records. In section 4, I turn to the heart of the article: the findings regarding South African cases in which the judicial decisions pointed to deficiencies in medical record-keeping. Section 5 then sets out the current state of South Africa's implementation of online electronic medical records (EMRs) via the Health Patient Registration System (HPRS). Section 6 provides conclusions.

2. Methodology

An initial scoping review was conducted to explore the nature and practice of medical negligence litigation in South Africa and to identify the various factors that have led to the marked increase in claims in the country. A further review was conducted to contextualise the effects of increased medico-legal litigation on the South African health care system. Drawing from the literature on the causes and effects of increased

medical negligence claims in South Africa, a systematic case law review was carried out, examining medical negligence claims in South Africa from 1994 to January 2022. The search for relevant cases was primarily conducted in the online repository of the Southern African Legal Information Institute (SAFLII),[1] as well as LexisNexis, Juta, PubMed, EBSCOhost, and Google Scholar (to check for any cases not stored in the SAFLII repository). The SAFLII repository was used as the primary data source largely because it is open access and publicly accessible. The cases found served as the primary data source for analysis and examination to better understand the relevance of poor record management to poor health care delivery and subsequent legal action.

The cases examined were limited to those involving the South African public health system at either the national or the provincial level. This focus on the public health system was based on the findings of the SALRC (2021) paper, which highlighted poor health record management as a particular challenge in the public health system. Furthermore, the various laws and regulations discussed in the paper are interventions to address the challenge of poor record management in the South African public health system. Initially, a total of 1,232 cases considering medical negligence claims against the public health system were found. From this corpus, I selected the cases where a non-biomedical concern was raised—either in support of the claim of negligence, or by the courts in their adjudication. This narrowing of the criteria led to 89 cases being found to be relevant. Among these cases, 10 were identified in which poor health record management was raised as an issue affecting either the care provided or the ability of the court to properly adjudicate the matter. These cases were subsequently analysed to generate the findings that are set out in this article.

3. South African policy and legal-regulatory instruments relevant to medical records

Constitution, 1996

While the South African Constitution of 1996 does not directly provide for health records, the rights that it enshrines are central to the tenets of health record management (RSA, 1996a). Section 27(1)(a), in the Constitution's Bill of Rights, provides for the right to access health care services, which section 27(2) mandates that the state must provide for by taking "reasonable legislative and other measures, within its available resources, to achieve the progressive realisation" of the right.[2] Here, there is a constitutional stipulation that all "reasonable" and affordable measures must be taken in support of the realisation of South Africans' right of access to health care. The constitutional guarantee of access to information is also relevant. Section 32 of

1 https://www.saflii.org
2 Sect. 27, Constitution, 1996.

the Constitution, also in the Bill of Rights, guarantees the right of everyone to "(a) any information held by the state; and (b) any information that is held by another person and that is required for the exercise or protection of any rights". Also relevant is section 14 of the Constitution, which provides for the right to privacy,[3] which is a central tenet in the management of health records. These provisions make the South African public health system, as an extension of the state, bound by the duty to provide the patient records in its possession on demand, especially when the demand is being made in a bid to facilitate the protection of the rights of the health user, as is the case with a medical negligence claim. The latter is itself guaranteed in section 34 of the Constitution, which protects the right to access the courts to seek legal redress.

White Paper, 1997

The White Paper for the Transformation of the South African Health System, made public by the national Department of Health (DoH) in 1997, provides policy objectives that form the core principles of a unified National Health System (DoH, 1997). Chapter 6 identifies the lack of reliable health information as a major obstacle to the ability to properly plan and deliver health services in the country. It identifies the existence of a fragmented and incompatible health information system as a challenge to the ability to have a coordinated national health information system.[4] Furthermore, it states that the health information systems being used are largely uncoordinated and not sufficiently comprehensive.

