

## SECTION II: PATIENT COMPLAINTS

### 3 TWO PERSPECTIVES ON PATIENT CARE

This section of the report deals with patient complaints, as described during visits, in written submissions and during testimony at the public hearings. These complaints are further examined in Section III, as we discuss the underlying causes.

In addition, in this section. We reflect the results of a survey conducted by means of questionnaires. The questionnaires were calculated to get a broader view of the degree of patient satisfaction/dissatisfaction with services at the hospitals, which form the subject of this inquiry. It should be noted that no questionnaires were returned from Natalspruit Hospital.

#### 3.1 THE NATURE OF PATIENT COMPLAINTS

A significant number of patients complained about poor quality of service and it was clear to the Commission that they had reason to complain.

Major categories of complaints were:

- **Unreasonable waiting times.** Bottlenecks typically occur at:
  - Out-patient departments, where patients wait both for files to be retrieved and for professional attention
  - Casualty departments, where there is often a delay in receiving professional attention
  - Dispensaries, where patients queue to get prescriptions filled
  - X-ray departments, where the wait is for professional attention.
- **Shortages of linen.** This includes not only bed linen, but also personal linen, such as gowns and pyjamas, supplied to patients.
- **Conduct of professional staff.** These complaints relate to:
  - General uncaring attitudes and rudeness
  - A failure by health workers to communicate with patients
  - A failure to counsel patients
  - Perceived negligence
  - Perceived shortages of staff.
- **Conduct of support staff.** Several complaints were received regarding the cleanliness of hospitals and delays in removing corpses to the mortuary.
- **Catering.** Patients complained about both the quality and quantity of food.
- **Reliance on family care.** Relatives complained about having to bath, feed or otherwise assist their loved ones at some hospitals.
- **Security.** Patients complained that they felt unsafe in the wards and that their possessions were stolen at some hospitals.

- **Being turned away.** At some pharmacies patients are turned away after a cut-off point had been reached, and are requested to return the next day. Sometimes patients experience difficulty in gaining admission to casualty at certain hospitals.

Commissioners had difficulty getting details on patient complaints at some hospitals. At some they noted an absence of posters inviting complaints or a lack of complaint boxes. The practice of conducting random exit interviews or patient surveys was not followed at some institutions. All these factors indicated that most of the hospitals do not yet fully appreciate the value of patient complaints.

## **Recommendations**

Many patients' complaints can be addressed by a return to basics by hospital management:

- Telling staff that, despite heavy workloads, they must communicate with patients to explain their ailments and treatment and to answer their questions
- Ensuring that staff obtain contact details of patients' family members and that they contact the family promptly in event of the patient's serious deterioration or death
- Installing help desks and signposting hospitals properly
- Training and empowering supervisors
- Reminding professional staff of their ethical duties to the ill
- Taking disciplinary action against workers when warranted
- Recognising good work, even if this entails only a personal visit to relevant staff members by the Superintendent.

The Commission further recommends that hospital management should:

- Use patient complaints as a tool to measure perceptions of service quality and to identify areas of concern
- Continuously emphasize the *Batho Pele* policy and its eight key principles.

### 3.2 SURVEYING PATIENT SATISFACTION

A survey was undertaken to obtain a status report for recipients of services on the general quality of hospital care. A combined sample of 345 patients from 4 hospitals, randomly identified, commented on a number of issues. The results are as follows:

TABLE 1: IN-PATIENTS' RESPONSES

Questions posed	Percentage of patients making a certain value judgement							
	Good		Fair		Poor		No Response	
1. How did you experience your admittance to the hospital?	Good	76.22%	Fair	13.29%	Poor	6.29%	No Response	4.20%
2. Were you attended to immediately?	YES	75.52%	NO	23.08%	No Response	1.40%		
3. How were you treated when admitted?	Good	74.13%	Fair	13.29%	Poor	6.99%	No Response	5.59%
4. Are nurses in your opinion well trained?	YES	85.31%	NO	13.29%	No Response	1.40%		
5. Are doctors in your opinion well trained?	YES	83.22%	NO	13.98%	No Response	2.80%		
6. How are the nurses treating you?	Good	69.93%	Fair	11.19%	Poor	6.29%	No Response	12.59%
7. How do you experience the attitude of -								
(a) Doctors?	Good	73.43%	Fair	12.58%	Poor	9.79%	No Response	4.20%
(b) Nurses?	Good	73.43%	Fair	11.18%	Poor	11.19%	No Response	4.20%
8. Do nurses respond promptly to your (emergency) calls?	YES	74.13%	NO	24.47%	No Response	1.40%		
9. Do nurses attend to your bodily functions when required?	YES	81.82%	NO	17.48%	No Response	0.70%		
10. Is your prescribed medicine administered punctually and correctly?	YES	82.52%	NO	13.98%	No Response	3.50%		
11. How do you find the hospital's food?	Good	49.65%	Fair	30.77%	Poor	13.99%	No Response	5.59%
12. Do you receive all meals on time?	YES	79.72%	NO	15.38%	No Response	4.90%		
13. How would you rate the Hospital's -								
(a) Medical equipment?	Modern	65.73%	Outdated	18.89%	No Response	15.38%		
(b) Toilets and bathrooms?	Good	55.94%	Fair	20.98%	Poor	20.28%	No Response	2.80%
(c) Wards?	Good	66.43%	Fair	25.18%	Poor	6.29%	No Response	2.10%
14. Are clean linen and pyjamas provided?	YES	87.41%	NO	11.19%	No Response	1.40%		
15. Are the wards neat and clean?	YES	81.82%	NO	18.18%	No Response	0%		
16. Do you think there are enough staff to attend to all the patients?	YES	63.64%	NO	34.96%	No Response	1.40%		
17. What is your general impression of the services rendered in the hospital?	Good	50.35%	Fair	33.57%	Poor	9.09%	No Response	6.99%

### Additional Remarks by In-Patients

- Female cleaners must be allocated to female wards
- Nurses consume patients' food
- Relations between doctors and nurses should improve
- Doctors' attendance is poor
- Administration staff should not lose their temper if patients cannot pay their admission fees
- Hospitals require more staff
- There should be more silence at night

**TABLE 2 CASUALTY PATIENTS' RESPONSES**

Questions posed	Percentage of patients making a certain value judgement							
	YES		NO		No Response			
1. Can you recall your admittance to the hospital?	YES	71.95%	NO	17.07%	No Response	10.98%		
2. Were you attended to immediately?	YES	62.20%	NO	36.58%	No Response	1.22%		
3. How did you experience your admittance?	Good	64.63%	Poor	21.96%	No Response	13.41%		
4. Did the nurses attend to you immediately?	YES	68.29%	NO	23.17%	No Response	8.54%		
5. Did you find the emergency facilities adequate?	YES	60.98%	NO	29.26%	No Response	9.76%		
6. How do you find your stay in hospital?	Good	37.80%	Fair	28.06%	Poor	17.07%	No Response	17.07%
7. Do you find the nurses efficiently trained?	YES	79.26%	NO	12.20%	No Response	8.54%		
8. Is your medicine administered punctually?	YES	67.07%	NO	21.95%	No Response	10.98%		
9. How are you being treated?	Good	59.76%	Fair	20.73%	Poor	4.88%	No Response	14.63%
10. How do you experience the attitude of -								
(a) Doctors?	Good	60.98%	Fair	15.85%	Poor	4.88%	No Response	18.29%
(b) Nurses?	Good	46.34%	Fair	26.83%	Poor	6.10%	No Response	20.73%
11. How would you rate the equipment in the hospital (e.g. X-Ray equipment)?	Modern	51.22%	Outdated	21.95%	No Response	26.83%		
12. Are clean linen and pyjamas provided?	YES	57.32%	NO	28.05%	No Response	14.63%		
13. What is your general impression of -								
(a) The hospital facilities?	Good	32.93%	Fair	34.15%	Poor	18.29%	No Response	14.63%
(b) The hospital staff?	Good	37.80%	Fair	39.03%	Poor	14.63%	No Response	8.54%
(c) The services rendered in the hospital?	Good	35.37%	Fair	32.93%	Poor	17.07%	No Response	14.63%

### Additional Remarks by Casualty Patients

- Nurses should not be impatient towards patients when they experience domestic or other problems

