SUBMISSION TO THE PORTFOLIO COMMITTEE ON HEALTH ON THE 2013/14 ANNUAL REPORT AND BUDGET OF THE NATIONAL DEPARTMENT OF HEALTH
SUBMITTED 14 OCTOBER 2014

Submission Compiled BY Thokozile Madonko, Marcus Low, Lieve Vanleeuw on behalf of the Treatment Action Campaign (TAC) and the Budget and Expenditure Monitoring Forum (BEMF)

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KEY RECOMMENDATIONS

INTELLECTUAL PROPERTY AND ACCESS TO MEDICINES

1.1. We request the Chair of the Portfolio Committee on Health to coordinate a joint sitting at the earliest convenience with PC Trade and Industry and PC Science and Technology to discuss with the relevant Ministries the impact of the Draft National Intellectual Property Policy on the availability of medicines in the health system and the broader implications that this has on the health budget.

1.2. We recommend that the Committee call on the National Minister to publicly demand the urgent finalisation of the draft national intellectual property policy in line with the pro-public health flexibilities outline in the agreement on Trade Related Aspects of Intellectual Property Rights and the Doha Declaration on Public Health.

1.3. In order to ensure that the Ministry is getting value for money the NDoH should provide to the Committee an accessible breakdown of the types and cost of the medicines and medical equipment and tools procured over the last three to five years.

MEDICINES REGULATION

2.1. As a matter of urgency the medicines Regulator (be it the MCC or SAHPRA) must proactively and continuously publish information on the medicines that have been registered, submitted for registration; rejected and the reasons for these decisions. Having this information is undeniably in the public interest.

2.2. The SAHPRA must replace the MCC in 2014/2015. The PC must ensure that the SAHPRA has sufficient funding, strong leadership, and independence from industry and government. The SAHPRA must provide regular updates on the time it takes to register medicines in South Africa.

COMMUNITY HEALTHCARE WORKERS

3.1. The NDoH must finalise in 2015/16 a National Community Health Care Worker Policy and CHW Training and Development Policy. The absence of a National Community Health Care Worker Policy and CHW Training and Development Policy must be addressed and coupled with broad strategic plans to establish a professional body headed by CHWs that can ensure that CHWs are incorporated into the public sector health workforce, remunerated in line with the scope of work they perform[1] and, have access to quality training and skills development programmes.

[1] One recommendation is that an entry level CHW should be employed full-time at a level 3 basis (earning approximately between R87 330 and R102 873 per year). It should be noted that in some provinces Community Development workers are currently employed at level 6 (earning full-time between R148 584 and R 175 023). *Reference http://www.westerncape.gov.za/text/2014/May/salary-scales-2014.pdf*

3.2. It is important to note that in the absence of broad national policy there can be no adequate planning, budgeting and monitoring of the CHW strategy. We also wish to bring to the Committee's attention that when assessing the consolidated National and Provincial health budget for 2015/16 and the medium term that the NDoH throughout the budgets ensure that the allocation to CHWs in all relevant line-items is clearly stated. In addition, the Committee should request that the NDoH provide more detail in the 2015/16 Annual Performance Plan regarding the budgeted resources for employing and training CHWs across the provinces.

3.3. These policies and plans must be developed in consultation with community health care workers as well as civil society stakeholders and broader public in a manner that is participatory and actually incorporates what CHWs, civil society organisations and public recommend into the objectives, plans and targets of the NDoH.

HIV and AIDS

4.1. We recommend that the Committee ask the NDoH to publish more regular and more detailed indicators of the state of the HIV treatment programme. These regular updates must include viral suppression rates by province, district and health facility.

4.2. 4.2. We recommend that the Committee ask the Minister what steps he will take to ensure that every person on the antiretroviral treatment programme in South Africa gets the annual viral load test that they are supposed to get in terms of national and WHO guidelines.

4.3. 4.3. We recommend that the Committee engages the Minister on his department's plans for addressing the high rate of loss to follow up in the HIV treatment programme at the provincial and district level.

4.4. 4.4. We recommend that the PC engages the Minister on the progress toward an electronic health records system with unique patient identifiers. Such a system would allow for better continuity of care between different facilities and between facilities and prison. In our view it is not necessary to wait for the Department of Home Affairs to introduce identity cards before this can proceed.

4.5. We recommend that the committee seriously considers and engages with the Minister on the question of access to condoms and comprehensive sex education in schools. This discussion must be informed by the extremely high infection rate in young women.

TUBERCULOSIS

5.1. We recommend that the Committee request the NDoH to provide regular updates of the progress in decentralisation of DR-TB care. While implementation is being done by provinces, the NDoH is ultimately responsible and there must provide oversight and direction.

5.2. We recommend that the Committee call on the Department to engage with provincial health departments to ensure commitment to implementing the national response to MDR-TB. Where necessary, the NDoH should indicate what budgetary resources should be earmarked and/or ring fenced for addressing MDR-TB in the provinces.

5.3. We recommend that the Committee call on the NDoH to publish the provincial operational plans as the pertain to MD-TB treatment and prevention with annual progress reports on implementation.

TB AND HIV IN PRISONS

5.4. We recommend the NDoH undertake a baseline survey on the prevalence of TB in prisons. We recommend the Committee request the NDoH on a annual basis provide an incidence report to evaluate the current TB strategy and monitor the extent of the TB epidemic within South Africa's correctional facilities.

5.6. The NDoH must play a greater role in ensuring the problem of TB in prisons is effectively addressed. This must include access to treatment and care – and not only screening. Inmates require adequate access to timely and appropriate health care services. We recommend that NDoH in collaboration with the Department of Justice and Correctional Services (DJCS) and the JICS to identify the main barriers to access healthcare services and develop an appropriate strategy for ensuring sufficient health care personnel and security officials to ensure inmate's right to health.

