SOUTH AFRICAN HUMAN RIGHTS COMMISSION REPORT

Complaint File Ref. No.: KZ/1516/0451

DR IMRAN KEEKA, **DEMOCRATIC ALLIANCE, MPL**	**Complainant**
and	
ADDINGTON HOSPITAL	**First Respondent**
INKOSI ALBERT LUTHULI CENTRAL HOSPITAL	**Second Respondent**
DEPARTMENT OF HEALTH, KWAZULU-NATAL	**Third Respondent**
MEC: DEPARTMENT OF HEALTH, KWAZULU-NATAL	**Fourth Respondent**

INVESTIGATIVE REPORT

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1. INTRODUCTION

1.1. This report sets out findings and recommendations in respect of the complaint lodged by Dr Imran Keeka with the South African Human Rights Commission (Commission).

1.2. The complaint relates to both shortages of staff and a lack of functional health technology machines for screening, diagnosing and treating cancer in the KwaZulu-Natal Province (KZN Province). This, it is alleged, has a negative effect on the provision of oncology services in the KZN Province.

2. POWERS AND FUNCTIONS OF THE COMMISSION

2.1. The Commission is an institution established in terms of section 181 of the Constitution of the Republic of South Africa, 1996 (the Constitution).

2.2. In terms of section 184 (1) of the Constitution, the Commission is specifically mandated to:

2.2.1. Promote respect for human rights and a culture of human rights;

2.2.2. Promote the protection, development and attainment of human rights; and

2.2.3. Monitor and assess the observance of human rights in the Republic.

2.3. Section 184(2) of the Constitution states that the Commission has the powers, as regulated by national legislation, necessary to perform its functions, including the power:

"(a) to investigate and to report on the observance of human rights;
(b) to take steps to secure appropriate redress where human rights have been violated."

2.4. The South African Human Rights Commission Act, 40 of 2013 (SAHRC Act/SAHRCA), provides the enabling framework for the powers of the Commission.

2.5. Section 15 of the SAHRC Act determines the procedure to be followed in conducting an investigation regarding the alleged violation of or threat to a fundamental right.

2.6. The Commission's Complaints Handling Procedures (CHP) articulate the procedures to be followed in conducting an investigation regarding an alleged violation of or threat to a fundamental right. Article 3(a) of the CHP provides that the Commission has the jurisdiction to conduct or cause to be conducted any investigation on receipt of a complaint into any alleged violation of, or a threat to a fundamental right after assessing a complaint for that purpose.

3. THE PARTIES

3.1. The Complainant, Dr Imran Keeka, is a Member of the Provincial Legislature for the Democratic Alliance in KZN Province (Complainant).

3.2. The First Respondent is Addington Hospital, a public hospital situated at 16 Erskine Terrace, Durban (First Respondent or Addington Hospital).

3.3. The Second Respondent is the Inkosi Albert Luthuli Central Hospital, a public hospital situated at 800 Bellair Road, Durban (Second Respondent or IALC Hospital).

3.4. The Third Respondent is the Provincial Department of Health in KZN Province (Third Respondent or the Department). The Department is responsible for providing health care services in KZN Province.

3.5. The Fourth Respondent is the Member of the Executive Council for Health in KZN Province (Fourth Respondent or MEC) and is cited in his nominal capacity as the MEC responsible for the health in the Province.

4. THE COMPLAINT

4.1. On or about 19 February 2016, the Commission received a written complaint from the Complainant in terms of which he raised a number of challenges regarding the provision of health care services to oncology patients in the KZN Province.

4.2. In particular, the Complainant alleged that:

4.2.1. There were insufficient radiotherapy treatment devices and/or facilities in the KZN Province which had a negative impact on the treatment of oncology patients who reside in the Province;

4.2.2. The radiotherapy machines, known as the Varian Rapid Arc Linear Accelerator Machine (VRALA), used for radiotherapy treatment at Addington Hospital were not working;

4.2.3. There were delays in the treatment of oncology patients which the Complainant attributed to the shortage of functional health technology including the VRALA Machines CT scanners; and

4.2.4. The Department was failing to provide oncology patients with adequate health care services.

5. PRELIMINARY ASSESSMENT OF THE COMPLAINT

5.1. The Commission conducted a preliminary assessment of the complaint and determined that the matter raises issues relating to the right to have access to health care services which is enshrined in section 27 of the Constitution as well as other interrelated rights that are implicated such as the rights to life and human dignity.

5.2. As highlighted above regarding the powers and functions of the Commission, the institution has the jurisdiction to investigate human rights violations and to

take steps to secure appropriate redress where human rights have been violated.

5.3. On this basis the Commission determined that an investigation into the complaint should be undertaken in order to establish the veracity of the allegations raised by the Complainant and whether the alleged shortage of health technology machines and delays in the provision of health care services constitute a violation of the right to have access to health care services in terms of section 27 of the Constitution.

6. STEPS TAKEN BY THE COMMISSION TO INVESTIGATE THE COMPLAINT

6.1. The methodology adopted in the Commission's investigation of the complaint included:

6.1.1. Written correspondence between the Commission and the Respondents;

6.1.2. Interviews with staff members and patients; and

6.1.3. Inspections *in loco*.

6.2. The Commission analysed the facts and evidence obtained during the investigation against the relevant legal framework, including the Constitution, legislation, international law, case law and policy.

6.3. After the conclusion of its investigation, the Commission provided the parties with a copy of its preliminary investigative report on 24 April 2017.

6.3.1. Parties were invited to provide comments to the Commission on or before 25 May 2017.

6.3.2. The Complainant responded on 25 May 2017 and indicated that he was satisfied with the preliminary report and did not wish to provide any comments.

6.3.3. No responses were received from the First, Second and Fourth Respondents. The non-responsiveness by the Respondents are in contravention of the SAHRCA which requires cooperation with the Commission in the course of an investigation.

6.3.4. A response, (including two (2) annexures) was received from the Third Respondent on 25 May 2017.

6.3.5. In summary, the following comments were submitted by the Third Respondent:

i. Third Respondent disputed the information obtained by the Commission from interviews conducted with hospital staff regarding the functionality of the scanning facility at IALCH; reasons for the resignation of highly skilled specialists and shortage of staff;

ii. That Third Respondent had advertised and head-hunted to fill the vacant posts of oncologists without success;

iii. That there is sufficient radio-therapy equipment available in eThekwini;

iv. That the backlog in patient treatment is not caused by the lack of machines;

v. Annexure 'A,' provides a summary of the patient flow and activities at the IALCH. It confirms that there are delays and/or lengthy waiting periods in the provision of oncology services; and

vi. Annexure 'B', which is entitled, "Oncology Services Report" provides an over-view of the oncology services for KZN. The report confirms that there is a back-log for patient treatment and further confirms that KZN Health oncology services are 'in crisis'.

6.3.6. The Commission considered the response of the Third Respondent and is of the view that the response while indicative that some steps are being taken to address the 'crisis' in part, does not materially alter the findings and recommendations of the report.

Written correspondence between the Commission and the Department

6.4. On 4 May 2016, the Commission addressed a letter to the Department in which it set out the allegations brought to its attention through the communication of the complaint and afforded the Department an opportunity to respond to the allegations.

6.5. On 8 June 2016, in response to the allegations, the Department advised that:

6.5.1. There are eighteen (18) CT scanners at various health establishments in the KZN Province, of which seventeen (17) were fully functional. One CT scanner was awaiting installation upon the finalisation of the preparation of its infrastructural site.

6.5.2. The Department had procurred four (4) additional CT scanners, which had been allocated to Addington Hospital, Grey Hospital, King Edward VIII Hospital and Empangeni Hospital respectively.[1] The Department stated that, with the provision of these additional CT scanners, there would be a sufficient number of functional CT scanners to cater for oncology patients in the KZN Province.

[1] The CT scanner at Ngwelezane Hospital was awaiting the completion of infrastructural work that was required to accommodate the new unit.

6.5.3. The Department also provided tables reflecting the status of the existing CT scanners in the KZN Province. These are provided below.

FIGURE A: EXISTING CT SCANNERS

DISTRICT	HOSPITAL	STATUS	SERVICE MAINTENANCE AGREEMENT (SMA)
eThekwini	King Dinizulu	Functional	SMA in place
eThekwini	Prince Mshiyeni	Functional	No SMA in place. Servicing is conducted on an *ad hoc* basis
eThekwini	Addington	Functional	No SMA in place. Servicing is conducted on an *ad hoc* basis
eThekwini	RK Khan	Functional	No SMA in place. Servicing is conducted on an *ad hoc* basis
eThekwini	Inkosi Albert Luthuli Central	Functional	SMA in place as per the Public Private Partnership arrangement
Ilembe	Stanger	Functional	No SMA in place. Servicing is conducted on an *ad hoc* basis
Ugu	Port Shepstone	Functional	No SMA in place. Servicing is conducted on an *ad hoc* basis
UMgungundlovu	Edendale	Functional	No SMA in place. Servicing is conducted on an *ad hoc* basis
UMgungundlovu	Greys (X-Ray Department)	Functional	SMA in place

Amajuba	Madadeni	Functional	No SMA in place. Servicing is conducted on an *ad hoc* basis
Uthukela	Ladysmith	Functional	No SMA in place. Servicing is conducted on an *ad hoc* basis
Uthungulu	Ngwelezana	Functional	No SMA in place. Servicing is conducted on an *ad hoc* basis

FIGURE B: NEWLY PROCURED CT SCANNERS

DISTRICT	**HOSPITAL**	**STATUS**	**SERVICE MAINTENANCE AGREEMENT (SMA)**
eThekwini	King Edward VIII	Functional	SMA in place as per the Lease Agreement
eThekwini	Addington (Oncology)	Functional	SMA in place as per the Lease Agreement
UMgungundlovu	Greys (Oncology)	Functional	SMA in place as per the Lease Agreement
Uthungulu	Ngwelezane	Awaiting installation	SMA in place as per the Lease Agreement

6.5.4. The Department also advised it has Service Maintenance Agreements (SMAs) in place with respect to fifty percent (50%) of the CT scanners in the KZN Province and that it was in the process of finalising SMAs for those that did not have any.

