Monitoring Our Health
An analysis of the breakdown of health care services in selected Gauteng facilities
A report for the period January - December 2012
First published in 2013
Johannesburg, South Africa

This report relies on information gathered by the Centre for Applied Legal Studies (CALS), the Treatment Action Campaign (TAC), and SECTION27 during the period February 2012 and December 2012. It has been endorsed by the TAC as well as the Southern African HIV Clinicians Society.

We acknowledge the contribution of the health care workers, patients, activists, lawyers and all those who are concerned about health care in Gauteng Province.
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1. CONTEXT

Over the last few years there has been a sharp deterioration in healthcare at hospitals and clinics in Gauteng, marked by shortages of medicines, collapsing infrastructure, broken equipment, inadequate provision of staff and misuse and misallocation of funds. This has led to a situation in which the access to health care services and patients’ dignity is compromised on a daily basis. These shortcomings have been widely acknowledged and there have been periodic episodes in which healthcare in Gauteng has been brought under intense public scrutiny. Examples include the photographs of newborn babies in hospital lying in cardboard boxes due to overcrowding published in 2007\(^1\), and news reports on the deaths of 6 babies at Charlotte Maxeke Johannesburg Academic Hospital in 2010 due to an outbreak of gastroentiritis\(^2\) and the cases of avoidable stillbirths in the labour ward at Chris Hani Baragwanath Academic Hospital due to a shortage of nursing staff in 2012\(^3\).

Subsequent official investigations and inquiries have found clear deficiencies in both the systems and operations in hospitals and clinics run by the Gauteng Department of Health and the Department itself. However, while each of these investigations were accompanied by a range of recommendations, earnest statements and loud promises, the Gauteng Department of Health failed to act on these recommendations or to remedy the systemic issues. Instead, the focus has been on putting out fires and the crisis has been addressed on a piecemeal basis. As such, the situation in Gauteng facilities remained largely unchanged and in many instances, it has actually deteriorated to the detriment of patients.


\(^3\) Examples include the Integrated Support Team (commissioned by the Acting Minister of Health Barbara Hogan in 2009), which found various systemic flaws in financial and budgetary management and leadership. The consolidated report is available from http://section27.org.za.dedi47.cpt1.host-h.net/wp-content/uploads/2010/06/Consolidated-IST-Report1.pdf.

The expert probe into the causes for baby deaths at Charlotte Maxeke in 2010, which found that a lack of infection control, supplies and equipment contributed to the deaths. See “SECTION27 comment on release of report on investigation into infant deaths at Charlotte Maxeke Academic Hospital in Gauteng” available from http://www.section27.org.za/2011/01/25/report-on-investigation-into-infant-deaths-at-charlotte-maxeke-hospital-released/.
Simultaneously, serious corruption and mismanagement of public funds by the Gauteng Department of Health has also been unearthed. In light of our Constitution, that enshrines the progressive realisation of access to healthcare services and legislation set up to protect public finances, this is entirely impermissible and unacceptable.

During 2012, public hospitals and clinics in Gauteng continued to experience a debilitating range of operational difficulties, which has directly resulted in increased morbidity, disability, stillbirth and death. SECTION27, together with our partner organisations the Centre for Applied Legal Studies (CALS), South African HIV Clinicians Society and the Treatment Action Campaign (TAC) received a range of complaints from concerned healthcare workers at various hospitals and clinics in Gauteng (primarily in the greater Johannesburg area) who reported a complete breakdown in their ability to provide services of a reasonable standard to patients, as well as similar accounts from both activists and patients. While both the healthcare workers and the TAC have raised their concerns with the authorities, these concerns have not been addressed adequately or sustainably. Though the GDoH unveiled a turnaround strategy in 2012, for the period 2012-2014 the situation on the ground did not improve substantially over the period under review and it is not clear what significant changes can be expected in the near future to address systemic problems.

The failures within the healthcare system must be addressed as a precursor to the implementation of the National Health Insurance (NHI). The NHI has the potential to improve equity and quality of healthcare in the country. However, high quality, functioning public facilities form the backbone of any national healthcare strategy. Acute crises in these facilities, left unaddressed, are likely to render ineffective any regulatory reforms aimed at improving care and have the potential to undermine the NHI reforms. As such, it is essential that there is awareness and acknowledgement of the extent of the crisis, and that steps are taken to ameliorate it.

Section 27 of the South African Constitution provides for the right of access to healthcare services, including reproductive health care, and affirms that the State must take “reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.” In addition, the National Health Act 61 of 2003 (NHA) places obligations on both the national and provincial departments. While the national department is tasked with developing policy, guidelines and norms and standards, provincial departments
While the national department is tasked with developing policy, guidelines and norms and standards, provincial departments are required to realise the right to health by implementing policy and adhering to those norms and standards. These roles must be carried out in a way that complies with the Constitution as well as other relevant legislation such as the NHA and the Public Finance Management Act 1 of 1999 (PFMA), which sets standards for financial management of public money at the national and provincial levels. Government departments are therefore directly tasked with ensuring that there is progressive realisation of access to healthcare and that no retrogressive measures are taken in respect of the delivery of healthcare services.

The consistent failure by the GDOH to properly budget and allocate sufficient finances for medicines, equipment, staff and infrastructure has directly led to the deterioration of health services and an increase in legal claims. A failure to remedy this would be a violation of the Constitutional rights of patients and a further breach of the Gauteng Department of Health’s obligations. Violations of law already include the following:

- breach of the obligations under the Constitution to provide for access to healthcare services and not to reduce the level of health care provided;
- breach of obligations under the Constitution to promote the efficient, economic and effective use of resources;
- breach of the obligations under the National Health Act 61 of 2003 to provide health care services and to plan, manage and control the cost of doing so; and
- breach of the obligations under the Public Finance Management Act 1 of 1999 to ensure the proper and efficient use of public funds, including proper stock control and to prevent fruitless and wasteful expenditure.

The gross disregard for the legal obligations of the Gauteng Department of Health and the vital oversight function of the National Department of Health is extremely worrying and cannot be allowed to continue unchallenged. This report makes a number of recommendations to address the systemic breakdown of services and bring the State closer to fulfilling its constitutional obligations. In particular, we identify appropriate financial management and accountability, improved supply chain management and shifts to an “activity-based” approach to both financing
and human resource allocation. In addition, greater accountability and transparency is essential. Violations of the PFMA must be investigated and those responsible must be prosecuted.