5.7. As a matter of urgency, the NDoH needs to convene a joint sitting with the DJCS and Department of Public Works to develop an emergency response plan that targets ventilation and overcrowding within the correctional facilities. The plan should prioritise, as a matter or urgency, the most overcrowded prisons. To curb the TB epidemic in South Africa it is crucial that there is a coherent plan in place to address the main factors that are fuelling the transmission of this infections disease in South Africa's prisons and correctional facilities.

CERVICAL CANCER

6.1. The NDoH must ensure better communication and public awareness of the HPV vaccine.

6.2. The NDoH must coordinate with the Department of Basic Education to ensure that school-going learners have access to means to protect themselves against sexually transmitted infections. The National Minister of Health has argued, in Parliament, that in order to support the NDoH's efforts the Department of Basic Education must facilitate the inclusion of a quality age appropriate sex and reproductive health education throughout the national curriculum as well as to ensure access to condoms where at schools facilities. We recommend that the Committee support the National Minister's call and recommend that the Department of Basic Education support the NDoH's initiatives to ensure better sexual and reproductive health amongst school-going learners.

EMERGENCY MEDICAL SERVICES

7.1. We recommend that the Committee to call on the Minister, as a matter of urgency, consider submissions on, finalize and bring into operation the Emergency Services Regulations published for comment on 24 July 2014. National standards on emergency medical services that make provision for the services to be made available in provinces are urgently required to ensure the realization of the right not to be refused emergency medical treatment and the right to emergency medical services.

HEALTH AND GENDER-BASED VIOLENCE

8.1. We recommend that the Committee call on the NDoH to show the political leadership necessary to drive the development of a fully-costed National Strategic Plan for Gender Based Violence (GBV-NSP).

8.2. We call on the Committee to hold public hearings on the development of a fully-costed National Strategic Plan for Gender Based Violence. The Committee would be playing a critical role in ensuring that there is broad public awareness and participation in shaping a national response to Gender Based Violence.

NATIONAL HEALTH INSURANCE

9.1. We recommend that the Committee call on the National Minister of Health to table for public comment the White Paper on NHI as well as publish for public comment the document on the creation of the NHI Fund.

9.2. We encourage the Committee to call on the National Minister of Finance to table for comment the Treasury Financing paper on NHI.

9.3. The absence of policy at national and provincial level on the status of Health Committees must be addressed as a matter of urgency and coupled with planning and budgeting for the necessary resources(human resource support, training, operational costs and physical infrastructure as needed) for health committees to function optimally. In developing policy on health committees the NDoH must do so in consultation with state, civil society and community stakeholders in a manner that is participatory and responsive.

9.4. The NDoH must provide clear plans for how they will monitor better spending, value for money and performance of the National Health Insurance Indirect Grant during the 2014/15 financial year.

PROVINCIAL PERFORMANCE

10.1. More detail is required in the National Department of Health's Annual Report regarding the performance of the provincial Department's of health in implementing key national priority programmes.

10.2. We recommend that the Committee call on the National Minister of Health as a matter of urgency to convene a national forum to develop a national strategy for addressing provincial delivery of health services. The National Minister should call on the various expert teams that have, over the years, developed turnaround strategies, made recommendations in the reports of Special Investigating Unit (SIU), Integrated Support Teams and so forth. Such a forum should seek to put an end to the year-on-year crisis management that the NDoH is called on to undertake within the provinces but rather develop a financial and non-financial diagnostic tool that serves as an early warning system to guide provinces and the National Minister.

10.3. The Committee should request from the National Treasury the expenditure reviews that Treasury has undertaken that are relevant for the Committee to better understand the financial performance of the National and Provincial Departments of Health.

10.4. We recommend that the Committee as a matter of urgency conduct an oversight visit to the Free State, Mpumalanga and the Eastern Cape to assess for the Honourable Members themselves the status of health care service delivery within in these provinces.

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1. Introduction

The Right of Access to Health Care Services

The performance of the Minister of Health and of his ministry should be assessed from a rights based perspective. The Constitution and the National Health Act (NHA) requires the Minister to provide the political leadership to progressively realise the right to health care services, within available resources. The Minister does this by providing the necessary guidance and oversight in developing and implementing national policy, coordinating the activities of the Department of Health and its administrations. A second important role that the National Minister plays is that of political steward over the provinces. South Africa's system of cooperative government between the three spheres of government requires, as provided for in the Constitution, much of the public money for social and basic service expenditure, including health, be allocated through the budgets of the provinces. While the three spheres of government are distinctive they are also interdependent and interrelated according to Section 40 of the Constitution. As a result, the Minister must work closely with the nine Members of Executive Council (MECs) of the Provincial departments of health to ensure that the Provinces too fulfil their constitutional obligations.

2. Context

Currently, people in South Africa obtain their health care services from either the public sector or the private sector or both. Currently 43 million people in South Africa access care through the public sector. Approximately 5% of GDP is spent on private health while 3.5% of GDP is used to fund the public health system. And while South Africa as a whole spends 8.5% of its GDP on health, we still have relatively poor health outcomes. South Africa's health system today is a reflection of a deeply unequal society and, as stated by the DG Ms M.P. Matsoso in the 2013/14 National Department of Health's ("NDoH") Annual Report, South Africa "*continued to be faced with a quadruple Burden of Disease (BoD) consisting of HIV & AIDS and TB; High Maternal and Child Mortality; Non-Communicable Diseases; and Violence and Injuries*".

