

# South African Human Rights Commission Public Enquiry

The South African Human Rights Commission (SAHRC) recently launched a public enquiry into the right to have access to health care services. The following is the submission to the SAHRC by Dr Thabo Rangaka on behalf of the South African Society of Psychiatrists (SASOP), in his capacity as President of SASOP. The submission was made on the 31st May 2007. The terms of reference for the inquiry can be found at: <http://www.info.gov.za/gazette/notices/2007/296111.pdf>

## 1. INTRODUCTION

- 1.1. My name is Thabo Rangaka. I am a South African registered with the Health Professions Council of South Africa as a Medical Practitioner since 1980, and as a Specialist Psychiatrist since 1990. I am presently working as a full time Principal Specialist Psychiatrist for the South African National Defence Force (SANDF) in the South African Military Health Services. I am the current President of the South African Society of Psychiatrists (SASOP), and founding Chairperson of Doctors for Human Rights: South Africa.
- 1.2. I make this presentation as President of the South African Society of Psychiatrists (SASOP).<sup>1</sup> This organisation is at one with SAMA and other Specialist Health Care Service Providers in welcoming the opportunity to discuss Barriers impeding access for patients to health care services.

## 2. OVERVIEW OF BARRIERS TO ACCESS

We view barriers to access in the following manner<sup>2</sup>:

- 2.1. PATIENT FACTORS
  - 2.1.1. A patient often presents with a Somatic complaint and trivialises the mood component.
  - 2.1.2. Concurrent medical illness often obscures psychiatric symptoms.
  - 2.1.3. Denial of psychiatric issues.
  - 2.1.4. Stigma and shame lead to fear of a mental health diagnosis or referral.
  - 2.1.5. The belief that psychiatric referral will lead to victimisation and abandonment by the Primary Care Physician.
  - 2.1.6. The belief that psychiatric illness is untreatable.
  - 2.1.7. The belief that psychiatric drugs are mind altering and or addictive.

- 2.1.8. The belief that treatment will be too expensive. Patients often are unaware of pharmaceutical company programs that help cover the cost of medications for indigent patients.
- 2.2. PHYSICIAN (Health Care Provider - HCP) FACTORS
  - 2.2.1. HCP with a negative attitude to psychiatry. Unfortunately, the majority of patient factors tabulated above apply to Health Care Providers with little or no Psychiatric training!
  - 2.2.2. Often there is a lack of time to make an accurate diagnosis and referral during a consultation.
  - 2.2.3. Fear of being embarrassed and inadvertently stigmatising a patient.
  - 2.2.4. Uncertainty about when and how to make an appropriate referral for psychiatric services.
  - 2.2.5. Fear that the patient will have an illness that is unresponsive to treatment.
  - 2.2.6. The HCP may have had prior negative experiences in which psychiatric consultants were seen as unavailable, unresponsive or uncommunicative.
  - 2.2.7. A lack of knowledge about the appropriate diagnosis, drugs and duration of treatment.
- 2.3. HEALTH CARE SYSTEM FACTORS
  - 2.3.1. The political heads of national, provincial and local health care services, as well the facility managers and CEOs, the majority of whom have had no clinical health care training, are motivated and even incentivised to save money. They then withhold access for patients to appropriate care and alleviation of suffering.
  - 2.3.2. Psychiatric resources may be insufficient or unavailable.
  - 2.3.3. Private sector heads of Medical Aid Insurance Schemes may "carve out" mental health care coverage and refer all psychiatric patients in their scheme to the public health care sector. They then save millions for their CEOs and share holders.
  - 2.3.4. The Mental Health Care Act policy to, "Integrate the provision of mental health care, treatment and rehabilitation services into the general health services environment," causes psychiatric patients to disappear from clinics as they seek alternative care in "Diagelo –

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informal Chronic Health Care Facilities."

- 2.3.5. Reluctance on the part of officialdom to embrace HCP Professional Associations and Non Profit Community Based Organisations as comrades and collaborators in the war on illness, retards the growth of national health care, frustrates HCPs and represents a major obstacle for access to patient care.

### 3. CONSTITUTIONAL BACKGROUND

- 3.1. The preamble to the supreme law, the Constitution of the Republic of South Africa, 1996<sup>3</sup>, seeks to:
- 3.1.1. "Improve the quality of life of all citizens and free the potential of each person;"
- 3.2. Chapter 2: Bill of Rights<sup>4</sup> says that, everyone has inherent dignity and the right to have their dignity respected and protected.