2. BACKGROUND

Gauteng is the most populous province in South Africa accounting for over 22%\(^5\) of the national population. Of the approximately 12.3 million people in Gauteng, at least 7.7 million do not have comprehensive medical aid cover and therefore depend on state facilities to meet the majority of their healthcare needs.\(^6\)

In addition, it is a province with the highest level of immigration, with a net immigration almost three times the size of the Western Cape, which is the only other province with positive net migration. A large part of this is due to migration from other provinces as well as surrounding countries.

Gauteng has a total of 33 hospitals spread across six districts (Johannesburg Metro, Tshwane, Ekurhuleni, West Rand, Sedibeng and Metsweding). In total, there are four central hospitals, two provincial tertiary hospitals, nine regional hospitals, 11 district hospitals and six specialised hospitals.

Johannesburg Metro serves approximately 37% of the population of Gauteng. The two central hospitals in this district, Charlotte Maxeke Johannesburg Academic hospital (CMJAH) with 1018 beds and Chris Hani Baragwanath Academic Hospital (CHBAH) with 2888 beds, serve a population beyond the provincial boundaries. The district has one tertiary hospital, Helen Joseph, which has 485 beds. In addition there are also several regional and district hospitals: Rahima Moosa Mother and Child Hospital (338 beds), Southrand Hospital (280 beds), Edenvale Hospital (230 beds), as well as Tara Psychiatric Hospital and Sizwe Tropical Diseases Hospital, which are specialised facilities. There is also a range of clinics across the province that provides primary health care services.

This report highlights some of the features of the crisis that we are currently aware of based on our own research, correspondence and interviews with healthcare workers and users of the system, particularly those at the larger hospitals in the

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\(^6\)Gauteng Turnaround Strategy, 2012. However, it should be noted that this estimates the population of Gauteng to be 11.1 million so it is likely that it undercounts the portion of uninsured residents in Gauteng.
Johannesburg Metro area, namely CHBAH, CMJAH, Helen Joseph and Rahima Moosa. However it also draws on reports from staff and users of facilities in Ekurhuleni and Sedibeng regions. Our sources are unnamed in this report due to a climate of fear that exists among healthcare professionals. This is somewhat warranted as several professionals have been threatened with disciplinary action for speaking out.\(^7\)

In July 2012, the GDoH launched the “Gauteng Turnaround Strategy: Towards Effective Service Delivery, Strengthening Primary Health Care and a Clean Audit in 2014”. It acknowledged that the health system required a significant turnaround in order to deliver health services to Gauteng. The strategy also acknowledges that certain steps need to be taken in order to realise the objectives of the Department’s Strategic Plan for 2009-2014. The plan spans three years and attempts to address major aspects of the health system, including financial management, human resources, district health services, hospital management, information technology and infrastructure, amongst others. The strategy sets out the challenges but does not have the detail as to how the plan will be implemented. For example, regarding an IT system; the plan states that a comprehensive, long term ICT strategy for health will be developed but does not indicate what that IT strategy should contain or by when it will be implemented. Similarly, regarding emergency medical services (EMS), the primary solution is to develop a plan and appoint a chief executive officer of the EMS (which has been vacant for some time) but no substantive aspects of such a plan are included, nor are any timeframes or responsibilities included.

Clearly, these are significant aspects of the health system, which must be addressed in a strategic manner. However, given that there is a crisis in the health system now, what is required is an open and transparent recovery plan to get health services back on track. Indeed, in the absence of concrete timelines and responsibilities, it is impossible for affected communities to hold the department to account for the implementation of the strategy.

It is our understanding that the severe shortages and failures identified at the larger hospitals in the districts highlight the acuteness of the problems as these hospitals are generally better funded and staffed than many of the district and regional hospitals. Given the importance of these hospitals not only to the

\(^7\)For example, three doctors in the Eastern Cape were subject to disciplinary action for holding an “unauthorised” press conference on shortages in staff, although this was later withdrawn. http://herald.newspaperdirect.com/epaper/viewer.aspx.
residents of the province, but to those that form part of the broader referral base of the central and tertiary hospitals, the effects are likely to be felt beyond provincial boundaries and have wider implications for access to healthcare.

3. CORE AREAS IN WHICH SERVICE WAS COMPROMISED

The areas in which service was compromised in 2012 can be grouped into five broad categories:

- Access to medicines and consumables.
- Availability and maintenance of equipment.
- Maintenance of infrastructure.
- Adequate human resources.
- Training of health professionals and research.

We discuss each in turn.

3.1. Access to Medicines

At both hospital and clinic level there are serious concerns over the lack of availability of medicines and consumables required to offer a complete healthcare service. These range from basic medicines and vaccines and basic consumables to those that are more complex. We briefly detail some of the shortages before exploring the causes for the shortages.

3.1.1. Basic consumables

There are often shortages in consumables required for the efficient and safe functioning of facilities and for the treatment of patients. For example, doctors at various hospitals have noted that the shortages in consumables include those required for infection control such as hand-washing supplies (soap, handtowels and hand spray), specialised masks, alcohol swabs and sterile gloves in different sizes. These have serious effects on patient and health care worker safety. In addition, there are shortages in medical consumables such as drip sets, needles and suture material of different sizes. Inappropriate consumables are often delivered. A stark example is a hospital, which does not see any paediatric patients but was provided with a mix of adult and paediatric needles. A shortage of adult-sized needles has meant that they had to use paediatric needles on adults resulting in sub-optimal care.
Apart from availability, the quality of consumables has also emerged as a key issue facing healthcare providers. We have been shown examples of sutures that are half the length that they should be, surgical needles that are bent, and have been told by numerous departments that the needles break so easily that it often requires using three or four tries before they are successful. The shortages even extended to essential non-medical products such as stationary. Doctors at a large regional hospital recounted how they photocopy patient charts and forms at their own cost as the hospital did not even have paper at times. At clinic level the lack of files and paper often results in patient visits not being recorded. At an even more basic level there have been situations in which the non-payment of suppliers has resulted in food not being delivered to hospitals.