For the 2013/14 financial year the Department of Health undertook its work guided by the Negotiated Service Delivery Agreement (NSDA) 2010 – 2014 (updated in 2011), which identified the following four performance areas:

1. Increased life expectancy
2. Reduction in maternal and child mortality rates;
3. Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis; and
4. Strengthening health system effectiveness.

The National Department of Health's annual report is a key document tabled before Parliament every year. While it is a backward looking document it enables parliament to call on the Minister for Health to account for his ministry's performance in delivering on its mission "*a long and healthy life for all South Africans"*. The department's annual report is meant to provide critical performance and budgetary information at the end of the financial year. It is also meant to provide a detailed

description of how successful the department had been in implementing the strategic plan and budget presented before Parliament at the beginning of the financial year.

This submission is thus concerned with providing to parliament with the necessary evidence-based information to better assess the performance of the National Department of Health in 2013/14 as well as to provide key recommendations for how service delivery by the National Department could be improved including whether the department used its budget in an effective, efficient manner.

SECTION A

3. The National Policy Framework Applicable to the Right to Health

3.1. Pharmaceutical Trade and Product Regulation| Programme 6: Health Regulation and Compliance Management.

3.1.1. Intellectual Property Policy

While the Minister has been outspoken about a pharmaceutical industry plan to delay the finalisation of the national Intellectual Property Policy, it is concerning that the Department has failed to engage substantively in the Department of Trade and Industry process to finalise the policy. It is our understanding that the Department of Health has failed to respond to various invitations to contribute to take part in the policy development process. Given the impact that this policy will have on access to medicines this lack of engagement is of concern.

RECOMMENDATIONS:

- We request that the Chair of the Portfolio Committee on Health coordinate a joint sitting at the earliest convenience with PC Trade and Industry and PC Science and Technology to discuss with the relevant Ministries the impact of the Draft National Intellectual Property Policy on the availability of medicines in the health system and the broader implications that this has on the health budget.

- We recommend that the Committee call on the National Minister to publicly demand the urgent finalisation of the draft national intellectual property policy in line with the flexibilities outline in the agreement on Trade Related Aspects of Intellectual Property Rights.

- In order to ensure that the Ministry is getting value for money the NDoH should provide to the Committee a breakdown of the types and cost of the medicines and medical equipment and tools procured over the last three to five years.

3.1.2. Medicines Regulation

While some legislative and regulatory progress has been made in the last year, the transition from the medicines control council to the South African Health Products Regulatory authority remains behind schedule. The activities of the regulator remain lacking in transparency. We note for example the delays in registering generic versions of the TB medicines Linezolid – which results in restricted access to this important treatment for drug resistant TB. The establishment of the

SAHPRA must be a high priority in the 2015/16 financial year since it provides a unique opportunity to solve many of the problems that have plagued the regulator in recent years.

We commend the Department on its undertaking to regulate complementary medicines and medical devices. We urge the Department not to circum to industry pressure to water down the regulations.

RECOMMENDATIONS:

- As a matter of urgency the Regulator must proactively and continuously publish information on the medicines that have been registered, submitted for registration; rejected and the reasons for these decisions. Having this information is undeniably in the public interest.

- The SAHPRA must replace the MCC in 2014/2015. The PC must ensure that the SAHPRA has sufficient funding, strong leadership, and independence from industry and government. The SAHPRA must provide regular updates on the time it takes to register medicines in South Africa.

3.2. Human Resources For Health |National Policy on Community Health Workers

Community Health Workers (CHWs) have been a vital part of the health workforce in the response to HIV & TB and now as part of primary health care re-engineering. According to the Annual Report of the Department by the end of 2013/14, they had a cumulative total of *"1063 Municipal Ward Based Primary Health Care Outreach Teams (WHBPHCOT) were [sic] established and reported their activities on the District Health Information System (DHIS). The NDoH managed to exceed the 2013/14 target of 750 WHBPHCOT reporting on the DBIS by 313 teams"*. The National Minister in the NDoH's Annual Performance Plan 2014/15 – 2016/17 states that as part of the six overall strategic objectives for *promoting health* in the National Development plan *"human capacity is key; managers, doctors, nurses and community health workers need to be appropriately trained and managed, produced in adequate numbers, deployed where they are most needed".*

However, throughout the 2013/14 financial year TAC and BEMF have received numerous reports from CHWs describing that they are unsupported fragmented, exploited, and poorly managed*.* Currently it is estimated that there are 70 000 community healthcare workers (CHWs) in the country. The umbrella term "CHW" embraces a variety of community health aides which include home based carers, care givers, lay counsellors, adherence counsellors, TB DOT supporters. CHWs have continued to communicate their frustrations to the TAC and BEMF about not being recognized as formal employees by the department; disputes around insufficient monthly salaries; lack of benefits; access denied to their contracts and pay slips and the general burden of continuing to dedicate their lives to a worthwhile cause of community work under disheartening circumstances.

The NDoH published in 2011 a *Ward Based PHC Out Reach Teams Implementation Toolkit*[2] on how to train and appoint "ward-based" primary health care outreach teams of which community health care workers form a core part. However, since publishing this Toolkit no national policy has

[2] http://www.rmchsa.org/wp-content/uploads/2014/04/PHC-Outreach-Team-Toolkit.pdf

been developed and implemented. As a result, as reported in the *Mail and Guardian*[3] earlier this year, there are huge discrepancies among provinces in what "ward-based" community health workers are paid, who pays them, the kind of work benefits they get and how many households they need to cover. In addition, in the absence of a coherent national policy funding for NDoH's WBPHCOT has been inconsistent and, in some of the provinces, an unfunded mandate without ring-fenced funding sources for the CHWs being made available by the provinces out of their equitable share.