### 4. ROADS AND TRANSPORT: A BARRIER TO HEALTHCARE

- 4.1. If we proceed to page 11 we find reference to the ENVIRONMENT (section 24): in this area, (a) says everyone has the right to an environment that is not harmful to their health or wellbeing. ROADS are a major part of the environment and a front runner in harming people because the roads are designed primarily for vehicles and not for cyclists and pedestrians.
- 4.2. Accepting that even the most committed motorists BECOME pedestrians when they have to alight - as they must at some point - from their fast and dangerous vehicles, we urge the Transport and Roads Departments to ensure that every existing and planned road and bridge makes allowance for pedestrians and cyclists to travel with dignity and safety. Road Engineers must be held responsible for ensuring that no roads remain a cause of injury and death to cyclists and pedestrians. Perhaps the Road Accident fund should spend its energy and money ensuring that our roads are made safe, so that we will have fewer cyclist and pedestrian casualties.
- 4.3. We propose that the HRC approach the constitutional courts to include a Right to:
- 4.3.1. Safe pedestrian and cycle paths along all existing and planned roads to protect the road-users from the harassment and trauma caused by motor vehicles.
- 4.3.2. A reliable, sustainable, regular, affordable, safe, dignified state-sponsored public transport reticulation of trains to promote access to the amenities provided to improve the quality of life of citizens.
- 4.3.3. Traffic jams, journey delays, uncertain, unreliable, scarce, costly and unsafe privately run mass-transportation systems affect citizens, especially the indigent in a catastrophic way. Such services show little respect for and protection of the dignity of commuters.

### 5. ACCESSIBLE PUBLIC HEALTHCARE FACILITIES

- 5.1. Section 27. (1) (a) "Everyone has the right to have access to health care services, including reproductive healthcare;"
- 5.2. 27. (2) "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights."
- 5.3. Regrettably, access to Healthcare Facilities is limited by

distance, unavailability of state-sponsored transport to the facilities, expensive and unreliable privately run mass-transport services, and also by other factors. These include;

- 5.3.1. Under-staffed clinics and hospitals often with a dearth of resources and medicines. This causes marginalised and underprivileged citizens to seek alternative health care solutions which are untested, unregulated and wont to blame the victim for any and all adverse events.
- 5.3.2. Enterprising and public spirited people often set up Non Profit Organisations to ensure access for hapless patients to health care services. A case in point is the Bureau For Prevention of Blindness. In their "Right to Sight" project, the Bureau reaches many blind people, mostly in remote rural areas of South Africa to do cataract operations and restore sight to many in a most cost effective manner. Such NGOs deserve maximal financial and moral support from the Department of Health. I dare say all Medical and Surgical Specialty Professional organisations have and support NGOs that are making a major difference in promoting access for patients to healthcare especially in far flung areas of South Africa.

### 6. DIMINISHING TRAINING OF SPECIALISTS

- 6.1. Training centres depend on the availability of Experts and Professors to train the incumbents of registrar posts. South Africa still has the capability to train specialists and super-specialists in every field of medicine and health care. Lamentably, many registrar posts in most academic training institutions are frozen and forgotten. Even rural hospitals with a crying need for specialists freeze their posts, save money for their CEOs and expect poor indigent patients to seek help in far away city hospitals. This practice is myopic and sabotages national health care.
- 6.2. If the registrar posts are unfrozen and increased and the appropriate equipment made available for their work, the country will have an increase in competent experts to train Health Care Providers and improve access for patients to quality health care. Retired professors who love teaching and researching will then be attracted to give their services and improve the culture of excellence in healthcare.

### 7. ACCESS TO MENTAL HEALTH CARE

- 7.1. The Mental Health Care Act, Act.No.17, 2002, notes in the preamble:
- 7.1.1. "Recognising that health is a state of physical, mental and social well-being and that mental health services should be provided as part of primary, secondary and tertiary health services;"
- 7.1.2. "Further recognising that there is a need to promote the provision of mental health care services in a manner which promotes the maximum mental well-being of users of mental health care services and communities in which they reside;"
- 7.2. The objects of the MHCA are to –
- 7.2.1. "Regulate the mental health care in a manner that makes the best possible mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental

- health care users within the limits of the available resources;
- 7.2.2. Co-ordinate access to mental health care, treatment and rehabilitation services to various categories of mental health care users;
- 7.2.3. Integrate the provision of mental health care, treatment and rehabilitation services into the general health services environment;"
- 7.3. In spite of all the lofty ideals outlined in the constitution, mental health problems continue to be a great source of distress, impaired productivity and diminished quality of life for a significant number of people and families in South Africa and in most of Africa.
- 7.3.1. The epidemiology of most psychiatric disorders in South Africa is similar to that found in developed countries. However the process of rapid urbanization is resulting in fast degradation of environmental and social resources bringing in its wake unemployment, illiteracy, malnutrition, violence, substance abuse, HIV and AIDS and a destruction of traditional social support networks and institutions. This has resulted in an increase in the prevalence of serious psychiatric illnesses.
- 7.4. The White paper for the transformation of health (White paper for the transformation of health in S.A., 1997) proposed a comprehensive, planned and coordinated community based mental health service at national, provincial, district and community levels.
- 7.5. The Mental Health Care Act {MHCA} (Mental Health Care Act of 2002) required that mental health services improve through a primary health care approach with an emphasis on community care. It stipulated that the best possible mental health care, treatment and rehabilitation services which are equitable to the population, efficient and in the best interest of mental health care users be made available. Finally, one of the strategic objectives of the Department of Health (Strategic objective of the Department of Health) is to promote mental well-being and improve early diagnosis, treatment and support of people with mental illness in a community based setting.
- 7.6. As a result of these policies there have been measures to promote mental wellbeing and attempts to prevent mental illness. However, there have not been sufficient efforts to improve the services for serious psychiatric disorders in that PSYCHIATRIC SERVICES are generally deteriorating, and Community Psychiatry has been dismantled.
- 7.7. The intention to, "integrate the provision of mental health care, treatment and rehabilitation services into the general health services environment;" whilst well meaning, has had the unintended effect of disbanding COMPREHENSIVE COMMUNITY PSYCHIATRIC SERVICES TEAMS which comprised the Community Support Worker, Psychiatric Professional Nurse, Psychiatric Social Worker, Clinical Psychologist, Occupational Therapist and Psychiatrist. These teams were able to treat the ailments of the Psychiatric patients in an inclusive, non-stigmatizing and affirming way, within the community and often at the homes of the patients, unlike what is now happening in the general health services environment, geared as it is toward curative services, with little primary and secondary preventative capability, and certainly with no inclination to

accommodate psychiatric patients – especially the chronically impaired ones.

- 7.8. Psychiatric patients are thus neglected and exposed to abuse at the village level and at regional and even provincial health facility levels.

## 8. ACCESS TO MENTAL HEALTH CARE IN THE MILITARY AND PRISONS

- 8.1. The Mental Health Care Act requires that the "minister issues authorisation and licensing of health establishments administered under the auspices of State, a non-governmental organisation or private body providing mental health care, treatment and rehabilitation services, and conditions to be attached to such authorisation or licence".
- 8.2. South African Military Healthcare Services Hospitals (SAMHS) are not yet authorised and licensed to provide Mental Health Care, treatment and rehabilitation. The effect of this is that the SAMHS functions outside of the MHCA, or it does not give adequate access to healthcare to its Clients.
- 8.3. Health services in the Defence force as well as Correctional services are outside of the scope of the National Health Act (public health system).<sup>5</sup> They are not governed through the National Health Act, but by either the Correctional Services Act or the Defence Act.
- 8.3.1. This means that there are THREE health care services, and possibly three Director Generals of the services in South Africa.
- 8.3.2. The South African National Defence Force and the Correctional Services Department duplicate health care services instead of collaborating and liaising with and reinforcing those provided by the Department of Health, Public Health Care Services.
- 8.3.3. The ideal situation would be that the SAMHS, given its synergy with the other arms of the South African National Defence Force, should provide Health Services to its clients namely (The employees of the SANDF, the dependents of these employees and other people deemed deserving of the services of the SAMHS), and to rural, inaccessible and other areas of South Africa which are poorly served by the National Department of Health.
- 8.3.4. SAMHS is best placed to provide services to Refugee and Illegal Immigrant Populations along the borders of South Africa and in informal settlements within conurbations that the Department of Health cannot access.
- 8.4. The other ideal function of SAMHS would be to serve as an alternative or Reserve National Health Care Service to run the Public Health Care Services in times of national disruptions and crises, and to provide emergency services to Neighbouring Countries in health care crises and catastrophes.

## 9. SASOP RECOMMENDATIONS TO PROMOTE ACCESS TO HEALTHCARE

- We, the members of the South African Society of Psychiatrists, would like to bring to the attention to the Commission some of our concerns with regards to Psychiatric Services in the South Africa:
- 9.1. *Availability:* There is a distinct scarcity in a number of hospitals, clinics and other health-related facilities, of