3.1.2. Essential medicines

There are shortages in medicines across facilities from clinics to tertiary hospitals. These include a range of medicines on the essential drug list published by the National Department of Health. According to the Department of Health:

“Essential medicines are intended to be available within the context of functioning health systems at all times in adequate quantities, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford”\(^8\)

It is therefore cause for concern that there are shortages of these medicines. Doctors at one regional hospital, for example, have estimated that they do not have access to approximately 25% of the medicines listed on the essential drug list.

Examples include basic analgesics such as paracetamol and aspirin and basic antibiotics (such as Augmentin). The consequences are a direct limitation on the ability to treat, and increases the severity of illness, pain and discomfort for patients. For example, the lack of aspirin, an inexpensive and readily available drug, means that patients with cardiovascular and vascular problems who require aspirin to thin their blood are placed at serious risk. The unavailability of basic antibiotics means that inappropriate and stronger ones have to be used at times, increasing the risk that antibiotic resistant strains will develop in the population.

**Critical medicines in short supply**

Below is a sample of critical medicines that were reported to be unavailable in hospitals in Gauteng at different points in 2012.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paracetamol</td>
<td>A basic analgesic</td>
</tr>
<tr>
<td>Aspirin</td>
<td>basic analgesic</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>A basic analgesic</td>
</tr>
<tr>
<td>Morphine</td>
<td>Narcotic painreliever</td>
</tr>
<tr>
<td>Augmentin</td>
<td>A basic antibiotic</td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td>An important antibiotic used for meningitis</td>
</tr>
<tr>
<td>Nitrocine</td>
<td>An important vasodilator used in patients with cardiac emergencies</td>
</tr>
<tr>
<td>Metformin</td>
<td>A basic oral agent for Diabetes</td>
</tr>
<tr>
<td>Insulin</td>
<td>The critical medication in Diabetes</td>
</tr>
<tr>
<td>Salmeterol</td>
<td>An important bronchodilator for Asthmatics and COPD patients</td>
</tr>
<tr>
<td>Furosemide</td>
<td>A critical and basic diuretic for cardiac patients</td>
</tr>
<tr>
<td>Phenytoin</td>
<td>A basic anti-epileptic medication</td>
</tr>
<tr>
<td>Warfarin</td>
<td>A basic oral anti-coagulant</td>
</tr>
</tbody>
</table>
There are often serious long-term impacts on patients as a result of shortages. One doctor raised his concern that because the hospital administration did not order the appropriate basic asthma pumps, young (and otherwise healthy) patients with asthma were developing “smokers lungs” which is likely to reduce their life expectancy by 10 years.

“How are we supposed to operate on our patients when we can’t even give them basic painkillers. It is inhumane … The problem is our patients are too forgiving.” Doctor C, Central Hospital, June 2012, Johannesburg

3.1.3. Childhood vaccines

It is universally accepted that immunisation programmes have led to dramatic improvements in the burden of disease and have nearly eradicated some communicable diseases in developed countries (for example, polio). A good vaccination programme is key to the effective management of communicable diseases and forms a part of World Health Organization recommendations\textsuperscript{9} and national policy\textsuperscript{10}. Despite this, staff, medical students and patients at primary healthcare clinics and at hospitals have highlighted shortages of childhood vaccines including the following: the 5-in-1 vaccine (which vaccinates against Diphtheria, Tetanus, Pertussis, Haemophilus Influenzae type B and Polio), Rotavirus and Pneumococcal vaccines. These vaccinations form part of the WHO Expanded Programme on Immunisation and are part of the national vaccination schedule. The table below shows the diseases that are immunised against as part of the national schedule and those for which shortages have been reported at some point in 2012.

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\textsuperscript{9} See for example various WHO position papers available on http://www.who.int/immunization/documents/positionpapers/en/index.html

<table>
<thead>
<tr>
<th>Disease</th>
<th>Description</th>
<th>When vaccine is required national Schedule</th>
<th>Shortages Reported (2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB</td>
<td>Contagious infection that affects lungs. Leading infectious cause of death in adults.</td>
<td>Birth</td>
<td>no</td>
</tr>
<tr>
<td>Polio</td>
<td>Contagious viral infection that affects nerves and can lead to permanent muscle weakness, paralysis and death.</td>
<td>Birth (oral), 6 weeks (oral), 6 weeks, 10 weeks, 14 weeks, 18 months (as part of 5-in-1)</td>
<td>yes</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>Contagious, respiratory tract infection. Sometimes fatal, mortality rate 20%</td>
<td>6 weeks, 10 weeks, 14 weeks, 18 months, 6 years, 12 years</td>
<td>yes</td>
</tr>
<tr>
<td>Tetanus</td>
<td>&quot;Lock jaw&quot;- muscles contract and become rigid. 50% of those with Tetanus die.</td>
<td>6 weeks, 10 weeks, 14 weeks, 18 months, 6 years, 12 years</td>
<td>yes</td>
</tr>
<tr>
<td>Pertussis</td>
<td>&quot;Whooping cough&quot;- contagious bacterial infection. Complications include pneumonia, ear infection and in rare cases, brain damage.</td>
<td>6 weeks, 10 weeks, 14 weeks, 18 months</td>
<td>yes</td>
</tr>
<tr>
<td>Haemophilus influenzae</td>
<td>Respiratory tract infection that can spread to other organs including joints, bones, lungs, skin, eyes, etc. Can cause meningitis and epiglottis. Vaccines reduce incidence of infection by 99%.</td>
<td>6 weeks, 10 weeks, 14 weeks, 18 months</td>
<td>yes</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Serious and sometime fatal form of hepatitis. Can cause fatal liver failure. Becomes chronic in 5-7% of people.</td>
<td>6 weeks, 10 weeks, 14 weeks</td>
<td>no</td>
</tr>
<tr>
<td>Pneumococcal Conjugated Vaccine</td>
<td>Causes pneumonia, meningitis, sinusitis and middle ear infections.</td>
<td>6 weeks, 14 weeks, 9 months</td>
<td>no</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>---------------------------</td>
<td>----</td>
</tr>
<tr>
<td>Measles</td>
<td>Contagious viral infection. Complications include pneumonia, encephalitis and middle ear infections.</td>
<td>9 months, 18 months</td>
<td>no</td>
</tr>
</tbody>
</table>

This is a matter of grave concern, particularly since some paediatricians have reported cases of children suffering from diseases that they should have been immunised against. For example, there was a case of pneumococcal meningitis in a child who did not receive the 14-week pneumococcal immunisation as the vaccine was not available at her clinic. In addition, we have been told of infants who were admitted to ICU with pertussis (a disease which should routinely be vaccinated against) one of whom had not been immunised despite regular clinic visits due to the vaccine being out of stock. Given the antibiotics to treat these diseases are often not available, this is even more egregious. This has consequences beyond patient welfare and has implications for public health, as these diseases are all highly contagious.