Nevertheless, the NDoH's Annual Performance Plan 2014/15 – 2016/17[4] identifies improving access to community based PHC services and quality of services at primary health care facilities as a core objective. One of the performance indicators that would enable NDoH to achieve this objective is the *"number of functional WBPHCOTs".* The Department plans during the next financial year 2015/16 to have 1500 functional WBHCOTs. However, it is not clear from the NDoH's annual performance plan what resources have been set aside to ensure the employment of CHWs into the WBPHCOTs across the country and also there is no indication of the other kinds of programmes or initiatives that require CHW support.

Understandably, the budget for employing and training CHWs will be spread across the various departmental line-items ranging from the WBPHCOTs, Integrated Schools Health Programme (ISHP), HIV and AIDS, TB and Maternal, Child and Women's Health. The CHW policy that needs to be developed by the NDoH must, in our view, be one that incorporates CHWs formally in the health care workforce and ensures that CHW be included as a specific employment category within the Human Resources management reporting on employment, salary bands and vacancies at a national and provincial level. Ensuring that the NDoH has the capacity to effectively provide primary health care services across the country require both financial and non-financial resources be dedicated to support CHWs. The NDoH by the end of 2013/14 failed to demonstrate that such resources had been made available.

RECOMMENDATIONS:

- The NDoH must finalise in 2015/16 a National Community Health Care Worker Policy and CHW Training and Development Policy. The absence of a National Community Health Care Worker Policy and CHW Training and Development Policy must be addressed and coupled with broad strategic plans to establish a professional body headed by CHWs that can ensure that CHWs are incorporated into the public sector health workforce, remunerated in line with the scope of work they perform[5] and, have access to quality training and skills development programmes.

[3] http://mg.co.za/article/2014-09-04-why-policy-is-failing-community-health-workers

[4] http://www.health-e.org.za/wp-content/uploads/2014/07/SA-DoH-Annual-Performance-Plan-2014-to-2017.pdf

[5] One recommendation is that an entry level CHW should be employed full-time at a level 3 basis (earning approximately between R87 330 and R102 873 per year). It should be noted that in some provinces Community Development workers are currently employed at level 6 (earning full-time between R148 584 and R 175 023). *Reference http://www.westerncape.gov.za/text/2014/May/salary-scales-2014.pdf*

- It is important to note that in the absence of broad national policy there can be no adequate planning, budgeting and monitoring of the CHW strategy. We also wish to bring to the Committee's attention that when assessing the consolidated National and Provincial health budget for 2015/16 and the medium term that the NDoH throughout the budgets ensure that the allocation to CHWs in all relevant line-items is clearly stated. In addition, the Committee should request that the NDoH provide more detail in the 2015/16 Annual Performance Plan regarding the budgeted resources for employing and training CHWs across the provinces.

- These policies and plans must be developed in consultation with community health care workers as well as civil society stakeholders and broader public in a manner that is participatory and actually incorporates what CHWs, civil society organisations and public recommend into the objectives, plans and targets of the NDoH.

SECTION B

4. Comment on Specific NDoH Programme Performance

4.1. Programme 3: HIV and AIDS, TB and Maternal and Child Health

4.1.1. HIV and AIDS

While over 2.5 million people have been started on treatment, there are worrying signs that the treatment programme is fraying and unravelling. In his budget vote speech the Minister of Health said that 37% of patients are lost to care after three years. He also said that only half of patients had received viral load tests in the last year (every patient requires an annual viral load test for optimal care according to WHO and SA guidelines). In addition, stockouts of antiretroviral s and other essential medicines continue to plague our healthcare system.

We are also concerned with the NDoH's lack of transparency regarding key indicators. The NHLS regularly provides the NDoH with detailed viral load suppression rates broken down by province, district and health facility. This information must be shared with the PC and with the public since it will provide a much clearer and more accurate picture of the state of our AIDS response than what we are getting from other indicators.

The Minister of Health did not consult with civil society or the South African National AIDS Council about increasing the ARV treatment initiation threshold from 350 CD4 cells/mm3 to 500 CD 4 cells/mm3. Furthermore, we not with concern that the Minister said in his budget vote speech that South Africa is heading toward a 'test and treat' policy - where patients who test positive are started on treatment irrespective of CD4 count. Such a decision should have been taken with broad consultation in order to ensure that the plans, budgets and broader public awareness is in place to implement such policies.

We also note that the HIV infection rate is particularly high amongst young women aged 15 to 24. Young women in this age group must be given the tools with which to protect themselves from sexually transmitted infections and unwanted pregnancies. This must include both comprehensive sex and reproduction health education and access to condoms in schools.

RECOMMENDATIONS:

- We recommend that the Committee ask the NDoH to publish more regular and more detailed indicators of the state of the HIV treatment programme. These regular updates must include viral suppression rates by province, district and health facility.

- We recommend that the Committee ask the Minister what steps he will take to ensure that every person on the antiretroviral treatment programme in South Africa gets the annual viral load test that they are supposed to get in terms of national and WHO guidelines.

- We recommend that the Committee engages the Minister on his department’s plans for addressing the high rate of loss to follow up in the HIV treatment programme at the provincial and district level.

- We recommend that the PC engages the Minister on the progress toward an electronic health records system with unique patient identifiers. Such a system would allow for better continuity of care between different facilities and between facilities and prison. In our view it is not necessary to wait for the Department of Home Affairs to introduce identity cards before this can proceed.

- We recommend that the committee seriously considers and engages with the Minister on the question of access to condoms and comprehensive sex education in schools. This discussion must be informed by the extremely high infection rate in young women.

