Provincial Findings in Preparation for The South African Human Rights Commission Public Enquiry into The Right to Have Access to Health Care Services

Synthesis Report

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Executive Summary

Background

The SAHRC embarked upon provincial assessments in all nine provinces in preparation for a national enquiry into the right to have access to health care. This report provides a synthesis of the findings and main themes emerging from those assessments.

Methodology

Provincial Reviews, comprising a combination of site visits in which observation checklists were completed, and interviews and questionnaires were undertaken by SAHRC staff, took place in all nine provinces. Facility managers were interviewed in all provinces, and staff and patients in most provinces. In KZN discussions took place with community members and in Limpopo visitors were interviewed.

Findings

While the Reviews found varying standards among the facilities visited, with some facilities, including some in deep rural areas, being well managed and maintained, the general impression is of an under-funded system struggling to cope with the demands made upon it. Many managers made reference to budget limitations constraining their plans to improve service delivery and to fill of vacant posts. There is a general sense that while on the whole hospitals are functional, they require improvement. Many facilities are dilapidated, run down and overcrowded, and long queues are common. In addition many facilities believe that their catchment area is too big.

Since 1994 the Health System has undergone radical transformation. The establishment of the three tiers – National, Provincial and District – has been an enormous challenge with staff needing to define, negotiate and internalise their roles and functions at each level. The difficulty of this challenge is highlighted by many comments in the Reviews that refer to poor relationships between provinces and districts and between districts and facilities.

Among the facilities visited, only rarely was there a sense of high staff morale and good management. Comments were made about poor communication, unnecessary bureaucracy, centralised decision making processes, and inadequate training.

There is a general feeling among health workers that staff, especially nursing staff, are underpaid and overworked. Many complain of a lack of adequate facilities and equipment, which in turn impacts on the quality of patient care. Despite staff feeling their profession is a calling, there is a strong sense on their part that more needs to be done by the Department of Health to attract nurses to fill vacancies, and to retain them by offering better remuneration packages, incentives and career advancement opportunities, as well as improved working conditions. There are also indications that health workers, especially nurses, feel undervalued, and that management and society in general does not sufficiently recognise their contribution.

There are many ways in which staff shortages impact on service delivery. These include long waiting times for all aspects of care and to access beds, poor record keeping and stock tracking, and inappropriate behaviour from health workers.

Many institutions in the public sector suffer from inadequate infrastructure, being old and run down, and/or too small. At the extreme, the Reviews identified facilities that have crumbling ceilings or gaping walls. There appears to be an ongoing discrepancy between urban and rural facilities, with the latter more likely to have inadequate infrastructure. Lack of space compromises patients' rights to privacy and many institutions were identified as being too small to cope with the demands upon them.

The introduction of the Hospital Revitalisation Programme is having a significant impact on eligible facilities and where hospital revitalization plans are in place they are making a positive difference.

Cleanliness of facilities, both inside and out varies enormously. There appears to be some correlation between cleanliness and appropriate staff attitudes and other indicators suggesting a link between well managed facilities and general quality and accessibility of care.

The overall impression is that equipment is mostly available. However much equipment tends to be old and in poor working condition and maintenance and replacement of equipment is commonly cited as being problematic. Some facilities manage to access the resources and equipment they need through a process of sharing equipment between facilities.

Pharmacists are in very short supply. This impacts on service delivery and reports of exhaustingly long queues at facility pharmacies are commonplace. As a result there are also frequent reports of pharmacy waiting areas being too small and cramped. Shortage of appropriate administrative equipment and lack of necessary IT skills hampers appropriate stock control sometimes causing stock outs and making theft of medicines easier than it might otherwise be.

Poor physical access is tantamount to a denial of access to health care services. Limited physical access to facilities arising from an absence of public transport, high transport costs and a lack of emergency transport, compounded by unacceptably long waiting times were widely reported. Although most patients indicated that they did not pay fees to visit a clinic or hospital, and that medication was mostly free of charge, the cost of transport was a major prohibitive factor in accessing their health entitlements. There is generally a feeling that it is difficult for poor and rural communities to access hospitals as a result of long distances and related high transport costs. It appears that the majority of patients are not aware of their rights despite the fact that the patients rights charter and information about Batho Pele are widely displayed in facilities.

There were very few reports of patents' consent not being sought indicating that the great majority of health personnel acknowledge the need to seek consent from their patients and do so appropriately. In every province there are reports of caring staff and well maintained and run facilities. However poor quality of care and inappropriate, often downright callous, attitudes on the part of health workers and administrative staff, are responsible for many complaints. Patients complain of being treated poorly by nursing staff and prefer to be treated by doctors who can get to the problem more quickly.

The majority of patients interviewed across the country responded that services were culturally acceptable to them despite the fact that many hospitals only cater for religious groups on request.

The Reviews shed limited light on issues to do with HIV although the findings as a whole are in themselves indicative of the strain placed upon the health system by the burden of HIV and AIDS. Waiting time for ARVs in sites visited varied between there being no waiting list to a four month waiting period. Problems with IDs compound delays. In some facilities there is a lack of counsellors, in others counsellors are available but there is a shortage of space.

Generally facilities for patients with psychiatric illnesses are inadequate and there are long waiting lists. The critical shortage of specialist staff in South Africa profoundly affects psychiatric care. Particular reference was made to a shortage of psychiatrists and to male nurses.

Refugees and asylum seekers experience numerous problems relating to denial of access to public hospitals and clinics, exacerbated by inconsistent application of relevant laws and policies among different facilities.

Recommendations

A number of the provincial reports included recommendations. Tellingly some of the recommendations were as simple as providing water to a particular facility or improving roads. There were calls for more systematic and ongoing monitoring and evaluation of service delivery through regular meaningful site inspections, to prioritise rural areas, and to address the persistent structural inequalities caused by the legacy of apartheid.

Recommendations are also made in the areas of financing, management, staffing, transport, including emergency transport, infrastructure, information and psychiatric services.

Conclusions

The provincial Reviews highlighted a wide range of factors that impact upon access to health for South African citizens. There are a number of areas that the HRC hearings may wish to focus on and interrogate further.

As a result of economic globalisation provision of health care is no longer the jurisdiction of sovereign states alone, and access to health care is constrained and influenced by the broader geopolitical context. International and multilateral trade agreements and treaties, together with multi-national corporate interests define the scope that national governments have to respond to the health needs of their population. In light of the limited public discourse around international treaties and agreements impacting on access to health this is an important area in which to heighten awareness and debate.

It appears that little specific definition has been given to the right to health and there is need to clarify and further define what it means in practice. Linked to this, exploration is required of what health care services need to be in place and available in order to qualify as providing access. Unless there are transparent policies to guide services that will and will not be provided, unequal distribution, constituting a

perverse form of rationing and an unequal application of human rights, will happen by default as is presently the case.

It is unclear as to what are the parameters of *acceptability and quality* of care that are necessary for care to be counted as *accessible*. Further definition needs to be given to this. What does "no-one may be refused emergency medical treatment" mean in the context of people apparently being denied basic health care.

There is an insidious growth in the role played by private health care providers which, in a context of a scarcity of resources, including finances and health personnel, inevitably impacts on access to care for the majority of the population, and this is a phenomenon worthy of further examination from a human rights perspective.

The Reviews recorded high levels of staff dissatisfaction. Consideration of patients rights alone, without attention also being paid to the rights of health workers will be of limited value. There is merit in exploring what efforts to acknowledge and protect health workers needs and rights are likely to impact positively upon delivery of care, and therefore play a beneficial role in improving patients' rights.

Transport, including emergency transport, emerges as a critical factor in enabling access to the right to health. High costs of transport result in differential and inequitable access with the poorest communities being excluded.

The Reviews point to a confrontational approach on the part of western trained health personnel towards traditional medicine. The appropriateness of this approach requires examination in view of limited access to western care.

Abuses in psychiatric institutions and prisons are especially worrying as these groups are in the care of the state. The impact of xenophobia on refugees and asylum seekers is resulting on occasions in a denial of access to health.

The information gleaned from the Reviews seems to be pointing to a 'leadership/hearing vacuum' in which things happen but nobody cares or hears. There is a need to create an independent office or unit – perhaps within the SAHRC - with responsibility for monitoring the progressive realisation of the right to health care.

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> "In so far as we have been able to ascend the height of the monitoring process as well as descending deep into the causes of the failure of realisation of right to health by some of the Hospitals and clinics in the Province, researchers have come to the following conclusion: the monitoring process serves as anti-biotic and the fact that there are some elements within the Health Institutions that are trying to build a resistance against this anti-biotic does not necessarily mean that this kind of treatment ought to be abandoned." (Limpopo Provincial Review)

1. **Background**

The right to health care is an important and critical right, without which other fundamental rights cannot be exercised. As part of the work of its ongoing mandate, the South African Human Rights Commission has a duty, *inter alia*, to monitor the exercise and enjoyment of this right.

Apart from high profile court judgments, reviews and annual surveys that pronounce on the ills of the sector, the SAHRC has received many complaints with regard to poor service delivery in the health care system in all the provinces. These information sources point to the lamentable state of many hospitals in the country, the shortage of trained health care workers, lack of drugs in clinics, long waiting periods for treatment, poor infrastructure, disregard for patients' rights, the shortage of ambulance services and poor hospital management. These factors have compelled the SAHRC to hold public enquiries on the right to access to health care services.