“I take my baby to the clinic on time but they don’t have the vaccination available. They have not told me when to come back. I am not sure when I will be able to get her vaccinated.” **TAC member, Ekhurhuleni, July 2012**

“There is definitely a shortage of “extended programme of immunisation” childhood vaccines in all Soweto clinics which has been alarming… Mothers are not always educated by nursing staff as to missing components of vaccination, so often they believe that all vaccines are up to date because they are not told otherwise. I tried to contact the Department of Health. The minute they would hear what I wanted to talk about they would drop the phone on my ear” **Doctor L, Community clinic, Soweto, July 2012**

“We have recently had 2 infants dying on ventilators in our ICU with proven pertussis. One was unimmunised, but the other had regularly been to the clinic, but the vaccine was out of stock!” **Doctor P, Regional Hospital, Johannesburg, March 2012**
3.1.4. ARVs and TB treatment and services

Stockouts of ARVs at many clinics around Gauteng were observed throughout 2012 (though this has been a cyclical occurrence over the last few years). By May 2012, shortages, particularly of Tenofovir and Abacavir, were becoming acute. Individuals were often provided with a few tablets (such as a supply for a week) instead of a monthly supply. Given the difficulty in repeatedly returning to a clinic (including the costs of taking time off work, transport costs etc), this increases default rates and can, in the long term, affect the health and immunological response of those on the treatment. In other cases, patients were switched to sub-optimal treatment regimes in light of shortages. For example, patients on Tenofovir where switched to Stavudine (D4T) which has a greater level of side effects. However, no measures were put in place to monitor the impact of these changes on patients. Apart from the fact that this has the potential to cost lives and place the national treatment programme at risk, it is grossly irresponsible as it can also create drug resistance.

According to national data, 75% of people living with HIV are co-infected with TB. As such, people living with HIV should also be screened for TB and vice versa. During 2012 (and in previous years) there were several issues in the screening and treatment of TB.

1. Firstly, many patients were not screened for TB for reasons such as a lack of sputum collection bottles. Even when sputums were collected, test results were often not made available. This was primarily linked with non-payment of the National Health Laboratory Service by the provincial department.

2. Secondly, the crisis has also led to the interruption of TB treatment for those initiated onto treatment.

3. Thirdly, there were Isoniazid (INH) interruptions for those on TB prophylactic treatment.

As indicated above, these interruptions have devastating effects on patients and communities, but cause an increased burden on an already weakened health care system. Given that TB is a communicable disease and there is an increasing burden of MDR and XDR TB in South Africa, this is not acceptable.
3.1.5. Medicines for tertiary treatment

Tertiary hospitals are becoming increasingly unable to offer adequate specialised care as a result of not having the medicines that they require. This is apparent across departments within the hospitals. In May 2012, this reached a peak when treatment for patients on courses of chemotherapy was interrupted at central hospitals in Gauteng due to an unavailability of medicines, including Tamoxifen (used in certain kinds of breast cancer), Bleomycin (used for among others, Kaposi’s Sarcoma treatment), and Cisplatin (used for among others, lung cancer treatment).

3.1.6. Sources of shortages and quality issues

The lack of sufficient medicines and consumables has been attributed to various factors.

1. Inefficiencies in the supply chain: Interviewees have raised concerns over various aspects of the supply chain. These range from concerns over the competence of clerks at hospital level who need to accurately record orders, administrators at the GDOH who process the orders without sufficient efficiency or urgency, and stock and delivery issues at the Auckland Park Medical Supplies Depot.

2. Failure to make payment: A lack of payment by GDoH resulted in some suppliers ceasing to supply hospitals at different points in 2012. This includes the National Health Laboratory Service.

3. Tender concerns: There are also repeated concerns over the quality of consumables and various stakeholders have raised suspicions of tender corruption.

3.2. Availability and maintenance of equipment

One of the key system failures that have been identified by healthcare workers relates to the purchasing and maintenance of equipment. Medical devices and equipment are essential to medical practice and play a role in the diagnosis and treatment of a wide range of medical conditions. The term “equipment” is fairly broad and covers a spectrum from small pieces of equipment such as scalpels and surgical scissors to more complex equipment like scanners.

Healthcare workers are concerned that a failure to maintain existing equipment
or purchase new equipment has meant that they are hampered in their ability to correctly diagnose and treat patients and as a result patient care is being compromised.

There are four core issues related to equipment:

- **Inadequate budgets for equipment**: Equipment budgets have been cut in order to pay suppliers for equipment purchased in previous financial years and for other goods and services. Various hospital departments have been told that there is insufficient budget for new equipment. It has been reported that CHBAH actually has a zero budget for new equipment in the 2012/2013 financial year due to the budget being spent on accruals from previous years. 11

- **Difficulties and delays in getting equipment ordered**: Hospital departments have to wait a very long time to get equipment that they have ordered. Sometimes it may take years for equipment to be delivered. In those circumstances, facilities either make do without the necessary equipment or continue to use equipment that is well past its lifespan.

- **Poor quality of equipment received**: There are serious concerns over the quality of equipment that is often provided, particularly in cases in which quality is paramount.

- **Poor maintenance of equipment**: Even where hospital departments have equipment, it is often non-functional due to delays in repairs or a lack of servicing.

In addition, the functioning of equipment is in many cases inextricably linked to the availability of consumables for that equipment. For example, CT scanners, even if functional, cannot operate if there is a shortage of contrast fluid and dermatomes, used for skin grafts, do not work if they do not have the correct blades. As such, equipment often cannot function due to a lack of consumables. This has had a significant effect on medical interventions that are equipment dependent (such as anaesthetics, radiology and oncology). For example, a lack of sufficient working radiology devices (which is currently a problem at some hospitals) prevents diagnosis of many diseases.