6.5.5. It asserted that it strives to maximise the utilisation of its scarce resources by adopting cost-containment strategies which compromises the quality of services. One of the critical components of this strategy is the proper and efficient implementation of a Patient Referral System

through which patients are referred by hospitals that do not have CT scanners to those that do.

6.5.6. As to the status of the VRALA Machines, the Department advised that there were two (2) VRALA Machines at Addington Hospital which are not functional. A service provider had apparently been appointed to undertake repairs to the VRALA Machines. One of the VRALA Machines was working in March 2016 but had broken down in November 2016. The Department stated that it was conducting an investigation into certain matters relating to the SMAs applicable to VRALAs.

6.6. Having addressed another letter to the Department with a view to soliciting a more comprehensive response to the allegations, the Commission was advised that the Department:

6.6.1. had prioritized the expansion of its oncology services at the Ngwelezana, Madadeni and Port Shepstone Hospitals which would be finalised within the next five (5) years.

6.6.2. Had attempted to recruit specialist oncologists to mitigate the shortage of same in the KZN Province.

6.6.3. The oncology services of Addington and IALC Hospitals had been combined due to a shortage of staff and the loss of oncologists in both hospitals. The Department stated that, over the past six (6) months, it had lost four (4) oncologists at IALC Hospital and two (2) from Addington Hospital. The Department conceded that the shortage of oncologists has a direct impact on the time that patients have to wait in order to access treatment.

6.6.4. The table below reflects the number of oncologists at the listed hospitals:

FIGURE C: NUMBER OF ONCOLOGISTS AND MEDICAL OFFICERS

HOSPITAL	NUMBER OF SPECIALISTS	NUMBER OF MEDICAL OFFICERS
Addington Hospital	3	2
IALC Hospital	1	4
Greys Hospital	4	5

6.6.5. The Department also stated that it had noted an increase in the incidents and prevalence of cancer conditions in KZN Province which resulted in a high demand for oncology services. It undertook intensifying its cancer screening programmes for early diagnosis and management within the 2017/2018 financial year.

6.6.6. An update regarding the functionality of CT scanners as at 11 January 2017 was provided by the Department and is reflected in the table below:

FIGURE D: STATUS OF CT SCANNERS IN KZN PROVINCE AS AT 11 JANUARY 2017:

DISTRICT	HOSPITAL	STATUS	COMMENTS
eThekwini	Addington	Functional	-
eThekwini	Addington Oncology	Functional	-
eThekwini	King Dinizulu	Functional	-
eThekwini	Prince Mshiyeni	Not Functional	Unit is in the process of being repaired
eThekwini	RK Khan	Functional	-
eThekwini	Stanger	Functional	-
eThekwini	King Edward VIII	Functional	-

eThekwini	Inkosi Albert Luthuli	Functional	-
eThekwini	Inkosi Albert Luthuli	Functional	-
eThekwini	Inkosi Albert Luthuli	Functional	-
Ugu	Port Shepstone	Functional	-
UMgungundlovu	Edendale	Not Functioning	Unit is in the process of repaired.
UMgungundlovu	Greys	Functional	-
UMgungundlovu	Greys Oncology	Functional	-
Amajuba	Madadeni	Functional	-
Uthukela	Ladysmith	Functional	-
Uthungulu	Ngwelezana	Functional	-
Uthungulu	Ngwelezana	Awaiting installation	-

6.6.7. The CT scanners that do not have SMAs are repaired on an *ad-hoc* basis and the Department advised that it was in the process of advertising an open tender for the maintenance of such CT scanners at the Addington and Greys Hospitals.

6.6.8. The Department provided statistics of patients treated at the Oncology Units between October 2016 and December 2016, illustrated below:

FIGURE E: STATISTICS OF PATIENTS TREATED BETWEEN OCTOBER 2016 AND DECEMBER 2016

HOSPITAL	INDICATOR	OCTOBER 2016	THIRD QUARTER: NOVEMBER 2016	DECEMBER 2016
INKOSI ALBERT LUTHULI CENTRAL	CT Scan – No. of patients seen	118	115	90
	CT Scan – No. of examinations performed	118	115	90
	Radiology and Oncology usage- Chemotherapy statistics	726	694	442
	Oncology Patient Load	40 patients per day		
	Waiting times – Palliative	1 month	2 months	4 months
	Waiting times – Curative and/or adjunct	8 months	9 months	10 months
	Backlog Status	**54 patients**	**80 patients**	**152 patients**

ADDINGTON	CT Scan – No. of patients seen	38	22	14
	CT Scan – No. of Examinations performed	26	6	26
	Radiology and Oncology usage – Chemotherapy Statistics	159	120	78
	Oncology Patient load	42 patients per day (patients from November and December referred to INKOSI ALBERT LUTHULI CENTRAL HOSPITAL)		
	Waiting times – Palliative	1 week	Refer to stats above for Second Respondent (Inkosi Albert Luthuli)	Refer to stats above for Second Respondent (Inkosi Albert Luthuli)
	Waiting times – curative and/or adjunct	2 – 3 weeks	2 months	3 months
	Backlog status	**120 patients**	**120 patients**	**120 patients**
GREYS	CT Scan – No. of patients seen (planning scans)	187	195	156

	CT Scan – No. of Examinations performed	50	49	28
	Radiology and Oncology usage – Chemotherapy statistics	503	556	554
	Oncology patient load	40 patients per day		
	Waiting times – Palliative	2 months	2 months	2 months
	Waiting times – curative and/or adjunct	7 months	7 months	7 months
	Backlog status	**128 patients**	**146 patients**	**171patients**

6.6.9. Grant funding had apparently been provided to all State-aided hospitals in an attempt to improve accessibility of palliative care services.

6.7. Having brought the response by the Department to attention of the Complainant, the Complainant furnished additional information to the Commission for its consideration in September 2016.

6.8. The Department proceeded to reply to the additional information provided on 12 January 2017. The Commission noted that despite being comprehensive in nature, the Department's response did not fully address the specific issues or concerns that it had raised.

6.9. On 20 January 2017, the Commission addressed another letter to the Department seeking pointed clarity on some of the outstanding issues.

6.10. On 9 March 2017, the Department wrote to the Commission:

6.10.1. Advising that the VRALA machines at the Addington Hospital were not functional and that it was finalizing an addendum to the main SMA contract. It further advised that the issue pertaining to the maintenance contract for the VRALA machines was still under investigation;

6.10.2. A breakdown of the facilities of the IALC Hospital, the number of patients treated through the use of the three (3) VRALA machines between September 2016 and January 2017, was provided as set out in the table below:

FIGURE F: BREAKDOWN OF THE NUMBER OF PATIENTS TREATED ON EACH VRALA MACHINE BETWEEN SEPTEMBER 2016 AND JANUARY 2017

Machine Name	**Number of patients treated on the machine between Sept 2016 and Jan 2017**	**Number of patients treated per day**
VRALA No.1	640	21
VRALA No.2	722	37
VRALA No.3	190	10

6.10.3. The Department advised the average waiting period for a patient to be seen by an oncologist is five (5) months whereas those waiting to receive radiotherapy usually wait eight (8) months. A process was underway to re-instate the functionality of the VRALA machines.

6.10.4. The Department denied however that these delays and the backlog of patients was caused due to the referral of patients from Addington Hospital. Instead, such backlog in the treatment of

oncology patients was apparently caused by staffing constraints including the shortage of specialist oncologists, medical officers and radiotherapists.

6.10.5. The Department advised that it had devised an integrated approach to dealing with the backlog, which inter alia entailed:

i. Merging of the Oncology Centres at the Addington and IALC Hospitals.

ii. Initiation of a process of acquiring the services available in the private sector to reduce oncology backlogs as an interim measure and to take on priority cases in both radiotherapy and chemotherapy.

iii. Focussing on existing cases with a view to fast track the current backlog within the Department's available resources.

iv. Prioritizing the recruitment through a headhunting process of staff at the Head Clinical Unit for Oncology, including Specialist Oncologists, Medical Officers and Radiotherapists.

6.10.6. The Commission released its provisional report to the parties on 27 April 2017. In its response to the findings, the Department through Dr Mtshali, Head of the Provincial Department of Health, provided the Commission with a response reiterating the information provided in paragraphs i – iv above. In addition, the Department provided the Commission with two reports annexed to the response, providing statistical information and confirming essentially that:

"The major challenge currently in KwaZulu-Natal is the shortage of Oncologists. In the past five months, the province has lost about five Oncologists to the private sector due to the lucrative

remuneration and the growing demand for the service even in the private sector. The treatment of cancers is heavily dependent on the presence of the Oncologists. The shortage of oncologists has caused long waiting times for patients to be seen at the clinic". [Our emphasis]

6.10.7. In its letter of 8 June 2016, the Department advised it had procured four (4) new dedicated CT scanners one of which would be installed at the Ngwelezane Hospital, Empangeni, upon the completion of infrastructural work that was required to accommodate the new oncology unit.

6.10.8. On 11 January 2017, the Department advised that the infrastructural work at Ngwelezane Hospital would be finalised within the next five (5) years. However, in its letter of 25 May 2017 the Department indicated that a new additional CT scanner will be installed at Ngwelezana once building alterations have been finalized with an anticipated completion date of 31 July 2017. It therefore remains unclear what the date of installation of the CT scanner at Ngwelezane Hospital. On the one hand, the Department advises it would take five (5) years to complete the infrastructural work. On the other hand, the Department advises in its letter of 25 May 2017 that the building alterations would be completed by 31 July 2017. The Department's response is accordingly vague. In any event, patients continue to suffer prejudices as a result of the lack of CT scanners, particularly at Ngwelezane Hospital, remains.

6.10.9. Furthermore, the Department advised the Commission that that there a "*Provincial Period Contract in place to replace Mammography Units in KwaZulu-Natal given budget availability.*" It further states that "*the installation at Prince Mshiyeni Memorial has commenced infrastructural works required to accommodate the new machine is in progress and is anticipated to be*

commissioned by 30 June 2016." This response was furnished on 25 May 2017 however remains unclear whether this infrastructural work was commissioned or not.

6.10.10. In addition, the Department responded that that the machines at Addington Hospital were subject to investigations by National Treasury against the service provider.

