Medical Innovation Bill (Cannabis guidelines): briefing; National Health Laboratory Service Amendment Bill: NEHAWU briefing

Health

13 September 2017

Chairperson: Ms M Dunjwa (ANC)

Meeting Summary

The Director General of the Department of Health introduced the Medical Innovation Bill on Cannabis Guidelines. South Africa was a signatory to the 1961 Convention on the Control of Narcotic Substance and cannabis was highly controlled, but the Convention allowed for any country to utilise narcotics should there be a medical use for the substance. The Medical Innovation Bill on Cannabis would re-schedule cannabis in South Africa from a Schedule 7 prohibited substance, to Schedule 6 and Schedule 4, where the cannabis products did not have psychoactive properties, and could be prescribed by doctors. Guidelines on the cultivation of cannabis for medicinal and research purposes had been developed to provide operating procedures in order to regulate the availability and quality of cannabis for medicinal purposes. Although there was opposition to the move, medicinal cannabis could provide invaluable relief in cases such as the lack of appetite in HIV/AIDS patients and for cancer patients, where the cost of conventional medicine was often prohibitively high. The guidelines would ensure strict control of access to medicinal cannabis. The Department had to be very careful about regulating cannabis, as it was subject to abuse.

The DG clarified the difference between cannabis and hemp, and pointed out that hemp was easily grown in the country and had a multitude of uses -- from the making of paper to vehicle dashboards -- and could be economically highly beneficial to the country.

The Committee accepted that there were some fears about the introduction of medicinal cannabis and a lot of questions about combating fraud and illicit use, as well as the capacity of the Medicines Control Council to deal with the matter, but the Committee was comfortable with the legislation. There was a strong suggestion that there should be programmes to educate the youth, as Members were worried about the prevalence of drug abuse among young people and were concerned that young people would see the move as legitimising drug use.

The National Health and Allied Workers Union (NEHAWU) made a presentation on the proposed amendments to the National Health Laboratory Service Act, No. 37 of 2000. The Union had two concerns. Firstly, the original Act had allowed for a representative of organised labour on the Board. However, the composition of the Board had changed and labour no longer had a representative. NEHAWU requested that the current status be maintained. The Committee noted that provincial representation on the Board had also been amended and therefore decided to consider the matter when it met to deliberate the amendments. A second concern was the lack of a specific funding model in the Amendment. The union referred to the highly problematic current funding model, which often meant that employees at the National Health Laboratory Service were not paid timeously. The Department of Health indicated that it had begun a pilot programme to test a different funding model. The Committee agreed with NEHAWU that funding needed to be addressed and undertook to investigate the matter further.

Reports on site visits to health care facilities in the North-West, Free State and Gauteng were presented to the Committee for adoption. Issues raised in the site reports included the outsourcing of the ambulance service in North West, poor infrastructure and outsourcing of catering and security services in the Free State and the state auxiliary service for catering and laundry in Gauteng. The Committee, did, however, note some excellent examples of good leadership, management and highly efficient health care practices.

Meeting report

The Chairperson said the Department of Health (DoH) would be presenting an update on the Medicines Control Council (MCC) guidelines on medicinal cannabis, which would be presented to the MCC before the end of September for the Council's approval. Thereafter, the guidelines would be published. She thanked Mr N Singh (IFP) for his efforts in tabling the Bill.

Medical Innovation Bill (Cannabis Guidelines)

Ms Malebona Matsoso, Director General: DoH, introduced the Medical Innovation Bill on Cannabis Guidelines, saying that they would be presented to the Board of Heath. The guidelines were important in the process of introducing medicinal cannabis.

Mr Griffith Molewa, Deputy Director: Law Enforcement, DoH, explained that South Africa was a signatory to the 1961 Convention on the Control of Narcotic Substances. Cannabis was highly controlled, but the Convention allowed for any country to utilise narcotics should there be a medical use for the substance.

In November 2016, recommendations and requests had been made by the Medicines Control Council (MCC) in relation to the proposed legislation and guidelines. Those issues had been addressed in the latest version. Cannabis had been re-scheduled for medicinal use. It had been downscaled from Schedule 7 to Schedule 6, and cannabis products that did not have psychoactive properties had been downscaled to Schedule 4 and could be prescribed by doctors. Cannabis used on the street was still regarded as Schedule 7 and prohibited.