11 The Budget and Expenditure Monitoring Forum together with the Treatment Action Campaign wrote to the MEC of Health to query this and to find out what steps have been taken to address this, but has received no response to date.
In addition, delays in patient diagnostics can often impact on timeous treatment of diseases, leading to poor health outcomes. In cases where equipment is required for high cost interventions such as brachytherapy, interruptions in treatment due to equipment failures leads to patient deaths, at a very high cost to the State. Poor functioning anaesthetic equipment places patients at unnecessary risk. We are aware of one case in which an anaesthetic machine malfunctioned while a patient was being operated on. While the patient fortunately survived this episode, this can have disastrous consequences.

A lack of equipment can also impact on a hospital’s capacity to operate. This is particularly pertinent in terms of ICU capacity (which is already lower than world standards). At one hospital 30% of ICU beds were not functional due to a lack of servicing of equipment because of a lapsed service agreement.

“We may not be able to offer a curative service soon and will be limited to providing only palliation for cancer patients, if essential components of treatment...do not become available soon.” Letter from oncologist at a central hospital, Johannesburg, May 2012.

“There is an imminent crisis with equipment. The equipment at Hospital X is very poorly maintained and consequently breaks often... I will not speculate here as to the reasons for these machines not being maintained, suffice to say that works orders and supplier orders have been placed a while ago... Most often, the equipment that is issued to us, is not the equipment that was originally ordered, but rather a generic version of the equipment. Thus, the equipment tends to malfunction at the slightest knock, and with prolonged use - at Hospital X, prolonged use occurs in 1 day, due to our patient loads! I think that currently we have reached our equipment threshold and any further malfunctions may tip the balance and result in our theatres not being able to function and result in delays to patients having operations.” Email from Anaesthetist, Central hospital, Johannesburg, August 2012

“We reported faults on a particular anaesthetic machine and this was not sorted out. The end result: it malfunctioned while we in the middle of an operation. This resulted in the patient requiring a resuscitation and CPR. Fortunately there was no major adverse repercussion, but this was completely preventable!” Doctor B, Central Hospital, Johannesburg.
These issues extend to various basic forms of equipment. A lack of wheelchairs, stretchers and beds is common at many of the Gauteng hospitals. In addition we have evidence of wards in which thermometers and blood pressure cuffs were not available, leaving staff unable to monitor patients vital signs.

3.3. **Maintenance of infrastructure**

Hospitals and clinics in Gauteng are being seriously affected by unsuitable infrastructure. This primarily relates to a lack of maintenance of existing infrastructure and failure to meet the needs for new infrastructure. In particular, we have noted the following key problems.

1. **Power:** There have been repeated power failures at various hospitals, notably Chris Hani Baragwanath Academic Hospital. In tandem, generators have not been a steady backup and have tripped repeatedly in instances in which they should have provided backup power. This has had predictably serious consequences including the cancellation of many operations (during one episode in a single hospital alone, 40 surgeries were cancelled). The power outages have led to instances in which surgeons operated using headlights and cellphone light.

2. **Buildings:** In many hospitals the buildings and infrastructure have not been maintained. Wards are in a poor condition and are sometimes dangerous (for example, medicine storage rooms without burglar bars; a temporary psychiatric ward in which male and female patients are separated only by cubicles). Passages are often potholed. Doctors’ quarters are often decrepit and uncomfortable. Various hospitals in Johannesburg have lifts that are often non-functional. This makes the transportation of patients within the hospital (ward to ICU, ICU to theatre, ward to X-ray facilities, etc) extremely difficult. In one hospital, children who require oxygen on admission sometimes need to be carried to the third floor without oxygen because of broken lifts.

3. **Temperature control:** Patients are generally vulnerable and more susceptible to temperature variations. However, the equipment necessary to maintain temperature control in many hospitals is
sometimes non-functional or non-existent. It is necessary for hospitals to ensure that wards are reasonably heated in winter. In addition, certain parts of a hospital such as theatres and x-ray facilities require air conditioning to ensure that temperatures do not get too high either. There was an incident this year in which the air conditioners serving the theatres at a large central hospital stopped working. Staff were faced with the difficult choice to either operate on patients in unsafe temperatures of over 30 degrees or cancel operations. Steamers and boilers are essential in hospitals. They are used for heating, cooking, washing linen and importantly, for sterilising equipment. In 2012, steamers and boilers broke down due to a lack of maintenance in one hospital. While they were ‘patched up’ there are serious concerns that they will break again, leaving wards and theatres unheated.

4. **Beds and linen:** There are generally insufficient beds for patients, who are sometimes lined up on stretchers and in one reported case, were even made to share a bed. Insufficient linen and problems with laundry machines and steamers and boilers mean that patients have to lie naked on beds for hours at a time. Some hospitals have a shortage of blankets.

5. **Medical infrastructure:** Problems experienced include difficulties with oxygen supplies and sufficient water filtration to ensure that sterile water is available to be used in haemodialysis. In one hospital, this has led to the cancellation of haemodialysis on occasion.

6. **Sanitation:** Bathrooms and toilets for patients, visitors and staff are often not maintained and remain out of service for long periods.

“At 22h00 last night there was an oxygen failure, from the VIE supplying our main theatre, ICU and a large part of the hospital. It apparently took 3 hours to sort out…. Fortunately we did not have any patients on the table in theatre, but I am concerned that there may be patient morbidity in the wards as a result of this…Then as you know, we had a power failure at 03h00, and the generator to theatres 1 and 2 did not kick in. Caesarean sections had to be completed by cell phone light!! The generator power to the main theatre was erratic, and eventually mains power was restored at about 10h30. At about this time, a burning smell was noted to be coming from theatre 3 with smoke coming out of the vents. There was fortunately no patient in the theatre.”

Email from Doctor Y at central hospital, 7 September 2012
3.4. Human resources

There is a widespread shortage of sufficient human resources in terms of essential medical and support staff. While this is generally a problem across disciplines there are four areas in which there are serious shortages in Gauteng that have a knock on effect. These are shortages of ICU nurses (which directly impact on the usability of ICU beds), radiographers (which also impacts on the level of treatment and diagnostics), anaesthetists and theatre nurses (which directly limits the number of operating lists possible). While there are various compounding factors such as the general lack of scarce skills in South Africa, this can also at times be directly attributed to policy decisions by the GDoH or the incorrect interpretation of these decisions.

