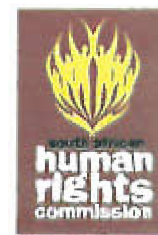

SOUTH AFRICAN HUMAN RIGHTS COMMISSION REPORT

File Ref No: MP/1213/0160

In the matter between:

Democratic Alliance, Mpumalanga **Complainant**

(Represented by Mr SJ Masango, Member of Provincial Legislature)

And

The Department of Health, Mpumalanga **Respondent**

REPORT

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1. Introduction

1.1. The South African Human Rights Commission (hereinafter referred to as the "Commission") is an institution established in terms of section 181 of the Constitution of the Republic of South Africa Act, 1996 (hereinafter referred to as the "Constitution").

1.2. The Commission is specifically required to:

1.2.1. Promote respect for human rights;

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

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

1.3. Section 184(2) of the Constitution empowers the Commission to investigate and report on the observance of human rights in the country.

1.4. The Human Rights Commission Act, 54 of 1994 (hereinafter referred to as the "Human Rights Commission Act"), provides the enabling framework for the powers of the Commission.

1.5. Section 9(6) of the Human Rights Commission Act determines the procedure to be followed in conducting an investigation regarding the alleged violation of or threat to a fundamental right.

1.6. Article 3(b) of the Commission's Complaints Handling Procedures, provides that the Commission has the jurisdiction to conduct or cause to be conducted any investigation on its own accord, into any alleged violation of or a threat to a fundamental right.

2. **The parties**

2.1. The complainant is the Democratic Alliance (hereinafter referred to as the "Complainant"), represented by its member of Mpumalanga Legislature, Mr J. S. Masango.

2.2. The respondent is the Provincial Department of Health (hereinafter referred to as the "Respondent"). The Respondent is responsible for providing health care services in the Mpumalanga Province.

3. **The complaint**

3.1. On 1 November 2012, the Commission received a complaint from the Complainant in which it alleged that the Respondent failed to provide adequate health care services in public hospitals in the province and thus violated patients' rights to health care services as well as their right to dignity enshrined in sections 27 and 10 of the Constitution respectively.

3.2. The Complainant submitted that public hospitals in Mpumalanga had critical shortages of doctors and nurses as well as lack of proper infrastructure.

3.3. The Complainant referred to several newspaper articles and documents to substantiate its complaint. The highlights of these articles and documents are set out below.

3.4. An article in the *Sowetan Newspaper* of 29 October 2012 entitled ***"hospital staff burnt-out"*** highlighted conditions at Bernice Samuel Hospital in Delmas. It stated that the hospital was struggling to cope with more than 5 000 (five thousand) patients visiting the hospital monthly. The cause of not coping was reportedly that the hospital patient-intake had increased from 14 744 in the first quarter of 2011 to 17 500 in the first quarter of 2012 and that the hospital had employed only 16 doctors instead of 24.

3.5. On 12 October 2012, the *Lowvelder Newspaper* contained an article entitled ***"Rob Ferreira hospitaal knak onder druk".*** The article related to poor infrastructure, a shortage of health care professionals and crucial medicines and malfunctioning equipment at Public Hospitals.

3.6. In its statement concerning Matibidi Hospital, the Complainant submitted that it had visited the said hospital and found the following:

3.6.1. Shortage of health professionals (doctors, nurses, etc);

3.6.2. The hospital had been without a qualified pharmacist since March 2012;

3.6.3. There was no mortuary assistant;

3.6.4. There had been no Chief Executive Officer since March 2012.

3.7. The Complainant referred to selected copies of the 2011/12 Department of Health Annual Report (hereinafter referred to as the "AR") and highlighted on page 37 of same the impact which the Department's moratorium on the appointment of staff during the 2011/12 financial year had on the accessibility of health care services to patients.

3.8. According to page 97 of the AR, the Respondent slashed 25 000 Department of Health posts during the 2011/12 financial year.