The SAHRC embarked upon provincial assessments in all nine provinces in preparation for the national enquiry. This report provides a synthesis of the findings and main themes emerging from those assessments.

2. Methodology

2.1 Provincial Reviews

Provincial Reviews[1] comprising a combination of site visits in which observation checklists were completed, interviews and questionnaires in all nine provinces.

Facility managers were interviewed in all provinces, and staff and patients in most provinces. In KZN discussions took place with community members and in Limpopo visitors were interviewed. With the exception of one or two provinces a far greater number of hospitals than clinics were visited.

Facility managers were asked about major challenges and major successes and what recommendations they have. Staff were asked about whether they are happy with their working conditions and remuneration, why they chose health as a profession and what would make them happy with their work. Patients were asked about physical and economic accessibility of facilities and about the acceptability and quality of services. In addition, through interviews and observation, information about physical and economic accessibility, staffing, physical infrastructure,

[1] The term Review refers here to the provincial assessments undertaken by SAHRC provincial staff

equipment, pharmacy and drugs, HIV/AIDS/STI and TB services, general quality of care, problem areas, cleanliness, seating, privacy, and health information was recorded for each institution.

Table 1 Sites visited as part of the Provincial Reviews, by Province

Province	Hospitals	Clinics	Specialist[2]	Rural/ Deep rural	Urban /Peri-Urban	Interviewees
Eastern Cape	11	1	1	-	-	M,S, Pat
Free State	6	3	3	-	-	M, Pat
Gauteng	5	4	1	0	10	M, Pat
KwaZulu-Natal	8	2	2	7	5	M,S, Pat, Com
Limpopo	8	1	3	5	7	M, S, Pat, V
Mpumalanga	8 (I tertiary, 2 Regional, 5 District)	2		8	2	M, S, Pat
Northern Cape	4	8 (Including 3 CHCs)		4	8	M, S, Pat
North West	6 (1 Tertiary, 2 Regional, 3 Level 1)	3	1	1	9	M
Western Cape	7 (2 Tertiary, 4 Secondary, 1 Level One)	2	1	4	6	M, Pat
South Africa	57	25	9			

2.2 Synthesis Report

An enormous amount of very valuable information was gleaned by the 9 Provincial Reviews. They provide a great deal of rich insight to many of the significant health systems issues which impact on the right to access to health.

This report draws together the information from the 9 Reviews using the Human Rights approach that informed the structure of the provincial investigations. This framework is based upon four essential principles namely:

a) Availability of goods and services
b) Accessibility
c) Acceptability of goods and services
d) Quality

The findings are presented here according to availability of goods and services including financing, management, health workers, physical infrastructure, equipment and drugs; accessibility of health care services including transport costs, emergency transport, out of pocket payments, waiting times and access to information; acceptability and quality including consent, staff attitudes, cultural acceptability, food quality; and finally specialist services including HIV, AIDs, TB and STI services, psychiatric services and services for prisoners and asylum seekers are then

[2] Psychiatric, Prison or Rehabilitation Centre

assessed. The report then synthesises recommendations of the provincial reviews. The final section reflects on the findings in relation to the coming hearings.

Each section of the report provides a general synthesis followed by examples drawn from provinces. The selected examples reflect **common issues and challenges faced throughout the country and their purpose is to highlight specific issues**, not target a particular institution or province. Where complaints that were included in the provincial reviews are relevant they are included at the beginning of each section to highlight issues raised by health care users.

2. 3 Limitations

It is difficult to ascertain from all the reports exactly who has been interviewed – for example how many patients were respondents - as not all provinces provided that information. The provincial reports were presented in various formats sometimes making comparisons difficult. For example one provincial report comprised only a synthesis of their findings, while some others comprised the completed questionnaires with no synthesis at all. Unfortunately time constraints prohibited standardising the provincial reports and this synthesis draws from the reports in their non-standardised format.

It appears that a greater number of responses (through interviews and questionnaires) were received from health service personnel often quite senior, than from service users, and this inevitably gives a particular slant to the information. For example the Gauteng review indicates that: "Site visits with prior announcement result in showcasing certain departments and wards. Due to size of the hospitals and time constraints it is not possible to visit all departments and sections." Additionally in Gauteng officials of the SAHRC were refused permission to conduct interviews with any staff or patients at clinics. In KZN one hospital manager was considered to be very uncooperative and the Review found that "very often there were discrepancies between what management told us and what we discovered on walkabouts and interviews with ground level health care workers and patients". In KZN managers were mostly reluctant to divulge information. Nonetheless it is apparent from the various provincial reports that bias on the part of managers is balanced by the combination of observation check lists and patient interviews.

Clinics comprise less than 50% of the facilities visited and with the exception of the Northern Cape count for a small percentage of the facilities monitored in each province. Thus the findings shed more light on the state of health care in South Africa's public hospitals than they do on clinics. This is a pity in view of the fact that clinics are the point of entry to the health system for patients and, as is apparent from the provincial findings, often the only level of care that the very poorest families can access.

3. Findings

"The health care system in the Northern Cape still has a long way to be in a normal degree of acceptability. Public hospitals are mostly dilapidated, old and in need to be revamped. The population does not have trust in the public health system. Beneficiaries complain about the unacceptable conduct of health care workers at the different facilities in the province." (Northern Cape Provincial Review)

"Most of the facilities visited in the North West are old and cannot adequately cater for the beneficiaries who need the services the most. The Provincial Government has not built facilities in recent years neither have they revitalised the existing structures." (North West Provincial Review)

3.1 Availability of Health Care - including finance, management, health workers, physical infrastructure, equipment, and drugs

Availability of health care in South Africa is a continuum. At one end care equal to the best in the world is provided, staffed by specialists using the most up to date equipment in glistening facilities. At the other end in poor rural settings clinics without doctors struggle to assist patients in facilities that sometimes have no water, no toilet and few medicines. The contrast are sharpest between the private and the public sectors, but even within the public sector availability can vary quite dramatically.

3.1.1 Financing

The South African Health system comprises the private for profit and not for profit sector as well as the public sector. The private for profit sector consumes the vast majority of health care resources with roughly 60% of health spending utilised for less than 20% of the population. Government contributes to this perverse funding through its medical aid contributions for government employees.

Public sector care is largely financed through the Treasury with a very small percentage of financing coming from user fees. Since 1994 the national Department of Health and the Treasury have attempted to bring greater equity to health financing. Over the years the formerly advantaged provinces of Gauteng and Western Cape have experienced cuts in their budgets, with poorer provinces such as the Eastern Cape and Mpumalanga receiving a greater share. However there remain variations in per capita expenditure between Districts.

While the Reviews found varying standards among the facilities visited, with some facilities, including some in deep rural areas, being well managed and maintained, the general impression is of an **underfunded system** struggling to cope with the demands made upon it. Many managers made reference to budget limitations constraining their plans to improve service delivery and to fill of vacant posts. There is a general sense that while on the whole hospitals are functional, they require improvement. Many facilities are dilapidated, run down and overcrowded, and long queues are common. In addition many facilities believe that their catchment area is too big.

Strides have been made in attempting to strengthen appropriate financing of services through improved planning and budgeting. Municipal Integrated Development Plans which endeavour to build an integrated approach to planning and

link financing to need, include health care. However **historically based budgeting** persists for some facilities.

The **HIV and AIDS pandemic** has profoundly impacted upon the health system. So while there have been increases in funding for the health system, these are quickly absorbed by the health care needs of patients with HIV and AIDS.

Although much progress has been made in establishing the District Health System, the issue of **centralised control** of budgets militates against efficient and creative responses to challenges at the institutional level. This was specifically raised in the North West where managers are unable to make even small decisions.

The Western Cape faces unique problems in that as a historically advantaged province it has had to face and cope with **budget cuts**, especially in relation to tertiary level hospital services. The combination of high bed occupancy rate combined with budget cuts puts pressure on the quality of care.

Also raised as problematic is the combining of the infrastructure and health technology budgets as this has the potential to divert monies intended for revitalisation projects. It was suggested that the revitalisation grant needs to be ring-fenced and used only for revitalisation projects. Similar arguments were made regarding conditional grants, suggesting that these should remain under the control of provincial departments.

3.1.2 Management

Since 1994 the Health System has undergone radical transformation, taking its toll on managers and staff alike with new structural arrangements, policies and protocols needing to be assimilated and implemented. The establishment of the three tiers – National, Provincial and District – has been an enormous challenge with staff needing to define, negotiate and internalise their roles and functions at each level. The difficulty of this challenge is highlighted by many comments in the Reviews that refer to poor relationships between provinces and districts and between districts and facilities.

Among the facilities visited, only rarely was there a sense of high staff morale and good management. Comments were made about poor communication, unnecessary bureaucracy, centralised decision making processes, and inadequate training[3].

Many facility managers complain of their **restricted authority** and how this impacts negatively upon service delivery. In the North West a lack of delegation of HR and financial functions specifically was identified as a problem. In KZN problems are poorly addressed by the health department and sometimes there is no response at all. There was a call to increase delegation of decision making to District and facility managers who currently have to go through the provincial office.

Recruitment and procurement policies are considered to be detrimental to efficient service delivery. Managers report that despite numerous follow-ups with their respective district or provincial offices trying to sort out issues to do with

[3] Management-staff issues are addressed in a subsequent section.

equipment and supplies they seem to get no positive response. In the Northern Cape the lengthy recruitment process was singled out.