Inspection *in loco* – Addington Hospital

6.11. On 15 February 2017, the Commission conducted a site inspection at the Oncology Department at Addington Hospital. The Chief Executive Officer (CEO), Dr M. Ndlangisa, and the Deputy Nursing Manager, Ms L. N. Mackenzie, who was the Acting Chief Executive Officer (ACEO) on the day, were unavailable.

6.12. The Commission obtained consent from the Human Resource Manager, Ms N. Mafunda, to engage with Ms T. Hlengwa, the Head of Department for Oncology and the following was established:

6.12.1. The VRALA Machines were commissioned on or about November 2009 and were fully functional from 2010. Each machine treats approximately forty (40) to fifty (50) patients per day. In the event where only one VRALA Machine is functional, Addington Hospital would extend its working hours, in order to ensure that all patients scheduled for treatment were attended to.

6.12.2. Two (2) VRALA Machines were not functional between August 2014 and March 2016. During this period Addington Hospital referred all oncology (radiotherapy) patients to the IALC Hospital for treatment.

6.12.3. VRALA Machine 2 was functional from March 2016 and broke down again in November 2016. On the day of the site inspection, 15 February 2017, both VRALA Machines were not functional.

6.12.4. The Department had a contractual dispute with the service provider that was appointed to service and maintain the VRALA Machines. This matter was being dealt with by the Department.

6.12.5. Addington Hospital no longer admits new oncology patients requiring radiotherapy but refers them to IALC Hospital. Patients who experience complications whilst awaiting radiotherapy treatment are treated by a Registrar[2] at Addington Hospital. Addington Hospital still treats patients requiring chemotherapy.

6.12.6. The Commission was informed that the CEOs of Addington and IALC Hospitals have entered into an agreement in terms of which:

i. Addington Hospital refers patients requiring radiotherapy treatment to IALC Hospital.

ii. Patients residing far from IALC Hospital are admitted to Addington Hospital and transported to IALC Hospital.

iii. Seven staff members from Addington Hospital had been deployed to IALC Hospital to assist with the increased number of oncology patients.

iv. IALC Hospital has allocated one (1) of its three (3) radiotherapy machines to patients from Addington Hospital.

6.12.7. Ms T. Hlengwa advised that the determination as to which patients should receive treatment is made by a clinician or oncologist after considering the patient's age, diagnosis and the stage of the cancer. She also advised that in other instances, a determination is made when a patient requires

[2] Addington Hospital has eight (8) Registrars, who are qualified medical practitioners studying towards specialisation in oncology and who work under the supervision of the oncologists.

further tests and/or medical examinations. This, in turn, may result in a delay in the provision of treatment to a patient and contributes to the backlog of patients awaiting radiotherapy treatment.

6.12.8. In November 2016, there were approximately six hundred (600) patients awaiting radiotherapy. It was unclear what the exact number was on the date of the inspection.

6.12.9. There was no confirmation as to when the VRALA machines would be fully functional.

Inspection *in loco* – IALC Hospital

6.13. On 16 February 2017, the Commission conducted a site inspection at the IALC Hospital Oncology Department. The CEO was not available and the Commission met with the ACEO, Dr Linda Mtshali (Senior Manager: Medical Services), Mr John Thusi (Public Relations Officer) and Dr Nerisha Tathiah (Clinical Care Manager) who advised the following:

6.13.1. The IALC Hospital has three (3) radiotherapy machines, one (1) Brachy[3] Therapy Unit (used for directive therapy) and one (1) simulator, all of which are fully functional.

6.13.2. It operates under a Public-Private Partnership, which includes private partners from the Impilo Consortium. The Consortium attends to the maintenance of the health technology machines and equipment at the IALC Hospital. This service is not afforded to any other provincial hospital.

[3] Brachy Treatment is a form of localised therapy, which is administered in conjunction with an external beam and is used primarily for cancer of the cervix.

6.13.3. The IALC Hospital is able to detect cancer at an early stage in a patient resulting in more patients being diagnosed with cancer on a daily basis. This has resulted in the hospital increasing its resources in order to meet the increased demand. However, there is a limited number of radiotherapy machines, which results in a backlog of patients and a longer waiting period for patients to access their treatment. This often results in the cancer advancing despite it having been detected at an early stage. In such circumstances, it becomes too late to treat the cancer resulting in most patients having to be treated with palliative care.[4]

6.13.4. The Commission was advised that the oncology treatment involves a series of investigations to determine whether a patient's condition is benign or malignant, as well as whether it is treatable. As such, a patient's first consultation is for primary investigations to be conducted. In complex cases, patients require a second booking in order to be assessed by a multidisciplinary team. Not every patient has to follow this process and in some instances where the cancer has progressed too far, a patient may have to only receive counselling and/or palliative care.

6.13.5. In order to manage the disease a number of clinicians and oncologists are required. However there is a shortage of these specialists in the KZN Province.

6.13.6. The Commission was informed that there is a backlog and delay in providing radiotherapy treatment to patients without the provision of specific details. There also appeared to be some confusion as to what constituted "a backlog", as some

[4] The IALC Hospital has not undertaken any research and/or audit of the disease progressing in this regard, however the interviewees were able to comment as medical practitioners.

radiotherapy patients also have to be accommodated for chemotherapy between their radiotherapy sessions.

6.13.7. Some patients require chemotherapy before undergoing radiotherapy treatment in which case a patient would have to be re-assessed before receiving radiotherapy. This often caused further delays in the provision of radiotherapy treatment to patients.

6.13.8. The Commission was informed at the time of the visit that at the IALC Hospital, all oncology appointments were fully booked. However emergency cases were moved up and/or prioritised.

6.13.9. The IALC Hospital attends to approximately eighty (80) patients per day, which includes patients receiving chemotherapy. In some instances, patients do not present themselves for treatment at their scheduled appointment, in which case other patients are contacted telephonically, in order for them to be accommodated sooner.

6.13.10. The current staffing capacity at IALC Hospital is inadequate to cope with the burden of the disease. The Commission was informed of the significant challenge the IALC Hospital had to face with regards to specialist oncologists who leave public hospitals for better remuneration in the private sector. One oncologist was scheduled to leave the IALC Hospital at the end of February 2017, after which only two (2) oncologists would be available to service patients. This is insufficient to meet the current demand of oncology services. In contrast, Greys Hospital has four (4) consultants.

6.13.11. The IALC Hospital has radiotherapy machines but not enough oncologists to assess and attend to the patients. Vacant posts have been advertised and notwithstanding oncologists in the

private sector having been approached to assist with patients in the interim, such attempts have been fruitless.

Interviews with staff at IALC Hospital[5]

6.14. The Commission interviewed several staff members from IALC Hospital. These staff members were interviewed on a basis of anonymity. The following was established:

6.14.1. There are delays in the provision of health care services to oncology patients at IALC Hospital which result patients waiting lengthy periods to access treatment. This has an ominous impact on patients as the cancer progresses rapidly resulting in the deterioration of the patients' condition. Some staff were of the opinion that mortalities could be linked to the lengthy period that patients have to wait before they are able to access their treatment. Given its nature, cancer progresses rapidly over time. A patient can progress from the generally curable stages of cancer (1 and 2) to the more advanced stages (3 and 4) which have to be treated with palliative care. Any delays in treatment will impact negatively on a patient.

6.14.2. The Commission was informed by the staff that the oncology unit at IALC Hospital receives and treats patients diagnosed from other clinics and hospitals. These patients ordinarily wait for three (3) months to have an initial consultation with an oncologist.

6.14.3. Patients whose cancer has advanced require radiotherapy immediately. However, most of these patients receive palliative care in order to manage their pain.

[5] The names and details of staff interviewed have not been disclosed in this report, as staff requested to remain anonymous for fear of victimisation.

6.14.4. Some patients requiring treatment within twenty four (24) hours only receive it in a period of twenty eight (28) days. Brachy therapy is also administered outside the prescribed period of 28 days.

6.14.5. The waiting period for patients to receive a date to access their treatment is approximately nine (9) months.

6.14.6. Patients requiring radiotherapy treatment ordinarily wait approximately six (6) months to receive treatment.

6.14.7. The existing waiting periods constitute a serious impediment to the provision of treatment to patients.

6.14.8. The backlog of the oncology patients at the IALC Hospital can be attributed to:

i. The referral of patients from Addington Hospital.[6] Some of the patients referred from the Addington Hospital had waited for approximately six (6) months due to VRALA Machines not being functional. They required urgent treatment after being transferred to the IALC Hospital resulting in a significant strain on staff;

ii. The shortage of oncologists at the IALC Hospital; and

iii. The IALC Hospital's Oncology Unit is the only Unit that treats children, who are given preference.

[6] Addington Hospital's backlog is smaller in comparison to that of the IALC Hospital. This is due to the fact that Addington Hospital only focusses on one category of cancer whilst IALC Hospital treats all types/categories of cancers. Addington Hospital provides chemotherapy treatment only and refers patients requiring radiotherapy to IALC Hospital. This has had a negative impact on IALC Hospital's existing backlog of patients.

6.14.9. The shortage of oncologists and the patient backlog has a negative impact on the provision of oncology services at the IALC Hospital which results in:

i. The inability to commence treatment until a patient has access to CT scans which, when dysfunctional, results in a protracted delay. Accordingly, the Radiotherapy Unit seldom receives patients who are diagnosed at an early stage;

ii. The delay in the provision of radiotherapy. Some patients who underwent CT scans in December 2016 had not commenced radiotherapy treatment by 16 February 2017; and

iii. Staff members often having to work beyond their normal working hours to ensure that the allocated chemotherapy sessions for the day are completed.

6.14.10. On average, the Oncology Unit receives two thousand two hundred (2200) to two thousand five hundred (2500) new patients per year. Between 1 January 2017 and 16 February 2017, the Oncology Clinic had registered three hundred (300) new patients. Between 17 and 16 February 2017, the backlog increased from two hundred and ninety four (294) to four hundred and fifty (450) patients awaiting treatment.

6.14.11. Oncologists specify how many patients they are able to consult with. The average number of patients that can be treated per day varies depending on the number of patients and/or the stage of their cancer.

6.14.12. As to the availability of health technology for screening, diagnosing and treating cancer, the Commission was advised that the IALC Hospital has two (2) functioning radiotherapy machines

which were recently installed. These new radiotherapy machines[7] operate using the same arch technique as the VRALA machines. These machines are housed in specifically constructed bunkers that are necessary to prevent exposure to radiation.