**TABLE 3: OUT-PATIENTS' RESPONSES**

Questions posed		Percentage of patients making a certain value judgement							
1	How did you experience your attendance as an out-patient?	Good	65.00%	Fair	12.50%	Poor	15.00%	No Response	7.50%
2	How were you treated during your admittance as an out-patient?	Good	66.67%	Fair	17.50%	Poor	12.50%	No Response	3.33%
3	Were you attended to immediately?	YES	47.50%	NO	45.00%	No Response	7.50%		
4	Was there a long delay before you were treated?	YES	62.50%	NO	30.83%	No Response	6.67%		
5	If yes, to what do you ascribe the long delay -								
	▪ Not enough staff?	YES	59.16%	NO	16.67%	No Response	24.17%		
	▪ Staff indifferent to their duties?	YES	40.83%	NO	36.67%	No Response	22.50%		
	▪ Inefficient administrative procedures?	YES	45.00%	NO	29.17%	No Response	25.83%		
6	How do you rate the waiting facilities?	Good	37.50%	Fair	24.17%	Poor	15.83%	No Response	22.50%
7	How do you experience the attitude of -								
	(a) Doctors?	Good	62.50%	Fair	18.33%	Poor	7.50%	No Response	11.67%
	(b) Nurses?	Good	67.50%	Fair	20.84%	Poor	5.83%	No Response	5.83%
8	What is your general impression of the services rendered in the hospital?	Good	49.17%	Fair	26.66%	Poor	17.50%	No Response	6.67%

**Additional Remarks by Out-Patients**

- More facilities should be provided, e.g. chairs, benches and waiting room space
- Reception should be improved - more efficient services are required
- The service at dispensaries should be improved - more staff is needed
- Information desks should be established to direct patients to facilities

## SECTION III: FACTORS BEHIND POOR CARE

This section of the report covers a complex web of factors which hospitals cited as reasons for their inability to render the level of health care that they would want. The Department concurred with the hospitals in many respects. The constraining factors, which are self-explanatory, are listed hereunder. They are explored in detail in items 4 – 14 of this report, as they contribute to or inhibit various aspects of patient care.

- Lack of equipment
- Inappropriate facilities
- Lack of medical officers
- Lack of nursing staff
- Low staff morale
- Lack of managerial training
- Budgetary constraints
- Lack of decentralisation
- Lack of incentives
- Poor information systems
- Inadequate support services, such as radiology, physiology, etc.

### 4 FINANCIAL CONSTRAINTS

#### 4.1 MANAGING THE BUDGET

The present financial (and service) problems of the Department must be seen in the context of its background. When the Department was constituted, it did not inherit a properly managed budgetary system. Every year since 1994, the Department has overspent its budget. But since the financial year 1996/97, overspending has been declining. In terms of the Public Finance Management Act of 1999, all government departments have a statutory obligation to prevent overspending on their budgets.

The Department's proposed budget for 1999/2000 is R5, 6 billion. In order to match expenditure to this budget, the Department will have to achieve a saving of between 5% and 6% (R300 million to R350 million) on existing spending patterns.

Much of the expenditure is "ring fenced" – to fulfil obligations in terms of existing contracts and payments to staff - and cannot be altered. There is therefore little "discretionary" spending.

All five hospitals reported financial limitations to be their biggest single constraint and the Commission noted intense frustration amongst staff at the financial limitations placed upon them. The Commission also observed a common understanding among all role-players that the health system is in real danger of collapse if it is too severely under-funded.

Several factors impacted on the Health Department's ability to properly manage its budget.

The budget allocation to the Province from national level is currently formula-based. It is the Commission's understanding that there is no input from the Province or the individual hospitals.

Decisions taken at national level which have budget implications are not always accompanied by an increase in grants to the provinces. Below are some examples of these "unfunded mandates":

- In 1994/95 free patient care was introduced for children under the age of 6 and for pregnant women. Its current financial impact is difficult to quantify
- In 1996/97 free primary health care was instituted. Its financial impact, is also difficult to quantify
- In 1996/97 rank and leg promotions for nurses were announced. The impact on the Gauteng health budget is about R270 million per annum.

The Commission has been informed that the Department is renegotiating the unfunded mandates.

The Commission has also noted the request by the Department for a national policy on the treatment of HIV/AIDS patients, including the establishment of step-down/hospice - type facilities.

Due to the financial constraints, the Department has taken several steps to curtail expenditure which reportedly had a severe impact on patient care. These are:

- A "moratorium" on post filling
- A decrease in capital spending on facilities
- A decrease in expenditure on equipment
- Savings on transport, medicines, cleaning agents and catering services.