4.1.2. Tuberculosis

Multi-Drug Resistant TB – MDR-TB

TB remains a significant public health problem in South Africa as the country continues to show one of the highest TB incidence rates in the world with close to 1% of the population estimated to have active TB. It is also facing a rising epidemic of drug resistant TB. With the introduction of the GeneXpert in 2011, the Department of Health has made great strides in the detection of TB and especially MDR-TB. There is, however, a large gap between the number of patients diagnosed with MDR-TB and those who start treatment.

To increase the treatment capacity for MDR-TB in provinces, the NDOH introduced the framework on decentralisation and deinstitutionalisation of DR-TB care in 2011. An increased decentralisation of MDR-TB services is expected to increase the treatment initiation rate and the MDR-TB treatment success rate. But three years later we find that implementation of the framework is happening slow and in a haphazard way.

While we welcome the inclusion of several new indicators relating to MDR-TB in the Annual Report 2013/14, we are concerned to see that three years into the implementation of the framework only 26 districts have a decentralised MDR unit which is just over half of the set target. Furthermore, it is highly concerning that the number of TB MDR clients initiated on treatment is as low as 7,218 when the number of notified MDR-TB cases is close to 15,000.

Delay of implementation by provinces means a continuous increase of the treatment gap, low cure rates and an increase in transmission of DR-TB. Without a concerted effort to speed up the implementation of the framework and increase the targets of the aforementioned indicators, we will see a further increase of an epidemic that is already spiralling out of control.

RECOMMENDATIONS:

11. We recommend that the Committee request the NDoH to provide regular updates of the progress in decentralisation of DR-TB care. While implementation is being done by provinces, the NDoH is ultimately responsible and there must provide oversight and direction.

12. We recommend that the Committee call on the Department to engage with provincial health departments to ensure commitment to implementing the national response to MDR-TB. Where

necessary, the NDoH should indicate what budgetary resources should be earmarked and/or ring fenced for addressing MDR-TB in the provinces.

13. We recommend that the Committee call on the NDoH to publish the provincial operational plans as the pertain to MD-TB treatment and prevention with annual progress reports on implementation.

TB and HIV in prisons

It is well established that the prison environment where a large number of people reside in an often small and badly ventilated space is highly conducive to the transmission of infectious diseases like TB and HIV. HIV prevalence in South Africa's prisons is estimated to be between 20% and 41%. The prevalence of TB is estimated to be between 3 to 7 times higher than in the general population. Sufficient access to healthcare services therefor is not a mere luxury, it is an essential condition to prevent prisons from becoming breeding grounds for infectious diseases.

In 2012 the Judicial Inspectorate for Correctional Services (JICS) reported that the number of health care complaints received by JICS dramatically increased by 255% during 2007-2010. The JICS Annual Report 2013/14 shows a further 54% increase in the number of healthcare related complaints compared to 2011/12. The top 3 complaints regarding healthcare are 1) failure to provide medical treatment, 2) inadequate medical treatment and 3) ARV –HIV/TB related treatment. With incidence rates of HIV and TB at levels higher than anywhere else in the world, poor access to and inadequate provision of healthcare services is exceedingly concerning.

While the Department of Health has made great progress in screening inmates for HIV and TB, treatment and support services are often not available to inmates and transmission dynamics are not being arrested. The consequences are dire: delayed ART initiation, interruption of treatment, CD4 counts and viral load not being monitored. We are further concerned that no attention is paid to the two most deciding factors in the transmission of TB: overcrowding and lack of ventilation.

RECOMMENDATIONS

14. We recommend the NDoH undertake a baseline survey on the prevalence of TB in prisons. We recommend the Committee request the NDoH on a annual basis provide an incidence report to evaluate the current TB strategy and monitor the extent of the TB epidemic within South Africa's correctional facilities.

15. The NDoH must play a greater role in ensuring the problem of TB in prisons is effectively addressed. This must include access to treatment and care – and not only screening. Inmates require adequate access to timely and appropriate health care services. We recommend that NDoH in collaboration with the Department of Justice and Correctional Services (DJCS) and the JICS to identify the main barriers to access healthcare services and develop an appropriate strategy for ensuring sufficient health care personnel and security officials to ensure inmate's right to health.

16. As a matter of urgency, the NDoH needs to convene a joint sitting with the DJCS and Department of Public Works to develop an emergency response plan that targets ventilation and overcrowding within the correctional facilities. The plan should prioritise, as a matter or urgency, the most overcrowded prisons. To curb the TB epidemic in South Africa it is crucial that there is a coherent plan in place to address the main factors that are fuelling the transmission of this infections disease in South Africa's prisons and correctional facilities.

4.1.3. Women's Maternal and Reproductive Health

Cervical Cancer

In his 2013/14 Budget Speech the Minister for Health, Dr Aaron Motsoaledi, raised the issue of cervical cancer and described it as "*one of the biggest killers of women".*[6] Despite it being a preventable disease, cervical cancer remains South Africa's biggest women's health problems, affecting one out of 41 South African women. [7] In spite of having a screening policy for cervical cancer the National Department of Health and Provincial Departments of Health have failed to ensure sufficient resources are available for instance appropriately equipped and staffed facilities for both diagnosis and treatment and that these facilities are accessible to the majority of South African women.

The HIV epidemic has had a further devastating effect on women. HIV-infected women have an increased risk of cervical cancer and yet they, despite already being in the health system, continue to be seriously disadvantaged by the lack of formally implemented population-based screening strategy.[8]

We commend the Department's announcement that funds will be made available within the National Health Grant of R200 million in both 2014/15 and 2015/16 for the roll out of free cervical cancer vaccines for girls aged 9 to 12.[9] It will be critical to monitor the implementation of this programme especially once it becomes funded through the provincial equitable share from 2016/17.