In June 2016, the MCC had created a sub-committee to take a look at cannabis and to develop a simplified legal framework so that people could understand and access the legal framework. The draft document had been published in March 2017 for public comments. The document presented to the Committee was the draft document that would be served before the Council at the end of September. After approval, the Bill would be gazetted. Other legislation ensured that cannabis could be used for research purpose.

Guidelines on the cultivation of cannabis for medicinal and research purposes had been developed to provide operating procedures relating to cultivation and manufacture, in order to regulate the availability of quality cannabis for medicinal purposes. The draft guidelines had been published in March 2017 for public comment and 402 comments were received and reviewed. Concerns included the possible access of unauthorised people to cannabis, although it could previously have been accessed under certain conditions, as it was a Schedule 7 medicine.

The International Narcotics Control Board (INCB) controlled the allocation of narcotics, and South Africa had made an application to increase the amount of cannabis that could be produced in South Africa. The question of how much to request was a delicate question, as if one asked for too much and did not use it, the INCB would apply limits to future applications. However, the Health Council was not entertaining the idea of making cannabis available for personal use, partially because a court case in that regard was in progress. Traditional healers, who had experienced exclusionary practices by the MCC, had expressed their concern regarding the proposed processes.

The legislation included Section 22c(1)(b), which regulated growing and production. Section 22A(9((a)(i) allowed for a person to acquire a permit from the Director General (DG) of the DoH to acquire, use, possess, manufacture and supply cannabis for the treatment or prevention of medical conditions, or for the purpose of education, analysis or research. Section 21 allowed access for patients where a clinical need existed, continued access to patients following clinical trials, and the opportunity to access cannabinoid medicine available in other countries. An application had been approved for the production of Bedrocan dried flowers for a patient in South Africa. Two applications to undertake research at universities had been granted. Other applications under Section 22 had been either had no substance or required further substantiation. The Department of Agriculture was looking at allowing hemp cultivation, but the MCC was not yet sure of the impact on the medical aspect.

Discussion

Dr P Maesela (ANC) commented that a lot of work had been done, and the Department was moving towards finding a holistic solution. If the use of cannabis was carefully directed and was not allowed to get out of hand, the sponsor of the Bill and the Department would have done people a good service. He had been worried when a person had been given permission by the courts to grow cannabis, but with the DoH everything was systematic and clear. The Members could find fault, but many questions had been pre-empted in the presentation.

Ms S Kopane (DA) wanted to find out if there were strict measures in place to ensure compliance. Was there vetting of applicants, as some people might abuse the opportunity? Would the MCC have restrictions on how many applications to grow cannabis would be approved? What had happened to the applications that had been rejected? Could applicants reapply?

Ms L James (DA) asked whether there were any plans to educate the youth, especially after the court ruling, as people thought that they could grow cannabis in their backyard. She was worried about the prevalence of drug abuse among young people.

Dr S Thembekwayo (EFF) wanted to know about the role of the Department of Agriculture, specifically regarding their capacity to monitor the growing of cannabis.

Mr Singh thanked everyone in the Committee, especially the ANC whip. He appreciated the public comment process. He agreed with Ms James that there was a need to educate the public. He asked the DG about the impact of the new approach to cannabis on the current legislation? Did the Act need to be changed? He was struggling to understand the sequence in Section 21. Could a prescription be filled at a pharmacy or did the doctor or patient have to get a Section 21 permit? Hemp products were currently being imported at a huge cost for the production of items. Why should it be imported when it could be grown in South Africa? Was it not going to become a money-making business for big industry? The Minister had spoken of the prohibitive cost of cancer treatments. Could ordinary people be given an opportunity to get involved in the business of growing cannabis? Traditional healers had to be considered. There had also been interest from around the world to set up research laboratories. He asked what was meant by 'specialist,' in that the treating physician had to be a 'specialist.' Specialists were not easy to access in the public health system.

