

Public Inquiry :
**Access to Health
Care Services**



acronyms

ALP	Aids Law Project
ANC	African National Congress
CEO	Chief Executive Officer
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
DICAG	Disabled Children's Action Group
CPIx	Consumer Price Index
CSP	Comprehensive Service Plan
DPLG	Department of Provincial and Local Government
DPW	Department of Public Works
DHA	Department of Home Affairs
DHS	District Health System
DoH	Department of Health
GDP	Gross Domestic Product
HRP	Hospital Revitalisation Plan
ICESCR	International Covenant on Economic Social and Cultural Rights
IMCI	Integrated Management of Childhood Illnesses
IPV	Intimate Partner Violence
IDP	Integrated Development Plan
IMF	Infant Mortality Ratio
KZN	KwaZulu-Natal
MDG	Millennium Development Goal
MDR TB	Multidrug-Resistant Tuberculosis
MIINMEC	Ministers and Members of Executive Council
MMR	Maternal Mortality Ratio
MRC	Medical Research Council
NDP	National Drug Policy
NEHAWU	National Education, Health and Allied Workers Union
NGOs	Nongovernmental organisations
NHA	National Health Accounts
NHI	National Health Insurance
NHS	National Health System
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PIP	Problem Identification Programme
PMB	Prescribed Minimum Benefits
RDP	Reconstruction and Development Programme
RWOPS	Right to Work outside the Public Sector
SAHRC	South African Human Rights Commission
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TB	Tuberculosis
ToP	Termination of Pregnancy
ToR	Terms of Reference
UN	United Nations
UNDP	United Nations Development Programme
UDHR	Universal Declaration of Human Rights
UNHRC	United Nations High Commission on Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Testing and Counselling
WHO	World Health Organisation

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foreword

The Vienna Declaration and Programme of Action reiterates the principle that “[a]ll human rights are universal, indivisible and interdependent and interrelated.”¹ However, a statement of a commitment to this principle is in itself inadequate. Commitment must be followed by implementation; implementation must consist of focussed and appropriate action; action must be an effective reflection of sound and comprehensive policy; and ultimately the promise of human rights must translate into peoples’ everyday lived experiences.

The right of access to health care services is one of the indivisible and interdependent rights entrenched in Constitution of the Republic of South Africa Act, 108 of 1996 (“the Constitution”), specifically the Bill of Rights contained in Chapter 2 thereof. As part of the work of its ongoing mandate, the South African Human Rights Commission (“SAHRC”) has a duty to, *inter alia*, monitor the access to and enjoyment of this right.

The SAHRC has received many complaints with regard to poor service delivery in the public health care system in all provinces in South Africa. These complaints point to the lamentable state of many public hospitals in the country due to many factors, including a shortage of trained health care workers, a lack of drugs in clinics, lengthy waiting periods that patients endure before receiving treatment, poor infrastructure, a disregard for patients’ rights, a shortage of ambulance services and poor hospital management.

In light of the large number of complaints received by the SAHRC and the outcome of the SAHRC’s own Provincial Review, the SAHRC initiated public hearings into the right to access health care services.

The role of public hearings within the broader mandate of the SAHRC should be noted. In applying a rights-based approach, people become part of the process; they are active participants; and the process itself becomes a tool for empowerment. This aims to close the gap between human rights as entrenched in the Constitution and lived experiences. In order for this to become a reality, the public hearings process itself should be as accessible as possible. Inclusivity is a core principle in ensuring the effectiveness of the process and the legitimacy and validity of any outcome. This process should also be located within the broader public participation provisions of the Constitution, which are important components of any democratic process. These include public participation in policy making, law making and service delivery.

Regard should also be had to the right of access to information entrenched in section 32 of the Constitution. The relevant enabling legislation is the Promotion of Access to Information Act, 2 of 2000. Apart from the objective of increased public participation, the legislation drives the aspirant objectives of transparency and increased accountability and integrates principles of sound corporate governance in both the public and private sector.

It is difficult to assess with accuracy whether the situation regarding health care services in South Africa has improved or worsened over time, and whether there is indeed a progressive realisation of the right to access to health care services. The Provincial Review undertaken by the SAHRC was the first comprehensive investigation into South African health care facilities that was undertaken within a human rights framework, and the 2007 public hearings were the first of their kind.

¹ A/CONF.157/23 (12 July 1993), at article 5.

Appreciation is extended to everyone who participated in and contributed to the public hearing. In particular, I wish to thank our colleague and Deputy Chairperson of the SAHRC, Dr Zonke Majodina, who has provided leadership and guidance. Thanks are also due to my fellow panellist, Professor Ngwenya, who gave generously of his time and expertise. In addition, a special word of thanks to all staff of the SAHRC who contributed in a variety of ways.

Most importantly, the Commission would like to extend its sincere gratitude to those individuals who contributed by

way of written submissions and those who shared with the panellists and the public, the details of their lived experiences. Throughout this report it is people's experiences which come to life from the page and provide further impetus for crafting a way towards the progressive realisation of the right of access to health care services. It is hoped that this report will provide a further platform for engagement and stimulate debate as we work towards a robust and healthy society committed to a culture of human rights in word and deed.

Yours faithfully,



Jody Kollapen

Chairperson, South African Human Rights Commission

executive summary

The conclusion and findings of the public hearings into the right to access health care services conducted at the SAHRC national office in Johannesburg on 30 May to 1 June 2007 are summarised below. The full text is set out in section 7 of this report.

1. Conclusion

“We don’t yet have a definition of essential health services. This means we don’t have a base line for the right to health and it is impossible to cost the health service and thereby determine objectively what can be afforded.”²

Poverty has long been recognised as a major cause of ill-health and as a barrier to accessing health care services, and the issue of poverty was raised repeatedly during the public hearings as an impediment to accessing health care services in South Africa.

International treaties, to which South Africa is a signatory, emphasise the development of a primary health care approach in which adequate nutritious foods, clean drinking water and a healthy environment must be provided. These public hearings focused on access to health care services in a more narrowly defined way.

As a result of economic globalisation, provision of health care is no longer the jurisdiction of sovereign states alone, and access to health care is constrained and influenced by the broader geo-political context. However there is limited public discourse

domestically around international treaties and agreements impacting on access to health care.

During the public hearings, the DoH indicated its explicit commitment to the progressive realisation of the right of access to health care services. However, it is the implementation of policies which has proved to be a major stumbling block.

1.1 The Progressive Realisation of the Right to Access Health Care Services

What is more difficult to assess with accuracy is whether the situation has improved or worsened over time, and thus whether there is indeed a progressive realisation of the right to access to health care services. The Provincial Review was the first comprehensive investigation into South African health care facilities that was undertaken within a human rights framework, and the 2007 public hearings were the first of their kind. Furthermore, it appears that little specific definition has been given to the right to health care and there is a need to clarify and further define what it means in practice and people’s everyday lives.

1.2 Access to Health Care Services

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.

² ALP (AIDS Law Project). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

2. Specific Recommendations

2.1 The Health Care System

Specific recommendations:

- Go back to the basic principles of an effective and functional health system and undertake a constructive evaluation. Emphasis should be placed on communicating the specificity of the content of obligations, planning and a continuum of care. The strength of a right is determined by a number of factors including the existence and effectiveness of a remedy. Therefore, obligations require monitoring and failure to deliver necessitates accountability and consequence. An emphasis is placed on planning and resource allocation.
- There needs to be a recognition and realignment of the location of health in national priorities. This should be reflected in resource allocation and the design and implementation of an effective and functional needs-based system.
- Institutional capacity to collect, analyse and utilise health data at national, provincial and local levels need to be strengthened and then translated into responsive policies and programmes.

2.2 The Public and Private Sector Divide

The South African health system consists of both a private for profit health sector and a public health sector. The majority of South Africans rely on the public health care sector for their health care needs but expenditure in the private sector far outweighs that in the public sector. This scenario, exacerbated by the global financial crisis, has resulted in an over-serviced private sector and under-serviced public sector.

Specific recommendations:

- The White Paper on Health must be reviewed in view of the policy prescriptions outlined concerning the proposed National Health Insurance. Introducing a mandatory insurance would enable a greater section of the population to benefit from the human resources currently located in the private sector and which are largely accessible only to medical aid members.
- Access private sector resources through regulation, which lends to collaboration between the private and public sector e.g. through the location of private wards within public hospitals thereby facilitating resource sharing, both human and financial.
- The long-term vision for one inclusive national health system should be pursued.

2.3 Management and Implementation

Findings on the management structure of public health facilities in South Africa highlighted the difficulties associated with the centralisation of decision-making authority. The resultant

restricted authority and accountability for facility managers impacted negatively on service delivery at a local level. Facility managers felt disempowered to take decisions and solve problems in their facilities.

Specific recommendations:

- Decentralise power by delegating decision-making to CEOs and district and facility managers, especially with regards to human resources and financial management.
- Conduct skills audits of senior management and implement appropriate interventions such as training and awareness campaigns to capacitate senior staff.
- Improve financial management and overall operational delivery efficiency by placing greater emphasis on capacity development, PFMA, good governance, implementation and accountability.

2.4 Infrastructure

The right to adequate health care is resource-based and appropriate infrastructure should be in place for the health care system to function optimally. The DoH has been surrendering funds to National Treasury particularly on infrastructure and the SAHRC's public hearing suggests that there is a great need for infrastructural development and therefore a need to accelerate development to address the problems highlighted in the report. The findings of this report illustrated problems of overcrowding in facilities leading to a lack of privacy and compromised cleanliness and out-dated technology, which compromises the quality of health care.

Specific recommendations:

- Funding should be allocated to the revitalisation of all facilities, especially those in the rural areas. Sufficient and contemporary infrastructure should be developed as well as appropriate technology in order to address the compromised ability of facilities to provide an adequate service to health care users.
- Environmental health services are part of the health care services and assist in the prevention of diseases and spread of infections. Municipalities need to plan for and support environmental health services, as with any other municipal service and this should be debated at a MINMEC level.

2.5 Accessing Services at a District Level

Since 1994, there has been a great transformation in health care, with emphasis on specific roles of the three tiers of government, namely national, provincial and local government, and the differing but equally important roles of tertiary and primary health care. Ideally, tertiary health care facilities should be reserved for referrals from primary health facilities and all

conditions that require more attention than can be afforded at a primary health care facility. This primary health care model is the key to service delivery as a whole in South Africa and the success or failure of South Africa's existing health care system is dependent on the optimal functioning thereof.

According to the findings in this report however, there have been difficulties with internalising roles at each level of government, which could be due to confusion at a management level and a lack of communication and direction leading to a lack of understanding at all lower levels. References were also made to poor relationships between provinces and districts and dysfunctional management structures.

Recommendations:

- Strengthen service at a district level, thereby effectively operationalising the primary health care approach.
- Ensure the full-time employment and attendance of medical professionals at district levels, who are compensated well for their services, ensuring their retention in the system.
- Generate greater awareness of the existence, services of and the cost of services at district facilities to entice communities to use local primary health care services.
- There should be greater communication to all employees of their specific roles in each level and sphere of government.
- Ensure that all facilities are appropriately resourced to deal with only those matters that are dealt with at that level (i.e. primary or tertiary) so as not to duplicate resource allocation.

2.5.1 Human Resources

A shortage of competent and qualified health personnel contributes to inadequate health care. The SAHRC's public hearings indicated that health institutions are severely understaffed and experience difficulties in retaining existing staff members, who are lured by incentives in the private sector and in other countries. Vacancy rates were particularly high in rural areas and facilities serving disadvantaged areas.

Specific recommendations:

- Embark on campaigns to attract young professionals to the medical sector, highlighting the non-monetary incentives that would be preferable to that in the private sector.
- The DoH should focus on retention strategies that include improving working conditions for health personnel, especially safety and security and highlighting the non-monetary incentives that the department provides.
- Training should be comprehensive and continuous for health care workers as learning is considered a great motivation for remaining in a specific position.

2.5.2 Vulnerable Groups

The findings of this report show that medical and health personnel often have a poor or discriminatory attitude towards vulnerable individuals or groups, which leads to poor access to health care for vulnerable people. It is clear that the opinion of portions of society project onto individuals in health care facilities, distorting their attitude and behaviour towards children, domestic workers, non-nationals, homosexuals, bisexuals, transgendered people, persons with disabilities, prisoners and older persons. Submissions during the Provincial Reviews have illustrated examples of violations of privacy, a lack of appropriate resources, a lack of access to medication and biased attitudes towards these individuals.

Recommendations: Non-Nationals

Noting that the primary responsibility for protection of refugees rests with the host government, the National DoH should:

- Work in partnership with relevant stakeholders such as the United Nations High Commissioner for Refugees, the SAHRC and civil society to provide ongoing training for staff on the rights of refugees to access health care so as to minimise the confusion over the various categories of non-nationals and the attendant rights for each category. This will also clarify the issue that any non-national has the right to emergency and life saving treatment regardless of one's immigration status and hopefully address challenges of xenophobia and related intolerances among staff.
- Ensure uniform application and implementation of national policies and directives that it has issued, at all health facilities so as to ensure equality and non-discrimination against refugees e.g. access to free anti-retroviral treatment and assessment of indigent refugees according to the means test in the fee structure.
- Promote the employment of skilled health professionals in the public health sector amongst refugees so as to alleviate the current skills shortage. In the same manner refugees can thus contribute meaningfully to the economy.
- Development of the country, create a positive image of non-nationals' contributions as well as a more receptive working environment for other refugees who utilise their services.
- Engage and liaise closely with the Department of Home Affairs on the different types of documents that non-nationals use and the timely issuance of permits for refugees as possession of immigration documentation remains central to all non-nationals in accessing services.

Recommendations: Older Persons

- With a growing older population there is a need to increase the number of health professionals with special training in Geriatrics i.e. not only medical practitioners but

physiotherapists, occupational therapists, nurses, social workers, etc.

- Immunizations: Persons over the age of 65 and those with chronic medical conditions are at particularly increased risk of complications from influenza, pneumococcal disease, and should be offered both immunisations including tetanus immunizations.
- The health care worker should provide the information and opportunity for preventive care that helps older patients to maintain functional independence for as long as possible. The ageing population is heterogeneous, recommendations for screening community dwelling, cognitively and functionally intact individuals will necessarily be quite different from those dealing with functionally dependent and cognitively impaired nursing-home residents with multiple co-morbidities.
- Dementia: Although routinely screening for dementia in the general older population is not recommended, health care workers should be alert to detect new cases as early as possible since a combination of medications, education, and counselling can benefit patients and their families. For primary prevention, aggressively controlling cardiovascular and cerebrovascular risk factors (e.g. hypertension, hyperlipidemia) may be helpful for both vascular and Alzheimer's dementias.

Recommendations: People with Mental and Physical Disabilities

- All healthcare facilities should be physically accessible to clients with disabilities.
- Resource allocations to mental healthcare should be reviewed and addressed accordingly.
- There should be substantive mental health research that clearly quantifies varying mental disabilities by region for resource allocation.
- There are cultural sensitivities around the perception and treatment of mental disabilities that must be explored with faith-based organisations and traditional healers in order to create a healthy working relationship with formal mental healthcare facilities.
- Mental health facilities that are properly serviced by trained staff should be available throughout the country at a community level.
- There should be incentives to train and retain psychiatric staff in the public sector.
- There should be consistent access to prescribed medicine for people with disabilities.
- The nursing staff should be trained on sensitivities and symptoms of different disabilities.
- There should be awareness programmes at a community level that seeks to eliminate discrimination and stigmatisation around mental health so that people with mental disabilities requiring health care services can access it.

- There should be consistent follow-up sessions with patients to ensure that assistive devices are correctly fitted and used.
- There should be relevant consideration of the client's needs when issuing wheelchairs rather than a one-size-fits-all approach.
- Healthcare facilities should be technologically-advanced so that new technologies are introduced as they are developed in order to facilitate the highest quality of health.
- Code of conduct for healthcare staff should be monitored.
- Quality of services and implementation of policy must be monitored.
- Client's feedback mechanism must be monitored.
- The lack of accessible transport poses a real challenge to accessing healthcare facilities; therefore the Department of Transport should play a critical role in ensuring access to health care services.

Recommendations: General

- Guidelines for the treatment of vulnerable groups and individuals should be developed to ensure acceptable methods of treatment for all health care users.
- Training and awareness is recommended to ensure that all health personnel are sensitised towards the plight of vulnerable groups and are able to execute their duties without prejudice.

2.5.3 Integration of HIV/AIDS and TB Programmes

Specific recommendations:

- HIV/AIDS and TB must be integrated within the context of PHC.
- Both TB and HIV/AIDS control programmes need to reinforce and adapt chronic care models, which are patient rather than process orientated and linked with information systems that are user-friendly and which strengthens problem solving at primary care level.
- Expansion of ART services to increase access is essential if this programme is to make more of an impact. PHC services have increased access to general health care. PHC should be utilised effectively to increase access to ART as well. The current policy restricts access to ART and thus negates the goals of the NSP. Effective ART should, in addition to reducing the burden of disease from HIV/AIDS (by reducing viral load), also help reduce HIV/AIDS transmission.
- Many people will die of HIV/AIDS and TB in the next few years. There should be rapid expansion of access to diagnostic, treatment and support services, as well as capacity to prevent the spread of infections and regularly evaluate programmes.

chapter 1

introduction

1.1 The Legislative Mandate of the SAHRC

The SAHRC is a constitutional body charged with promoting respect for human rights and the culture of human rights, promoting protection, development and attainment of human rights and monitoring and assessing the observance of human rights in the Republic of South Africa. Section 9 of the South African Human Rights Commission Act, 54 of 1994 (“Human Rights Commission Act”) empowers the SAHRC to investigate and report on the observance of human rights and to take steps to secure appropriate redress where human rights have been violated. The SAHRC uses public hearings as a tool to investigate and monitor the observance of human rights in the South African context.

1.2 Terms of Reference for the Public Hearing

The SAHRC initiated this public hearing to investigate, assess and report on the right of access to health care services. The Constitution states that everyone has the right to have access to health care services in the public sector—

- a. health care services, including reproductive health care;
- b. sufficient food and water; and
- c. social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

The public hearings were a platform to explore the content and context of the right to access health care services in the public sector in South Africa. The main aim of the public hearings were to highlight the key issues that need to be addressed in order to fulfil the right to have access to adequate health care. As a matter of emphasis the public hearings are an important mechanism available to the SAHRC, as a forum that creates opportunities for dialogue between stakeholders and also allows for public accountability as envisaged by the Constitution. The public hearings also act as an assessment tool for critically evaluating progress made in the health sector and determining the advancement of the right to have access to health care services in the public sector.

The following principles were outlined in the Terms of Reference (“ToR”) and directed the investigation:

- The normative content of the right to health: This includes equal access for all, based on the principle of non-discrimination, to health care facilities, goods and services. It is essential that these be available in sufficient quantity; physically and economically accessible to everyone; ethically and culturally acceptable; and of appropriate quality.³
- The obligation on states to satisfy the minimum essential requirements of all the rights enunciated in the International

³ General Comment No. 14. The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003), (“General Comment No. 14 of the CESCR”), at para 12 (1).

Covenant on Economic Social and Cultural Rights (“ICESCR”).⁴

- The state obligation to ensure:⁵ access to essential primary health care; the right of access to health care facilities, access to goods and services on a non-discriminatory basis, especially for vulnerable and marginalised groups; equitable distribution of all health facilities, goods and services; the provision of essential drugs as defined by the World Health Organisation’s (“WHO’s”) Programme on Essential Drugs;⁶ to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population which shall be devised and periodically reviewed.
- Equitable access requires rural populations having the same entitlements to medical care as people living in urban areas.⁷
- Obligations of comparable priority include taking measures to prevent, treat and control epidemic and endemic diseases.⁸

1.3 Process and Methodology

In 2007, the SAHRC conducted public hearings, as mentioned above, to determine the state of public health care in South Africa. The SAHRC conducted an investigation and visited health care institutions at a national and provincial level. This process was undertaken through the development of a ToR for public hearings into the right to access to health care services in the public sector. The ToR was published in the Government Gazette and informed members of the public about the planned public inquiry.⁹ The closing date for submissions on the state of public health care in South Africa was 30 March 2007.

The planned public inquiry consisted of two phases: the public inquiry and the public hearings. The first phase, conducted by staff of the SAHRC, entailed visits to various randomly selected

sites,¹⁰ interviews with health care professionals and observation using checklists.¹¹ Approximately one hundred (100) health care facilities were visited at secondary or tertiary, district and primary levels. On site, the staff of the SAHRC met with the senior management of hospitals, that is, heads of hospitals, Chief Executive Officers (“CEOs”), and the heads of various departments or units of the hospitals. Health care workers were also interviewed. These representatives were required to complete comprehensive questionnaires regarding their unit or department. Users of health care services were also interviewed to ensure a balance in the information gathered. Following these site visits, reports were produced by the various provinces, a process which culminated in the development of a synthesised provincial report.¹²

The second phase of the overall investigation involved the receipt of written submissions and presentation of oral submissions at the public hearings by members of the public. The SAHRC received fifty nine (59) written submissions from a wide variety of stakeholders including government departments.¹³ The submissions were from various individuals and groups within the health sector such as health professionals; training and regulatory individuals or groups; management institutions; government departments; children; women; disability, domestic workers; refugees, gays, lesbians; older persons; mental health; HIV and AIDS; health care users and private sector organisations. Of the submissions received, the SAHRC selected a few, which were representative of all the clusters participating at the public hearings.

The public hearings were conducted before a panel. The persons who presided over the public hearings were the Chairperson and the Deputy Chairperson of the Commission and Professor Charles Ngwenya, professor at law at the University of the Free State and a specialist in the field of health and human rights.¹⁴

This report is a consolidation of the processes detailed above. Public hearings were held on 30 and 31 May 2007 and 01 June 2007.¹⁵

⁴ See General Comment No. 3. The nature of States parties’ obligations (Fifth session, 1990), U.N. Doc. E/1991/23, annex III at 86 (1990), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 14 (2003) (“General Comment No. 3 of the CESCR”).

⁵ See General Comment No. 4. The right to adequate housing (Sixth session, 1991), U.N. Doc. E/1992/23, annex III at 114 (1991), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 18 (2003) (“General Comment No. 4 of the CESCR”).

⁶ See WHO Model List of Essential Drugs, revised December 1999, WHO Drug Information, vol.13, No.4, 1999.

⁷ See Recommendations Concerning Medical Care in Rural Areas, 29th World Medical Assembly in Tokyo, 1975.

⁸ General Comment No. 4 of the CESCR.

⁹ 16 February 2007 in Government Gazette Notice 162 of 2007, GG No. 29611 (16 February 2007).

¹⁰ A list of sites visited is attached to this report and is marked Annexure A.

¹¹ A copy of the “public hearing monitoring and evaluation toolkit – questionnaires” is attached to this report and is marked Annexure D.

¹² This report is available on the SAHRC website at <http://www.sahrc.org.za>.

¹³ A scheduled of the submissions received is attached to this report and is marked Annexure B.

¹⁴ See para 5.9, ToR.

¹⁵ The programme for the public hearings is attached to this report and is marked Annexure C.

1.4 Structure of the Report

Section one of the report provides a rationale behind the initiation of the investigation and development of the report. The aim is to explain the process and methodology utilised to generate critical information on the state of public health care in South Africa. It is important to indicate at the outset that the SAHRC utilised specific tools to collect and summarise the data and information presented in this report.

Section two also provides a legislative context and background to the right of access to health care services in the public sector in South Africa through outlining the critical international, national and regional laws and instruments, which govern South Africa's approach to the progressive realisation of this right. The section also provides a very brief overview of the transformation of the South African public health care system by focusing on progress that has been achieved in relation to strengthening the public health care system and by highlighting information, which illustrates the burden of disease in the country.

The Committee on Economic, Social and Cultural Rights ("CESCR") defines the right to health as equal access, based on the principle of non-discrimination to health care facilities, goods and services.¹⁶ These have to be available in sufficient quantity; must be physically and economically accessible to everyone; must be ethically and culturally acceptable; and must be scientifically and medically appropriate and of a good quality.¹⁷ The Provincial Reviews, the public hearings and this report have utilised this framework to guide the collection and dissemination of information. In addition, particular attention has been given to "vulnerable groups" including women, children, people with mental or physical disabilities, lesbians, gay and trans-gendered people, prisoners and refugees.

Sections three to six of the report focuses on the findings of the public hearings, drawing from presentations and written submissions received by the SAHRC, and the Provincial Reviews. Inevitably, coverage of issues was not uniform, with some receiving more attention than others at the different stages of the process. In addition, there are issues that are so complex and significant in their impact on the right to access healthcare, for example the issue of health personnel, that far greater coverage of them is given in this report than to some other issues.

Section seven of the report concludes with the SAHRC's findings and the recommendations necessary to abide by to, to realise the right to access to health care services.

¹⁶ General Comment No. 14 of the CESCR.

¹⁷ *Idem*, at para 1.

1.5 The South African Health System Prior to 1994

The South African health care system, prior to 1994, resembled the fragmented and failed system that apartheid was. As such, the health care system was characterised by abject discrimination, unequal distribution of resources, unethical execution of responsibilities by health practitioners and large scale complicity in upholding the system of apartheid. A lack of coordination and lack of accountability was also common. Apartheid South Africa offered a co-existence of first-world and third-world health care services (often operating just metres apart), with the first-world experience being the almost exclusive preserve of Whites.

The system of apartheid necessitated the fragmentation of health care, resulting in fourteen separate health departments representing the then four provinces of South Africa (Cape Province, Natal, Orange Free State and Transvaal), the four homelands (Transkei, Bophuthatswana, Venda and Ciskei), as well as the six "self-governing" territories (Gazankulu, KaNgwane, KwaNdebele, KwaZulu, Lebowa and Qwaqwa). Complicating this fragmentation was the division of the provincial health departments into separate sections to cater for "Black", "Coloured" and "Indian" race groups. Budget allocations were heavily tilted in favour of Whites, with the Bantustans suffering the brunt of this unequal distribution of resources. This racially-based allocation severely compromised the ability of Black people to access public health care, with disastrous social consequences in most instances.