6.14.13. The Addington Hospital's radiotherapy team[8] that was deployed to the IALC Hospital, works independently and has been allocated one (1) planning system and one (1) radiotherapy machine to treat patients. This Unit uses the Primus machine which has a capacity to attend to forty (40) patients per day. It was, however, pointed out that the Primus machine is slower than the VRALA Machine due to its imaging process taking a longer period of time. The Commission was also informed that the VRALA machine is faster and can administer more accurate and effective treatment, whilst the Primus machine limits the type and number of patients who can be treated. This Unit treats only patients diagnosed with cancer in the pelvic region of the body. The Commission was also informed that VRALA machine causes little or no side effects on patients, whereas side effects noted in respect of the Primus include diarrhoea, severe skin reactions, incontinence and discomfort when urinating.

6.14.14. The staff had not been trained to use the newly installed radiotherapy machines.

6.14.15. Scanners are frequently not working throughout the KZN Province and it takes longer for the Department to repair same. This impacts on the 'staging' of a patient. In certain instances, an oncologist would consult with patients and recommend a CT scan, for which a patient would have to wait for a lengthy period

[7] These radiotherapy machines are situated in specifically constructed bunkers that are necessary to prevent exposure to radiation.
[8] Seven (7) staff members from the Addington Hospital's oncology unit were deployed to work at the IALC Hospital.

of time. This result in a patient having to be re-assessed by an oncologist, which in turn, delays the provision of treatment.

6.14.16. On 16 February 2017, staff members were informed that the scanning facility at the IALC Hospital would not be functional from 17 February 2017, allegedly due to the service provider not receiving payment. The response from the Department, received on the 25th of May 2017, disputes such communication was ever made. The Commission does not address these differences in this report.

6.14.17. The IALC Hospital has a significant shortage of staff in its oncology department which has a negative impact on its ability to provide oncology services to patients and to manage its oncology patient workload. Oncologists are required to plan, prescribe, approve and oversee treatment for oncology patients which may include surgical intervention, chemotherapy and/or radiotherapy. Oncologists are also required to supervise Registrars[9] who are unable to function independently without the supervision of an oncologist.

6.14.18. A number of senior and highly skilled specialists have resigned due to their frustrations with the operation and management of the Department. Currently, there is no Head of Department for Oncology at the IALC Hospital.[10]

6.14.19. The Oncology Department is therefore unable to function at an optimal level as a result of the shortage of oncologists. The Oncology Department could attend to approximately sixty (60) chemotherapy patients per day with adequate staff. However it

[9] Doctors who are studying and training to become oncologists.

[10] A Head of Department is responsible for the training of Registrars who are studying to become oncologists. However, this post is currently vacant at IALC Hospital.

currently only attends to forty (40) to forty five (45) patients per day.

6.14.20. Staff members expressed that there is a need for additional oncologists and oncology nursing staff to be recruited.

Interviews with oncology patients

6.15. The Commission conducted interviews with a number of oncology patients with a view to establishing the veracity of the allegations made by the Complainant and to determine whether or not any of the fundamental rights of the oncology patients were violated as a result of the state of affairs in oncological services in the KZN Province.

6.16. Save for Ms S Rahman, all patients interviewed by the Commission agreed to speak on the condition of anonymity. Their names and details are known to the Commission but will be referred to as "Patient 1" to "Patient 10".

6.17. The patients provided the Commission with the following information:

Ms S. Rahman

6.17.1. Ms Rahman informed the Commission that she was diagnosed with Adeno cancer in January 2015. In January 2015, she required an endoscopy but was only provided with a date for such intervention in June 2015. The specialist also subsequently referred her to Addington Hospital for a colonoscopy. Upon approaching Addington Hospital she was informed that she was not considered to be a priority patient and that she would have to wait approximately one (1) year to have the procedure. The nursing staff at Addington Hospital informed Ms Rahman that the diagnostic machine was not working and that this resulted in the further delay as to when the colonoscopy could take place.

6.17.2. She wrote to the Addington Hospital and the MEC for their urgent intervention but to no avail.

6.17.3. Concerned for her mother's health and life, Ms Mumtaz Rahman, the daughter of Ms Rahman, took a loan from her employer to pay for her mother to have the colonoscopy procedure at a private health care facility. Ms Rahman underwent the colonoscopy procedure at the Entabeni Hospital on or about 27 January 2015 and the results confirmed that she had a tumour in her colon. A biopsy of the tumour was subsequently performed and her diagnosis of Adeno cancer was made on or about 30 January 2015.

6.17.4. After her diagnosis, Ms Rahman went to Addington Hospital for a CT scan in February 2015 and was informed that the CT scan was not working. She was admitted for a week without having the CT scan. The nursing staff informed her that she could not be transferred to another hospital since she was not considered as an emergency case. Mrs Rahman had no option but to leave Addington Hospital to have the CT scan performed at a private health care facility. The CT scan was subsequently performed on 17 February 2015 at a private health care facility and it revealed that the cancer was contained in her colon. She was informed that she required an urgent operation.

6.17.5. On 23 February 2015, she was admitted to Addington Hospital and then transferred to Wentworth Hospital for the operation to be performed on 24 February 2015. After the operation, she was required to undergo chemotherapy treatment at the IALC Hospital for approximately three (3) to four (4) days in a month. She was due for a follow-up colonoscopy but was unable to have the procedure performed at Addington Hospital since the machine was not working.

6.17.6. She has been since allocated an appointment in June 2017 and was advised to contact Addington Hospital three (3) days prior to her appointment, in order to establish whether the machines are functioning.

Patient 1

6.17.7. Patient 1 was diagnosed with cervical cancer in June 2015 and required both radiotherapy and chemotherapy treatment. The patient was told that there was a waiting period for radiotherapy treatment, the length of which the patient was unable to recall. As an interim measure, the patient managed her condition with medication until she commenced her radiotherapy treatment in December 2016.

6.17.8. Patient 1 informed the Commission that the IALC Hospital advised her that treatment would be provided over a period of twenty eight (28) days. However, the patient also informed the Commission that the treatment was interrupted for three (3) days during the twenty-eight (28) day treatment period due to the machine undergoing service.

Patient 2

6.17.9. Patient 2 was diagnosed with lung cancer in February 2016 at King George V Hospital. The patient was subsequently referred to the IALC Hospital for treatment where she was required to wait for five (5) months to have an appointment with an oncologist.

6.17.10. The patient's treatment plan includes both chemotherapy and radiotherapy. However radiotherapy treatment has not yet commenced.

Patient 3

6.17.11. The patient was diagnosed with cancer in March 2016 at the R. K. Khan Hospital. The patient had to wait for three (3) months to consult with an oncologist in June 2016.

6.17.12. As at 16 February 2017, Patient 3 had not commenced radiotherapy treatment, despite being diagnosed with cancer in March 2016.

Patient 4

6.17.13. Patient 4 was diagnosed with cancer in April 2016. She waited for three (3) months to have an appointment with an oncologist at the IALC Hospital. The patient was scheduled to commence radiotherapy treatment on 28 February 2017. However, the date was rescheduled to 1 March 2017 as the oncologist was unavailable.

Patient 5

6.17.14. Patient 5 was diagnosed with cancer in May 2016, at King Edward VIII Hospital. She was then referred to the IALC Hospital for treatment.

6.17.15. The patient waited four (4) months to have an appointment with an oncologist in September 2016. She only commenced with chemotherapy in October 2016.

6.17.16. Patient 5 required a CT scan for which she had to wait approximately six (6) months.

Patient 6

6.17.17. The patient was diagnosed with cancer in May 2016 at the Prince Mtsheni Hospital and was referred to King Edward VIII Hospital for a Mammogram as the Mammogram machine was not functional at the Prince Mtsheni Hospital.

6.17.18. The Mammogram was performed in August 2016, after which the patient was referred to the IALC Hospital for treatment.

6.17.19. The patient underwent surgery in November 2016 and was allocated an appointment for radiotherapy in January 2017.

Patient 7

6.17.20. The patient was diagnosed in April 2016, at the First Respondent and was referred to the IALC Hospital for treatment.

6.17.21. The patient underwent surgery in July 2016 and waited approximately two (2) months to see an oncologist.

6.17.22. The patient waited for a further six months to secure an appointment for radiotherapy which was scheduled to commence on or about 1 March 2017.

Patient 8

6.17.23. The patient was diagnosed in February 2015. Patient 8 was unable to recall the exact period that the patient had to wait to access chemotherapy. It took approximately one (1) year for the patient to secure an appointment for radiotherapy treatment.

Patient 9

6.17.24. The patient was diagnosed in June 2016. The patient waited for a considerable period of time to access chemotherapy and radiotherapy.

Patient 10

6.17.25. The patient was diagnosed with cancer in September 2015. Addington Hospital advised the patient that radiotherapy treatment could only commence in or around February 2017.

7. APPLICABLE LEGAL FRAMEWORK

The Constitution

7.1. Section 27 of the Constitution provides that:

> "(1) Everyone has the right to have access to-
>
> (a) health care services...
>
> (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
>
> (3) No one may be refused emergency medical treatment."

7.2. Section 10 of the Constitution provides that everyone has inherent dignity and the right to have their dignity respected and protected.

7.3. Section 11 of the Constitution provides that everyone has the right to life.

7.4. Section 7(2) of the Constitution states that the State must respect, protect, promote and fulfil the rights in the Bill of Rights.

7.5. Part A of Schedule 4 of the Constitution lists "health services" as a functional area in respect of which both national and provincial legislative authorities have concurrent legislative powers. The Constitution mandates the two spheres of government to work together in a collaborative way on health issues concerning the province. This inter alia entails the development of a coordinated plan to address provincial healthcare challenges.

Domestic Legislation

7.6. **The National Health Act**

7.6.1. The National Health Act, 61 of 2003 (NHA), is one of the legislative measures envisaged in terms of section 27(2) of the Constitution which obliges the State to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the right of the people of South Africa to have access to health care services.

7.6.2. Section 2 of the NHA states that "*the objects of this NHA are to regulate national health and to provide uniformity in respect of health services across the nation inter alia by –*

(a) establishing a national health system which –

(i) encompasses public and private providers of health services; and

(ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford;

(b) setting out the rights and duties of health care providers, health workers, health establishments and users; and

(c) protecting respecting, promoting and fulfilling the rights of-

(i) the people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care;

...

