

Operationalizing the Right to Health in South Africa: The role of the Patients Rights Charter

- Health and Human Rights Division, School of Public Health and Family Medicine, University of Cape Town
- Centre for Health Policy, Wits University

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Context

- Health is one of a panoply of socio-economic rights
- SA Constitution guarantees health rights
- Institutions to build culture of human rights
- Patient Rights Charter = opportunity to realize the right to health?

The Patients Rights Charter

- Access to health care
- A safe and healthy environment
- Part of decision-making
- To refuse treatment
- To a second opinion
- To continuity of care
- To complain about inadequate treatment
- Informed consent
- To choose health services
- To be treated by a named health care provider
- To knowledge about Medical Aid insurance
- To confidentiality and privacy
- Taking care of one's health
- Protecting the environment
- Respect rights of other patients and providers
- Take care of health records
- Provide information for diagnosis, treatment, rehabilitation and counseling
- Comply with treatment
- Obtain knowledge about local health services
- Ask about costs and make payment arrangements
- Not to abuse the health care system
- Advising health care providers with regard to his/her health

Context

- Health sector reform ongoing (White Paper)
- Previous studies of the Charter: poor knowledge, awareness, implementation
- Language, literacy
- TRC identified importance of patients' rights in its 1998 report

Objectives

- Literature review international experience
- Review current implementation
 - process of implementation
 - describe current monitoring tools
 - awareness, utilisation, attitudes amongst users and providers
 - identify obstacles
- Identify elements for implementation, including strategies & responsibilities
- Develop a Tool

Research Strategy

- Rapid Appraisal – National and Provincial Interviews with programme and other managers:
 - 27 interviews with national + 8 ex- 9 provinces
- Provincial Case Studies: W Cape and Limpopo
 - provider interviews (90 Limpopo and 73 W Cape)
 - facility observations (9+9 at 1^o, 2^o and 3^o levels)
 - user / community interviews
- Workshop with Dept of Health
- Develop tool / strategy

Findings I.

National Rapid Appraisal

Challenges

- National managers give direction but have little say at lower levels. Discordant responsibilities
- Constant conflation PRC with Batho Pele, etc (linked to poor understandings)
- Reliance on training – not always effective
- Legacy of lack of preparation on the ground
- Lack of monitoring mechanisms
- Broader H Rights culture both opportunity and threat

Ambivalence towards rights

- ‘...try to move away from that mentality to say it’s like, ... patients have rights, we (health workers) don’t have rights. And it’s not supposed to be like that. It’s like we are putting our patients above our health workers.’
- ‘...They (health workers) think we have given patients more power, you know like we say criminals have more rights than us law-abiding citizens. It’s the same thing.’

Negative views notwithstanding, the Charter could be used positively

- ‘... My feeling is that people are supportive of the idea of a patients’ rights charter. From a political point of view I think it’s the right time ...it will be something good for health to have it and I think that we would get support from people around the hospital if we really try to put it up everywhere and really make it an important aspect...’

Key Provincial differences

- Integrated versus dedicated delivery – earmarked (Pt rights coordinator) versus general personnel (health promotion trainer)
- Uneven implementation – e.g. urban-rural
- Very diverse methods for dealing with complaints: Boxes, Complaints officers, or facility manager, Helpdesk, etc.
- Training both specific and integrated
- Follow up of training very varied – cascade efforts unsuccessful
- Not all provinces reported detailed interactions with community structures; varied effectiveness

Obstacles

- Political will: “*no buy in from senior managers*” reflects lack of institutional commitment
- Some monitoring reflected lack of local buy in: planned and surprise visits by the MEC and HoD: some of the people in the facilities didn't even know about the visits
- Institutional support:
 - Time made available
 - Is it part of a job description?

Opportunities and Threats

- **Opportunity:**
 - **Access to resources and institutions**
 - **Generally heightened awareness and willingness to engage with human rights**
- **Threat**
 - **Overuse of rights**
 - **Inappropriate understandings of rights**
 - **→rights can be ‘cheapened’ or turned into vehicles for interests**

Findings II.

Provincial Case Studies

- Visible signs of output (posters, training) are important but cannot substitute for actual impact
- (add tables here)

Charter implementation W Cape: Observations

	Name tag		Complain		Material		C Partic	
	y	n	y	n	y	n	y	n
Tertiary	11	1		X		X	X	
Regional rural	6	0		X	X			X
District urban	9	0		X		X	X	
Clinic urban	1	4		X	X			X
Clinic rural	0	5	X		X			X
CHC urban	6	0	X		X		X	
CHC rural	5	2	X		X		X	
District rural	3	17	X		X		X	
Reg/distr urban	14	3	X		X		X	
TOTAL	55	32	5	4	7	2	6	3