The pre-1994 period saw a predominant concentration of resources in tertiary health care services at the expense of primary health care services. This situation was exacerbated by a burgeoning for-profit private health care sector, which further widened the gap between the levels of health service experienced in South Africa. In 1992, 64% of the national health budget went to 60% of doctors who provided medical services to 17% of the insured population.¹⁸ This rapid expansion of private medicine was not met with a concomitant increase in strategic spending on public health facilities. Benatar effectively highlighted the consequences of such a situation in the *New England Journal of Medicine*:

"Three statistics show the extent of the disparities in health care at the end of the apartheid era. First, the infant mortality rate in 1990 was 7.4 per 1000 live births among whites, as compared with 48.3 per 1000 among blacks, with malnutrition, diarrheal

¹⁸ Benatar, S.R (1997). "Health Care Reform in the New South Africa" (1997) 336 (12) *The New England Journal of Medicine* 891

diseases of childhood, and measles contributing a heavy burden of morbidity and mortality. Second, infectious diseases continued to account for about 13 percent of all deaths among blacks, as compared with 2 percent among whites, with approximately 90 000 new cases of tuberculosis, mainly among blacks, reported annually. Third, the life expectancy at birth in 1990 was 60 years and 67 years, for black male infants and female infants, respectively, as compared with 69 years and 76 years for whites.”¹⁹

In 1987, the number of dentists for each person in the White population was 1:2,000, while for Black people it was 1:2,000,000. In 1990, the doctor to patient ratio in urban areas was 1:900, while in rural areas it was 1:4,100. Black people were prevented from training as doctors or dentists at White universities, and Black doctors and nurses were not allowed to supervise White nurses even if they were more qualified.²⁰

The apartheid government spent less money on health care for Black people. The table below, shows spending for each person according to race in 1985 and 1987. Figures illustrate that spending for Black Africans increased by just 19% between 1985 and 1987, while spending on individual Whites increased by over 1000% during this period. By 1987, there was a R460 difference in the amount allocated to Black African and White individuals for health care, with Whites being allocated the higher amount.²¹

Table 1: Spending Per Capita (in Rands) between 1985 and 1987, by Race Group²²

Race Group	Spending Per Capita in Rands	
	1985	1987
Africans	R115	R137
Coloureds	R245	R340
Indians	R249	R356
Whites	R451	R597

With regard to primary health care, the apartheid era government lacked a coherent primary health care strategy. The system was biased towards curative services with only 11% of the total public sector health care expenditure devoted to primary health

care services. A key feature of the apartheid health system was a strong emphasis on the privatisation of health, which led to further inequalities in health. The private sector was mainly accessible to the White population and a minority of Black people who could afford private health care. In 1987, South Africa spent 5.8% of its Gross Domestic Product (“GDP”) on health care. Of this, 44% was spent in the private sector, which cared for 20% of the population. The remaining 56% was spent on care of 80% of the population that was dependent on the public sector. In 1992/93, expenditure in the private sector was estimated to be 61% of total health expenditure, which cared for approximately 23% of the population. Despite these glaring injustices in the pre-1994 health care system, calls to establish a national health care system were ignored by the apartheid government.²³

The lack of transformation in the health care sector prior to 1994 was in part due to the fact that the system was predominantly structured on a racial basis and did not accommodate an equal development in health for all race groups. Moral disengagement, a lack of exposure and understanding of the living conditions and social fabric of Black communities, complicity, complacency and ignorance of human rights violations perpetrated this inequality. A lack of commitment to strengthen primary health care as well as a general inability to conceptualise health and human suffering, were all factors that negated the efforts of some health care professionals campaigning for a much-needed health care reform during this period. In 1994, South Africa’s first democratic government inherited inequalities in health. They included inequalities in:

- The impact of diseases across races;
- Access to health care services between urban and rural inhabitants, and between South Africa’s nine new provinces; and
- The quality of health care services in the public health system and the private health system.

The White population experienced low levels of infant and child mortality (due to access to clean water and antenatal services). In contrast, Black people experienced a high rate of transmission of infectious or transmissible diseases such as tuberculosis (“TB”), as well as poverty-related diseases such as cholera and kwashiorkor.

Inequalities also existed in access to health care services between urban and rural areas and between South Africa’s

¹⁹ *Ibid.*

²⁰ Hassim, A., Heywood, M. and Berger, J. (eds) (2007). *Health & Democracy* (SiberInk, Cape Town), at p. 12.

²¹ *Idem*, at p.13.

²² *Idem*, at p. 13.

²³ For all paras below: National Department of Health, SAHRC: Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007, at pp. 1-4.

nine provinces. Sixty three percent (63%) of public doctors, 70% of dentists and 61% percent of pharmacists were located in two provinces, namely Gauteng and the Western Cape. In one Bantustan, the ratio of doctors to population was 1:33,000 people.

There were also serious inequalities between health care services in the public health system, paid for with tax revenue, and the private health system, paid for mainly by employers and individuals who could afford it. For example, in 1994/1995, out of the total population of doctors, dentists and pharmacists, the private sector served only 20% of the population and employed 58% of medical doctors, 89% of dentists and 94% of pharmacists.

Immediately after 1994, many new policies were introduced including free primary health care ("PHC"), free care to children under the age of 6 and pregnant women. In keeping with its major policy goal of reducing inequities both between formerly advantaged and disadvantaged provinces and between the private and public health systems, an important focus of early policy development was on the regulation of the private sector. The National Health Act, 61 of 2003 ("National Health Act"), is now in place to provide the overarching policy framework of the entire health system.

The Department of Health ("DoH") embarked upon an ambitious hospital revitalisation programme and a project to rebuild clinics in an effort to extend access to health facilities and upgrade the condition of existing facilities. Attention was also given to policies designed to make medicines more affordable. In keeping with its focus on PHC, the DoH endeavoured to strengthen inter-sectoral collaboration and community involvement in health care service delivery.

Attempts were made to reduce inequalities in the public sector through the introduction of an equity component to the resource allocation formula, which governs the transfer of funds from the national DoH to the provinces. Attention was given to strengthening district systems in relation to planning and financial management. A range of initiatives were introduced in order to increase the number of skilled personnel in the public health care sector. For example, a government to government agreement with Cuba was signed, where Cuban doctors would assist with training in South Africa and would work in South Africa, especially in rural areas. Other initiatives included the introduction of community service for newly qualified personnel, the introduction of rural and scarce skills allowances and the reintroduction of community health workers.

1.6 The Importance of HIV/AIDS Specifically and as a Context

The pandemic of HIV/AIDS as a reality in South Africa is given specific status and emphasis in this section of the report and is dealt with as a general context throughout the report and in the conclusion and recommendations.

In terms of the mid-year population from Statistics South Africa for 2007, life expectancy at birth is estimated at 48, 4 years for males and 51, 6 years for females. The life expectancy for both sexes is estimated at 50 years. This release assumes a mother-to-child transmission rate (the proportion of babies born to HIV-positive mothers who will also become HIV-positive) of 32% if no HIV treatment program is followed and 11% if such a program is in place. The estimates take the administration of Nevirapine treatment to pregnant HIV-positive women and the promotion of alternative infant feeding options into account. The median time lapse from becoming HIV-positive until death due to AIDS is estimated to be 10 years for both males and females and a female-to-male HIV prevalence ratio of 1,2 was assumed for 2007. The estimated adult-prevalence rates (the proportion of adults who are infected with HIV) are shown in the table below. The total HIV prevalence rate was estimated at 11% in 2007. The HIV-positive population is estimated at 5,3 million. The report estimates the infant mortality rate ("IMR") at 45, 2 per 100.²⁴

²⁴ Mid year population estimates, July 2007, Statistics South Africa.

CHAPTER ONE

Estimated adult-prevalence rates (the proportion of adults who are infected with HIV) as per the mid year population estimates of Statistics South Africa in July 2007²³

Women 15-49	Women 20-64	Men 20-64	Adults 20-64	Adults 15-49	Total population
20,4	18,1	17,7	17,9	18,8	11,1

The submission by the Aids Law Project (ALP) contained specific support for their conclusions concerning government's failure to adequately respond to the reality of HIV/AIDS in South Africa.²⁶ The state response to HIV is described as indicative of its' broader failures in respect of health service planning and delivery. In November 2000, the Health Minister received a report that demonstrated the impact HIV would have on the health sector. The report said that there would be an increase to more than 1 million HIV-related hospital admissions and 15 million HIV-related bed days in public health facilities by 2006. It is said that instead of preparing to mitigate this impact, the Minister was actively engaged in denying the benefits of registered ARV-medicine (covering a period from 2000 to late 2006), creating confusion and uncertainty about medical care. This has directly contributed to the burden of ill-health on individuals, families and the health system.²⁷

South Africa is ranked only 11th in Africa for the proportion of people on ARV treatment who require it. There are long waiting lists for ARV treatment at many of the facilities that provide it. The ALP submission supports their conclusion that the Minister had done little to address these bottlenecks.²⁸

The Cabinet statement of 17 April 2002 and many subsequent statements emphasised that prevention is the key aspect of government HIV programmes. Yet despite government having invested significant financial resources in HIV prevention, systemic and political failures have undermined rise in HIV prevalence for 17 years, notwithstanding the high rates of AIDS-related mortality.

- On average over 1000 people are infected with HIV in South Africa every day.
- Prevalence among pregnant women attending clinics continues to rise. Prevalence amongst pregnant women under twenty years, the age group at which most state-

sponsored prevention efforts are aimed, has been at 16% with statistically insignificant fluctuations for several years.

- The decline in the growth rate of prevalence is likely due primarily to deaths of people with HIV, rather than a decline in new HIV cases.²⁹

This despite the importance of the female condom in a society where "current HIV prevention methods are male-initiated or require a male partner's co-operation, leaving women without sufficient means to protect themselves from infection. The female condom is the only female-initiated method (women instigate use but need co-operation of their partner) that is known to be safe and effective in reducing the risk of pregnancy and the transmission of sexually transmitted infections ("STIs").³⁰

The recent commitments to accelerate and improve HIV prevention contained in the NSP are important, but require great political will if they are to be implemented. For example, although there is a national programme to make life skills education, including sex education available in schools, the Minister of Education has undermined this plan by opposing access to condoms in schools. Generally, while condom distribution has improved, it is still insufficient. The submission concludes that no effort had been made by the state at the time to compel the patent-holder of the female condom to reduce the price.³¹

Similarly, there is also no constitutionally defensible national plan to reduce violence against women, which has been described by UNAIDS as a key factor driving the HIV epidemic. Many health facilities do not provide post-exposure prophylaxis ("PEP") services. The Treatment Action Campaign ("TAC") continues to receive reports from health care workers and survivors of rape who have been unable to access PEP services in the public health system timeously.³²

²⁵ Statistics South Africa, Mid year population estimates, July 2007.

²⁶ Hassim, A., Heywood, M. and Berger, J. (eds) (2007). *Health & Democracy* (SiberInk, Cape Town)

²⁷ *Ibid.*

²⁸ *Ibid.*

²⁹ *Ibid.*

³⁰ Matthews, J. and Harrison, T. (2006). An Update on Female Controlled Methods for HIV Prevention: Female Condom, Microbicides and Cervical Barriers, *South African Journal of HIV Medicine*, 7(4), at p. 7

³¹ *Ibid.*

³² *Ibid.*

The ALP submission continues that in recent years, the Ministry of Health has allowed unethical experimentation on Black African people, violating international conventions, common law, statutory and constitutional provisions. This has fostered an environment in which unproven “quack” remedies are now advertised and sold with impunity. Yet despite being presented with clear evidence that health of the public has been placed at risk, the DOH has refused to act.³³

In particular, the TAC has put evidence before the courts of the state’s failure to take appropriate action as contemplated by the medicine regulatory framework against Matthias Rath, a discredited vitamin salesman with court rulings, advertising authority rulings and regulatory authority warnings against him for unethical marketing in several countries including South Africa. The ALP concludes that instead of investigating the allegations, which include unlawful marketing and selling of unregistered medicines and conducting clinical trials without ethical committee approval, at the time of the submissions the DoH inappropriately supported Rath’s activities.³⁴

In addition, it is noted that the DoH issued two statements in support of Ubhejane, an untested and unregistered product that is marketed and sold as a medicine for the treatment of AIDS. Despite doctor’s reports of deaths and illness due to patients taking Ubhejane and Matthias Rath’s products instead of ARV treatment, at the time of the submissions, the DoH remained unwilling to act.³⁵

Generally, the HIV/AIDS epidemic has impacted especially harshly on poor urban and rural communities who are dependent on the public health care system. In addition, this is noted as one possible cause of escalations in use of health care services by young people.

The epidemic is also taking its toll on health care workers who carry a major burden as carers of patients, as carers of family members, and often as patients themselves. Worryingly “one out of seven nurses and nursing students are HIV positive” and a “high proportion has a CD4 count below 350”.³⁶



³³ *Ibid.*

³⁴ *Ibid.*

³⁵ *Ibid.*

³⁶ Connelly, D et al,(2007) Prevalence of HIV infection and median CD4 counts among health care workers in South Africa, 97 (2) South African Medical Journal 115

chapter 2

legislation and background to the right of access to health care in south africa

The objective of this section is to look at the legal regime that governs the provision of health care services in the public sector in South Africa.

The right to health care is generally referred to as fundamental to the physical and mental well-being of all individuals, and as a necessary condition for the exercise of other human rights including the pursuit of an adequate standard of living.³⁷ According to former Deputy Minister of Health, Ms Nozizwe Madlala-Routledge, reports from the World Health Organisation (“WHO”) show “*that governments that invest in health will derive benefits in development and equality. Put another way this means that ensuring that people can live in dignity, free from disease, is good for government*”.³⁸ Below is a summary of key health care legislation changes introduced after 1994.

³⁷ Deputy Minister of Health, Ms Nozizwe Madlala-Routledge. Speech given at the launch of *Health & Democracy*, held at Constitutional Hill, 27 February 2007.

³⁸ *Ibid.*

2.1 South African Instruments

2.1.1 The Constitution

The South African Constitution Act, 108 of 1996, specifically recognises the right of access to health care in section 27: health care, food, water and social security

- i. “Everyone has the right to have access to –
 - a. health care services, including reproductive health care;
 - b. sufficient food and water; and
 - c. social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.
- ii. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
- iii. No one may be refused emergency medical treatment.”

In terms of the above provision, the South African government has an obligation to provide health care services for everyone, to ensure that legislation and programmes are in place to provide these services and ensure that everyone is able to access these services.

South Africa has many poor people who are dependent on the state for the provision of health care services. Given this reality, isn't the state then obliged to provide these necessary health care services and treatment when called upon by poor people to provide them? In the case of *Soobramoney v Minister of Health (Kwazulu-Natal)*,³⁹ Justice Chaskalson also referred to the South African reality in which our Bill of Rights must find application:

*"We live in a society in which there are great disparities in wealth. Millions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted and a commitment to address them, and to transform our society into one in which there will be human dignity, freedom and equality, lies at the heart of our new constitutional order. For as long as these conditions continue to exist aspirations will have a hollow ring."*⁴⁰

The Appellant in this case, an unemployed man in the final stages of chronic renal failure, had approached a hospital with a view to receiving ongoing dialysis treatment in its renal unit. The hospital in question had refused him admission to its renal unit as it followed a set policy in regard to the use of dialysis resources. It was submitted that the State's failure to provide renal dialysis facilities for all persons suffering from chronic renal failure constituted a breach of its obligations under section 27 of the Constitution. In this case the Constitutional Court was of the opinion that, given the socio-historical context of South Africa, the scarcity of resources available to the State was reason enough to prevent Mr. Soobramoney from exercising his right to emergency medical treatment.

Section 27 (1)(b) of the Constitution provides for the State to "take reasonable legislative and other measures, within its available resources to achieve the progressive realisation of the right". According to the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural

Rights,⁴¹ progressive realisation does not imply that the State can defer indefinitely, efforts towards the full realisation of the right. On the contrary, state parties are to "move as expeditiously as possible towards the full realisation of the right".⁴² States are further urged to take immediate steps to provide minimum core entitlements. In the case of *Government of the Republic of South Africa v Grootboom and Others*⁴³ the government of the Republic of South Africa (the National Department of Housing), the Premier of the Province of the Western Cape representing the Western Cape Provincial Government (the Western Cape government), the Cape Metropolitan Council (the Cape Metro) and the Oostenberg Municipality challenged the correctness of the judgement in *Grootboom vs Oostenberg Municipality and others*,⁴⁴ in which the Cape of Good Hope Provincial Division of the High Court ordered government to provide those respondents who were children (and their parents) with adequate basic shelter or housing until they obtained permanent accommodation. The judgement of the court provisionally indicated that "tents, portable latrines, and a regular supply of water (albeit transported) would constitute the bare minimum".

The Constitutional Court defined the parameters of what constitutes "reasonable measures", by questioning the reasonableness of a programme that excludes a significant segment of society. The Court stated that "[i]t may not be sufficient to meet the test of reasonableness to show that the measures are capable of achieving a statistical advance in the realisation of the right...if the measures, though statistically successful, fail to respond to the needs of those most desperate, they may not pass the test".⁴⁵

It is also clear from our court judgments that there must be a reasoned justification for policies, which affect people's rights. In the case of *Minister of Health v Treatment Action Campaign*,⁴⁶ the government had refused to allow medical personnel in hospitals and clinics to provide their patients with Nevirapine, a life-saving drug, which helps to prevent the transmission of HIV from mothers to their babies. The Court held that this refusal was unreasonable, and that the State could not withhold an inexpensive drug that may save lives. This case further illustrates

³⁹ 1998 (1) SA 765 (CC).

⁴⁰ *Idem*, at para 8.

⁴¹ Limburg Principles on the Implementation of the International Covenant of Economic, Social and Cultural Rights. pp. 63-78 in *Economic, Social and Cultural Rights: A Compilation of Essential Documents*, International Commission of Jurists, 1977.

⁴² *Idem*, at para 21.

⁴³ 2000 (11) BCLR 1169 (CC).

⁴⁴ 2000 (3) BCLR 277 (C).

⁴⁵ *Idem*, at para 42.

⁴⁶ 2002 (1) SA 46 (CC).

that governmental policies in South Africa can be tested against the requirements of the Constitution.

In the remainder of this chapter we will continue to look at both the legal regime that governs health care in South Africa, as well as international human rights instruments related to health care, which impose further obligations on the South African government.

2.1.2 The White Paper on the Transformation of the Health Care System in South Africa, 1997

The White Paper sets out a detailed framework for health care delivery. It states that government's overall objective is to develop a unified health care system capable of delivering quality health care to all, guided by the strategic approach of providing comprehensive PHC. According to the White Paper, all health care sector policies and legislation would be *"based on a common vision which reflects the principles of the Reconstruction and Development Programme ("RDP")*:

- *The health care sector must play its part in promoting equity by developing a single, unified health care system*
- *The health care system will focus on districts as the major locus of implementation, and emphasise the PHC approach*
- *The three spheres of government, NGOs and the private sector will unite in the promotion of community goals*
- *An integrated package of essential PHC services will be available to the entire population at the first point of contact".*

2.1.3 Choice of Termination of Pregnancy Act, 92 of 1996

This Act made the option of termination of pregnancy available to women on request within certain parameters. This was in accordance with the constitutional mandate to take reasonable legislative and other measures to progressively realise the right of access to reproductive health care services. This Act recognises the Constitutional right of women to reproductive choices.

2.1.4 Amendments to the Medicine and Related Substances of Medicine Act, 101 of 1965

In keeping with the National Drug Policy ("NDP") relating to pricing of medicine, the amendments includes provision for the parallel importation of medicines, the establishment of a medicine price committee and the introduction of a transparent, non-discriminatory pricing system for medicines. The bonusing and sampling practices in the sale of medicines were prohibited by amendments to the Act.

2.1.5 Amendments to the Pharmacy Act, 53 of 1974

Amendments to this Act saw the opening up of a pharmacy ownership in South Africa to non-pharmacists subject to regulatory requirements to be imposed by the Minister of Health. It was the hope of government that this move would increase access to pharmacy services and encourage the opening of pharmacies in rural and under-served areas. In the year 2000, amendments to the Pharmacy Act, 53 of 1974, required newly qualified pharmacists to perform a year of community service for the first time.

2.1.6 Medical Schemes Act, 131 of 1998

This Act was passed into law, repealing the previous Medical Schemes Act, 72 of 1967. The Medical Schemes Act, 131 of 1998, re-introduced community-rating into a medical schemes environment that was practising predominantly risk-taking on the heels of a 1993 amendment to the previous legislation.⁴⁷ This was a bid to promote equity of access to medical scheme benefits for the sick and elderly. There was also a concern on the part of government that medical schemes were designing their benefits in such a way that acutely ill and injured were absorbed by the public health care sector when their treatment became too expensive. The stated objects of the Prescribed Minimum Benefits ("PMB") are:

- Avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfounded utilisation of public hospitals; and
- To encourage improved efficiency in the allocation of private and public health care resources.

This is consistent with the policy objective of the White Paper of integrating the activities of the public and private health care sectors in ways that maximise the effectiveness and efficiency of all available health care resources.

In 2001, the Medical Schemes Act of 1998 was amended to extend certain rights to dependents of medical aid members, further regulating the practice of re-insurance and strengthening the powers of the Council and the Registrar to act in the interest of beneficiaries. The Act also made provision for the regulation of marketing of medical schemes, for more frequent reporting by schemes to the Registrar and defined circumstances in which schemes may be inspected. These amendments constitute a refinement of the existing Act.

⁴⁷ Pearmain, D. (2007) Health Policy and Legislation, *South African Health Review 2007*, Durban, Health Systems Trust, pp. 19-31.

2.1.7 Sterilisation Act, 44 of 1998

This Act deals with the circumstances under which sterilisation and in particular, sterilisation of persons incompetent or incapable of consenting due to mental disability may occur. The previous legislation had combined legislative provisions on abortion and sterilisation and required revision due to the passage of the Choice on Termination of Pregnancy Act, 92 of 1996, and the Constitution in 1996.

2.1.8 Mental Health Care Act, 17 of 2002

This Act repealed the previous Mental Health Act, 18 of 1973, and set out procedures for the admission of the mentally ill to health care establishments and the steps to be taken by family members and caregivers to ensure that they obtain the necessary treatment. The new procedures included an increase in the number of checks and balances and gave more rights to the South African Police Service to intervene in mental health cases. The overarching goal of the new Act was to make mental health care services in the country more accessible and to prohibit unfair discrimination against the mentally ill.

2.1.9 National Health Act, 61 of 2003

The purpose of the National Health Act, 61 of 2003, was to enable the creation of a uniform health care system in South Africa, which would take into account the constitutional and legislative obligations imposed on the DoH. The Act also acknowledged the socio-economic injustices of the past and sought to eliminate these past divisions through a system based on the promotion of democracy and human rights. It also took into account the responsibility of the government to make use of its available resources to ensure the progressive realisation of the right to health care for all South Africans. Special mention was made of the protection of this right for women, children, older persons and persons with disabilities. The Act aspired to improve the national health care system and through cooperative governance and management, to establish uniform standards of quality health care service delivery. It also advocates for a mutual responsibility and co-operation among private and public health care professionals. The responsibility to prioritise the health care services the State can provide was afforded to the Minister of Health, along with the responsibility to determine the eligibility for persons to access free primary health care services at public establishments.

2.1.10 The Traditional Health Practitioners Act, 22 of 2007

It would be inaccurate to consider the formal health care sector of South Africa in isolation from traditional medicine, as it is estimated that 70% of the South African population consult traditional health practitioners.⁴⁸ It is therefore necessary that a framework be available for the regulation of these services. The Traditional Health Practitioners Act, 22 of 2007, is the Act that provides this framework. It ensures that quality, safety and efficacy of these services is regulated and maintained through the control of management, training and registration of traditional health practitioners. The main purpose of the Act is to create a juristic person to be known as the Interim Traditional Health Practitioners Council of South Africa. The Council's responsibilities would include a variety of duties such as promoting public health awareness, encouraging research and education within the traditional health sector and distinguishing between the specific categories of health care in the traditional health practitioners' profession. The four main categories to which recognition was given included diviners (izangoma), herbalists (izinyanga), traditional birth attendants and traditional surgeons (iingcibi). The Council would be responsible for establishing a code of conduct, a minimum training requirement for registered traditional health professionals and investigating complaints and allegations of misconduct, including taking disciplinary action against traditional health practitioners when necessary. Furthermore, it would be required that the Council ensures that traditional health practice complies with universally accepted medical norms and values, therefore making it possible for the Council to liaise with other health professionals as required by law. The Traditional Health Practitioners' Act also looked at the remuneration of registered traditional practitioners through Medical Aid Schemes. However, this regulation has not yet materialised.

It was estimated that in 2006 only 15% of all South Africans had Medical Aid cover and that coverage has since declined to approximately 14% of the country's total population.⁴⁹ With the elevated cost of living and challenges such as the continued growth in unemployment, the alarmingly low number of people with private health insurance cover is not surprising. It should also be noted that private health insurance in South Africa is dominated by private companies; although in recent times there has been a motion of intervention from the government. Since 1994, the government has made efforts to stabilise the

⁴⁸ Matomela, N., "Recognition of Traditional Healers", http://www.southafrica.info/ess_info/sa_glance/health/update/traditional-healersbill.htm.

⁴⁹ Health Systems Trust, Health Statistics on Medical Aid Coverage, <http://www.hst.org.za/healthstats/77/data>.

medical aid industry, ensure its solvency, introduce community ratings, make it illegal to exclude people because of pre-existing conditions and introduce prescribed minimum benefits. Furthermore, government has worked hard to reduce the cost of medicines through the introduction of the single exit pricing system, which covers the regulation of the price of anaesthetic gasses. However, despite all these measures, the State is still unsatisfied with the performance of the private health care sector and has suggested further regulations, particularly where private hospitals are concerned.

Life expectancy, the Maternal Mortality Ratio (“MMR”), and the Infant Mortality Ratio (“IMR”) are considered to be important indicators of the state of health for any health care system in a country. They reflect in part on the health care system as well as on the broader well being of the country. In 1996, life expectancy was 57 years. This had dropped to 50.7 years in 2006. This decrease is largely attributed to the impact of the HIV epidemic. The MMR (deaths per 100,000 women through child-birth) is considered to be an important indicator of the wellbeing and robustness of the health care system since the majority of maternal deaths are preventable. The MMR decreased from 150 deaths in 1998 to 98 deaths in 2001,⁵⁰ but increased again, and reached 110 deaths in 2003. Factors contributing to the progress in the earlier period included the fact that 92% of women were able to access ante-natal services, which were free, and that South Africa held a “Confidential Enquiry into Maternal Deaths,”⁵¹ which assisted in understanding the cause of deaths and enforcing appropriate national guidelines and protocols.

The IMR (deaths under one year per 1,000 live births) increased from 45 in 1998 to 53.6 deaths in 2005. However this aggregated rate masks deep inequalities. In 1998, the rate for the richest 20% of the population was 17 as compared with 61.6 for the poorest 20% of the country.

TB is closely associated with HIV and is one of the leading opportunistic infections linked to HIV. In 2004, 34% of adults with newly diagnosed TB were also infected with HIV in Africa.⁵² The National DoH’s strategic plan described TB as a “*formidable challenge...with low cure rates*” and a national crisis has been

⁵⁰ However, it should be noted that the figures available for South Africa need to be treated with some caution since poor reporting of deaths could distort the actual numbers dying.

⁵¹ National Committee for the Confidential Enquiry into Maternal Deaths (1998). Interim Report on the Confidential Enquiry into Maternal Deaths in South Africa, DoH, Pretoria http://www.doh.gov.za/docs/reports/1998/mat_deaths.html.

⁵² Van Wyk, C. (2009). “Tuberculosis and the Limitations of Rights in South Africa”, (2009) 72(1) *Journal of Contemporary Roman-Dutch Law (THRHR)* 92.

declared due to the disease. Incidents of TB of all types (per 100 000) increased from 550 in 2003 to 645 in 2005. TB fatalities increased from 3% in 1993 to 7.4% in 2003.⁵³

An Afrobarometer Briefing Paper identified HIV along with crime and security and the lack of job creation as one of the three most serious problems facing the country.⁵⁴ Prevalence has escalated steadily over the years although the most recent findings from the ante-natal survey do indicate a slight decrease in prevalence. Prevalence in the population aged between 15 and 49 years was estimated to be 15.2 % in 2004, and increased to 18.2% by 2006.⁵⁵ Women and girls are disproportionately affected and have higher a prevalence rate than males.