Mr A Mahlalela (ANC) welcomed the process, especially considering that it had been a private Member's Bill. What was the DG's view about it becoming a DoH Bill? Should the Bill continue as it now stood? He would also be interested to hear from Mr Singh, who was sponsoring the Bill. Was the Bill even necessary, as the current laws allowed for any institute to do research using cannabis? Referring to the presentation, he asked about the capacity of the MCC to administer applications and monitoring. A Board should have already been established. How far was the process for the establishment of the Board, as the intention had been for the Board to supplement the capacity lacking in the MCC? In relation to the research with the Department of Agriculture, was there a timeframe, as it had been going on for more than ten years? Economically, the country was losing a lot in not producing hemp products. Was it not possible to accelerate the process? Where was the blockage? In relation to the capacity of the MCC, how long did it take it to process an application? Was there a timeline by which an application would be approved or disapproved? Research was a very broad term. Was it possible to categorise the research so that one could know more about the intended research?

DoH's response

The DG agreed that there had been considerable progress regarding the Bill. In response to Ms James, she said that the Central Drug Authority was a collaboration between the DoH and the Department of Social Development. However, the drug problem in the country was huge, so she believed that the country needed a different approach -- something more effective so that the Department could manage the scourge of drug abuse. She was not just talking about marijuana, but even nyaope, which contained a lot of things, including drugs used in anti-retro viral (ARV) treatment. The DoH was looking for other suitable medicines that could help them drive the HIV/AIDS program.

The DoH had worked with the Department of Agriculture, Forestry and Fisheries (DAFF), particularly regarding the implementation of the guidelines. In terms of the relationship of her Department with DAFF, however, she pointed out that the DoH worked directly with the Agricultural Research Council (ARC), which was engaged in much of the health research. She thought that a more robust system was necessary, and in talking to that she would be addressing some the questions raised by the Members.

She told Mr Singh that the process had been quite inclusive, and that the Department had received many comments. There had been a very interesting reaction to the court ruling about the use of marijuana, and some of the members of the public had major concerns about substance abuse, while others wanted much more liberal policies regarding access. There was a need for public education on the concerns about drug abuse, but those concerns had to be countered to permit access to the medicinal drug for those who needed it.

Historically, Section 21 of the Act had been specifically for use of an unregistered medicine, but it was also for the compassionate use of a product, as well as instances where one would like to conduct research. If one wanted to conduct clinical trials, one had to submit a protocol which was then the basis on which one could access an unregistered product in the country. That had evolved, but the Department was still mindful that industry might use it as an alternative route for registry products, and that would not be permitted. However, it should be used in such a way that people were able to conduct research. In cases of compassionate use, Section 21 should be used -- for example, where a patient would be able to access medicine for cancer at a low cost because there was no suitable registered product in the country, especially as cancer drugs were often prohibitively expensive.

The DG reminded the Committee that hemp and cannabis were not the same product, although they were from the same genus: genus *Cannabis* and species *Cannabaceae*. Because of lack of education and information, sometimes the words hemp and cannabis were used interchangeably, but that should not be the case. There was a difference, depending on the yield and the quantities of psychoactive cannabinoids in the plants. Hemp had significant economic and industrial uses, and a country could build the economy by producing a broad range of products. Hemp seed was

used for producing beer, flour and snacks. Hemp oil was used for salad dressing, for paint and for detergents. Hemp fibre produced paper and fabrics and automobile parts, such as dashboards, and ceiling boards. The Department of Agriculture, the Department of Science and Technology and the Department of Trade and Industry ought to consider the prospects for cultivating hemp and producing hemp products, and invest in that area. The Council for Agricultural Research had received many applications for the use of hemp to produce fabric, largely from the Eastern Cape. The DG said she had mentioned those applications because they could be of significant benefit to the country.

Different countries had defined cannabis differently. Canada had come up with a definition for cannabis *sativae* as having, or containing less than, 0.3% of Tetrahydrocannabinol (THC). In the USA, hemp was described as all parts of the plant. South Africa could come up with its own definition in the context of the international obligations to which it was subject.