3.9. The Complainant alleged that page 133 of the AR reflected the failure of the Respondent to implement 119 of its 221 programmes. The AR reflects however that 119 of 221 targets have not been implemented and not programmes as stated by the Complainant.

3.10. The Complainant also alleged that page 135 of the AR reflected gross under- spending of the Department's infrastructure grants.

4. **Steps taken by the Commission**

4.1. Upon receipt of the complaint and on 7 November 2012, the Commission dispatched an allegation letter and requested the Respondent to respond to the allegations raised by the Complainant.

4.2. On 23 November 2012, the Commission received a response from the Respondent.

4.3. On 27 November 2012, the Commission provided the Complainant with the Respondent's response and requested comments thereto.

4.4. On 28 December 2012, the Complainant provided a reply to the response.

5. **Summary of the response by the Respondent**

In response to the complaint, the Respondent submitted that:

5.1. The reason for the shortage of professional personnel at the hospitals was that they get better offers and opportunities to further their studies closer to areas where there are Universities. Further, that they resign or request to be transferred to other provinces which are closer to their homes.

5.2. It had undertaken to advertise all vacant posts within the 2013/14 financial year to ensure that service delivery was not adversely affected.

5.3. It had developed a Human Resource Plan and the benchmarking of human resources strategy to ensure that adequately skilled health care professionals were employed.

5.4. Doctors and nurses who received bursaries were placed at different health establishments after completing their studies.

5.5. Headhunting shall be implemented as a strategy to attract and retain health professionals with scarce skills.

5.6. As part of the retention strategy, newly built facilities shall also include accommodation for staff.

5.7. The process of interviewing for and ultimately appointing incumbents for critical posts was already underway.

5.8. With regards to the moratorium that previously was in place on the filling of vacant posts was due to the financial constraints. This was apparently was as a result of overspending on staff recruitment during the previous financial years.

5.9. The Executive Council lifted the moratorium in September 2011 and, as a consequence, posts were filled through a process of headhunting prospective candidates.

5.10. Steps were taken to improve and renovate health care facilities each year. However, there are challenges experienced in that regard, such as delays in finalising some of the phases of the infrastructure improvements.

5.11. There had also been an under spending with regard to the budget item aimed at improving health care facilities. The reason proffered by the Respondent for this was that there had been a rollover of the budget in the previous financial years when moneys were not spent.

6. Summary of the Complainant's reply

The Complainant replied as follows to the response by the Respondent:

6.1. In May 2010, the Respondent advertised posts of professional nurses in the *Sunday Times* newspaper and appointment letters were issued only on 26 July 2012 to successful candidates to commence employment on 1 August 2012. The Complainant argued that this undue delay resulted in the posts not being filled because candidates would have already secured employment somewhere else.

6.2. The Complainant made reference to a document entitled "Enhlanzeni District Hospitals Vacancy Rate" allegedly circulated to the members who served on the Portfolio Committee of Health. The document revealed a high vacancy rate at Umjindi sub-district, Nkomazi sub-district and Thaba Chweu sub-district.

7. Site inspections

The Commission conducted sites inspections with both parties at Rob Ferreira Hospital, Matibidi Hospital and Bernice Samuel Hospital. In all these hospitals, the inspections took the form of introductory meetings,

visits to reception, administration and casualty areas as well as an inspection questionnaire (herein after referred to as the "Questionnaire") which was completed by the respective hospitals. The completed questionnaires are summarised below.

During the introductory meetings, the Commission emphasised its independence, outlined the purpose of the inspections, namely, to observe the state of health care services in the hospitals concerned, particularly in critical operational areas such as administration and casualty departments, and to gather information for purposes of subsequently compiling a report on the complaint.

7.1. **Inspection at Rob Ferreira Hospital**

(1) The inspection was conducted on 18 January 2013 in the presence of representatives of all parties. The hospital is situated in an urban area in Nelspruit.