The indirect impact of the epidemic, especially on the health care system, is severe and includes losses to the system through health worker illness and mortality, the overburdening of the health care system, a high rate of hospital bed occupancy resulting from HIV related morbidity, an increased workload due to absenteeism due to illness, and increasingly stressful and unsafe working conditions. These factors combined exacerbate the problem of the shortage of health care personnel in the public sector which is acknowledged as a major constraint to providing both quantity and quality health care.

Alongside infectious diseases South Africa faces problems of violence, violence against women as well as crime related violence, high levels of traffic accident related injuries and death, and an increasing level of non-communicable diseases reflecting unhealthy eating habits and poor lifestyle choices. Whilst the causes of these epidemics lie outside the health care system, it falls to the health care system to provide services as a response to the associated health complications.

2.2 International Human Rights Instruments

The objective of this section is to briefly show that international law has both a direct and indirect impact on health law and policy-making in South Africa. The Constitution is the starting point for determining the role of international law domestically. Section 39 of the Constitution states that when interpreting the Bill of Rights, a court, tribunal or forum must consider international law and may consider foreign law. Section 231

⁵³ Day, C. and Gray, A. (2007). Health and Related Indicators, South African Health Review 2007, Durban, Health Systems Trust.

⁵⁴ Ijumba P and Padarath A (2006). South African Health Review, Durban, Health Systems Trust.

⁵⁵ Statistics South Africa (2007). Midyear population estimates, <http://www.statssa.gov.za>

states that an international agreement binds South Africa after approval by resolution in both the National Assembly and the National Council of Provinces, unless it is self-executing, or of a technical, administrative or executive nature.

International human rights law recognises two sets of norms relating to health care: one relating to the protection of public health care and the other, which creates entitlements for individuals and imposes obligations on states. The “entitlements for individuals” norm, which imposes obligations on states, forms part of the South African constitution. The norm has been expressed in a variety of ways by different organisations. Below are meanings and explanations given to the norm.

2.2.1 Universal Declaration of Human Rights

The individual’s right to health care was first recognised in 1948 in the Universal Declaration of Human Rights (“UDHR”).⁵⁶ Article 25 states that “[e]veryone has the right to an adequate standard of living for the health and well-being of himself and of his family...including medical care.”

2.2.2 International Covenant on Economic, Social and Cultural Rights

In 1966, the right to health care was more precisely defined in article 12 of the International Covenant on Economic, Social and Cultural Rights which provides for the “*enjoyment of the highest attainable standard of physical and mental health conducive to living a life of dignity.*”

2.2.3 World Health Organisation

In 1977, the Constitution of the WHO echoed the view that health is a “*state of complete physical, mental and social well-being and not just the absence of disease or infirmity.*”⁵⁷ Subsequently, many international and regional human rights, instruments and declarations have recognised the right to health care.

2.2.4 Committee on Economic, Social and Cultural Rights

The CESCR defined the right to health care as “*fundamental to the physical and mental well being of all individuals and as a necessary condition for the exercise of other human rights.*”⁵⁸ The

right to health care is universally recognised and is fundamental to the enjoyment of civil and political rights as well economic, social and cultural rights as enshrined in the International Bill of Rights and in the South African Bill of Rights.⁵⁹

2.2.5 Vienna Declaration and Plan of Action

According to the Vienna Declaration and Plan of Action, human rights and fundamental freedoms are the birthright of all human beings and are universal, indivisible and interrelated.⁶⁰ The right to health care is indivisible from other socio-economic rights which form the underlying determinants of health, such as the right to adequate food and nutrition, housing, safe and potable water, a safe and healthy environment, access to education and social security.⁶¹ The right to development and civil and political rights such as the right to life and the right to pursue economic activities are compromised without the enjoyment of the right to health care.

In terms of General Comment No. 14 of the Committee on Economic, Social and Cultural Rights (“CESCR”), the right to health care includes the following:

- The state must refrain from denying or limiting access to health care services to any individual;
- Health care services should be available to all on a non-discriminatory basis;
- The obligation to protect include, *inter alia*, adopting legislation and other measures to ensure equal access to health care facilities provided by third parties; to ensure that privatisation does not constitute a threat to the availability, acceptability and quality of services provided; and to control the marketing of medicines by third parties;
- The State must disseminate appropriate information; foster research and support people to make informed choices;
- The State must facilitate and implement legislative and other measures in recognition of the right to health care and must adopt a national health policy with detailed plans on how to realise the right; and
- The State must provide the right for people in disaster situations or in dire need when an individual or group is

⁵⁶ G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948).

⁵⁷ The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (*Off. Rec. Wld Hlth Org.*, 2, 100), and entered into force on 7 April 1948, <http://www.who.int/governance/eb/constitution/en/>, in the preamble.

⁵⁸ General Comment No. 14 of the CESCR.

⁵⁹ Chapter 2 of the Constitution of the Republic of South Africa Act, 108 of 1996.

⁶⁰ Vienna Declaration and Programme of Action, A/CONF.157/23 (12 July 1993), at articles 1 and 5.

⁶¹ The “right to health care services” as provided for by the South African Bill of Rights does not encompass the scope of the “right to health” as defined by the UDHR, the WHO and article 12 of the ICESCR. However, the other determinants of health are provided for in the Constitution such as the right to adequate housing, food and nutrition, education, a safe and healthy environment, safe water and social security and assistance.

unable, for reasons beyond their control, to realise that right themselves with the means at their disposal.

Furthermore, the South African state entered into agreements with a number of international and regional bodies in promoting the right to health care. The section below simply describes these bodies and what they stand for. After each description a comment is provided on the position of South Africa.

2.2.6 The International Covenant on Economic, Social and Cultural Rights (“ICESCR”)

The right to health care is defined in ICESCR⁶² and outlines the steps to be taken by State parties. Article 12 (1) provides for the “*enjoyment of the highest attainable standard of physical and mental health conducive to living a life of dignity*”. Article 12 (2) outlines the steps to be taken by State parties in order to achieve the full realisation of the right including those necessary for: (1) the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (2) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and (3) the creation of conditions that would assure to all medical services and medical attention in the event of sickness.

It should be noted that South Africa signed the ICESCR on 3 October 1994, but has not yet ratified it and is therefore bound not to defeat the clauses contained therein.

2.2.7 The Declaration of Alma Ata⁶³

The Declaration of Alma Ata on primary health care was adopted by the WHO and the United Nations Children’s Fund (“UNICEF”) in 1978, which set out *inter alia* minimum core obligations imposed on states by the right to health care, which were expanded on by the Committee on Economic Social and Cultural Rights (“CESCR”) in General Comment No 14 on the normative content of the right to health care. These are discussed below.

It should be noted that the South African Constitution provides for universal access to health care services and not the right to attain the highest standard of physical and mental health.

2.2.8 The Convention on the Rights of the Child⁶⁴

According to article 24(1) “State parties recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.” Article 24 (2) provides that State Parties must take appropriate measures to ensure full implementation of this right, and specifies the following:

- a. “To diminish infant and child mortality;
- b. To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- c. To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
- d. To ensure appropriate pre-natal and post-natal health care for mothers;
- e. To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
- f. To develop preventive health care, guidance for parents and family planning education and services.”

South Africa signed the Convention on 29 January 1993 and ratified it in June 1995.

Section 28 (1)(c) of the Constitution provides that children have the right “*to basic nutrition, shelter, basic health care services and social services*”.

2.2.9 Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)

Another international human rights instrument that includes the right to health care is the Convention on the Elimination of all forms of Discrimination against Women (“CEDAW”),⁶⁵ which was adopted in 1979 by the UN General Assembly. Article 10 (h) indicates that State parties shall take all appropriate measures

⁶² The International Covenant on Economic, Social and Cultural Rights (“ICESCR”), GA.Res.2200A (XXI), 21 UN.GAOR Supp. (N0 16), at 49, UN Doc.A/6316 (1966), 993, U.N.T.S.3, entered into force 3 January 1976.

⁶³ International Conference on Primary Health Care (1978). Declaration of Alma-Ata, USSR, 6-12 September 1978, http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

⁶⁴ G.A. res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force 2 September 1990.

⁶⁵ Articles 1 (1)(f) and 12, 14 and 16 of CEDAW.G.A.res. 34/180, 34 UN GAOR Supp. (No.46) at 193, UN Doc.A/3.

to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, access to specific educational information to help to ensure the health care and well-being of their families, including information and advice on family planning. Article 12 (1) further enjoins State parties to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. Article 12 (2) requires State parties to ensure appropriate services for women in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 14 enjoins State parties to take into account the particular problems faced by rural women and the significant roles, which rural women play in the economic survival of their families. Section 2 (b) urges State parties to make provisions that will enable rural women to have access to adequate health care facilities, including information, counselling and services in family planning.

South African signed CEDAW on 29 January 1993 and ratified it on 15 December 1995.

2.2.10 Conventions Protecting Vulnerable Groups

Amongst those human rights instruments that protect the health care rights of vulnerable groups are the International Convention on the Rights of the Child, the African Convention on the Rights of the Child,⁶⁶ the Convention on the Rights of Non-Nationals that protect the rights of refugees and asylum seekers,⁶⁷ and the Standard Minimum Rules for the Treatment of Prisoners that protect prisoners and detainees.⁶⁸

⁶⁶ The Convention on the Rights of the Child (1989) articles 6, 23, 24. G.A. res. 44/24, ANNEX, 44 UN.GAOR Supp. (No. 149) at 167, UN Doc.A/44/49 (1989), entered into force Sept. 2, 1990. Similar provisions are contained in the African Convention on the Rights of the Child (1960).

⁶⁷ The Declaration on the Human Rights of Individuals who are not Nationals of the Country in which they live (1985) article 8. Refugees and asylum seekers are protected through the 1951 UN Convention Relating to the Status of Refugees and the 1969 OAU Convention Governing Specific Aspects of Refugee Problems in Africa.

⁶⁸ The Standard Minimum Rules for the Treatment of Prisoners (1957) sets out minimum health rights of detainees and prisoners. According to the UN's Basic Principles for the Treatment of Prisoners (1990), "[p]risoners shall have access to health care services available in the country without discrimination on the grounds of their legal status." The WHO's Guidelines on HIV Infection and AIDS in Prison (1993) provides standards for dealing with HIV/AIDS in prisons.

Not all users of the health care system are in a position to be able to exercise their health care rights easily. Certain vulnerabilities, such as having a disability or being an undocumented migrant, place additional barriers to accessing health care services. One of the aims of the National Health Act in the South African context is to protect, respect, promote and fulfil the rights of vulnerable groups such as women, children, older persons and persons with disabilities. The Patients' Rights Charter,⁶⁹ proclaimed by the Department of Health, in addition says there must be provisions for the special needs of vulnerable groups such as infants, children, pregnant women, the aged, people with disabilities and people living with HIV/AIDS. Vulnerable groups are:

- Persons with disabilities, including people with impaired decision making capacity;
- Older persons;
- Refugees, asylum seekers, and undocumented immigrants;
- Prisoners and detainees;
- Children; and
- Women.

In its' General Comment No. 14, the CESCR defined the normative content of the right to health care as equal access, based on the principle of non-discrimination, to health care facilities, goods and services. These should 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.⁷⁰ These four principles are outlined below:

1. *Availability*: Functioning public health care and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity.
2. *Accessibility*: Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:
 - *Non-discrimination*: Health facilities, goods and services must be accessible to all, in law and without discrimination on any of the prohibited grounds.
 - *Physical accessibility*: Health facilities, goods and services must be within safe physical reach for all sections of

⁶⁹ DoH, Patient's Rights Charter, <http://www.doh.gov.za/docs/legislation/patientsright/chartere.html>

⁷⁰ General Comment No. 14 of CESCR, at para 12.

the population, especially vulnerable or marginalized groups.⁷¹

Economic accessibility or affordability: Health facilities, goods and services must be affordable for all.⁷²

Information accessibility: Accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

3. *Acceptability*: All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
4. *Quality*: Health facilities, goods and services must be scientifically and medically appropriate and of good quality.⁷³

In its' General Comment No. 3, the CESCR enjoins State parties to ensure the satisfaction of minimum essential levels of all the rights enunciated in the ICESCR.⁷⁴ In the view of the CESCR, this core includes at least:

“Essential primary health care: the provision of essential drugs as defined by WHO’s Programme on Essential Drugs; to ensure equitable distribution of health facilities, goods and services; to adopt and implement a national public health care strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised and periodically reviewed,...[and] shall give particular attention to all vulnerable or marginalised groups.”⁷⁵

The CESCR also confirms that obligations of comparable priority include taking measures to prevent, treat and control epidemic and endemic diseases.

⁷¹ Such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS, including people living in rural areas.

⁷² Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all.

⁷³ This requires, *inter alia*, skilled medical personnel, scientifically approved treatment regimens, unexpired drugs and adequate hospital equipment, safe and potable water, and adequate sanitation.

⁷⁴ General Comment No. 3 of the CESCR, at para. 10.

⁷⁵ General Comment No. 14 of the CESCR, at para. 44 (3).

2.2.11 The UN Millennium Development Goals

In September 2000, world leaders made wide-ranging commitments in the Millennium Declaration.⁷⁶ The topics included peace, security, human rights, the environment and number of time-bound development targets. Those targets were later configured into eight Millennium Development Goals (“MDGs”). They address many dimensions of poverty, such as hunger, disease, inadequate water supplies and lack of education. According to a recent assessment of achievements made by various countries, human rights have not yet played a significant role in supporting and influencing MDG-related activities. The content of the MDGs partly resembles some aspects of human rights, but a systematic human rights based approach to understanding and achieving the MDGs remains an unmet challenge.

Four of the MDGs relate to health care, thus underlying the importance of the status of the health of a nation on the path to development. A number of laudable development targets for health have been agreed to at the Millennium Summit and in other United Nations conferences and international forums. These include, for example, reducing mortality rates for children under five by two-thirds, and the MMR by three-quarters by 2015; by 2010, reducing HIV prevalence in all young people (aged 15-24 years) by 25%, and the proportion of infants infected with HIV by 50%; as well as reducing TB related deaths and prevalence, and the burden of disease associated with malaria by 50%, also by 2010. South Africa has pledged to meet the eight MDG goals by 2015.

2.3 Regional Instruments

2.3.1 The African Charter of Human and People’s Rights⁷⁷

Article 16 (1) states that “[e]very individual shall have the right to enjoy the best attainable state of physical and mental health.” Article 16 (2) enjoins State parties to take the necessary steps to protect the health of their people and to ensure that they receive medical attention when they are sick.

South Africa has signed and ratified this Charter on 9 June 1996.

⁷⁶ United Nations Millennium Declaration. General Assembly Resolution 55/2. 8 September 2000.

⁷⁷ OAU Doc CAB/LEG//67/3 rev 5, adopted 27 June 1981 and entered into force 21 October 1986.

2.3.2 The African Charter on the Rights and Welfare of the Child

The African Charter on the Rights and Welfare of the Child⁷⁵ enumerates a comprehensive list of the measures to be taken by the state including primary health care, preventative measures to reduce infant and child mortality, nutrition and safe drinking water, and the participation of the community and nongovernmental organisations (NGOs) to provide health care services for the child.

South Africa participated in the Special Session on Children at the UN World Assembly in 2002 and adopted a declaration on *A World Fit for Children* and committed itself to an action plan to meet the targets for child development. The Charter was signed by South Africa on 10 October 1997 and ratified on 7 January 2000.

2.4 Population Health

According to the table below the population of South Africa is increasing. The figures are presented mainly to show trends on population growth. They will be useful when it comes to health care financing. The question around the population is thus to what extent health care financing has adequately addressed increases in the population. This question will be looked at together with other important variables, such as inflation, medical prices, the GDP and so forth.

Table 2: Population Growth between 1996 and 2007, by Province⁷⁹

Year	EC	FS	GP	KZN	LP	MP	NC	NW	WC
1996	6302525	2633504	7348423	8417021	4929368	2800711	840321	3354825	3956875
2001	6436763	2706775	8837178	9426017	5273642	3122990	822727	3669349	4524335
2005	7039300	2953100	9018000	9651100	5635000	3219900	902300	3823900	4645600
2006	7051500	2958800	9211200	9731800	5670800	3252500	910500	3858200	4745500
2007	6906200	2965600	9688100	10014500	5402900	3536300	1102200	3394200	4839800

The above table illustrates a consistent growth rate in the total population in South Africa. The population increased in all provinces between 1996 and 2007, the Eastern Cape, Limpopo and the North West.

⁷⁸ African Charter on the Rights of the Welfare of the Child adopted in July 1990 by the Assembly of Heads of State and Government, Addis Ababa, Ethiopia.

⁷⁹ Day, C. and Gray, A. (2007). Health and Related Indicators, South African Health Review 2007, Durban, Health Systems Trust

Table 3: Population in South Africa Dependent on the Public Sector for Health Care Services⁸⁰

Year	Population Dependent on the PS	Total Population	Percentage of Population Dependent on the PS
2001	37 321 736	44 819 778	83%
2005	39 922 438	46 888 200	85%
2006	40 263 557	47 390 900	86%
2007	40 809 284	47 850 700	88%

The above table indicates a steady increase in the number of people in South Africa that are dependent on the public sector for health care. The proportion of people dependent on the public sector for health care increased by 7% from 2001 to 2005 and by 3% between 2005 and 2006. Overall, by 2006, 86% of the total population in South Africa was dependent on the public sector for health care.

Table 4: Population in South Africa Dependent on the Public Sector for Health Care Services, by Province⁸¹

Year	EC	FS	GP	KZN	LP	MP	NC	NW	WC
2005	6438146	2626949	6482009	8612926	5373045	2751834	758329	3488981	3526353
2005	91%	89%	72%	89%	95%	85%	84%	91%	76%
2006	6437303	2617251	6617391	8640056	5369944	2760113	761101	3492508	3588017
2007	5924367	2519901	7562085	8900580	4906870	3051037	964811	3010643	3980381

Table 4, above, indicates the number of people per province that were dependent on the public sector for health care in 2005. The Northern Cape and KwaZulu-Natal had the highest number of people in this category, while Mpumalanga had the lowest number of people dependent on the public sector for health care. The second row of the table indicates the proportion of the population per province that were dependent on the public health system for health care. The results clearly indicate that the majority of all residents in South Africa, particularly those in non-urban centres, are dependent on public health care, as only Gauteng has a slightly lower proportion in this category.

⁸⁰ Day, C. and Gray, A. (2007). Health and Related Indicators, South African Health Review 2007, Durban, Health Systems Trust

⁸¹ Day, C. and Gray, A. (2007). Health and Related Indicators, South African Health Review 2007, Durban, Health Systems Trust

chapter 3

the public hearings

3.1 Availability of Health Care

The following chapter assesses the availability of health care including stewardship, finance, management, health workers, physical infrastructure, equipment, availability of drugs and provision of specialised services.

The objective of this section is present the findings of all public hearings conducted by SAHRC in assessing the progressive realisation of the right to health care in the South African context. Various key elements or variables of health have been examined to discover the extent to which the health care system adequately respects the right to health care. All the variables selected are discussed below.

3.2 Finance

“Now if you split the 8.7% GDP spent in healthcare, the public portion is an equivalent of 3.2% of GDP ... we are not really addressing the issue of duality ... we don't have one health system, and that basically poses a chronic problem for the public sector.”⁸²

The South African health care system comprises the private for profit and not for profit sector as well as the public sector. The

⁸² Thulare, A. South African Medical Association, submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

private for profit sector consumes a disproportionate share of resources spending around R43 billion servicing 7 million people in contrast to the public sector which spends R33.2 billion servicing 38 million people.⁸³ Government contributes to this anomalous funding system through its medical aid contributions for government employees.

Since 1994, huge gaps between private and public health care sector expenditure have persisted. The Draft Health Charter released by the DoH in 2005 states that the “most significant challenge facing the South African health system is to address the inefficient and inequitable distribution of resources between the public and private health sectors relative to the population served by each.”⁸⁴ Per capita expenditure in the private sector is approximately R8000 in comparison with R1000 in the public sector (DoH). The gap would seem to be widening. Between 2002 - 2005 increases in the public and private hospital sectors were R105 per capita (2005 prices) as compared with R498 respectively.⁸⁵

⁸³ National Department of Health, SAHRC: Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

⁸⁴ Ijumba P. and Padarath A. (2006) *Consent laws influencing children's access to health care services* South African Health Review, Durban. Health Systems Trust.

⁸⁵ Van der Heer, A. SAHRC: Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

3.2.1 Private for Profit Sector

“The internationally recognised approach when you are looking at new private beds and expensive technology is that you will focus on need not demand and not on whether somebody can make a profit on that facility.”⁸⁶

Public sector hospitals aim for high occupancy. In the Western Cape, for example, occupancy is 82% and the target is 85%.⁸⁷ In contrast, private sector occupancy is estimated to be around 53%.⁸⁸ However, private hospitals continue to be licensed despite the fact that each time new beds are provided the ratio of occupancy to need deteriorates. There are two serious related consequences. Costs escalate making private care increasingly unaffordable, and more health care professionals are drawn away from the public sector, enticed by packages and conditions that are hard for the public sector to match.

Costs within the private sector rose steadily between 1990 and 1998. However, they rose more steeply after 1998, and this was largely consistent with the period in which the private hospital market became heavily consolidated into three hospital groups, which continue to dominate in terms of buying and building new hospitals.⁸⁹ This cost escalation and over-provision is a consequence in part of the fact that regulation of the private sector has focused more on medical schemes and less on providers. As a result, the potential for profit, rather than need appears to have been the deciding factor in the expansion of private sector facilities. Over-provision is also found in the fact that some of South Africa’s private hospitals are better resourced with equipment than many rich countries.

High costs appear to have also been fuelled by unethical practices in which private hospitals overcharge on surgical supplies and materials. In July 2007, accusations were levelled by the Board of Healthcare Funders and supported by the country’s biggest medical aid provider, Discovery, suggesting that inflation on items such as drip sets, gloves, syringes and suture materials were costing medical aid companies about R2 billion per year.⁹⁰ The DoH published (non-binding) regulations requiring all

private sector healthcare providers to submit details of their costs.

The rapid increase in private sector costs resulted in dwindling numbers accessing private care and a consequent increased burden on the public sector. Medical aid coverage decreased from 14.9% to 14.0% between 2004 and 2005.⁹¹ Between 2000 and 2010, the increase in the population served by the public sector is anticipated to increase to 7,424,741, as compared with 680,044 served by the private sector.⁹²

Aware of the challenges, the DoH has various measures in place to try to contain the negative impact of the private sector on the health care system as a whole. Measures include amendments to the Medical Schemes Act; the Health Charter and proposals encompassing national health insurance. Medicine pricing regulations have resulted in a 15% to 20% reduction in the cost of medicine prices at the factory gates, and there is good evidence to support increased volumes of drugs purchased in the private sector resulting from lower prices.⁹³ However, regulation of the private sector has proved to be challenging, and the DoH has encountered fierce resistance from some private stakeholders to their efforts to reduce inequities between the private and public sectors.⁹⁴

3.2.2 Public Sector

“The budget is meaningless; it bears no relation to operational activity.”⁹⁵

The public health sector is financed largely through the Treasury with a very small percentage of financing generated from patient fees. It was found, from the DoH submissions and during the SAHRC Provincial Reviews and public hearings that health professionals and the public held a perception that the public sector was under-funded. There have been improvements in expenditure in the public sector, but these have been modest increases from a low base-line after many years of a lack of

⁸⁶ *Ibid.*

⁸⁷ Engelbrecht, B. Comprehensive Service Plan for the Implementation of Health Care 2010, Western Cape Department of Health, Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

⁸⁸ Van der Heer, A. SAHRC: Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

⁸⁹ *Ibid.*

⁹⁰ Business Day. 26 July 2007, <http://www.businessday.co.za/articles/topstories.aspx?ID=BD4A524803>.

⁹¹ Ijumba P. and Padarath A. (2006) *Consent laws influencing children’s access to health care services* South African Health Review, Durban. Health Systems Trust.

⁹² Van der Heer, A. SAHRC Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

⁹³ National Department of Health, SAHRC Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

⁹⁴ *Ibid.*

⁹⁵ Von Holdt, K and Murphy, M (2007) (Naledi). *Dysfunctional hospitals*, SAHRC Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31st May 2007, at pp. 9-27.

increased expenditure in the public sector.⁹⁶ Although there have been real increases in provincial public health expenditure, from R38 225 million in 2002/3 to R48 928 million in 2005/6,⁹⁷ population growth coupled with the rapid increase of healthcare needs due to the HIV and AIDS epidemic and opportunistic infections, have resulted in enormous demands being made on the public health care system. This additional funding is therefore quickly absorbed by added burdens on the provincial health care system. Despite the increase in per capita spending from R512 in 1995/6 to R1208 in 2004/5 (1995 prices), the DoH indicated that all provinces need additional funding to deal with the increased burden of disease and to address backlogs (DoH). Furthermore, the DoH indicated that spending in the health care sector needed “to significantly improve to enable the sector to speed up the hospital revitalisation project, improve health worker remuneration, improve equipment and address backlogs to the system.”

Efforts to improve service in and access to PHC, requires sustained funding to the sector. This funding should not, however, be redirected from secondary health expenditure, as has happened in the past, as this could impact negatively on secondary health care.⁹⁸ In the Western Cape, the national tertiary services grant has decreased in real terms despite an increased demand.⁹⁹ This resulted in a reduction of clinical teaching staff.

Since 1994, the National DoH and the Treasury have attempted to bring greater equity to public health financing and there has been some improvement in the levels of inequality between provinces.¹⁰⁰ Over the years, the formerly advantaged provinces of Gauteng and Western Cape experienced cuts in their budgets, with poorer provinces such as the Eastern Cape and Mpumalanga receiving a greater share of the budget. However, inequities continue to be found between districts. For example, there are significant differences in PHC per capita expenditure across health districts with the lowest expenditure being R115

⁹⁶ Van der Heer, A. SAHRC: Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

⁹⁷ Ijumba P. and Padarath A. (2006) *Consent laws influencing children's access to health care services* South African Health Review, Durban. Health Systems Trust

⁹⁸ Thulare, A (2007) South African Medical Association. Submission to the SAHRC Public Inquiry into the Rights to have access to Health Care Services, at pp. 4-33.

⁹⁹ James, M. Faculty of Health Sciences, University of Cape Town. Submission to the SAHRC. Presented at SAHRC Public Hearings on 30 May 2007.

¹⁰⁰ National Department of Health, SAHRC: Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

as compared with the highest of R416 being almost 4 times more.¹⁰¹

While the Provincial Reviews found varying health care standards among the facilities visited, with some facilities, including some in deep rural areas, being well managed and well maintained, managers mentioned the limited budget as a constraint to their plans to improve service delivery and to fill vacant posts.

Although much progress has been made in establishing the district health care system, the fact that budgets are controlled from the provincial DoH militates against efficient and creative responses to challenges at an institutional level. Respondents in the Provincial Reviews also raised the process of combining the infrastructure and technology budgets as problematic, as this decreased the proportion of this budget intended for revitalisation projects. It was suggested that the HRP grant be ring-fenced and used exclusively for revitalisation projects. Similar arguments were made regarding conditional grants, suggesting that these remain under the control of provincial departments.