(iv) vulnerable groups such as women, children, older persons and persons with disabilities."

7.6.3. Section 3 of the NHA states that "*the Minister must, within the limits of available resources*

(1) (a) endeavour to protect, promote, improve and maintain the health of the population;
(b) promote the inclusion of health services in the socio-economic development plan of the Republic;
(c) determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population;
(d) ensure the provision of such essential health services, which must at least include primary health care services, to the population of the Republic as may be prescribed after consultation with the National Health Council; and
(e) equitably prioritise the health services that the State can provide.

(2) The national department, every provincial department and every municipality must establish such health services as are required in terms of this Act, and all health establishments and health care

providers in the public sector must equitably provide health services within the limits of available resources."

7.6.4. Section 25 of the NHA states that:

(1) The relevant member of the Executive Council must ensure the implementation of national health policy, norms and standards in his or her province.

(2) The head of a provincial department must, in accordance with national health policy and the relevant provincial health policy in respect of or within the relevant province—

(a) provide specialised hospital services;

(b) plan and manage the provincial health information system;

...

(f) plan, co-ordinate and monitor health services and must evaluate the rendering of health services;

...

(i) plan, manage and develop human resources for the rendering of health services;

(j) plan the development of public and private hospitals, other health establishments and health agencies;

(k) control and manage the cost and financing of public health establishments and public health agencies;

(l) facilitate and promote the provision of comprehensive primary health services and community hospital services;

...

(n) control the quality of all health services and facilities;

(o) provide health services contemplated by specific provincial health service programmes;

(p) provide and maintain equipment, vehicles and health care facilities in the public sector;

...

(w) provide services for the management, prevention and control of communicable and non-communicable diseases."

7.6.5. Section 44 of the NHA states that:

"(1) Subject to this Act, a user may attend any public health establishment for the purposes of receiving health services.

(2) If a public health establishment is not capable of providing the necessary treatment or care, the public health establishment in question must transfer the user concerned to an appropriate public health establishment which is capable of providing the necessary treatment or care in such manner and on such terms as may be determined by the Minister or the relevant member of the Executive Council, as the case may be, in a procedurally fair, economical and expeditious manner."

Regulations

Norms and Standards Regulations in terms of Section 90 (1) (b) and (c) of the NHA, applicable to certain categories of Health Establishments[11]

7.6.6. Regulation 4 states that the purpose of the regulations is to guide, monitor and enforce the control of critical risks to the health and safety of users by means of the required systems and relevant supportive structures within different categories of health establishments, in order to provide safe quality services to the citizens.

7.6.7. Regulation 5 (1) states that the health establishment must protect the rights of users and ensure that they are treated with respect and dignity as espoused in the South African Patients' Rights Charter.

7.6.8. Regulation 9(1) states that the health establishment must maintain a system of referral and discharge planning for further care which protects users from unnecessary costs and promotes continuity of care.

[11] Norms and Standards Regulations in terms of Section 90 (1)(b) and (c) of the National Health Act, 61 of 2003, Applicable to Certain Categories of Health Establishments No. R. 109 (18 February 2015).

7.6.9. Regulation 10(1) states that the health establishment must ensure that users are attended to in accordance with the nature and severity of their condition, to reduce delays in accessing care.

7.6.10. According to Regulation 11 (1), a health establishment must ensure that users booked for procedures, surgery or outpatient services receive these services within agreed timeframes to prevent delays in treatment and to protect users from morbidity and mortality.

7.6.11. In addition Section 11 (2) provides that the health establishment must:

"(a) Monitor and manage waiting lists for elective procedures;
(b) Monitor and manage waiting lists for users who are accessing outpatient services at higher levels of care;
(c) implement measures to reduce waiting lists; and
(d) Monitor and manage that in-patients referred for specialist care receive the needed service."

7.6.12. Regulation 14 states that:

"(1) The health establishment must provide services that are appropriate to the category of the health establishment as contemplated in section 35 of the Act, to ensure availability of services.
(2) For the purposes of sub-regulation (1), the health establishment must:
...
(b) Provide essential equipment to deliver the services that are appropriate to the category of the health establishment.
...
(f) Develop plans to adjust services to meet the needs of the population."

7.6.13. Regulation 38 states that:

"(1) The health establishment must ensure that medical equipment is available and functional to provide effective care to user.

(2) For the purposes of sub-regulation (1), the health establishment, must:

(a) Develop medical equipment management plans to meet the needs of the health establishment;

(b) Demonstrate that medical equipment needs will be fulfilled within budget allocations;

(c) Ensure that –

(i) licensed medical equipment is available and functional across all service areas;

(ii) medical equipment has a planned maintenance schedule and it is followed;

(iii) the medical equipment is documented as being functional compliant with manufacturer operational specifications; and

(iv) medical equipment is disposed of in accordance with applicable legislation; and monitor the service level agreement for the maintenance of medical equipment and report any contractual breaches in the maintenance of medical equipment to the relevant authority."

National Policies

National Policy on Quality in Healthcare (2007) (National Policy)

7.6.14. The National Policy identifies a number of challenges in health care. These include disregard for human dignity, drug shortages, inefficient use of resources, lack of resources as well as inadequate diagnosis and treatment.

7.6.15. The National Policy identifies ways in which the challenges in health may be overcome, which inter alia includes ensuring that appropriate use of

services, training and professional development are made available to staff. It also provides for the establishment, in each Provincial Health Department, of a dedicated unit to manage all provincial initiatives regarding quality assurance and continuous quality improvement. It also provides for the ongoing monitoring of compliance with standards to determine whether health services are delivering quality care to patients.

National Core Standards for Health Establishment in South Africa (2011) (National Core Standards)

7.6.16. The National Core Standards open with a Foreword by the Minister of Health which reads:

"The importance of providing quality health services is non-negotiable. Better quality care is fundamental in improving South Africa's current poor health outcomes and in restoring patient and staff confidence in the public and private health care system. If quality is defined as "getting the best possible results within available resources", then these National Core Standards set out how best to achieve this."

7.6.17. The Preamble by the Director General states that:

"The National Core Standards for Health Establishments have been expressly created as a statement of what is expected, and required, to deliver decent, safe, quality care."

7.6.18. The Preamble goes on to say that the National Core Standards are "applicable ... from the smallest rural clinic to the largest tertiary academic hospital."

7.6.19. The National Core Standards identify six quality priorities which have been identified for the first phase of implementation. Included in these six priorities are the following:

i. Reducing queues and waiting times; and

ii. Ensuring availability of medicines through improved procurement and supply management.

7.6.20. The National Core Standards are structured into seven cross-cutting domains, with a domain being defined by the World Health Organisation (WHO) as an area where quality or safety might be at risk. Within each domain are sub-domains which further break down the domains into sub-sections or critical areas, which together describe the scope of that domain. Within each sub-domain are a set of standards which define what is expected to be delivered in terms of quality care and best practice. Linked to each standard are a number of criteria, which are the elements setting out the requirements to achieve compliance with the standard.

7.6.21. The following domains, standards and criteria are relevant to the investigation in this matter:

i. **Domain 1** sets out the rights of patients which include the right to dignity and continuity of care. The domain also sets out what a hospital or clinic must do to make sure that patients are respected and their rights upheld. In this regard, health care staff is enjoined to treat patients with care and respect. It also enjoins health care staff to ensure that patients who need to be referred or transferred receive the care and support they need.

ii. **Domain 2** states that patients should receive care and treatment that follows nursing protocols, meets basic needs and contributes to their recovery.

iii. **Domain 3** deals with specific services essential in the provision of clinical care and includes the timely availability of medicines. Under the sub-domain "Pharmaceutical Services", one of the standards set is that medicines and medical supplies should be in stock and their delivery reliable.

iv. **Domain 5** deals with the strategic direction provided by senior management, through proactive leadership, planning and risk management, supported by the hospital board, clinic committee as well as the relevant supervisory support structures and includes the strategic functions of communication and quality improvement. Under the sub-domain "Strategic Management" a standard is set as "budget allocations and staffing to ensure services can be delivered as planned". The criteria established to give effect to this standard include the human resource allocation plan, which should ensure sufficient staff to meet the service levels for the health establishment.

v. **Domain 6** which deals with the standards set is the efficient and fair management of staff, as well as ensuring that recruitment, administrative and registration processes ensure safe and effective service delivery. The criteria for giving effect to this standard include ensuring that:

a) An approved staffing plan is in place, in accordance with occupancy rates, utilising rates and patient profiles.
b) A human resource retention strategy is in place in order to ensure adequate and motivated staff.

International Law

7.7. Normative content of the right to health care services is set out in a number of international and regional law instruments. Section 39(1) of the Constitution enjoins that a court, tribunal or forum must, inter alia, to consider international law when interpreting the Bill of Rights.[12]

[12] Section 39 of the Constitution states that:
(1) When interpreting the Bill of Rights, a court, tribunal or forum—
(a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;
(b) must consider international law; and
(c) ...