(2) During the inspection, the hospital submitted that:

(a) It consults approximately 500 (five hundred) patients on Wednesdays and Thursdays, which are considered to be busy

days. On other days, the hospital consults with approximately 300 (three hundred) patients;

(b) The average waiting time for a patient to be consulted was approximately 90 minutes; and

(c) The hospital had a shortage of medical staff personnel.

(3) There were seldom administrative delays and challenges in procuring services required to address *ad hoc* operational needs of the hospital.

(4) The hospital was provided with a questionnaire form for completion.

7.2. **Observations by the Commission at Rob Ferreira Hospital**

(1) The hospital was overcrowded with patients on the day of the inspection.

(2) Notwithstanding the availability of a new building, same was not in use due to shortage of health care professionals.

(3) There were ongoing refurbishments of the infrastructure in the hospital.

(4) In the old building, the air-conditioning system was not working. It had not been working for a long time.

7.3. **Summary of the questionnaire - Rob Ferreira Hospital**

(1) On 24 January 2013, the Commission received a completed questionnaire from the Chief Executive Officer (hereinafter referred to as the "CEO") of the hospital.

(2) The CEO submitted that the hospital is authorised to accommodate 301 patients but operated with only 267 beds. She also submitted that there was a shortage of staff and that once the refurbishments, which were still taking place, have been completed, the hospital will have approximately 407 beds.

7.4. Inspection at Matibidi Hospital

(1) The inspection was conducted on 22 January 2013 in the presence of representatives of all parties. The hospital is situated in a rural area, Matibidi village, which reportedly serves a population of approximately 20 000 (twenty thousand) community members.

(2) The hospital submitted that:

(a) It consults approximately 80 (eighty) patients per day from Mondays to Thursdays and, less on Fridays;

(b) The hospital was generally underutilised as it was not busy particularly in the evenings when there are often no patients visiting the hospital;

(c) The waiting time for patients was about 45 minutes;

(d) A post for a permanent CEO had been vacant since October 2011. The hospital had an acting CEO and an acting medical manager;

(e) In the casualty department, the hospital operated with a professional nurse during the day and another during the night;

(f) It was expensive to keep the hospital operational as it was underutilised;

(g) It was difficult to attract and recruit more health care professionals as the hospital is situated in a rural area and there was insufficient accommodation within the vicinity;

(h) A permanent pharmacist shall be appointed soon;

(i) There was delay in the appointment of personnel and procurement of infrastructure services as the recruitment and procurement functions are centralised and executed only by the Respondent's Provincial Office in Nelspruit; and

(j) The Commission was further advised that the hospital experienced shortage of personnel in the administrative section.

7.5. Observations by the Commission at Matibidi Hospital

(1)The hospital was not busy as there were few patients on the day of the inspection.

(2)Some sections of the hospital were not being utilised.

7.6. Summary of the Questionnaire - Matibidi Hospital

(1)On 28 January 2013, the Commission received a completed questionnaire from the Acting Chief Executive Officer (hereinafter referred to as the "ACEO") of the hospital.

(2)The ACEO submitted that there were 24 vacant posts of Professional Nurses, 7 staff nurses, 21 auxiliary nurses and 9 doctors.

(3) There were 100 beds approved and only 50 beds were being used.

(4) The hospital's Defibrillator, a device which delivers a therapeutic dose of electrical energy to an affected heart, was broken. The Autoclave Device, a device used to sterilise equipment and supplies, used by the hospital was old and constantly broke down.

7.7. **Inspection at Bernice Samuel Hospital**

(1) The inspection was conducted on 25 January 2013 in the presence of representatives of all parties. The hospital is situated in a semi-urban area in Delmas.

(2) The hospital submitted that:

(a) About 50 (fifty) patients visit the hospital to do X-rays during the day only.