3.2.3 Budget Process

The government has a constitutional obligation regarding the provision of health care services. The budget tells us whether government is actually spending enough to ensure that the rights that are enshrined in the Constitution are realised. If people are unable to access or enjoy their rights, or if government does not have enough money to pay for services that are currently needed, the budget can be used to assess whether government has at the very least been increasing the amount of money allocated to health care to ensure the progressive realisation of the right of access to health care, as the Constitution demands.

However, the process of budgeting for health care at present is beset with challenges relating to optimal health care. Public health budgets are a response to the budget process and not according to need encapsulated in specific policies and plans.¹⁰² Furthermore, the budget system removes the determination of the national health budget from sight, impacting on the budget bidding process as well as removing political accountability for the national allocation. Hence, in the absence of a specification of the minimum level of service required to ensure appropriate access to health care, public health care system levels and quality are determined implicitly. Nor is it clear if population

¹⁰¹ Barron, P (2006). *The District Health Barometer*. Health Systems Trust.

¹⁰² Van der Heer, A. SAHRC: Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

changes, including migration, and changes in morbidity, which fundamentally impact on health care needs, are taken into account.

Strides have been made in attempting to strengthen appropriate financing of services through improved planning and budgeting. Municipal Integrated Development Plans (“IDPs”), which endeavour to build an integrated approach to planning and link financing to need, include health care. However, historical budgeting on a racial basis¹⁰³ remains common. The legacy of this type of budgeting still influences funding received by Chris Hani Baragwanath and Johannesburg General Hospital.¹⁰⁴

The Western Cape provincial DoH, a previously advantaged province, has experienced budget cuts as a result of the national process to achieve greater equity between provinces. Partly as a result of these cuts, the province experienced massive projected overspends, which became a catalyst for introducing a new planning and budgeting process. The province developed a Comprehensive Service Plan (“CSP”) and budgeted for the project according to a needs based approach.

According to the provincial DoH, the CSP is based on robust planning models and indicates both the requirements and cost of the full package of health care for the province as prescribed by the national health policy. A key consideration of the CSP determines the resources necessary to deliver the required level of care in terms of nationally accepted standards and does not reduce the level or amount of patient contact. Implementation of the CSP will enable the DoH to move significantly toward a new service shape that will promote improved service delivery. The plan identified a shortfall in funding and the DoH accepts that as a consequence, they need to source the additional funds.¹⁰⁵

The Western Cape DoH recommended that provincial DoH throughout the country use this type of robust planning, which will systematically move all provinces to deliver on National Health Policies. However, there is contestation as to whether the CSP has been developed based on need or is in fact planning

in response to budget constraints.¹⁰⁶ Greater debate and interrogation of the processes and outcomes would therefore be desirable before this process is emulated elsewhere in the country.

The case for a needs-based approach to budgeting was explored and supported in a number of submissions to the SAHRC. The process followed in the development of the National Strategic Plan for HIV and AIDS was held up as an example of best practice, in which broad consultation laid the foundation for the plan which was budgeted for according to need. The budgeting exercise resulted in a figure much higher than the funds provided for in the allocated budget, and a commitment was therefore made to seek additional funding to meet the shortfall. The debate as to whether to adopt a needs based funding approach has been discussed in Cabinet, and there appears to be concern as to whether the costly process of determining resource requirements would be worthwhile in light of overarching funding constraints.¹⁰⁷

3.2.4 Government Expenditure on Health

Generally, over the past twelve years health care spending has improved significantly in nominal terms. However, taking into account the effect of general inflation and population growth, the trends indicate that health care spending has fluctuated since 1995/96, with a slight decrease in real spending between 1998 and 2000, and an improvement from 2001 onwards. The table below shows trends in consolidated public health expenditure. At current prices, spending increased from R17.4 billion in 1995/96 to R48 123 billion in 2005/06. The total estimated government expenditure for the fiscal year 2007/2008 amounted to R60 586 billion.

¹⁰³ Historically based budgeting refers to budgets that are compiled on the basis of past practice and expenditure. In contrast, needs based budgeting quantifies the service requirements based upon morbidity and mortality levels and the anticipated service provision requirements of a facility, district or province.

¹⁰⁴ Von Holdt, K and Murphy, M (2007) (Naledi). Dysfunctional hospitals: Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007.

¹⁰⁵ Engelbrecht, B. Comprehensive Service Plan for the Implementation of Health Care 2010, Western Cape Department of Health, Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

¹⁰⁶ James, M. Faculty of Health Sciences, University of Cape Town. Submission to the SAHRC. Presented at SAHRC Public Hearings on 30 May 2007 and Stein, D.J. (2007). Faculty of Health Sciences, University of Cape Town. Human Rights and Mental Health, Submission to the SAHRC. Presented at SAHRC Public Hearings on 30 May 2007.

¹⁰⁷ Minister of Health. Address to SAHRC Hearings. Presented at SAHRC Public Hearings on 1 June 2007.

Table 5: Consolidated Public Health Expenditure between 1995 and 2005¹⁰⁸

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Spending	1995/1996	1996/1997	1997/1998	1998/1999	1999/2000	2000/2001	2001/2002	2002/2003	2003/2004	2004/2005	2005/2006
Nominal	17,388	21,296	23,001	23,528	25,472	28,061	31,580	34,392	38,673	42,319	47,752
Real	17,388	19,829	19,726	18,598	18,557	18,841	19,543	19,616	20,330	20,504	21,323
CPI	100	107	117	127	137	149	162	175	190	206	224
		0.070	0.067	0.069	0.078	0.066	0.093	0.068	0.045	0.039	0.050
CPIx	1	107	114	122	132	140	153	164	171	178	187
Real per capita	512	618	657	661	705	764	846	907	1,172	1,208	1,327
% of govt spending	0.000	0.000	11,130	11.20	14.30	11.30	14.30	13.00	12.80	12.60	0.00
Annual GDP in Millions	803710	838326	860515	864968	885365	922148	947373	982327	1011556	1056771	1108255
Health Care Budget	14,756,353	16,487,755	18,913,162	21,125,675	23,636,286	26,421,179	29,633,909	32,966,000	33,332,136	41,134,071	47,275,762
% of GDP	1.84	1.97	2.20	2.44	2.67	2.87	3.13	3.36	3.30	3.89	4.27
Total govt expenditure	154,525,000	175,331,000	189,947,000	204,293,000	231,780,000	233,934,000	262,905,000	291,529,000	331,685,000	368,904,000	404,654,000
Govt Revenue	126,058,000	146,519,000	163,490,000	184,005,000	198,162,000	215,592,000	248,262,000	278,508,000	299,431,000	347,854,000	411,085,000
Health care % of total govt revenue	11.71	11.25	11.57	11.48	11.93	12.26	11.94	11.84	11.13	11.83	11.50
Health care budget as percentage of Total govt expenditure	1.0%	1.2%	1.2%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.2%
Real Growth	14.04%	-0.52%	-5.72%	-0.22%	1.53%	3.27%	0.37%	3.64%	0.86%	4.00%	2.41%
% increase in govt revenue	16.2%	10.4%	11.1%	7.1%	8.1%	13.2%	10.9%	7.0%	13.9%	15.4%	
Medical Inflation	9.3%	7.8%	18.8%	12.3%	10.7%	8.9%	12.9%	12.4%	8.9%	9.8%	

¹⁰⁸ National Treasury, Intergovernmental Fiscal Reviews, 2005, <http://www.treasury.go.za>.

3.2.5 Provincial Health Expenditure

There are still inequalities relating to per capita public health expenditure between provinces. By 2005/06, five of the nine provinces were above the national average in per capita health expenditure, whilst the four formerly disadvantaged provinces are still below the national average.

3.2.6 Trends in Private Sector Expenditure

Given that health care expenditure in South Africa was approximately R107 billion in 2003/04, equivalent to 8.7% of GDP in that year, and that this compares favourably with many other countries in terms of percentage of GDP, there is a strong basis for arguing that the key challenge facing the national health care system is not necessarily one of inadequate resources, but inequitable and inefficient application of resources. Inequitable application of resources results in inadequate access to health care services for many. In 2003/04, medical schemes spent approximately R8,800 per beneficiary while in the public sector the figure was approximately R1,050 for persons who were members of medical schemes. According to the latest figures, the state spends some R33,2 billion on health care for approximately 38 million people, while the private sector spends some R43 billion on health care for about 7 million people.

3.3 Management

“You have to show transformation from the top if you don't have good management and leadership to drive transformation you will find you don't go forward.”¹⁰⁹

Management-related challenges were singled out during a number of presentations at the public hearings, and this was reiterated during the Provincial Reviews. Ineffective relationships between different levels of government within the health care system and bureaucratic and ineffectual inter-departmental relationships were cited as two key management problems. Particularly problematic was the relationship between the DoH and the Department of Public Works (“DPW”), which impacted negatively on the ability of the DOH to provide services.

The impact of poor management particularly affected financial and human resource management, where the impact of poor management decisions regarding recruitment and employment of personnel becomes increasingly problematic in light of staff shortages throughout the system. Health care availability is

¹⁰⁹ Engelbrecht, B. Comprehensive Service Plan for the Implementation of Health Care 2010, Western Cape Department of Health. Submission to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

also limited as a consequence of less than optimal management arrangements that impact on transport and buildings.¹¹⁰

Since 1994, the health care system has undergone radical transformation, taking its toll on managers and staff alike with new structural arrangements, policies and protocols needing to be assimilated and implemented. The establishment of the three tiers of government, national, provincial and district has resulted in an enormous challenge with staff needing to define, negotiate and internalise their roles and functions at each level. The difficulty of this challenge is highlighted by respondents in the Provincial Reviews who made reference to poor relationships between provinces and districts and between districts and facilities. These findings were echoed in reports of dysfunctional management structures during the public hearings. Research on eight hospitals concluded that dysfunctional management structures coupled with underfunding and understaffing has resulted in public hospitals that are overstretched, which impacts upon clinical outcomes.¹¹¹

Fragmentation of management structures arising from decision making processes, which are centralised, is one critical component of this a lack of functioning and results in both a lack of authority and a lack of accountability for managers.¹¹² This was reiterated in the Provincial Reviews where facility managers complained about their restricted authority and explained how this impacted negatively upon service delivery. Such restricted authority resulted in pervasive disempowerment of managers, leaving them powerless to solve problems.

Fragmented structures also resulted in poor decision making, as suggested by one of the respondents in the Von Holdt and Murphy research above, implying the need to devolve more decision making to CEOs: “Head office does not have the necessary competence to do their tasks. They do not know what is happening on the ground. More powers is precisely what is required, especially for HR and finance.”¹¹³ Respondents of the Provincial Reviews also suggested increasing delegation of decision making to district and facility managers, who currently have to go through the provincial office. They too identified the delegation of human resources and financial functions to be especially important. The DoH submitted that the decision to delegate power has been made and suggests that “a major

¹¹⁰ Certain functions, for example to do with building work, are under the control of the Department of Public Works and not under the control of the Department of Health. This can result in undue delays.

¹¹¹ Von Holdt, K and Murphy, M (2007) (Naledi). Dysfunctional hospitals. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31st May 2007, at pp. 9-27.

¹¹² *Ibid.*

¹¹³ *Ibid.*

challenge is not whether authority has been delegated, but what are the management and administrative structures and procedures that impede full implementation.”¹¹⁴

Facility managers also make reference to this perceived lack of leadership from provinces, suggesting that bureaucratic structures do not allow for full engagement and support for the transformation process, which are essential if unnecessary morbidity and mortality are to be reduced.¹¹⁵ The community is frustrated because those in charge have no solution to the financial and staff shortages.¹¹⁶ This is not surprising in light of the limited funding and the national scarcity of health workers for public sector posts. This in turn could reduce the effectiveness and morale of provincial managers.

The need to delegate authority to hospital managers has been recognised by the DoH and there has been an apparent presidential acknowledgment of this shortfall.¹¹⁷ All provinces are supposed to have a delegated authority, but inevitably there is variation in application of this requirement between provinces. However, management and administrative procedures impede the ability of the department to delegate authority to hospital managers.

Respondents in the Provincial Reviews identified recruitment and procurement policies as detrimental to efficient service delivery. Lengthy recruitment processes are detrimental to employment practices and some managers reported that despite numerous follow-ups with their respective district or provincial offices in an attempt to resolve problems with equipment and supplies, no assistance is received.

The lack of proper communication, lack of adequate consultation, long and cumbersome reporting lines and overly bureaucratic processes, which contribute to delays in addressing problems, serve to compound management challenges. Inter-sectoral problems also cause strain, especially where the DoH is dependent on the DPW, and progress can take up to 5 years. Clinics using municipal buildings have problems with maintenance as municipalities assert that maintenance is the responsibility of DoH.

¹¹⁴ Department of Health, Submission to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

¹¹⁵ Von Holdt, K and Murphy, M (2007) (Naledi). Dysfunctional hospitals: presentation to HRC. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31st May 2007, at pp. 9-27.

¹¹⁶ *Ibid.*

¹¹⁷ Department of Health, Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

The challenge posed by patients bypassing clinics and going directly to hospitals was identified during the Provincial Reviews; a sentiment reiterated at the public hearings.¹¹⁸ The shortage of drugs, a lack of expertise, a lack of ambulances, weaknesses in the referral system and insufficient capacity at a clinic level all contribute to this.¹¹⁹

The need to strengthen the district health care system was identified by a number of hospitals during the Provincial Reviews. The absence of doctors at clinics often resulted in the duplication of services, as patients who were referred by a hospital to a clinic, would be assessed at the PHC level and then be referred back to the hospital. In addition, as a result of a lack of resources, clinics refer patients to a hospital that they should, under normal circumstances, be able to treat, or patients themselves seek care at a higher level. This user pattern places an additional burden on the already limited space and resources available and results in over-utilisation of resources and expertise at a secondary level. In addition to the need for more doctors, the need for additional district hospitals to overcome this problem was identified in some provinces.

3.4 Human Resources

“Our patients are helpless. Others come and go, I remain. I must skip my tea. I have to jump, to rush time - I must stop washing and serve tea. If there are no ward attendants I must make tea myself. There’s no point in washing the patient and giving medications, but failing to feed him. You cannot leave the patient with an empty stomach. Again, how can you leave a sick person in a wet bed and go for lunch?”¹²⁰

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 scarcity of staff in the private sector appears less acute and less of a constraint on service provision as compared with the public sector. Both the public hearings and the Provincial Reviews highlighted numerous human resource issues, problems and challenges, including those relating to staff shortages and the impact thereof in the public sector.

¹¹⁸ *Ibid.*

¹¹⁹ Goudge, J., Gumede, T., Russell, S. and Mills, A. (2007). The SACOCO Study: Poor Households and the Health System. Submission to the SAHRC Public Inquiry into Access to Health Care Services.

¹²⁰ Von Holdt, K and Murphy, M (2007) (Naledi). Dysfunctional hospitals. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007, at pp. 9-27.

A number of concerns with regards to the health workers in the public health care system were highlighted in the public hearings. It was maintained that:

- Nursing staff are underpaid;
- Nursing staff are overburdened with large workloads;
- There is a lack of adequate facilities and equipment, which impact negatively on the availability and quality of patient care;
- Nurses feel undervalued as management do not always take their issues, concerns and complaints seriously;
- Existing staff shortages have resulted in long waiting time by patients, lack of access to beds, poor record keeping and stocktaking and inappropriate behaviour from health workers because they are working under abnormal conditions; and
- In relation to HIV and AIDS, health workers carry a quadruple burden. They are themselves affected by the disease, they care for patients at work, their vocation places them at risk of infection and they are often the main carer for family members who are sick. In the Free State between 10-15 staff are dying per year at one facility alone and a number of departments are considered to be short staffed.

In recognition of the challenging human resources environment, the DoH developed a human resources plan which serves as the overarching policy framework to guide initiatives designed to ameliorate and address problems that have been identified.

3.4.1 Distribution of Health Personnel

“The biggest change since democracy is a shortage of staff”¹²¹

Effective health care requires that all levels of institutions providing health care should be adequately staffed. However, South Africa does not have adequate numbers of staff at all levels in the health care system. Staff shortages were referred to frequently throughout the public hearings.¹²² The shortage is illustrated by the fact that the current numbers of staff, although improved since 2004, are still less than in 1994.

National public health sector staff complements:

- 235 000 (1994)
- 213,000 (2004)
- 225,000 (2006)

¹²¹ *Ibid.*

¹²² *Ibid.*

Patterns of understaffing also continue to reflect inequities of the apartheid era as evidenced by the relative understaffing levels at two Johannesburg Hospitals.

Table 6: A Comparison of the Staff Compliment at Two Johannesburg Hospitals¹²³

Johannesburg General	Chris Hani Baragwanath
23% understaffed – all staff (1 100 posts)	52% understaffed – all staff (5200 posts)
28% understaffed – nurses (500 posts)	46% understaffed – nurses (1 750 posts)

Hospital staff shortages may be exacerbated as staff is redirected from tertiary care to primary care in an effort to provide services to the majority of the population at the point at which they are most accessible. The Western Cape experienced a 40% reduction in hospital service posts in the period between 1994 and 2000, and the trend has continued since then albeit it at a slower rate.¹²⁴ Problems relating to staff shortages were reiterated by the findings of the Provincial Reviews. For example, of all the hospitals visited in Gauteng, CEOs indicated that they needed more doctors, pharmacists, nurses, physiotherapists, radiographers, porters and other allied workers. In addition:

- A lack of staff accounted for 29% of the hospital's administrative modifiable factors. This figure has increased more than five times since 2004; and
- Professional nurses (especially those that would work after hours) and senior doctors (post community service) accounted for most of the shortages in expertise.¹²⁵

The vacancy rate in some hospitals was reported as more than 40%, which substantially impacts on service delivery. In addition, there was a perception that the number of vacancies is increasing and that there is an “*ever dwindling number of health professionals due to resignations*”.¹²⁶ For some facilities there appears to be particular difficulty in replacing professional nurses.

¹²³ *Ibid.*

¹²⁴ Proudcock, P. The Children's Institute, submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹²⁵ Mulaudzi. Access to health care services for children: The Child Healthcare Problem Identification Programme (Child PIP). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹²⁶ Von Holdt, K and Murphy, M (2007) (Naledi). Dysfunctional hospitals. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007, at pp. 9-27.

Many of South Africa's clinics do not enjoy the services of a doctor on a full time basis, while some clinics have access to a doctor only for a specific period (e.g. one day a week). Other clinics do not have access to a doctor at all. The absence or erratic presence of doctors at clinics impacts on user patterns. In Gauteng, all CEOs that were interviewed complained that patients, who should first visit primary health care facilities¹²⁷ were not in fact doing so, and were opting to obtain the services of doctors at hospitals. However, none of the CEOs and superintendents, of the central hospitals in Gauteng that were interviewed during the Provincial Reviews, despite all noting staff vacancies across a wide range of health professionals, identified specific programmes that suffered or were not offered at their respective facilities because of staff vacancies. Pharmacists were also considered to be in short supply, with many facilities visited during the Provincial Reviews indicating a shortage of 50% or more.

In assessing the small increase in the absolute number of health personnel in the public sector that has occurred over the last two years, one challenge is understanding where staff are deployed to and whether the increases are impacting positively on those facilities most in need. What is further difficult to ascertain, is the number of posts and type of positions that remain vacant because of a lack of suitably qualified applicants or due to financial constraints.

Specific shortages with regard to psychiatric personnel were identified at the public hearings, where especially in rural areas, only a few psychiatrists and mental health nurses are available. There was almost no expertise in sub-specialties such as intellectual disability psychiatry or addiction psychiatry.¹²⁸

The DoH has instigated a range of initiatives intended to counter staff shortages. These include developing country-to-country agreements to recruit foreign health workers to under-served and rural areas and actively trying to curb migration through engagement with International Codes and initiatives designed to manage migration. The DoH reports that these efforts are having a positive impact.

¹²⁷ South Africa's district based health care system is designed so that users first visit a clinic, where, if their condition can be treated it is. If they cannot be treated at this level they are referred to the next level, a District Hospital. When patients by-pass the clinic, and go straight to the hospital, it creates an undue burden on the hospital facilities.

¹²⁸ Stein, D. J. (2007). Faculty of Health Sciences, University of Cape Town. Human Rights and Mental Health. Submission to the SAHRC. Presented at SAHRC Public Hearings on 30 May 2007.

3.4.2 Retention of Health Personnel

"We always have to rush: we wash, we medicate, we move on. You miss some things. You cannot listen to the patient. You cannot implement things that would improve health care and staff morale. We also have to do inventory, push patients to other departments, clean floors, take a trolley to fetch food and dish up, all because there is a shortage of support staff. Nurses resign, die, retire, and they cannot be replaced. You cannot have tea, you cannot eat. We become de-motivated and no longer have empathy."¹²⁹

Staff retention is a challenge for many departments in the public sector. High labour turnover brings instability, stifles continuity and has an effect on the quality and quantity of the provision of services. In the context of absolute shortages, the retention of staff becomes a critical component of managing human resources. South Africa and the public sector in particular, has experienced and continues to experience "brain drain" as skilled staff leave for other countries, move to the private sector and abandon rural postings for urban positions.

The DoH reported that efforts to persuade professionals who have migrated to other countries or the private sector to return are showing positive results.¹³⁰ The public hearings recorded a number of testimonies highlighting factors that impact on staff retention interventions, which vary across professions. For example, research undertaken by the Centre for Health Policy highlighted the following issues affecting midwives and thereby impacting on maternal health:

- Midwives feel overworked and underpaid;
- Midwives have no career paths;
- Advanced midwives are not remunerated in return for their extra training or management roles in wards;
- There is weak management of health care facilities;
- Committed midwives who try to bring about change face hostility from colleagues and supervisors; and
- Scarce skills and rural allowances policies have not improved the situation.¹³¹

¹²⁹ Von Holdt, K and Murphy, M (2007) (Naledi). Dysfunctional hospitals. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007, at pp. 9-27.

¹³⁰ National Department of Health, SAHRC Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

¹³¹ Kekana, P. (2007). Access to Safe Motherhood, Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007.

Respondents in the Provincial Reviews highlighted the difficulties in getting staff to remain in their positions. Managers highlighted the difficulties associated with attracting staff to rural areas and retaining the staff in these areas.

Further negative impacts of staff shortages include skilled staff having to do the job of unskilled staff and nurse managers spending time re-deploying staff because of illnesses inundating other staff members.¹³² Research in eight districts revealed that staff at district level was distracted because of too many requests, which inhibited them from focusing on service delivery.¹³³

3.4.3 Staff Retention Initiative

In KwaZulu-Natal (“KZN”) a scholarship scheme in which students are recruited locally, funded to attend training and then return to work in the area seems to hold some promise.¹³⁴

3.4.4 Public Sector Salaries versus Private Sector Salaries

The acute shortage of nursing staff at all levels is attributed to low salaries, the structure of salary scales, poor working conditions and the absence of career-planning. Salaries, which is uncompetitive with the private sector and with other countries, are a major reason for health worker migration out of the public sector. The industrial action taking place at the time of the public hearings highlighted the strong dissatisfaction that health workers held over their inadequate pay. However, in keeping with international research, the Provincial Reviews found that what would make staff happy with their work included a range of both financial and non-financial incentives, confirming that, alongside remuneration, working conditions play a major role in job satisfaction.

3.4.5 Department of Health Initiatives

The DoH has begun the process of effecting improvements in salary remuneration and a phased implementation strategy, with nurses being the first recipients of the proposed change. With regard to the scarce skills and rural allowances which have been introduced, whilst the DoH would have liked this to cover all health workers, there were insufficient funds. However, it is important to note that the allowances have made a fundamental

difference, as a doctor or pharmacist can get up to 40% in addition to their basic salary in rural areas.

Staff unhappiness can however be exacerbated by a perceived lack of fairness in how allowances are allocated and over the late payment of allowances. The Provincial Reviews highlighted issues of contention, where rural allowances are available but not scarce skills allowances. There were also requests made that allowances be made available for night duty, for being on duty on special holidays such as Christmas and New Year, and for working with patients who are considered to be dangerous (in psychiatric care for example).

3.4.6 Non-Financial Incentives

Non-financial incentives constitute a significant component of any staff retention strategy and the Provincial Reviews and public hearings recorded complaints relating to the application of non-financial incentives, a lack of career-planning for nurses and inadequate opportunities for in-service training. In addition, there were perceptions of unfairness as to who was selected to attend workshops and allowed to take study leave.

The lack of proper educational and other facilities was an impediment to attracting expertise to hospitals located in rural areas. The lack of accommodation for staff was singled out as a problem by a number of facilities in the Provincial Reviews. According to the DoH, the HRP is addressing the issue of accommodation especially in rural areas.

The right to work outside the public sector (“RWOPS”) was introduced as one means of retaining skilled staff within the public sector. However the presence of skilled specialists at secondary and tertiary care facilities does not necessarily guarantee the expected levels of care for public sector patients since there are reported cases of absenteeism of doctors who are working in private facilities under the RWOPS programme.¹³⁵ A number of senior managers in the Provincial Reviews reported that doctors refused to sign registers and attendance could not be satisfactorily supervised.

3.4.7 Working Conditions

The shortage of staff in the health care system is creating a vicious cycle leading to extremely stressful working conditions as well as unduly high workloads for those remaining, resulting in further resignations. Many employees interviewed during

¹³² Von Holdt, K and Murphy, M (2007) (Naledi). Dysfunctional hospitals. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007, pp. 9-27.

¹³³ National Department of Health, SAHRC: Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

¹³⁴ Provincial Reviews Synthesis Report (2007), SAHRC.

¹³⁵ National Department of Health, SAHRC Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

the Provincial Reviews were unhappy with their working conditions and felt that their working environment was often poor and poorly maintained as a result of lack of personnel and equipment. The Provincial Reviews also heard reports of nurses being required to perform non-nursing duties, which was discouraging. A further burden resulted sometimes from new programmes that were put in place with no dedicated staff attached to them, and existing staff having to take on additional duties.

Some hospitals were notable exceptions despite problems with staff shortages. For example, in the Western Cape more than one hospital was identified as providing a pleasant working environment or being of a standard equivalent to that of the private sector.

Staff also face dangerous working conditions, as a result of being at risk of infection (e.g. from HIV or MDR TB) or of physical harm or of not being properly protected when working in a highly acute ward. The rape of a medical student in July 2007 on the grounds of Chris Hani Baragwanath Hospital highlighted the reality of health workers concerns. There was also the perception among some staff that efforts have been made to protect the rights of patients, for example the Batho Pele initiative, at expense of the wellbeing of staff.

3.4.8 Management - Staff Relations

“When we meet with management we complain about the shortage of staff, the linen, cleaners - they tell us to try your best! It’s a joke! They come with no solutions. Who do we cry to? We never see the head of nursing. We never see the CEO. We never see the clinical head.”¹³⁶

There is evidence that good management has the potential to play a significant role in staff retention and, conversely, that poor management exacerbates the problem of staff turnover. Staff-patient relationships mirror management-health worker relationships and a management emphasis on policies and structures could benefit from more attention to “soft” skills and issues, which impact on organisational culture.

The Provincial Reviews recorded scant praise from staff about their managers. Many comments were made about inadequate supervision of staff at all levels and there were also reports of an unsatisfactory climate in certain hospitals where staff does

¹³⁶ Von Holdt, K and Murphy, M (2007) (Naledi). Dysfunctional hospitals. Submission to the SAHRC Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31st May 2007, at pp. 9-27.

not feel free to speak, and seemed to be afraid of unspecified repercussions.