RECOMMENDATIONS:

17. The NDoH must ensure better communication and public awareness of the HPV vaccine.

18. The NDoH must coordinate with the Department of Basic Education to ensure that school-going learners have access to means to protect themselves against sexually transmitted infections. The National Minister of Health has argued, in Parliament, that in order to support the NDoH's efforts the Department of Basic Education must facilitate the inclusion of a quality age

[6] Dr Aaron Motsoaledi, Health Budget Vote Speech 2013/14, 15 May 2013 available from http://www.pmg.org.za/briefing/20130515-health-ministers-budget-vote-speech-responses-ancifp-and-da

[7] Prevention of cervical cancer – how long before we get it right? Snyman, Vol 19, No 1, 2013 SAJOG available from http://www.sajog.org.za/index.php/SAJOG/article/view/651/336

[8] Prevention of cervical cancer – how long before we get it right? Snyman, Vol 19, No 1, 2013 SAJOG available from http://www.sajog.org.za/index.php/SAJOG/article/view/651/336

[9] 2014 Estimates of National Expenditure, Vote 16: Health available from http://www.treasury.gov.za/documents/national%20budget/2014/ene/FullENE.pdf

appropriate sex and reproductive health education throughout the national curriculum as well as to ensure access to condoms where at schools facilities. We recommend that the Committee support the National Minister's call and recommend that the Department of Basic Education support the NDoH's initiatives to ensure better sexual and reproductive health amongst school-going learners.

4.2. Programme 4: Primary Health Care Services (PHC)

4.2.1. Sub-Programme Violence, Trauma and *EMS*

Emergency Medical Services and Planned Patient Transport

We commend the Department on establishing in 2013/14 the National Committee on Emergency Medical Services in order to coordinate emergency medical services throughout the country. The TAC and BEMF has received a number of reports from the Eastern Cape, Mpumalanga and Free State that EMS services are largely inaccessible. Ambulance services are inadequate and the response times of emergency medical services are poor especially in rural areas. There have also been reports of planned patient transport shortages limiting the accessibility of health facilities to patients requiring transport.

Section 90 (1) (m) of the National Health Act enables the Minister to develop national regulations with minimum standards for the operation of emergency medical services and planned patient transport. In July 2014 the NDoH released for comment Emergency Medical Services Regulations. We look forward to seeing the finalisation of these regulations after thorough consultation with both the state, civil society and broader public.

RECOMMENDATION:

- We recommend that the Committee to call on the Minister, as a matter of urgency, consider submissions on, finalize and bring into operation the Emergency Services Regulations published for comment on 24 July 2014. National standards on emergency medical services that make provision for the services to be made available in provinces are urgently required to ensure the realization of the right not to be refused emergency medical treatment and the right to emergency medical services.

Health and Gender-Based Violence

The Minister of Health in his 2013/14 Health Budget Speech made no mention of the costs of gender-based violence to the health system and the need for the health system to address these needs.[10] This is despite the Department drawing a correlation between gender-based violence and women's health in the NHI Green Paper. However, in the absence of the publication of the NHI white paper, despite promises by the Minister of Health and Minister of Finance, it remains difficult to assess developments with respect to role the NDoH is playing in addressing gender based violence.

[10] Dr Aaron Motsoaledi, Health Budget Vote Speech 2013/14, 15 May 2013 available from http://www.pmg.org.za/briefing/20130515-health-ministers-budget-vote-speech-responses-ancifp-and-da

It should be acknowledged that a multisectoral, interministerial approach needs to be adopted to address the costs of gender-based violence, including costs of policing, judicial system, education programmes, care and compensation of victims for loss of work. A welcome development was the establishment of a new sub-programme – Violence, Trauma and EMS – within the Primary Health Care Services of the National Department of Health with a sub-programme budget of R12.5 million.

According to the Department in 2013/14 a National Health Sector Strategic Plan for injury and violence prevention was developed. They also report that as part of this strategic plan a National Forensic Pathology Services Committee was established and gazetted including a notice for Nomination for this Committee in relation to the National Health Act.

It is hoped that this programme will be able to play a critical role in addressing the burden of gender-based violence on the health sector. In particular, the National Department of Health should ensure that at the level of service delivery that mechanisms are put in place to track those using health facilities being treated as a result of gender-based violence as well as tracking, wherever possible, the cost of providing these services. [11]

RECOMMENDATIONS:

- We recommend that the Committee call on the NDoH to show the political leadership necessary to drive the development of a fully-costed National Strategic Plan for Gender Based Violence (GBV-NSP).

- We call on the Committee to hold public hearings on the development of a fully-costed National Strategic Plan for Gender Based Violence. The Committee would be playing a critical role in ensuring that there is broad public awareness and participation in shaping a national response to Gender Based Violence.

4.3. Health Financing and National Health Insurance| Programme 2: National Health Insurance, Health Planning and Systems Enablement.

Nearly three years after Green Paper was published in August 2011, the National Department of Health has still not published for comment the White Paper on National Health Insurance (NHI). According to the NDoH's Annual Report they had planned by the end of 2013/14 to have *"White Paper on NHI finalised and Gazetted".* However, the Department reports that they managed to have the "*draft White Paper on NHI revised and tabled to the Social Cluster in November 2013"* and did not finalised and gazetted as planned. The reason the Department provides for not having achieved their planned target for 2013/14 was because of *"consultations with the National Treasury to determine consistency between the proposals outlined in the White Paper and the discussion issues in the Treasury paper on Financing NHI".* Furthermore, the Department had set itself the target of developing a conceptual framework for the creation of a NHI fund and that by the end of the

[11] Watson, J. The Cost of Justice In South Africa. Tracking expenditure on gender-based violence in the Department of Justice and Constitutional Development. Available from http://www.shukumisa.org.za/wp-content/uploads/2014/03/The-Cost-of-Justice-in-South_-Africa-_Final-07Mar.pdf

2013/14 financial year they had developed a *"draft document outlining the proposed structure of the NHI Fund".* According to the Department the reason for why they had not been able to finalise the document for the creation of the NHI fund was because to do this depended on the finalisation of the NHI White Paper.