The challenge of lack of ease of use is attributed to the predominance of manual, paper-based data collection and storage. The inadequate computerisation of data collection, collation, and storage is pointed to as a limitation to be addressed. Accordingly, a key goal established by the White Paper is the development of a comprehensive National Health Information System.[5] The White Paper states that, in order to create and consolidate this system, there needs to be significant improvement in the management of health facility records.[6] The White Paper proposes that the system should be nationally coordinated, with an overall parent system that is user-friendly, to support the effective delivery of health services at all levels.[7]

National Health Act (NHA), 2003

The National Health Act No. 61 of 2003 (NHA) establishes a framework for the responsibilities and duties of each level of government in the fulfilment of health services for the South African populace. The NHA regulates the interactions and

3 Sect. 14, Constitution, 1996.
4 Chap. 6, White Paper, 1997.
5 Chap. 21, White Paper, 1997.
6 Chap. 21, White Paper, 1997.
7 Chap. 6, White Paper, 1997.

interdependence between health provision at the national, provincial and local levels. With respect to health record management, section 13 of the NHA provides that

> [s]ubject to the National Archives of South Africa Act, 1996 (Act No. 43 of 1996), and the Promotion of Access to Information Act, 2000 (Act No. 2 of 2000), the person in charge of a health establishment *must* ensure that a health record containing such information *as may be prescribed* is created and maintained at that health establishment for every user of health services. (emphasis added)

This section of the NHA places a duty on every South African public health facility to have mechanisms for the creation and storage of patients' health records. On the specifics of how health records are to be maintained at the health facility, section 17(1) states:

> The person in charge of a health establishment in possession of a user's health records must set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept.

Section 17(2) outlines the numerous actions that would constitute breaches of the obligation set out in section 17(1), with conviction for performing such a breach punishable by a fine and/or imprisonment for up to one year. In furtherance of the recognition of the need for a systemic approach to the collation and management of health records, the NHA mandates, in section 74, a coordinated "national health information system", which ought to include health data from across the country:

> (1) The national department must facilitate and co-ordinate the establishment, implementation and maintenance by provincial departments, district health councils, municipalities and the private health sector of health information systems at national, provincial and local levels in order to create a comprehensive national health information system.
> (2) The Minister may, for the purpose of creating, maintaining or adapting databases within the national health information system contemplated in subsection (1), prescribe categories or kinds of data for submission and collection and the manner and format in which and by whom the data must be compiled or collated and must be submitted to the national department.

This must be read in conjunction with section 47 of the Act, which places an obligation on all health facilities to ensure compliance with requirements and standards as they may relate to facilities and services such as "health technology", equipment, and the delivery of health services, which are all relevant to the gathering and storage of patient health records. Section 47(3) mandates the Office of Standards Compliance

and the Inspectorate for Health Establishments to "monitor and enforce compliance with the quality requirements and standards contemplated in subsection (1)".

DHMIS Policy, 2011

The District Health Management Information System (DHMIS) Policy, finalised by the national DoH in 2011, seeks to consolidate the lessons learnt in the implementation of health information systems and to chart a course for addressing challenges that have arisen from their implementation (DoH, 2011). The policy seeks uniformity in the implementation and use of the DHMIS through streamlined processes and unified norms and standards. Citing the DoH's obligations in terms of the NHA, the policy mandates

> establishment, implementation and maintenance of the information systems by provincial departments, district health councils, municipalities and the private health sector at national, provincial and local levels in order to create a comprehensive national health information system.[8]

The policy sets out the requirements for users of the DHMIS at all levels of health care provision in South Africa. The policy mandates the proper collection and management of service delivery data by health facilities as crucial to the DHMIS.[9]

Normative Standards Framework, 2014

The National Health Normative Standards Framework for Interoperability in eHealth, gazetted by the national DoH in 2014, was formulated in accordance with the provisions of section 74(1) and (2) of the NHA (DoH, 2014). The framework prescribes the use of an interoperable patient information system (PIS), and mandates sufficient budgetary allocation to ensure the creation and maintenance of a foundational national eHealth infrastructure that enables secure health information exchange and shared clinical repositories.[10]