(b) The hospital consults with approximately 125 (one hundred and twenty five) patients a day and, 500 (five hundred) patients visit the hospital for medical assistance.

(c) The average waiting time for a new visiting patient is approximately 90 minutes depending on the circumstances and the reason of the visit.

(d) As a level 1 (one) health institution, the hospital does not have specialists and, in the event that a patient would require assistance of a specialist, the patient is transported to Witbank Hospital thus extending the turnaround time for attending to such a patient.

7.8. **Observations by the Commission at Bernice Samuel Hospital**

(1)The male toilets were dilapidated and filled the air with an unpleasant smell. It had reportedly not been functional since the beginning of 2011.

(2)A section of the ceiling of the hospital had been ragged and as a consequence, during rainy days, water would leak into the building affecting other sections of the hospital. Three sections of the hospital were affected by the leaking water and the

hospital reported that this matter had long been reported to the Department of Public Works.

(3)A casualty room had not been functional for a long period and that affected the efficiency of the casualty department.

(4)There was no maternity ward in the hospital and as a result maternity patients were observed lying on the floor in a passage on one of the floors in the hospital.

7.9. Summary of the Questionnaire - Bernice Samuel Hospital

(1)On 4 February 2013, the Commission received a completed questionnaire from the CEO of the hospital.

(2)The CEO described the vacancy rate of the hospital as follows: Doctors - 58%; Professional Nurses - 33%; Staff Nurses - 63%; Nursing Assistants - 75%; Administrative Clerks- 81%; HRM - 91%; Auxiliary Services - 45%; Supply Chain - 42%; Budget Reporting and Revenue - 75%; and Fleet - 40%.

(3)The CEO submitted that the hospital was not able to keep up with increased numbers of patients who visited the hospital.

(4) Further, he submitted that a hospital must have separate surgical and medical wards to avoid infection. At the said hospital "all patients were forced to share a ward on admission and, for that reason there was an increase of nosocomial infections". A nosocomial, or hospital-acquired, infection is a new infection that develops in a patient during hospitalisation.

(5) "There was further no dedicated ward for children. Children were admitted in adult wards or alternatively in the corridors".

(6) "There were no provision of a kit-room for the storage of clothes and belongings of admitted patients. This, in turn, contributed to the escape of patients without being noticed".

(7) "In the admission unit there was no provision for ventilation hence the ever increasing number of staff infected with TB virus. The re-designing of this area cannot be over emphasised".

(8) "The design of hospital did not make provision for the maternity unit. The current area used for this service was traditionally designed for the out-patient department. Historically, we are just improvising to render this service and

we do this in response to the demand at hand. The department must allocate funds for the construction of a maternity wing which is compatible to the set core standards and serve the interest of patients without violating their rights. Our main concern is the fact that maternal services are highly compromised to an extent that mothers are made to lie on the floor and this is totally unacceptable".

(9)"The casualty and the entire roof required extra ordinary urgent intervention. The situation had been like this since 2010 with nothing less being done and, as it is now, the structure is gradually giving in and collapsing".

8. **Preliminary Assessment and Findings**

8.1. The Commission assessed the complaint in the light of the inspections conducted at the abovementioned hospitals and made the following preliminary findings in its inspection report dated 11 March 2013 which was shared with all parties:

(1)That the report of the AG recorded negative findings in respect the Respondent's 2011/2012 Annual Report.

(2) That the AG's findings were, *inter alia*, in relation to poor financial and human resource management as well as infrastructure development.

(3) That all three hospitals acknowledged and reported challenges of shortage of human resource.

(4) That the hospitals also acknowledged that the centralisation of core operational functions such as procurement and recruitment, contribute to the inefficient of operations in the hospitals.

(5) That the situation in the three hospitals has impacted negatively on the Respondent's ability to provide health services to public members.