Three key decisions taken in 2012 to limit expenditure had a dramatic effect on services.

1. **The non-payment of nursing agencies:** The non-payment of the Khalipha nursing agency in late 2011 and January 2012 as a result of financial difficulties, had serious effects on delivery of healthcare services. In particular, it precipitated an acute shortage of midwives and maternity theatre staff. In many instances where 13 midwives were required, there were only 3 or 4 on duty. This led to catastrophic consequences and there were reports of avoidable stillbirths due to asphyxiation as a result of the long waits for caesarean sections or lack of monitoring of patients in the labour wards.  

2. **Prohibition on use of nursing and pharmacy agencies:** According to a circular 27 of 2012 dated 20 March 2012, budget items to be curtailed included compensation for employees, goods and services and CAPEX. Nursing and pharmacy agents were specifically targeted for cuts. The circular stated the following:

> “All contracts for the employment of nursing and pharmacy agencies have been stopped. All institutions are required to submit a monthly report to Central Office of all nursing and pharmacy agencies used, including full details of their areas of involvement together with the monthly invoices. Institutions are advised to utilise current nursing staff to work overtime for this purpose.”

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Nursing and pharmacy agencies provide nurses to perform a crucial role in the public health system. Whilst the contracts with agencies were curtailed, in several hospitals nurses overtime payment was stopped and nurses were not allowed to work overtime during their leave period. In addition the province did not fill vacant nursing posts. This has led to a severe shortage in nursing staff, particularly those with specialised skills such as theatre and ICU nurses.

3. **The moratorium on the appointment of new staff:** On 11 May 2012, Dr Xundu, the then Head of Department for Health in Gauteng (HOD) issued personnel circular minute 29 of 2012 regarding the Monitoring of the Compensation of Employee (COE) Budget that instituted a number of measures for the purposes of achieving efficiency and accountability of the management of the human resources budget. These included:

a. The abolishment of all unfunded vacant posts;
b. The freezing of all funded vacant posts; and

c. The approval of the HOD required for filling funded posts that were not frozen.

This was implemented in a rigid manner, which had both acute and long-lasting consequences. In particular, the need for HOD approval on new appointments even for posts that were available and funded and the sheer volume that required approval led to unacceptable delays in the appointment process. The net result was that hospitals had to function without an adequate complement of staff, and in many cases, applicants accepted jobs in other provinces.

For example, freezing of posts in 2012 meant several hospitals faced a situation in which they were unable to fill posts of specialists and registrars (qualified doctors training to be specialists) despite having suitable applicants. This reached a level of crisis at Charlotte Maxeke Johannesburg Academic Hospital (CMJAH) with the cancellation of 20-25% of surgeries due to shortages in anaesthetists. Though the implementation of the policy was changed due to media exposure of the issues, there are still serious shortages at several hospitals. For example, at a regional hospital, patient operating lists were reduced from 6 per week to 4 per week, which meant that 6-7 cases were cancelled on a weekly basis.
However, even thought this occurred at the same time as the CMJAH crisis, it was not reported in the media and therefore did not receive much attention. Interviewees have also pointed to the fact that a shortage of support staff also has an impact on health care. Due to shortages of porters and cleaners, skilled healthcare workers divert their focus to completing low skill tasks. In addition, the lack of support staff also leads to delays in health care delivery. For example, doctors have noted that teams of surgeons, anaesthetists and nurses ready to operate in theatre are often unacceptably delayed as they wait for patients to be brought in by porters. The shortage of porters often resulted in the cancellation of operations for patients later in the day due to time constraints.

At primary health care level the shortages of nurses have also had effects on the functioning of the system as a result of reduced referrals to hospital, and increased morbidity and mortality as a result of delayed treatment.

“The HR dept tell me that they have applied for more than 100 vacant posts to be filled since the beginning of the year. They had the applicants. Only 5 Registrars posts were approved!” Email from Doctor M, July 2012

“The moratorium has meant that highly skilled specialists such as transplant surgeons applying for vacant posts are being turned away and forced into the private sector. These superspecialists take at least 15 years to train in total. In a country with such a skills shortage, it is unbelievable that this is happening.” Interview with Doctor C, Tertiary Hospital.

“I had a patient that required ventilation and ICU care post-operatively. The ICU was full and short of 2 staff members. The reason was that agency staff were no longer being used and a new policy did not allow nurses to claim for overtime pay if they worked during their leave. The result was that there were insufficient staff and we had the choice of denying the patient his operation, or risking sub-optimal care post-operatively. We chose the latter, he came back intubated to a general ward and his care was compromised.” Email from Doctor A in June 2012

“The Gauteng DOH also appears not to have any idea as to staff requirements at the hospitals. This has directly affected mortality at the ICU at Hospital A. This ICU has 10 beds, but the occupancy is in the region of 60-70 percent. This is bizarre given the mass of critically ill patients. In order for the 10 beds to be fully functional, full time ICU trained nurses are required. The shortage of these nurses results in the beds remaining
remaining empty, and a critical resource being underutilised. Deserving patients are denied ICU access, be it temporarily, often to their detriment. Similar problems occur in the operating theatres where shortages of anesthesiologist and theatre trained nurses’ means that patients wait for months for elective surgeries.” Interview with Doctor M, Secondary Hospital, July 2012.

3.5. Training of health professionals and research

Gauteng plays an integral role in the training of healthcare professionals including doctors, nurses and pharmacists, at both an undergraduate and postgraduate level. While the number of graduates vary on an annual basis, approximately 380 - 400 doctors graduate from the two medical schools in Gauteng (the University of Witwatersrand and the University of Pretoria), and a range of nurses and allied health professionals are trained in facilities in the province.

Training of high calibre healthcare professionals is essential to ensuring the quality and sustainability of the healthcare system. However, the acute problems faced in facilities in Gauteng have had a direct impact on the training of healthcare professionals (including doctors) at both an undergraduate and post-graduate level, as well as on research.

In particular, training students on the best practices becomes difficult when suitable medication is not available, where equipment is broken or being used in an sub-optimal manner, where theatre lists are cut and where patient-to-provider ratios are too high.