Standard Operating Procedure, 2016

The Standard Operating Procedure for Filing, Archiving and Disposal of Patient Records, published by the national DoH in 2016, provides guidance to staff of

8 Introduction, DHMIS Policy, 2011.
9 Para. 3.2, DHMIS Policy, 2011.
10 Para. 1(e), Normative Standards Framework, 2014.

primary health care facilities on how to properly and safely store patient records (DoH, 2016). The document states that its primary purposes are

> to give guidance to staff in Primary Health Care facilities on the procedures to follow to ensure that patient records[11] are stored safely and filed in a systematic and orderly manner so that [they] can be retrieved in the most efficient manner possible [and to] give guidance to staff on archiving and disposal of patient records to ensure that there is sufficient space available for filing of patient records.[12]

The document lays out the procedure for ensuring that these records are stored in an orderly and systematic manner that facilitates efficient retrieval. It places responsibility for ensuring that all records are properly kept, with adequate security measures, on provincial health departments.[13] The regulations address the proper procedure for filing patient records (regulation 6), handling patient records (regulation 7), archiving the records (regulation 3), disposing of records (regulation 8), and the proper conditions and requirements for the storage of records (regulation 4).

National Guideline for Patient Records, 2017

Also in 2017, the national DoH released the National Guideline for Filing, Archiving and Disposal of Patient Records in Primary Health Care Facilities (DoH, 2017). The guideline refers to the requirements of the Constitution, the National Archives and Records Service of South Africa Act 43 of 1996, the Promotion of Access to Information Act 2 of 2000 (PAIA), the Protection of Personal Information Act 4 of 2013 (POPIA), and provincial instruments on archives and records. The guideline does not, however, refer to the NHA of 2003.

In setting out the responsibilities of employees in the health system, the guideline envisages the predominant use of physical copies of records, while recognising that an electronic record system may be used "where it is in place".[14] A focus on paper-based record-keeping and storage is found in paragraph 6.1, which specifies the need for "shelves or cabinets that are made of coated metal".[15] However, paragraph 6.4 does provide for both physical and electronic records, with the electronic records to be saved and backed up based on the stipulations of the software application being used.[16]

11 The Standard Operating Procedure uses "patient records" as the operative term—different from the NHA, which refers to "health records".
12 Introduction, Standard Operating Procedure, 2016.
13 Regulation 3, Standard Operating Procedure, 2016.
14 Para. 5.4, National Guideline for Patient Records, 2017.
15 Para. 6.1, National Guideline for Patient Records, 2017.
16 Para. 6.4, National Guideline for Patient Records, 2017.

Norms and Standards Regulations, 2018

In accordance with section 90(1A) of the NHA, the national DoH gazetted the Norms and Standards Regulations Applicable to Different Categories of Health Establishments in 2018 (DoH, 2018). Regulation 6 requires health establishments to have accurate records for health system users, and to ensure that these records are adequately protected and managed, and kept confidential, in accordance with the provisions of the NHA.[17] The health records to be maintained must also include all relevant biographical data of the health user, together with all relevant information related to their examination and health interventions. In terms of the regulations, patient health records must always be secure.[18]

National Digital Health Strategy, 2019

Published by the national DoH in 2019, the National Digital Health Strategy for South Africa 2019–2024 builds on the eHealth Strategy of 2012 (DoH, 2012) and includes, as one of its nine strategic goals, the use of a unique identifier linked to an EMR, accessible across all levels of the health system, for each patient using the system (DoH, 2019). The strategy sets the goal of establishing, by the end of 2024, the necessary integrated information architecture, via the aforementioned HPRS, for a robust and integrated electronic health record system. The HPRS is, in turn, central to the national government's efforts to establish a National Health Insurance (NHI) system.[19]

HPCSA Guidelines, 2022

The Health Professions Council of South Africa (HPCSA) Guidelines on the Keeping of Patient Records, which were revised in 2022, set out the best practices for the collection and management of health records (HPCSA, 2022). In February 2023, the body reiterated the importance of proper health record management and the ethical principles and professional conduct expected in their management. The Council noted, in its 2020/21 Annual Report, that "a concerning number of complaints lodged against practitioners were related to medical records" (HPCSA, 2023).The guidelines specify that accurate record-keeping is required in instances of, inter alia, litigation and orders of the court.[20]