9. **Issues for determination**

The Commission conducted an investigation in this matter to determine whether shortage of personnel, delay in the recruitment processes, delay in the procurement of services and infrastructural problems amounted to a violation of right to have access to health care services and consequently their right to dignity as enshrined in section 27 and section 10 of the Constitution respectively.

10. **Applicable Legal Framework**

10.1. Relevant provisions in the Constitution

(a)**Section 27(*1*)** *provides that:*

"Everyone has the right to-

health care services, including reproductive health care;

(b)**Section 27(2)** *provides that:*

"the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights".

(c)***Section 7(2)*** *provides that:*

"the state must respect, protect, promote and fulfil the rights in the Bill of Rights".

(d)***Section 10*** *provides that:*

"Everyone has a right to inherent dignity and the right to have their dignity respected and protected".

(e) ***Scheduled 4, Part A*** *of the Constitution lists health care services as a functional area of concurrent National and Provincial legislative competence.*

10.2. Case law

(a) ***Soobramoney v Minister of Health (KwaZulu-Natal)[1]:*** *This case relates to a 41 year old unemployed man who was diabetic and suffered from both ischemic heart disease and cerebra-vascular disease. His health condition caused him to have a stroke in 1996. In the same year, his kidney also failed. As a consequence, his condition was irreversible and he was on the final stages of chronic renal failure. In dealing with this case, the Constitutional Court analysed section 27 of the Constitution.*

(b) The court held that *"the state has a constitutional duty to comply with the obligations imposed on it by section 27 of the Constitution[2]. Further, the court held at paragraph 11 that "what is apparent from these provisions is that the obligations imposed on the state by sections 26 and 27 in regard to access to ..., health ... are dependent upon the resources available for such purposes,*

[1] [1997] ZACC 17; 1998 (1) SA 765 (CC); 1997 (12) BCLR 1696
[2] Soobramoney case Paragraph 36

and that the corresponding rights themselves are limited by the reason of the lack of resources".

(c) In a concurring judgment, Madala J held that *"the state must take reasonable and legislative and other measures, within its available resources to achieve the progressive realisation of each of these rights. In the language, the Constitution accepts that it cannot solve all of our society's woes overnight, but must go trying to resolve these problems. One of the limiting factors to the attainment of the Constitution's guarantees is that of limited or scarce resources"*[3].

(d) The case of Grootboom[4] deals with the right to have access to adequate housing. However, the court analysed the phrase "reasonable legislative and other measures". At paragraph 39 the court held that *"what constitutes reasonable legislative and other measures must be determined in the light of the fact that the Constitution creates different spheres of government: national government, provincial government and local government. The Constitution allocates powers and functions amongst these*

[3] Soobramoney case at Paragraph 43

[4] [2000] ZACC 19; 2000 (11) BCLR 1169

different spheres emphasising their obligation to co-operate with one another in carrying out their constitutional tasks. In the case of housing, it is a function shared by both the national and provincial government. *A reasonable programme therefore must clearly allocate responsibilities and tasks to the different spheres of government and ensure that the appropriate financial and human resources are available".* [own emphasis added]

(e) The Court continued in paragraph 42 to hold that *"Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The state is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well directed policies and programmes implemented by the executive. These policies and programmes must be reasonable both in their conception and their implementation. The formulation of a programme is only the first stage in meeting the state's obligations.* *The programme must also be reasonably implemented. An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the state's obligations".* [own emphasis added]

(f) Furthermore, at paragraph 45, the Court dealt with the phrase *"Progressive realisation of the right".* The court held that the term *""progressive realisation" shows that it was contemplated that the right could not be realised immediately. But the goal of the Constitution is that the basic needs of all in society be effectively met and the requirement of progressive realisation means that the state must take steps to achieve this goal. It means that accessibility should be progressively facilitated: legal, administrative, operational and financial hurdles should be examined and, where possible, lowered overtime".* [own emphasis added]

(g)At paragraph 46, the Court dealt with the phrase "within available resources". The Court stated that *"the measures must be calculated to attain the goal expeditiously and effectively but the available of resources is an important factor in determining what is reasonable".*

11. **Analysis of the Complaint**

11.1. At the centre of this complaint is the extent to which the delay in the recruitment of staff, the concomitant shortage of staff and

poor infrastructure negatively impacted on the provision of health care services at the hospitals as well as the rights of patients enshrined in the Constitution.