In the Eastern Cape a **lack of proper communication** amongst the various levels of the Department was identified, and this was said to impact on the ground, limiting front line health workers' ability to provide quality health care. In the North West, head office was thought not to be in touch with hospital services at ground level, and there are complaints of a lack of consultation on the part of the Provincial office in Mpumalanga. In KZN there is frustration that reporting lines are long and cumbersome with managers having to go through the District office rather than having direct access to head office. There are also concerns that Province takes a long time to address problems.

In Limpopo, **bureaucracy** was identified as a barrier to improving the delivery of healthcare and it is claimed that too much red tape prevents innovative health workers from improving health care delivery.

Inter-sectoral problems also cause strain. In KZN when building work is needed the department of health is dependent upon the department of public works, and progress can take up to 5 years. Inter-sectoral gaps were said to impede maintenance in the Northern Cape. Clinics using municipal buildings have problems getting things fixed as a result of municipalities asserting that maintenance is the responsibility of DoH.

In the Western Cape it was suggested that management of health facilities could be improved but none seemed to be in a crisis. In other provinces reference was made to administrative systems, for example patient records and maintenance, needing to be improved. Indeed a number of facilities identified a shortage of basic equipment such as filing cabinets without which it is impossible to run efficient administrative systems (see 3.1.5 below).

At the systems level, the need to **strengthen the District Health System** was identified by a number of hospitals. The absence of doctors at clinics often results in duplication as patients who are referred by a hospital, get assessed at the PHC level and then referred back to the hospital. Alternatively, as a result of a lack of resources, clinics refer patients that they should be able to treat to a hospital, or patients themselves seek care at a higher level. This user pattern places an additional burden on the already limited space and resources available and results in over-utilisation of hospitals. In addition to pleas for more doctors the need for additional district hospitals to overcome this problem was identified in some provinces.

3.1.3 Health Service Personnel

A new hospital in Calvinia fitted with modern equipment had not been able to perform any operation, not even the removal of tonsils, due to unavailability of qualified nurses to assist at theatre. The report states that there are private doctors available to proceed with operations but there are no qualified nurses at theatre.

A local newspaper article (Diamond Field Advertiser) published an article on the shortage of health professionals in the province. It states that there is a serious challenge of attracting health professionals to rural towns in the Northern Cape. The article related a sad story of a family who have been waiting for a medical certificate to be signed by a qualified medical doctor, after a patient died at the Jan Kempdorp hospital. The department of health is in the process of filling the vacancy at the Jan Kempdorp hospital and securing a resident doctor at the hospital.

A report by another newspaper article (Diamond Field Advertiser) is that a doctor has not been appointed after the previous one resigned his position at Jan Kempdorp hospital. A doctor from Hartswater who also used to work for two hours per day at Jan Kempdorp hospital also resigned. As a result, rape victims cannot be examined, and nurses are left with no choice than to make critical decisions regarding medicine."

Health workers are the lifeblood of the health system. Without sufficient numbers of adequately trained and motivated health workers no health system can fulfil its human rights obligations. The Reviews highlighted numerous issues, problems and challenges to do with health workers.

There is a general feeling among health workers that staff, especially nursing staff, are underpaid and overworked. Many complain of a lack of adequate facilities and equipment, which in turn impacts on the quality of patient care. Despite staff feeling their profession is a calling, there is a strong sense on their part that more needs to be done by the Department of Health to attract nurses to fill vacancies, and to retain them by offering better remuneration packages, incentives and career advancement opportunities, as well as improved working conditions. There are also indications that health workers, especially nurses, feel undervalued, and that management and society in general does not sufficiently recognise their contribution.

There are many ways in which staff shortages impact on service delivery. These include long waiting times for all aspects of care and to access beds, poor record keeping and stock tracking, and inappropriate behaviour from health workers.

Staff Recruitment and Retention

There is an **absolute shortage** of personnel throughout the public health system. This shortage has a negative impact on the quality of care provided, despite the fact that, as was suggested in the Western Cape, the general impression is that "health care workers at all levels are doing much more with much less". One example given is of an 8 bed ICU ward where there are only two staff working at night, only one of whom is trained. In some facilities in KZN "staff have to do more than their share of the work". In all hospitals in Gauteng CEOs indicated that they needed more doctors, pharmacists, nurses, physiotherapists, radiographers as well as porters and other allied workers.

The **vacancy rate** in some hospitals is more than 40 per cent, in itself an indicator of poor service delivery. The Gauteng Review pointed out that it is unfortunate that this state of affairs is considered to be the norm in many institutions. In the words of one health care professional "that is what we've got" ie we have to make do with what is available!

Linked with, and compounding staff shortages are high levels of **staff turnover**. KZN managers highlighted the fact that staff don't stay - they go to hospitals in urban areas - and there is great difficulty in recruiting staff to rural areas. An example was given of posts in an out patients department and theatre that have been vacant since 2004. Generally least affected appear to be tertiary hospitals in Gauteng and the Western Cape which tend to find it easier to attract staff. For example in Gauteng, none of the CEOs and Superintendents of the central hospitals identified programmes that suffered or were not offered at their respective facilities because of staff vacancies.

The **shortage appears to be getting worse**. In Limpopo there is an "ever dwindling number of health professionals due to resignations". Professional nurses are never replaced at all according to one interviewee in Limpopo. The staff shortage leads to a downward spiral in which overburdened staff fall sick and need sick leave, thereby increasing the pressure on those remaining at work.

The absence of doctors at clinics impacts on user patterns. In Gauteng, all CEOs interviewed complained that patients who should first attend primary health care facilities were not in fact doing so, and were opting to obtain the services of doctors at hospitals.

Alongside nurses, **pharmacists** were singled out as being in extremely short supply, with many facilities indicating a shortage of 50% or more. In the Northern Cape, which included a greater percentage of clinics in its Review than other provinces, a shortage of admin clerks was noted.

In KZN a scholarship scheme in which students are recruited locally, funded to attend training and then return to work in the area seems to hold some promise.

Salaries

The acute shortage off nursing staff at all levels is attributed to **low salaries**, the structure of salary scales, poor working conditions and the absence of career – pathing. Salaries, which are uncompetitive with the private sector and with other countries, are a major reason for health worker migration out of the public sector. However in keeping with international research the Reviews found that what would make staff happy with their work included a range of both financial and non-financial incentives, confirming that working conditions play a major role alongside remuneration in job satisfaction.

Staff unhappiness is exacerbated by an absence of **allowances** or inappropriate allowances. In the North West it seems as if rural allowances are available but not scarce skills allowance. In other provinces some professionals working in rural areas seem not to qualify for appropriate allowances. There are also complaints that allowances should be made available for night duty, for being on duty on special holidays such as Christmas and New Year, and for working with patients who are considered to be dangerous (in psychiatric care for example).

Some complaints were made about late payment of rural allowances in Mpumalanga and other staff complained about the late distribution of payslips, sometimes occurring after two months or longer after the pay date.

Non-Financial Incentives

Non-financial incentives comprise a significant component of any staff retention strategy. The Reviews picked up several complaints regarding the application of non-financial incentives. There are complaints about a **lack of career pathing** for nurses and of inadequate opportunities for in-service training. Added to which there are perceptions of unfairness as to who is selected to attend workshops and to go on study leave. Staff shortages also result in study leave forms not being signed.

The lack of proper **educational and other facilities** is an impediment to hospitals located in rural areas attracting skilled and professional personnel. In the North West and KZN **lack of accommodation** for staff was singled out as a problem by a number of facilities.

The **right to work outside the public sector** (RWOPS) was introduced as one means of retaining skilled staff within the public sector. However the presence of skilled specialists at secondary and tertiary care facilities does not necessarily guarantee the expected levels of care for public sector patients since there are widely reported cases of absenteeism of doctors who are working in private facilities under the RWOPS programme. This was a common concern from senior managers in Gauteng who claimed that doctors refused to sign registers and attendance could not be satisfactorily supervised.

Working Conditions

While salaries and other financial and non-financial incentives are commonly understood to be the major push factors for staff leaving the public sector there is a growing body of evidence highlighting the importance of working conditions in the retention of staff. Decrepit and unsuitable buildings, poorly maintained equipment, and lack of drugs and emergency transport (see sections 3.1.4 and 3.2 below) all serve to demoralise and undermine staff.

The shortage of staff in the health system is creating a vicious cycle leading to extremely stressful working conditions as well as unduly high workloads for those remaining, resulting in further staff leaving. Most employees are unhappy with their working conditions and the working environment is often poor and poorly maintained as a result of lack of personnel and equipment. There were reports of staff who look drained and exhausted and this leads to unfriendliness. In the Northern Cape almost all staff interviewed indicated unhappiness with their working conditions. In the Eastern Cape nurses are required to perform non-nursing duties which is discouraging for their morale. In KZN new programmes are put in place with no dedicated staff attached to them, and existing staff have to take them on.

Some hospitals are notable exceptions even though they also suffer from staff shortages. For example in the Western Cape more than one hospital was identified as providing a pleasant working environment or being of a standard equivalent to that in the private sector.

Staff also face dangerous working conditions, as a result of being at risk of infection or of physical harm. In KZN particularly staff were concerned about the risk of exposure to harmful infection including XDR TB. Other staff felt that they were not properly protected when working in a highly acute ward. When they tried to discuss the issue with management they failed.

Finally there is the perception among some staff that efforts have been made to protect the rights of patients, for example the Batho Pele initiative, at their expense.