4. Judicial decisions pointing to lapses in health record management

Despite the various laws and regulations discussed above, which dictate how health records are to be maintained, various court cases have demonstrated instances where public health facilities have failed to meet their obligations. These failures, and the

17 Sect. 6, Norms and Standards Regulations, 2018.
18 Sect. 6(1C), Norms and Standards Regulations, 2018.
19 Executive Summary, National Digital Health Strategy, 2019.
20 Para. 9.3, HPCSA Guidelines, 2022.

effects of these failures on healthcare delivery and health system accountability, are discussed below by examining the judicial decisions resulting from the court cases in question.

In *Mbola obo M v Member of the Executive Council for Health, Eastern Cape*,[21] an integral issue in the patient's claim required support from medical records. In the absence of those records, the plaintiff remained adamant, and the veracity of her claims had to be tested on trial during cross-examination. While the defendant tried to use the absence of records as proof that the plaintiff was in fact never at the medical facility, the court noted, in its 2018 judgment, that there were lapses in the record management process and that, in fact, "several stop gaps to preventing wrong information from being recorded were missed due to human error and not following due process".[22] As noted by the court:

> It further emerged whilst she [the plaintiff] was being cross examined that the entries on the referral book and the Road to Health Card did not match. According to her it did often happen, in an emergency situation such as the observation of jaundice symptoms, to forthwith make a referral without insisting on the production of the Road to Health Card or the noting of a clinic attendance.[23]

Here, the importance of medical records in establishing the sequence of events that occurred and the facts of the case became apparent. A similar conclusion was drawn by the court in the case of *M obo M v Member of the Executive Council for Health of the Gauteng Provincial Government*.[24] In this case, the medical experts called to examine the facts of the case and to determine the merits of the claim of medical negligence refused to make pronouncements because of the absence of hospital records. The court observed, in its 2018 judgment on the case, as follows:

> The [HPCSA] guidelines […] emphasise the importance and crucial nature of patients' records, in particular in the case of minor children, such as occurred in the present matter. […] Indeed, several of the expert witnesses involved in this matter have expressed utter frustration of not having available the hospital records, and therefore not being able to assist the court. In my view, the frustration was well-grounded, particularly where no acceptable and plausible explanation was advanced for the absence of such records.[25]

21 (4521/18) [2018] ZAECMHC 67 (6 December 2018).
22 Para. 23, *Mbola obo M v Member of the Executive Council for Health, Eastern Cape*.
23 Para. 24, *Mbola obo M v Member of the Executive Council for Health, Eastern Cape*.
24 (2014/32504) [2018] ZAGPJHC 77 (20 April 2018).
25 Para. 42, *M obo M v Member of the Executive Council for Health of the Gauteng Provincial Government*.

It its judgment, the court pointed out that the obligation to provide quality health care also includes the duty to "create, maintain, keep and store her medical records"[26] and that their absence unwittingly makes adjudication unduly difficult.[27]

When the necessary medical records are not present, it will often be necessary to rely heavily on the statement of the plaintiff, as occurred in the case of *NN obo ZN v MEC for Health, Eastern Cape Province*.[28] As the court noted in its 2017 judgment on the case:

> The plaintiff was not subjected to any meaningful cross-examination. The reason for this is not far to seek: there was [a] paucity of records from which the monitoring of the birth process could be gleaned. Not even the version suggested in the plea was put to the plaintiff. It became clear, at this stage of the trial, that the defendant would no longer persist in its contention that the treatment meted out to the plaintiff and her baby had not been negligent. This is evidenced by the following interaction between the Court and the defendant's counsel:
> […]
> "MR DUKADA: No, the question, M'Lord, relates to whether she's able to recall what assessment were done.
> COURT: And you've got a version in relation to that?
> MR DUKADA: The version is simple, there's no version because of the records, M'Lord. That is the problem. We don't have the records."[29]

