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Alcohol addiction treatment in Cape Town: Exploratory investigation of the public-private mix

Laura Fleming

FLMLAU001

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Supervisor: Dr. Edina Sinanovic
Health Economics Unit

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DECLARATION

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Abstract

Public health and safety are compromised by the effects of alcohol addiction. Some of the consequences include transmission of infectious diseases, disproportionate use of medical and social services, traffic accidents, and street crimes. Additionally, when dealing with alcohol addiction, many expenses are incurred by public services such as the criminal justice system, emergency medical care centers, foster home placement centers, employee assistance programs and family violence centers. The clinical and economic benefits of addiction treatment are therefore clear.

The aim of this study was to investigate Cape Town's alcohol addiction treatment center public-private mix and to determine quality of care and access. Document review and semi-structured interviews were the methods used. Provider reporting on quality of care and the limited number of sites interviewed were the main research limitations. Nevertheless, the thesis reached its objectives and contributed to the limited information on alcohol addiction treatment public-private mix, quality of care and access in South Africa.

It is notable that there were few differences in the quality of care reported by public, public-private mix, private registered and private unregistered facilities. Quality of care was found to be good across sectors.

Public and public-private mix facilities provided superior access in terms of income. Private facilities had the shortest wait-time. Geographic access was a pronounced issue for the poor population that resides in the Southern suburbs, far from affordable primary care alcohol addiction treatment services. Both horizontal and vertical inequities were identified in terms of access to primary care alcohol addiction treatment services in the Cape Town metropole.

A strong case is made for involving more of the private sector in public-private partnerships in order to scale up alcohol addiction treatment within the South African setting. This will allow quality of care to be maintained while improving access.

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List of Abbreviations

CDA	Central Drug Authority
MNSITC	Minimum Norms and Standards for Inpatient Treatment Centers
PPP	Public Private Partnership
PCIAAT	Primary Care Inpatient Alcohol Addiction Treatment

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Chapter 1: Introduction

Problem

Alcohol addiction is a problem found in countries worldwide. The manufacture and sale of addictive substances including alcohol is a global business which has been studied extensively (Kimberly & McLellan, 2006). Academic researchers, investigative reporters and legal scholars have studied the alcohol industry's structure, organization and competitive dynamics. Conversely, little research has been conducted on the alcohol addiction treatment industry. As Kimberly & McLellan (2006) note in their paper, this gap is curious because the social and economic costs of alcohol addiction are enormous and there are now highly effective alcohol addiction treatment therapies available although they are not widely diffused.

Public Health & Safety

Public health and safety are compromised by the effects of alcohol addiction. Some of the consequences include transmission of infectious diseases, disproportionate use of medical and social services, traffic accidents, and street crimes (NAS-IOM, 2005). The World Health Organization estimates that 20-30% of worldwide oesophageal cancer, liver cancer, cirrhosis of the liver, homicide, epilepsy and motor vehicle accidents are caused by alcohol (WHO, 2008). They state that there is a causal relationship between alcohol consumption and more than 60 types of disease and injury (WHO, 2008). The result is that safety and quality of daily life are compromised.

South Africans, especially those living in urban areas, are concerned with crime. Alcohol and crime are difficult to separate. American research has shown that "...as much as 50% of all property crimes are committed under the influence of alcohol, drugs, or alcohol and drugs, or with the intent to obtain alcohol, drugs, or alcohol and drugs with the crime proceeds" (CASA, 2003). A 3-Metro's study found a South African association between alcohol and crime. Forty five percent of the 999 arrestees studied tested positive for drugs or alcohol, and a high proportion of these arrestees reported the need for alcohol or drug addiction treatment (Parry, Pluddemann, Louw & Leggett, 2004).

There is also a link between alcohol use and transport-related deaths and homicides. A recent survey revealed that 51% of homicides and 53% of transport-related deaths in Cape Town, and 40% and 47% respectively, of such deaths in Durban had links to alcohol use (CDA, 2005/6). However, research also has shown that incarceration

fails to solve these problems (Goldkamp, 2000; Inciardi, 2001).

Extreme use of alcohol leads to more sexual risk-taking such as multiple partners and not using a condom. This risk-taking is reflected in the percentage of HIV-positive people among problematic drinkers. At a large infectious disease clinic in Cape Town (2003), 20% of HIV patients met the criteria for an alcohol use disorder (CDA, 2005/6).

South Africa has paid a high price for alcohol use. In addition to individual costs regarding health and happiness, there is also the cost of public services when dealing with addicts including the health and welfare system, criminal justice system, emergency medical care centers, foster home placement centers, employee assistance programs and family violence centers (Cherpitel, 1994; Edelman, 2001; Field, Claasen, & O'Keefe, 2001; Morgenstern et al., 2001; Weisner, 1994). Within the health sector alone, direct and indirect costs resulting from alcohol use include alcohol addiction treatment, increased use of emergency services due to alcohol-related trauma, increased use of mental health services due to alcohol-related psychiatric problems, overuse of medical services due to alcohol-related medical complications, and specific disease costs such as Foetal Alcohol Syndrome, Hepatitis C, and HIV/Aids (Alterman, Langenbucher, & Morrisson, 2001; Best et al., 2002; Xie, Rehm, Single & Robson, 1999). Several US studies have illustrated inpatient alcohol treatment to be associated with long-term reductions in the use of health services, resulting in cost-savings (Holder & Schachtman, 1987; Humphreys & Moos, 1996). Costs of alcohol addiction within the criminal justice system include policing and prosecuting alcohol-related crimes, costs of incarcerating and rehabilitating the alcohol-related offenders and finally, the costs to the victims of crime (Alterman et al., 2001). Fletcher (1997) and Gossop et al. (2001) demonstrated cost-savings for the criminal justice sector resulting from alcohol addiction treatment. Alcohol use has been shown to be associated with lower productivity, increased absenteeism from work and tardiness, high employee turnover, and more frequent work-related accidents (Alterman et al, 2001). Thus alcohol addiction negatively affects many aspects of South African society, including the country's rate of economic development. The clinical and economic benefits of addiction treatment are therefore clear.

Due to the considerable morbidity and mortality caused by alcoholism, it would make sense for employers as well as federal, provincial and local governments to place a

high priority on addiction treatment. However, addiction treatment is often misunderstood and underappreciated, leading to the public's ambivalence regarding taxpayer financing and treatment expansion (French et al., 2006). "A potential reason for this disconnect between economic evidence and public opinion is a weak identification with the need for, or the success of, addiction treatment for those individuals without a substance abuse problem themselves or in members of their family" (French et al., 2006, p. 245).

Individuals struggle with problems in all spheres of their lives including job, family scholastic achievement, male-female relationships, money and the search for life's meaning. People use terms such as 'anger', 'frustration', 'confusion', 'repression', 'unmotivated pain' and 'lonely' to describe how they feel about the conflicts in their lives (RSA Parliament, 1999). These situations are difficult to handle especially in an ever-changing world. People may therefore turn to alcohol in an attempt to cope with the stress (Kalichman et al., 2006).

Alcohol abuse is associated with innumerable social problems such as child abuse, drunken driving, divorce, prostitution, violence and crime. "The health and socioeconomic consequences of substance use, abuse and dependency are of growing concern. Substance dependence demands large investments in the detection, detoxification and treatment of substance dependents" (CDA, 2005/6).

Rationale and justification for research

Alcohol Addiction Treatment

Addiction treatment has seen advances in recent years in the form of new and effective medications, behavioral therapies and programmatic interventions. Four safe and effective medications now exist for the treatment of alcohol addiction (McLellan, 2002; McLellan & McKay, 2002). New behavioral therapies have been developed and shown effective for alcohol-dependent individuals including 12-step facilitation therapy (Project MATCH Research Group, 1997), motivational enhancement therapy (Miller & Rollnick, 1991) and cognitive-behavioral therapy (Carroll, 1996). "Finally, certain programmatic interventions combining therapies with social and family services, such as the matrix model (Rawson et al., 1995), multisystematic family therapy (Henggeler, 1991) and community reinforcement and family training (Meyers & Miller, 1998), have been shown to produce sustained improvements in patterns of substance abuse and in reductions in the associated health and safety problems of those affected" (Kimberly & McLellan, 2006, p. 214).

Another significant change in the addiction treatment industry is that alcoholism is now frequently classified as a chronic illness rather than an acute condition (Anglin et al., 1997; McLellan et al., 2000; White, 1998). “Traditionally, addiction has been treated as an acute condition with time-limited, often residential, forms of care designed to teach the affected patient a lesson or to produce an insight leading to continued abstinence without continuing care” (Kimberly & McLellan, 2006, p. 214). Since the 1960s, such treatment approaches have produced poor results (Hunt et al., 1971). The research of the last decade has demonstrated the role of genetic heritability (Uhl, 2004) and the ensuing brain changes that accompany the sustained use of alcohol (Volkow et al., 2003). This altered conceptualization of alcoholism has a view that even severe chronic cases of alcoholism will respond well to medications and therapies as long as long-term care is provided.

Alcohol addiction treatment centers have taken note and there has been a shift from short-term treatments to long-term outpatient care in the past five years. Addiction treatment is slowly being integrated into mainstream health care (NAS-IOM, 2005; Weisner et al., 2001) and evidence-based clinical practices are being demanded (Garnick et al., 2002; McCorry et al., 2000). Some examples of these changes include: giving medications to recovering patients in order to help them deal with recurrent cravings to use (NAS-IOM, 2005; Science, 1997; The Lancet, 1996); the state incentivizing programs that retain patients in outpatient care for longer durations (McLellan et al., 2005); and efforts to educate primary care physicians so that they may perform screening and brief interventions early on (NAS-IOM, 2005; Saitz, 2005; Watkins et al., 2003). Overall, there is much optimism regarding an evidence-based, treatment-oriented approach to addressing society’s health and social problems associated with alcohol addiction.

Treatment delivery issues

Despite the hope offered by these research advances, the South African alcohol addiction treatment field is experiencing problems which are impeding the realization of its potential. One concern is the status and function of unregistered care programs that comprise an unknown percentage of the nation’s treatment resources for alcohol abuse. This is a problem because they are operating outside mainstream health care.

Within America, there are several shortcomings in the regulation of the addiction

treatment industry. Some of these include: no agreed upon standards for quality of care provided; no widely accepted protocols for assessing treatment problems and formulating a treatment plan; for providing or coordinating care delivery; for exchanging clinical management information among the many community agencies that are expected to provide supportive services; or for referring a patient to primary care (McLellan et al., 2003, NAS-IOM, 2005; Garnick et al., 2002; McCorry et al., 2000). Given this situation, it is not surprising that the addiction treatment industry is experiencing problems. Some observations over a 2-year period include: a 19% closure rate, 30-40% reorganization rates (through purchase or administrative takeover) among programs, 50-60% staff turnover rates at all levels of the workforce within programs, and a general decline in the quality of care available to the public (McLellan et al., 2003; Roman et al., 2000; Substance Abuse and Mental Health Services Administration, 2002). "Perhaps because of these factors, there has been only a limited demand for addiction treatment by potential consumers: Only about 2 million of the more than 20 million adults with diagnosable alcohol and drug abuse problems have ever sought treatment within this system" (Kimberly & McLellan, 2006, p. 215). Therefore, in America, though addiction research has seen many advances over the past decades, the national addiction treatment infrastructure has been in decline. This is an unfortunate paradox when it comes to citizens seeking treatment for alcoholism.