Management - staff relations

There is evidence that good management has the potential to play a significant role in staff retention and, conversely, that poor management-staff relations exacerbate staff shortages. Comments from staff praising their managers are notable by their absence in the Reviews.

In the North West it was felt that there is inadequate supervision of staff at all levels. In other provinces an unsatisfactory climate was reported in certain hospitals where staff do not feel free to speak, and seem to be afraid of unspecified repercussions.

There are also perceptions of poor management on the part of nurse supervisors who "always see mistakes, no eye for job well done" being one of the reasons for a deterioration in standards. There were calls for management to be more supportive and realistic, and of the need for better leadership and management. Additionally there were reports that the Labour Relations Act is not properly followed regarding holiday and weekend work.

In some institutions there is a breakdown of good labour relations between management and union members. This has led to a poor work ethos and a general sense of malaise, resulting in an unsatisfactory quality of service delivery. NEHAWU is perceived to be very strong and management unwilling to take them on, and as a result, finding it extremely difficult to discipline health care workers. A general lack of discipline and refusal to do work assigned is said to be often ignored by senior managers. A senior surgeon cited examples where pools of blood on a hospital floor were not cleaned up, and when a porter refused to take blood to the operating theatre because he was about to go off duty.

There were also complaints of nurses not being at their stations at all times. At two of the hospitals visited it was noted that senior nurses were unavailable in the afternoon. Once again, no disciplinary measures were taken for fear of Union action. Inadequate HR training was identified by some managers.

Staff Relations

Little information was gleaned about staff relationships although culture and race were identified as causing friction in the Western Cape.

3.1.4 Physical Infrastructure

One of the most obvious differences between private and public facilities is the state of the buildings and equipment. Many institutions in the public sector suffer from inadequate infrastructure, being old and run down, and/or too small. At the extreme,

the Reviews identified facilities that have crumbling ceilings or gaping walls. There appears to be an ongoing discrepancy between urban and rural facilities, with the latter more likely to have inadequate infrastructure. Lack of space compromises patients' rights to privacy and many institutions were identified as being too small to cope with the demands upon them.

Waiting areas and pharmacies are singled out as often being inadequate and too small. This may be a reflection of the unacceptably long queues that are all too common in these parts of facilities.

The need to improve hospital infrastructure has been widely acknowledged and a hospital revitalization programme has been introduced which seems, despite some problems with implementation, to be having the intended outcome.

Infrastructure

In the Eastern Cape there is still a huge discrepancy between **rural and urban** hospitals, with adequate physical infrastructure in urban areas in contrast to inadequate structures in rural areas. In Gauteng all the hospitals visited were very old some dating back to 1911, except for Johannesburg General Hospital which is relatively new. In KZN many buildings were considered to be in a shocking state, dilapidated and not user friendly. In Mpumalanga most buildings needed repair and/or upgrading and waiting areas are often small, lacking ventilation. In one facility the laundry ceiling was falling in. In the North West there are complaints of a lack of support from public works in building maintenance.

Waiting areas are often inadequate and pharmacies are often too small. In Gauteng there is inadequate space in all hospitals, especially in outpatient waiting areas and pharmacy areas. This is attributed to the increase in the population and the high number of patients who access services at hospitals in order to be attended to by a doctor. In the Eastern Cape there are sufficient seats for patients in the waiting areas except for the Nompumelelo hospital, a very small institution, where even at 16h00 the Review found it was still full of people, indicating that it is serving more people than the infrastructure can hold.

Reference was made to the need on the part of a District Hospital for additional facilities, and in particular an Intensive Care Unit, in light of the fact that patient transport to secondary or tertiary hospitals remains a problem for patients who are in urgent need of medical attention.

In the North West organised crime and vandalism were identified as a challenge to well maintained infrastructure. In the Northern Cape at least one building was considered to be so dilapidated that it poses a threat to staff and patients. The same clinic had no security.

Rural clinics and hospitals indicated that they experience problems with a **shortage of water** from time to time.

Hospital Revitalization

The introduction of the Hospital Revitalisation Programme (HRP) appears to be having a significant impact on eligible facilities and where hospital revitalization plans are in place they are making a positive difference.

In Gauteng, **success stories** included a pharmacy that had been revitalized and new systems put in place to streamline the functioning of the pharmacy, and sections of hospitals undergoing revitalization which were cleaner and more cheerful than "unrevitalized" areas. In the Western Cape the HRP was identified as playing a big role in **access to equipment**, especially furniture and computers, and it is those facilities not eligible for HRP that seemed to experience a lack of resources.

However in some instances plans are proceeding at a **slower pace** than anticipated. Lack of progress is primarily attributed to problems with provincial departments of Public Works including delays in awarding tenders and the procurement procedure, as well as lack of technical capacity in public works. The short-term impact of the delays experienced by the provincial departments of health is severe. In the long term, the delays cause contract price escalation, resulting in more expensive health services. It was suggested that a possible solution would be that the provincial departments of health be more involved in the tender and procurement procedures, and have the authority to manage the deadlines.

Privacy

Inadequate infrastructure results in a lack of privacy. There were several reports of patient's privacy being compromised, especially patients with HIV or wanting to attend Voluntary Counselling and Testing services. In some hospitals patients being treated can be seen by visitors walking through the passages and in other facilities patients are actually treated in the corridors.

General Cleanliness

Cleanliness of facilities, both inside and out **varies enormously**. There appears to be some correlation between cleanliness and appropriate staff attitudes and other indicators suggesting a link between well managed facilities and general quality and accessibility of care.

In some hospitals the approach is characterized by informal traders, taxis, litter, and a general sense of chaos. Inside at least one hospital grounds there was a beer bottle lying on the grounds, which was littered with papers and people milling around. In other hospitals the grounds are well kept.

In general in Gauteng the state of hygiene of the hospitals left much to be desired. Although cleaning staff were observed at all facilities, the level of cleanliness and standard of hygiene was below the standard expected of a hospital. In KZN some facilities are filthy and this is especially true of toilets.

In the North West the majority of facilities were clean, with reasonable waiting areas. In the Eastern Cape, generally all hospitals are clean and the cleaning is done by the people employed full time by the hospitals. In some hospitals the laundry room is not up to standard and clothes are not properly cleaned and washed. In the Northern Cape the majority of facilities are clean and well maintained.

Security

A complaint that an elderly ill patient was kept in the same ward with a mentally disturbed patient. At night he had difficulty to breath, he was attacked by mentally disturbed patient and was found dead in the morning. The relatives of the deceased blame the hospital for his death in that they allowed a mentally disturbed patient in the same ward with him. (Northern Cape)

Security concerns were identified mostly in connection with psychiatric institutions or institutions with psychiatric wards.

In Gauteng, security concerns were raised at Yusuf Dadoo, Leratong, Kalafong, and Weskoppies hospitals. A patient who was in a psychotic state has been charged with murder. The incident is alleged to have taken place on the grounds of one of these hospitals.

At the Weskoppies psychiatric hospital aggressive behaviour by patients means they require guards, especially at night. Nursing staff are expected to fulfil this function as well as their clinical duties, a task which is especially onerous for female nurses (who by and large shoulder this responsibility in view of the difficulty of recruiting male nurses).

Ensuring patient and staff safety was identified as an acute challenge at one general hospital due to the nature of the infrastructure. Wards are all at ground level with glass doors. Female patients are molested and some had been sexually assaulted.

3.1.5 Equipment

The overall impression is that equipment is mostly available. However much equipment tends to be **old and in poor working condition** and maintenance and replacement of equipment is commonly cited as being problematic. Some facilities manage to access the resources and equipment they need through a process of sharing equipment between facilities.

In Gauteng specialist doctors have sourced essential equipment from donors, but otherwise there is generally a feeling that equipment is either not available or is old and in poor condition. In Mpumalanga equipment is generally available but tends to be old. In Limpopo it was felt that equipment is either not available or is old and not user friendly, and in need of repair, servicing or replacement. In KZN at one hospital all equipment is over ten years old.

Despite annual maintenance plans for equipment, and generally an availability of functioning up to date equipment, facilities in the North West identified shortages of bed sore mattresses, monitors and scans. In Gauteng maintenance contracts have only recently been entered into. One hospital had received a new X-Ray machine, after a two year wait, which had been un-utilized for the last two months because of technical reasons.

Part of the problem for acquisition and maintenance of equipment is attributed to the **procurement and tendering process**. In Mpumalanga unnecessary protocol results in delays.

Clinics are prone to suffering from a lack of **communication and management tools** such as telephones, faxes, filing cabinets, photo copiers and computers. This clearly militates against efficient management record keeping and reporting. Other facilities report absence of IT support and staff.

Theft of bed linen to and from the central cleaning depot was commonly reported while pilfering and **vandalism** is common. Theft of patients' possessions by hospital staff is also a problem. In the North West several facilities indicated a shortage of bed linen and pyjamas. In a facility in the Northern Cape it was reported that sometimes there is a shortage of food, linen, soap and toilet paper for patients, a shortage of medicines and no cook or housekeeper.

3.1.6 Pharmacy

Pharmacists are in very short supply. This impacts on service delivery and reports of exhaustingly long queues at facility pharmacies are commonplace. As a result there are also frequent reports of pharmacy waiting areas being too small and cramped. In a hospital in KZN the pharmacy and toilets of one hospital were described as filthy and unstocked, while the queues in others were considered to be shocking with hundreds of people standing in line. Shortage of appropriate administrative equipment and lack of necessary IT skills hampers appropriate stock control sometimes causing stock outs and making theft of medicines easier than it might otherwise be.