11.2. The Respondent submitted that shortage of doctors and professional nurses is a national problem. This challenge, the Respondent stated, was caused by many factors such as personnel getting better offers and opportunities closer to areas where there are Universities. The lack of accommodation at hospitals situated at rural areas was also cited as a contributory factor.

11.3. All the questionnaires completed and submitted to the Commission also revealed a high rate of vacancies at these hospitals. The moratorium on filling up vacant posts exacerbated the situation.

11.4. The Complainant related an incident during which an advertisement of professional nurse posts was placed in the *Sunday Times* newspaper during May 2010. Letters of appointment were given to successful candidates only in July 2012. It took the Respondent two years to fill the posts. Further

that during the inspection at Matibidi Hospital, the hospital representatives submitted that the delay in the appointment of personnel and procurement of infrastructure services was as a result of the centralised execution of the processes by the Respondent's Provincial Office in Nelspruit. To this end, in Grootboom, the Court held that "*measures must be calculated to attain the goal expeditiously and effectively but the available of resources is an important factor in determining what is reasonable*". [own emphasis added]

11.5. As a consequence, the Commission finds that the delay in filling the vacant posts was excessive and negatively impacted on the right to access to health care services.

11.6. There were serious infrastructural problems at Bernice Samuel Hospital mentioned above in this report. It has been submitted that these challenges place the health of the patients and staff members at risk. There was no dedicated maternity ward at this hospital which in turn caused women to lie on the floor. There were also no ventilators at the admission unit and that created a risk of Tuberculosis and other infections for staff members and

patients. Furthermore, there were no dedicated wards for children, no dedicated surgical and medical wards. Children were put together with adults and this placed their health at risk.

11.7. There were renovations and improvements being made by the Respondent at Rob Ferreira Hospital. However, shortage of personnel still resulted in the hospital delaying or even failing to provide access to health care services.

11.8. At Matibidi Hospital there were no infrastructural problems noted by the Commission or the Acting CEO. However, during the inspection, it was submitted that the centralisation of procurement of goods and services as well as recruitment processes at the Respondent's Head Office resulted in some failure and/or delays in proving health care services.

12. Background to Health Care Services Nationally

In June 2007 the Commission conducted an inquiry into access to health care services provided by public hospitals in the country and a report with the following findings and recommendations was compiled:

(1) Hospital Management

(a) Findings on the management structure of public health facilities in South Africa highlighted the difficulties associated with the centralisation of the 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.

(b) 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.

(c) 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 Departments of Health 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.

(d) 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.*"

(e) 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.*" The enactment of the Public Finance Management Act, 1 of 1999 (hereinafter referred to as the "PFMA"), is part of the broader scheme of capacity development to ensure good financial governance.

2. Specific recommendations:

(a) Decentralise power by delegating decision-making to CEOs and district and facility managers, especially with regards to human resources and financial management.

(b) Conduct skills audits of senior management and implement appropriate interventions such as training and awareness campaigns to capacity senior staff.

(c) Improve financial management and overall operational delivery efficiency by placing greater emphasis on capacity development, PFMA, good governance, implementation and accountability.

3. Infrastructure

(a) 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 Department of Health has been surrendering funds to National Treasury particularly on infrastructure and the Commission'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.

(b) The findings of the 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 Human Resources Planning, the lack of sufficient and contemporary infrastructure and technology compromises the ability of facilities to provide an adequate service to health care users.

(c) 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.

4. Specific recommendations:

(a) 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 healthcare users.

(b) 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 Ministers and Members of Executive Council level.