Since April 2012, the piloting of NHI in 11 pilot districts in all nine provinces of South Africa has seen uneven progress across the districts in piloting for the implementation of the NHI. Since 2012, some of the key areas where the department experienced uneven progress include the contracting of general practitioners (GPs) and other health service providers in the pilot districts, the implementation of innovative information management systems, reimbursement mechanisms and revenue management at central hospitals, and lastly the availability and quality of health facilities in the pilot districts.

Overall, Programme 2 underspent its budget by R295 089 (59.9%) million against a budget of R 492 994 million for 2013/14. The sub-programme 2.4. Health Financing and NHI contributed the most to the under expenditure having, at the end of 2013/14 financial year, spent only R76 029 million (or 20.7%) of its budget of R 366 499 million. According to the Department the *"the under expenditure is mainly due to the slow take-off of the national Health Insurance Indirect Grant"*.

Given the performance of the programme and the reported under expenditure during 2013/14, it comes as no surprise that the NDoH has reported uneven progress in the piloting of NHI. In the Department's annual report they state that some of the challenges they experienced during 2013/14 were that they had only being able to contract 119 general practitioners (GPs) out of a target of 600 GPs for 533 clinics. The NDoH claims that the contracting of GPs was challenging because of "*the slow uptake from potential GPs and contractual concerns raised GPs".*

A second challenge has been the lack of adequate improvement to the infrastructure in the pilot districts. In March 2014 the NDoH reported to the Standing Committee on Appropriations that *"there were 872 health facilities in the 11 NHI districts which required a variety of upgrading and refurbishments so as to meet the required quality standards prescribed by the National Health Insurance programme"*. The Department reports in its Annual Report that by the end of 2013/14 a total of 91 projects were cancelled, 842 projects were in various stages of construction, 587 projects were in different stages of planning, 39 projects were handed over and 409 were at the retention stage. In addition, the Department reports that they made progress towards finalisation of Infrastructure Norms and Standards through the CSIR and that Forty-Three activities/packages were developed and presented to the Technical Advisory Committee of the National Health Council (NHC) and approved by the NHC to be gazetted in 2014/15. These guidelines are critical for the NDoH and civil society, activists and individuals to be able to assess the quality of the health facilities they are monitoring and using.

A third significant challenge has been the lack of progress in establishing clinic/health committees and hospitals boards in the pilot sites. These structures are meant to serve as the principal institutions for community participation in primary healthcare service delivery. The available

information from the NDoH, to date, suggests that while nearly all the pilot districts reported to have hospital boards and clinic/health committees there is little detail about how these bodies function and the extent to which they facilitate meaningful community participation. The NDoH has been slow in finalising for public comment national regulations/guidelines on health committees that set out a national policy for the provinces to follow in order to institutionalise the structure, role, function and mandate of clinic committees. This includes planning and budgeting appropriately for the resources to enable health committees to work optimally, as set out by section 42 of National Health Act, including providing for human resources, physical infrastructure and operational costs.

The resources that have been spent and will be spent for the new NHI services and innovations being currently being piloted necessarily depend on improvements to the standard of the quality of services being provided at facilities (including the quality of infrastructure) and the presence of strong community participation and oversight of health facilities. As part of its review of the piloting process, the NDoH must ensure that standards are maintained in terms of cleanliness, the availability of medicines and supplies, staff attitudes, patient safety and functional hospital boards and clinic/health committees.

The provision of a comprehensive package of primary healthcare services is the foundation of South Africa's health system. It is of concern that by the end of 2013/14 almost a 3rd of the NHI pilot sites reported having the necessary staffing levels, infrastructure, pharmacy services, equipment to ensure the access to the right to health care.

RECOMMENDATIONS

- We recommend that the Committee call on the National Minister of Health to table for public comment the White Paper on NHI as well as publish for public comment the document on the creation of the NHI Fund.

- We encourage the Committee to call on the National Minister of Finance to table for comment the Treasury Financing paper on NHI.

- The absence of policy at national and provincial level on the status of Health Committees must be addressed as a matter of urgency and coupled with planning and budgeting for the necessary resources(human resource support, training, operational costs and physical infrastructure as needed) for health committees to function optimally. In developing policy on health committees the NDoH must do so in consultation with state, civil society and community stakeholders in a manner that is participatory and responsive.

- The NDoH must provide clear plans for how they will monitor better spending, value for money and performance of the National Health Insurance Indirect Grant during the 2014/15 financial year.

SECTION C

5. National Department of Health's Performance in 2013/14 is only as good as the worst performing of the Provincial Health Departments

The National Department of Health performance in 2013/14 should be assessed against the performance of the nine provincial departments of health. We note with grave concern that the Department's Annual Report does not report, in any meaningful way, the challenges that the Provincial Departments faced during the 2013/14 financial year in realising the right to health care.

5.1. Learning from the Free State[12] to Prevent Provincial Health Crisis

The crisis in the provision of health care services in the Free State is not a new one and nor is it unique to the Free State. In fact, it is merely a symptom of the continued malaise in the provision of health care services across South Africa's nine provinces.