Addiction treatment resources & organization

As discussed thus far, "...the problems faced by those professionals and organizations in the business of delivering addiction treatment services are substantial, and the public health and safety problems associated with alcohol abuse are not likely to be relieved simply by the discovery of new medications, therapies and interventions" (Kimberly & McLellan, 2006, p. 216). As innovations in treatment modalities are developed, there is a need for research on the industry's structure, quality of care and access, and at devising new solutions to problems as they arise. However, research on the organization and effectiveness of addiction treatment has not advanced to the level of the clinical and pharmaceutical research (Weisner & McLellan, 2004). Yet, it is these issues which are currently reducing the impact of addiction treatment. It is important to note that studies of these issues in other industries may be of use in addressing the lack of standards in information, procedures and quality measures, and stigma (Cappelli, 1995; Kimberly & Minvielle, 2000). For example, "the waste management industry has been very stigmatized and, until recently, most of those in the field worked for small community companies

with different sets of regulations and practices in each locale. Companies such as Waste Management were able to consolidate these 'mom-and-pop' companies under national standards..." (Kimberly & McLellan, 2006, p. 216).

America has seen a significant amount of private investment in addiction treatment in recent years (Jackson, 2005, 2006). Private firms have recognized the business opportunity of addiction treatment due to unmet needs and the potential for earning attractive returns. "Two large private firms have begun to purchase treatment programs across the country..." (Jackson, 2005, 2006). In South Africa, significant amounts of private capital are invested into the private sector addiction treatment industry. Ironically, due to the government subsidization of private health care through government contributions to private medical insurance, a lot of public funds are also used to support a private industry which serves only a minute proportion of the population (McIntyre, 2007). On the other hand, the public sector allocates very little money to public addiction treatment (McIntyre, 2007).

The entry of private capital into an industry that is traditionally non-profit piques interest and raises questions. On the one hand, modern management techniques and practices may enhance access to services and quality of care. On the other, there may be conflicts of interest between investors and patients. Investigations of the addiction treatment public-private mix structure and dynamics are needed to shed light on how the addiction treatment delivery system may become more efficient and ultimately more effective in the future.

Aims & Objectives

Aim:

The aim of this study is to investigate Cape Town's alcohol addiction treatment center public-private mix and to determine quality of care and access.

Objectives:

1. To describe the current structure of Cape Town's addiction treatment delivery including public-private interactions.
2. To evaluate the quality of care of different providers of addiction treatment.
3. To do an exploratory assessment of equity in access in relation to public, private and PPP addiction treatment services in Cape Town.

4. To make recommendations on the basis of these findings on how policy-makers in South Africa and elsewhere could best improve quality of care and equity with regard to the provision of addiction treatment.

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Chapter 2: Literature Review

Introduction

The literature review examines the theoretical and empirical literature on alcohol addiction as well as the roles of public, private and PPP providers in the health system. The chapter begins by reviewing alcohol addiction globally then narrows to the context of South Africa and Cape Town. South African legislation pertaining to alcohol abuse is explored followed by an explanation of the various treatment options in the country. Public, private and PPP provision of health care is discussed under the umbrella of economic theory. Finally, issues of quality of care and access are examined.

To conduct the literature review, the researcher consulted a number of sources including government websites (Cape Gateway, Department of Health, Department of Social Development), online peer-reviewed journals (accessed via search engines such as PubMed, Medline, Sabinet, Biblioline, Ebsco, etc.), the University of Cape Town library database, the Medical Research Council website, and websites of addiction treatment providers. The search terms included the following: public, private, public private partnership, public private mix; provision of care; addiction; alcohol addiction; addiction treatment; treatment centers; treatment guidelines; South Africa; Cape Town; legislation; quality of care; access; economics.

The global problem of addiction

The World Health Organization (WHO) estimates that alcohol causes 1.8 million deaths (3.2% of total) and 58.3 (4% of total) Disability-Adjusted Life Years (DALYs) each year (WHO, 2008). WHO recognizes that better cross-national epidemiological data is needed in order to give an accurate picture of the extent of the illness, specifically within developing countries where it is difficult to obtain accurate data (Degenhardt et al., 2008). Global comparisons of diseases and their risk factors have proven difficult. "Historically, cross-national comparisons for alcohol and tobacco were undertaken using correlation studies of nation-level consumption (e.g. taxation data) plotted in relation to pertinent causes of death (e.g. liver cirrhosis, lung cancer)" (Deganhardt et al., 2008, p. 141). One issue that arises is the variability amongst international classification of causes of death. Another problem is that much alcohol abuse goes unrecorded for obvious reasons and therefore rates of alcohol abuse are underestimated based on statistics.

WHO states a significant prevalence of alcohol addiction globally however its burden is not equally distributed among countries (WHO, 2008). Clear differences were found regarding lifetime alcohol use across countries. For example, the majority of Americans, Europeans, Japanese and New Zealander respondents reported lifetime alcohol use where as a small proportion of Africans, Chinese and Middle Easterners reported alcohol use (Deganhardt et al., 2008). "Globally alcohol consumption has increased in recent decades, with all or most of that increase in developing countries. This increase is often occurring in countries with little tradition of alcohol use at population level and few methods of prevention, control or treatment. The rise in alcohol consumption in developing countries provides ample cause for concern over the possible advent of a matching rise in alcohol-related problems in those regions of the world most at risk" (WHO, 2008). It is interesting to note that the WHO study on global alcohol use found that the median age of onset for alcohol use was between 16 to 19 years of age for all countries except South Africa which was an outlier at 20 years (Deganhardt et al., 2008).

Demographic variables such as sex, age and income are directly related to alcohol use. Income and education are positively related to lifetime alcohol use (Deganhardt et al., 2008). Disposable income is generally necessary for alcohol expenditure so this finding is unsurprising.

Addiction in South Africa

South Africa has a high burden of alcohol-related mortality and trauma. Just under half of all non-natural deaths in 2002 had blood alcohol concentrations greater than or equal to 0.05g/100ml and up to two-thirds of all cases tested annually at trauma units in three cities between 1999 and 2001 had breath-alcohol concentrations above that level (Matzopoulos et al., 2003; Pluddemann et al., 2004). In addition, fetal alcohol syndrome (FAS) in South Africa is at the highest level ever recorded (Parry, 2005). The high levels of mortality and morbidity due to alcohol use in South Africa points to the high health-care costs the country pays. However, based on production figures, there does not appear to have been a significant increase in overall alcohol consumption between 1994 and 2004 (Alcoholic Beverage Review, a. 1999 & b. 2004; SAWIS, 2004).

The South African Demographic and Health Survey (SADHS) conducted by the Department of Health contained an alcohol component which revealed high levels of risky drinking and alcohol problems among South Africans (Parry et al., 2002). One

of the findings was that 28% of male and 10% of female respondents screened positive for symptoms of alcohol dependence (Parry et al., 2004). Such results point to a need for inpatient alcohol treatment, however the exact figures required are unclear (Myers, 2007).

Risky drinking includes frequent drinking apart from meals, drinking in public places, communal drinking (i.e. drinking from a common container that is passed around) and high levels of drinking at community events such as weddings and funerals (Parry et al., 2002). In total, one third of South African current drinkers were determined to be drinking at risky levels over weekends. This proportion included both men and women usually from the 35-54 age range. Risky drinking behavior was most likely to be exhibited among individuals living in non-urban areas, those with low levels of education and among those racially classified as Colored or Black/African. Parry et al. (2004) state that risky or binge-drinking is an important factor associated with future alcohol addiction treatment needs.

Other statistics indicate that between 7.5% and 31.5% of South Africans have an alcohol problem or are at risk of having such a problem (CDA, 2005/6). The term 'drinker at risk' refers to an individual who is likely to become alcoholic or whose health is affected by drinking. Approximately 7.5% of the population engages in risky drinking on weekdays where as 31.5% of individuals between 25 and 54 engage in weekend 'binge drinking', another form of risky drinking. The term 'binge drinker' refers to someone who drinks nine tots of spirits, a bottle or more of wine or more than than two liters of beer in a day. According to the CDA (2005/6), the average annual per capita consumption of alcohol is approximately 20 liters which ranks the country as one of the highest consumption rates in the world.

It has been estimated that alcohol alone costs the country about 1% of its Gross Domestic Product (Weich, 2006). The annual cost of alcohol abuse to the economy was estimated at R10.6 billion in 1996 (Bateman, 2006). At the same time, concerns have been raised regarding South Africa's legislation and rehabilitation programs being out of sync with alcohol addicts' needs (Bateman, 2006). According to a Social Development invitation to a consultative review workshop, The Prevention and Treatment of Drug Dependency Act (1992) is outdated and ineffective (Bateman, 2006).

South Africa has high rates of risky drinking and consequently considerable rates of related morbidity and mortality. Symptoms of alcohol problems are high (Parry et al., 2005; Reddy et al., 2003). Therefore, there is an urgent need to focus on the development and implementation of a comprehensive targeted intervention strategy to address the misuse of alcohol.

Drug and alcohol dependency is one of the greatest social and health problems facing South African society. Research has shown the link between substance abuse and crime, poverty, reduced productivity, unemployment, prostitution, dysfunctional family life, political instability, the escalation of chronic diseases such as Aids and tuberculosis, injury and premature death.

South Africa has little accurate information on the extent of alcohol addiction in the Black/African community. The abuse of alcohol is known to be an element of social disintegration. One must consider alcohol rates within the context of poverty, malnutrition and disease that exists within South Africa.

Disadvantaged communities have experienced the most severe rates of alcoholism. The apartheid government devoted few if any resources to substance dependency, especially in disadvantaged communities. However, alcoholism indirectly affects everyone despite social, racial, cultural, language, religious and gender barriers. Therefore, if South Africa fails to adequately address substance abuse, development of the country could be hindered. "...It should never be forgotten that alcohol misuse blights individual lives, destroys families, damages communities and makes whole countries unstable" (RSA, 1999, p. 2644).

Cape Town

The Western Cape Province has the highest prevalence of risky drinking in South Africa (Shisana et al., 2005). Cape Town is its capital. Cape Town was found to have a higher proportion of alcohol-related traumatic transport injuries as compared to Port Elizabeth and Durban (Pluddemann et al., 2004). Mortality statistics also reveal that Cape Town has a higher proportion of alcohol-related deaths due to violence as compared to Durban, Johannesburg and Pretoria (Matzopoulos, 2005). In addition, at the time of their arrest, criminals were more likely to report being under the influence of alcohol in Cape Town than criminals in the comparison cities of Durban and Johannesburg (Parry et al., 2004). Cape Town is therefore a relevant study focus for inpatient alcohol addiction treatment.