The importance of health records was re-emphasised later in the same judgment, where the court noted the following statement by the defence counsel when asked if the absence of medical records disadvantaged the defence arguments:

> It does because we don't know what happened. For example, we don't know if the m[other] took [the] baby home and came back, if there was infection, if there were seizures, if there was hypoglycaemia we don't know what happened to bring that child back again. And that's where the disadvantage is for us.[30]

26 Para. 40, *M obo M v Member of the Executive Council for Health of the Gauteng Provincial Government*.
27 Para. 40, *M obo M v Member of the Executive Council for Health of the Gauteng Provincial Government*.
28 (CA 470/2017) [2020] ZAECBHC 14 (17 June 2020).
29 Para. 12, *NN obo ZN v MEC for Health, Eastern Cape Province*.
30 Para. 22, *NN obo ZN v MEC for Health, Eastern Cape Province*.

Accordingly, the court found as follows:

> […] [C]ounsel for the defendant, quite correctly so in my view, conceded that the absence of records demonstrative of appropriate care meted out by the relevant hospital employees to Z, rendered the case hard to defend.[31]

In the case of *Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal*,[32] the court noted, in its 2016 decision, that the failure to properly collate and store health records could, in terms of the NHA, result in criminal charges:

> In terms of ss 13 and 17 of the National Health Act 61 of 2003 the defendant's employees have a statutory duty to preserve and protect such hospital and medical records. *Failure to do so opens the defendant's employees to criminal prosecution* and liable on conviction to a fine or to imprisonment for a period not exceeding one year or to both such fine and imprisonment.[33] (emphasis added)

The court further specified that the duty to keep proper health records also includes prohibiting the alteration of records, except where an alteration that is made is adequately specified and justified in the record. As noted by the court:

> Errors may be corrected but the date of the change must be entered, and the correction signed in full. The original record must remain intact and fully legible. Additional entries at a later date must be dated and signed in full. The guidelines[34] also provide for the retention of health records, which must be stored in a safe place and if stored electronically then safeguarded by passwords.[35]

Nevertheless, in this case, the core issue addressed by the court was the complete lack of the provision of records by both the defendant and the health care facility where the plaintiff received care. In this case, the only records that could be referenced by both parties were those provided by the plaintiff from her own personal records. The court noted with dismay the defendant's failure to produce the necessary records: "How else does one begin to fix the recurring and costly problem of missing records if one cannot unravel why they are missing or unavailable?"[36]

31 Para. 24, *NN obo Z v MEC for Health, Eastern Cape Province*.
32 (14275/2014) [2016] ZAKZPHC 27 (14 March 2016).
33 Para. 10, *Madida obo SSM v MEC for Health for the Province of KwaZulu-Natal*.
34 HPCSA Guidelines of 2008.
35 Para. 11, *Madida obo SSM v MEC for Health for the Province of KwaZulu-Natal*.
36 Para. 13, *Madida obo SSM v MEC for Health for the Province of KwaZulu-Natal*.

In *AD obo KLO v MEC for Health for the Province of KwaZulu-Natal*,[37] the court drew attention to the recurring problem, in KwaZulu-Natal Province, of incomplete medical record-keeping:

> [I]t 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 crucial stage of the labour of plaintiffs.[38]

In another KZN Province case, *PS obo AH v MEC for Health for the Province of KwaZulu-Natal*,[39] the court noted with disapproval, in its 2017 judgment, as follows:

> 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, the experts were left to draw their own conclusions because none of the defendant's staff who were involved in the activities which the documents purport to record was called either to give an account of what happened (if the witness had any recollection of it), or to explain the record keeping and what conclusions ought to be drawn from some of the entries which could have done with explanation.[40]
> […]
> At the end of the trial, the hospital file relating to this matter was miraculously found. There is still no clear explanation for all of this.[41]

