

## ‘Fix the damn system!’ – Johannesburg’s tertiary hospital doctors



National Health Minister, Dr Aaron Motsoaledi.

Picture: Chris Bateman

**Poor planning, incompetent budgeting and dysfunctional administration are killing patients, prolonging suffering and driving some specialists, who could otherwise deliver world-class medicine, to the point of resignation at Johannesburg’s two top hospitals.**

The frustration of doctors who try year in and year out to fight for the replacement or repair of vital equipment that would enable them to save and/or properly treat patients, often simmers just below boiling

point at Chris Hani Baragwanath (Bara) and Johannesburg hospitals. Administration is so bad that several junior doctors in new posts this year were simply ‘not captured’, resulting in their being unpaid at the end of January. The problem lies in a succession of what doctors cynically call ‘turnstile’ Health MECs, politically responsible only to their provincial premier (and not a sympathetic national health minister) and sometimes poorly qualified hospital CEOs financially in ransom to the notorious Gauteng Shared

Service Centre (GSSC). These straight-jacketed individuals, sometimes the target of misplaced health care-worker anger, do their best to fly under the political radar, often minimising problems.

Five senior clinicians in radiology and radiation oncology, surgery and cardiology, four of whom work mainly in Chris Hani Baragwanath but whose responsibilities cover both hospitals, painted a frightening picture of administrative dysfunctionality to *Izindaba*.

Chris Hani Baragwanath’s 3 000-bed complex sprawls across 173 acres in 430 buildings, making it the largest acute hospital in the world, but if you’re a stroke patient or suffer from anything that might require a CT scan, avoiding it is a potentially life-saving move (as at 11 February this year). *Izindaba* was told that its 9-year-old CT scanners were ‘broken more often than not’, that there were no echo machines, operating theatres lacked sufficient anaesthetic equipment while incubators and other monitoring gear remained in critically short supply. Old, leaky buildings mean some theatres have been flooding for almost a decade, terminal water damage to ventilators supporting high-tech equipment (i.e. historically some CT scanners and currently some air dryers in the neonatal unit), boilers don’t work, compressors malfunction and there are gas leaks – despite continual, ongoing and exhaustive written motivations by department heads.

According to Dr Richard Nethononda, a specialist cardiologist at Bara, the ‘bottom line’ was that the impasse was ‘impacting very badly on patient care – things are done late and some die while waiting. It also makes for prolonged hospital stays for patients’. He said an inpatient with a stroke can wait up to six weeks for a potentially life-saving scan while the waiting time for an outpatient is usually six months. (A CT scan is ‘normally’ done within a day or two to establish whether the patient has bleeding or a blood clot on the brain – each requiring vitally differing treatment. ‘If you treat a patient with a bleed with blood thinners you’ll kill them and you don’t want surgery when all the blood clot requires is thinning, so yes a CT scan is pretty vital’, Nethononda says dryly.)

## Multiple system failure – of organs of state

Conditions that would normally require relatively 'simple' procedures can quickly become complicated, unless your doctors get creative and 'wing it', as in borrowing an echo machine from Philips for use in the cardiology department. This single, tenuously acquired machine services patients from Gauteng, the North West Province, Mpumalanga and Limpopo, not to mention those from further afield. *Izindaba* learnt that a straight-forward 10-minute cardiac scan enabling referring doctors to treat their patients appropriately also requires booking 6 months in advance.



*Emergency rooms require efficient, modern equipment to help doctors save lives.*

The CEO of Bara, Ms Johanna More, told *Izindaba* that three new 64-slice CT scanners to replace the old (4-slice) ones were on order, 'promised to me by head office at the end of February, but I'll believe it when I see it'. They are destined for the 'new' radiology section that has been standing under-equipped for 18 months.

Dr Victor Ngomezulu, Academic Head of Radiology at Wits University, of which Bara is a training hospital, said only the new angiography (for sophisticated vascular interventions) and mammography suites were up and running while 'a few fluoroscopic machines' had been installed but were not yet commissioned. At the time of writing, the other general radiology rooms were barren of equipment for the other various modalities. The newly built section is intended for general X-ray, ultrasound, mammography, MRI and CT scanning equipment.