In 2004, Coetzee evaluated the treatment program used by one of Cape Town's addiction treatment centers. His focus was on patient behavior post treatment including alcohol and drug usage, support group attendance, use of sponsorship, aftercare attendance, quality of life as well as a patient evaluation of the treatment program. The current study will focus on quality of care and access to PCIAAT services.

South African Legislation Pertaining to Alcohol Abuse

The Abuse of Dependence-Producing Substances and Rehabilitation Centers Act (Act No 41) was created in 1971 (NDS, 1971). It was introduced because of an increase in alcohol (and other drug) problems and encompassed both criminal matters and the rehabilitation of alcohol/drug dependents (RSA, 1999, p. 1010). These were separated into two clearly distinguishable parts. Chapter I primarily addressed criminal matters where as Chapter II focused mainly on rehabilitation.

Rather than amending the existing Abuse of Dependence-Producing Substances and Rehabilitation Centers Act, a new Act entitled Prevention and Treatment of Drug Dependency was introduced in 1992 (DOH, 1992). The fact that a new Act was created made a statement as to how seriously government was committed to addressing the alcohol/drug problem. It indicated the South African government's desire to stay abreast with scientific and social developments throughout the world.

In 1992, the former Abuse of Dependence-producing Substances and Rehabilitation Centers Act, Act 41 of 1971, was split into two separate laws. One dealt with criminal matters and was administered by the Minister of Justice. The other addressed prevention and treatment and was administered by the Minister of National Health. 'Prevention is better than cure' is a prevalent theme within the 1992 Act. The tested and proven rehabilitation aspects of the 1971 Act were preserved. However, new aspects such as prevention programs and processes of treatment were added. The 1992 Act 'decriminalises' prevention and treatment of alcohol addiction. It was determined that rehabilitation will be facilitated if it is separated from prosecution (RSA, 1999).

The national Drug Master Plan was written in 2006. It summarizes national policies and recommends the establishment of the Central Drug Authority to replace the Drug Advisory Board (as contained in the original Act, Act 20 of 1992). The goal was to

change the name of the controlling body and to render the CDA responsible and capable of implementing the national Drug Master Plan. The Prevention and Treatment of Drug Dependency Amendment Bill legislated the establishment of the CDA as well as its functions and powers. The purpose of the CDA is to encourage community health and welfare by buffering against drug trafficking and alcohol and drug dependency. This includes developing after-care capacity within the community because alcohol addiction treatment does not end at the conclusion of inpatient care.

One criticism of the Bill is the obligatory treatment of criminals deemed to be in need of alcohol addiction treatment. The entire model of addiction treatment is based on a patient's desire to change and voluntary cooperation. Therefore, there is concern as to how effective this method will be. However, to the state's credit, an attempt to rehabilitate has been legislated despite the possibility of a poor outcome. Another criticism of the Bill is the lack of detail outlining the strength of contact at the community level. Community services are key to rejuvenating South African neighborhoods. Finally, the CDA needs to be accountable for their work. Annual reports should be presented to parliament.

South Africa recognizes that the majority of those suffering from alcohol addiction are in the productive prime of their life. In addition to a social obligation, it is in the economic best interest of the country to treat these people so that they can again contribute as citizens.

The drink trade is a powerful lobbyist. In addition, jobs, exports and government revenue would all be impacted by a decrease in alcohol consumption. One must therefore carefully examine the question of vested interests in terms of politics and health.

One potential avenue for reducing alcohol consumption is to increase the price and control production and consumption. There is evidence of this being effective in reducing the amount of alcohol consumed by heavy drinkers (Deganhardt et al., 2008).

Addiction Treatment Centers

The business of addiction treatment has a long, obscure history (Musto, 1973; White, 1998). It has been in transition during recent years due to significant investments of private capital (Jackson, 2005, 2006). The *National Academy of Sciences Institute of*

Medicine (2005) has indicated that there are highly effective therapies available however, they are not widely diffused. Alcohol dependency is complex. Research has shown that a multidisciplinary approach including physical, psychological, social and spiritual aspects is most effective for treatment.

Note that the number of people who access alcohol addiction treatment are a minute proportion of those in need. According to respondents in Myers' study (2007), people who have severe alcohol addiction problems (who required detoxification and/or treatment for co-occurring psychiatric problems in addition to AOD treatment) experience more difficulty in accessing alcohol addiction treatment than people with less severe problems.

Both outpatient and inpatient addiction treatment services are offered in the Cape Town region. Outpatient alcohol addiction treatment services are more available and financially accessible however these services are not appropriate for people with severe alcohol addiction (Kosanke, Magura, Staines, Foote, & Deluca, 2002). Inpatient alcohol addiction treatment refers to a treatment program that is offered while the patient is residing at the treatment center. The primary benefit of inpatient addiction treatment as compared to outpatient addiction treatment is its more intensive approach.

Inpatient addiction treatment services may be separated into primary, secondary and tertiary facilities. Primary care is defined as the first point of consultation for all patients. Secondary care refers to addiction treatment provided by facilities who generally do not have first contact with patients. In the field of addiction, tertiary care refers to the final phase of treatment. Patients are supported as they reintegrate into their normal school, work or volunteer routines.

This paper will focus on primary care inpatient alcohol addiction treatment (PCIAAT) services because they are deemed to be most appropriate for those who suffer severe alcohol addiction problems (Kosanke et al., 2002).

Public-Private Mix

Neo-classical Economic Theory

The market system fails in the realm of health care resulting in consumers inefficiently allocating their resources. According to neo-classical economic theory, this is reason for government to intervene (McPake et al., 2002). There are four

types of market failure in health care including externalities and public goods, imperfect information, risk and uncertainty as well as market structures. It is externalities and imperfect information that are relevant to the purposes of this paper.

Externalities refer to the behavior of one individual affecting other individuals but not being considered during the market transaction. Health care can have positive externalities meaning that an individual's consumption may benefit someone else. As mentioned in the introduction, there are positive clinical and economic externalities of alcohol addiction treatment. The reason externalities cause the market to fail is because individuals do not factor in all social costs and benefits when making a decision (Hammer, 1997; Musgrove, 1999). For example, completion of alcohol addiction treatment would benefit the individual. However, the individual is likely to underestimate the extent to which society would benefit, resulting in underconsumption from a societal perspective. In this case, government could intervene by subsidizing the cost of treatment, thus incentivizing individuals to consume more.

Perfect competition theory assumes that consumers have perfect knowledge of the goods and services they consume (Rothschild & Stiglitz, 1976; Strong & Waterson, 1987). This is not the case when it comes to health care. In this context, imperfect information can result in inefficient addiction treatment. Patients are not in a position to determine the quality of care offered at a certain treatment facility. If each patient were to obtain 'second opinions' and seek all relevant information, it would be inefficient. For this reason, patients (principals) usually have providers (such as doctors) operate as their agents. The provider thus makes decisions on the patient's consumption. The interaction of the principal and the agent is referred to as agency theory (Pratt & Zeckhauser, 1985). One reason for providers being an imperfect agent is their desire to make income (Bennett et al., 1997). If providers are paid on a fee-for-service basis, there is an incentive to provide services to patients even though those services may not be appropriate for the patient's needs. According to economic theory, the agent is tempted to pursue his/her own goals at the expense of the principal. Thus, problems are likely to arise in any principal-agent relationship (McPake et al., 2002).

There are numerous factors which determine the severity of market failure. These are often country specific therefore the appropriate role for government is context specific (Jack, 2001). According to Bennett et al. (1996), some of these factors may

include: the epidemiological profile within the country; sophistication of care provided; professional ethics and regulation; organization and development of the business sector; education; the media and civil society and social values. Specific services should be investigated under these headings.

Neo-classical economics determined that health care does not meet the requirements for a free market. Externalities and imperfect information were the main concerns for the purposes of this paper. Neo-classical theory suggests that government should therefore take over roles relating to financing and provision of health services however it does not offer any further detail. This is where New Institutional Economics may assist.

New Institutional Economics

The efficiency, equity and cost containment goals of the health system are influenced by provider behavior. New Institutional Economics suggests that one way to address market failure, including problems involving the principal-agent relationship, is by creating appropriate incentives for agents as well as to monitor and sanction agent behavior (Mills et al., 2001). McPake et al. (2002) define economic incentives as “allowing individuals to behave in accordance with expected material rewards or favors that can be traded for such rewards including leisure.” There is the option of either managing or regulating incentives. One example of incentive management is how agent behavior can be influenced by the way in which providers are paid (various reimbursement methods).

Addiction treatment is part of health care and thus there are market failures within addiction treatment. However, market failure does not mean that the public sector should completely take over financing and delivery of addiction treatment care. New institutional economics makes a case for private ownership, stating that when there are appropriate incentives associated with it, private ownership may stimulate competition and result in efficient service (Russell et al., 1999). In this case, government’s role would focus on policy making rather than provision of services. Bennett et al. (1996) have identified that many of the weaknesses in the public sector including lack of competition and inappropriate incentives are the result of problems with the institutions themselves. An approach which encompasses strengthening of management and accountability; specification of priorities, objectives standards and monitoring of outcomes and resource use; and clarification of institutional relationships will assist with the institutional reform of the public health sector

(Cassels, 1995).

New institutional economics emphasizes the importance of appropriate incentives. When these are offered within institutional arrangements, issues related to market failure, such as externalities and imperfect information, can be reduced.

Public-private Mix History

Three traditional characteristics of developing country health systems are that health services are viewed as the responsibility of the state, health services tend to be curative and hospital based and health sector constituents develop alongside the health sector (Russell et al., 1997; Russell & Attenayake, 1997; Mills et al., 2001; Cripps, 1997; Smithson et al., 1997). This pattern may be due to a common history of colonialism amongst developing countries.

The military, civil service and general settlers were served by organized health services (Zwi and Mills, 1995). It was in the colonizers' best interest to serve aboriginal populations as well because of the nature of communicable disease. Thus, churches and missions set about providing health care to aboriginal populations free of charge in the interest of limiting the spread of disease to the settler population (Mills et al., 2001). Due to such origins, developing countries, particularly in the African setting, commonly have a substantial presence of not-for-profit health providers.

Structural adjustment encouraged the privatization of health care in developing countries. It was introduced by the World Bank in the 1980s (World Bank, 1987). The ideology behind the recommendations was (a) costs of health care are rising and government resources are scarce; (b) private health expenditure in most developing countries exceeds government expenditure; (c) people tend to prefer private health care and pay for it rather than avail themselves of free public sector services; (d) the private sector is free from administrative and political constraints and therefore delivers health services efficiently; (e) increasing privatization will free up scarce resources which can be targeted to provide services for the poor; and, (f) infusion of market forces such as competition and incentives will lead to improvements in service quality (World Bank, 1993). Unfortunately, structural adjustment did not fare well in reality. Issues around cost, quality of services and equity concerns regarding access to private health care came to light (Mills et al., 2001).

There are three basic health sectors which exist. These include the public sector, the private sector and public-private partnerships. Countries frequently have a combination of the three sectors.