In response to Mr Singh, Ms Matsoso said that the Medicines Control Council (MCC) regulated research if it contained a product controlled by the MCC, but the Medical Research Council and the Council for Agricultural Research should be driving the hemp-related research,as they were centres for research and innovation. The Minister of Science and Technology had called for a single body to manage funding research throughout the country. That was an opportunity for the hemp-related work to be promoted. She agreed that if the writing of a prescription for a medicinal cannabis product was limited to a specialist physician, it might be difficult in public health institutions. In public health settings, medicines had been controlled by getting a specialist to sign a statement, mainly to limit uncontrolled prescriptions. Mechanisms were necessary for the rational use of medicinal cannabis and that was the purpose of suggesting that a specialist should prescribe the cannabis medication. There should be a measure for monitoring the prescription of cannabis, but the Department would have to consider other mechanisms to do this, rather than finding a specialist to give the prescription.

In response to the question about whether the new legislation was necessary, she asserted that the new regulation was different from previous legislation which dealt with cannabis as a banned substance and was restrictive. The new legislation was not prohibitive, but facilitated access, as the schedule had been lowered. In her opinion, it was a positive move forward. It was opportunity not just for medicines, but for human use, for industrial application and offered potential for the country broadly.

The capacity of the MCC to work with research institutions was adequate, as medical researchers would engage with the regulatory agency and discuss their ideas for research well in advance of commencing any research, sharing plans for research even before research was done. Pre-clinical studies also required pre-discussion. These preparatory engagements should be regulated. The Board, as per the legislation, would be announced by the Minister. There had been 180 applications for the Board, but the Minister could appoint only 15 persons. The DoH had engaged with labour as to how the MCC would work in the future, and staff at the MCC had received letters in that regard.

Mr Molewa said that the Department had to be very careful about regulating cannabis, as it was subject to abuse. The MCC had to be very careful about to whom permits were given, as they were cautious about enhancing the drug problem. They did not want unintended consequences from the issuing of permits. They did not want people with legal permits producing cannabis for the streets and increasing the drug problem. The “how” part of issuing permits was still being determined. They were engaging with the South African Police Services (SAPS). When that was finalised, it would be put on the website. When an application was received, there would be a joint inspection between the Department and SAPS to look at all the issues, such as security, personal vetting etc. They were going to restrict the area for plantation. Applicants whose applications were rejected, would be informed of the reasons for rejection and they would be permitted to re-submit if they had undertaken to remedy the problems. There would be consultation and transparency. There would also be an appeals process via the MCC, the DG and the Minister.

The role of DAFF would be to advise the DoH on good agricultural practices and to verify the end product. They would be involved in the inspection process, as they understood the environment, but the DoH would inspect from a medical perspective. Pesticides were used in agriculture, and certain tests could be done to ensure that incorrect pesticides had not been used. Certain substances would be banned up front. Carcogenics, such as lead and mercury, could not be found in products to be used for human consumption, so the DoH would get advice from the DAFF as to which pesticides could not be used. It was necessary to have appropriate information, and also guidance regarding the best method of getting an appropriate yield. He agreed that the research process had been going on for a long time, but the final report had been submitted by the National Agricultural Marketing Council (NAMC) and DoH would be engaging them. The DoH had seen the benefits of hemp as a plant in South Africa, but it was not a controlled substance. They would have a consultative meeting with the DAFF and define the rules and responsibilities, and the DAFF could then go ahead with the cultivation of hemp.

He understood Mr Singh’s concerns about it becoming a money-making scheme. The Department was looking for quality products. The DoH would walk with a new producer until they were permitted to start producing, which was what the DoH did with anyone wanting to produce pharmaceutical products. Cannabis was a new product, and they would consider a person who met agricultural requirements. They would also consider people with start-up plans if they had

suitable agricultural knowledge and experience. The DoH would consider big companies but, firstly, they wanted to help small farmers. Big farmers might come into the picture when it came to the extraction of the oil, as the process was costly.

The Chairperson said she remained concerned about big farmers and how a monopoly could prevail. She asked how the process would be monitored to give up-and-coming farmers a chance. How were the huge fields of cannabis growing on the eastern side of the Eastern Cape going to be managed? She understood that it was not solely the responsibility of the Department of Health, and that other agencies would have to be involved, but how were they going to manage and monitor it?