All facilities in the Northern Cape reported having only 50% or less of their **staffing complement** for pharmacists but this might reflect the large number of clinics included in their Review. The situation was not so severe in other provinces, but was nonetheless identified as a serious problem throughout the country. For example the North West appears to have on average between 70-80% of pharmacy posts filled. In the Western Cape all pharmacies seemed inadequate with patients waiting for up to 12 hours for their medication in some cases. In Gauteng nurses are dispensing prescribed medicines to both in and out patients and finding it difficult to cope as a result of their workload. Some pharmacies have queue managers in place to monitor queues and ease waiting times.

In all provinces there are reports of **stock outs**. For example in Mpumalanga almost all facilities reported stock outs of some drugs on the EDL and in other provinces regular stock-outs of between 5 and 20% were reported. In Limpopo there is generally a shortage of special drugs/ medication particularly those that are used for the treatment of chronic diseases. In one facility such basic supplies as Diuretics, Imodium, Anti-Septic Hand wash were in short supply and mouthwash was hardly ever available. In some instances specialised drugs are not available. In KZN facilities attribute stock outs to problems with suppliers and manufacturers.

In some provinces there are differing perceptions of stock-outs with some interviewees reporting that there are no stock outs while others claim that only 50 of facilities are EDL compliant. This apparent contradiction may in part be attributable to a commonly noted problem of **poor drug control and labeling** systems. For example it was noted in some provinces that the storage of medicines was not meeting the requirements that stock must be easily identifiable, labeled and in a good condition. Limited equipment, poor or non-existent IT systems, and the fact that staff are not adequately trained on IT systems mean that adequate control systems are not in place to prevent stock theft. There are instances where

inadequate systems become an obstacle to patients receiving their medication before leaving a facility.

3.2 Access to Health Care Services – transport costs, emergency transport, out of pocket payments, waiting times and access to information

The complainant resides at Skoonplaas Boschfontein and is complaining that the community has no access to health since there are no health facilities or a mobile clinic in the area. The department accedes to the fact and have promised to consider the matter. However further than that there has not been action taken by the department. Follow up letters have been written and we await further communications." (Mpumalanga)

Poor physical access is tantamount to a denial of access to health care services. Limited physical access to facilities arising from an absence of public transport, high transport costs and a lack of emergency transport, compounded by unacceptably long waiting times were widely reported. Although most patients indicated that they did not pay fees to visit a clinic or hospital, and that medication was mostly free of charge, the cost of transport was a major prohibitive factor in accessing their health entitlements. There is generally a feeling that it is difficult for poor and rural communities to access hospitals as a result of long distances and related high and prohibitive transport costs. It appears that the majority of patients are not aware of their rights despite the fact that the patients rights charter and information about Batho Pele are widely displayed in facilities.

3.2.1 Distance to Facility and Availability and Cost of Transport

Inadequate access arising from long distances to reach facilities, expensive and poor public transport coupled with poor roads was a frequent complaint. As sick people have to be accompanied, real transport costs are in fact double the quoted amount. Patients reported having to borrow money to get to the clinic and often not seeking care because of the lack of funds. Those who do not have money or are too sick to walk have no choice but to stay at home. Some who do access transport have to leave their homes very early in the morning. Having reached the hospital, even after they have been attended to, they then have to wait outside for the same transport to pick them up in the evening. There are reports of patients dying in this process.

In Mpumalanga, poor accessibility results from the **poor conditions of the roads** and the **long distances** people have to travel to get to hospitals which serve patients within a 30 km to 128 km radius. Public transport costs to reach these facilities can be as much as R90. In the Northern Cape an **absence of public transport** was noted in the vicinity of a number of facilities, and estimates for using private transport were as high as R500. In KZN patients accessing tertiary level care may pay as much as R400 for transport. In the Eastern Cape, the lack of public transport, coupled with excessively **high transport costs**, hinders access. Patients can pay as much as R35.00 return to get to hospital, while others have to walk long distances to reach the facilities.

Even in Gauteng where physical distances are not as challenging as in many provinces, patients use taxis as a means of transport (except for most refugees and asylum seekers who walked). The return taxi fare for people living within a radius of

15 km is around R12-R15 per visit. Accessing Regional and Central hospitals, whose catchments areas are greater than 25-50 km's, is more costly with patients paying more than R25.

In addition to costs patients complained of transport being unsafe. This was also true for those patients who walk long distances often through dangerous areas. It appears that even where transport is available, it is of limited accessibility to those patients with disabilities.

In a minority of institutions home visits are done by staff. In some provinces the need for home visits and/or additional mobile services was highlighted.

3.2.2 Emergency Transport

In most hospitals the ambulance service is at best **inadequate and at worst non-existent**. This impacts especially harshly on rural patients. In some cases ambulances arrived after 5 or 6 hours or even the following day, when the patient had already died. While the Constitution states that no person may be denied access to emergency care, there does not seem to be provision for alternative arrangements, for example, utilisation of private sector ambulances, in instances where public ambulances are unavailable or non-existent.

In Mpumalanga if patients resort to private transport, those from rural areas have to pay a minimum of R300 and a maximum of R450 to reach some hospitals at night, making medical care economically inaccessible for the rural poor.

In rural parts of the Eastern Cape, when responding to emergencies, ambulances travel from one village to another collecting patients. Should an ambulance get full it then has to do another collection round. However the poor state of the roads means that some areas are completely inaccessible to the ambulances. There were also reports of ambulances being hijacked.

In Gauteng the shortage of ambulances means they rarely arrive on time. There are reports that staff need to be better trained to deal with emergencies and life threatening situations.

3.2.2 Out of Pocket Payments

Even though medication is free, many patients are paying for transport costs and user fees from their grants. This deters poor people from accessing care, resulting in a heavy burden of untreated disease and sometimes death.

In the Northern Cape estimates of between 80 and 90% could not afford to pay hospital fees. Most patients in North West were unable to pay user fees, and estimates of patients unable to pay were as high as 98% for one facility.

In KZN economic factors are barriers to accessing health care and patients gave lower scores to economic access than they did to the acceptability of care they received.

3.2.4 Waiting times

Lengthy and bureaucratic registration, long queues to see the nurse or doctor as well as for the pharmacy, and preferential treatment for some patients all serve to constrain access for many health service users. Thee are various harrowing reorts of patients arriving in the early hours of the morning and waiting many hours to be registered, and again many hours before they see a doctor. This is unacceptable and especially so for patients who travel long distances and are ill.

In Gauteng the most common grievance from patients is the issue of the long queues when waiting to be registered, to be seen by a health professional, and particularly, in pharmacies for medication. Patients sometimes spend as much as eight hours at a hospital to see the doctor and obtain their medication. In one urban KZN hospital some patients arrive at 3 am, are registered at 10 am, only able to see a doctor in the afternoon and have to return the following day for their medication.

In the Western Cape most patients were not satisfied with the treatment they received explaining that they waited too long in the hospital before getting attention. Patients wait between one and four hours on average, and upto forty eight hours depending on the level of seriousness of their condition. The long wait which causes extreme discomfort causes offence to some patients as well as undermining their dignity.

In Mpumalanga it is common for patients to queue for upto four hours before they receive attention or are seen by a doctor. The situation is better for those who are transferred by Patients Transport vehicle or by ambulance. In these instances patients get to see a doctor almost immediately.

In the Eastern Cape, unacceptably long waiting times before seeing a doctor and before receiving medicine are reported at some hospitals. In one hospital it was observed that ill patients, including children, who had waited from 08h00 to see a doctor, were still waiting at 14h40.

3.2.5 Access to Information

Access to information seems to be limited both by language, since most information that is provided is in English, as well as by the fact that posters are the main means of communication with some examples of pamphlets and community radio being used, and occasional examples of workshops.

The majority of facilities display posters outlining **Batho Pele and the Patient Rights Charter.** In Gauteng for example all the hospitals displayed the Batho Pele Principles and the Patients' Rights Charter, however they were in English limiting their impact. In the North West all facilities displayed Batho Pele principles and some information is available in Tswana. In the Western Cape less than half of the facilities display the patients charter, and then only in English rather than in Xhosa or Afrikaans, and as a result most patients were unaware of their rights. In KZN information is usually available in Zulu and English.

In the Eastern Cape it was found that very few people know their rights, and there is a consequent lack of awareness among communities of how these rights could be enforced. In Mpumalanga although some patients seemed to be aware of their rights, the majority did not know about Batho Pele principles.

There were quite a few examples of information being disseminated through **community outreach** activities and the use of **community radio**. In the Free State more than one institution uses Lesedi radio and radio Roosestadt to disseminate information.

However very few facilities have organised **workshops** for communities to inform them of their health rights.

Displays of health information are erratic. In Gauteng there were no or very few immunization *posters* displayed. The maternity wards did not have adequate poster displayed regarding child care although one hospital was well organized and provided more information on maternal and infant care. There were no signs of health information in the form of *pamphlets* in any of the hospitals visited. In the Northern Cape pamphlets comprised part of the information dissemination.

Many patients interviewed reported that they received information relating to their health status from nurses and doctors, and that they were happy with the information and advice received. A need for interpreters to overcome language barriers was identified.