Respondents of the Provincial Reviews linked the deterioration in standards to *inter alia* poor management of nurse supervisors who “*always see mistakes, no eye for job well done.*” There were requests for management to be more supportive and realistic, and for better leadership and management.

In some institutions there was a breakdown of good labour relations between management and union members, as reported to during the Provincial Reviews. This has led to a poor work ethos and a general sense of malaise, resulting in an unsatisfactory quality of service delivery. National Education and Health Allied Workers Union (“NEHAWU”) is perceived to be very strong and management are unwilling to challenge them, and as a result, find it extremely difficult to discipline health care workers¹³⁷. There were also complaints of nurses not being at their stations at all times. At two of the hospitals visited it was noted that senior nurses were unavailable in the afternoon. It was reported that no disciplinary measures were taken for fear of union action.

3.4.9 Health Personnel Training

Effective training of health personnel is a complex process that is dependent upon many factors, including the country’s education system and the opportunities for contact time with patients, that is required in order for a skilled professional to garner sufficient experience. Training in the public sector used to be of such a high standard that private practitioners would refer complicated investigations to public institutions. However, the quality of training has systematically been eroded to the point where training of specialists is not of a sufficiently high standard any longer.¹³⁸ The three academic hospitals in the Western Cape provide one of the few areas remaining in the country where a full range of care can be provided to poor patients.¹³⁹

Unfortunately, a number of nursing schools were closed in the period after 1994 as the DoH attempted to bring some rationalisation and consistency to training centres. At that time,

¹³⁷ A general lack of discipline and refusal to do work assigned is said to be often ignored by senior managers. A senior surgeon cited examples where pools of blood on a hospital floor were not cleaned up, and when a porter refused to take blood to the operating theatre because he was about to go off duty.

¹³⁸ Thulare, A (2007) South African Medical Association. Submission to the SAHRC Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearing on 31 May 2007.

¹³⁹ James, M. Faculty of Health Sciences, University of Cape Town. Submission to the SAHRC. Presented at SAHRC Public Hearings on 30 May 2007.

it was impossible to predict both the loss of staff that would accrue as a result of the HIV and AIDS epidemic as well as the increased burden of disease leading to much higher demands upon the health care system. This has contributed to the current crisis in which the yearly production of nurses, set against the estimated number who are succumbing to AIDS, highlights that supply is clearly not meeting demand.¹⁴⁰ There is clearly a need for an increase in the number of nurses and other health care professionals who are being trained. However the national human resource policy has not yet attracted new funds, although there is a plan in existence which may ameliorate this.¹⁴¹

In an effort to address staff shortages, new categories of mid-level workers are being introduced by the DoH.¹⁴² These include clinical associates, emergency care technicians, and pharmacist assistants. The DoH has also established a task team between the Department of Education (“DoE”), DoH and the Department of Finance that is addressing the issue of production of health workers and funding of training.

3.5 Physical Infrastructure

“Most of the facilities visited are old and cannot adequately cater for the beneficiaries who need the services the most. The Provincial Government has not built facilities in recent years neither have they revitalised the existing structures.”¹⁴³

The right to adequate health care services is resource based. Appropriate infrastructure must be in place for health care to be available and of an adequate standard. The public hearings have revealed the following problems, challenges and issues around infrastructure:

Despite the HRP and the extensive clinic building programme, some institutions in the public sector continue to suffer from problems due to a lack of adequate infrastructure, buildings being old and derelict and buildings being too small for the

required use.¹⁴⁴ This is likely to affect rural facilities more than urban ones, although not exclusively. In addition, the following problems have been observed:

- Overcrowding in facilities;
- A lack of space, which compromises patients’ rights to privacy;
- Small facilities that cannot cope with patients demands;
- Small waiting areas;
- Inadequate pharmaceutical facilities or services; and
- A shortage of water in some rural areas and a lack of adequate security in some health care institutions.

3.5.1 Department of Health Infrastructural Development Initiatives

The DoH has in terms of the public hearings done the following in developing health care infrastructure:

3.5.2 Clinic Building

Since 1994, 1300 new clinics have been built, 252 clinics have had major upgrading and 2298 clinics have received new equipment. However, the DoH recognises that the infrastructure of a number of clinics needs to be improved.¹⁴⁵ The percentage of clinics with emergency response times of less than an hour increased from 55% in 1998 to almost 58% in 2000.¹⁴⁶ Overall utilisation rates remained fairly constant between 2003 and 2005, increasing slightly for children below five years.¹⁴⁷

3.5.3 The Hospital Revitalisation Programme

The DoH initiated the HRP following a facilities audit, which took place in 1996. The HRP focused on infrastructure, equipment, organisational development and quality. To date 7 hospitals have been audited, 46 projects are under construction and 26 hospitals have approved business cases, but are awaiting funding. Psychiatric hospitals are now also included in this process. If hospitals are too dilapidated, new hospitals are built and if they are inappropriately located, they are relocated to new sites, closer to the area they service.

¹⁴⁰ See Connelly, D et al, “Prevalence of HIV infection and median CD4 counts among health care workers in South Africa”, (2007) 97 (2) *South African Medical Journal* 115.

¹⁴¹ James, M. Faculty of Health Sciences, University of Cape Town. Submission to the SAHRC. Presented at SAHRC Public Hearing on 30 May 2007.

¹⁴² National Department of Health, SAHRC Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

¹⁴³ Provincial Reviews, Synthesis Report (2007), SAHRC.

¹⁴⁴ National Department of Health, SAHRC: Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

¹⁴⁵ National Department of Health, SAHRC Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

¹⁴⁶ Ijumba P and A Padarath (2006). *South African Health Review*, Durban, Health Systems Trust.

¹⁴⁷ *Ibid.*

The introduction of the HRP appears to be having a significant impact on eligible facilities and where HRPs are in place they are making a positive difference.

In some instances, however, plans are proceeding at a slower pace than anticipated. A lack of progress is primarily attributed to problems with provincial Departments of Public Works such as delays in awarding tenders and the procurement procedure, as well as lack of technical capacity in public works. The short-term impact of the delays experienced by the provincial DoHs is severe. In the long term, the delays cause contract price escalations, resulting in more expensive health care services. It was suggested that the provincial DoHs be more involved in the tender and procurement procedures, and have the authority to manage the deadlines. The DoH reported that in order for the HRP to be extended additional funds would be required.¹⁴⁸

Inadequate infrastructure, especially the absence of private wards, lead to poor protection of privacy as the use of general wards, open or publicly accessible areas prevails. For example, the Provincial Reviews reported cases of patients' privacy being not properly observed especially patients with HIV or wanting to attend voluntary counselling and testing ("VCT") services. In some hospitals patients were being treated in the corridors or in view of visitors walking through the passages.

Cleanliness is clearly of utmost importance in the health care environment. For example, the deaths of several babies in a hospital in KZN 2005 were attributed generally to poor cleanliness and a lack of appropriate hygienic procedures. The cleanliness of facilities visited in the course of the Provincial Reviews, both inside and out varied. There appears to be some correlation between cleanliness and staff attitudes and other indicators suggesting a link between well managed facilities and general quality and accessibility of care.

3.6 Equipment and Drugs

"We have had cases of wound sepsis because we have nothing to wash our hands with."¹⁴⁹

Health care workers need a variety of equipment to discharge their duties effectively. Without appropriate equipment, patients cannot be treated according to the required standards. The Provincial Reviews found that equipment is mostly available, however:

- Much equipment tends to be old and in poor working condition and the lack of maintenance and replacement of equipment is commonly cited as being problematic;¹⁵⁰
- Some facilities manage to access the resources and equipment they need through a process of sharing equipment between facilities;
- In Gauteng for example, some specialist doctors have sourced essential equipment from donors. Rural facilities are most vulnerable as their equipment is out of service for longer periods;¹⁵¹
- Part of the problem for acquisition and maintenance of equipment is attributed to delays in the procurement and tendering processes; and
- Some clinics lack communication and management tools such as telephones, faxes, filing cabinets, photo copiers and computers. This clearly militates against efficient management record keeping and reporting. Other facilities report a lack of information technology support and staff.

Examples of theft of bed linen to and from the central cleaning depot, pilfering and vandalism were reported during the Provincial Reviews as was theft of patients' possessions by hospital staff.¹⁵²

The DoH stated that their immediate focus would be on completely modernising radiation oncology equipment, after which they will focus on diagnostic radiology. An essential equipment list for level one services has been developed.¹⁵³

¹⁴⁸ National Department of Health, SAHRC: Public Inquiry into Access to Health Care Service. Submissions to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearing on 31 May 2007.

¹⁴⁹ Von Holdt, K and Murphy, M (2007) (Naledi). Dysfunctional hospitals. Submission to the SAHRC Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31st May 2007, at pp. 9-27.

¹⁵⁰ *Ibid.*

¹⁵¹ *Ibid.*

¹⁵² Provincial Reviews Synthesis Report (2007), SAHRC.

¹⁵³ Von Holdt, K and Murphy, M (2007) (Naledi). Dysfunctional hospitals. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007, at pp. 9-27.

chapter 4

access to health care services

“In one vulnerable household a pregnant mother with a sick child had 9 clinic visits, 5 [visits to a] public hospital, 2 visits to a traditional healer, and a visit to a faith healer and the pharmacy, representing a massive cost burden to the household.”¹⁵⁴

The objective of this chapter highlights the findings of the public hearings regarding the following elements of health care:

- Out-of-pocket payments (payment by patient for health care);
- Transports costs;
- Emergency transport;
- Waiting time; and
- Access to information.

The Provincial Reviews revealed the following problems with various aspects of access to health care:

- Poor implementation of fee exemption at public hospitals; limited physical access to facilities arising from the absence of public transport;
- High private transport costs and a lack of emergency transport; and
- Unacceptably long waiting times

¹⁵⁴ Goudge, J., Gumedé, T., Russell, S. and Mills, A. (2007). *The SACOCO Study: Poor Households and the Health System*, Written submission to the Public Inquiry into Access to Health Care Services.

Research into 30 households, comprising of both vulnerable and highly vulnerable respondents, found that 50% of people with an illness did not seek care mainly because of a lack of finances, but also because respondents felt that the health care system could do nothing for them. Other barriers were also mentioned, such as there being no-one available to go with the patient to the health care facility.¹⁵⁵

The public hearings revealed greater detail of each element of access to health care mentioned in the introduction. The detail of these findings are summarised below.

4.1 User Fees

Primary health care is provided free of charge. Children under six years of age, pregnant women, the disabled and the indigent do not pay user fees for high levels of care, and the National Health Act allows for free care to be extended to other categories of users. However in research presented to the public hearings it was found that only half of those who visited a public hospital obtained an exemption despite all being eligible.¹⁵⁶ The research also found that general private facilities were more popular than public hospitals despite the costs involved with the former. Of the households interviewed, 20% incurred “unaffordable” costs.

¹⁵⁵ *Ibid.*

¹⁵⁶ *Ibid.*

4.2 Transport Costs

“Ernest had to visit the district hospital 4 times in the first month of HIV treatment, which generated a cost burden of 50%”¹⁵⁷

Even when patients indicated that they did not pay fees to visit a clinic or hospital, and that medication was mostly free of charge, the cost of transport was a major prohibitive factor in accessing their health entitlements. Historically, transport was provided between different levels of care, but subsidies have since been withdrawn resulting in deteriorating access to care.¹⁵⁸ The presence of an affordable, safe, dignified, state sponsored public transport system is required to fulfil the constitutional obligation to a an environment that is not harmful to one’s health and well-being of communities.¹⁵⁹

In a submission focusing on women’s access to care, research found that some women were not able to access maternal health care services. In the Eastern Cape, it appears that as many as 40% of poor women are not accessing services. The reasons for this include:

- The poor status of women in society and communities;
- A lack of trust in the public health care system;
- A lack of funds & transport;
- A lack of availability of ambulances;
- Referral systems and emergency transport not functioning optimally; and
- The gate keeping role of clerks and health care workers.¹⁶⁰

The Childcare Problem Identification Programme (“PIP”) found that one-third of child deaths occurred during the first 24 hours in hospital of admission, suggesting amongst other things, transport problems for sick children.

However, despite seeming challenges in accessing care, the number of visits to PHC facilities increased by roughly 25% from 82 million in 2000/01 to 102 million in 2005/06 and 96% to PHC facilities, which are open five days a week. The view

¹⁵⁷ *Ibid.*

¹⁵⁸ Thulare, A. South African Medical Association, submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹⁵⁹ Rangaka, T. Obstacles on the Way for Patients to have Access to Healthcare in South Africa. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹⁶⁰ Kekana, L. Access to Safe Motherhood. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

has been expressed that this represents an increase in user visits but a decrease in quality of care. The DoH is developing a rural transport strategy.

4.3 Emergency Transport

“Access in the rural areas is a major challenge”¹⁶¹

While the Constitution states that no person may be denied access to emergency care, there does not seem to be provision for alternative arrangements. The Provincial Reviews heard of shortcomings of the ambulance service, which for some hospitals was at best inadequate and at worst non-existent. This impacted especially harshly on rural patients. A case was reported in which the ambulance arrived at its destination 5 to 6 hours after requested, by which time the patient had already died. There were also suggestions that staff needed to be better trained to deal with emergencies and life threatening situations. Poor conditions of the roads meant that some areas were completely inaccessible to ambulances and there were reports of ambulances being hijacked.

4.4 Waiting Times

“Why do we have to stand from 05h00 in the morning outside a health facility that only opens at 07h00 in order for us to be serviced by a medical doctor who only treats 50 patients a day? Whoever is unfortunate to be number 51 has to come back the following morning and get up a little earlier to ensure that the doctor will attend to them”¹⁶²

The Provincial Reviews and 80% of submissions reported lengthy and bureaucratic registration, long queues to see a nurse, doctor or pharmacist, and preferential treatment was reported for some patients, which all served to constrain access for many health care service users. There are various harrowing reports of patients arriving at a health care facility in the early hours of the morning and waiting many hours to be registered, and again many hours before they see a doctor. This is unacceptable and especially so for patients who travel long distances and are ill.

¹⁶¹ Engelbrecht, B. Comprehensive Service Plan for the Implementation of Health Care 2010, Western Cape Department of Health, Submissions to the Public Inquiry into Access to Health Care Services, presented at SAHRC Public Hearing on 31 May 2007.

¹⁶² Jacobs, P. Accountability for the Implementation for the Right to Health. Testimony from Health Care User. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 30 May 2007.

CHAPTER FOUR

Patients complained about long queues when waiting to be registered, to be seen by a health professional, and particularly, in pharmacies for medication. There have been occasions when a patient spent as much as eight hours at a hospital to see the doctor and obtain their medication. In one instance there were reports of patients arriving as early as 03h00, being registered at 10h00, and only being able to see a doctor in the afternoon and then having to return the following day for medication.¹⁶³

Waiting times for surgery are also problematic. For cataracts the waiting list is over a year and for joint replacements over three and a half years. For colon cancer the waiting list is two months and for breast cancer six weeks.¹⁶⁴

It appears that the majority of patients are not aware of their rights despite the fact that the Patients' Rights Charter and information about Batho Pele are widely displayed in facilities. Those who are aware of their rights appear to find difficulty in laying complaints, being unsure of who to hold accountable and having restricted telephonic access because of the associated costs. Communities get frustrated when their first line of communication, the facility manager, appears to be unavailable, for various reasons.¹⁶⁵



¹⁶³ Provincial Reviews Synthesis Report (2007), SAHRC.

¹⁶⁴ James, M. Faculty of Health Sciences, University of Cape Town. Submission to the SAHRC. Presented at SAHRC Public Hearings on 30 May 2007.

¹⁶⁵ Jacobs, P. Accountability for the Implementation for the Right to Health. Testimony from Health Care User. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 30 May 2007

chapter 5

acceptability: consent, staff attitudes, culture and quality

5.1 Consent

The Provincial Reviews reported very few instances of patients' consent not being sought, indicating that the great majority of health personnel acknowledge the need to seek consent

from their patients and do so appropriately. However issues of consent have been raised in relation to the treatment of patients with the highly infectious multidrug-resistant tuberculosis ("MDR TB").

The SAHRC has monitored the case in the WLD High Court of *The MEC of Health for the Gauteng Province v. M. Malebo and 12 Others* (case no: 2007/6526).

The case involved an application brought by the MEC for Health, Gauteng Province to confine the respondents, thirteen patients suffering from multiple-drug-resistant Tuberculosis (MDR TB), indefinitely. The purpose of the application was to enable the medical and non-medical staff of the Applicant "to be in a position to treat and care for the Respondents which is in their interest and that of the community at large", in terms of the National Health Act.

The presiding Judge in the matter ordered that the matter be postponed pending appointment of legal representation for the patients, at state expense.

On 5 April 2007, the matter was again postponed *sine die*, the respondents having been afforded legal representation. The court further ordered that the Respondents file their answering affidavits in due course. Pending final determination of the matter, the respondents (patients) were interdicted from leaving Sizwe Tropical Diseases Hospital until they have been discharged by the medical personnel employed by the above hospital.

The SAHRC determined that it should consider intervening in the matter as an *amicus curiae* (friend of the court), depending on where the matter lay at the time, since it raised two significant issues viz.

- how the decision is taken to confine patients suffering from MDR TB and how a review of such a decision is to take place;
- once such a decision has been taken to confine these patients, how to ensure that there are checks and balances

The following developments have taken place since the filing of the above application:

The SAHRC conducted an onsite visit to Sizwe Tropical Diseases Hospital where the patients raised their concerns relating to the conditions to which they are subjected. The patients complained that their personal freedom was undermined in that they were not allowed to leave the hospital to attend the funerals of their closest family members. They were unable to provide financially for their families as they were denied their right to employment.

In August 2008 the Cape High Court authorised the compulsory isolation of four XDR-TB patients who previously absconded from the Brooklyn Chest Hospital. In reaction to this judgement SAHRC Chairperson commented that the matter had to be treated with caution because it presented significant challenges of personal freedoms from both sides – that of the patients and that of the communities. The Chairperson stated that the circumstances of individual patients had to be considered in future cases.

In August 2008 the Respondents' attorney filed their Expert Reports as well as a counter-application regarding renovations that must be made to the facilities at Sizwe Tropical Diseases Hospital after the Respondents raised complaints about their safety and comfort in the wards.

On 18 March 2009 the Respondents' attorney advised that there is only one Respondent left in this matter since its inception in 2007. Some of the Respondents have been discharged whilst the other Respondents have died.

5.2 Staff Attitudes

“After 2 years of an unresolved chronic illness and an instance of inhumane treatment at a public hospital, Nomsa only consulted a private allopathic doctor and a traditional healer, despite a recommendation by the doctor to attend a public clinic.”¹⁶⁶

Staff attitudes have been widely identified as a problem for the South African health care system. In research into access on safe motherhood it was found that at least 37% of maternal deaths were avoidable. A variety of factors contributed to the deaths, including the fact that the poor treatment of women is commonplace and that midwives and doctors are extremely de-motivated.¹⁶⁷

Women survivors of sexual violence face challenges because of poor health worker attitudes. Research highlighted that 1 in 3 (32.6%) of health practitioners said they did not consider rape to be a serious medical condition.¹⁶⁸

A common reason given during the public hearings as to why services are not available was the attitudes and beliefs of health workers in various respects and with regard to a number of vulnerable groups. This appears to be especially problematic with regard to termination of pregnancy (“TOP”) services, for rape survivors wishing to access care and for lesbian, gay, bisexual and transgender (“LGBT”) communities. LGBT people experienced treatment sometimes characterised by subtle or not so subtle homo-prejudiced or heterosexist attitudes. Homophobic attitudes, as well as the lack of knowledge about male-on-male rape, affected men and boys as they were unable

¹⁶⁶ Goudge, J., Gumede, T., Russell, S. and Mills, A. (2007). *The SACOCO Study: Poor Households and the Health System*, Written submission to the Public Inquiry into Access to Health Care Services.

¹⁶⁷ Kekana, L. *Access to Safe Motherhood*. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹⁶⁸ Vetten, L. *Women's access to healthcare: Gender-based violence, termination of pregnancy*; The National Working Group on Sexual Offences, Tshwaranang Legal Advocacy Centre, Reproductive Rights Alliance (RRA) and Women's Legal Centre (WLC). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

to access appropriate health care. Xenophobic attitudes were also noted during the Provincial Reviews.

More generally, poor attitudes stem from many factors but have most often been associated with the unhappiness of many health personnel with their working conditions and remuneration as well as being a reflection of inadequate management from superiors. In every province the Provincial Reviews heard reports of caring staff and well maintained and well run facilities. However, they also uncovered evidence of poor quality of care and inappropriate, often downright callous, attitudes on the part of health workers and administrative staff that were responsible for many of the complaints. Some patients complained of poor treatment by nursing staff and preferred to be treated by doctors who could solve the problem more quickly. There were reports of rudeness from nursing staff and one example was given of a patient in pain who was refused pain tablets, and had to wait for a doctor.

The Provincial Reviews highlighted a perception held by service users that to complain to health workers might be counterproductive and harmful to their prospects of receiving good care. This seemed to be especially true for the most vulnerable patients. For example, elderly patients complained about the lack of respect and the rudeness of some of the officials. They were, however, afraid of reporting it because their life depends on the hospital staff and the care that they receive, and to complain might result in poor care of older persons and them being given the incorrect medication as punishment.

During the Provincial Reviews, it was found that most patients interviewed were not aware of their rights, have never lodged a complaint, and would not know how to do so. Most have seen the various suggestion boxes at facilities, but poor use was made of this complaints mechanism. Language is sometimes an issue with suggestion boxes marked only in English.

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

5.3 Cultural Acceptability

The majority of patients interviewed across the country felt that services were culturally acceptable to them despite the fact that many hospitals only catered for certain or specific religious groups on request. In the Western Cape, however, patients complained that service was culturally unacceptable. In Gauteng, there was a perception that the under-utilisation of PHC facilities (and over-utilization of hospitals) arose because

there was a belief that nurses, being mostly women, were not qualified to treat patients effectively.

The issue of traditional medicine was referred to in many provinces during the course of the Provincial Reviews. At worst, deaths were attributed to the use of traditional medicines by patients and several institutions made reference to barring traditional medicines from their premises. The regulation of traditional medicine is complex. Most clients come from a very poor background and because traditional medicine is firmly rooted in African culture it is difficult to turn patients away even if they are unable to pay.¹⁶⁹

Patients generally expressed a preference for Western medicine. Some service providers argued that traditional health care treatment must be acceptable because although patients do visit traditional doctors they still go to hospital. In contrast, during the Provincial Reviews, SAHRC staff was told about people utilising the services of traditional healers and only resorting to the use of Western medicine when their condition was uncontrollable.¹⁷⁰

5.4 Quality of Health Care

Provision of good quality health care requires that the whole health care system be functioning with well trained and motivated staff; adequate services and equipment, good referral networks and appropriate management and support. The consequences of poor quality of care included increased mortality and morbidity. Submissions highlighting quality of care issues were made almost exclusively by those representing vulnerable groups. For this reason quality of care issues are covered in the following section, which reports on access to health care issues as experienced by vulnerable groups.

5.4.1 Food quality

The Provincial Reviews received reports on the poor quality of hospital food, including insufficient quantity of food and a lack of a sufficient number of food trolleys and pots. Some providers indicated that they have made determined efforts, which they feel have been successful, to provide good food (i.e. sufficient food that is well cooked).

¹⁶⁹ Mahepe. South African Traditional Health Practitioners. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 30 May 2007

¹⁷⁰ Provincial Reviews Synthesis Report (2007), SAHRC.

chapter 6

services for vulnerable groups

For conceptual clarification for the purposes of this report, vulnerable groups include women, domestic workers, children, older persons, the mentally ill, persons with disabilities, lesbian, gay, bisexual and transgender (“LGBT”) individuals, and refugees. Vulnerable groups highlighted *inter alia* problems associated with accessibility to health care as access was restricted to some individuals and the quality of health care, which was thought to be sub-standard.

6.1 Women

A woman’s state of health is especially sensitive when she is pregnant or giving birth, but women are also vulnerable because of gendered roles, which result in women usually assuming a primary role of a caregiver such as a partner, parent or domestic worker. Women are also particularly vulnerable because of gender-related violence.

Submissions to the public hearings focused on safe motherhood, access to termination of pregnancy services, survival of sexual and intimate partner violence, and specific factors affecting domestic workers.

6.1.1 Safe Motherhood

“She was told to go to the hospital, but she didn’t have money for transport. So she walked home. We took her back to the clinic the next day, but we were chased away and told to go to the hospital”¹⁷¹

Maternal deaths are largely preventable, and this is one reason why a reduction in maternal mortality has been identified as one of the Millennium Development Goals (“MDGs”). In South Africa, 92% of women are able to access ante-natal and delivery care. This success came about, in part, because health care was free for all pregnant women. Coupled with this, excellent evidence-based national guidelines and protocols exist. The Confidential Enquiry into Maternal Deaths initiated by the DoH, revealed that at least 37% of maternal deaths were clearly avoidable. Research into safe motherhood found that the underlying reasons for these deaths could be:

- A lack of integration of HIV/AIDS and maternal health care services;
- Care that is not patient centred;

¹⁷¹ Kekana, L. Access to Safe Motherhood. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

- Poorly motivated and inadequately trained staff; and
- Managers being primarily held accountable for financial management (as opposed to quality of care).¹⁷²

Furthermore, some facilities are not provided with comprehensive essential services, and are not able to undertake the relatively simple and life saving procedure of a caesarean section often because of the unavailability of doctors.

Transport and especially sub-optimal emergency transport also inhibits women accessing health care.

6.1.2 Termination of Pregnancy

“Only 50% of designated TOP facilities are up and running, predominantly in urban areas – effectively limiting rural women’s reproductive rights.”¹⁷³

Provision of TOP services has significantly reduced the number of women dying due to illegal or incomplete abortions. In 1994, the Medical Research Council (“MRC”) estimated that 425 women died in public health care facilities from unsafe abortions. The Second Confidential Enquiry into Maternal Deaths in South Africa (1999 – 2001) found that there were 40 abortion-related deaths per year, which constituted a 90% reduction, particularly benefiting young women under 30.¹⁷⁴ However, only 50% of designated TOP facilities are operational and these are predominantly in urban areas, thereby effectively limiting the reproductive rights of rural women.¹⁷⁵ This was reflected in the Provincial Reviews, which found several facilities that did not provide TOP services, largely because of unwillingness on the part of staff to be involved for ethical reasons and /or because of skills shortages.

Provincial TOP health care providers raised a number of cross-cutting issues, which they considered to be compromising the

quality of the services they provides. All the issues centred around a disabling environment, including inadequate human resource capacity, unsupportive management at a facility level and the career limitations of being involved in TOP service provision and in some provinces (Mpumalanga and the Northern Cape) limited access to TOP services (DoH)¹⁷⁶.

6.1.3 Survivors of Sexual and Intimate Partner Violence (“IPV”)

“Intimate partner violence is associated with increased risk of several risk factors for HIV infection including involvement in transactional sex, having multiple male sex partners and problem drinking”¹⁷⁷

Despite rape being such a critical problem in South Africa, statistics found that only one in two rape survivors in South Africa reported being raped to the police, while the MRC found that only one in nine women reported being raped.¹⁷⁸ A range of conditions requiring health care can result from IPV and sexual violence. Women with HIV who live in violent relationships experience many obstacles to accessing HIV testing and treatment, and have difficulties in complying with treatment regimes as a result of domestic violence.