The Department has taken steps to generate more revenue. These include:

- Improving the billing system
- Preparing to increase outdated tariffs
- Attempting to negotiate contracts with medical aid schemes
- Providing incentives for hospitals that achieve revenue targets.

Although the Department's strategy for the management of the budget has been discussed in detail with superintendents of hospitals, it appears that this vision has not been internalised by various hospitals. It is clear to the Commission that health care is compromised if much needed personnel cannot be appointed and equipment cannot be acquired in the short term.

The Commission has noted that the Department has implemented a system in terms of which hospitals will make inputs in future budget determinations. This replaces budget allocation on past expenditure and is necessary to address past imbalances.

It would be premature at this stage for the Commission to evaluate the strategies

adopted by the Department. It would also not be appropriate for the Commission to comment on the delay in the formulation and implementation of such strategies, as this would require a detailed historical analysis, including an analysis of changes in legislation.

### **Recommendation**

The Commission recommends that -

- the Department continue its efforts of improving revenue generation and that these be closely monitored;
- the Department pay specific attention to its communication strategy to hospital management, ensuring that relevant information reaches important role-players;
- hospitals introduce measures to prevent future overspending. The following are examples of such measures:
  - Creation of joint financial committees
  - Regular expenditure reports from all hospital departments
  - Establishment of cost centres; and
- regular forums be organised where superintendents and other appropriate members of hospital management can exchange ideas on budget management in a structured way and identify weaknesses in their practices.

## **4.2 SERVICE PLANNING AND EXPENDITURE**

Among the possible causes for the financial constraints are the following major factors:

- Insufficient budget. The decision on how much to expend on health-care services is a political one, which falls outside the Commission's terms of reference. It would however, appear that the budget is insufficient for current services and that policy will have to be developed to limit the level of health care services.
- Inappropriate levels of service. The remarks that follow are a short summary of a detailed plan presented to the Commission:
  - The strategic plan of the Department is to place greater emphasis on level 1 and level 2 patient care, and to place less emphasis on level 3 patient care. This can only be successful if a clear referral system is developed and implemented.
  - The intention is further to pool resources in certain specialities and to redeploy others to regional hospitals.

The nett effect of the strategic plan is to reduce the number of beds used for expensive high-level care on the assumption that much of that care could be provided at a lower level, provided that adequate expertise is available.

It would be inappropriate for the Commission to express views on the feasibility of the plan, as it is still subject to negotiation with role-players. It is, however, clear to the Commission that in an environment where the budget is fixed or static, a reorganisation of health-care services is inevitable. In stating this, the Commission has due appreciation for the fact that the medical faculties and the academic hospitals are national assets and that the expertise represented therein should be protected.

### **Recommendations**

The Commission believes that the issuing of affordable levels of public health care also needs to be taken up with the national Department of Health and the Department of State Expenditure. Until the matter of what the country is willing and able to afford in terms of health care is properly addressed, the objective of optimal, cost-effective health care delivery will be elusive.

The Commission recommends that:

- The Department should engage appropriately skilled people to assist with the process managing the changes involved in implementing its strategies. There are vested interests, which will be affected by the strategies, and it is vital that their co-operation is obtained.
- Additional funding be made available during the implementation of the Department's strategic plan for restructuring services.

### **4.3 WASTAGE AND LOSS OF RESOURCES**

Other issues which have a serious impact on the adequacy of financial allocations are -

- absenteeism, which is high and which has been exacerbated by the old system of Limited Private Practice for state doctors; and
- corruption, which manifests as petty pilfering and organised large-scale theft.

These issues are merely mentioned here because of their bearing on the adequacy of the budget.

In many ways the budgetary constraints are unfortunate as State Hospitals have to be accessible to all ill people at all times.

### **Recommendation**

The Commission strongly supports the Department's decision to abolish Limited Private Practice. In addition, the Commission recommends that appropriate measures be introduced to monitor availability of doctors when on duty.

## **5 STAFF BEHAVIOUR**

### **5.1 UNCARING ATTITUDES AND ABUSIVE BEHAVIOUR**

In all hospitals various categories and levels of professional staff were accused of uncaring behaviour. This included refusal to assist needy patients, arrogance, and intimidation, breaking of confidentiality and poor communication.