In *Khoza v Member of the Executive Council for Health and Social Development of the Gauteng Provincial Government*,[42] it was found that health records had been altered. In its 2015 judgment, the court expressed a fear that the alterations were the result of a deliberate attempt to falsify the records. As noted by the court in this case, the inability to ascertain the intent behind the alteration of the records was primarily due to the poor handling of the records, which the court noted was common at the health facility that provided care to the plaintiff. In another case involving the same health facility, *Ntsele v MEC for Health, Gauteng Provincial Government*,[43] the court noted that all clinic notes and files involving the patient had gone missing with no

37 (8700/2013) [2019] ZAKZPHC 13 (13 March 2019).
38 Para. 18, *AD obo KLO v MEC for Health for the Province of KwaZulu-Natal*.
39 (14197/2014) [2017] ZAKZPHC 37 (24 August 2017).
40 Para. 10, *PS obo AH v MEC for Health for the Province of KwaZulu-Natal*.
41 Para. 27, *PS obo AH v MEC for Health for the Province of KwaZulu-Natal*.
42 (2012/20087) [2015] ZAGPJHC 15; 2015 (3) SA 266 (GJ); [2015] 2 All SA 598 (GJ) (6 February 2015).
43 (2009/52394) [2012] ZAGPJHC 208; [2013] 2 All SA 356 (GSJ) (24 October 2012).

explanation offered. In *Ntsele* the court pointed to a pattern of lack of accountability by the health system and its officers, even when there had been a demonstrable lapse in the execution of their duties, particularly with regard to record-keeping. The court stated as follows:

> The custodians of the clinic and hospital records were not called to explain the reason why these records are missing or lost. No explanation or reason was proffered regarding the attempts made if any, of finding or recovering the missing or lost records.[44]

In *Madida obo M v MEC for Health for the Province of Kwa-Zulu Natal*,[45] the court noted that instances of poor health record management were sufficiently common as to warrant systemic remedial intervention.

In all the cases examined above, the failure to properly keep health records led to the court taking judicial notice of the systemic failure, and also buttressed the legal claims of the patients against the public health system. In all these cases, entities of the public health system were found guilty of medical negligence and ordered to pay damages.

5. South African progress towards a national EMR system

In the SALRC Discussion Paper of 2021 that was cited earlier in this article, one of the Commission's core proposals, titled "Record keeping", included the following specified requirements (2021, p. 351):

> 4) Proper system of record keeping supported by a state-owned information technology system. The same system and technology should be used in all provinces and the national department.
> 5) Reporting system supported by the same system and technology to enable data sharing and a centralised data base. The information to be reported and the manner of reporting should be determined at national level and the guidelines should be followed by all provinces.

As seen above in section 3 of this article, in the review of South African policy and legal-regulatory instruments relevant to medical records, the core South African national government strategy—implementation of a national, universal EMR system via the HPRS—is in line with the record-keeping remedy that the SALRC proposes. However, the roll-out of the EMR and the HPRS faces numerous challenges. At present, in mid-2024, the HPRS is in varying stages of development across the nine

44 Para. 117, *Ntsele v MEC for Health, Gauteng Provincial Government*.
45 (14275/2014) [2016] ZAKZPHC 27 (14 March 2016).

provinces. In a September 2023 written reply from the Minister of Health to an MP's question in the National Assembly, it was stated that "a fully-fledged EMR will take approximately 5 years",[46] i.e., it will only be completed in about 2028—significantly later than the 2024 deadline set by the National Digital Health Strategy published in 2019.

Numerous studies make the case for EMRs (Ayaad et al., 2019; Lin et al., 2019). It has been found that paper-based health records are insufficient for meeting the requirements of high-quality documentation and communication (Yu et al., 2013). Successful EMR interventions have been found to enable easier access to information, improved decision-making, and more rapid delivery of health care services (Makeleni & Cilliers, 2021). Among other things, EMRs, when properly maintained, are able to highlight issues that may be missed when relying upon paper records—especially if those paper records are held at a health facility different from the one where a patient is seeking care (Makeleni & Cilliers, 2021).