7.8. Accordingly, the following international and regional law instruments ought to be taken into account when interpreting the right to have access to health care service:

Universal Declaration of Human Rights, 1948

7.8.1. Article 25 (1) states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

International Covenant on Economic, Social and Cultural Rights

7.8.2. Section 12 states that:

> "1. *The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
>
> 2. *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
>
> *(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
>
> *(b) The improvement of all aspects of environmental and industrial hygiene;*
>
> *(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
>
> *(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.*"

African Charter on Human and Peoples' Rights

7.8.3. Article 16 states that:

> *"1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.*
> *2. States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."*

World Health Organisation (WHO)

7.8.4. According to the WHO, the right to health includes access to timely, acceptable, and affordable health care of appropriate quality.[13]

Committee on Economic, Social and Cultural Rights (CESCR) General Comment on the Right to Health (General Comment 14)

7.8.5. This view finds support in the CESCR's General Comment on the Right to Health (General Comment 14), which provides that the right to health means that health care facilities, goods and services have to be available in sufficient quantity; must be physically and economically accessible to everyone; must be ethically and culturally acceptable; and must be of a medically appropriate quality.[14]

7.8.6. Moreover, in terms of General Comment No. 14, the right to health entails the following:

i. The obligation of state parties to **respect** the right to health, which obliges the state parties to refrain from denying or limiting access to health care services to anyone. These should be available to all on a non-discriminatory basis.[15]

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[13] http://www.who.int/mediacentre/factsheets/fs323/en/ [accessed on 30 January 2017]
[14] General Comment No. 14 of the Committee of ESCR, 2000, para 12
[15] Paragraph 34 of General Comment No. 14

ii. The obligation of state parties to **protect** the right, which includes, *inter alia*, adopting legislation and other measures to ensure equal access to health care facilities provided by third parties.[16]

iii. The obligation of state parties to **promote** the right, which requires the state parties to disseminate appropriate information; foster research and support people to make informed choices.[17]

iv. The obligation of state parties to **fulfil** the right, **which** requires that the state parties facilitate and implement legislative and other measures in recognition of the right to health and adopt a national health policy with detailed plans on how to realise the right.[18]

v. The obligation of state parties to provide for people in disaster situations or in dire need when an individual or group is unable, for reasons beyond their control, to realise that right themselves with the means at their disposal. [19]

7.9. Case law

Our courts have provided guidance through precedent about the interpretation of key elements which underpin socio-economic rights. Although the excerpts provided below do not all deal with health as a socio economic right in itself, the interpretation articulated by the court remain relevant to this analysis.

Reasonableness

7.9.1. In *Government of the Republic of South Africa v Grootboom*[20] (*Grootboom*) the Constitutional Court held that a programme for the

[16] Paragraph 35 of General Comment No. 14
[17] Paragraphs 36 and 37 of General Comment No. 14
[18] Ibid
[19] Paragraphs 16 and 37 of the General Comment No. 14
[20] *Government of the Republic of South Africa and Others v Grootboom and Others* (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000)

realisation of socio-economic rights must "be balanced and flexible and make appropriate provision for attention to ... crises and to short, medium and long term needs."[21]

7.9.2. The Constitutional Court also held that:

"[t]o be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right."

7.9.3. The Constitutional Court went on to state that legislative measures by themselves are not likely to constitute constitutional compliance. The state is obliged to act to achieve the intended result.[22]

Within available resources

7.9.4. In *Minister of Health v Treatment Action Campaign (2)*[23], the Constitutional Court emphasised the socio-economic rights entrenched in the Constitution, and that the state is obliged to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of each of them.[24]

7.9.5. In *Soobramoney v Minister of Health (KwaZulu-Natal)*[25] the Constitutional Court stated that the scarcity of resources available to the State were constraints to the enjoyment of the right by the appellants, given the socio-historical context of South Africa.

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[21] *Grootboom* para 44
[22] *Grootboom* para 42
[23] *Minister of Health and Others v Treatment Action Campaign and Others (No 2)* (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002)
[24] *Minister of Health* para 94
[25] *Soobramoney v Minister of Health (Kwazulu-Natal)* (CCT32/97) [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696 (27 November 1997).

7.9.6. In *Grootboom*, the Constitutional Court held that the requirement to take reasonable measures within available resources means that the State is not required to do more than its available resources permit.[26]

7.9.7. In *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd*,[27] the Constitutional Court held that:

> *"This Court's determination of the reasonableness of measures within available resources cannot be restricted by budgetary and other decisions that may well have resulted from a mistaken understanding of constitutional or statutory obligations. In other words, it is not enough for the City to state that it has not budgeted for something, if it should indeed have planned and budgeted for it in the fulfilment of its obligations."*

Progressive realisation

7.9.8. In *Grootboom*, the Constitutional Court held that:

> *"[t]he term 'progressive realisation' shows that it was contemplated that the right could not be realised immediately. But the goal of the Constitution is that the basic needs of all in our society be effectively met and the requirement of progressive realisation means that the State must take steps to achieve this goal. It means that accessibility should be progressively facilitated: legal, administrative, operational and financial hurdles should be examined and where possible, lowered over time."*

7.9.9. In *Grootboom*, the Constitutional Court held that our Constitution entrenches both civil and political rights and social and economic rights.

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[26] *Grootboom*, para 46

[27] *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd and Another* (CC) [2011] ZACC 33; 2012 (2) BCLR 150 (CC); 2012 (2) SA 104 (CC) (1 December 2011), para 74

All the rights in our Bill of Rights are inter-related and mutually supporting.[28]

7.9.10. In *Khosa and Others v Minister of Social Development and Others, Mahlaule and Another v Minister of Social Development*[29], the Constitutional Court held that:

"The socio-economic rights in our Constitution are closely related to the founding values of human dignity, equality and freedom. Yacoob J observed in Government of the Republic of South Africa and Others v Grootboom and Others that the proposition that rights are inter-related and are all equally important, has immense human and practical significance in a society founded on these values."[30]

7.9.11. The right to health is, therefore, interrelated with the rights to dignity and life.

7.9.12. In *S v Makwanyane*[31] the Constitutional Court held that:

"The right to life, thus understood, incorporates the right to dignity. So the rights to human dignity and life are entwined. The right to life is more than existence, it is a right to be treated as a human being with dignity: without dignity, human life is substantially diminished. Without life, there cannot be dignity.

8. ANALYSIS

8.1. Reflecting on the allegations placed before the Commission and information secured through its investigation of the complaint, it should be noted that this

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[28] *Grootboom* para 23
[29] *Khosa and Others v Minister of Social Development and Others, Mahlaule and Another v Minister of Social Development* (CCT 13/03, CCT 12/03) [2004] ZACC 11; 2004 (6) SA 505 (CC); 2004 (6) BCLR 569 (CC) (4 March 2004)
[30] *Khosa* para 40
[31] *S v Makwanyane and Another* (CCT3/94) [1995] ZACC 3; 1995 (6) BCLR 665; 1995 (3) SA 391; [1996] 2 CHRLD 164; 1995 (2) SACR 1 (6 June 1995)

matter is among those that are extremely challenging. Regrettably, this is the type of matter which amongst many others involving alleged violations of the human rights of patients, who by their very medical conditions are most in peril of not being able to claim the full enjoyment of their rights, are in need of quality and timely medical support.

8.2. After having hosted a hearing into the right to access health care services from 30 May to June 2007, the Commission published a report with findings and recommendations.[32] The Commission found that access to health care services, especially for the poor, is severely constrained by expensive, inadequate or non-existent transport, by serious shortages with regard to emergency transport, and by long waiting times at clinics and other health care service providers. These constraints amount to a denial of the right to access health care for some of the poorest and exacerbate existing vulnerabilities of marginalised groups and individuals within the country.

8.3. Turning to the complaint before the Commission, the primary determination to be made is two-fold.

8.3.1 First, the Commission had to determine whether the measures taken in respect of providing health care services to cancer patients are reasonable within the meaning of section 27 of the Constitution.

8.3.2 The second determination is whether the alleged shortage of oncologists, the lack of timely treatment, and delays in the provision of treatment constitute a violation of the right to have access to health care services in terms of section 27 of the Constitution.

8.4. These determinations will be made against the following factual and evidentiary findings:

[32] The report is available at https://www.sahrc.org.za/home/21/files/Health%20Report.pdf.

8.4.1. There is a shortage of oncologists and oncology nursing staff in public hospitals, including the Addington and IALC Hospitals, in the KZN Province.[33]

8.4.2. There is a shortage of functional equipment to diagnose, screen and treat cancer. These include the VRALA machines and CT scanners.

8.4.3. There is a backlog of patients awaiting oncology services.

8.4.4. There are delays in the provision of oncology services at the Addington and IALC Hospitals.

8.4.5. There are lengthy waiting periods for patients to have appointments with oncologists for the screening and treatment of cancer.

Reasonableness in the legal framework

8.5. In terms of section 27(2) of the Constitution, the obligation of the State is to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to health. Accordingly, the right to health is violated by the State in circumstances where the State fails to comply with its obligations in terms of section 27(2) of the Constitution.

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[33] In its response to the Commission's provisional report, Dr Mtshali, Head of the Department of Health in KZN provided the Commission with a response, to which were attached two annexures. In the Oncology Services Report, one of the two annexures dated 11/05/17, the report concludes that: "Health oncology services are in a crisis. The major challenge currently is the shortage of appropriately trained doctors and not the availability of functional medical equipment. Various solutions have been tried without success, but there is a commitment from all oncologists (public and private) to finding a solution. In his response to the Commission, dated 25/05/17, Dr Mtshali too concedes that oncologists have long been resigning from the sector in KZN, this trend was noticeable long before the events at Addington. He states it is impossible to have oncological services without oncologists.

8.6. As is apparent from the above, significant legislative and policy measures have been introduced towards the progressive realisation of the right to health care services. These include the introduction of legislation and policies which:

8.6.1. Assign roles and responsibilities in relation to the realisation of the right to health;

8.6.2. Set norms and standards for staffing of medical facilities;

8.6.3. Set norms and standards for the procurement of medicines and the management of the supply chain process; and

8.6.4. Set norms and standards for patients' access to life saving medicines and medical supplies.

8.7. The Constitution requires the State to "respect, protect, promote, and fulfil the rights in the Bill of Rights".[34] In *Grootboom* the Constitutional Court stressed that in so far as socio-economic rights are concerned:

> *"[t]he State is required to take reasonable legislative and other measures. Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The State is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programmes implemented by the executive."*

8.8. Legislative measures have been taken in terms of the NHA which sets out the general principles applicable to provision of health care services in South Africa. The NHA is the legislative framework within which the delivery of health care services is to take place nationally and at the provincial level.

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[34] Section 7(2) of the Constitution.

8.9. The Commission noted in its Report on the Public Hearings into the Right to Access Health Care Services that, in the main, these legislative and policy measures conform to international best practices and if they were to be successfully implemented, would enhance the progressive realisation of the right to access to health care and would in particular, have averted the staffing and medicine shortages identified by the Commission in its investigation.

8.10. The impact of the different cancers on individuals has long been documented. In the matter before the Commission, it is common cause that persons with cancer have been subjected to delays in accessing health care for their condition. The degree of the delays which have been noted to be in excess of 6 months has been expressed by a number of the patients with whom we directly engaged, and which was supported through the information provided by staff. This indicates that the degree of the delays and the very likely impact of these delays on the health of these patients amount to a denial of their right to access basic health care. In light of the above, the Commission cannot find that the legislative and policy measures adopted by the National and Provincial Department of Health do not meet the constitutional standard of reasonableness. However, the legislative and policy measures, do not mean that evaluation, and implementation of policy into practise has met the standard of what could plausibly be deemed to be reasonable.