Public Sector

The public sector is the health system funded, managed and delivered by government. One strong reason to favor public addiction treatment is the positive externality associated with it (Kimberly & McLellan, 2006). The attainment of social goals, including equity concerns about access and types of service available, is an additional reason for public addiction treatment. The public health system is in constant need of government funding and leadership for its activities.

Private Sector

In this study, the term private providers refers to both non-profit and for-profit organizations working in the community or health care market outside the direct control of the state (Bennett, 1991). Private addiction treatment centers play an important role in providing care for alcoholism, which is a disease of public health importance. The main reasons for consulting private providers include: (1) better geographical access, shorter waiting times, longer or more flexible opening hours; (2) greater availability of staff and drugs; (3) greater confidentiality in dealing with diseases which carry social stigma; (4) the perception that private service providers are more considerate, caring and sensitive to client needs; (5) perception, in some settings, that the private services are technically superior, and, (6) continuity of care (Swan & Zwi, 1997; Uplekar et al., 1998; Lonroth, 2000; Schneider et al., 2001). High, middle and low income groups all use private providers for these reasons (Berman, 1996). Though there are positive aspects of private practitioners' addiction treatment-related practices, these are countered by some practitioners' disregard of recommended treatment regimes and their refusal to share essential records with the public sector.

In the last few decades, developing countries have seen a considerable growth in the private health sector (Uplekar, 2000). The private sector is therefore substantial in developing countries. For example, 80% of modern medicine doctors and 60% of hospitals in India are currently private (Ogden et al., 1999). 66% of Zimbabwean doctors work in the private sector (Bennett et al., 1997). According to Bennett et al (1997), private providers tend to focus on the provision of acute curative services including alcohol addiction treatment. Alcohol addiction is a disease of public health

importance, therefore, there is a need for better use of private providers who supply alcohol addiction services (Mills et al., 2002).

In South Africa, apartheid shaped the provision and financing of health services. Resources were not allocated based on need, therefore the majority of the population suffered while a small percentage received first world level health care (Thomas & Gilson, 2004). As is still the case today, the public health care system was inefficient and fragmented, and the private sector soaked up health care resources. This contributed little to the human development of the country (McIntyre et al., 1995).

South Africa currently has a dual-financed, mixed health care system. This means that on the one hand, the population pays taxes, which are the primary source of funding for the public health care system (McIntyre & Doherty, 2004). Public health care is contributed to by all and is therefore available to the total SA population. At the same time, a certain sector of the population choose to contribute to private medical schemes in addition to public health. Funding of the private sector can take place in the form of out-of-pocket payments to providers, individual private payments to health insurance companies, employer contributions to private medical schemes, or tax subsidies given to those who pay for private care. In the case of health insurance, the scheme pays the provider. Overall, the public sector serves approximately 80% of the population, whereas the private sector serves about 20% (McIntyre & Doherty, 2004). South Africa is a developing country with a higher level of gross domestic product (GDP) than India and Zimbabwe. It is characteristic for higher GDP countries to incorporate an insurance sector into the private sector rather than to concentrate private provision and expenditure at the low levels of the system. Therefore, in South Africa, the private sector participates in secondary and tertiary health care provision.

The private sector has very different objectives as compared to the public sector. According to Bennett et al. (1994), problems with private sector provision of health care include: (1) the main objective is profit maximization; (2) failure to address public health; (3) lack of integration with government services; (4) attraction of professionals out of the public sector and (5) provision of poor quality or inappropriate services.

Public-Private Partnerships (PPPs)

The desirability of using the private sector to deliver public services is widely debated. The World Health Organization (WHO) suggests that partnership with the private sector can offer a degree of long-term sustainability (2001). One may examine the relationship between public and private sectors in terms of financing and provision (Donaldson & Gerard, 1993; Bennet et al., 1997). According to Mills et al. (2001), there are four main types of organizational arrangements that may exist between the two sectors. These include: the case where the public sector both finances and provides health care; where the government finances health care through contracts or subsidies, while private providers are responsible for service provision; where private agents including users finance health care services which are delivered by publicly owned agents. For example, leasing out public beds/wards for private patients, where private providers pay to use public facilities; or limited private practice, where public sector doctors are allowed to spend a specified number of hours in private practice; and finally, the case where the private sector both provides and finances health care, relegating the government to a role of regulation and standard setting. When the term public-private mix is used in health care, it is public financing and private provision or private financing and public provision arrangements that are being referred to. A public-private partnership (PPP) is a type of public-private mix which refers to formal or informal collaboration between the government and the private sector. Public-private partnerships are increasingly seen to be a way of promoting cooperation among public and private health care sectors in developing countries.

There are both advantages and disadvantages to PPPs. Giutsi *et al.* (1997) list the following benefits:

- An increased number of people receiving health care services;
- Redirection of scarce public resources to provide essential health care needs;
- Combination of public and private resources to increase the resource base;
- A source of additional revenue for private sector entities;
- Improved efficiency and management in health care delivery;
- Structural improvement through new investments; and,
- Improved technical competence through training and capacity building efforts.

In contrast, criticisms of PPPs include private sector objectives such as profit maximization being in conflict with public health objectives (Hancock, 1998). Clearly, different ethos and principles form the backbone of the public and private sectors

(Buse & Walt, 2001).

According to Rosenthal and Newbrander, the ideal public-private mix is a balance of efficiency and equity considerations (1996). The public sector is more equitable where as the private sector is often deemed to be more efficient. Therefore, some argue that allocative efficiency may be improved by private care for certain groups because this would free up resources in the public sector in order to provide health services for the underprivileged (World Bank, 2003).

The government of both Ghana and Zimbabwe provides substantial subsidies to church providers (Mills et al., 2001). This qualifies as a PPP arrangement. Other examples of PPPs include: the government contracting private provision of sterilization and IUD insertion in Taiwan (Foreit, 1992); a South African academic hospital leasing out vacant space to a private hospital group (Cleary and Thomas, 2002). As demonstrated, PPPs may occur on both the large and small scale. They are an important option when addressing complex social and health problems (Kolehmainen, 1999). PPPs are governed by public health policy objectives and monitored by government. This is what differentiates PPPs from the purely private sector.

This section has reviewed both public and private sectors as well as the potential of the public-private mix. Health resources are under pressure. Economic theory highlights some areas where the role of government is conflicted. PPPs are suggested as a solution to shifting ideologies and trends including changing international economic priorities, the private sector's desire to participate in the provision of health care and the potential for 'win-win' interactions in an increasingly interdependent world (Buse and Walt, 2001).

Quality of Care

The private sector has rushed to fill the gap between demand and what the state provides. Both licensed and unlicensed private treatment services have increased dramatically since 1994, of which the majority are not registered and are thus functioning illegally (Bateman, 2006; Parry, 2005). On the positive side, the government has developed and published *Minimum Norms and Standards for In-Patient Treatment Centers* (NDS, 2004). However, Pierre Viviers, Deputy Director of Substance Abuse in the Department of Social Development, stated that "inspections and monitoring are patchy and vary hugely from province to province,

with even annual inspections the exception rather than the rule” (Bateman, 2006, p. 380). Despite national treatment guidelines being in place, a lack of monitoring means that there is the possibility that quality of care varies greatly between facilities. Addiction treatment services have had little attention in terms of efforts to improve quality of care (McCarty, 2009).

The *Network for the Improvement of Addiction Treatment* (NIATx) is a network based in the United States, which teaches alcohol treatment programs to apply ‘process’ quality of care improvement strategies in order to improve quality of care (McCarty et al., 2009). For example, their suggestions lead to reducing days to admission, increasing retention in care, increasing admissions and minimizing appointment no-shows. NIATx supports the American *Institute of Medicine’s* six dimensions of quality care including safe, effective, patient-centered, efficient, timely and equitable. These can be applied to treatment for alcohol disorders. This means that alcohol treatment centers should prioritize patient needs, implement evidence-based decision making and reduce inefficiency and errors in care (McCarty et al., 2009).

Continuum of Care

Continuum of care and treatment center management are two topics outlined by *The Minimum Norms and Standards for Inpatient Treatment Centers* (2004). Continuum of care includes patient assessment/treatment, individualized treatment planning and daily activities. According to the *Minimum Norms and Standards for Inpatient Treatment Centers*, patient assessment/treatment focuses on the patients’ right to receive holistic assessment processes. This entails a medical practitioner doing an initial assessment within 8 hours of admission which includes:

- a) Personal details and brief personal history.
- b) Mental state examination, including intoxication status and needs.
- c) Physical examination and history of medical conditions, including tests to facilitate evaluation.
- d) Brief history of substance abuse (and other mental health problems).
- e) Provisional psychiatric history and diagnosis.
- f) Assessment of risk potential (i.e. for suicide and other forms of self-harm) and specifications for detoxification (if offered).

Followed by a qualified professional(s) with adequate mental health and social work skills and experience, conducting a timely comprehensive assessment which entails:

- a) Psychiatric and physical assessment and diagnosis, with special reference to any

co-morbid conditions.

b) Comprehensive psychosocial, developmental and functional assessment including an evaluation of the patient's social situation (e.g. family, employment, housing and legal situation) and vocational and developmental needs (especially in the case of adolescents/children and the elderly).

c) Referral for a more in-depth psychological, social work, psychometric or physical evaluation, as appropriate.

d) Provisional treatment goals and prognosis.

Assessments are to be recorded in the patient's case record in a timely and accurate manner. The next step is for each patient's comprehensive assessment to be reviewed by the case manager and the center's multidisciplinary team. Each week, the multidisciplinary team meets in order to formally review the patient's treatment progress. Patients receive feedback on the results of their initial assessment and progress.

Individualized treatment planning is the second component of continuum of care.

The focus is on ensuring that each patient has a documented, individualized treatment plan which encourages participation, motivation and recovery. It is important that each patient has given informed consent prior to treatment. Patients should be given the opportunity, as far as possible and appropriate, to make choices regarding their care. This includes providing them with adequate information on the specific treatment and risks, benefits and options of the treatment offered. Each facility should include a health promotion/prevention component which includes:

a) Information and practical support to maintain a healthy, alcohol-free lifestyle (e.g. exercise, better nutrition, stress management).

b) Information and practical support to prevent the onset and spread of HIV and other sexually transmitted and infectious diseases (e.g. voluntary testing & counseling).

c) Access to reproductive health care and support of pregnant patients.

d) Access to nutritional support and supplements for chronic alcohol-dependent patients.

Individualized treatment planning entails each patient having a customized treatment plan according to the extent of their alcohol dependency, medical profile, personal characteristics and social situation. The comprehensive assessment is used in order to create the written individualized treatment plan which consists of:

a) Clear and concise statement of the patient's current strengths and needs.

b) Clear and concise statements of the short-and long-term goals the patient is

attempting to achieve.

- c) Type and frequency of therapeutic activities and treatment program in which the patient will be participating.
- d) Staff responsible for the patient's treatment and their individual counselor.
- e) The patient's responsibilities and commitment to the rehabilitation process.
- f) The plan is dated and signed by the individual counselor and the patient; a copy of the plan is given to the patient.