The HPCSA requires a minimum ratio of consultants to trainees and interns. In July 2012, the directive, which prevented hospitals from filling posts, came close to jeopardising these ratios in particular facilities.
4. CAUSES OF THE CRISIS

Our research has suggested that there are various causes for the decline in hospital services. In particular, we have identified the following three contributing factors.

1. Improper budgeting and financial management.
2. Poor supply chain management.
3. Poor management.

4.1. Budgeting and financial management

The Gauteng Department of Health has been overspending its budget for at least the past seven years. This overspending lies at the core of many of the service delivery issues. It has been directly responsible for the annual cycle of shortages close to the financial year-end and was also the cause of austerity measures that had serious consequences for human resources.

The causes of the budgetary crises can be roughly divided into two key groups, corruption and lack of accountability and inadequate budgeting.

4.1.1. Corruption and lack of accountability

We understand that in the past, the management at GDoH made several multiyear commitments and expenditure decisions that were corrupt and that were not directly related to the delivery of health care services. These included the improper use of consultants and service providers for basic departmental functions, the irregular procurement of goods or services and tender fraud. This is also evident from multiple reports of the Auditor-General.

The Special Investigating Unit (SIU) was commissioned by the President in 2010 to investigate the GDoH over the period from 2006-2010. The scope of the investigation included the improper use of consultants and service providers both in general and specifically for the establishment of a project management unit; irregular procurement of services for the Gauteng AIDS conference held in November 2007; and the procurement of goods and service relating to an IT and electronic health records (which has not been rolled out in facilities). We understand that the SIU is still investigating a R1 billion tender fraud allegation and have recommended that R16.5 million be recouped from former officials.

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13Page 28, IST report notes that in all the years under review at that point (2005/06-2008/09) Gauteng Provincial Health had overspent their budget.
However, it is not clear what has happened following the SIU investigation three years on. In addition, there have been no disciplinary measures undertaken against GDoH officials in line with the Public Finance Management Act. Corruption Watch and the TAC are seeking further information on the SIU investigations. While this type of investigation is essential, it will only have an impact if it leads to disciplinary or criminal proceedings in which those who are found guilty are held accountable and that controls are put in place to avoid future transgressions of the law. While there have not been any outcomes of the SIU investigations, it is unlikely that the maladministration and corruption have been stamped out in the intervening years.

The overspending in past years has had a lasting impact on the financial health of the Department, as will be discussed in the next section.

The Health Sector Audit 2011/12 undertaken by the Auditor-General showed the following:

- Material underspending of certain budgets of R 855 573 000. This includes underspending of R 55 948 300 on Health Facilities Management and R 1 091 000 on district health services.
- Poor debt collection.
- Accruals that exceeded the payment term of 30 days to the value of R 2 610 847 000.
- Unauthorised expenditure (R 1 001 114 000), irregular expenditure (R 1 115 884 000) and fruitless and wasteful expenditure (R 155 422 000).
- Poor procurement and contract management. In other words, goods were procured without the required price quotations and without inviting competitive bids.
- Investigations into financial misconduct were not instituted within 30 days of discovery.

This contravenes the provisions of the Public Finance Management Act.
4.1.2. Inadequate budgeting:

The GDoH has failed to create a budget that accurately reflects the cost of running an effective health care service. The budgets are historically based. It is not clear whether the GDoH routinely undertakes accurate assessments and projections based on patient volumes, utilisation, the correct staffing and equipment needs for providing an effective service for those volumes and the resultant costs. The following has compounded this:

a) Changes in the burden of healthcare:

Gauteng has experienced an increase in patient numbers due to natural growth as well as migration across provincial and national borders. For example, between 2001 and 2012 the population of Gauteng has increased by 2.9 million.\textsuperscript{14} Anecdotally it is claimed that residents of surrounding provinces also utilise Gauteng hospitals. It is not clear that allocations have increased in line with the rise in patient numbers. In addition, Gauteng is owed money by other provinces for services delivered by the GDoH that should have been delivered or paid for by other provinces.\textsuperscript{15}

b) Changes in the cost of healthcare:

The healthcare budgets have not changed in line with the changing costs of health care. Costs have risen at a rate above inflation. The higher than inflationary costs of goods and services is supported by the StatsSA estimates of medical inflation. These increases have not been catered for appropriately in the development of budgets. Employment costs are particularly high: In addition, the increases in the scale and cost of employment have also not been adequately budgeted for. The introduction of the Occupation Specific Dispensation (OSD) contributed significantly to increases in personnel expenditure. The GDoH staff establishment grew at a higher rate compared to other provinces. In addition, annual increases are centrally negotiated and have in recent years been more than the budgeted level. Budgets have failed to account for this.

\textsuperscript{14} Census 2011.

\textsuperscript{15} It has been reported that the Gauteng Health Department is owed between R4.4 million and R672 million from other government and provincial departments

http://www.timeslive.co.za/local/2011/07/20/gauteng-hospitals-owed-r1.5bn
4.1.3. Impact of financial mismanagement

The result has been that on a yearly basis, GDOH has been accruing debt by exhausting goods and services budgets (for example, pharmaceuticals and medical supplies) prior to the financial year-end and paying invoices out of the budget for the following financial year. This in effect means that pressure is placed on the following year’s budget, which is spent prior to the year-end. Prior to 2012, this debt accumulated and resulted in the outstanding amounts of around R3 billion recorded in November 2011. This led to payment defaults in early 2012, which led to many suppliers cutting off supplies of medicines, consumables and other goods and services.

The GDOH committed to paying these accruals by 30 June 2012. While this was done in part, it has been reported that by December 2012 the GDOH still owed money to 883 suppliers. However, a key concern is that even though some suppliers have been paid, the source of the deficit has not been adequately addressed.

Indications are that payments made in June were made through a combination of (1) the 2012/13 financial year health budget and (2) through “austerity measures” (3) funds from the reallocation of the provincial budget. While there were a range of austerity measures for which the GDOH should be commended (such as limitations on expenditure on entertainment) but such measures have fallen short of that required to sustainably resolve the situation. In addition, other measures such as freezing the appointment of staff (including critical staff such as specialists) had knock-on consequences for health care in the Province, particularly due to measures that affected human resources.