The DG asked whether Members knew of the Department of Trade and Industry's (DTI's) policy to deal with patents, which was aimed at how best to improve access, and looking at intellectual copyrights and whether countries could develop their own generics. They had worked with the DTI, so a policy environment could be created. The DoH had assisted with some of the policy provisions. She did not see problems of monopoly, as the policy would promote access. What the DoH would have to look at very carefully was the policy of approvals, and there might be a need to look at restrictions. For example, if one applicant had 20 permits, that would block other producers, so the MCC would have to administer that process carefully and with clear standard operating procedures. Lawyers had informed the DoH that their clients had planted huge fields of cannabis in the Eastern Cape. They had to find out whether it was hemp or cannabis.

Mr Molewa said that the public would have to be educated about applying for a licence. The Department had to educate the public about how to acquire a permit. They would have to look at the Eastern Cape, Venda and Mpumalanga. The modalities still had to be determined. The country had to apply for permission to increase production of cannabis, but could not apply for a large amount from the INCB because it would be cut by the international body if the quantity was not used. On the other hand, they did not want an oversupply, so the request would have to be carefully calculated.

The Chairperson appreciated the presentation and the Committee felt more empowered. There were some fears, and a lot of questions about combating fraud etc, and about the capacity of the MCC to deal with the matter. However, the Committee was comfortable and she wanted to thank Mr Singh and the Whip for working together to navigate the Bill. Good things did not come easily, so it had taken a long time, but it was for the good of the country. She agreed that people had to be educated so that they understood that it was about health.

The next meeting was on 13 October, at which the Committee would pronounce on the legislation. Mr Singh indicated that he would consult with the Chairperson prior to the meeting.

National Health Laboratory Service Act: NEHAWU briefing

Mr Tengo Tengena, Policy Development Unit: National Health and Allied Workers Union (NEHAWU), said that NEHAWU fully supported the amendments to the National Health Laboratory Service Act, number 37 of 2000, but there were areas that they wished to highlight for the consideration of the Committee. They would be dealing with the proposed amendments of the legislation that would support the provision of diagnostic health services. Most importantly, the Bill did not speak about a funding model to bring about financial stability.

In terms of Section 7, the principal Act had allowed for a representative of labour on the Board. In the amendment to Section 7, there was no reference to a labour representative on the Board. There was also no explanation for the removal of labour from the Board, so NEHAWU requested that the current status be maintained, which meant that there would be a representative of labour on the Board. Section 8 was supported with the inclusion of a labour representative, as proposed in Section 7.

With reference to Section 13, the Bill had said that it would bring about financial stability, but did not say how it would be brought about. NEHAWU proposed that the funding model should have, at its core, funding allocated by Parliament directly to the National Health Laboratory Services (NHLS); fees rendered for services; fees received from foreign governments and private entities; and money received from any other source. In all other legislation, specific funding models were proposed, so NEHAWU believed that the funding model should be included in the legislation. It was necessary to have core funding from Parliament for the sustainability of the NHLS.

Discussion

Mr Mahlalela wanted to clarify the common understanding of the symbols used -- [ ] as deletions, and __ as new additions. He asked whether the labour representative on the Board had been deleted, as it was not mentioned as having been deleted. He assumed therefore that it remained as part of the Act. He realised that there was a problem in the section, as it was not shown as a deletion and was not included in the additions. He assumed that a labour representative would remain on the Board.

As far as the funding model proposed by NEHAWU was concerned, he asked whether it excluded the current funding model, where the bulk of the budget came from appropriations by Parliament through the Division of Revenue Act (DORA) to the provincial government, where the bulk of the service was delivered. Funds allocated through DORA had to be equitably distributed by the provinces. There were two types of appropriations: DORA-appropriated funds to the provinces, and the national allocations that were allocated to national departments. He wanted to understand exactly what NEHAWU was wanting. The Bill was classified as Section 76, as the service was provided largely to other levels of government, i.e. provincial and local authorities. Did they want the money to be appropriated directly, and then the provincial departments could send as many tests as they liked, as there would be no costs involved?