Each patient should be assigned a case manager. A case manager is a professional staff member or addiction counselor. Their role is:

- a) Responsible for assisting patients to develop their treatment goals (and other individual treatment tasks), for providing regular documented support and motivation, and for acting as a liaison person for families, caregivers and role players.
- b) The individual counselor meets weekly with the patient for a minimum of 30 minutes.
- c) The individual counselor is reasonably accessible to patients for support and crisis intervention (i.e. outside of fixed counseling sessions).

The third component of continuum of care is structured treatment programs and daily activities. The treatment/rehabilitation program promoted by the facility should be updated regularly in accordance with internationally accepted standards. It will include:

- a) Individual counseling
- b) Family counseling
- c) Organized group activities such as sport, health, education (e.g. HIV/Aids)
- d) Recreation
- e) Creative activities

The program will not be less than forty hours per week. The facility should have documented policies and procedures implemented to regulate and guide daily activities including:

- a) waking and sleeping times
- b) phone use for private conversations
- c) visits from family, caregivers, friends, religious leaders and legal counsel
- d) outings

Treatment Center Management

Another aspect of quality of care is treatment center management. This study

focused on staff training and support. Staff training and support refers to the need for facilities to have appropriately qualified, skilled and supervised staff to deliver quality services. Professional staff are to be registered with the appropriate official accreditation body such as the South African Nursing Council or the South African Council for Social Work Professionals.

Procedures for Treatment Center Management

Treatment centers are to have mechanisms for patients to make complaints. Each center is to respond appropriately to all valid complaints.

According to the MNSITCs, the minimum interdisciplinary team consists of a professional staff member (a social worker, or clinical/counseling psychologist), accredited addiction counselors and a part-time professional nurse.

There are three domains of quality of care. Process and outcome consist of two of these (Donabedian, 1980). Process quality of care is the actual delivery of care. This includes: access, diagnosis, treatment interventions and their administrative and technical support, discharge and community after-care arrangements, and health promotion and education activities. Outcome quality of care is defined as the end result of care. It includes health status, improvement in function, longevity, comfort and, more broadly, quality of life. By examining process and outcome aspects of continuum of care and treatment center management, one may establish quality of care.

Access

Health care access is a key determinant of health status (Brewer, 2005; Millman, 1993). Numerous international studies have been conducted in order to provide evidence of the benefits of alcohol addiction treatment including reduction in alcohol use and criminal activity; improvements in physical and psychological health; and finally, improved social functioning (Gerstein, 1997; Hubbard et al., 1997; Paraherakis, Charney, Palacios-Boil & Gill, 2000; Simpson, Joe & Brown, 1997). There has been little research conducted in developing countries on inpatient alcohol treatment outcomes. A Sri Lankan study found that 36% of 234 patients attending a treatment center were still abstaining from alcohol 2 years post-treatment (De Silva *et al.*, 1992). Within South Africa, two studies have been conducted, both by Coetzee (2001, 2004). Each study showed significant rates of abstinence post-treatment as well as improved quality of life including physical health, emotional well-being and

improved family relationships. These studies bring to light the benefits of inpatient alcohol treatment and demonstrate the importance of ensuring those in need have access to inpatient alcohol treatment.

For the purposes of this study, access will refer to potential access which is the degree to which health services are available and the opportunity to access these services when required (Myers, 2007; Gulliford et al., 2002; Litaker & Love, 2005). This definition focuses on supply stating that "...whether or not the opportunity is exercised is not relevant to equity defined in terms of access" (Mooney, 1983, p. 180). Here, there is a focus on structural and process components of access (Racher & Vollman, 2002). That is, availability of personnel and facilities and the organization of services (structural components), and characteristics of the target population that inform service use (process components) (Racher & Vollman, 2002).

Myers was the first to investigate barriers to alcohol addiction treatment access in the South African context (2007). According to her findings, non-need factors that may influence access to inpatient alcohol treatment include affordability factors, availability of services, geographic access, service appropriateness, competing priorities, stigma, psychological functioning, social support, and social capital (Myers, 2007). When barriers to access are disproportionately encountered by certain groups of people, identifying and addressing factors that adversely affect vulnerable persons' access to care becomes a matter of equity, specifically horizontal equity (Mooney & Jan, 1997; Hurley, 2001; Aday et al., 1999). Horizontal equity is the just distribution of services in relation to need factors (Richard & Montoyas, 1999). Equity differs from equality in the sense that equity understands that some people will require more than their equal share of services (Morris et al., 2005) where as equality refers to the equal distribution of services. The *United Nations Convention on Social, Economic, and Cultural Rights* highlights this when it recognizes access to health services as a fundamental human right (UN, 1966). On a national level, the Constitution of South Africa guarantees access to health care (Ngwenya, 2003). The *Prevention and Treatment of Substance Abuse Act* states that all persons with alcohol dependence problems have the "right to be provided with treatment, rehabilitation and reintegration services" (NDSD, 2006).

Despite high rates of alcohol addiction and the proven benefits of alcohol addiction treatment, there are those who do not access treatment. Some studies have compared out-of-treatment addicts with recipients of addiction treatment services

(Green-Hennessy, 2002; Hser et al., 1998; Power, Harnoll & Chalmers, 1992; Schell, Orlando & Morral, 2005). They found that seeking treatment was a function of problem severity (as demonstrated by impairment in psychosocial functioning) coupled with recognition of the problem and desire for help to change (Griffith, Knight, Joe & Simpson, 1998; Knight, Hiller, Broome & Simpson, 2000; Rapp et al., 2006). The term 'problem severity' puts alcohol use on a continuum ranging from non-problematic use to pathological dependence. It is the extreme end of this scale (pathological dependence) that would require PCIAAT services (Institute of Medicine, 1990; Miller, 1996). Those who do not fall into this category have a lower need for PCIAAT and may experience treatment success using outpatient programs. However, greater severity of alcohol problems has been associated with greater treatment-seeking behaviour (Haller, Miles & Dawson, 2002; Tucker, 2001; Freyer, Tonigan, Keller, Rumpf, John & Hauke, 2005; Nyamathi, Stein, Dixon, Longshore & Galaif, 2003).

There are three broad categories of factors that can impact on treatment use. The first was already discussed. It relates to problem severity coupled with recognition of the problem and desire for help to change being a determining factor for PCIAAT use. Sociodemographic factors including race and gender represent the second category. Environmental factors and the sociocultural context are also included here. The last category is availability and characteristics of alcohol addiction treatment services including geographic access, waitlisting and cost of treatment. Though there are many variables which can impact on access to PCIAAT services, this study will focus on income, geography and waitlist barriers. Race and gender will be briefly touched upon.

The Apartheid system resulted in Black/African and Colored South Africans receiving fewer and poorer quality addiction treatment services than those offered to the White population (Myers et al., 2004; Myers & Parry, 2005). Despite the end of apartheid, socio-economic disadvantage in South Africa has remained associated with race. Evidence suggests that poor Black/African and Colored communities may be especially at risk for alcohol addiction due to the factors that characterize their communities including stress associated with rapid urbanization, poverty and neighborhood social dysfunction (Flisher & Charlton, 2001; Kalichman et al., 2006; Latkin, Williams, Wang & Curry, 2005). Post-apartheid, the government has tried to address the disparity, however, concerns about the need for and accessibility to alcohol addiction treatment services for the Black/African and Colored populations

remain (Sanders & Chopra, 2006).

Schober & Annis (1996) found that female alcoholics did not exhibit as much treatment-seeking behavior as their male counterparts where as studies by Green-Hennessey (2002) and Kertesz et al. (2006) found the opposite. Other research findings pointed to gender being a non-issue in addiction treatment service use (Hser et al., 1998; Weisner et al., 2002). The differences in findings may be due to the research taking place in a range of contexts (Myers, 2007). Lack of child care and lack of influence over household use of income choices may negatively impact on a woman's ability to seek PCIAAT (Grant, 1997).

Most addiction treatment services available in South Africa serve those who have the ability to pay, leading to a lack of access to services by disadvantaged groups, including the poor, Black South Africans and women (Parry, 2005). Income, employment status and access to medical insurance are all factors which determine the affordability of PCIAAT. Sturme and Sherbourne (2001) pointed out that low income relates to two factors. One is an individuals' ability to pay out-of-pocket treatment costs. Income and employment status also determine the individual's ability to acquire health insurance. Transport costs, replacement of wages and childcare are all indirect costs to take into consideration (Myers, 2004). If one has medical insurance, then the direct costs of treatment may be reduced or eliminated however the individual is still expected to cover their own indirect costs. Even private insurance benefits run out after three weeks, resulting in compromised treatment for those who cannot afford to stay on (Bateman, 2006). Due to limited funding, Non-profit facilities have had to request financial contributions from patients towards treatment (Myers, 2004b). For poor patients, these contributions may make treatment unaffordable. This information makes a case for the importance of free, publicly-funded treatment services.

Geographic accessibility of services refers to the distance a patient must travel from his/her place of residence in order to receive treatment (Monnet et al., 2005). The spatial distribution of services, the proximity of services, the distance required to travel to services, travel times and travel costs are all included under the geographical access umbrella (Myers, 2007). Numerous studies have found geographic access barriers to be negatively associated with addiction treatment use (Friedmann, Lemon & Stein, 2001; Hser et al., 1998; Reif, Golin & Smith, 2005). Low-income groups tend to not have access to private transport therefore distance

and travel time are significant barriers (Allard, Tolman & Rosen, 2003).

Research has identified waiting lists to be an access barrier for addiction treatment (Grant, 1997; Hser et al., 1998; Sturm & Sherbourne, 2001; Tucket et al., 2004). It is a safety risk for patients to be waitlisted for treatment. Intoxication increases the risk of traumatic injuries and automobile accidents while also decreasing sexual inhibitions thus increasing chances that a condom will not be used putting the patient at risk for HIV infection (RWJF, 2001). Safety risks are associated with each day of delayed treatment. It has been demonstrated that alcoholics may be ambivalent about seeking treatment. These individuals therefore have little patience for waiting (Carr et al., 2007; Graham, Brett & Bois, 1995; Kaplan & Johri, 2000). Myers found that South African non-profit treatment facilities serving the indigent and uninsured were those most likely to have delays in treatment access due to waitlists (2004b). Myers suggests that such findings imply that waiting list barriers are underpinned by limited addiction treatment resources (Myers, 2007). Another reason for delayed addiction treatment access may be requirements of social work reports prior to admission at some South African facilities (Myers, 2004b).

South Africa has a limited availability of treatment services. The closure of certain state treatment centers with a focus on alcohol-related problems has resulted in a seeming decrease in demand for treatment of alcohol-related problems (Parry, 2005). The government's broader treatment plan is to increase care of patients with alcohol problems at the outpatient level (community based primary health care), in order to limit the number of patients demanding inpatient care services. Unfortunately, this has not been fully implemented therefore services do not meet demand. Specific issues relate to geographical distribution and fragmentation between health and social welfare sectors (Parry, 2005).