3.2.6 Access for those with Disabilities

The Reviews shed limited light an access for the disabled. In the Western Cape a rehabilitation centre was assessed. The Centre is considered a best practice model and specialises in rehabilitation for people living with disabilities. Challenges include a growth in the number of patients and a corresponding high bed occupancy rate. Transportation was singled out as problematic. In Gauteng xenophobic attitudes are heightened towards refugees with disabilities.

Wheelchair accessibility

Wheelchair accessibility is by no means universal. In Gauteng although all hospitals reported that the facility had wheel chair access it was noted that several departments and wards did not cater for wheel chair access. In the North West ward toilets are not wheel chair accessible.

Public transport is not easily accessible for those with disabilities and becomes an obstacle to accessing care. It is also more costly since wheelchair users are expected to pay for the additional space that their chairs occupy.

3.2.7 Termination of Pregnancy Services

Several facilities indicated that they do not provide TOP services, largely because of unwillingness on the part of staff to be involved for ethical reasons and /or because of skills shortages.

3.3 Acceptability and Quality - consent, staff attitudes, cultural acceptability, food quality

The complainants' daughter had suffered an asthma attack one night, and was rushed to the Hlengiswe clinic. Upon arrival at the clinic, the security guard refused to let him in, stating that they only allow pregnant patients in at night and no one else. He thereafter went to Hammersdale Police station, where an ambulance was called, which arrived after a long wait. Whilst waiting for the ambulance they used an inhaler on the child. When the ambulance arrived, the paramedics tried to help her but she died. An allegation letter has been sent to the clinic. There has been no response from them. (KZN)

The complainant was suspected of being pregnant at the Mpumelelo clinic she went to, she was then referred to the Stanger Hospital for an ultra sound, it was found that the baby was not in the correct position. The doctor advised her of the need to operate of which she consented to by signing the necessary documentation. When the operation was done, no baby was found. She still suffers from pains as a result of the operation and cannot work. She feels she was neglected. (KZN)

"A complainant who complained that she was Trisequens hormone tablets while she resided in George. When she relocated to Deben, in the Northern Cape, she was offered Prempack. When she complained, she was informed that Trisequens were too expensive. She complaint that she got a rash, as she was allergic to Prempack. When she consulted the doctor she was given prescription for Trisequens to get them at the pharmacy at the cost of R140, 00 per month, which she had to pay out of her pension. She was forced to sometimes skip a month or two because she could not afford. She complains that she moved from George as state patients where she received the best treatment and correct medicine, she argues why does it has to change when she moved to the Northern Cape." (Northern Cape)

A complaint that a patient was sent home to recuperate via the Postmasburg hospital after undergoing an operation in Kimberley. The neighbour allege that before he was discharged he was not taken care of at the hospital as he was inserted a catheter and it had not been changed before he was discharged. The patient experienced complications while at home and was forced to return him to the hospital. The patient's neighbour complained of the lack of proper care at the hospital.(Northern Cape)

A complaint lodged with our office on the delay of the nursing staff and doctor at Keimoes hospital where her son was stabbed with a sharp object bled to death while she alleged that the staff were reluctant to refer him to Upington hospital. She alleges that had they acted timeously and referred him, maybe he could have survived. (Northern Cape)

A newspaper article on the Lowvelder of 24 August 2006 on page 6 headlined " Man dies on bench at local hospital" resulted in the office writing a letter to the head of department indicting the impact that the alleged negligence of the hospital personnel has on human rights. The article reports that the deceased patient was brought to the hospital by ambulance complaining of painful legs, vomiting and diarrhoea. On arrival at the hospital the patient had to lie in the reception area for almost two hours before he could be attended to. The doctor who attended discharged him at 21:23 and told him to wait until 08: 30 to access drugs as the pharmacy was closed. Unfortunately, just after midnight the patient allegedly died on a bench in he corridors of the hospital.

The department conceded to the fact that the incident as avoidable and the doctor in question was subjected to corrective counselling which included guidance on consulting senior colleagues. Routine pharmaceutical services are available from 08H00 to 21H00 daily and there is a pharmacist on standby 24 hours daily should the need arise. (Mpumalanga)

A newspaper article on the Lowvelder of 08 August 2006 on page 3 headlined " Father claims daughter surely could have lived." The report indicates that a couple expecting their child's birth rushed to Rob Ferreira immediately when the wife started bleeding. At the hospital the wife was instructed to sit on the

bench and wait. The attitude of the nurses and their reluctance to help was shocking. They did not offer any assistance even though she was weak from the blood loss and when they asked for a wheelchair hey were told she was still able to walk and that she should. When sonar was done the child was still alive. A junior doctor arrived and examined. The doctor was so bad that she even told the sick lady that she should not get any of her blood on her even though nothing was done to stop the bleeding. Another doctor arrived and after doing the scan the couple were informed that their baby died.

The office wrote a letter to the department of health indicating the effects of the staff's conduct on the patients' rights and requested that an review into the matter be conducted. The department responded indicating the difficulty involved in investigating cases of this nature and requested to be given extra time to conduct the review.
Follow up letters on progress made on the matter had been written to the department to no avail. A letter informing the department of the commission's intention to subpoena for failure to respond has been sent on 19/02/2007. (Mpumalanga)

The community is complaining about access to the local clinic located in Glory Hill in Graskop. The clinic does not operate properly in that the nurse stationed at the clinic does not observe the operating times. She comes and goes as she pleases, despite the fact that the community may be waiting for medical assistance. (Mpumalanga)

3.3.1 Consent

There were very few reports of patents' consent not being sought indicating that the great majority of health personnel acknowledge the need to seek consent from their patients and do so appropriately. In the Western Cape and KZN however it was felt that only sometimes was their condition explained to them, and only sometimes was their consent obtained.

3.3.2 Staff Attitudes

Staff attitudes have been widely identified as a problem for the South African health system. Poor attitudes stem from many factors but have most often been associated with the unhappiness of many health personnel with their working conditions and remuneration.

In every province there are reports of caring staff and well maintained and run facilities. However poor quality of care and inappropriate, often downright callous, attitudes on the part of **health workers and administrative staff,** are responsible for many complaints. Patients complain of being treated poorly by nursing staff and prefer to be treated by doctors who can get to the problem more quickly.

In the Eastern Cape patients complained of rudeness from the nursing staff and an example was made of a patient in pain who was refused pain tablets, and had to wait for a doctor. In Mpumalanga more than half the patients were not happy with the treatment they received.

Night staff seem to be especially likely to treat patients callously. In Mpumalanga patients complained that night staff come and chat until eleven o'clock and when they are called they usually don't respond. This is made worse by the fact that the bells on patient beds are often not working and on occasions critically ill patients have fallen from their beds trying to get assistance. Nurses have been found making up their beds at around 8pm and getting ready to settle down for the night.

There is also a perception from service users that to complain might be counterproductive and harmful to their prospects of getting good care. This seems to be especially true of patients who are the most vulnerable. For example, in Mpumalanga, elderly patients complain about the lack of respect and the rudeness of some of the officials. They are however **afraid of reporting** it because they say their life depends on the hospital staff, and that if they complain they might be given wrong medication as a punishment."

Most patients are **not aware** of their rights and have never lodged a complaint, and would not know how to do so. Most have seen the various suggestion boxes at facilities, but less than optimal use seems to be made of these complaints mechanism. Language is sometimes an issue with suggestion boxes marked only in English.

At some hospitals where long queues were noted groups of staff were observed eating and talking in the tea room despite it not being tea time.

In the Western Cape **high readmission rates** were noted and may indicate poor quality of care.

3.3.3 Cultural Acceptability

Issues of religion and traditional medicine were referred to in relation to the acceptability of services.

The majority of patients interviewed across the country responded that services were **culturally acceptable** to them despite the fact that many hospitals only cater for religious groups on request. However in the Western Cape patients complained that services are culturally unacceptable. In Gauteng there is a perception that under utilization of PHC facilities (and over utilization of hospitals) arises because there is a belief that nurses, being mostly women, are not qualified to treat patients effectively.

The issue of **traditional medicine** was referred to in many provinces. At one extreme deaths are attributed to patients use of traditional medicines and several institutions made reference to barring traditional medicines from their premises. Patients generally expressed a preference for Western medicine. Some service providers argued that treatment must be acceptable because although patients do visit traditional doctors they still go to hospital. However there does appear to be a pattern for people of utilising traditional healers and only resorting to western medicine when their condition is uncontrollable.

3.3.4 Food quality

Some reports of poor quality hospital food were received. In KZN there were reports of poor quality and quantity and insufficient food trolleys and pots. In contrast some providers indicated that they have made determined efforts, which they feel have been successful, to provide good food.

3.4 Special Services - HIV/AIDS/STI and TB services, mental health, asylum seekers and prisoners

3.4.1 HIV/AIDS/STI and TB Services

The complaint was on behalf of Afripath, a medical and research laboratory, against a medical practitioner, who accused them of being racist, and accused them of being lucrative and states that the cost of their HIV reviews are perverse. The complainant also states that the doctor is intimidating their staff and probably his patients, precluding the patients from accessing affordable health care, in order to maintain his perverse lucrative relationship. (KZN)

The complainant the patient's farther alleged that his son visited the Witbank hospital for a sugar diabetes check-up. The boy was however subjected to an HIV/AIDS testing without his permission and the consent of his family. Further that counselling was not given. After the office communicated with the department, meetings were arranged between the department and the complainant. The department apologise for their conduct and made an undertaking that the department will provide counselling to the child and the mother. Further that the department will provide transportation for the counselling sessions with the psychologist.(Mpumalanga)

HIV services have come under the spotlight perhaps more than any other health service. Within civil society there are many experts who have not only developed high levels of literacy with regard to the treatment and care of the epidemic, but are also experts from a patient's rights perspective.