Responses to women who have experienced IPV and sexual violence include a set of norms and standards as part of the Primary Health Care Package for South Africa; the availability of anti-retroviral drugs to prevent HIV infection among rape survivors, *National Management Guidelines for Sexual Assault Care* and the *National Sexual Assault Policy* released by the DoH in 2005.

The National Sexual Assault Policy aims to establish accessible, designated, specialised 24-hour health care service for sexual assault patients. However, there is wide variation in practice implying a wide variation in post-rape care. The location of services in casualty seriously compromises the quality of care provided to victims of sexual assault, where casualty staff are likely to see their services to rape survivors as an add-on (if not burden) and generic work in casualty as their first priority.

¹⁷² Kekana, L. Access to Safe Motherhood. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹⁷³ Vetten, L. Women’s access to healthcare: Gender-based violence, termination of pregnancy; The National Working Group on Sexual Offences, Tshwaranang Legal Advocacy Centre, Reproductive Rights Alliance (RRA) and Women’s Legal Centre (WLC). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹⁷⁴ National Committee for the Confidential Enquiry into Maternal Deaths (1998). Interim Report on the Confidential Enquiry into Maternal Deaths in South Africa, DoH, Pretoria, http://www.doh.gov.za/docs/reports/1998/mat_deaths.html.

¹⁷⁵ Vetten, L. Women’s access to healthcare: Gender-based violence, termination of pregnancy; The National Working Group on Sexual Offences, Tshwaranang Legal Advocacy Centre, Reproductive Rights Alliance (RRA) and Women’s Legal Centre (WLC). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹⁷⁶ Vetten, L. Women’s access to healthcare: Gender-based violence, termination of pregnancy; The National Working Group on Sexual Offences, Tshwaranang Legal Advocacy Centre, Reproductive Rights Alliance (RRA) and Women’s Legal Centre (WLC). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹⁷⁷ *Ibid.*

¹⁷⁸ Hirschowitz, Worku and Orkin 2000 quoted by Vetten .L, Women’s access to healthcare: Gender-based violence, termination of pregnancy. The National Working Group on Sexual Offences; Tshwaranang Legal Advocacy Centre; Reproductive Rights Alliance (RRA); and Women’s Legal Centre (WLC). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

Rape survivors wait for examinations, HIV testing and VCT. Waiting periods are generally longest at night and over weekends, when services are most dependent upon casualty staff or district surgeons. Since VCT counsellors are also not available at night this additional responsibility is placed on casualty nurses. Staff shortages exacerbate waiting times as do police failing to bring sexual assault evidence, crime kits, and the whereabouts of doctors on call. As many women do not have access to transport and depend upon the police in particular to help them access healthcare this can impact negatively upon women's right to emergency medical treatment. Cases have been recorded of the police sometimes refusing to open cases of rape, or delaying transporting victims to health care facilities to the extent that the 72-hour period has lapsed.

Inadequate quality of care for survivors of sexual violence was found to be linked to:

- The extent of prior training and knowledge around rape survivors' health care needs;
- A lack of familiarity with existing protocols and policies; and
- A lack of provision of psychosocial support, counselling and therapy.

A national survey of 31 health care facilities exploring access to healthcare for women who have experienced gender based violence found that only:

- 79.6% of facilities had pregnancy tests;
- 66.7% had emergency contraception;
- 52.4% had an angle lamp (an essential basic for the forensic examination);
- 7.8% had spare clothing for emergencies; and
- 15.2% had a lockable cupboard for storing crime kits and other evidence.¹⁷⁹

6.2 Domestic Workers

"We do appreciate the free health care we are getting... We got an appointment at the hospital and the appointment is maybe [8h00]. You go there Some of them sit there the whole day...if the government can maybe change the system at the hospitals where workers can go...say your appointment is [9h00] and not [10h00] or [11h00]. Now domestic workers get problems at work...sometimes the employer doesn't want to give the

¹⁷⁹ Christofides et al (2006) quoted by Vetten .L, Women's access to healthcare: Gender-based violence, termination of pregnancy. The National Working Group on Sexual Offences; Tshwaranang Legal Advocacy Centre; Reproductive Rights Alliance (RRA); and Women's Legal Centre (WLC). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007.

*worker, that is the reality, the worker [time] off to go to the hospital"*¹⁸⁰

A series of workshops focusing on workplace health and safety revealed a number of issues impacting on domestic workers' access to healthcare services. Services for domestic workers are often not available near their place of work. Thus if they need to access health care services they face constraints arising from travel costs as well as time, both to travel to and from the facility as well as that, spent waiting in queues.¹⁸¹

Domestic workers complain of the quality of care indicating that the *"drug of choice for domestic workers seems to be Panado"*. Thus, they are forced to make out of pocket payments for drugs purchased in the private sector. Furthermore, issues of confidentiality pose a major problem for domestic workers who reported instances where the health carers or professionals had informed their employers of their condition before informing them and without seeking their consent to do so.

Due to the poor working conditions of domestic workers, they are exposed to numerous health and safety risks. There is, however, no systematic enforceable process of making risks known to domestic workers. Nor is there any legal provision for health and safety inspections.

6.3 Children

*"In South Africa child survival warrants urgent attention because children continue to die at an unacceptably high rate from largely preventable causes"*¹⁸²

The issue of under-infant and child mortality received a great deal of attention following the unannounced visit by the then Deputy Minister of Health to a hospital in the Eastern Cape in mid-2007. Statistics released by various agencies are variable, however even the most conservative data sets show a regressive trend with child deaths increasing primarily as a result of the HIV epidemic which contributes to 40% of deaths of children under five years.¹⁸³

"Saving Children 2005" compiled by the Child Healthcare PIP and the MRC found an overall death rate of 6.8 per 100

¹⁸⁰ Domestic Worker – Name Withheld (2007). Presentation to the SAHRC at the Public Hearings.

¹⁸¹ SADSAWU. Me or the Carpet? From Omo to Everything. Domestic Workers Discussing Issues of Health and Safety. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 1 June 2007

¹⁸² Proudcock, P. The Children's Institute, submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹⁸³ *Ibid.*

admissions and that there were 2.3 modifiable factors per death.¹⁸⁴

The PIP audit found that 63% of audited deaths among children were considered avoidable and that 52% of all modifiable factors related to sub-standard care by clinical personnel.¹⁸⁵ Fifteen percent of all modifiable factors occurred at PHC level and 80% reflected a lack of IMCI implementation. Thirty-one percent of children died during the first 24 hours in hospital.

With regard specifically to HIV and AIDS, despite the very high proportion of children dying from AIDS related illnesses:

- Only 54% of the children who died had been tested for HIV. Of those who were tested;
 - 37% were HIV-exposed, and
 - 48% HIV-infected.
- PMTCT data were lacking in two out of three deaths. Of those with data, and at risk for vertical transmission, only 28% received Nevirapine;
- PCP prophylaxis was indicated in 48% of all deaths but only 14% of children who died received it; and
- 50% of deaths were assessed as WHO stage III or IV and were thus eligible for ART yet only 3% of deaths were on ART¹⁸⁶.

Problematic areas underpinning poor quality care for children included:

- Some facilities were not providing comprehensive obstetric services;
- Referral systems and emergency transport systems were not functioning optimally;
- Staff were demotivated; and
- Professional nurses did not receive sufficient training in midwifery and there were insufficient numbers of advanced midwives.¹⁸⁷

Where administrative factors were associated with child deaths the following was highlighted:

- Almost one out of three of administrative modifiable factors related to lack of access or facilities for sick children especially a lack of high care beds and resuscitation areas;

¹⁸⁴ Proudcock, P. The Children's Institute, submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹⁸⁵ Mulaudzi. Access to health care services for children: The Child Healthcare Problem Identification Programme (Child PIP). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹⁸⁶ *Ibid.*

¹⁸⁷ *Ibid.*

- 9% related to lack of equipment; and
- 7% to a lack of drugs and IV fluids.¹⁸⁸

6.4 People with Mental Disabilities

"It saves the Government money to spend on appropriate mental health care services."¹⁸⁹

A specific inequity within the public sector identified by the submissions related to the under-funding of psychiatric services.¹⁹⁰ As far back as 1997, a DoH White Paper emphasised lack of parity for mental health care services. There is no parity in budgets and posts for mental health and this is true both in the public and in private sectors, where those with mental health disorders encounter discrimination from medical aids. This is compounded by under-funding of mental health research by national bodies with research mandates and unacceptable delays in approving mental health research by the Medicines Control Council. Unsurprisingly then, the Provincial Reviews uncovered an inadequate number of facilities for patients with psychiatric illnesses, accompanied by long waiting lists of people who need treatment.

As highlighted in the section on financing above, psychiatric services remain a "poor cousin" in the health care system. There are very few beds for psychiatric patients in general hospitals, for example, in the entire Western Cape Province there were only 12 such beds. Hospital de-institutionalisation has taken place without first building community treatment services. Psychiatric resources, including therapy, are either insufficient or unavailable and there is a perception that health care providers are reluctant to develop meaningful partnerships with community based organisations who are potential service providers.¹⁹¹ Very little mental health prevention occurs at the primary level. For example, there was an absolute shortage of school mental health nurses. Many components of the health care system have given scant attention to mental health (e.g. military, EPAs, correctional services, emergency services). The DoH acknowledges that accessibility is a major challenge, that facilities are poor and that quality of care needs to be

¹⁸⁸ *Ibid.*

¹⁸⁹ Stein, Dan J. Prof and Head, Dept of Psychiatry / MH, UCT, Chief Psychiatrist, PGWC, Director, MRC Unit on Anxiety Disorders, US. Human Rights and Mental Health. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

¹⁹⁰ *Ibid.*

¹⁹¹ Rangaka, T. Obstacles on the Way for Patients to have Access to Healthcare in South Africa. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

improved.¹⁹² However, they point to the fact that progressive legislation has been passed, that guidelines are now in place, and that what will be required is active monitoring of care for people with psychiatric disorders.

Reasons underpinning this inequity is that physical disorders always seem so much more important, for example the HIV/AIDS epidemic. However, behavioural factors contribute to the epidemic and the majority of HIV/AIDS patients will develop a neuro-psychiatric disorder. In addition, it is culturally difficult to accept the view that mental illness is a medical disorder and this is particularly the case with alcoholism and drug dependence where few policy-makers would easily agree that this is a medical disorder.¹⁹³

Nurses, who have undergone specialised psychiatry training interviewed as part of the Provincial Reviews complained that they do not qualify for a scarce skills allowance and there is a perception that psychiatric nursing is considered unimportant in comparison with other specialisations. Since patients may be dangerous and there have been instances in which staff have had their clothes dirtied or torn or been personally injured and therefore feel that they should also be entitled to a “danger allowance”. Security is also a problem as some specialised wards are without a full time security guard.

The limited number of specialist institutions is likely to place a great financial burden on patients living a distance away from a hospital and there are examples of some patients having to pay up to R400 for a return trip, which inhibits easy access to a medical facility, especially for follow-up care.

6.4.1 Cognitively-impaired

National guidelines on the cognitively impaired do not provide adequate direction to health care workers for assessing and dealing with the range of functionality displayed by cognitively-impaired people and it is unclear what training healthcare workers receive around the effective management, care and treatment of this group of victims.

6.5 People with Physical Disabilities

From the time they are born, children with disabilities and their families have a lot of contact with health care facilities and

¹⁹² DoH Submission to the SAHRC. Presented at SAHRC Public Hearings on 30 May 2007.

¹⁹³ Stein, Dan J. Prof and Head, Dept of Psychiatry / MH, UCT, Chief Psychiatrist, PGWC, Director, MRC Unit on Anxiety Disorders, US. Human Rights and Mental Health. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

health care professionals.¹⁹⁴ They face difficulties in accessing medication as well as ensuring continual access to medication. However, in the experience of Disabled Children’s Action Group (“DICAG”) there is inadequate attention given by the DoH to explaining the need and correct use of medicines to parents, and this is especially problematic in view of the fact that many children with a disability are on long term medication. People with disabilities and families caring for people with disabilities also face physical barriers to access, including narrow doorways, steps into buildings, lack of accessible toilets and difficulties with specific procedures. Children with disabilities encounter specific problems such as devices that do not fit and a lack of monitoring on the use of assistive devices.

There are compassionate, effective and knowledgeable staff working at rehabilitation centres and in state facilities, however there are also reports of inappropriate health worker behaviour, and a lack of competent support staff.¹⁹⁵ For children, access to care is impeded by the attitude of health workers who at times are unable to cope with the behavioural challenges posed by some disabled children. Adults with disabilities experience poor care where general staff do not understand the particular needs that disabled patients have. There are also reports that xenophobic attitudes are heightened towards refugees with disabilities.¹⁹⁶

Not all facilities are wheelchair accessible, or accessible to individuals with some or other form of mobility impairment.¹⁹⁷ This was reiterated by the findings of the Provincial Reviews, which illustrated that even in those facilities with wheelchair access; this access was not necessarily adequate. Public transport is not easily accessible for those with disabilities and this becomes an obstacle to accessing care. It is also more costly since wheelchair users are expected to pay for the additional space that their chairs occupy.

Access to wheelchairs is erratic as facilities in only three provinces provide wheelchairs and even then they adopt a “one-size fits all” approach, which means that people do not necessarily receive a chair which meets their individual needs.

¹⁹⁴ DICAG (Disabled Children’s Action Group). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings

¹⁹⁵ Quadpara Association of South Africa. Submission to the Public Inquiry into the Right to have Access to Health Care Services. Presented at SAHRC Public Hearings on 1 June 2007

¹⁹⁶ Jesuit Refugee Services. Update on Asylum Seekers and Refugee Access to Health Care in South Africa 2007. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on June 1st 2007

¹⁹⁷ Quadpara Association of South Africa. Submission to the Public Inquiry into the Right to have Access to Health Care Services. Presented at SAHRC Public Hearings on 1 June 2007

Only one province provides pressure-care cushions which are essential for preventing pressure sores. Disabled patients have limited access to appropriate urinary and bowel incontinence products and this impacts profoundly on their quality of life.

Wheelchair bound individuals face further challenges in accessing health care if they live in a disadvantaged municipality. It is for example, extremely difficult to access water from a stand pipe, or to use a ventilated pit latrine.

6.5.1 Rehabilitation

A submission about vocational rehabilitation services pointed to extreme shortcomings in availability. With an unemployment rate of over 70% for people with disabilities in the Western Cape, vocational rehabilitation has a major role to play. Unfortunately, major gaps and constraints exist. These include high transport costs to reach the centre which has limited facilities for people to stay for the assessment period, which creates further cost implications. Added to which, are waiting lists of 3 months for two of the units and of one year for the other two.¹⁹⁸ Physiotherapy is not available after hours or at weekends, which can be life threatening for quadriplegics and paraplegics.¹⁹⁹

Vocational rehabilitation is an inter-sectoral issue and cannot be tackled by any one department. However, there is currently lack of agreement about roles and responsibilities of departments in the public sector.

A task team has now been established to increase access to vocational rehabilitation. The team will meet with the four government departments and disability sector, and will make presentation at various provincial and national forums as well as form a partnership with the Institute for the Promotion of Disabled Persons and the Western Cape Disability Network.

In view of the relatively good level of service provision in the Western Cape, in comparison with some of the other historically disadvantaged provinces it is likely that the availability of vocational rehabilitation services in other provinces is equally, if not more, limited.

According to the DoH, a lack of human resources and a lack of proper equipment pose challenges to providing disability and rehabilitation services.

¹⁹⁸ Coetzee, Z. One Year Waiting List for Vocational Rehabilitation Services - Is this acceptable? Presented at SAHRC Public Hearings on 1 June 2007

¹⁹⁹ Quadpara Association of South Africa. Submission to the Public Inquiry into the Right to have Access to Health Care Services. Presented at SAHRC Public Hearings on 1 June 2007

6.6 Lesbian Gay Bi-sexual and Transgendered People

“The OUT studies found that health care practitioners often assume heterosexuality.....the vast majority of HIV/AIDS public education has focused on assumed heterosexuality. National HIV messaging and service provision is presently not equipped to deal with a range of sexual and gender identities.”²⁰⁰

The treatment of LGBT individuals was found to be sometimes characterised by subtle or not so subtle homo-prejudiced or heterosexist attitudes. Homophobic attitudes, as well as a lack of knowledge about male-on-male rape, affected the access that men and boys’ had to health care, as well as quality of care they received.²⁰¹

Research conducted by OUT (LGBT Well-Being) in KZN and Gauteng found that the LGBT community experience systematic discrimination in accessing healthcare.²⁰² The findings in KZN indicate that not all health care practitioners provide a safe and accepting environment for LGBT people:

- 5% were refused treatment because of their sexual orientation;
- 13% delayed seeking treatment because of their fear of discrimination;
- 50% of respondents felt that health care workers do not respect their confidentiality;
- 30% indicated that health workers do not make them feel comfortable;
- 23% reported that heterosexist questions were asked; and
- 37% indicated that health workers assumed they were heterosexual.

In Gauteng:

- 6% had been refused treatment because of their sexual orientation; and
- 12% delayed seeking treatment for fear of discrimination.

²⁰⁰ Judge, M (2007). Health care for lesbian, gay, bisexual and transgender people: Issues, implications and recommendations. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearing on 31 May 2007.

²⁰¹ Vetten, L. Women’s access to healthcare: Gender-based violence, termination of pregnancy; The National Working Group on Sexual Offences, Tshwaranang Legal Advocacy Centre, Reproductive Rights Alliance (RRA) and Women’s Legal Centre (WLC). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

²⁰² OUT, LGBT Well Being. Healthcare for Lesbian, Gay, Bisexual and Transgender People: Issues, implications and Recommendations. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

Delay in seeking treatment is of concern, where living with STIs, for example, can accelerate the spread of HIV. Despite the fact that the HIV virus affects all groups of people, in different types of intimate relationships, HIV prevention initiatives have targeted mainly heterosexual individuals in South Africa and have neglected to target bisexual and homosexual individuals.

6.7 Asylum Seekers and Refugees

Eight asylum seekers and refugees were interviewed in Gauteng. They experienced numerous problems relating to the denial of access to public hospitals and clinics, exacerbated by the inconsistent application of relevant laws and policies among different facilities. There were delays in obtaining official documentation and permits from the Department of Home Affairs (“DHA”) and without these documents many refugees were refused access to treatment at health care facilities. Some indicated that hospitals insisted on payment of sometimes exorbitant amounts, before they could be consulted by a health care professional.²⁰³

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

6.8 Prisoners

The Provincial Reviews reported on access to care for prisoners in KZN, the Northern Cape, the Free State and Gauteng. Access seems to vary between provinces. In one province at least, no records were available, prisoners could not see the doctor of their choice and they experienced long waiting periods before consultation. However, in other provinces when prisoners attended a clinic they were treated first for security reasons, which impacted on the service to other patients. Dedicated prison wards, while aiming to provide care of the same standard as that provided to other patients experienced particular staffing challenges as conditions were unsuitable for female nurses.

It was difficult to ascertain the level of access to support that prisoners received for the treatment of HIV and TB. In one province at least, HIV tests were available on request to some, but seemingly not all prisoners. There were no reports of prisoners that were in need of ARVs. In another province,

²⁰³ Jesuit Refugee Services. Update on Asylum Seekers and Refugee Access to Health Care in South Africa 2007. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on June 1st 2007.

negotiations are underway for the Correctional Services Centre to have a dedicated ARV site.

6.9 Older Persons

Both the Constitution and the Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000, prohibit discrimination on the basis of age. While these are important provisions, they are insufficient in and of themselves to ensure that older persons are able to access appropriate health care services. Consider, for example, the South African Demographic and Health Survey (1998), which indicated that:

- only 13% of people over 65 years of age had access to private medical scheme coverage;
- 50% of people over 65 years were taking one or two courses of prescribed medication for chronic conditions; and
- 61% of all aged persons were women.

Added to this, is the frequent need of many older people to use tertiary health care establishments, primarily because of the nature of their illness. This adds to transport and treatment costs, which are often unaffordable. These ancillary costs are a significant barrier to access in a context where old age pensions are used almost entirely to support extended families in the context of high unemployment. In the last decade, HIV/AIDS has further diverted the spending patterns in poor households to cover costs related to the virus. These include *inter alia* costs associated with the care of family members infected by HIV/AIDS, burial costs, the cost of caring for orphaned grandchildren.²⁰⁴

In recent years, South Africa has had to distribute scarce resources to meet persistent and emerging health care challenges such as the HIV/AIDS epidemic which affects the young population most severely. The government prioritises the needs of the young and maternal and child health, and allocates budgetary resources accordingly. The health care needs of older persons are not a priority for the government and such clients tend to be marginalized in health care services.

The department of health has redesigned the health care system with an emphasis on primary care and an aim to improve access to equitable health care for the large poor and previously disadvantaged section of the population. A three-tiered health care system is operated and policy prescribes that 92% of clients be served at primary clinics, 6% at secondary level hospitals and only 2% referred to tertiary level care. Primary clinics are the point of entry to health care services for the majority, including older persons.

²⁰⁴ Hassim, A., Heywood, M. and Berger, J. (eds) (2007). Health & Democracy (SiberInk, Cape Town)

South Africa, like the rest of the world, has a growing older population. In 2006, older persons numbered 3.7 million and constituted 7.7% of the older population.²⁰⁵ These figures are projected to almost double to 6.4 million, representing 13% of the total population, by 2050. This means that as population ages and life expectancy increases primary and secondary prevention becomes important. As age advances, the cumulative biological changes that occur ultimately result in an individual's decreased ability to function in a specific environment. These time-related deteriorations may be biologically inherited in part; they may also be accelerated by environmental conditions such as stress, physical inactivity and poor nutrition.

However, because the prevalence of chronic non-communicable disease increases in old age, a large part of the data of functional loss with ageing in studies may have been due to effects of disease rather than to ageing. As we grow older, slow damage happens to the DNA, thus changing its structure lightly. The functional quality of the immune system declines with increasing age. There is a decline in the number and type of immune cells produced. Immune cell function decreases and fewer protective antibodies are produced.

Geriatric medicine

Little is known about Geriatric Medicine in Sub-Saharan Africa ("SSA"). Within SSA countries, it is most established in South

Africa. Geriatric Medicine is the study and clinical practice of medical care for older people.

In South Africa, Geriatric Medicine is a relatively recent subspecialty. Geriatric Medicine in South Africa is located at tertiary level institutions." After "South Africa currently has only 8 registered geriatricians, 5 of whom work in private practice.

Challenges faced by older persons

There is a lack of statistics on the quality of health care services delivered to older people. Dissatisfaction by older persons with the situation in public health care services has been reflected in several studies. Complaints include the inefficient appointment systems, long waiting times, client overloads, understaffed facilities, shortages of medication, unavailability of assistive devices, and health personnel who were perceived as not doing thorough examinations, not explaining older persons' health problems to them, and not treating them with respect.

The combination of a poorly informed population, access barriers to health care services, a lack of professionals with knowledge and skills and inadequate policy development and implementation contribute to the inadequacy in management and prevention of non-communicable disease and disability. Older persons in the majority tend to seek medical attention with acute or chronic disease causing symptoms and disability and not for screening of pre-symptomatic illness.



²⁰⁵ Statistics South Africa (2006). Mid-year population estimates, South Africa, <http://www.statssa.gov.za/>.

chapter 7

conclusion and recommendations

7.1 Conclusion

“We don’t yet have a definition of essential health services. This means we don’t have a base line for the right to health and it is impossible to cost the health service and thereby determine objectively what can be afforded.”²⁰⁶

The health and well-being of a population are both a product and reflection of the general health of a society. An equitable and effective health care system is just one, albeit important, component of a healthy society. High levels of inequity coupled with a high prevalence of poverty are indicators of a generally unhealthy society. Poverty has long been recognised as a major cause of ill-health and as a barrier to accessing health care services, and the issue of poverty was raised repeatedly during the public hearings as an impediment to accessing health care services in South Africa. Poverty alleviation or eradication is not in itself the explicit jurisdiction of the DoH. However, in light of the impact of poverty on access to health care there may be an advocacy or consciousness-raising role that the DoH could appropriately adopt and develop specific strategies to deal with the impact of poverty on population health and health care services.

²⁰⁶ AIDS Law Project. (2007). Presentation to the SAHRC at the Public Hearings.

International treaties, to which South Africa is a signatory, emphasise the development of a primary health care approach in which adequate nutritious foods, clean drinking water and a healthy environment must be provided. These public hearings focused on access to health care services in a more narrowly defined way

As a result of economic globalisation, provision of health care is no longer the jurisdiction of sovereign states alone, and access to health care is constrained and influenced by the broader geopolitical context. International and multi-lateral trade agreements and treaties, together with multi-national corporate interests, define the scope that national governments have to respond to, in respect of the health care needs of their population. However there is limited public discourse domestically around international treaties and agreements impacting on access to health care.

During the public hearings, the DoH indicated its explicit commitment to the progressive realisation of the right of access to health care services. There is no doubt that since 1994 a great deal has been achieved and that many policies have been put in place which, if they were to be successfully implemented, would enhance the progressive realisation of the right to access to health care. These include the National Health Act, legislation designed to regulate the private sector, policies to address the collection and analysis of information,

distribution and availability of drugs, and initiatives to manage the retention and distribution of health personnel. However, it is the implementation of policies which has proved to be a major stumbling block.²⁰⁷

Significant initiatives, which have contributed to the right to access health care, include the integration of a formerly fragmented health care system into one unified system. The adoption of a primary health approach in which care is delivered through a district health care system, and where primary health care is provided free of charge, are exemplary measures and in line with the most progressive health policy in the world. So too is the provision of free health care to children and to pregnant women.

There has been substantial progress with regard to clinic building and hospital revitalisation programmes. Almost all clinics are open five days a week and funding has been provided to enable the modernisation of tertiary services. The gap in finances available to historically advantaged and disadvantaged provinces has been reduced and efforts have been made to strengthen financial planning processes. Strengthening of primary health care delivery has been attempted through various measures, including support and training for staff as well as the development of treatment protocols and guidelines.

However, notwithstanding these initiatives, a number of serious challenges face the South African health care system leading to the conclusion that the right to have access to health care services for the majority of South Africans is poor and clearly inadequate.

7.1.1 The Progressive Realisation of the Right to Access Health Care Services

What is more difficult to assess with accuracy is whether the situation has improved or worsened over time, and thus whether there is indeed a progressive realisation of the right to access to health care services. The Provincial Review is the first comprehensive investigation into South African health care facilities that was been undertaken within a human rights framework, and the 2007 public hearings were the first of their kind. Furthermore, it appears that little specific definition has been given to the right to health care and there is a need to clarify and further define what it means in practice and to people's everyday lives. This requires specification of the minimum levels of service required to ensure appropriate access

²⁰⁷ DoH (Department of Health). South African Human Rights Commission: Public Inquiry into Access to Health Care Services. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2

to healthcare, which is unavailable for the public sector although the prescribed minimum benefits package exists for the private sector. This makes comparisons, necessary to measure whether a progressive realisation of rights is underway, difficult.

Further clarity is needed as to what the parameters of *acceptability and quality* of care are. What does “*no-one may be refused emergency medical treatment*” mean in the context of people apparently being denied access to basic health care. Unless there are transparent policies to guide services that will and will not be provided, unequal distribution, constituting a perverse form of rationing and an unequal access to and fulfilment of human rights will result by default, or by omission, as is presently the case.