The medical condition of patients and treatment procedures are often not communicated to patients. Complaint mechanisms are not available to patients in many situations where poor or unacceptable care is alleged.

Incidences of intimidation and harassment of patients were reported. It seems that patients are harassed for simply making routine requests for assistance – for instance, asking for bedpans to relieve themselves.

Patients are also not encouraged to complain and where it is believed that a patient has complained or is likely to do so, the patient is sometimes intimidated by hospital staff.

Both nurses and doctors have been accused by patients of negligent and indolent behaviour when discharging their duties. Some procedures are performed without proper supervision.

It came to the attention of the Commission that relatives find plates of food placed next to patients who are most often critically ill and cannot feed themselves. Patients who have a problem with bathing themselves are sometimes left unbathed.

Relatives complain about being expected to bath, feed or otherwise assist hospitalised patients without the necessary support from hospital staff. The problem arises when this occurs as a result of a failure to perform by those employed specifically to perform such functions.

### **Recommendations**

The Commission recommends that:

- the Department and hospital managers implement the Code of Conduct for Public Servants and monitor adherence;
- the public service or professional bodies provide training on the Public Service Code of Conduct and various professional codes;
- health workers who do not abide by the Public Service Code or professional codes, or who are unwilling to give assistance to patients and render the services they are employed for, should be counselled and/or subjected to disciplinary measures;
- any staff member found to be intimidating or harassing patients or colleagues be

subjected to disciplinary measures;

- professional bodies be invited to assist in the monitoring of adherence to professional codes of conduct;
- patients be encouraged to understand their rights and responsibilities, as contained in the Service Charter; and
- various methods of communication between professional workers and patients be explored, stressing that information must always be conveyed in an empathetic and confidential manner.

## **5.2 CONDUCT OF SUPPORT STAFF**

Patients felt that the attitude displayed by support staff is uncooperative and evidence was cited in a number of areas.

### **5.2.1 CLEANLINESS OF HOSPITALS**

The state of hygiene in hospitals leaves much to be desired. Besides a lack of cleanliness due to the unavailability of linen, patients reiterated what the Commission observed: Hospitals are not adequately cleaned.

The Commission believes that hospital hygiene does not meet clinically required standards. Patients and nursing personnel complained that hospitals are generally dirty and, specifically, that toilets are not regularly cleaned.

Hospital staff ascribed this situation to the indolence displayed by cleaners.

All hospitals rated their cleaning services and the general cleanliness of hospitals only as fair. In addition to indolent behaviour, cleaning staff were said to be unwilling to heed to requests or instructions coming from people other than their direct supervisors.

Although these issues are discussed at management meetings, this turns out to have very little effect. On probing, the Commission was told that lower level supervisors often experience difficulty being firm with subordinates who are in many instances also their friends.

Another dimension of the hospital cleanliness that needs review, is the basic attitude of employees, patients and visitors towards cleanliness. There is sometimes the perception that one need not use dustbins, in order to create job opportunities for others!

If the littering problem is not addressed, cleaning staff will continue to feel overburdened and that they are fighting a losing battle – a perception which is already taking its toll on their morale.

## **Recommendations**

The Commission recommends that -

- the Department, in conjunction with hospitals, develop a tailor-made training course for these levels of supervisors to assist them in dealing with sometimes conflicting interpersonal roles; and
- hospitals should have ongoing awareness programmes calling on all stakeholders to work together towards creating an environment that they can be proud of. Such awareness programmes should establish a link between the escalating cost of cleaning services and other aspects of service that must be sacrificed to maintain cleanliness.

### **5.2.2 PORTERS**

All hospitals reported that their portering services left much to be desired. The main reasons cited were:

- The number of porters could not cope with the number of patients that had to be moved
- Hospitals sometimes occupied vast areas
- Porters displayed indolent behaviour
- Porters only reacted to requests from their direct supervisors
- There was a shortage of trolleys and wheelchairs.

It was also discovered that porters were not willing to take on work that was not specified in their Personnel Administration Standard and/or job descriptions or duty sheets. They cannot really be blamed for this.

However, nursing staff are more often than not obliged to take on porting work, especially in respect of the moving of corpses. This willingness by nurses is commendable, but nevertheless detracts from their primary nursing responsibilities.