Mr Sidney Kgara, Head: Policy Development Unit, NEHAWU, suggested that if there were an opportunity to make an amendment, it should be taken. The Bill dealt mostly with governance, but the funding model was also a systemic problem. At the time of the passing of the Bill, NEHAWU had provided a critique of the type of institution designed to provide government services, but to stand alone and run along commercial lines, assuming that the fee-for-service model could be self-sustaining. The current situation was a result of that assumption. NEHAWU had assumed that, in amending the Act, the Department would have wanted to resolve the financial model. The union was not providing a comprehensive and scientifically guided solution, but was putting the matter on the table and making initial recommendations about the division of revenue. The union appreciated the constitutional context of the division of revenue. If provinces were currently financing, the laboratories could not be dependent on fees only, but also required direct funding by government as it was a national asset. It might require some adjustment of fees to provinces. If funding was allocated via DORA, provinces would struggle with the demands on the funds. Fees for services did not seem to be affecting the many, and seemingly unnecessary, requests for tests. It would be a missed opportunity if the amendments did not trigger a re-look at the funding model.

Mr Tshegofatso Moralo, Organisation Secretary: NEHAWU, said the union wanted a combination of the current model and the new model, i.e. the inclusion of baseline funding plus secondary funding through fees charged to the provinces to control the requests for diagnostic tests. The union knew that there were many funding crises. There should have been a greater analysis of the funding situation. Regarding the issue of the labour representative, he agreed with Mr Mahlalela that if the position remained, the union would be happy with it as labour had done much to resolve crises in the institutions. If it were an omission, they had wanted to highlight it.

The Chairperson asked what NEHAWU was saying in respect of the financial challenges. Had the Department not discussed the financial challenges with NEHAWU as a stakeholder?

Mr Tshegofatso said the point was that the NHLS would provide services, but not all provinces would pay the bills, and that crippled the institution. It had always been emphasised that NHLS was part of government. They wanted to know what had happened to the money allocated to the provinces when the NHLS had not been paid. They did not want thumb-sucking about money being shifted etc. NEHAWU wanted to know exactly what the reason was when there was no money in the provinces to pay for services rendered. It wanted an analysis of provincial spending to see where the money had gone. There were allegations that they were checking the billings of the NHLS, as there were claims that the NHLS had been over-billing. The union needed more information to develop the funding model more fully. Historic information would assist in that regard.

Dr Maesela asked if NEHAWU would be comfortable with the NHLS being declared an essential service. Would they be comfortable with the Minister appointing the chairperson of the Board?

Mr Tshegofatso responded that they were comfortable with the Minister making the appointment of the chairperson, as Parliament had oversight of the Minister's choice of appointee. They would not be happy with the NHLS being declared an essential service, as the NEHAWU believed that they were sufficiently responsible to manage the services provided.

Ms Matsoso said that when the NHLS Act came into force, KwaZulu-Natal had not been part of the model, as they did not agree with it. When they had become integrated, they had wanted to pay on capitation, but the Act required a service fee, so KZN had paid a capped amount that did not cover the number of tests undertaken. The oH had commissioned an investigation into an appropriate system of financing, and an audit of the NHLS. It was clear that the volume of tests was an issue. Certain tests were conducted at the primary health care level and certain tests at the hospital level. Certain tests accounted for a significant portion of the tests rendered -- approximately 80% of all the tests. The remaining 20% of the tests should be based on a fee-for-service model and the 80% should be based on a capitation model.

The DoH had approached National Treasury, and it was piloting the funding model as from September, but the current system was not a sustainable funding model. Health workers in the NHLS did not know whether they would be paid each month. The NHLS sold services to provinces, but if their estimate of the testing numbers was incorrect, it could not afford the additional tests. KwaZulu-Natal said that the province had owned the laboratories and so would not pay for services, and the NHLS had to pay rent. The NHLS was running at a loss. The model had been intended to spread laboratory services to former homelands, but the funding model had not been properly considered. The DoH had told

National Treasury that they needed front loading so that staff salaries could be funded. The response from National Treasury was that the Act did not allow it, hence the pilot. They were hoping that by the time the Act came into force, the pilot would have yielded results.

Dr Yogan Pillay, Deputy Director General, DoH, explained that the model was a capitated model. Since September, the NHLS had delivered a service bill and a capitation bill to show the province what it would cost for capitation funding, and the idea was to encourage provinces to manage the number of tests. The intention was to move to the capitation model. They thought that, given the complexities and the core funding that they believed should be funded separately, it would be appropriate to include a funding model in the regulations, which was why the regulations indicated that the Minister would determine the funding model. This would also mean that it would be possible to change the funding model without having to change the Act.