## Procurement ceiling paralyses Bara's CEO

More, a qualified nurse and manager, took exception to any implication of 'incompetence', saying her hands were tied by a R25 000 equipment procurement ceiling recently set by provincial head office.

'It's not only the GSSC; you have to ask why our own head office stopped us from procuring above R25 000 (from November last year)', she said. New austerity measures were introduced by Dr Kamy Chetty when she was appointed provincial Health Director-General last April, slashing the former pre-World Cup hospital procurement ceiling of R2 million. More said that since she began the job in 2009 (she was formerly Chief Director for Health Systems Support at provincial head office), she had managed, with the help of doctors on her procurement advisory committee, to 'repair or buy' a swathe of critical equipment. She challenged any clinician 'to say I can do what I'm doing better than I'm doing it', adding that it was standard practice to refer non-emergency patients requiring CT scans to nearby hospitals.

'Emergency CTs are all done here. Nobody can postpone a scan from January to September ... the managers inform us, and say, for example, we have 16 patients left for today and the scanner's packed up, so we send those non-emergency patients to Helen Joseph or Charlotte Maxeke hospitals.' She said that in addition to dire equipment shortages, 'you can't just wish away a flooding theatre, it's an integral part of the solution'. She was currently drafting a 'circular' to the health minister to hopefully address the intrinsic shortcomings.

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'I'm hands on. I understand and can establish systems, make them work and can push people to do what needs to be done,' she added testily.

## Radiation chief disillusioned

Dr Willie Vangu, head of Radiation Sciences at Wits University and clinical head at Bara (responsible for clinical services at Johannesburg General as well) was scathing in his assessment of management. 'Nobody wants to be responsible, or tell the truth. We had all the revitalisation under MEC Brian Hlongwane, then MEC Quedani Mahlangu came in – apparently she didn't want to sign off all these millions to ensure everything was in order. The whole process took more than a year and then finally in November last year she promised all the equipment would be delivered this August. Now she's gone, we have a new MEC and her procurement guy is saying they're not going to touch the millions!'

Vangu said the new provincial team was now questioning long-completed equipment tenders and their carefully compiled list of vital equipment. 'Personally I'm reaching the point where it's about time to leave, but I want to first give them yet another chance,' he added. He quantified the impact of broken CT scanners thus: 'We have 5 000 outpatients daily at Bara; you take just one per cent of them booked for daily CT scans (50 patients), imagine the implications when they're down – when taken together with inpatients, it's a disaster'. Johannesburg General Hospital scanned 100 or more patients a day and he questioned why equipment worth millions was being purchased 'when we can't even pay maintenance costs. The equipment is fine for the first two years under warranty but after that it's a shambles.' Vangu said it was unfair



*Professor Martin Veller, head of surgery at Witwatersrand University and Johannesburg Hospital's surgery Chief.*

*Picture: Chris Bateman*

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**No pay, no cure**

‘For example, the director of finance at Bara says OK the CT scan company must be paid so somebody can come and fix things – but he doesn’t have the key to the safe to pay – he must send the request to province. If they don’t pay, nothing is done.’ He called for an ‘*Indaba* at the highest level’ to solve what he saw as essentially a political/management impasse in which health MECs were subordinate not to the national health minister, but to the provincial premiers who appointed them.

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Dr Nethononda, who as Acting Chairperson of Bara’s doctors’ forum, met with Dr Aaron Motsoaledi on 27 January this year, agreed with Vangu, saying local management found themselves in a predicament. ‘On the one hand they can see the need for equipment and do indeed process and pass on orders for equipment to Province, but to no avail.’

‘The Province itself is disorganised, with poor or no proper budgeting and a complete lack of forward planning. Aggravating this is that procurement has to be done through the GSSC. He confirmed that some housemen and registrars were, at the time of the interview, unpaid for January. ‘It may

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be just a matter of time before the situation explodes,’ he added.

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‘What’s the point of the Occupation Specific Dispensation (systemic salary adjustments for public service health care workers) when you don’t give the doctors the tools to work with? Doctors are not interested in ordering equipment; they just want to come to the hospital and find things that work – somebody must provide that.’ *Izindaba* established that unless the national health department finds some legal tool to take back control of tertiary hospitals from the provinces, the national minister has only his powers of persuasion to remedy such situations.

