



Service level drop 'inevitable'

Most senior specialists interviewed said it was 'too early' to say what the human cost of the eventual rationalisation would be, although several believed that a drop in service levels was inevitable. Lazarus doubted that the current rationalisation was sustainable, adding that in a decade's time, 'we'll be back to duplicated services'. 'Fundamentally what we've been fussing about is that there are very large numbers of ordinary people who are not critically ill but need help and care and will no longer get it in their environment,' he added. He and many of the other specialists rejected accusations from Bisho (the seat of the Eastern Cape government) that they were 'old guard and anti-transformation'. 'One cannot deny many of us have comfort zones, but that's not where we are coming from,' he emphasised. The oldest serving specialist, Dr Peter Swift (28 years in the Department of Medicine), and currently Head of Medicine for both hospitals, said transformation should not cause any harm to patients or 'be significantly for the worse'. 'It needs to be for the better and not be transformation for transformation's sake,' he said. Several longer serving specialists said that, on ethical grounds, they would have refused to participate in closing down entire departments in East London.

CEO vows to 'continue consulting'

The CEO of the East London Hospital Complex, Mr Derek Pryce, promised that every consultant/specialist involved would be thoroughly consulted and partnered with before any recommendation on the evolving plan was put to Bisho. Clinical Head of the complex, Dr Narad Pandey, based with Pryce at the new hospital administrative centre on East London's beachfront, said the rationalisation was aimed at creating 'optimum utilisation'. Both he and Pryce rejected claims of any current deterioration in health care quality or delivery and denied that there was inadequate transport to ferry patients to the requisite hospital. They pointed to a 'good public transport system operating in the Buffalo City region', as supplementing their transport arrangements. 'It's all working, but if you want to find a negative person, they will obviously tell you otherwise,' Pandey said.

Public 'happy and well informed'

He had not heard 'a single complaint from the public' or of any patient deaths or additional suffering. Pryce said the public had been informed through 'numerous press statements', newspaper advertisements and posters and pamphlets at all clinics and customer service points in the region. Bill boards were erected at entrances to both institutions while regular

'stakeholder' briefings took place. He admitted however that radio campaigns were needed for the illiterate. Of the specialists' complaints, Pandey said, 'In the South African system you'll still be talking to the beneficiaries of apartheid – and the system is not good for them – but as a community member or patient, I see this as very positive – I want what is right for society'.

Specialists see at least two alternative solutions. The first is to build a specialist level hospital between Frere and Cecilia near the N2 highway and turn the existing hospitals into level-one district general hospitals. However with hundreds of millions of rands of the health budget having gone into building the Nelson Mandela Academic Hospital at Umtata, this is probably a pipe dream.

The second is to turn one hospital into a primary specialist hospital and the other into a district general hospital, both with functionality at all three levels. Pryce acknowledged the need for a district hospital and said planning was underway for the completion of a day hospital in Mdantsane next year.

Current trends indicate that management may pay more attention to doctors as the plan meets harsh health care realities on the ground. 'Hearing one another has never been more important,' observed one veteran physician.

Chris Bateman

WORKPLACE-ACQUIRED HIV – IGNORANCE PERVASIVE



Dr Joe Shikwane, principal medical officer responsible for the Compensation Fund in the Department of Labour.

Only one of 158 known claims for occupational exposure to HIV over the past 25 years received a 100% permanent disability and a monthly pension from the South Africa's Department of Labour, it emerged last month. A second case in which the victim died has been settled with a monthly payout to the dependants.

January was the deadline for comment on a definitive set of HIV claims procedures but it was reliably learnt that the department was considering input from as recent as late February.

Officials are battling with dysfunctional and scattered data systems and the absence of a central data collection mechanism in order to track, budget for and appropriately address what is believed to be a seriously underestimated workplace problem.

Dr Joe Shikwane, the principal medical officer responsible for the Compensation Fund in the Department of Labour, admitted to *Izindaba* that there were 'no proper or reliable national statistics' on workplace-acquired HIV/AIDS.



'You may go from hospital to hospital, to their individual safety offices but there is no national reporting structure,' says Shikwane, adding that he had made strenuous but fruitless efforts to paint an overall national picture while studying for his diploma.

What he could tell *Izindaba* was that between 1987 and 2002, 158 HIV/AIDS cases were reported to the Compensation Commission for investigation. Data for the past 2 years were still being collated.

A full 101 cases (or 63%) had yet to be finalised 'because of incomplete information', and 11 (or 6.9%) had been repudiated on grounds of being non-work related. Of the 44 occupational exposures, 2 seroconverted and the rest either stayed HIV-negative or did not report having seroconverted.

The claims came from all sectors and included mortuary workers, police staffers, health care staff and emergency workers. The guidelines initially catered only for health care workers but this was soon adjusted to include all sectors.

Stigma bolsters ignorance

Shikwane said the full extent of workplace-acquired HIV may never be known because of stigma surrounding the disease, strict time-based exposure protocols, worker resistance to the 'hassle factor' of post-exposure procedures and inadequate reporting systems.

He made an urgent appeal for stakeholders to help the department develop an efficient national reporting system.

Professor Robin Wood, Director of the Desmond Tutu HIV Centre in Cape Town, said fragmented responsibility for dealing with workplace-acquired HIV was a major problem. 'For example, the infection control sister is often tasked with this function as part of her duties - people just don't know who to go to, so they get the run-around'.

Shikwane said it was the moral and ethical responsibility of every employer to designate a person to deal with HIV/AIDS in the workplace and, equally importantly, to let all staff

members know who this person was. 'Also, from the very first day interns (for example) arrive, they must be educated on workplace-acquired HIV and given the appropriate documentation,' he added.