Critical work has been done that makes the case for EMR interventions as viable and necessary in the South African context (Katurura & Cilliers, 2018), while also seeking to understand the challenges to their uptake (Popela et al., 2019). It is clear that the successful implementation of EMRs in public health systems requires strong government funding and leadership (Ohuabunwa et al., 2016). Studies such as that of Makeleni and Cilliers (2021) have evaluated EMR implementation in specific South African public health facilities where EMRs have been piloted and/or fully built into operations. The study found that more than a quarter of the South African EMR systems in operation were stand-alone applications that could not share information with other systems (Makeleni & Cilliers, 2021). EMR interoperability, allowing for a smooth process of information-sharing across provinces and medical facilities, was thus still considerably limited.

As several health systems scholars have pointed out, the success of EMR interventions is greatly dependent upon the existing organisational culture (Munir & Kay, 2003; Sood et al., 2008). Additionally, there are, of course, significant challenges in uptake when health workers are overworked, underpaid, and serving in under-resourced and under-staffed public health facilities. Such workers will naturally be resistant to any new system perceived as cumbersome and adding complications to their already difficult jobs. As Saleem et al. (2011) explain, when an electronic medical management system does not fully match the needs of health care workers, "paper workarounds" tend to emerge. A 2016 study conducted at South Africa's Khayelitsha Hospital in greater Cape Town found that, despite the hospital's incorporation of a

46 Question 2575, Internal Question Paper No. 27 (1 September 2023). https://pmg.org.za/files/RNW2575-230922.docx

n EMR system, 15% of the records for trauma cases were missing or incomplete, with some missing information on vital signs, and many not recording the patients' time of arrival (Ohuabunwa et al., 2016). Such findings highlight the fact that EMR systems are not, on their own, a remedy for problems in health record management. The means to ensure compliance and accountability are also required.

6. Conclusions

Democratic South Africa has been the site of numerous instances of judicial intervention in support of health rights and the measures necessary to actualise such rights (Heywood, 2009). Accordingly, with respect to the management of health records, the South African courts must once again show the required judicial courage, and maximise their constitutionally granted powers in respect of socioeconomic rights (Bilchitz, 2003). The courts must hold the state and its health system accountable for delivery on the record-keeping provisions in the legal-regulatory and policy instruments set out in this article.

Such action by the courts would be in line with the school of thought that posits that the act of a court compelling state action is not inherently wrong in and of itself. What is of consequence is the nature of the remedies that the court feels entitled to make and is able to enforce (Wiles, 2006). Flowing from this, rather than compelling specific actions that are best left to the state's administrative powers, the judiciary should act as an arbiter of accountability, holding the state accountable for the interventions that it has committed to making, and the timelines that it has set. Such an approach would comply with the principles of both progressive realisation and reasonableness—the two elements of the litmus test for court influence on state action (Wilson & Dugard, 2011).

The task of judicial enforcement of the implementation of proper health record management in the South African public health system is, therefore, two-fold. First, the courts must be willing to enforce the existing legal instruments that penalise the failure to properly store and manage health records. Here, erring health facilities, managers, and/or workers ought to be held to account—for their roles in failing to comply and/or failing to ensure compliance with procedures required by law and/or regulation. Second, the courts ought to hold the state accountable for its own stated goals with respect to the implementation of an interoperable national EMR system in terms of the National Digital Health Strategy published by the national DoH in 2019.

At the same time, government delivery on policy requires the executive branch to make the necessary budgetary allocations, provide clear timelines for action, and adhere to the timelines. The role of the legislature in providing parliamentary oversight is

also important. This critical task is necessary to hold the executive accountable. It is therefore imperative that the South African state, Parliament, and the courts all play their roles in ensuring compliant health record-keeping for the benefit of users of the public health system.

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Data availability
The data supporting the results of this study is available, upon written request, from the author at ookolawole@gmail.com.

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AI was not used in the writing of this article.

Competing interests
The author has no competing interests to declare.

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