**Easy solution – but a bureaucratic minefield**

Motsoaledi is known to have made efforts to unblock the overall vital equipment jam at Bara – which some insiders said could be done for less than R100 million – and to have promised to be up-front when money really is the problem. Asked about the systemic political conundrum, Nethononda said people without the pre-requisite management training were too often appointed to head Health, both within hospitals and provincial governments and ‘this is a large part of the problem’.

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Professor Martin Smith, head of surgery at Bara, said the scanners were ‘an index of frustration. We run the biggest trauma unit in the country. Modern trauma management principles require easy and fast access to CT scanning. Every discipline relies on this; it’s a core clinical support service. You can’t transfer all your patients to other hospitals – in fact on Monday (31 January) we had both scanners down. Who is taking



*Professor Martin Smith, head of surgery at Chris Hani Baragwanath Hospital.*

*Picture: Chris Bateman*

accountability for the delays and why are they only ordering stuff now?’ he asked. His counterpart at Johannesburg Hospital and head of surgery at Wits University, Professor Martin Veller, said Johannesburg Hospital was experiencing similar problems, citing the lack of equipment for a recent patient who needed a fast Urografin enema which resulted in far more invasive surgery than would otherwise have been required.

‘We haven’t been able to do a formal angiogram here (Johannesburg General) in five to six years – there’s an extremely remote subset of people who make many promises which they can’t keep,’ he added.

South African Medical Association (SAMA) Chairman, Dr Norman Mabasa, called on Dr Motsoaledi to intervene immediately and demanded he close down the dysfunctional GSSC and review procurement procedures. ‘This situation has not only affected the procurement of equipment, but we’re greatly disturbed by the mismanagement of the payroll system regarding the newly appointed doctors. That it took a whole month for people to realise this mistake is irresponsible and deplorable.’ Mabasa said the public was being put at unnecessary risk while it was ‘incomprehensible’ that such a premier hospital had been allowed to continue, unsupported and unequipped.

**National intervention imminent?**

The Auditor-General issued a disclaimer on the Gauteng Health Department’s financial

statements for 2009/10 after he was unable to verify the accuracy and authenticity of R19 billion in transactions. He said there were no clear financial systems in place as required by the Public Finance Management Act, which makes it far easier to disguise endemic corruption, theft and waste.

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Dr Chetty, who inherited a R800 million deficit when she took over as provincial health Director-General in April last year, said demands for equipment had to be

balanced against available resources while the primary health care system also needed financing.

She expressed 'concern at the frustrations of health professionals,' and promised to 'personally address these issues with them to ensure quality health care is delivered.' However, she insisted that equipment for hospitals was being prioritised. She said that over the past two financial years, central hospitals were a major contributor to the department overspending its budget, 'so we had to put in place cost containment measures to ensure rational use of resources and bring expenditure in line with budget in order not to compromise patient care.'

Over the past nine months the 'largest amount' of money for equipment had been spent on Chris Hani Bara, Charlotte Maxeke (also a tertiary hospital), 'as well as other central and regional hospitals. Charlotte Maxeke had received a newly equipped neonatal unit, Dr George Mukhari Hospital a fluoroscopy unit, four mobile X-rays, an ultrasound machine and one Bucky table while a cathlab was due for delivery there on 11 February and three more Bucky tables

before the end of this financial year. R110 million had been spent on equipment for Chris Hani Bara, including the two CT scans, digital fluoroscopy and Bucky units (none of which the clinicians spoken to had seen at the time of writing).

'We're committed to the latest technology in our hospitals but you must bear in mind that R20 million for one piece of high-tech equipment in one hospital could run a community health centre for a year,' Chetty said. She promised to provide greater detail on what equipment had been procured in her discussions with the hospital clinicians, insisting that she'd 'prefer not to debate this issue in the media.' A flurry of phone calls between Chetty and some of the clinicians quoted in this story ensued after she was given a final draft for comment, with one clinician later claiming moves were underway by the national health ministry to facilitate 'all the necessary equipment.'

'Your article may be belated, I think,' he warned.

**Chris Bateman**