## **Recommendations**

The Commission recommends that -

- the Department consult with trade unions in order to establish a mutual understanding of the prevalent constraints and to reach an agreement on a more flexible approach by porters;
- where porters are expected to perform work above the level at which they are remunerated, merit awards should be utilised as recognition – and this should be communicated to porters;
- more wheelchairs and trolleys should also be provided and included in

hospitals' equipment replacement programmes (discussed later in the report); and

- hospitals should consider issuing porters with beepers.

### **5.2.3 MESSENGER SERVICES**

Four hospitals rated their messenger services only as fair. The main causal factors cited were :

- A limited number of messengers have to react to many requests
- Messengers display indolent behaviour
- Messengers will only attend to matters brought to their attention by their direct supervisors
- Messengers are not adequately trained for their responsibilities
- Messengers are at times inaccessible whilst busy elsewhere on hospital premises.

As with both cleaners and porters, messengers do not like taking orders from all and sundry. This is understandable. It creates a feeling among these employees that they have limited standing in their organisations and that they are at the beck and call of everybody else.

### **Recommendation**

The Commission recommends as follows:

- Although it is impractical for all requests/instructions to flow via direct supervisors, hospital management need to clarify who should be entitled to make direct requests or give direct instructions to cleaners, porters and messengers. Hospitals would be well-advised to involve the unions and direct supervisors of each group in establishing such practical arrangements.
- It is also recommended that messengers be issued with beepers.

#### **5.2.4 SECURITY SERVICES**

All hospitals rated their security services as poor to fair. The causal factors were the following:

- A shortage of security staff relative to the size of the grounds and scope of security services
- Indolence
- A lack of commitment by security staff to bring corrupt behaviour to book
- Intimidation of security staff by organised syndicates, thugs or fellow employees
- A lack of adequate training
- Inadequate selection and security screening of applicants for security officer posts.

All the hospitals have fairly large grounds. Some have many gates, which cannot be secured properly with the present numbers of security staff. This situation obviously makes it easy for corrupt employees and even visitors to remove hospital equipment.

As there are only a few security staff on duty during any given shift, it is difficult for them to attend to unruly visitors or patient escorts (in some cases wielding guns or knives) who threaten and verbally abuse health workers. These occurrences illustrate the ineffectiveness of current hospital security services in preventing people from entering the hospitals' grounds with lethal weapons.

Patients also reported cases of assault to the Commission.

With an appropriate security system, hospitals would be able to curb and reduce incidences of theft, which runs into hundreds of thousands of rands and deal with the safety element that both staff and personnel complained about.

The Commission found that security in all the hospitals leave much to be desired and in some instances security staff members collude with staff and syndicates involved in criminal activities.

Although heads of security in many instances have practical solutions to a large number of security dilemmas at hospitals, it would appear that they are not being consulted regularly by hospital management. If this were done, hospital management would be able to act in an informed manner and be able to prioritise security measures.

#### **Recommendations**

The Commission recommends that -

- hospital management consult regularly with their heads of security and include them in management meetings in order to identify and co-manage security-related problems; and
- the outsourcing of security services to private security companies, whose staff are continually rotated in order to prevent them from being intimidated or drawn into crime syndicates, be investigated.

## **6 PATTERNS OF SERVICE USAGE**

### **6.1 PRIMARY HEALTH CARE**

According to four hospitals, the development of primary health care facilities has not reached fruition and hospitals are still under pressure from patients requiring primary level care.

According to the Department, there has been a considerable expansion of primary care facilities and a steady growth in people making use of such facilities.

However, it is clear that while the primary care strategy has not failed, it will only bring meaningful relief to the hospital system once it is fully functional. Hospitals still see too many patients who could have been assisted successfully at primary health care facilities. The following reasons are cited for this:

- A shortage of adequately trained staff at clinics and community health centres
- A shortage of correct medicine at clinics/community health centres
- Lack of patient confidence in the effectiveness of primary care facilities and a belief that hospitals render better services
- A lack of patient knowledge on how health care works
- A lack of comprehensive clinic facilities
- Inadequate co-ordination between clinics and hospitals
- Fragmented district health systems
- A lack of commitment to the district health policy by local authorities
- No involvement by community health committees in hospital affairs.

### **6.2 PATIENT NUMBERS AND BED OCCUPANCY**

All hospitals reported a steady growth in the size of the population they served, as a result of ever-growing informal settlements, natural population growth and the closing down of other hospitals and clinics in their catchment area.