The Western Cape province has sufficient inpatient addiction resources to offer approximately 2500-3000 beds per year (Pluddemann et al., 2007). In the Cape Town region, this consists of "... approximately 14 inpatient clinics, one of which is a specialized ward of a general state psychiatric hospital and another of which is a state treatment facility providing free services. The remainder of these facilities are either private non-profit facilities (n=7) offering low-cost services (but requiring co-payment fees) or private for-profit facilities charging high fees (n=5)" (Myers, 2007). A minimum of 10% of the Cape Town population meet DSM-IV criteria for alcohol abuse and/or dependence (Parry et al., 2005). Cape Town is home to approximately

3 million people meaning that 300 000 possibly require treatment for alcohol (Statistics SA, 2005). This number is in stark contrast to the number of beds available.

It is clear that access barriers must be explored in order to ensure South Africans receive needed alcohol addiction treatment. Income, waitlist and geographic distance were some of the barriers to treatment initiation that were experienced. The benefits of alcohol addiction treatment point to the importance of addressing these barriers thus resulting in accessible services.

Conclusion

Alcohol addiction poses social and economic burdens worldwide. The literature review has explored the literature on the public-private mix in the health sector as well as quality of care and access to addiction treatment services. The literature review revealed no South African evidence on inpatient alcohol addiction treatment quality of care or how the public-private mix of alcohol addiction treatment facilities operate in South Africa. There was limited South African research on issues of access as related to addiction treatment. This represents a gap in the literature. Therefore, this study will focus on evaluating how the various provider types compare in terms of quality of care and access.

Chapter 3: Methodology

Introduction

The literature review explored alcohol addiction with a focus on the public-private mix, quality of care and access. It is important to note that the private sector plays a major role in the provision of health care in South Africa. The high prevalence of alcohol addiction in South Africa has a profound impact on current and future health system resources. For this reason, public and private sectors need to work together in order effectively address alcohol addiction.

This chapter will describe the methodology. It begins with a conceptual framework which is supported by the literature review. Next, each objective is listed followed by a description of the methods used to address them. The chapter then goes on to explore sampling strategy, ethical considerations and finally, dissemination of findings.

Conceptual Framework

The literature review listed a variety of financing and provision arrangements between the government and the private sector. Both PPPs in the Cape Town region consist of partial government financing of private non-profit provision. In these cases, the government subsidizes the private providers to provide good quality inpatient alcohol addiction treatment following the MNSITCs. One is an NGO and the other is a church related facility. These facilities offer PCIAAT services which are an important compliment to the PCIAAT offered by the public sector because they make PCIAAT services more available/accessible.

The private alcohol addiction treatment sector is determined to be all providers who are outside the direct control of government. This includes:

1. For-profit providers
 - a. Private practitioners working in solo or group practices
 - b. Commercial clinic companies
 - c. Traditional healers
2. Non-profit providers
 - a. NGOs, the majority of non-profit providers in South Africa.
 - b. Mission or church related facilities

The private sector was divided into PCIAAT that were registered with the Department of Social Development and those that were not. PPP and private PCIAAT provision is compared with the public sector PCIAAT services.

Purposive sampling was used in order to capture facilities in each of the main ownership groups. This included two PPP facilities, two private registered facilities and two private unregistered facilities. At the time of data collection, only one public PCIAAT facility existed in the Cape Town region.

This study aimed to evaluate different providers of alcohol addiction treatment in terms of quality of care and equity. Public, private and public private partnership PCIAAT centers were investigated. Each was assessed based on process and outcome quality of care as well as geographic, wait-time and income access. The conceptual framework below shows the main links.

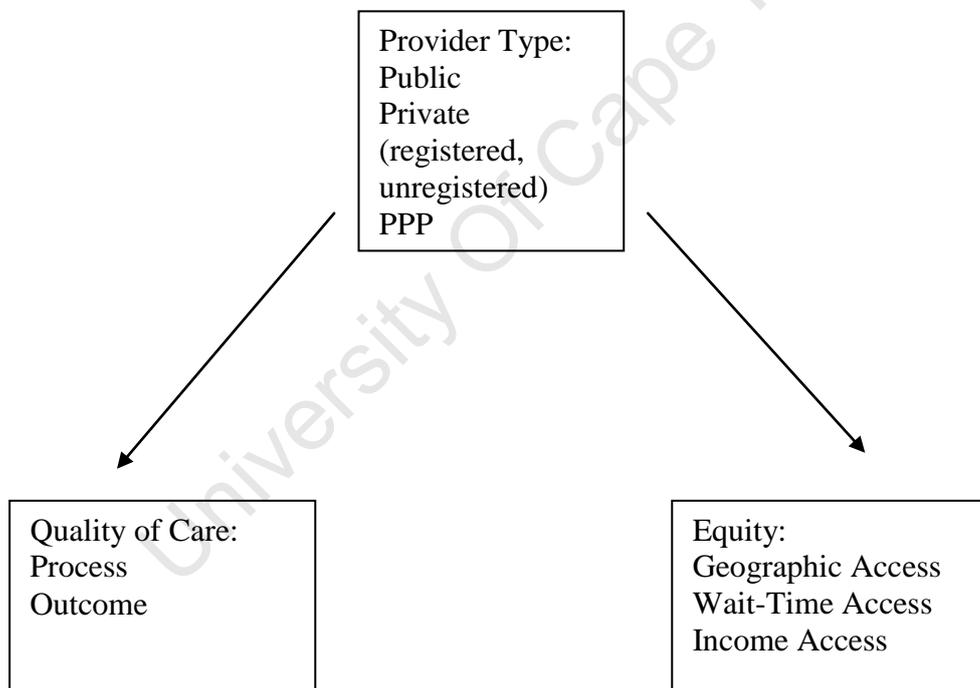


Figure 1: Overall conceptual framework for evaluating providers of alcohol addiction treatment

Document review and semi-structured interviews are the study methods which were used to achieve the aforementioned aim and objectives. Table 1 on page 44 outlines the methods and outcome measures associated with each objective. A detailed

explanation of methods and analysis for each study objective follows. This study was qualitative in nature.

Objective One: To describe the current structure of Cape Town's addiction treatment delivery including public-private interactions.

The researcher used document review in order to answer the first objective. Document review is non-reactive and low in cost. It is therefore frequently used as a starting point for research (Robson, 1993; Bowling, 1997). The content and context in which documents were produced was considered in order to acknowledge potential bias or incompleteness.

The researcher's first task was to list all inpatient alcohol addiction treatment centers in the Cape Town region. The Cape Town region was defined as any facility within a 100 kilometer radius of the city center. The *Overcoming Substance Abuse Resource Directory Western Cape* (NDS, no date) and the *Resource Directory on Alcohol and Drug Related Services and Facilities* (NDS, 2008) were the two publications the researcher consulted for the listing (private unregistered not included).

The *Overcoming Substance Abuse Resource Directory Western Cape* listed the names and provider type (private, public, PPP) of various facilities. The researcher created a chart to record this information. The researcher called facilities in order to determine whether private facilities were profit or not-for-profit. The researcher also asked PPP facilities about their financing/provision agreement.

The researcher looked online in order to determine whether each facility had a website. When a website existed, the researcher read the information in order to ascertain the program duration, inpatient services offered and treatment capacity (for adult men and women) at that particular facility. The points of interest for inpatient services offered included: Level of care (whether the facility was classified as primary, secondary or tertiary), the availability of detoxification, whether a multidisciplinary approach was taken, whether family counseling was offered and finally, whether an aftercare program is in place. Note that only primary care inpatient alcohol addiction treatment facilities were included. If a treatment center did not have a website or if the treatment center's website did not include the necessary information for the study, the researcher consulted the Government's CapeGateway website. All primary alcohol addiction treatment center's program duration, services

offered and capacities were recorded on the chart.

Private unregistered facilities were not included in the *Overcoming Substance Abuse Resource Directory Western Cape* (NDSO, no date) and the *Resource Directory on Alcohol and Drug Related Services and Facilities* (NDSO, 2008). The researcher used the phone book, internet, personal knowledge and key informants to gather unregistered facility names. When speaking to key informants, the researcher's questions were open-ended and exploratory asking whether they were aware of any private unregistered alcohol addiction treatment centers in the Cape Town region. Many of the private unregistered facilities operate under the public's general radar therefore it was impossible to compile an all-inclusive listing.

Objective Two: To evaluate the quality of care of different providers of addiction treatment.

Semi-structured interviews with providers were used to evaluate primary care inpatient alcohol addiction treatment center quality of care. Interview questions were formed based on the *South African Minimum Norms and Standards for Inpatient Treatment Centers* (National Department of Social Development, 2004). The MNSITCs outline the components of care that should be present at all PCIAAT facilities. The review focused on characteristics of provider, treatment methodology, patient assessment/treatment, individualized treatment planning, structured treatment programs and daily activities, follow-up procedures and quality assurance. Quality of care was measured in terms of process and outcome as defined in the literature review.

Data collection was undertaken between April and May 2009. Seven treatment centers were contacted by telephone. The researcher spoke to the director of each facility. She explained her study and asked if they would be interested in participating. The directors asked for the researcher to provide more information and to give them time to decide. The researcher emailed each director a copy of the proposal abstract, full proposal and a consent form for study participation. Written consent for the participation of each facility was obtained from the manager of each respective facility (appendix 3).

One nurse, one addiction counsellor and one manager was interviewed in each facility with few exceptions. A total of 19 semi-structured interviews were conducted

with the managers (n=7), nurses (n=5) and addiction counsellors (n=7) in order to evaluate and compare quality of care between treatment centers. Purposive sampling was used to select participants because the researcher wanted to represent the range of health care providers. Approximately three interviews took place in each of the seven facilities including one interview with the manager, one nurse interview and one addiction counselor interview.

Process quality of care was assessed using half hour semi-structured interviews with nurses, addiction counselors and facility directors. The researcher aimed to collect factual information on providers' implementation of standard addiction treatment guidelines including treatment methodology and patient education. Interviews were conducted at the PCIAAT center being investigated.

Outcome quality of care questions were included in the half hour semi-structured interview with the manager of each treatment facility. This individual was asked about the follow-up procedures used to track patient relapse rates. Interviews were conducted at the PCIAAT center being investigated.

A copy of the interview schedules can be found in appendices 1 and 2. Notes were taken by the interviewer during each interview then analyzed afterwards. The outcome was a break-down of structural and process quality of care for each treatment center revealing the extent to which the MNSITC criteria were present.

Face-to-face interviews enabled the researcher to clear up any confusion through probing, clarifying misunderstandings and/or answering interviewee questions. This meant that the number of "don't know", "unsure" and "neutral" responses was decreased.

Objective Three: To do an exploratory assessment of equity in access in relation to public, private and PPP addiction treatment services in Cape Town.

This study investigated wait-time, income and geographical factors associated with access to PCIAAT in the Cape Town region. The data collection methods that were used to assess the equity of access included document review and semi-structured interviews of facility managers.