Adv Micro Moabelo, Director: Legal Services, DoH, said that Section 7 was amended by substitution of the original Section 7. There were too many amendments within Section 7 itself, so the better way of amending in terms of the drafting regulations was to substitute the section. In the original section, all provinces had had a representative on the Board, as did the SA Local Government Association (SALGA) and labour. In future, only three provinces would be members of the Board, and so six provinces had lost representation. There were three specialists or experts on the old Board. The number of specialist representatives had been increased to six, but six provinces, SALGA and labour had lost their seats. The Amendment did not have sub-section 2.

Mr Mahlalela suggested that the Committee needed to re-look at the membership, as three provinces could not fulfil the idea of provincial representation, as indicated in the Act. That was literally creating a problem. If the NSHC was to agree on the three names, those members would in no way be provincial representatives. They would also have to look into the funding model at some other level, as he did not see that the Bill addressed the point made by the DG and DDG regarding funding.

The Chairperson thanked NEHAWU, noting that the process had been for listening and asking questions of clarity, but not for deliberations.

Committee Oversight Reports

Three reports were to be considered: North-West, Free State and KwaZulu-Natal

The secretariat was requested to put hard copies of important documents in the pigeonholes of Members as a contingency plan.

Site visit to North West

Mr Mahlalela asked for full details of the ambulance situation in North West. There was a need to reflect the fact that the ambulances were privately supplied by a company called Buthelezi EMS. If there were complaints about ambulances, the community needed to know that it was not a state service. It should be reflected in the findings and the recommendations.

The Chairperson commented that the Committee had observed that the theatre staff was not trained. The Committee had raised the danger of that practice, and hospital management had been requested to ensure that only trained staff worked in theatres. That needed to be included in the report and in the findings.

Mr Mahlalela suggested that financial issues should be packaged together in a single paragraph and not collated into a single sentence. Going forward, it would be good to point bullets under headings so that the points were clear for easy reference. The Chairperson indicated that the report would be corrected.

Mr Mahlalela asked whether the Committee was going to take action regarding the privatisation of ambulances, as the service had been more efficient when rendered by the state. The state had to render ambulance services. The privatisation of several services were simply money-making enterprises, especially as they used government facilities. Contracts had to be terminated.

The Chairperson asked for comment on the ambulance proposal.

Ms C Ndaba (ANC) suggested the recommendation had to be specific, and ambulances had to belong to government. The Committee had to be very strict in regard to the state ambulance services. Also, kitchens should not be privatised. In the same hospital where the Committee had encountered bad smelling food in the kitchen, the private security had been inadequate. Kitchens should be taken over by the state, and proper security officials should be appointed by the state.

Dr Maesela said that the Committee had agreed that ambulances, catering and security had to be in-sourced. Outsourcing was milking the institutions dry. Where a hospital had no water, it should not be allowed to admit patients.

The Chairperson agreed that there needed to be recommendations in respect of in-sourcing and on staff training in respect of theatre nurses.

The adoption of the report, with amendments, was proposed by Mr Mahlalela and seconded by Ms Ndaba.

Site Visit to the Free State

The Chairperson suggested that all notes on infrastructure be clustered together.

Mr Mahlalela reminded the Committee that at Monapo Hospital, they had found that civil society structures had been raising exactly the same issues that the Committee had found, and were protesting outside the hospital during their visit. The issues relating to security services had to be included, as well as the lone maintenance person who was responsible for managing maintenance, although there had originally been seven maintenance staff.

Ms Ndaba said that there had been an issue about two generators were not working. The Committee had been so disgusted with Monapo Hospital, where all government equipment and facilities were used by a private catering company, that they would have closed it down if they could have. The Department of Labour had previously recommended that the hospital should be closed down. It was in a dire state.

The Chairperson made the point that they should also note the good things that they had observed. She referred to the hospital where everything was in-sourced and the good leadership and management had ensured that the hospital was functional and efficient, even though conditions were not ideal. She suggested that the Department of Labour be requested to provide a report on the hospitals.