However, this experience of increased patient loads is not apparent from recorded patient numbers. (See Table 5)

**TABLE 5: UTILISATION OF SELECTED HOSPITALS**

HOSPITAL	NO. OF IN-PATIENTS		NO. OF OUT-PATIENTS	
	1996/1997	1997/1998	1996/1997	1997/1998
Chris Hani Baragwanath	749741	642030	521628	536136
Natalspruit	253659	259727	682026	767933
Pretoria Academic	308789	306405	734441	742175
Sebokeng	270929	279311	164662	179899
Tembisa	232416	215147	192075	190729

Although overall patient numbers have dropped at certain hospitals, it needs to be recognised that certain departments in hospitals have actually experienced increases – notably in casualty, paediatrics and obstetrics and gynaecology.

It is possible that shortages of staff could have had the effect of giving the impression of a work overload without an actual growth in patient numbers.

**TABLE 6: BED OCCUPANCY RATES AT SELECTED HOSPITALS**

HOSPITAL	AVERAGE BED OCCUPANCY (%)
Chris Hani Baragwanath	47,5*
Natalspruit	87.8
Pretoria Academic	79.6
Sebokeng	79.8
Tembisa	72.8

\*The hospital reports that the average occupancy could be as high as 62%

### **6.3 TRAUMA**

All hospitals have indicated that preventable gunshot wounds, assaults, stabbings and motor vehicle accidents - in which intoxication played a major part - make up the bulk of trauma cases over weekends, putting the casualty departments of all the hospitals under strain.

## **6.4 FOREIGN PATIENTS**

All hospitals have reported that significant numbers of foreign patients were treated by them, contributing significantly to the strain on resources. The Commission was not able to cost this impact.

## **6.5 IMPACT OF HIV/AIDS ON HOSPITALS**

All hospitals indicated that patients with HIV/AIDS-related illnesses have an enormous impact on their ability to meet health-care needs. Hospitals estimated that at times as many as 60% of patients admitted to medical wards are HIV-positive or have AIDS. They occupy beds much longer than other patients do.

The considerable number of patients dying from AIDS has a negative psychological effect on all staff, who tend to use apathy as a defence mechanism and this affects their relationship with patients.

Three hospitals also reported difficulty coping with counselling demands related to HIV/AIDS and other terminal conditions as well as termination of pregnancy. The nursing staff responsible for such counselling themselves also require counselling to cope with the stress of their work, but do not currently receive such counselling.

## **6.6 REHABILITATIVE SERVICES**

Only two hospitals reported that their rehabilitative services were at a satisfactory level. Shortages were mainly experienced in respect of:

- Social workers
- Psychologists
- Physiotherapists
- Speech therapists
- Occupational therapists
- Orthotists/prothesitists.

This is in part attributable to a general under-supply of such staff in the labour market.

Rehabilitative services play an important part in the overall treatment of patients. With the acute shortages being experienced in respect of these categories of staff, important back-up treatment is being neglected, in many cases nullifying the work of expensive procedures like neuro-surgery.

As a result, many patients are lost to the labour market and become dependent on the State for welfare grants. It is important to realise the impact of this shortcoming in the health service on the Province as a whole. It would make financial sense to expend more on this area of health care in order to prevent an socio-economic burden being placed on the State welfare system.

Special mention should be made of the Rehabilitation Unit at Natalspruit Hospital, which deals with patients who have been paralysed and assists them to cope with their new situation. Depending on the nature of the injury and the patient's willpower and acceptance of the situation, the process takes four to six months.

The necessary psychological service to aid adjustment is not available. Furthermore, some of the patients require regular turning and repositioning. Because of staff shortages this physically taxing work is not always timeously done and some patients develop bedsores.

### **Recommendations**

The Commission recommends that -

- the Department engage the Gauteng Department of Transport on the issue of traffic-related accidents and their impact on casualty services;
- an inter-departmental task force be formed to investigate the prevention of trauma in the Province;
- hospitals ensure that health professionals dealing with AIDS patients and other emotionally taxing situations receive counselling;
- the Department use bursaries strategically to recruit trainees into the allied medical professions where there is a scarcity of personnel which impacts adversely on rehabilitation services; and
- The Department also prioritise the filling of vacant posts in rehabilitation services.