Whether the shortage of staff and health technology machines amount to a violation of the human rights of oncology patients?

8.11. The Commission also had to make a determination as to whether the alleged shortage of oncologists, shortage of functional health technology machines and delays in the provision of treatment constitute a violation of the right to have access to health care services in terms of section 27 of the Constitution.

8.12. The establishment by the State of a legislative and administrative structure for providing health care services and the appropriation of monies for that purpose,

together go a long way to fulfilling the State's constitutional obligation but by themselves they are not enough. What is required, in addition, are reasonable measures to make the system effective. These measures would be dependent on adequate screening, diagnostic and treatment machines, sufficient numbers of oncologists, radiotherapists, nursing staff and other medical doctors available to perform the various tasks. However, the shortage of functional health technology machines and staff have been and continue to be a major problem at the Addington and the IALC Hospitals and throughout the KZN Province. In line with the information secured during its investigation of the complaint it appears that there has been conspicuous failure to provide adequate oncology services in the KZN Province for a considerable time. It is not clear to the Commission whether the management plan for ensuring access to health services has ever been evaluated in accordance with the NHA section 25 (2) (b) since the time of it being implemented, nor whether the Department/Respondent had satisfied itself that the level of continuity of care envisaged in its management plan was adequate to meet the needs of oncology patients in the public health system in KZN.

8.13. There is no doubt that a shortage of staff and functioning health technology machines and equipment at the Addington and IALC Hospitals has had an adverse impact on the rendering of adequate oncology services at the two hospitals. It appears that the IALC Hospital receives cancer patients from Addington Hospital, King Edward Hospital and other hospitals in the KZN Province as a result of shortage of oncologists and health technology treatment machines in those hospitals. This Patient Referral System has resulted in a backlog at IALC Hospital with large numbers of patients not receiving timely and possibly lifesaving treatment. The Commission has noted with grave concern that patients are required to wait considerably lengthy periods of time to secure appointments and consultations with an oncologist. Other patients who are on treatment sometimes do not receive timely treatment when the radiotherapy or chemotherapy treatment machines are out of order. It is these conditions which ultimately have forced patients such as Ms Rahman to seek medical assistance from the private sector without the means to do so and

others to suffer the mental and physical effects attributable to the barriers to their ability access adequate healthcare.

8.14. The Commission further established that patient appointments have to be re-scheduled due to staff shortages and the non-functioning of treatment machines.[35] In addition, the Department has acknowledged, in its correspondence dated 8 June 2016, that there is an increase in the incidents and prevalence of cancer conditions in the KZN Province, which in turn creates a higher demand for oncology services.

8.15. That the Department has a plan to dedicate resources to patients who treatment has been backlogged, is not entirely coherent as this response does not recognise that the ailing system of health in the province will simply be building a new backlog, will effectively deny new patients attention and will continue working to provide access to healthcare in 'crisis' mode. The response from the Department relating to measures it will put in place is therefore inadequate and unacceptable.

8.16. The Commission also established, during the interviews, that the CT scanners break down regularly despite there being service maintenance agreements in place to maintain at least 50 % of these scanners.

8.17. The Department also indicated that on average patients wait for a period of five (5) months before they can be seen by an oncologist and a further eight (8) months before they are able to access their radiotherapy treatment.[36] These lengthy periods result in the Addington and IALC Hospitals being unable to detect cancer at an early stage, or to delay its progression. The World Health Organisation recently released a statement regarding early diagnosis and treatment indicating that:

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[35] As per the interviews with patients, particularly Patient 4 whose radiotherapy 2was rescheduled from 28 February 2017 to 1 March 2017 due to the unavailability of the oncologist.

[36] See paragraph 6.10.3 above which record the contents of the Department's letter of 9 March 2017 stating that *"The Department advised the average waiting period for a patient to be seen by an oncologist is five (5) months whereas those waiting to receive radiotherapy usually wait eight (8) months."*

"diagnosing cancer in the late stages, and the inability to provide treatment, condemns many people to unnecessary suffering and early death...by taking steps to implement WHO's new guidance, healthcare planning can improve early diagnosis of cancer and ensure prompt treatment. This will result in more people surviving cancer. It will also be less expensive to treat and cure cancer patients"[37]

8.18. Cancer that is responsive and/or containable by means of radiotherapy are likely to advance and/or progress rapidly during the long waiting periods that patients have to endure before they are able to access the necessary treatment in the affected areas in KZN. The process of diagnosis, waiting, re-diagnosis, transfers between hospitals and place of diagnosis does little to reduce waiting periods and promote access to treatment.

8.19. The Commission also notes the impact such backlog potentially has on staff members, and must consider whether staff are able to deliver services to the standard required in a working environment that is short on human resources and equipment, but where demand is doubled if not quadrupled through intake from other hospitals in the province.

8.20. As indicated above, notwithstanding the laudable norms and standards set out in health legislation and policies, many health establishments in the KZN Province continue to experience shortages of staff and screening, diagnosis and treatment machines.[38]

8.21. The main reasons provided for staff shortages were that experienced oncologists leave public hospitals for the private sector.

8.22. As evident from the Department's response of 8 June 2016, the reasons provided for the shortage or dysfunctional machines for screening, diagnosing

[37] Who.int/mediacentre/newsreleases/2017, accessed on 12/05/17

[38] As fully set out above in paragraphs 6.6.2 and 6.6.3 of this report.

and treating cancer appears to be contractual disputes with service providers. None of the reasons provided for dysfunctional machines and poor maintenance was irrefutably attributed to resource constraints by the Respondents.

8.23. The Commission also established that hospitals that do not have functional radiotherapy or chemotherapy treatment machines refer patients to the IALC Hospital. These referrals add to the human and technological resources strains and challenges to the IALC Hospital. Some of the challenges experienced at IALC Hospital are:

8.23.1. Shortage of staff;

8.23.2. Shortage of functional health technology machines to cater for the increased demand for oncology services;

8.23.3. Backlogs in the treatment of cancer patients;

8.23.4. Lengthy waiting periods for appointments with oncologists for screening and treatment of cancer;

8.23.5. Patients defaulting on treatment; and

8.23.6. Lengthy waiting periods for accessing treatment.

8.24. The Commission learnt, from interviews with staff members, that these challenges facing oncology services, are due to the failure to put in place adequate resources, including oncologists, to enable the IALC Hospital to cope with the increased demand for oncology services.[39] More importantly, the Commission can surmise that the Department has sufficient resources as it has

[39] See paragraph 6.13.10 of this report which records that staff members informed the Commission that that the current staffing capacity at IALC Hospital is inadequate to cope with the burden of the disease.

initiated the process to recruit the Head Clinical Unit for Oncology, Specialist Oncologists, Medical Officers and Radiotherapists at the IALC Hospital.

8.25. The delays in the provision of, and in some cases – the denial of, oncology services to cancer patients, some of whom are destitute and in need of health care, affects them in a most fundamental way. It poses a serious threat to the patients' lives and the enjoyment of other rights. It cannot be denied that the rights to life and human dignity, which are intertwined in our Constitution, are implicated in this matter. In *Dawood and Another v Minister of Home Affairs and Others, Shalabi and Another v Minister of Home Affairs and Others, Thomas and Another v Minister of Home Affairs and Others*[40], the Constitutional Court held that:

"Human dignity . . . informs constitutional adjudication and interpretation at a range of levels. It is a value that informs the interpretation of many, possibly all, other rights. . . . Section 10, however, makes it plain that dignity is not only a value fundamental to our Constitution it is a justiciable and enforceable right that must be respected and protected. In many cases, however, where the value of human dignity is offended, the primary constitutional breach occasioned may be of a more specific right such as the right to bodily integrity, the right to equality or the right not to be subjected to slavery, servitude or forced labour.[41]

8.26. That there is a duty on the Respondents in this complaint to provide adequate health care services, as part of the constitutional right of all oncology patients to access health care services, their rights to human dignity and life is beyond dispute. The NHA recognises this duty and requires that within available resources the provincial department **must** [our emphasis] promote, improve and maintain health care standards to users. The failure to manage service providers and equipment in a timely fashion since 2015, evaluate its

[40] *Dawood and Another v Minister of Home Affairs and Others ; Shalabi and Another v Minister of Home Affairs and Others ; Thomas and Another v Minister of Home Affairs and Others* (CCT35/99) [2000] ZACC 8; 2000 (3) SA 936; 2000 (8) BCLR 837 (7 June 2000)
[41] *Dawood* para 17

management plan which resides primarily on transferring certain oncology patients, recruit and retain staff, does not meet the obligation to promote or improve access to health care. In fact it cannot purport to maintain standards, and, instead amounts to a regression in the provision of access to health care.

8.27. The Commission accepts that the Department and two hospitals attempted to develop a response which would variously address human resource constraints; integrate services through the patient referral system, put in place equipment in certain hospitals and enter into a private public approach through the Impilo Consortium at the IALH in the province. However, these approaches lack coherency, and most significantly appear to have been formulated without a comprehensive evaluation of patients and staffs lived realities. In this sense the approaches have done little to effectively contain attrition of oncologists, effect timely installation, acquisition and maintenance of equipment; secure resources for wider public private partnerships as an interim measures which support the public's right to health care.

8.28. The evaluation which the NHA requires of the Department to maintain, promote or improve access to specialised health care through its many dimensions therefore appears to have fallen short on the critical component of patient needs and realities. Had the evaluation included patients' needs, it is likely the 'crisis' to which the Department refers, would have been more appropriately addressed to meet the needs. This obligation can therefore not have been said to be discharged within the spirit of the NHA.

8.29. It is not in dispute that the Respondents are aware of the crisis in respect of the provision of oncology services at the Addington and IALC Hospitals and throughout the KZN Province.[42] Being aware of that crisis, the Respondent had at the very minimum, a duty to take reasonable measures through recruiting sufficient staff, and putting in place effective screening, diagnosis and treatment of cancer throughout the KZN Province.