- trained medical and professional personnel.
- 9.1.1. This situation can be corrected by the DoH and other Public Health Care Providers seeking the collaboration of professional organisations such as SAMA, SASOP, OSSA, Nurses Associations to partner them in providing services at such facilities. The Public Health Care Provider must in turn un-freeze posts and provide the requisite equipment and consumables (such as drugs and Ophthalmologic and Orthopaedic ones), for the organisations to function efficiently for the benefit of the patient.
  - 9.1.2. In most of the provinces specialised psychiatric services are restricted to academic and Psychiatric hospitals. The number of staff is well below the acceptable standard minimum norms for the services. The number of inpatient beds are also well below the norms for the population.
  - 9.1.3. This state of affairs causes patients and their care-givers to seek help in urban tertiary institutions rather than in peripheral, smaller facilities in their village or location. Community based care is thus made impossible.
  - 9.2. *Accessibility:* The limited facilities, goods and services are not geographically accessible to this marginalised group of mentally ill persons. Ill patients often have to be accompanied by at least one care-giver.
  - 9.2.1. This makes travelling prohibitively expensive for the mentally impaired patient, possibly not yet receiving the Disability Grant.
  - 9.2.2. Whilst state-sponsored trains and mono-rails are being built, we believe it is the constitutional duty of the Public Health Care Provider and the DoH to ferry patients and their care givers between their homes and the health care facilities.
  - 9.3. *Acceptability:* The facilities, goods and services are not sufficiently respectful of the dignity of the health care users and medical ethics, not sensitive to age and gender requirements, nor designed to respect confidentiality and improve the mental health status of those concerned.
  - 9.3.1. Mentally ill in-patients are mostly treated in wards that are:
    - 9.3.1.1. not conducive to care,
    - 9.3.1.2. are closed facilities that restrict movement,
    - 9.3.1.3. do not separate sexes and age groups,
    - 9.3.1.4. voluntary and involuntary patients are inappropriately lumped together,
    - 9.3.1.5. lack adequate seclusion facilities for aggressive patients.
  - 9.4. *Affordability* – clearly, the indigent and impecunious are doomed to be given with the left hand. The rich who can afford a platinum GEMS card will receive five star accommodation and possibly professorial quality services.
  - 9.4.1. Another side to affordability is the weapon used by the Public Health Care Provider, saying that a given consumable, deemed best clinical practice care for a patient, is too expensive. If the client was a GEMS card holder, he or she would most probably have been given the consumable. Sometimes, the public hospital CEO should be asked to donate such a consumable to the patient for at least a month from his or her generous bonus!
  - 9.5. *Sustainability:* Community Based psychiatric services are eminently sustainable because the care givers and the patient are trained to take ownership of the care of the patient. Taking away facilities and services from

communities in rural, inaccessible localities creates cripples, terminates access to science-based health care.

- 9.5.1. Traditional Health Practitioners are community and family based; their service, whatever its evidence and science base, is available and sustainable - for as long as the practitioner lives of course!
- 9.5.2. We think the best way for air-conditioned office based Public Health Care Administrators to view Community Psychiatry is for them to go and spend a month in a village such as Hlabisa, Pitsi-di-sule-jang or Derdepoot. They will then formulate policies and regulations appropriate for the care of the most indigent and marginalised. Richer people would then augment that basal level of care as their purses allowed.
- 9.6. *Quality:* The Mental Health Care act requires "care, treatment and rehabilitation services which are equitable to the population, efficient and in the best interest of mental health care users."
- 9.6.1. Most Public Health Care facilities are not scientifically and medically appropriate and of good quality. These, mind you, serve the great majority of voters in South Africa.

Although we have not specified the problems as they exist from facility to facility, it would not be wrong to generalise and to state that these circumstances exist at most facilities throughout the country.

These issues have been raised at various levels in the Department of Health and in numerous Commissions of Enquiry, with assurances that the problems would be addressed.

However, psychiatric services appear to be of the lowest priority compared to medical, surgical and other disciplines. Most of the funds are directed towards improving these other services.

We consider this to be an unfortunate choice by the DoH given that more than 40% of the population in South Africa have mental disorder and substance abuse, and that significant numbers of people with Medical illnesses have an associated mental illness such as anxiety and depression confounding their care. Adherence by people living with HIV and AIDS and other chronic medical disease to their prescribed treatment is unlikely to occur unless their psychiatric ailments are addressed by a psychiatrist or psychiatric nurse.

## CONCLUSION

The Constitution of South Africa and the motto to provide A BETTER LIFE FOR ALL, guarantee optimal access for all to good quality Health Care. It is for us, the Public Health Care Providers and Health Care Practitioners to collaborate in creative ways to give South Africa the service she deserves.

SASOP is open to work with the director of Mental Health and Substance Abuse to implement the mental Health Care Act and improve access for all citizens.

## References

1. SASOP has a membership of more than 350 Psychiatrists, and is an interest group in the South African Medical Association. SAMA.
2. Stern TA et al. Massachusetts General Hospital guide to Primary Care Psychiatry. McGraw Hill, New York. 2004. p4-5.
3. The Constitution of the Republic of South Africa, Act 108 of 1996
4. Ibid pages 6 to 24
5. Sifiso Phakathi Director: Mental Health and Substance Abuse [mailto:phakao@health.gov.za]