The relevant government gazette published on 19 November 2004, entitled 'Draft circular instruction regarding the compensation for occupationally acquired HIV infection and AIDS,' would become official policy and added to the relevant 1993 Act.

Diagnostic criteria

Diagnostic criteria to qualify for a claim include: documented proof of a reported work-related incident/accident involving a potential HIV-infected source, laboratory blood test results of the affected employee within 72 hours of the incident (confirming the absence of HIV antibodies), confirmation that the source was HIV-infected 'as far as reasonably practicable' and confirmed laboratory results of seroconversion at 6 and/or 12 weeks or 6 months after the date of the incident.

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HIV impairment may only be assessed once 'no further improvement is anticipated' on currently available medical treatment.

Full (100%) impairment equates to clinical stage 4 AIDS and when HAART and other therapies are no longer anticipated to produce significant clinical improvement.

Wood said the existing gazetted guidelines seemed to omit a key component - that of compensation for the loss of life expectancy. 'It seems different to other areas of work-related compensation - perhaps a more generalised system for the assessment of



these complex disabilities is needed.'

Shikwane responded, 'You get 100% once the syndromic stage is reached and your medical bills are taken care of - it's immaterial whether you're working or not'.

He said the relevant act looked at the open labour market and was not 'job specific'.

In contrast to commercial insurance policies, Workman's Compensation payouts were linked to a claimant's salary.

Eligibility for benefits lapsed if there was no seroconversion beyond 6 months after the date of the incident. Payment for 'reasonable' temporary total disablement was capped at 24 months. Any confirmed diagnosis of occupationally acquired HIV infection equates to 15% of permanent disablement while confirmed diagnosis with AIDS and/or poor response to HAART will be considered permanent.

Wood said the use of ARVs once a person developed AIDS made the assessment of payouts 'pretty complex'. According to the gazette, medical aids will cover the diagnostic and treatment costs while the Compensation Commissioner will decide on the need for, the nature and sufficiency of the medical aid supplied.

Employers will be responsible for the immediate post-exposure prophylaxis costs and medical costs but can claim back from the Compensation Commissioner once (or if) liability of the claim has been accepted.

Employers or their health services must obtain Labour Court authorisation within 72 hours of exposure if they wish to test for an employee's HIV status, unless the test is voluntary and confidential. Shikwane said this was in order to comply with an Employment



Equity Act that prevented the unilateral testing of staff by employers.

'Employers need to clarify why they want to test for HIV. The Labour Court then rules on whether this is justifiable and authorises or refuses the test - in the best interests of the employee,' he added.

Dodging legal land mines

Shikwane said the issue of HIV/AIDS and Workman's Compensation was 'very sensitive and has been dragging on for a long time', mainly because of the legal hurdles.

The Compensation for Occupational Injuries and Diseases Act (1993) requires the employee to disclose their HIV status at the time of exposure and after seroconversion, in order to discharge the onus of proof. However, this is in obvious contravention of the right to privacy around HIV/AIDS contained in

common law and enshrined in the Constitution.

The Employment Equity Act (1998) prohibits the testing of employees for HIV, unless the Labour Court imposes special conditions on authorised testing.

'We were faced with the challenge of ensuring employees were compensated without contravening these other laws,' Shikwane said. He urged employers and employees to read the Labour Department's guidelines on technical assistance for managing HIV/AIDS in the workplace, calling it 'an essential management tool'.

The input from stakeholders would be incorporated in the policy by the Compensation Commission Board 'wherever it improves things', before the document was submitted to the Director General of the Department of Labour for approval. 'Then comes the

implementation phase with workshops to make people aware that such a policy exists,' he added.

Asked whether the Act covered sex workers, Shikwane said prostitution, while 'liberalised', remained illegal in South Africa. Brothels and/or individual sex workers therefore did not qualify for compulsory registration with the Compensation Commissioner and so could not claim.

However, should sex work be legitimised, employers might insist sex workers have HIV tests after applying to the labour court for exemption - on the grounds that this constituted 'fair and justifiable discrimination'.

Helpful website: www.labour.gov.za or contact Dr Shikwane on tel (012) 321-7115 or 082 499 7105, e-mail: joe.shikwane@labour.gov.za.

Chris Bateman

ASIAN TSUNAMI – A LESSON IN MISPLACED UBUNTU



Acehnese residents wade through a flooded street to higher ground a moment after the tsunami struck in the provincial capital of Banda Aceh, Aceh province.

Lack of overall public/private co-ordination, dismal joint disaster management planning and poorly developed resource data bases could severely embarrass South Africa should a tsunami-type disaster strike closer to home, the Asian catastrophe has revealed. A survey of top government and private sector managers by *Izindaba*

last month threw into sharp relief several debilitating capacity flaws - and revealed that a concerted bid to address them is being accelerated and adjusted since the devastating tsunami struck. The South African search, rescue and repatriation mission, led by top private sector companies and NGOs with a hastily assembled seven-person Foreign

Affairs team assisting, failed to give South African victims the benefit of an overall national plan. Most were left to rely largely on the good graces of the Thai and Indonesian governments for accommodation and transport, with some highly critical of the tracing capacity of South Africa's Foreign Affairs Department.

One senior government department manager, who declined to be named, admitted, 'in future we don't want to embarrass ourselves by not having systems like the Indonesians'.

One senior government department manager, who declined to be named, admitted 'in future we don't want to embarrass ourselves by not having systems like the Indonesians. Imagine if there's a sudden disaster in Africa - South Africa will be the first port of call'. By mid-February this year, the official Asian victim toll stood at 117 810 confirmed dead and 137 000 confirmed missing (read, 'probably dead'). With thousands of bodies washed out to sea