The researcher consulted the *Overcoming Substance Abuse Resource Directory*

Western Cape (NDS, no date) and the *Resource Directory on Alcohol and Drug Related Services and Facilities* (NDS, 2008) in order to obtain the addresses of the public, PPP and private registered primary care inpatient alcohol addiction treatment facilities. She consulted the websites of the two private unregistered facilities in order to determine their addresses. Addresses were divided into one of two categories: Northern suburbs or Southern suburbs. The Northern suburbs of Cape Town are characterized by low and mid socioeconomic status and mid-high unemployment. The Southern suburbs of Cape Town are characterized by low unemployment and high socio-economic status. Facility locations were listed on a chart according to provider type.

The cost of treatment at each facility was determined by reviewing the facility's website or contacting the facility directly (phone, email, in person).

Seven facility managers were interviewed in order to determine wait-time access. Managers were questioned regarding wait-list time in a semi-structured interview format.

In order to add to the richness of the data, the researcher questioned PCIAAT facility managers regarding the average race and gender make-up of those seeking treatment at their facility. A copy of the facility manager interview schedule may be found in Appendix 2.

Objective Four: On the basis of these findings, to make recommendations on how policy-makers in South Africa and elsewhere could best improve quality of care and equity with regards to the provision of addiction treatment.

Based on her findings for objectives two and three, the researcher made recommendations for improving the equity and quality of care of addiction treatment delivery in Cape Town region. The generalisability of findings to other settings was explored.

Table 1. Objectives, methods and outcome measures

Objective	Methods Used	Sampling Method	Sample Size	Outcome Measures
1. Describe current structure of Cape Town's addiction treatment delivery including public-private interactions	1. Document review of published and unpublished literature	1. Not relevant	1. Not relevant	List Cape Town region's PCIAAT providers, their public/private orientation, length of treatment program, description of services they offer, capacity
2. Evaluate and compare procedural and outcome quality of care between different providers of addiction treatment	1. Outcome Quality: Semi-structured interview with facility manager 2. Process Quality: Semi-structured interview with nurse and addiction counsellor at each facility	1. Purposive sampling 2. Purposive sampling	1. 7 interviews 2. 12 interviews	1. Outcome Quality of Care: Follow-up procedure for patients 2. Process Quality of Care: Characteristics of provider, treatment methodology, patient assessment/treatment, individualized treatment planning, structured treatment programs and daily activities
3. To do an exploratory assessment of equity in access in relation to public, private and PPP addiction treatment services in Cape Town.	1. Determine geographic location and cost of treatment at PCIAAT facilities in Cape Town 2. Semi-structured interview questions regarding wait-times	1. Not relevant 2. Purposive sampling	1. All PCIAAT facilities in Cape Town region 2. 7 interviews	1. Geographic location of facilities 2. Cost of treatment 3. Knowledge of how time-accessible PCIAAT is
4. Make recommendations on how policy-makers in South Africa and elsewhere could best improve quality of care and equity with regards to the provision of addiction treatment.	Interpretation of results from objectives 2 and 3	Not relevant	Not relevant	1. The information gathered in the study will be used to make recommendations on how to improve PCIAAT quality of care and equity in the Cape Town region. 2. The generalisability of findings to other settings will also be explored.

Sampling (Size and Technique)

Non-randomized purposive sampling was used to select sites according to the manager's availability and willingness to participate in the study. The researcher selected cases with the purpose of capturing facilities in each of the main ownership groups. Seven treatment centers including one from the public sector, two from the private registered sector, two from the private unregistered sector and two public private partnerships were investigated in order to explore the variation in access and quality of PCIAAT received in Cape Town.

The researcher approached eight PCIAAT facilities. One manager at a private registered facility did not agree to participate. All others were keen to take part in the study. When a manager agreed for their facility to participate in the study, the researcher asked that the manager arrange for the researcher to meet with him/herself as well as one nurse and one addiction counselor within the facility. Through interviewing different providers at alcohol addiction treatment centers with various orientations, the researcher gained a range of perspectives.

In the end, only five out of seven nurses were interviewed. This was because two Treatment Center Managers felt their nurses had other priorities and were too busy. Seven addiction counselors and seven managers were interviewed.

Ethical Considerations

The researcher was granted ethics approval for this study from the University of Cape Town Health Sciences Ethics Committee. The researcher adhered to the principles of informed consent, minimization of risk and anonymity. Each facility director was contacted, given a short explanation of the study and asked whether they would like to participate. Those who agreed were asked to sign a consent form. The consent form explained that the facility could withdraw from the study at any time (see appendix 3). Risk was minimized because no patients were interviewed, only providers. The study was anonymous meaning that the names of the interviewees were not identified.

Dissemination of findings

Information from this study may be used to improve quality of care and equity of

access to addiction treatment in the Cape Town region. Results will be disseminated to appropriate stakeholders within South Africa, and other low and middle-income countries that may benefit from the findings.

The author intends to publish her findings. She will submit a manuscript for peer-review publication upon completion of the study.

Conclusion

This chapter described and justified the methodology used for each objective. It presented a conceptual framework then went on to describe sampling strategy, ethical considerations and dissemination of findings. This study used document review and nineteen semi-structured interviews in order to examine quality of care and access to PCIAAT services in the Cape Town region.

University Of Cape Town

Chapter 4: Results

Introduction

The objectives of this study were listed and described in detail in Chapter one. This section presents the results in accordance with each objective. A description of Cape Town's primary care inpatient alcohol addiction treatment structure is followed by the results of the quality of care and access investigations. The results section of this study separated addiction treatment centers according to their orientation in order to observe whether there were any patterned differences between them.

Description of PCIAAT in Cape Town

Table 1 below presents the PCIAAT Centers in the Cape Town region investigated. Twelve PCIAAT centers were identified. They are organized according to their provider type. The length of treatment program and services offered at each institution are described as well as their capacity.

University Of Cape Town

Table 2: Description of PCIAAT Services in Cape

Primary Care Inpatient Addiction Treatment Centers serving Alcohol Addicts	Provider Type (public, PPP, private registered or private unregistered)	Length of Treatment Program	Inpatient Services Offered: Detox, multidisciplinary treatment approach, family counseling, aftercare	Capacity, adult men and women
Facility 1	Public	7 weeks	No detox; Multidisciplinary approach; Family therapy; Aftercare not in full operation though starting	80 adults (60 men, 20 women)
Facility 2	PPP	5 weeks	1 week detox; Multidisciplinary approach; Family therapy; Aftercare	40 adults, men and women
Facility 3	PPP	12 weeks	No detox; Multidisciplinary approach; Family therapy; No aftercare	60 adults, men only
Facility 6	Unregistered Private	4 weeks	Detox; Multidisciplinary; Family counseling; Aftercare	18 adults, men and women
Facility 7 ***Consider themselves an extended primary facility i.e. between primary and secondary	Unregistered Private	4 weeks	No detox; Multidisciplinary; Family counseling; No aftercare	18 adults, men and women
Facility 8	Registered Private	3 weeks	Detox; Multidisciplinary approach; Family program; Aftercare	24 adults, men and women
Facility 9	Registered Private	3 weeks	Detox; Multidisciplinary approach; Family therapy; Aftercare	15 adults, men and women
Facility 4	Registered Private	3 weeks	Detox; Multidisciplinary approach; Family therapy; Aftercare	24 adults, men and women
Facility 10	Registered Private	4 weeks	No detox; Multidisciplinary approach; Family therapy; Aftercare	15 adults, men and women
Facility 11	Registered Private	8 weeks	No detox; Multidisciplinary approach; Family therapy; Aftercare	20-25, men only
Facility 5	Registered Private	3 weeks	Detox; Multidisciplinary approach; Family program; Aftercare	30 adults, men and women
Facility 12	Registered Private	12 weeks	Detox; Multidisciplinary approach; Family program; Aftercare	22 adults, men and women

One public facility and two PPP facilities are found amongst the total of twelve PCIAAT centers identified in the Cape Town region. All others are private. These are divided into registered and unregistered. Seven facilities are registered with the Department of Social Development for the Cape Town region. It is very difficult to identify unregistered addiction treatment centers due to their lack of regulation. Two unregistered facilities were identified however it is certain that more exist. Note that the centers listed treat people struggling with a range of addictions including drug abuse and eating disorders. Alcohol addiction treatment is just one of their services.

The public and PPP facilities have some of the longest treatment program durations. The public facility has a seven week program where as the PPP facilities have twelve and five week programs. Note that in the private sector, a patient can choose to pay to extend their stay however in the public and PPP sectors, treatment duration is set. Both private unregistered facilities had four week program durations. Five weeks was the average duration of a private registered facility's program duration. The range for private registered facility treatment duration was between three weeks and twelve weeks with a median treatment duration of three weeks.

The public facility does not offer detox services nor does one of the two PPP facilities. These patients are expected to detox using hospital programs before being admitted. One of the two private unregistered facilities offered detox. However, it is important to note that the private unregistered facility which does not offer detox considers themselves to be in-between a primary and secondary care facility rather than a pure primary care facility. Five of the seven private registered facilities offer detox services.

All facilities use a multidisciplinary approach and included some form of family counseling. Aftercare is not offered at the public facility or one of the two PPP facilities. One of the two private unregistered facilities provides aftercare. All private registered facilities offer aftercare.

With a capacity of 80 patients, the public facility was the largest primary care inpatient alcohol addiction treatment center in existence in the Cape Town area. The PPP facilities were mid-size including one 40 patient facility and one 60 patient facility. Each of the private unregistered facilities had a patient capacity of 18. The private registered facilities were small in size, averaging 22 patients and ranging

between 15 and 30 patients. It is interesting to note that despite the fact that there are fewer public and PPP facilities in existence, these serve a total of 160 patients where as the more numerous private registered and unregistered facilities serve a total of 188 patients.

Two sites were men only including one PPP and one private registered. The other treatment centers welcomed both men and women. However, an unequal ratio requisite of 60:20 men:women was stated for the public facility.

Cape Town inpatient alcohol addiction treatment quality of care

The second objective was to investigate quality of care using the *Minimum Norms and Standards for Inpatient Treatment Centers* as a benchmark. These standards were published in 2004 by the National Department of Social Development. The purpose was to standardize services, facilitate transformation and improve the quality of services. The standards "...contribute positively towards the regulation of treatment centers as well as ensure that services rendered by these centers are sensitive to the prevailing human rights culture and are in line with the legal and constitutional framework of the country" (NDSD, 2004, p. 3). Semi-structured interviews with providers revealed the extent to which the standards are followed at various treatment centers. The quality of care results were separated under various headings including: characteristics of provider, treatment methodology, patient assessment/treatment, individualized treatment planning, structured treatment programs and daily activities, quality assurance as well as follow-up procedures.

Five of the seven facilities agreed to the researcher interviewing a nurse. One PPP facility does not have a nurse on its staff. One private registered facility stated that their nurses were busy with other priorities. All addiction treatment centers agreed for the researcher to interview an addiction counselor or their equivalent as well as the facility manager.