The payment from the 2012/13 budget is of concern because it ultimately means that the budgetary issues are likely to roll over to 2013, leading to repeated problems unless there is very careful financial management. In addition, it is of concern that GDOH has not instituted more robust measures to deal with future violations of the PFMA. It was announced in December 2012 that the Provincial Treasury would step in to assist the GDOH in developing

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16 Medium Term Budget Policy Statement, November 2011.
18 This includes a percentage that was taken from the budgets of a selection of other provincial departments as well as from the provincial infrastructure budget in instances in which budgeted projects are not ready for implementation. (Provincial Appropriation Bill 2012, Gauteng Provincial Government).
systems with an administrative body of experts being appointed to the department. We hope that this intervention will assist in improving the financial management of the department.

**4.2. Supply chain management**

Many of those interviewed raised serious concerns about the supply chain. There was a high level of frustration over the lack of capability of those tasked with ordering essential medicines and supplies. As noted earlier, goods ordered were generally delayed inexplicably (often for months at a time). In addition, inferior quality goods were often provided. Healthcare workers noted that often more expensive (but not necessarily correct) products were provided, which suggests that there are other factors at play outside of those normally relevant for procurement decisions such as quality and price. It has also been reported in the press that the Auckland Park depot only has 70% of essential medicines in stock.\(^{19}\)

In addition, allegations of corruption were widespread with many healthcare workers alleging that the GDoH was paying more for inferior quality goods than comparator products on the open market and that it was paying high margins to agents rather than ordering directly from the manufacturers. The GDOH has commissioned a forensic report into the Auckland Park Medical Depot. However, this report has still not been made public.

**4.3. Management capacity and accountability**

Both research and interviews suggested a lack of capacity in management at both hospital and provincial levels and highlight the challenges that result from a lack of sufficient responsiveness to clinical needs. The GDOH has an obligation to make savings in the context of limited resources, but this should not be done at the expense of health care services. Some of the austerity measures that were imposed from the provincial department such as not paying service providers, not renewing contracts for the maintenance of equipment, and excluding consignment stock from procurement processes had serious repercussions on good patient care and highlight the need to keep clinical necessities at the forefront of such decisions. In this instance, while the clinical and hospital management were acutely aware of the need for additional staff and had the posts available as well as suitable candidates, delays and bureaucracy at provincial level led to situations that were close to catastrophic.

In addition, a lack of management capacity has also led to financial mismanagement and violations of the PFMA.
5. THE WAY FORWARD

Healthcare in Gauteng is being severely compromised. The failure to manage finances and ensure that facilities are functioning efficiently has led to serious consequences including increased morbidity, disability, stillbirth and death.

Access to healthcare services enshrined in Section 27 of the Constitution is being flagrantly violated and the GDOH is failing to meet its legal obligations in terms of the Constitution and the National Health Act, amongst others.

Section 27 requires the GDOH to take reasonable steps to ensure that factors that contributed to the crisis in health care in Gauteng in 2012 is not repeated and that adequate measures are taken to not only stem the decline, but to create the conditions in which a progressive realisation of the right of access to health care services becomes a reality. This requires more than what is currently contained in the current Gauteng Health Turnaround Strategy as set out above.

Recommendations:

- The province must take measures to improve the budgeting and financial management of the GDOH. We support the intervention of the Provincial Treasury to assist the GDOH to improve its financial systems. However, we caution that any measures taken do not compromise patient well-being in the manner that the ill-executed austerity measures of 2012 did.

- Budgets should be drawn up using an activity-based approach that takes into account actual patient volumes and the burden of disease and accurate predictions thereof rather than a historical approach, and to map this to the appropriate staff and technology in order to determine costs.

- The GDOH must ensure that medicines on the national Essential Drug List are in stock in hospitals and clinics (where relevant) and a ring-fenced portion of the budget should be used to pay for these medicines. Measures need to be put in place to ensure that this is monitored and, where there are shortages, the situation is remedied with urgency. We recommend that a hotline is set up through which stock-outs can be reported, with no recriminations for the reporting of shortages by healthcare workers.
• Equipment needs to be audited and a plan needs to be drawn up to ensure that budgets and plans are made for the replacement of old equipment. Service contracts that were cancelled should be audited, replaced or reinstated.

• A reasonable human resource plan needs to be developed and made public to ensure that the appointment of essential medical and support staff are prioritised relative to head office administrators. Appropriate recruitment and retention procedures must be put in place to ensure that vacant posts are filled timeously.

• Individual and collective accountability needs to be emphasised by GDOH. The Public Finance Management Act and other legislation needs to be enforced and violations must be dealt with in a decisive manner. In this regard, the findings of the forensic investigation into the Auckland Park Medical Supplies Depot should be made public as soon as possible together with the steps that the GDOH intends taking in order to address the findings.

• An appropriate health information system should be implemented to facilitate timely and evidence-based interventions and to ensure accurate monitoring and evaluation of those interventions.

• Recommendations of inquiries into various aspects of the health system (such as the investigation into baby deaths at CMJAH) should be incorporated into the department’s strategic plans.

• The GDOH must engage in consultation with health care providers. The impact of initiatives has to be discussed with providers prior to implementation to ensure that access to quality health care services is not compromised.

• A Provincial Consultative Forum, as envisaged by the National Health Act should be set up. This forum is essential to ensure that there is interaction, communication and the sharing of information on provincial health issues between provincial authorities and stakeholders.

• Lastly, we call for openness and transparency in all steps taken by the GDOH to address the problems in the health care system.
In the context of a Constitution that enshrines the progressive realisation of access to healthcare the state cannot afford to fail in its Constitutional obligation to provide access to healthcare services on a progressive basis.

The GDOH must ensure that healthcare workers who work in adverse circumstances to treat their patients are provided the tools to effectively deliver healthcare. In addition, given the intrinsic importance of health and the resource constraints under which they operate, it is imperative that the GDOH ensures the efficient, economic and effective use of resources and holds to account those who squander them. A failure to do so places the GDOH in breach of the Constitution, the National Health Act and the PFMA. It is essential that the provincial authorities build up the system so that it can be a foundation for meaningful healthcare reform in South Africa. The litany of failures experienced in 2012 cannot be allowed to continue into 2013.