5. Accessing Services at a District Level

(a) 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.

(b) 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.

(c) 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.

(d) This model fails to operate efficiently due to a dysfunctional and poor relationship between provincial and district 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 medication 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.

(e) 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.

6. **Specific Recommendations:**

(a) Strengthen service at a district level, thereby effectively operationalising the primary health care approach.

(b) 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.

(c) 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.

7. **Human Resources**

(a) 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 care personnel contributes to inadequate health care.

(b) The Commissions 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.

(c) To address these human resources issues, the Department of Health 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 people into the health profession should be based on thorough research such as a departmental needs-analysis.

(d) The Department of Health 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. 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.

(e) Organisations with poor monetary incentives therefore need to invest in the training of staff if they are to retain employees. The more opportunities for employees to be trained, 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.

(f) 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.

8. **Specific recommendations:**

(a) 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.

(b) The Department of Health 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.

(c) Training should be comprehensive and continuous for health care workers as learning is considered a great motivation for remaining in a specific position.

13. Findings

Based on the inspection report and the completed questionnaires as well as the analysis of the complaint and application of the legal framework, the Commission makes the followings findings:

13.1. As previously highlighted in the Commission's 2007 national inquiry into the state of public hospitals, the Commission finds that the very challenges identified in that inquiry continue to persist. These challenges pertain primarily to a lack of effective management structures, infrastructure, adequate access to primary healthcare facilities and sufficient human resources required to deliver quality health care services

13.2. That the shortage of personnel in hospitals and the delay in the recruitment and appointment of staff still remains a challenge and continues to negatively impact on the provision of health care services to the public. In view of the time lapse between the advertisement of the posts and the appointment of staff, the Commission finds that the

delay was occasioned by maladministration on the part of the Respondent.

13.3. The Commission also finds that the moratorium and the reason behind it, namely, overspending during the previous financial years, were precisely the symptoms of maladministration of financial and human resources by the Respondent.

13.4. The infrastructural problems noted at Bernice Samuel Hospital are a cause for concern as they had a negative impact on the provision of health care services to communities.

13.5. The centralisation of procurement and recruitment functions within the Provincial Department of Health is still a concern and continues to cause unnecessarily delays in the provision of health care services.

13.6. In view of the above, the Commission finds that the Respondent has violated the right of the public to have access to health care services enshrined in section 27 of the Constitution.

13.7. As a consequence, the right to human dignity enshrined in section 10 of the Constitution was also violated.

14. Recommendations

In the light of the above mentioned findings and in line with the recommendations made in the public hearing referred to above, the Commission makes the following recommendations:

14.1. That the Respondent must formulate and submit no later than 31 March 2014 a well coordinated programme aimed at dealing with and addressing the above mentioned infrastructural, administrative and other challenges that undermine the right to have access to health care services in all Mpumalanga public hospitals.

14.2. The said programme must stipulate timeframes within which the Respondent has planned to resolve the said challenges.

14.3. In the interim, the Respondent is required to submit a report setting out the steps taken to address undue delays in the recruitment processes and the procurement of services. The report must be submitted to the Commission by 31 March 2014.

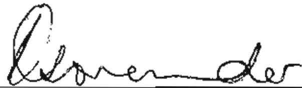
14.4. The programme in 14.1 above must specifically also set out steps to be taken to deal with the issues at Bernice Samuel Hospital.

15. APPEAL

You have the **right to lodge an appeal** against the report. Should you wish to lodge such an appeal, you are hereby advised that you must do so in writing **within 45 days of the date of receipt of this report**, by writing to:

The Chairperson, Adv M.L. Mushwana
South African Human Rights Commission
Private Bag X2700
Houghton, 2041

SIGNED IN JOHANNESBURG ON THE 20TH DAY OF DECEMBER **2013**.



Deputy Chairperson
Commissioner P. Govender
South African Human Rights Commission