[42] As per the Department's correspondence dated 11 January 2017 and 25 May 2017. In addition, it has been publically shortly prior to the release of this report that access to health care in the KZN province is in crisis, with the MEC indicating on television on the 12th of June 2017 that the remaining oncologist had resigned.

8.30. As noted in the Commission's 2007 Report, health workers are integral to the functioning of the health care system. Without sufficient numbers of adequately trained and motivated health workers, no health care system can fulfil its human rights obligations. The report further noted that, a shortage of competent and qualified health personnel contributes to inadequate health care.

8.31. The impact of inadequate staffing, as well as shortages of screening, diagnosis and treatment machines, should also not be underestimated. They have a devastating impact on both staff and patients. In this regard, staff shortages, inter alia, result in the deterioration of health care services; patients having to wait for excessively long periods of time to receive medical attention; and patients having to go home without having been attended to. These realities have impacts on the psychological and physical health of patients, their families and on staff.

8.32. Moreover, the availability of life saving treatment, including chemotherapy and radiotherapy, is integral to the functioning of the health care system. Cancer Alliance submitted to the Commission that:

"*Cancer mortality is preventable by the full spectrum of primary prevention / avoidance, early detection and effective treatment.*

Cancer cases, and subsequent deaths, can be reduced by prevention activities, but only when these prevention activities are properly carried out ..."[43]

8.33. The Respondents have a duty to act pre-emptively to diagnose and provide early treatment. A great deal of scientific information exists to support this view. It should not be case where cancer patients are attended once their condition has become critical to have access to health care.

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[43] Consolidated response from the Cancer Alliance - 27 April 2016: Policy Framework and Strategy on Cancer in South Africa 2016-2021 available at https://www.canceralliance.co.za/wp-content/uploads/2015/01/Policy-Framework-and-Strategy-on-Cancer-in-South-Africa-2016-2021-CA-Response-Final-2016-04-27.docx.

8.34. The Department has acknowledged the shortage of oncologists, and the severe impact that this has on the provision of oncology treatment, and level of care that patients receive. Its delay in filling these critical posts and failure to implement urgent interim measures to address these challenges, impact negatively on the right to access health care.

8.35. The Department has also advised, in its response dated 8 March 2017, that it is in the process of acquiring the services of the private sector to assist in reducing the backlog in oncology services. The Commission notes that the Department did not provide the further details regarding this interim measure.

8.36. The facts of this matter are distinguishable to those in *Soobramoney* in which Department of Health in KwaZulu-Natal did not have sufficient funds to cover the cost of providing renal dialysis treatment to patients suffering from chronic renal failure. The Department has not cited resource constraints in this matter. In the event that a lack of resources has resulted in the quality of health care provided, monitoring and evaluation would have allowed for early interventions including requests to the National Department of Health for support to address the needs of the oncology patients. These sentiments have clearly been articulated through our courts in matters such as *Grootboom*, where the Constitutional Court emphasised that financial and human resources must be made available for the implementation of measures aimed at the progressive realisation of socio-economic rights, to avoid the government's action being seen as unreasonable.[44] The Court added that the government is required to plan, budget and monitor the fulfilment of immediate needs and the management of crisis.[45]

8.37. In light of the reasons provided above, the Commission is of the view that the Respondents failed to allocate necessary and appropriate human and technological resources to the provision of oncology services. In the

[44] *Grootboom* para 39.
[45] *Grootboom* para 68.

circumstances therefore, the Commission cannot find that the Respondents complied with their obligation to provide access to health care services to cancer patients. Accordingly, the Department of Health, both nationally and provincially, failed to take reasonable measures to progressively realise the right to have access to health care services in the KZN Province.

8.38. The Commission's investigation has been confined to a few key hospitals in the KZN province. Due to the urgency of this matter and its complexity, the Commission's investigation did not cover all hospitals in the KZN Province. The Commission however, is satisfied that a comprehensive probe of this matter is required in the KZN province and reserves its authority to initiate such a probe in the future should this be warranted. With regard to the complaint before it however, the need for a comprehensive probe in respect of oncology is recorded in its recommendations below. It is envisaged that such a probe which is likely to contain sector specific findings, together with this report will be of assistance to the Department in implementing corrective action.

8.39. In light of the above, the Commission is of the view that certain aspects of this investigation must be conducted at a more technical level through the following institutions or persons:

8.39.1. **Provincial Health Council established in terms section 27 of the NHA** with a view to advise the MEC on policy concerning the screening, diagnosis and treatment of cancer to protect, promote, improve and maintain the health of the population within the KZN Province, including – specifically on the issues of the:

i. responsibilities for health within the province by individuals and the public and private sector;

ii. an evaluation of the level and quality of access to health care services for oncology patients throughout KZN; together with targets, priorities, norms and standards within the province

relating to the equitable provision and financing of health services;

iii. efficient co-ordination of health services within the province and between neighbouring provinces;

iv. human resources planning, production, management and development;

v. development, procurement and use of health technology within the province;

vi. equitable financial mechanisms for the funding of health services within the province; and

vii. the design and implementation of programmes within the province to provide for effective referral of users between health establishments or health care providers or to enable integration of public and private health establishments.

8.39.2. **Ombud established in terms of section 81A of the NHA** with a view to investigate whether the shortage of staff and health technology in the KZN Province amounts to the violation of the Constitution and the contravention of the NHA and applicable policy.

8.39.3. **The Premier of the KZN Province**, as the political head of the province of KZN, with a view to determine whether the MEC as the accountable authority has responded adequately in the provision of interim, short term and long-term measures in the performance of all functions of the executive that the Constitution and legal framework assigns to him.

9. FINDINGS

9.1. In light of the above, the Commission makes the following findings:

9.2. The Respondents have violated the rights of the patients with cancer at the Addington and IALC Hospitals to have access to health care services as a result of their failure to comply with applicable norms and standards set out in legislation and policies, by failing to:

9.2.1. Evaluate and identify the need for functional equipment such as CT scanners and VRALA machines within a reasonable time;

9.2.2. Failing to procure, maintain and or, put in place adequate functional equipment such as CT scanners within a reasonable time

9.2.3. Failing to recruit and retain suitably qualified staff including oncologists, radiotherapists, medical officers and oncology nursing staff in the province, and;

9.2.4. Failing to monitor and evaluate the health needs of oncology patients in the province in time to implement appropriate interim models such as sufficient Public-Private Partnerships to meet needs.

9.3. The Respondents failure to provide access to adequate oncology services also violate interconnected, inter-dependent rights to human dignity and life of affected patients.

10. RECOMMENDATIONS

10.1. In terms of section 13 (1) (a) (i) of the SAHRC Act, the Commission is entitled to make recommendations to organs of state at all levels of government where it considers such action advisable for the adoption of progressive measures for the promotion of fundamental rights within the framework of the law and the Constitution.

10.2. In view of the findings set out in paragraph 9 above, the Commission makes the following recommendations:

10.2.1. That the Respondents are required to immediately take steps to:

i. repair and monitor all the health technology machines including CT scanners and VRALA Machines regardless of contractual disputes yet to be finalised through the courts;

ii. adopt a management plan to deal with the backlog through, amongst others, entering into interim Public Private Partnership arrangements with private oncologists, medical officers, radiotherapists and oncology nurses; and

iii. adopt an interim referral management plan to facilitate the referral of patients to private service providers for screening, diagnostic and treatment of cancer.

10.2.2. The Respondents are required to report to the Commission, within ten (10) days of this report, in relation to:

i. Progress in recruiting the Head Clinical Unit for Oncology, Specialist Oncologists, Medical Officers and Radiotherapists at Addington Hospital and IALC Hospital.

ii. The status of immediate interim measures and action plan to be implemented to reduce the backlog in the provision of oncology services, including steps to be taken to acquire the services of the private sector to support the remedial action.

iii. The detailed plans that have been, or will be, implemented to efficiently and effectively manage the current crisis in oncology services at the Addington and IALC Hospitals and throughout the KZN Province; including plans to communicate with known affected patients.

iv. The process initiated by the Department to engage the private sector to take on priority cases for both radiotherapy and chemotherapy.

v. The details relating to the Public-Private Partnership between the Department and the Impilo Consortium. In particular, the Department is required to report to the Commission on the success of the Public-Private Partnership and the viability of rolling it out to other hospitals in the KZN Province.

vi. The specific types of health care treatment that is provided to the oncology patients who are currently awaiting radiotherapy and/or chemotherapy in the province, including transfers; and

vii. Addington and IALC Hospitals are required to furnish the Commission with:

(a) A detailed list of the patients awaiting radiotherapy treatment at Addington Hospital and IALC Hospital, including the duration of waiting periods for treatments respectively.

(b) A list of cancer patients who have passed away whilst waiting for treatment or undergoing treatment at Addington Hospital and IALC Hospital. This must also include the cause of death in respect of each and every deceased patient.

10.2.3. The Department, at the provincial level, in collaboration with the National Department of Health, is required to develop a strategy

and/or programme to meet the current medical staffing challenges in the KZN Province. The Department must also provide the Commission with:

i. Its human resources retention plan and immediate actions to attract and retain the relevant oncologists, radiotherapists and other skills and specialties in the area of oncology.

ii. Details of service agreements for the maintenance of health technological machines at Addington Hospital and IALC Hospital.

10.2.4. The Department is required to evaluate and prioritize the expansion of oncology services at the Ngwelezana Hospital, Madadeni Hospital and Port Shepstone Hospital.

10.2.5. The Department is required to prioritise capacity building at the administrative level and retention of professional health care workers, including specialists, registrars, medical officers and nurses.

10.2.6. The Department, in collaboration with the National Department of Health, is required to prioritise the procurement of essential health technology machines for screening, diagnosing and treating cancer.

10.3. The Respondents are required to provide the Commission with a detailed time bound plan of action for the implementation of the recommendations herein within thirty (30) days of receipt of this report.

10.4. The Commission shall in addition to the parties, furnish this report to the Speakers of both National and Provincial Parliaments, the KZN Provincial Health Council, the Office of the Ombud for Health and the Premier of the KZN.

Signed at Braamfontein on this the 15th **day of** JUNE **2017.**

pp Adv Tseliso Thipanyane
CEO SAHRC

ADV. B. C. MAJOLA
THE CHAIRPERSON
SOUTH AFRICAN HUMAN RIGHTS COMMISSION