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

7.1.2 Access to Health Care Services

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 acerbate existing vulnerabilities of marginalised groups and individuals within the country.

7.2 Specific Recommendations

7.2.1 The Health Care System

There is general recognition that a strong health system is an essential element of a healthy and equitable society. However, according to recent WHO publications, health systems in many countries are failing and collapsing. Too many health systems are inequitable, regressive and unsafe.

The SAHRC recommends going back to the basic building blocks of an efficient and functional health system. The basic features of a health care system are drawn from two sources,

namely the World Health Organisation²⁰⁸ and Beckman's *Health Systems and the Right to Health*.²⁰⁹ They include the following: legal recognition; standards; participation; transparency; equity, equality and non-discrimination; respect for cultural differences; quality; planning; referral system; coordination; international cooperation; legal obligation; monitoring and accountability.

Specific emphasis is placed on planning as an element of an effective health care system, including consideration of the right to health as being subject to progressive realisation and resource availability. The crucial importance of planning is recognised in the declaration of Alma-Ata, General Comment No. 14 of the ICESCR. States must have comprehensive national health plans, encompassing both the public and private sectors, for the development of health systems. These plans should be evidence-based and situational with disaggregated data. According to General Comment No. 14, the plan must include certain features, such as clear objectives, timeframes, a detailed budget, effective coordination mechanisms, reporting procedures, financing arrangements, assessment arrangements, indicators and benchmarks to measure achievement, and one or more accountability devices.

There needs to be a recognition and realignment of the location of health in national priorities. This should be reflected in resource allocation and the design and implementation of an effective and functional needs-based system.

However, the integrity of a needs-based system relies on the accurate measurement. It is important for the DoH to measure health problems, evaluate actions, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health. Health information systems and population data must be improved continuously, because it is essential to be able to monitor progress and inequities. Institutional capacity to collect, analyse and utilise health data at national, provincial and local levels need to be strengthened, so that programme and policies can be responsive to the changing burden of disease profile.

Specific recommendations:

- Go back to the basic principles of an effective and functional health system and undertake a constructive evaluation of South Africa's health care system. Emphasis is placed on communicating the specificity of the content of obligations, planning and a continuum of care. The strength of a right is determined by a number of factors including the existence and effectiveness of a remedy. Therefore, obligations require

monitoring and failure to deliver necessitates accountability and consequence. An emphasis is placed on planning and resource allocation.

- There needs to be a recognition and realignment of the location of health in national priorities. This should be reflected in resource allocation and the design and implementation of an effective and functional needs-based system.
- Institutional capacity to collect, analyse and utilise health data at national, provincial and local levels need to be strengthened and then translated into responsive policies and programmes.

7.2.2 The Public and Private Sector Divide

The South African health system consists of both a private for profit health sector and a public health sector. Given that the majority of South Africans rely on the public health care sector for their health care needs but that expenditure in the private sector far outweighs that in the public sector, there is a disproportionate share of resources in the private sector that could benefit the public sector tremendously. In addition, government should recognise that it contributes to this spending model through medical aid contributions paid to public sector employees, who in turn utilise private sector facilities. With the current global financial crisis, private health care has become unaffordable to many people, who then seek health care services at public facilities, further burdening a strained system. This scenario has resulted in an over-serviced private sector and under-serviced public sector.

There is a need to access private sector resources through regulation that lends to collaboration and not control. South Africa's model of a dual health system does not compliment the country's policy and movement towards equity and progressive realisation of the right to health care. Innovative policy is therefore required and the ultimate vision of a single health care system should be pursued. Although there are numerous obstacles to achieving this vision, it should be viewed as a long term objective.

There has been an insidious growth in the role played by private health care providers which, in a context of a scarcity of resources, including finances and health care personnel, inevitably impacts on access to health care for the majority of the population. The major inequities between the public and private systems have increased despite government's efforts to regulate the private system and the private system continues to drain the financial and human resources of the public sector. This is true both in relation to the provision of services and to the time and money that comes from the public budget to monitor and regulate the private sector. The tax expenditure subsidy provided to medical scheme members is hard to understand within the context of the poor resourcing of the public health

²⁰⁸ World Health Organisation (2008). Primary Health Care: Now More Than Ever, <http://www.who.int/whr/en/index.html>

²⁰⁹ Beckman, G. et al (2008). Health Systems and the right to health: An assessment of 194 countries, vol 372, 13 December 2008.

care system. Mechanisms for controlling the increase in private hospitals provided by the National Health Accounts (“NHA”) do not seem to be utilised effectively and private hospitals continue to be licensed without due consideration to the existing pool of human resources.

Specific recommendations:

- The White Paper on Health must be reviewed in view of the policy prescriptions outlined concerning the proposed National Health Insurance. Introducing a mandatory insurance would enable a greater section of the population to benefit from the human resources currently located in the private sector and which are largely accessible only to medical aid members.
- Access private sector resources through regulation, which lends to collaboration between the private and public sector e.g. through the location of private wards within public hospitals thereby facilitating resource sharing, both human and financial.
- The long-term vision for one inclusive national health system should be pursued

7.2.3 Management and Implementation

Findings on the management structure of public health facilities in South Africa highlighted the difficulties associated with the centralisation of decision-making authority. The resultant restricted authority and accountability for facility managers impacted negatively on service delivery at a local level. Facility managers felt disempowered to take decisions and solve problems in their facilities. This situation led to backlogs in service delivery and a low morale among managers, who felt powerless to change their situation and the circumstances in their facilities. In addition, the centralisation of power meant that decisions pertaining to local facilities were taken at a municipal or provincial level and some respondents felt that personnel at these levels did not necessarily have the competence or local knowledge to take such decisions. Respondents felt that by decentralising power to district and facility managers and CEOs to make decisions, backlogs would be alleviated, especially with regards to human resources and financial management.

Operational efficiency will be enhanced not just through the decentralisation of power, but also by the ability of management personnel to manage and lead a department competently. As such, an audit of the skills that management personnel hold would enable provincial DoHs to identify gaps in management skills and thus ascertain the type of training and capacity-building that is needed amongst senior staff. This would be especially helpful in addressing issues of a lack of supervision and poor support to junior and general staff, who highlighted the lack of direction and communication from senior management as a problem.

In order to address implementation problems there is a need for emphasis on improving operational efficiency. Operational efficiencies hampering service delivery were once stressed by former President Thabo Mbeki when he stated that, “we cannot allow that government departments become an obstacle to the achievement of the goal of a better life for all because insufficient attention to the critical issue of effective and speedy delivery of services. The department needs integrate planning and implementation as a prime area of focus.”²¹⁰

To improve financial management and overall operational delivery efficiency by the department of health, more emphasis needs to be placed on capacity development. This must go beyond the challenge of a skills mismatch to encompass “the process by which individuals, groups, institutions, organisations and societies increase their abilities to deal with their health needs in a sustainable manner.”²¹¹

The enactment of the Public Finance Management Act, 1 of 1999 (“PFMA”), is part of the broader scheme of capacity development to ensure good financial governance. The financial management of government departments and state institutions has markedly improved although some challenges still persist. For instance, according to the Presidency, “unauthorised expenditure increased from R30 million in 2004 to R103 million in 2006 and a third of the departments received qualified audits in 2006.”²¹² The problem is even more acute at provincial and local government levels. In 2005/06 financial year, only 55% of the provincial departments received unqualified reports. This is indicative of the challenges that still exist in achieving financial efficiency.

Specific recommendations:

- Decentralise power by delegating decision-making to CEOs and district and facility managers, especially with regards to human resources and financial management.
- Conduct skills audits of senior management and implement appropriate interventions such as training and awareness campaigns to capacity senior staff.
- Improve financial management and overall operational delivery efficiency by placing greater emphasis on capacity development, PFMA, good governance, implementation and accountability.

²¹⁰ Mbeki, T. Presidency (2006). State of the Nation Address by President Thabo Mbeki, www.presidency.gov.za.

²¹¹ UNDP (1997). Capacity Development New York: Management Development and Governance Division, UNDP.

²¹² Presidency (2008). Towards a Fifteen Year Review. <http://www.info.gov.za/view/downloadsFileAction?id=89475>.

7.2.4 Infrastructure

The right to adequate health care is resource-based and appropriate infrastructure should be in place for the health care system to function optimally. The DoH has been surrendering funds to National Treasury particularly on infrastructure and the SAHRC's public hearing suggests that there is a great need for infrastructural development and therefore a need to accelerate development to address the problems highlighted in the report. The findings of this report illustrated problems of overcrowding in facilities leading to a lack of privacy and compromised cleanliness and old out-dated technology, which compromised the quality of health care. Despite the HRP, the lack of sufficient and contemporary infrastructure and technology compromises the ability of facilities to provide an adequate service to health care users.

Environmental health services are part of the health care services and assist in the prevention of diseases and spread of infections. Major health benefits are possible when these services are functioning optimally. Municipalities need to plan for and support environmental health services, as with any other municipal service. Arising from a Development Bank of Southern Africa dialogue, where the results from a national study were shared with key relevant role players such as the National DoH, the Department of Department of Provincial and Local Government ("DPLG"), National Treasury and municipal health services should be debated at a Ministers and Members of Executive Council ("MINMEC") level and that the National DoH, supported by DPLG, should facilitate such interaction to determine the way forward.

Specific recommendations:

- Funding should be allocated to the revitalisation of all facilities, especially those in the rural areas. Sufficient and contemporary infrastructure should be developed as well as appropriate technology in order to address the compromised ability of facilities to provide an adequate service to health care users.
- Environmental health services are part of the health care services and assist in the prevention of diseases and spread of infections. Municipalities need to plan for and support environmental health services, as with any other municipal service and this should be debated at a MINMEC level.

7.2.5 Accessing Services at a District Level

Since 1994, there has been a great transformation in health care, with emphasis on specific roles of the three tiers of government, namely national, provincial and local government, and the differing but equally important roles of tertiary and primary health care. Ideally, tertiary health care facilities should

be reserved for referrals from primary health facilities and all conditions that require more attention than can be afforded at a primary health care facility. As such, a primary health care facility should be the first port of call for health care users. In addition, these district facilities should be accessible to the greater population, particularly outlying and marginalised communities so that all people are able to access free primary health care within walking distance from their homes. This would alleviate the costs associated with transport on the part of patients and transport provision on the part of the state, bearing in mind that transport provision for vulnerable people such as the ill, persons with disabilities and older persons will still be necessary. This primary health care model is the key to service delivery as a whole in South Africa and the success or failure of South Africa's existing health care system is dependent on the optimal functioning of thereof.

According to the findings in this report however, there have been difficulties with internalising roles at each level of government, which could be due to confusion at a management level and a lack of communication and direction leading to a lack of understanding at all lower levels. References were also made to poor relationships between provinces and districts and dysfunctional management structures.

In addition, the model fails to operate efficiently because patients often bypass clinics and go to hospitals for their first consultation. This occurs for various reasons including a lack of access to drugs and other resources and insufficient capacity or expertise at a primary health care level. Clinics are unable to employ or retain doctors and when a doctor is in employ; their visits are sometimes short or erratic.

The problem of unnecessary consultation at a tertiary level then arises, where patients visit a clinic and because of the lack of resources or staff, are referred to a hospital for treatment for relatively minor conditions. This user-pattern places an additional burden on tertiary health institutions, where a lack of space, resources and staff is already a problem.

Recommendations:

- Strengthen service at a district level, thereby effectively operationalising the primary health care approach.
- Ensure the full-time employment and attendance of medical professionals at district levels, who are compensated well for their services, ensuring their retention in the system.
- Generate greater awareness of the existence, services of and the cost of services at district facilities to entice communities to use local primary health care.
- There should be greater communication to all employees of their specific roles in each level and sphere of government.

- Ensure that all facilities are appropriately resourced to deal with only those matters that are dealt with at that level (i.e. primary or tertiary) so as not to duplicate resource allocation.

7.2.6 Human Resources

The current labour environment is a challenge to all state departments, which endeavour to employ and retain skilled people to provide services to the public. A shortage of competent and qualified health personnel contributes to inadequate health care. The SAHRC's public hearings indicated that health institutions are severely understaffed and experience difficulties in retaining existing staff members, who are lured by incentives in the private sector and in other countries. Vacancy rates were particularly high in rural areas and facilities serving disadvantaged areas.

To address these human resources issues, the DoH should embark on a two-pronged approach to firstly encourage more young people to join the health profession and to retain existing staff. The campaign to entice new people into the health profession should be based on thorough research such as a departmental needs-analysis. The DoH needs to be proactive in integrating recent development into its policies and practices to ensure that it attracts health personnel.

In a recent study on South African talent management practices, results showed that high salaries and benefits were low on the list of priorities for graduates to remain in a job.²¹³ The most important factors to graduates were achieving a good work-life balance, and future employability in terms of marketable knowledge and skills within and outside of their current jobs. Organisations with poor monetary incentives therefore need to invest in the training and the continuous investment in staff if there is they are to retain employees. The more employees are learning, the less likely they are to look to greener pastures.

This again calls for proactive measures to investigate methods and practices that would suit the health sector. Recent studies advocate the concept of servant leadership. This role requires leaders to have certain attributes, all of which help existing staff to develop their skills for the future. These attributes include a genuine commitment to helping others grow and develop, even if it means sacrificing self-interest for the good of the group. According to Marshall²¹⁴ a servant leader does not hoard knowledge and try to wield power over others, but is interested in empowering others.

²¹³ Sunday Times, 22 February 2009.

²¹⁴ Sunday Times, 22 February 2009.

Specific recommendations:

- Embark on campaigns to attract young professionals to the medical sector, highlighting the non-monetary incentives that would be preferable to that in the private sector.
- The DoH should focus on retention strategies that include improving working conditions for health personnel, especially safety and security and highlighting the non-monetary incentives that the department provides.
- Training should be comprehensive and continues for health care workers as learning is considered a great motivation for remaining in a specific position.

7.2.7 Vulnerable Groups

The findings of this report show that medical and health personnel often have a poor or discriminative attitude towards vulnerable individuals or groups, which leads to poor access to health care for vulnerable people. It is clear that the opinion of portions of society project onto individuals in health care facilities, distorting their attitude and behaviour towards children, domestic workers, non-nationals, homosexuals, bisexuals, transgendered people, persons with disabilities, prisoners and older persons. Submissions during the provincial reviews have illustrated examples of violations of privacy, a lack of appropriate resources, a lack of access to medication and bias attitudes towards these individuals.

In addition, despite ensuring that health care is available free of charge to vulnerable groups including pregnant women and children, the actual availability of health care services is limited for many vulnerable groups including children, pregnant women, the disabled, LGBT and the mentally ill. Availability is constrained primarily through systems issues including financial shortages, management related deficiencies, shortage and the unplanned redistribution of health workers, and shortages with regard to equipment and drugs.

Recommendations: Non-Nationals'

Noting that the primary responsibility for protection of refugees rests with the host government, the National DoH should:

- Work in partnership with relevant stakeholders such as the United Nations High Commissioner for Refugees, the SAHRC and civil society to provide ongoing training for staff on the rights of refugees to access healthcare so as to minimise the confusion over the various categories of non-nationals and the attendant rights for each category. This will also clarify the issue that any non-national has the right to emergency and life saving treatment regardless of one's immigration status and hopefully address challenges of xenophobia and related intolerances among staff.

- Ensure uniform application and implementation of national policies and directives that it has issued, at all health facilities so as to ensure equality and non-discrimination against refugees e.g. access to free anti-retroviral treatment and assessment of indigent refugees according to the means test in the fee structure.
- Promote the employment of skilled health professionals in the public health sector amongst refugees so as to alleviate the current skills shortage. In the same manner refugees can thus contribute meaningfully to the economy.
- Development of the country, create a positive image of their contributions as well as a more receptive working environment for other refugees who utilize their services.
- Engage and liaise closely with the Department of Home Affairs on the different types of documents that non-nationals use and the timely issuance of permits for refugees as possession of immigration documentation remains central to all non-nationals in accessing services.

Recommendations: Older Persons

- With a growing older population there is a need to increase the number of health professionals with special training in Geriatrics i.e. not only medical practitioners but physiotherapists, occupational therapists, nurses, social workers, etc. The training period for a geriatrician like for any other subspecialty is long (about 10 years post undergraduate degree). After training as a physician, one has to train for a further two years to become a geriatrician.
- Immunizations: Persons over the age of 65 and those with chronic medical conditions are at particularly increased risk of complications from influenza, pneumococcal disease, and should be offered both immunisations including tetanus immunizations.
- The health care workers should provide the information and opportunity for preventive care that helps older patients to maintain functional independence for as long as possible. The ageing population is heterogeneous, recommendations for screening community dwelling, cognitively and functionally intact individuals will necessarily be quite different from those dealing with functionally dependent and cognitively impaired nursing-home residents with multiple co-morbidities.
- Dementia: Although routinely screening for dementia in the general older population is not recommended, health care workers should be alert to detect new cases as early as possible since a combination of medications, education, and counselling can benefit patients and their families. For primary prevention, aggressively controlling cardiovascular and cerebrovascular risk factors (e.g. hypertension, hyperlipidemia) may be helpful for both vascular and Alzheimer's dementias. There is some evidence that staying mentally active (e.g., reading, pursuing new areas of learning, working crossword puzzles) may be beneficial in prevention as well.

Recommendations: People with Mental and Physical Disabilities

- All healthcare facilities should be physically accessible to clients with disabilities.
- Budget/resource allocations to mental healthcare should be reviewed and addressed accordingly.
- There should be substantive mental health research that clearly quantifies varying mental disabilities by region for resource allocation.
- There are cultural sensitivities around the perception and treatment of mental disabilities that must be explored with faith-based organizations and traditional healers in order to create a healthy working relationship with formal mental healthcare facilities.
- Mental health facilities that are properly serviced by trained staff should be available throughout the country at a community level.
- There should be incentives to train and retain psychiatric staff in the public sector.
- There should be consistent access to prescribed medicine for people with disabilities.
- The nursing staff should be trained on sensitivities and symptoms of different disabilities.
- There should be awareness programmes at a community level that seeks to eliminate discrimination and stigmatisation around mental health so that people with mental disabilities requiring health care services can access it.
- There should be consistent follow-up sessions with patients to ensure that assistive devices are correctly fitted and used.
- There should be relevant consideration of the client's needs when issuing wheelchairs rather than a one-size-fits-all approach.
- Healthcare facilities should be technologically-advanced so that new technologies are introduced as they are developed in order to facilitate the highest quality of health.
- Code of conduct for healthcare staff should be monitored.
- Quality of services and implementation of policy must be monitored.
- Client's feedback mechanism must be monitored.
- The lack of accessible transport poses a real challenge to accessing healthcare facilities; therefore the Department of Transport should play a critical role in ensuring access to health.

Recommendations: General

- Guidelines for the treatment of vulnerable groups and individuals should be developed to ensure acceptable methods of treatment for all health care users.
- Training and awareness is recommended to ensure that all health personnel are sensitised towards the plight of vulnerable groups and are able to execute their duties without prejudice.

7.2.8 Integration of HIV/AIDS and TB Programmes

Specific recommendations:

- HIV/AIDS and TB must be integrated within the context of PHC.
- Both TB and HIV/AIDS control programmes need to reinforce and adapt chronic care models, which are patient rather than process orientated and linked with information systems that are user-friendly and which strengthen problem solving at primary care level.
- Expansion of ART services to increase access is essential if this programme is to make more of an impact. PHC services have increased access to general health care. PHC should be utilised effectively to increase access to ART as well. Current policy restricts access to ART and thus negates the goals of the NSP. Effective ART should, in addition to reducing the burden of disease from HIV/AIDS (by reducing viral load), also help reduce HIV/AIDS transmission. Particularly in a high HIV/AIDS burden country like South Africa, where there are likely to be many HIV/AIDS sero-discordant couples, it is important to find ways to assess and promote how to identify and decrease the risk of infection. This should be done together with promoting standard precautions appropriately and thoughtfully with good understanding of the principles involved.
- Many people will die of HIV/AIDS and TB in the next few years. Rapid expansion of access to diagnostic, treatment and support services, as well as capacity to prevent the spread of infections and regularly evaluate programmes, will save many lives and many families.



chapter 8

references

1. ALP (AIDS Law Project). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
2. Barron P *et al* (2006). The District Health Barometer 2005/6. Durban: Health Systems Trust
3. Beckman, G *et al* (2008). Health Systems and the Rights to Health: An Assessment of 194 Countries, Volume 372, 13 December 2008
4. Benatar, S.R (1997). "Health Care Reform in the New South Africa" (1997) Vol 336 (12) *The New England Journal of Medicine* 891
5. Business Day. July 26 2007 <http://www.businessday.co.za/articles/topstories.aspx?ID=BD4A524803>
6. Proudcock, P (2007) Children's Institute. Submissions on Inquiry into the Right to have Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
7. Christofides *et al* (2006) quoted by Vetten, L. Women's access to healthcare: Gender-based violence, termination of pregnancy. The National Working Group on Sexual Offences; Tshwaranang Legal Advocacy Centre; Reproductive Rights Alliance (RRA); and Women's Legal Centre (WLC). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
8. Coetzee, Z. One Year Waiting List for Vocational Rehabilitation Services - Is this acceptable? Presented at SAHRC Public Hearings on 1 June 2007
9. Connelly, D *et al*, "Prevalence of HIV infection and median CD4 counts among health care workers in South Africa", (2007) 97 (2) *South African Medical Journal* 115
10. Constitutional Law Reports (1997), July to December, volumes (7) to (12), Butterworths, Durban
11. DICAG (Disabled Children's Action Group). Submission to the Public Inquiry into Access to Health Care Services
12. Day, C. and Gray, A. (2007). Health and Related Indicators, *South African Health Review 2007*, Durban, Health Systems Trust
13. Deputy Minister of Health, Ms Nozizwe Madlala-Routledge. Speech given at the launch of Health & Democracy, held at Constitutional Hill, 27 February 2007.
14. DoH (Department of Health), Patient's Rights Charter, <http://www.doh.gov.za/docs/legislation/patientsright/chartere.html>
15. DoH (Department of Health). South African Human Rights Commission: Public Inquiry into Access to Health Care Services. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007

16. Duncan, A. Faculty of Health Sciences, University of Cape Town. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
17. Engelbrecht, B. Comprehensive Service Plan for the Implementation of HealthCare 2010, Western Cape Department of Health. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 30 May 2007
18. Goudge J, Gumede T, Russell S, Gilson L, Mills A. The SACOCO Study, Poor Households and the Health System. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
19. Hassim, A., Heywood, M. and Berger, J. (eds) (2007). *Health & Democracy* (SiberInk, Cape Town)
20. Health Systems Trust, Health Statistics on Medical Aid Coverage, <http://www.hst.org.za/healthstats/77/data>.
21. Hirschowitz, Worku and Orkin 2000 quoted by Vetten .L, Women's access to healthcare: Gender-based violence, termination of pregnancy. The National Working Group on Sexual Offences; Tshwaranang Legal Advocacy Centre; Reproductive Rights Alliance (RRA); and Women's Legal Centre (WLC). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
22. Ijumba P, Padarath A (2006). South African Health Review 2006. Durban. Health Systems Trust
23. International Conference on Primary Health Care (1978). Declaration of Alma-Ata, USSR, 6-12 September 1978, http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf
24. Jacobs, P. Accountability for the Implementation for the Right to Health. Testimony from Health Care User. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 30 May 2007
25. James, M. Faculty of Health Sciences, University of Cape Town. Submission to the SAHRC. Presented at SAHRC Public Hearings on 30 May 2007
26. Jesuit Refugee Services. Update on Asylum Seekers and Refugee Access to Health Care in South Africa 2007. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on June 1st 2007
27. Jewkes and Abrahams 2002 quoted by Vetten, L. Women's access to healthcare: Gender-based violence, termination of pregnancy. The National Working Group on Sexual Offences; Tshwaranang Legal Advocacy Centre; Reproductive Rights Alliance (RRA); and Women's Legal Centre (WLC). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
28. Judge, M (2007). Health care for lesbian, gay, bisexual and transgender people: Issues, implications and recommendations. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearing on 31 May 2007
29. Kalula, S. (Dec 2008). Conference on Social Gerontology. International Institute on Ageing and North West University
30. Kekana, L. Access to Safe Motherhood. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
31. Lehohla, PJ (2007). Mid-year (July) Population Estimates, Statistical Release, Statistics South Africa
32. Limburg Principles on the Implementation of the International Covenant of Economic, Social and Cultural Rights. pp. 63-78 in Economic, Social and Cultural Rights: A Compilation of Essential Documents, International Commission of Jurists, 1977.
33. Matomela, N., "Recognition of Traditional Healers", http://www.southafrica.info/ess_info/sa_glance/health/update/traditional-healersbill.htm
34. Mahepe. South African Traditional Health Practitioners. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 30 May 2007
35. Mbeki, T. Presidency (2006). State of the Nation Address by President Thabo Mbeki, www.presidency.gov.za
36. Minister of Health. Address to SAHRC Hearings. Presented at SAHRC Public Hearings on 1 June 2007
37. Mulaudzi. Access to health care services for children: The Child Healthcare Problem Identification Programme (Child PIP). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
38. National Committee for the Confidential Enquiry into Maternal Deaths (1998). Interim Report on the Confidential Enquiry into Maternal Deaths in South

CHAPTER EIGHT

- Africa, DoH, Pretoria, http://www.doh.gov.za/docs/reports/1998/mat_deaths.html
39. National Treasury (2005). Intergovernmental Fiscal Reviews (September), Republic of South Africa
 40. Netshitenze, J. And Chikane, F (2008). Toward a Fifteen Year Review, Office of the Presidency
 41. OUT, LGBT Well Being. Healthcare for Lesbian, Gay, Bisexual and Transgender People: Issues, implications and Recommendations. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
 42. Pearmain, D (2007). Health Policy and Legislation, *South African Health Review 2007*, Durban, Health Systems Trust, pp. 19-31
 43. Presidency (2008). Towards a Fifteen Year Review. <http://www.info.gov.za/view/downloadsFileAction?id=89475>
 44. Proudcock, P. The Children's Institute, submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
 45. Quadpara Association of South Africa. Submission to the Public Inquiry into the Right to have Access to Health Care Services. Presented at SAHRC Public Hearings on 1 June 2007
 46. Rangaka, T. Obstacles on the Way for Patients to have Access to Healthcare in South Africa. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
 47. SADSAWU. Me or the Carpet? From Omo to Everything. Domestic Workers Discussing Issues of Health and Safety. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 1 June 2007
 48. Schaay, N and Sanders, D (2008). International Perspective on Primary Health Care Over the Past 30 Years, Schools of Public Health, University of the Western Cape
 49. Statistics South Africa (2007). Midyear Population Estimates, <http://www.statssa.gov.za>
 50. Stein, Dan J. Prof and Head, Dept of Psychiatry / MH, UCT, Chief Psychiatrist, PGWC, Director, MRC Unit on Anxiety Disorders, US. Human Rights and Mental Health. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
 51. Sunday Times, 22 February 2009
 52. Thulare, A (2007) South African Medical Association. Submission to the SAHRC Public Inquiry into the Rights to have access to Health Care Services, at pp. 4-33.
 53. UNDP (1997).Capacity Development New York: Management Development and Governance Division, UNDP
 54. Van der Heever, A. South African Human Rights Commission's Public Hearings on Access to Health Care Services. Presented at SAHRC Public Hearings on 30 May 2007
 55. Van Wyk, C. (2009). "Tuberculosis and the Limitations of Rights in South Africa", (2009) 72(1) *Journal of Contemporary Roman-Dutch Law (THRHR)* 92
 56. Vetten, L. Women's access to healthcare: Gender-based violence, termination of pregnancy; The National Working Group on Sexual Offences, Tshwaranang Legal Advocacy Centre, Reproductive Rights Alliance (RRA) and Women's Legal Centre (WLC). Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
 57. Von Holdt, K and Murphy, M (2007) (Naledi). Dysfunctional hospitals: presentation to HRC. Submission to the Public Inquiry into Access to Health Care Services. Presented at SAHRC Public Hearings on 31 May 2007
 58. World Health Organisation (2008). Primary Health Care: Now More Than Ever, <http://www.who.int/whr/en/index.html>

chapter 9

annexure a: provincial review site visits

Sites visited as part of the Provincial Reviews, by Province

Province	Hospitals	Clinics	Specialist	Rural/Deep rural	Urban/Peri Urban
Eastern Cape	11	1	1	-	-
Free State	6	3	3	-	-
Gauteng	5	4	1	0	10
Kwa Zulu Natal	8	2	2	7	5
Limpopo	8	1	3	5	7
Mpumalanga	8 (1 Tertiary, Regional, District)	2	8	8	2
Northern Cape	4	8(Including 3 CHCs)	4	4	8
North West	6 (1 Tertiary, 2 Regional, 3 Level I)	3	1	1	9
Western Cape	7 (2 Tertiary, 4 Secondary, 1 Level I)	2	1	4	6
South Africa(TOTAL)	57	25	24	29	47

chapter 10

annexure b: list of submissions received for public inquiry

Submissions for the Public Inquiry in the Right of Access to Health Care Services in the Public Sector