Charter implementation Limpopo: Observations

	Rights	Lang	≤ A3	B/W	Resp	Lang	≤ A3	B/W
Hospital 1	Yes	E	all	Most	No	-		-
Hospital 2	Yes	E	All	No	Yes	E,P	All	All
Hospital 3	Yes	E,S,Z, Sh	some	N/a	Yes	E,S,Z, Sh	Some	n/a
Hospital 4	Yes	E,S,Ts	All	Few	Yes	E,S,Ts	All	n/a
Hospital 5	Yes	E,S	most	Most	Yes	E,S	All	n/a
Clinic 1	Yes	E,S,P	All	All	Yes	E,S	All	All
Clinic 2	Yes	E	some	Few	Yes	E	All	All
Clinic 3	Yes	E,S,Ts	All	??	Yes	E	All	n/a
Clinic 4	Yes	E	All	??	Yes	E	All	n/a
TOTAL	9/9	E9,S5,Z1,T s2,Sh1,P1			8/9	E8,S4,Z1, Sh1,P1		

PRC and H Service Mx

- Top-down decision making was perceived to greatly undermine trust
- Managers tended to be more willing to ignore obstacles whilst providers were more likely to voice concerns. Trust and safe spaces needed
- PRC needs well functioning management systems, able to manage change, learn from experiences, both positive and negative, and engage in problem-solving

Patient rights vs. provider rights

- ‘...I would say the modern rights of the patient are getting excessive particularly in the HIV world. One cannot move because there’s too much, the patient’s got too many rights. You can’t even do a test on him...’
- ‘...but many of the personnel have asked me where are their rights? The public come, the public shout obscenities at the nurses, swear at them, do you understand? Especially weekends when the trauma comes and many of the people are inebriated or (*have*) been in accidents. (*Some*) of the doctors are also shouted at, now they ask but where are their rights, you see?’
- ‘...I personally feel yes, we, ... I think it is more about respect for me, respect for you, and the respect goes a long way and I don’t know if it’s a general thing, but patients regard the work we do as, you get paid for it, you must come and do it and finished, and they owe us nothing. Not a ‘Thank you’, not anything. ... we have to respect other people’s rights and think about human rights, but what we get in return is actually minimal.

Using rights approaches

- ‘...I think it’s a very good tool. It makes you aware of what the patients’ rights are. It makes the patients aware of what his rights are and ...what his responsibilities are. It helps you as a provider to improve your service, to improve the quality of your service. In doing so, you are able to treat the patient better, ‘
- But:
 - Uncertainty in the context of h sector change
 - Challenges to provider’s power over users.
 - Exacerbates powerlessness and undermine authority of providers if HRM policies unsupportive
- Key misconceptions
 - HR = a framework of accountability for government obligations
 - HR = relevant to issues of vulnerability and power (users and providers)
 - HR ≠ solely individual entitlements.

Patients rights: challenges for management

- “Many staff are under pressure. The management is putting pressure on them. They are not working freely, because the management is putting a weight on the patient's rights, than on the workers' rights. Now they feel that they are working under pressure. If there is a small problem, it's them they blame. But never they can say 'no', this patient also did wrong. Most of the time it is the staff who's wrong.”
- “I'll also say to you I also don't have my rights. I can't provide you with your rights, whereas I also don't have my rights. It goes back to district. They also don't have their rights. Then it goes back to province. So let the province give us our rights also. We put them together with the patients' rights.”

Discussion

1. PRC as part of 'software' interventions: management styles, communication approaches, values and organizational culture because it addresses power relationships

- Impose PRC → exacerbate ***distrust***
- Recognise power issues → build ***trust*** → easier able to realise rights
- Vertical programme ignore management

Discussion

2. Rights are not just individual claims.

Rights also about values and organizational culture because they addresses power relationships

- Rights as individual claims → health worker as gatekeeper → conflict → ***distrust***
- Rights as collective obligation → recognises power issues → build ***trust*** → easier able to realise rights
- Vertical programmes ignore building collective vision

Recommendations: National leadership

- High level political leadership – allocate to an appropriate senior leader
- Different clusters must come together for planning implementation (e.g. Hospitals, Health Info, Eval & Research; District Dev; HR Dev)
- Adequate resourcing for the national Quality Assurance directorate to
- High level meetings with professional groups
- Pro-active communication strategy to identify and profile positive experiences of service delivery, commend high performers
- Move away from solely fault finding; complement disciplinary procedures, where appropriate, with processes of capacity building through learning from mistakes
- QA a standing item on National Health Council agenda
- Indicators around management processes and styles should be built into senior managers' performance contracts

Recommendations: National/provincial collaboration for implementation

- QA and PRC related objectives integrated within provincial strategic plans
- QA standing item on the agenda of senior management
- Regular imbizos to allow face to face engagement with health workers over their concerns
- QA and general managers work together to share positive experiences.
- Pro-active communication strategies to profile positive experiences of service delivery
- Provide additional support to less well-resourced areas or areas/facilities performing less well
- Relevant monitoring and evaluation systems that allow learning by doing, focusing on process as well as outputs, linked to user and community satisfaction surveys
- Strengthen community participation structures such as clinic committees and hospital boards to enable PRC implementation

Recommendations: Specific implementation actions

- New training materials to support non-individual, non-adversarial understanding of human rights
- Training materials to strengthen management that enables learning by doing
- Care for Caregivers programme to address the role of rights in supporting health workers
- Strengthen community participation structures and roles, capacity and resources to support PRC implementation
- Widen media engagement with communities on PRC
- Improve the quantity, quality and language appropriateness of materials.
- Review and strengthen training curriculae of health managers and undergraduate health care providers
- Include the PRC in the orientation and induction programmes for all newly appointed health workers