These reviews shed limited light on issues to do with HIV although the findings as a whole are in themselves indicative of the strain placed upon the health system by the burden of HIV and AIDS. It is common knowledge that the HIV epidemic has ravaged communities, and especially poor urban and rural communities who are dependent on the public system. In addition there are many people who are insured, but whose benefits have run out, and who therefore revert to the public system. The epidemic is also responsible for a sharp escalation of use of health care by young people between the age of 15 and 39 who otherwise would expect to be reasonably health and not much in need of care. Many facilities attribute overcrowding to the HIV/AIDS epidemic.

Health workers carry a quadruple burden. They are themselves affected by the disease, they care for patients at work, their vocation places them at risk of infection, and they are often the main carer for family members who are sick. In the Free State between 10-15 staff dying per year at one facility alone and a number of departments are considered to be short staffed because of the burden of HIV.

In KZN a number of facilities that are **ARV sites** were visited. Waiting time for ARVs in these sites varied between there being no waiting list to a four month waiting period. Problems with IDs compound delays and in some institutions it is patients without IDs on the waiting list. In some facilities counsellors are available but there is no space.

In the Northern Cape most services are available and there are sufficient counsellors to undertake VCT. However in some sites there is between a one and four week waiting period for ARVs. In another clinic there is no privacy, no counsellors and no information available. In the North West a shortage of trained nurses and counsellors to support the VCT programme was identified, along with inadequate number of

private rooms. Despite this the province is obviously very proud of its HIV services since numerous successes regarding the programme implementation were identified, and HIV services were presented as being examples of best practice. In the Western Cape there are dedicated programmes at key sites.

High ratings were also given to provision of HIV services at Free State facilities with TB, STI, VCT, PMTCT and ARV services mostly receiving scores of between 7 and 10 out of 10 with one or two receiving a 5 or a 6.

3.4.2 Mental Health

The complainant a psychiatrist logged a complaint against the department regarding the human right abuses experienced by psychiatric patients in the form of service delivery, facilities, verbal and physical abuse. Further that the hospital is not supposed to keep psychiatric patients in terms of the Act since it is a 72-hour facility. The office investigated the violations and during n on-site review, discovered the allegations to be true. A meeting was held with the MEC health who informed the office that the ward will be closed down for renovations and that patients will be referred to Rob Ferreira.
The ward was closed for renovations and patients referred to Rob Ferreira. (Mpumalanga)

Generally facilities for patients with psychiatric illnesses are inadequate. A hospital in Mpumalanga is expected to keep psychiatric patients when it has no facility to do so. There are long waiting lists.

The critical **shortage of specialist staff** in South Africa profoundly affects psychiatric care. Particular reference was made to a shortage of psychiatrists and to male nurses. In KZN there is a shortage of staff at the psychiatric hospital in part as a result of high staff turnover and staff migration, the difficulty in recruiting male nurses, and because staff are dying. In Mpumalanga, in one of the two hospitals with specialised psychiatrics, patients have no access to a psychiatrist. In one 48 bed ward there are only two staff working at night.

Nurses who have undergone specialised psychiatry training complained that they do not qualify for a scarce skills allowance and there is a perception that psychiatric nursing is considered unimportant in comparison with other specialisations. Since patients may be dangerous and there have been instances in which staff have had their clothes dirtied or torn or been personally injured feel they should also be entitled to a "danger allowance".

Security is also a problem as some specialised wards are without a full time security guard.

Generally psychiatric hospitals appear to be neglected. In KZN the hospital is in urgent need of renovation with **generally dilapidated buildings**. Some wards are considered to be in a shocking state. In Limpopo patients sleep in wards with no privacy and no lockers for their personal belongings. Exceptions are the hospital in the North West which is clean, provides privacy and confidentiality and has upto date equipment even though it has not yet been revitalized, and the hospital in the Free State. This hospital is in the process of being revitalized, has enough linen and adequate equipment. One hospital is without its own generator so that interruption in the electricity supply could lead to drugs being destroyed and to a greater chance of patients escaping.

The limited number of specialist institutions is likely to place a great **financial burden** on patients living at a distance from the hospital. In KZN some patients have to pay R400 return which mitigates against easy access and especially for follow up care.

One hospital in Northern Cape was **without a policy** for treating patients with psychiatric disorders and had no seclusion facility, the other had both. In another hospital there was no information system but the facility was compliant in other respects

With reference to HIV/AIDS,STI and TB services, in one hospital only TB services were available and there were **no patients on ARVs**. Interestingly a comment in relation to provision of HIV/AIDS, STIs/TB from a member of staff at Oranje psychiatric hospital is that "This hospital is for mental patients only".

Medication increases patients' appetites and as a result the quantity of food is insufficient in some, although not all, hospitals.

However **informed consent** appears to be sought before treatment from voluntary patients. In at least one hospital it is claimed that all complaints are investigated and addressed.

3.4.3 Prisoners

The complainant is a male prisoner at Ncome prison. Complainant states that while he was at Zonderwater prison he was assaulted by prison official and sustained injuries. When he was transferred to Ncome Prison he underwent X Rays which indicated that his ribs and spinal cord had been broken, and was referred to a specialist. As a result of these injuries he required medication, which was not provided to him. (KZN)

The complainant is a prisoner at Westville prison who states that sick prisoners are not attended to on time; one prisoner died and was only moved out the next morning. There is a lack of medical parole considerations for AIDS infected prisoners. (KZN)

In KZN the prison was visited but the prison manager was unavailable and no records were available. Thus the results of the review are incomplete. Prisoners cannot access a doctor of their choice and experience long waiting periods to get their medical needs met. The food is considered inadequate.

In the Northern Cape when prisoners they attend a clinic they get treated first for security reasons. One clinic has provides daily access to a doctor, the others have bi-weekly visits from doctors. Prisoners health records are kept, their health care needs are met, including accessing support around HIV and TB support. HIV tests are available on request to some but seemingly not all prisoners. There are no reports of prisoners in need of ARVS.

In the Free State although there was a sufficient complement of doctors, a grave shortage of nurses was attributed to prison conditions not being suitable for female nurses.

In Gauteng the prison ward provides care of the same standard as that provided to other patients. The shortage of male nurses is problematic in llightof their being only male patients in the ward.

3.4.4 Asylum Seekers

Eight asylum seekers and refuges were interviewed in Gauteng. They experience numerous problems relating to denial of access to public hospitals and clinics, exacerbated by inconsistent application of relevant laws and policies among different facilities. There are delays in obtaining official documentation and permits from the Department of Home Affairs and without these many are refused access or treatment at health care facilities. Some indicated that hospitals insist on payment, sometimes exorbitant amounts before they can even have a consultation.

The majority were not aware of their rights and had never lodged complaints with relevant health care facilities. Many raised the issue of xenophobic attitudes amongst health care workers as a concern that ultimately impacts on them accessing their rights.

4. Recommendations

A number of the provincial reports included recommendations and this section synthesises **recommendations from the provincial reports**. Tellingly some of the recommendations were as simple as providing water to a particular facility or improving roads. There were also calls for more systematic and ongoing monitoring and evaluation of service delivery through regular meaningful site inspections. There were also calls to prioritise rural areas and to address the persistent structural inequalities caused by the legacy of apartheid.

4.1 Financing

Recommendations linked to financing included calls to provide adequate funds that would allow for services to match needs; to decentralise budgets and to introduce a fee exemption system that would protect the poor from user fees, hidden and unofficial costs. There were also suggestions that national and provincial departments should engage in more consultative and transparent budgeting processes, including involving health facilities.

4.2 Management

There were repeated calls for the decentralisation and delegation of power, especially with regard to recruitment. Likewise, provincial governments should reduce their red-tape and delegate administrative power to the district and facility level. Communication channels need to be improved between staff and management and between management and the provincial offices. Provincial and District offices need to respond more timeously to requests. Management structures need to be standardised.

There is a need to strengthen the District Health System and reduce the number of referrals from clinics to hospitals by making doctors more available to clinics, perhaps through hospital doctors undertaking outreach activities and by giving more

authority to clinic doctors. Coupled with this effective referral systems need to be established and adhered to. More mobile clinics are needed.

4.3 Staffing

Provincial salaries should be standardized and competitive salaries should be offered across the board. Staff retention policies need to be put in place. Many calls were made for aggressive recruitment drives to attract scarce skills, including the recruitment of skilled professionals from outside the country, and to employ support staff. Alongside this hospital managers should be allowed to headhunt staff. Human Resource and financial managers should be appointed at district health facilities to relieve hospital managers of the workload. Conditions of employment need to be improved.

Staff development needs to be prioritized and should include strengthening the administrative skills of managers. In addition it was suggested that training and appointment of staff should be decentralized to facility level.

Relations between management and unions should be addressed. Lessons learnt from the interventions at Baragwanath hospital in conjunction with NALEDI should be emulated.

4.4 Transport

Patient transport systems need to be strengthened possibly through collaboration between the Departments of Transport and Health. Public transport needs to be improved to curb exploitation by transport owners who charge exorbitant fares.