MARCH 2007

Date received	Name of institution / individual
1. 24/02/07	Station Pharmacy – Pretoria
2. 28/02/07	Premilla Deonath
3. 08/03/07	Adv. Takalani Masevhe
4. 19/03/07	Dr Reg Broekmann
5. 20/03/07	Mr Clive Hill
6. 21/03/07	Dr G Levin
7. 22/03/07	Mr MD Harrower
8. 26/03/07	Polly Jacobs
9. 26/03/07	Thembile Mathews Mnyakama
10. 27/03/07	Dr Mark Patrick MRC,
11. March 2007	Dr Stein, School of Psychiatry, UCT
12. 28/03/07	Prof KC

Date received	Name of institution / individual
14. 29/03/07	Jenny Hendry, WC Rehabilitation Centre,
15. 29/03/07	Marion Heap, Health & HR, School of Public Health UCT
16. 29/03/07	Dr Martha Lik, Psychiatric Services
17. 29/03/07	Sue Parton, Social Worker
18. 29/03/07	Jesuit Refugee Services, SA
19. 29/03/07	Dr HJD Jeggels
20. 29/03/07	NALEDI (Von Holdt and Murphy)
21. 30/03/07	Sue Phipott, Paediatric Specialist
22. 30/03/07	Dr John Sutton, Paediatric Specialist
23. 30/03/07	ACW
24. 30/03/07	Emma Coop (WC)
25. 30/03/07	Reinhard Coetser
26. 30/03/07	HPCSA
27. 30/03/07	Damaris Fritz, Cape Metro Health Council
28. 30/03/07	GM New Business Development Toga Laboratories

Date received	Name of institution / individual
40. 11/04/07	SAMA (GP)
41. 12/04/07	Veronica Mitchel, Undergraduate Training, UCT (WC)
42. 12/04/07	Dr Susan Steinman, Workplace Dignity Institute (GP)
43. 13/04/07	Liezl Gertholtz, Tshwaranang Legal Advocacy Centre
44. 13/04/07	Epilepsy SA (WC)
45. 13/04/07	The Women's Circle
46. 16/04/07	Jonathan Grossman, SADSAWU
47. 16/04/07	Angie Coetzee, Faculty of Health Sciences, UCT (WC)
48. 16/04/07	Children's Institute, UCT (WC)
49. 16 /04/07	Cheshire Homes Durban, (KZN)
50. 16/04/07	Lisa Vetten, National Working Group on Sexual Offences
51. 16/04/07	Dr Renay Weiner, Centre for Health Policy,
52. 16/04/07	Dr Jane Goudge, Centre for Health Policy,
53. 17/04/07	PHANGO
54. 17/04/07	AIDS Law Project

CHAPTER TEN

BUNDLE 'D'

Date received	Name of institution / individual
56. 18/04/07	DementiaSA (WC)
57. 20/04/07	DeafSA (GP)
58. 20/04/07	Disabled People SA (KZN)
59. 21/04/07	Masimanyane (EC)



chapter 11

annexure c: programme – south african human rights commission’s public hearings on access to health care services

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DAY 1

09H30- 10H00	Registration
10h00-10h15	Welcoming address
10h15- 10h45	Background to the Public hearings Legal Services Programme
10h45- 11h15	NALEDI (Von Holdt and Murphy)
11h15-11h45	HPCSA
11h45-12h15	SAMA
12h15-12h45	Faculty of Health Sciences, UCT
12h45- 13h00	TESTIMONY BY PATIENT/ CONSUMER
13h00-14h00	LUNCH

CHAPTER ELEVEN

14H00-14h30	Western Cape Provincial Dept of Health
14h30-15h00	Private Consultant- Private Health care services
15h00-15h15	Tea/ Refreshments
15h15-15h45	Traditional Healers Association
15h45-16h00	TESTIMONY BY PATIENT/ CONSUMER
16h00-16h30	Open discussion & Wrap up

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DAY 2

08H00-8H30	Tea
08h30-08h45	RECAP
08h45- 09h45	Address by the Honourable Deputy Minister of Health
09h45-10h15	Doctors for Human Rights
10h15-10h45	MRC- Grey's Hospital
10h45-11h15	Children's Institute
11h15-11h45	National Working Group on Sexual Offences
11h45-12h00	TESTIMONY BY PATIENT/ CONSUMER
12h00- 12h30	Centre for Health Policy, School of public Health, Wits
12h30-13h00	AIDS Law Project
13h00-14h00	LUNCH
14h30-15h00	DementiaSA
15h00-15h30	Dept of Psychiatry, UCT
15h30-16h00	Quadpara Association of SA
16h00- 16h45	Open discussion & Wrap up



DAY 3

08H00-8H30	Tea
08h30-08h45	RECAP
08h45- 09h15	DPSA
09h15- 09h45	SADSAWU
09h45-10h15	Centre for Health Policy, School of Public Health, Wits University
10h15- 10h45	OUT
10h45- 11h00	Tea/ Refreshments
11h00-11h30	Jesuit Refugee Association
11h30-12h00	PHANGO
12h00-12h15	Vote of thanks

chapter 12

annexure d: public hearing monitoring and evaluation toolkit - questionnaires

Inquiry into the Right to Access to Health Care
Services in the Public National Health System –
Primary, Secondary and Tertiary Health sectors

Guide for Interviewers

A. Additional Information

Information on policy documents & legislation can be found on the national department of health's website www.doh.gov.za

Provincial and local governments are responsible for implementation and useful information can **be accessed on their websites**

Past ESR Reports also contain useful information

The Protocol on Health sent to Departments of Health will give you a valuable guide for the type of programmes and questions the SAHRC seeks to elicit

It would be useful to look at these BEFORE the field study

B. Outputs

What is expected of the interviewer

Each interviewer should be looking to obtain

- Reliable information
- Make observations and record them
- Make an informed assessment of the quality of service delivery in the public health care sector

OUTPUTS from Provincial Managers

- Accurately completed questionnaires
- A summary of findings of each facility – after analysis of ratings and observations using scientific methodology
- A narrative report for the province which will include a scientific analysis of the above findings and an assessment of delivery in the province highlighting successes and challenges with recommendations
- The completed questionnaires, the summary of findings for each facility and the final narrative Report to reach the Committee for the Health inquiry headed by the HOD of legal by 30th March 2007.

C. A minimum of ten facilities should be visited and should include

1. Primary Health Care Clinics and Community Health Centers
2. Secondary and Tertiary Hospitals including Mental Health institutions in your province

D. Who should be interviewed? – Stakeholders, role players & beneficiaries some suggestions

Note There should be a gender balance in the choice of respondents

Also to be included are elder people, non – citizens, children, refugees, the indigent and minorities

1. Provincial MEC for Health – to obtain official data, statistics, challenges, budgets, ect
2. Hospital CEOs/ managers – Obtain an organogram of the staff and programmes and learn how the hospital is managed and whether it is efficiently run or not, identify challenges
3. Heads of programmes e.g. Hospital Revitalisation Programme,
4. Department heads – e.g .Head of Physchiatry, Surgery etc
5. Professional nurses and other category of nurses
6. Other health care workers, such as physiothetapists, occupational therapists, pharmacists, ambulance drivers,
7. Cleaning staff ,laundry workers, waste disposal technicians, etc
8. Patients – randomly selected in waiting rooms, casualty, in – hospital patients AS WELL as community members using the facility
9. People in the community – randomly selected
10. Home based care – receivers and givers
11. NGO's providing services in the area eg TAC or other health care workers, such as home based care providers
12. Academics and other experts working on health care issues

Questionnaires are provided but additional notebooks to be provided in order to add questions and make detailed notes and observations. Both of these to be used for final assessment

CHAPTER TWELVE

Some questions have a rating scale

Ratings Scale	1- 10
Very Good (V.Good):	8 -10
Good	6 -18
Satisfactory	5
Bad	3-5
Very Bad (V.Bad)	0-2

All forms must be signed by both the interviewed and interviewer and provincial managers after verification of data



Note this Form to be Filled in for each Interview / Questionnaire and to be Submitted with Final Report to the Committee for Health Inquiry

Province	_____
Name of Interviewer	_____
Position	_____
Date Interview/ Survey conducted	_____
Name of Interviewee	_____
Department / Organisation	_____
Position / Title	_____
Length of time in \Position	No of years _____ No of months _____
Brief description of main duties & Responsibilities	_____
Signature of Interviewee	_____
Date and Place	_____
Signature of Interviewer	_____
Date of place	_____
Date Report filed to SAHRC	_____
Signature of Provincial Manager	_____

Questionnaire 1:

Questionnaire on Management of Health Facilities

1. What credentials/ qualifications do you have as a manager? Did you receive sufficient and adequate training? Is it ongoing?
2. What systems are in place to ensure smooth running of the facility? Can you explain how the facility is run?
3. Is there adequate supervision of staff at all levels
4. Identify the staff shortages?
5. Are there recruitment plans in place and there and adequate budget to fill vacant posts?
6. What are the systematic challenges faced by the CEO's office and what needs to be done to overcome them?
7. How are problems addressed by the local and provincial departments responsible for health? Are you satisfied with reporting lines and addressing of problems? How can this be improved?
8. What recommendations would you make to improve service delivery to beneficiaries?

Form 1:

Observation Check List on Walkabout the Facility

Next to each question place your rating in the box provided

Eg. The hospital is clean? Yes. Place rating in the box provided

Additional notes to be made in notebooks

You are required to provide a rating for each question in ALL the questionnaires to facilitate. This will facilitate the report where you will be required to make an assessment of the state of health care delivery

	Yes/No	Score
1. Is the hospital in good working order? What are the problem areas?	_____	<input type="text"/>
2. Is it clean? Note floors, departments, bathrooms, toilets etc.	_____	<input type="text"/>
3. Who is responsible for cleaning – if outsourced ascertain whether cleaning staff report to a supervisor and if so does the supervisor report to the hospital staff	_____	<input type="text"/>
4. Is there a waiting room, are there sufficient seats for patients	_____	<input type="text"/>
5. Note if there are long queues and in which department eg. Casualty, pharmacy	_____	<input type="text"/>
6. Are nursing staff, doctors at their stations	_____	<input type="text"/>
7. Is the staff helpful, professional, friendly towards patients	_____	<input type="text"/>
8. How long does it take to register a patient and be seen by a doctor? Make your own observations	_____	<input type="text"/>
9. Observe how patients are treated, is their privacy and confidentiality respected, are they treated with dignity, are there separate rooms for counseling for HIV, etc.	_____	<input type="text"/>
10. Note what information is displayed at facility and is the language used appropriate for the region?	_____	<input type="text"/>

Eg. Are the Batho Pele principles, the Patients Rights Charter displayed?

Make a note appropriate to programme – eg ART Clinic – does it have information on AIDS,

Maternal Care – does it have breastfeeding, PMCT, cervical and breast cancer screening posters or pamphlets? Pediatrics department. Does it have the immunization posters etc displayed.

Questionnaire 2

This form should be administered to a

1. Hospital Managers
2. Information Officers (DHIS data capturer)
3. Doctors, nurses, pharmacists and other HCW

Availability of goods and services including infrastructure, health care professionals, equipment and medication

Physical Infrastructure

1. Is the physical infrastructure adequate?
2. Has the facility been revitalized?
3. How can it be improved?
4. Is there enough bed linen and pyjamas for all?
5. What is the quality of the food provided and is it adequate
6. How many functioning departments are there in this hospital eg. Paediatrics, geriatrics, surgery
7. Which departments are short staffed and indicate number and position eg. Surgery – no full time surgeon, qualified surgical nurses, ICU, Life style diseases, chronic care etc
8. What would constitute a full complement of staff
9. What is the actual number currently?
10. What in your opinion is the reason for the acute staff shortage?
11. Is training provided on a regular basis?
12. Is it adequate and sufficient to upgrade skills?
13. How many staff positions are vacant?
14. Which positions need to be filled?
15. How many doctors are needed?
16. How many nurses?
17. Other HCW eg. Specialists, pharmacists, radiographers, physiotherapists etc.
18. Which programmes are not provided?
19. What are the reasons for this?

CHAPTER TWELVE

Equipments

1. Do all departments have functioning and up to date equipment eg. XRAY machines, respirators for neonates etc
2. Which equipment need urgent replacement?
3. How does a shortage affect quality of care provided?
4. How often is the equipment checked?
5. What equipment does the facility not have
6. How does this affect the quality of care provided
7. How can equipment maintenance and replacement be improved?

Pharmacy and drugs

1. How many qualified pharmacists are employed? How many do you need?
2. How many assistants are employed?
3. What is the idea number to serve the patient population?
4. Do you have a full complement medicines as per the Essential Drug List
5. Do you have enough medication for the number of patients served
6. How often do you have stock outs?
7. Which drugs are in short supply
8. Which ones are hardly ever available

HIV AIDS / STIs/TB

Services

1. ARE THE FOLLOWING SERVICES PROVIDED?

	Yes	No	Rating
Sexually Transmitted Infections (STIs)			
HIV / AIDS			
Tuberculosis (TB)			
Voluntary Counseling and Testing (VCT)			
Preventing of Mother to Child Transmission (PMTCT)			
Nutrition			
Treatment with anti – retroviral drugs			

Voluntary Counselling And Testing (VCT)

2. Are there enough private rooms at the hospital / clinic where VCT can take place?
3. Who does the counselling?
4. Are there enough counselors at the hospitals/ clinic?
5. Does the hospital / clinic have information on HIV/AIDS that community members can take away with them?
6. Do the hospital/clinic staff treat people differently if they are HIV positive?

HIV / Tests

7. Does a person who has come for an HIV test get counseling before and after the test?
8. How long do people wait for the results of their tests?
9. If a person is HIV negative what does s/he get told to do?
10. If a person is HIV positive, what does s/he get told to do?

HIV Treatment

11. Is the clinic /hospital an ART site?
12. If yes, are there people on the waiting list to access ARVs?
13. How many people are on the waiting list to access ARVs?
14. How long is the waiting period for ARVs in this hospital/clinic?
15. If a person is HIV positive but does not need antiretroviral drugs, what does s/he get told to do?

Information

16. Is there information displayed at the local clinic in African languages

Questionnaire 3:

Access to health care services

Physical Access

Name of Facility _____

Name of person interviewed _____

Position and title _____

1. How would you classify the hospital

Regional	District	Secondary	Tertiary	Mental institution
----------	----------	-----------	----------	--------------------

2. Is the hospital located in an area classified as

Urban	Peri- urban	Rural	Deep - rural
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3. What is the total head count for a year?
4. What is the catchment area served by the hospital?e.g. Buffalo city, Soweto etc

CHAPTER TWELVE

5. What is the population served e.g. 100 000 people
6. What is the percentage of population that resides within the following distances from the nearest clinic

	Total No.	Urban %	Rural %	Rec No.
5km radius				
Greater than 25km radius				
Greater than 100km radius				
Number of mobile clinics				
Number of ambulances				
Number of patient transport vehicles				

7. What is the percentage of population that resides within the following distances from the nearest hospital

	Total No.	Urban %	Rural %	Rec No.
5km radius				
Greater than 25km radius				
Greater than 100km radius				
Number of mobile clinics				
Number of ambulances				
Number of ambulances				
Number of patient transport vehicles				

8. What is the size of the population served?
9. Are the number of beds sufficient to serve the needs of the population?
10. What is farthest distance travelled by clients to reach the facility?
11. What means of transport is available to reach the hospital?
12. How long does it take _____.
13. Is there wheel chair access to the facility? To all departments within the facility?
14. Indicate how many departments are not accessible by wheel chair?
15. Does your staff do home visits?
16. Are there sufficient number of ambulances/patient transport vehicles
17. What is the required number
18. How is this number arrived at
19. How can access to the facility be improved

Overall rating for physical access to the facility based on above

Economic access

1. How many of your clients pay user fees
2. What percentage of patients cant afford to pay
3. Do you have records with a gender breakdown
4. What is the average amount taxi fare to the hospital from the nearest residential area, from the furthest residential area
5. In your opinion does transport cost impose an impediment to access health care
6. Can most of the population in the cathment area afford transport to the hospital?
7. Do women access health care to the same extent as men?
8. If so provide figures for males and female admissions per month, per rear

Overall rating for economic access to the facility based on above

Access to Information

Acceptability and

Quality of Care

1. How is information disseminated regarding health issues

Posters	Pamphlets	Doctors	Nurses	Other	Languages
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2. Does the hospital. Provincial department of health conduct any outreach information programmes in the community and how often
3. Are patients aware of their rights
4. How are patients informed? By health care workers, pamphlets in which languages?
5. Does the SAHRC or NGOs do training workshops regarding patients rights?
6. Do you disseminate information regarding health issues via the printed media , community radio?

Acceptability and Quality of Service Provided

1. Do health care workers (doctors, nurses, counselors specialists etc) obtain informed consent from the patient before proceeding with treatment?
2. Are patients rights and dignity protected
3. Are you are of cultural taboos for different ethnic comminuties e.g. Mslem women?
4. Does medication from traditional healers have an adverse/beneficial effect on the treatment regimen prescribed

CHAPTER TWELVE

5. Are you satisfied with the quality of medical care provided? IF not what are the constraints
6. Which programmes (eg.TOPS) are not catered for at all
 - Are poorly catered for
 - Are badly catered for
7. Is there a suggestion box at the facility? In each department?
8. How are complaints handled
9. What measures have you taken to improve service deliver
10. What measures are planning for the next fiscal year
11. Is the budget sufficient to run the hospital efficiently
12. In your opinion what needs to be done to improve the quality of care provided?

Mental Health Questions for Quality Assurance Survey

13. Is the hospital compliant with the Mental Health Care Act of 2004, in the following key areas:
 - Does the hospital have a policy on seclusion that is consistent with the Mental Health Care Act? (Yes /No)
 - Is there a seclusion facility(Yes/No)
 - Are patients who are secluded reviewed at least once every 30 minutes by a mental health practitioner, and more frequently if conditions so req

PRISONER'S RIGHTS and OTHER VULNERABLE GROUPS

NAME OF PRISON _____

PROVINCE _____

PRISON POPULATION _____

1. Do prisoners have access to doctors, clinics, hospitals of their choice?
2. Does the doctor visit the hospital and how often?
3. What are procedures to follow for the prisoner to see a doctor?
4. Is there any support for TB and HIV/ AIDS patients?
5. Do you have records of how many patients suffer from AIDS, TB, Other Diseases?
6. How are their medical needs catered for?
7. Is adequate food provided for prisoners with special dietary needs?
8. How many prisoners have tested for HIV?
9. How many are on ARV's?
10. How many need ARVs?

Job Satisfaction

Interview different categories of health care workers, specialists, doctors, nurses, pharmacists, managers, cleaners etc

Name (optional) _____

Position/ Title _____

1. Are you happy with your working conditions
2. Your remuneration
3. With your chosen profession
4. Why did you enter the health care profession
5. What will make you happy in your work?

CHAPTER TWELVE

Information to be Sourced from District Health Information System for 2007, MEC for Health or any other Reliable Source.

Indicators and Statistical Data

Public Hospitals

	Total	Urban	Rural	Recommended No.
Number of hospitals				
Number of mental hospitals				
Patient/ doctor ratio				
Patient/ nurse ratio				
Number of patients for the year (headcount)				
Number of available beds				
Average length of stay				
Bed occupancy rate*				
Number of hospitals with inadequate supply of medication for patients				
Number of hospitals with inadequate supply of staff provision				
Number of hospitals with inadequate supply of beds				
Number of hospitals with inadequate supply of linen				
Number of hospitals with inadequate supply of clothes for patients				
Number of overcrowded hospitals				
Number of population denied access to medical services because of fees				

Public Health Care Personnel¹ Provincial Level

Type of Personnel	Total	Urban	Rural	Recommended No.
Nurses				
Chief Professional Nurses				
Midwives				
Doctors, including interns, registrars, community service doctors				
Specialist				
Pediatricians				
Dentists				

¹ Fulltime as well as part time staff whose main task is caring for patients.
Note to Interviewer- Obtain provincial and facility level data.

Pharmacists				
Ambulance Drivers				
Other Allied Medical Personnel				
Nurses				
Chief Professional Nurse				
Midwives				
Doctors, including interns, registrars, community service doctors				
Specialists include speciality				

Clinics/ Community Health Centre

	Total	Urban	Rural	Recommended
Number of clinics				
Number of clinics with inadequate supply of medication for patients				
Number of clinics with inadequate staff provision				
Number of population without a medical clinic within a 5km radius				
Number of overcrowded clinics				
Number of population denied access to medical services because of fees				

PHC Personnel

	Total	Urban	Rural	Recommended No.
Patient/ doctor ratio				
How many times a week do you have a doctor				
Patient/ nurse ratio				
Number of clinics per 1000 population				
Number of patients for the year (headcount)				
Number of PHC patient visits per capita				

Give the Recommended Number of Hospitals and Bed Occupancy Rate.

CHAPTER TWELVE

Reproductive of Health Care and Women's Health

Termination of Pregnancy (Top) Public Hospitals²

	Total	Urban	Rural	Recommended No. where applicable
Patient/ doctor ratio				
Nurse/ patient ratio				
Number of referred cases resulting from back street abortion				
Number of maternal deaths				
Number of terminated pregnancies				
Number of health care facilities providing TOP services				
Number of trained personnel providing TOP services				

Screening

	Total Number	Urban	Rural
Mammograms			
Cervical Screening			
PMCT services			

Disease Indicators³

	Total	Urban	Rural	African	White, Indian & Coloured
Percentage of population with HIV/ AIDS					
Percentage of population with TB					
Percentage of population with STDs					
Percentage of population with Hepatitis B					
Incident of population with Malaria					
Incident of population with water-borne diseases e.g. cholera, typhoid etc.					
Percentage of clinics/ hospitals with AIDS testing facilities					
Percentage of clinics/ hospitals that provide ARV therapy in MTC the programme					

² According to the Choice of Termination of Pregnancy Act No 92 of 1996.

³ Expressed as a percentage of the population.

Number of HIV positive mothers who received Nevirapine					
Percentage of clinics/ hospitals that provide ARVs to all					
Number of clients who received ARVs					
Percentage of clinics with Tuberculosis Services everyday					
Percentage of clinics with STDs services everyday					
Percentage of clinics with Cervical Cancer Screening Services					
Percentage of clinics with Family Planning services					
Percentage of clinics with Antenatal Care services					
Percentage of clinics where condoms are freely available					

General Indicators-Provincial

	Total	Urban	Rural	Male	Female	Ethnic Group
Infant mortality rate ⁴						
Maternal mortality ratio ⁵						
Life Expectancy						

Indicators for Children's Right to Basic Health Care

Public Hospitals

	Total	Urban	Rural	Recommended
Child/ doctor ratio				
Child/ pediatrician ratio				
Child/ nurse ratio				
Doctor/ nurse ratio				
Number of hospitals				
Number of pediatric patients				
Number of available pediatric beds				
Average duration of bed occupancy for children				

⁴ Per 1000 live births.

⁵ Per 100 000 live births.

CHAPTER TWELVE

General Indicators

	Total	Urban	Rural	Female	African	Coloured	Indian
Infant mortality rate ⁶							
Under 5 mortality rate ⁷							
Early neonatal death rate ⁸							
Neonatal death rate							
Maternal mortality ratio ⁹							
Prevalence of children with mental health problems							
Prevalence of teenage pregnancy							
Estimated number and percentage of children born with HIV/ AIDS							
Estimated number and percentage of children with HIV/ AIDS							
Prevalence of Tuberculosis amongst children							
Prevalence of measles amongst children							
Prevalence of viral hepatitis amongst children							
Percentage of children with physical disabilities							
Percentage of children with Mental disabilities							
Percentage of immunization coverage of children 0-11 months							
Percentage of immunization coverage of children 12- 23 months							
Coverage of measles immunization at 9 months							
BCG Immunisation coverage (immunization against Tuberculosis)							
Number of children 6-71 months suffering from wasting ¹⁰							
Percentage ¹¹ of children 6-71 month suffering from wasting							
Number of children in grades ¹² 1-2 suffering from wasting							

⁶ Per 1000 live births.

⁷ Per 1000 live births.

⁸ Deaths per 1000 live births within 7 days.

⁹ Per 100 000 live births.

¹⁰ Wasting: weight for height under 2 standard deviations of the norm.

¹¹ Expressed as a percentage of the population of children.

¹² Grades refer to first and second years of schooling.

Percentage of children in grades 1-2 suffering from wasting							
Number of children 6-71 months under weight ¹³							
Percentage of children 6- 71 months under weight							
Number of children in grades 1-2 under weight							
Percentage of children grades 1-2 underweight							

Provide information according to the table below for the reporting period in question

	Total	Total %	Urban	Urban %	Rural	Rural %
Number of children who do not have access to basic health care services						
Number of children denied access to medical services because of fees						
Number of children with AIDS						
Number of AIDS Orphans						
Number of overcrowded medical clinics						
Number of children from households with no access to clean, safe and portable water						
Number of children from households with no access to adequate sanitation facilities						

Provide information of measures taken by the department to improve the rights in terms of indicators referred to above. What progress has been achieved by the department?

Monitoring

1. Describe any internal mechanisms used by the department to monitor and assess the realization of the right of access to health care services including reproductive health care.
2. Describe the nature of the statistics and the manner in which they are collected by the department in order to facilitate the monitoring and assessment of the right.
3. Were there any difficulties experienced by the department in monitoring and assessing the realization of the right? If yes, explain.

¹³ Under-weight: weight for age under 2 standard deviations of the norm.