In November 2013, the Stop Stockouts Project (SSP)[13] released the results of a large national survey of stockouts of HIV and TB medicines in public healthcare facilities across South Africa. The survey found that the Free State was the hardest hit of all the provinces with over half of health facilities surveyed having experienced a stockout in the preceding three months. In the months before the release of the SSP report the TAC and partner organisations had been receiving reports and releasing alerts. These alerts stated concern over a slowly collapsing public health system, the evidence of which is borne out of the many stories[14] the TAC and its members were receiving on a frequent basis from those who are dependent on the Free State's crumbling health system.

By July 2014, well into the first quarter of the new financial year, it was revealed that an effective moratorium had been placed on certain public health services in the Free State. As a result of the reported failures in health care delivery in the province, the Free State Provincial Treasury was given the financial delegations of the Free State Department of Health in order to address the financial challenges facing the Department. In reply to a request by the BEMF and the TAC to better understand the financial status of the Free State Department of Health, the Provincial Treasury informed us that the Free State Department of Health at the beginning of the 2014/15 financial year had unpaid accounts from the 2013/14 financial year (as well as previous years) amounting to R657 million just over half a billion rand.

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[12] Unfortunately these concerns are not new. In 2008/09 the TAC revealed a moratorium on enrolling new patients on ARVs that lasted for five months. We also drew attention to other deep problems with the delivery of health services. Essentially the same concerns as exist today were outlined in the 2009 Integrated Support Team investigation that was commissioned by then Health Minister Barbara Hogan into the Free State health system. There seems to be no evidence that its recommendations have been implemented.

[13] The SSP is a joint project of the Southern African Clinicians Society, Medicins Sans Frontiers (MSF), Rural Doctors Association of South Africa (RuDASA), Rural Health Advocacy Project (RHAP), SECTION27 and the TAC The report can be access on the Stop Stock Outs Project website http://stockouts.org/

[14] The Timeline of the Free State Health Crisis is available on the Treatment Action Campaign Website on http://www.tac.org.za/sites/default/files/Free%20State%20Health%20Crisis%20-%20Timeline_1.pdf

Similar reports of failures in the delivery of health services were being reported in Mpumalanga, Eastern Cape and Gauteng. For example, in October 2013 the Mpumalanga Provincial Government placed the Health Department under curatorship which was effectively an admission on the part of the Premier and the executive of the province that health delivery in the Province was in a crisis. By October 2013 the Mpumalanga Health Department was on course to overspend its budget by nearly half a billion rand (R500 million). In order to prevent the Mpumalanga Health Department from overspending measures were put in place to cut spending which had a knock on effect on service delivery in the province.

Despite implementing a turnaround plan, the Gauteng Health department continues to be dogged by stockouts and drug shortages due to non-payment of suppliers. In addition, in March 2014 the TAC and BEMF received reports that the Gauteng Department owed the National Health Laboratories (NHLS) over R900 million putting at risk the ability of the NHLS to provide services in the province.

The TAC and BEMF have been monitoring the state of health services in the Eastern Cape and in September 2013, SECTION27 and the TAC released a comprehensive report titled Death and Dying in the Eastern Cape[15]. The report was informed by years of monitoring, community consultations from across the province.

Common themes emerged from the various reports that the TAC and BEMF received on the state of health services in the Free State and from the provinces that TAC and BEMF are monitoring. The following themes were emerging:

19. **Facilities** – The poor quality of facilities hampers health care delivery with a lack of electricity, running water and inadequate space, the buildings often falling apart.
20. **The availability of medication and supplies/supply chain management** – Stock outs and shortages of essential medicines and medical supplies are rampant with supply chain management throughout the health care system in a state of chaos, directly impacting patient care.
21. **Human Resources** – The combination of a high vacancy rate and an out of date personnel system has catastrophic consequences for the delivery of health care and it frequently takes at least six months for an appointment to be confirmed if at all, with employees not paid.
22. **Management** – There is no proper management and the day-to-day functioning of health facilities goes unattended, with chronic under-staffing; facilities falling into disrepair; equipment going unrepaired and new equipment not obtained.
23. **Transport and Emergency Medical Services** – Patient transport and EMS are entirely absent in many places and insufficient in others with patients waiting hours for an ambulance that at times do not arrive.

[15] To read the report and the work of the Eastern Cape Health Crisis Action Coalition go to http://echealthcrisis.org/

24. **Equipment** – Equipment shortages and faulty equipment are rife with reports of TB Hospitals without x-ray machines and busy clinics with only one blood pressure cuff.
25. **Staff accommodation** – Many facilities have no or poor quality and insufficient accommodation and in some no electricity or running water. and the accommodation is filthy and run down.
26. **Rehabilitation and home based care** –Some facilities have no budget for rehabilitation supplies, making preventative and home-based care impossible.
27. **Budgeting and expenditure** – Underpinning many of the challenges are the chronic failures in the effective mobilisation of the budget.

RECOMMENDATIONS

28. More detail is required in the National Department of Health's Annual Report regarding the performance of the provincial Department's of health in implementing key national priority programmes.

29. We recommend that the Committee call on the National Minister of Health as a matter of urgency to convene a national forum to develop a national strategy for addressing provincial delivery of health services. The National Minister should call on the various expert teams that have, over the years, developed turnaround strategies, made recommendations in the reports of Special Investigating Unit (SIU), Integrated Support Teams and so forth. Such a forum should seek to put an end to the year-on-year crisis management that the NDoH is called on to undertake within the provinces but rather develop a financial and non-financial diagnostic tool that serves as an early warning system to guide provinces and the National Minister.

30. The Committee should request from the National Treasury the expenditure reviews that Treasury has undertaken that are relevant for the Committee to better understand the financial performance of the National and Provincial Departments of Health.

31. We recommend that the Committee as a matter of urgency conduct an oversight visit to the Free State, Mpumalanga and the Eastern Cape to assess for the Honourable Members themselves the status of health care service delivery within in these provinces.

ENDS