4.5 Emergency Transport

Access to emergency transport needs to be increased and more ambulances are desperately needed. This may require establishing more depots.

4.6 Infrastructure

Facilities need to be improved through expansion and fast tracking of the hospital revitalisation programme. More health care facilities need to be built, especially sub chronic facilities for HIV and AIDS patients. Strategies need to be found to ensure that public works do a better job in maintaining facilities. Security needs to be improved at some institutions.

4.7 Information

Effective community projects that will raise health awareness at all levels need to be put in place in schools, social clubs and churches. Administrative staff could play a role in increasing public awareness through liasing with civil socity organisations, especially those that rights issues. More effective use must be made of the suggestion boxes.

4.8 Psychiatric Services

There is a need for additional, properly staffed psychiatric institutions. Staffing of existing psychiatric services needs to be addressed, especially with regard to specialists such as in-house psychiatrists.

5. Reflections and Conclusions

The provincial Reviews have highlighted a wide range of factors that impact upon access to health for South African citizens. There are a number of areas that the HRC hearings may wish to focus on and interrogate further.

As a result of economic globalisation provision of health care is no longer the jurisdiction of sovereign states alone and access to health care is constrained and influenced by the broader geopolitical context. The influence of powerful business on international institutions such as the WHO, deepening inroads made by privatisation of the social sector, the proliferation of international funds in the health sector, and increasing migration of health and other skilled personnel all play a part in directing national priorities while eroding country initiatives.

Several countries, including South Africa, report increasing socio-economic inequities. Many key indicators such as life expectancy and infant and maternal mortality rates are worsening as a result of the HIV and AIDS epidemic exacerbated by high unemployment rates. While access to health care may be said to have improved in light of free provision of primary health care to all South Africans and free care for children and pregnant mothers, distribution is still inequitable, creating a hierarchy of who is able to access state services.

5.1 Interrogation of International Treaties and Agreements

International and multilateral trade agreements and treaties, together with multi-national corporate interests define the scope that national governments have to respond to the health needs of their population.

For example, staff shortages, a major and intransigent problem for the health system, are fuelled by migration of health workers. Migration occurs between levels of care, between the public and private sectors and out of the country. The international movement of health workers is now governed in South Africa by the fact that we are a signatory to the **General Agreement in Trade and Services (GATS) Mode 4** (which tends to favour rich nations). Under this mode in relation to the "temporary" movement of health workers, concern exists over the ability of signatory countries to enter into bi-lateral agreements with other countries because of the principle Most Favoured Nation (MFN). This principle states that any GATS member that grants favourable treatment to any other country must do the same with all other GATS signatories. Therefore, if a developing country has signed onto the Mode 4 of the GATS agreement and enters into a bi-lateral with another GATS country the same privileges within the bi-lateral agreement must be open to all other GATS countries under the MFN principle. As yet no clear definition of what is meant by "temporary" movement has been determined.

Many South African health workers migrate to the UK. The UK has established an **NHS Code of Practice** for the International Recruitment of Health Workers to manage the impact of migration on developing countries. The code of practice has done little to stem the tide of migration, primarily because the code is not legally binding and is thus unenforceable.

5.2 Clarifying and Further Defining the "Right to Access to Health Care"

Fulfilling the human right of access to health care in South Africa would seem to imply a continuum that includes conventional individual human rights at one end with broader group based access to socio-economic rights at the other. The Constitution states that "Everyone has the right to have access to health care services, including reproductive health care and no one may be refused emergency medical treatment". The Constitutional Court has concluded that "measures that do not include meeting the needs of the most vulnerable groups in society are unreasonable".

It appears that little definition has been given to this right apart from that: *the right to access to health care includes reproductive health care; no one may be refused emergency medical treatment; basic health care services for children; and adequate medical treatment for detainees and prisoners at the State's expense*.

5.2.1 What health care services need to be in place and available to constitute access?

The department of health has attempted to define the minimum requirements for primary health care, at least in the private sector, by identifying a package of "minimum prescribed benefits" and what this should include. What should be accessible in the public sector is more open ended.

In theory an individual in need of care can attend a clinic where they will be able to access a range of primary health care services. If their condition cannot be treated at the clinic they are then referred up the system to a higher level of care. Implicit in this is a vague notion that individuals will be able to access the care that is necessary to help them recover.

It is however clearly impossible that everyone in South Africa will be able to be provided with the highest quality of care available in light of the necessarily limited resources available to the health system, the extremely costly nature of certain treatment regimens, and the prohibitive cost of some equipment.

By implication there is a need for policies and guidelines to determine the care and treatment options that a citizen can expect to be available. Health systems in other countries have had varying degrees of success in making choices about the services that will and wont be provided in a way that is rational and acceptable to their citizenry. However it is a deeply contentious issue that has been avoided by many health services in the world, and South Africa is not alone in not having explicitly addressed this issue of rationing.

Not to do so though, would seem inevitably to result in compromising human rights. For unless there are transparent policies to guide services that will and will not be provided, rationing will happen by default as is presently the case.

5.2.2 Unequal Distribution of Services

South Africa's policy trajectory of emphasising primary health care, delivered through a district health system certainly holds the most promise of meeting the human rights of all South Africans. There is not really enough information about provision at clinics in the Reviews to judge the access to care in clinics. However it

would appear from the Reviews that many patients are by-passing clinics and going straight to hospitals. This seems to indicate that despite clinics being geographically accessible they are unable to meet patient needs.

The opportunity to go directly to a hospital is not uniformly available. The Reviews indicate clearly that the poorest and most vulnerable members of society are frequently excluded from accessing higher levels of care because of high transport costs, lack of emergency transport, or simply a lack of information. In the context of the increasing inequities in our society, does the access enjoyed by a few imply universal access, what is the yardstick?

5.2.3 How to define what is a sufficiently acceptable level of care to constitute access?

It is unclear as to the level of **acceptability and quality of care** that is necessary for care to be counted as *accessible*. It is by no means obvious that just because a facility provides a service such as ante-natal care, that pregnant women automatically have access to it. If the service is provided in a dilapidated building, without privacy, by nurses who are rude and bad tempered, does that qualify as access? Or if a patient has to wait four to five hours to be registered when they are sick or in pain, does that count as access to health care? What does "no-one may be refused emergency medical treatment" mean in the context of people apparently being denied basic health care.

5.2.4 What is the relationship between other socio-economic rights and access to health?

There is an interplay between access to other socio-economic rights for example access to water and electricity, and access to health. As some Reviews reported there are health facilities that do not always have access to water and this inevitably impacts on the surrounding community's access to health.

5.3 Impact and role of private sector on access to health care.

There is an insidious growth in the role played by private health care providers which in a context of a scarcity of resources, including finances and health personnel, inevitably impacts on access to care for the majority of the population. Sharply escalating medical aid costs, with rates increasing faster than the rate of inflation, reinforce the perverse funding of health care. So called "medical tourism" is on the increase with foreigners exploiting the relatively cheap care provided by South Africa's private sector. Private health care companies compete for contracts internationally often sending health workers to relatively wealthy countries to provide care for specified periods of time. Many of the health professionals involved will have been trained at the expense of the state.

5.4 Fostering Health Workers' Rights

The Reviews recorded high levels of staff dissatisfaction. Consideration of patients rights alone, without attention also being paid to the rights of health workers will be of limited value. Efforts to acknowledge and protect health workers needs and rights are likely to impact positively upon delivery of care and therefore play a beneficial role in improving patients' rights.

An important component of addressing staff rights is increasing the number of key staff in order to improve the work environment. However, staff shortages cannot be addressed within provinces or even the Department of Health alone. Addressing staff shortages requires a *multi-sectoral* response and the Department of Education is critical if the production of key categories of health workers is to be increased.

Furthermore a sensitive balance needs to be achieved between the human rights of health workers to have the freedom to move and work where they wish, with the human rights of marginalized and poor communities to access health care.

5.5 Improving Transport

Transport, including emergency transport, emerges as a critical factor in enabling access to the right to health. High costs of transport result in differential and inequitable access with the poorest communities being excluded. Without changes to the public transport system it is unlikely that the state will be able to fulfil its mandate in respect of access to health to marginalized communities.

5.6 Traditional Medicine

The Reviews point to a confrontational approach on the part of western trained health personnel towards traditional medicine. While the limitations of traditional medicine need to be explained to patients, the high use of traditional practitioners is likely to continue for some time, and especially in view of limited access to western care. The possibility of collaboration between the two systems, including provision of training, education and information to traditional healers has been effectively piloted in some settings and has the potential to increase access to health to marginalized communities.

5.7 Specialised Services

Abuses in psychiatric institutions and prisons are especially worrying as these groups are in the care of the state. The impact of xenophobia on refugees and asylum seekers is resulting on occasions in a denial of access to health.

5.8 Complaints System

In light of the fact that the most disadvantaged communities are struggling to access care, they are also unable to make use of the existing system of suggestion boxes. They are equally unlikely to lay a complaint through normal channels in that they are unable to access services about which they could complain, and are essentially "outside the system". This implies the necessity for special measures to protect the right to health of our most vulnerable communities.

5.9 Health Ombudsman

The information gleaned from the Reviews seems to be pointing to a 'leadership/hearing vacuum' in which things happen but nobody cares or hears. The Limpopo Review makes the case for ongoing monitoring and maybe there is a need to create an independent office or unit – perhaps within the SAHRC - with responsibility for monitoring the progressive realisation of the right to health care.