Dr Maesela suggested that the Committee simply recommend a review of all hospitals and clinics in the Free State and that if they did not meet an acceptable standard, they should be closed down.

Ms Ndaba recommended that the good things had to be noted so that all was not doom and gloom. They could benchmark against the leadership, management and in-service training in places. The Committee had to raise a concern about the infrastructure of clinics, as grants were being given to provinces for clinics, but in the Free State, the Committee had found four-roomed buildings. Some of the infrastructure constituted a risk to staff and patients. Where things were wrong, the Committee had to say that they were wrong. The Committee could not cover up things that were wrong.

Mr Mahlalela commented that the report on the Phekolong Hospital in Bethlehem was very positive, as it was a fully public hospital and well-managed and should be used as a benchmark for the province. In the recommendations, he suggested that the report had to be re-structured under headings, and specifics needed to be included under the headings. He asked that the dire state of Monapo Hospital be highlighted and that they ask for updated reports on the hospital from the Department of Labour.

Mr Mahlalela proposed the adoption of the report and Ms James seconded the proposal.

Site Visit to Gauteng

One of the most noticeable issues in Gauteng was that hospitals in Garankuwa were used predominantly by foreign nationals. The kitchen in one of the Gauteng hospitals was very neat, food was professionally served, and the laundry was spotlessly clean.

Dr Maesela commented that the laundry and catering was provided by a separate state entity, Masakhane, which delivered meals to Tshwane hospitals. The staff at the hospital had complaints about some aspects of the service delivered by Masakhane which did not always meet the hospital needs. Not all of the laundry was returned, etc. The laundry was of a very poor standard. He mentioned the concern about a question of safety, and an assault had taken place at a hospital. The Committee had also found a problem with ward-based teams that did not report, as there was a conflict between the clinics and the head office in Gauteng, including Soshanguve. In one facility, files were lying around in the consulting room.

Ms Ndaba recalled the number of United States Aid for International Development (USAID) personnel working in clinics in Tshwane. The Committee had not been sure what they had been doing -- whether they were filling vacant posts and whether there was a service level agreement.

The Chairperson said that the matter had not been discussed with the MEC.

Mr Mahlalela pointed out that all issues had to be included in the report, regardless of whether the information had been shared with the MEC at the meeting during the visit. The facility was operating as a clinic instead of as a community hospital. It had to be reflected in the report.

Ms Ndaba recalled a concern about community health workers who had been indicated as present on paper, but they had not been there and the services were not being offered.

Ms James said that community health workers were not being absorbed.

Dr Maesela added that some people had been dismissed. Previously, there had been conflict as some had wanted to be paid through the Personnel Administration System (Persal) and not Smartpay. They had complained that Masakhane did not return laundry.

The Chairperson said that there were no findings in the report.

Mr Mahlalela noted an inconsistency between the reports. The report read as if, in the meeting with the MEC in Gauteng, the Committee had presented findings to the MEC, but that was not correct. The meeting with each MEC in each province had to be recorded. There had to be a section on findings in each report.

Ms Ndaba agreed that specific items discussed with the MEC should not be detailed.

Dr Maesela added that Masakhane had to improve service, as it was compromising service delivery. Security should be looked at as a matter of urgency. The challenge of the high number of foreign nationals was problematic.

Mr Mahlalela noted the issue of USAID, about which they required detailed terms of reference from the Department. In Pretoria, people were queueing outside with no shelter at a clinic where there was no space to wait inside the facility. A new clinic needed to be built, as it did not seem that there was space for expansion. The queue was unbearable. At one clinic in Pretoria, a doctor was not wearing appropriate clothing. The sister-in-charge had said that she had a problem with that doctor.

The Chairperson found it problematic that the municipality could give permission for the opening of a bottle store directly outside the clinic.

Dr Maesela proposed the adoption of the report, with amendments, and Ms Ndaba seconded the proposal.

Mr Mahlalela said that the reports would be ATC'd and presented to the House.

The Chairperson recommended that reports be presented and adopted immediately after a visit, as the Committee Members forgot what they had seen when they adopted the reports months after the visits. She also recommended an amendment to the way in which the site reports were written. There had to be consistency.

The meeting was adjourned.