Characteristics of Provider

This section explains the characteristics of the addiction counselors and nurses interviewed. It was valuable for identifying the reliability of the responses provided by the interviewees as it states their qualifications, work experience and work experience with the treatment center investigated.

Table 3: Nurse and addiction counselor characteristics

	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7
Orientation	Public	PPP	PPP	Private Registered	Private Registered	Private Unregistered	Private Unregistered
Nurse: Most recent qualification	1981 Psychiatric Nurse qualification	Theatre Nurse qualification		RN 2000		Anesthetic Course 2004	1981 Psychiatric Nurse qualification
Counselor: Most recent qualification	Social Worker Degree 2002	Masters Psychology/ Counseling 1994	BA, BTheology -trained as addiction counselor via practical experience and addict himself	Diploma Counseling and Communication 2005	National counselor in England -1 st completed 2001, updated every three years	Graduate Diploma Counseling 2007	4 year Social Work Degree Honors Psychology 91
Nurse: Duration of time working at facility	21 years	8 years		6 years		3 months	1 year, 4 months
Counselor: Duration of time working at facility	4 years	5 years	10 years	4 years	11 years	8 months	11 months
Nurse: Prior work placement	Psychiatric Hospital	Surgical Theatre		Child Psychiatry		Entrepreneur Nurse	Another Addiction Treatment Center
Counselor: Prior work placement	NGO	Children's home, reformatory	Another Addiction Treatment Center	Home with kids	Another Addiction Treatment Center	Another Addiction Treatment Center	Another Addiction Treatment Center
Nurse: Registration with an official professional or accrediting body?	SA Nursing Council	SA Nursing Council		SA Nursing Council		SA Nursing Council	SA Nursing Council
Counselor: Registration with an official professional or accrediting body?	SA Council of Social Service Profession	Health Professionals Council of SA Registered Psychologist	No	No	England Federation of Drug and Alcohol Professionals	No	SA Council of Social Service Profession

It is notable that four of the five nurses interviewed further educated themselves in the nursing field after their RN certification. The public center nurse and one of the private unregistered nurses' most recent qualification was specialized training in psychiatric nursing. The other two nurses' most recent specialized training was unrelated to the field of addiction. The nurse who did not have further training was located at the private registered facility.

Addiction counselors at the various treatment centers had a variety of qualifications including social worker, counseling and theology. There is no official addiction counselor qualification. However, all counselors had formal qualifications in related fields.

Three nurses had greater than five years experience at their respective treatment centers. The public center nurse had worked at the facility for 21 years followed by the PPP nurse working for eight years and the private registered nurse working for 6 years at their respective facilities. The two private unregistered facilities were recently opened which explains the nurses' short term there.

With the exception of those working at the two recently opened private unregistered facilities, all addiction counselors have worked at their respective addiction treatment centers for four years or more. One of the PPP counselors worked at his post for eleven years. One of the private registered counselors had been with their organization for ten years.

The public sector nurse and one of the PPP nurses had previously worked in a psychiatric hospital. One of the private unregistered nurses had previously worked in an addiction treatment center. The remaining private registered and private unregistered nurses had unrelated prior jobs.

Four of the seven addiction counselors worked in another addiction treatment center immediately prior to their current job. The public sector social worker, one of the PPP counselors and one of the private registered counselors had unrelated previous jobs.

All nurses interviewed were registered with the South African Nursing Council. There is no accrediting body for addiction counselors, therefore, three addiction counselors

were not registered with an accrediting body including one PPP, one private registered and one private unregistered counselor. The public counselor had a social work degree and was therefore registered with the SA Social Service Profession Council. The PPP counselor who had a Masters in Psychology was a Registered Psychologist with the SA Health Professionals Council. The private registered clinic counselor was registered with the England Federation of Drug and Alcohol Professionals. The remaining private unregistered counselor has a social work degree and is therefore registered with the SA Social Service Profession Council.

Treatment Methodology

Both nurses and addiction counselors were questioned regarding the treatment methodology at each treatment centre. The findings indicate that the interviewees at the treatment centers investigated generally believe that their sites follow the recommended guidelines. A copy of the guidelines is available to staff at the majority of facilities.

The public and PPP interviewees responded that the MNSITCs were followed. At one of the private registered facilities, the nurse said they try to follow the MNSITC guidelines and the addiction counselor said they don't know whether the guidelines are followed or not. The nurse at one of the private unregistered facilities indicated that the center is not registered and is therefore unable to follow the MNSITCs for some things e.g. not registered for medication. The addiction counselor at this facility said that yes MNSITC standards were adhered to. The other private registered and private unregistered facility respondents indicated that MNSITC standards were adhered to.

A copy of the MNSITCs was available for staff at all facilities with the exception of one PPP and one private registered facility. At the PPP facility, both the nurse and addiction counselor were unaware of whether there was a staff copy of the MNSITCs available. At the private registered facility, the nurse stated that a copy of the guidelines was available for staff, however, the addiction counselor did not know.

Patient Assessment/Treatment

In order to more thoroughly examine treatment methodology with regards to the *Minimum Norms and Standards for Inpatient Treatment Centers*, more detailed questions were asked. These questions centered around patient assessment and

treatment.

It was difficult to determine whether each facility did both an initial and comprehensive assessment. Each had a different admittance procedure for patients to undergo. The trend was for public and public-private mix facilities to require medical assessments to be completed by external medical practitioners prior to admission. It is unclear as to whether these can be counted as intake assessments. At one of the private registered facilities, the nurse indicated that the intake assessment is completed within eight hours unless the patient comes in at night in which case, they are assessed in the morning. The counselor at this same facility said that patients are not always assessed within eight hours of arrival because, if intoxicated, the center allows a couple days for detox before assessment because the assessment would otherwise be inaccurate. The counselor stated that if the patient is sober upon arrival, the intake assessment is undergone within a day. Note that this facility offers a detox program.

Providers indicated that all facilities had medical practitioners complete the intake assessment. The initial assessment at all facilities included: Personal details/history, mental state examination, physical examination/history and a history of substance abuse. Just about all centers covered provisional psychiatric history and assessment of risk potential in their initial assessment. For one private registered and one private unregistered facility, there was some disagreement between nurses and counselors as to whether the intake assessment included a provisional psychiatric history and diagnosis. One of the private registered facilities' nurse said a provisional psychiatric history is assessed however the counselor said that the patient usually volunteers this information or it comes up during the treatment program then further assessment takes place. This implies that a provisional psychiatric history is not covered in the initial assessment. The nurse at the private unregistered facility indicated that sometimes the provisional psychiatric history does not come up until counseling group due to the addict's denial. The counselor at the same facility said it is covered in the initial assessment. It should be considered that nurses have a greater knowledge of intake assessment procedures as compared to addiction counselors because of their medical involvement.

Table 3 explores some of the responses of nurses and addiction counselors regarding patient assessment and treatment.

Table 4: Patient Assessment/Treatment

	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7
Orientation	Public	PPP	PPP	Private Registered	Private Registered	Private Unregistered	Private Unregistered
Comprehensive assessment completed when and by whom?	Various professionals (nurse, doctor, social worker) during first week	Doctor day after admission	?	Nurse sometimes immediately after doctor upon admission. Patient sees counselors within 24 hours of admission if detoxed.	Psychiatrist when sober (48 hours)	Doctor after admission i.e. 6-24 hours Counselor: By counselor, within first few days	Within 24 hours of arrival assessments done by nurse, psychiatrist, counselor & dietician
Results reviewed by case manager and multidisciplinary team	Yes	Nurse: Yes Counselor: 'sort of'	Yes	Nurse: No. In process of happening but not at moment Counselor: Yes	Yes	Yes	Yes
How often does the multidisciplinary team formally review the patient's treatment progress?	Formal evaluation at fourth week. Informal every morning between members of multidisciplinary team.	Twice during 5 week program	weekly	Nurse: Every day Counselor: Clinical meeting once a week	daily	weekly	weekly

Comprehensive assessments were completed at all facilities with the possible exception of one PPP facility where it was vague as to whether this was done. A variety of professionals see the patient within their first week which may include nurse, doctor, social worker, counselor, psychiatrist, dietician. Each conducts their own assessment making up the psychiatric, physical, psychosocial, developmental, functional and vocational components of the comprehensive assessment. Patients are referred for more in-depth psychological, social work, psychometric or physical evaluations if necessary. Private registered facility five does not cover vocational needs because their patients are educated and of high-socio economic status, therefore, the treatment center does not feel this is necessary. Though PPP facility three does not conduct a full comprehensive assessment, they do refer patients for more in-depth psychological, social work, psychometric or physical evaluations if needed. All facilities recorded assessments in a timely and accurate manner and gave patient feedback on the results of the assessment process.

Assessments at all facilities are reviewed by the case manager and the center's multidisciplinary team. Both registered and unregistered private facilities were able to follow the MNSITC recommendation for a weekly formal assessment of patient treatment progress. One PPP facility also adhered to the MNSITC recommendation. However, one public-private mix facility formally evaluated the patient's treatment progress twice during their five week program and the public facility completed one formal progress review during the duration of the patient's stay.

Individualized treatment planning

The following section explores the extent to which the various treatment programs were individualized. This includes informed consent, care choice, patient education, pregnant patient support, nutrition, written treatment plans and case management.

There is one private registered treatment center that admits patients without informed consent. The nurse said patients may be admitted without informed consent because it could be a family, work or legal intervention that admits the patient. The counselor at the same facility said that patients' informed consent is not necessarily obtained. All other treatment facilities require patient informed consent prior to admission.

One private registered center's nurse stated that patients are not always given the opportunity, as far as possible and appropriate, to make choices regarding their care. However, the counselor at the same facility said the opposite. All other treatment facilities incorporate patient participation in choices regarding their care.

All facilities have patient education programs on addiction and provide information and practical-support on maintaining a healthy, alcohol-free lifestyle. All facilities, except potentially one private unregistered facility, provided information and practical support to prevent the onset and spread of HIV and other sexually transmitted infections. At the aforementioned facility, the nurse said yes however the counselor said that voluntary testing and counseling for HIV was offered on an adhoc basis.

Four of the seven clinics including public, both private registered and one of the private unregistered offered support to pregnant patients. One PPP facility does not intake pregnant patients due to the ethical questions with regards to the detox medication. The other PPP facility only admits men. And finally, the second private unregistered facility is new and has never had a pregnant patient request treatment. Therefore, they are unsure as to their pregnant patient policy.

Access to nutritional support and supplements is available at all treatment centers with the exception of one PPP facility. This PPP facility provides supplements but does not have dietician support.

Patient plans are individualized with relevant patient factors considered at all centers investigated. Relevant factors considered when creating a patient's treatment plan included nature of their substance addiction/dependency, psychiatric/psychological conditions (symptoms, severity and history), personal preferences, strengths and characteristics as well as social needs and circumstances.

At all but two alcohol addiction treatment centers including one PPP and one private registered facility, the patient's written individual treatment plans contained a clear and concise statement of patient's current strengths and needs as well as the short and long-term goals the patient is attempting to achieve; type and frequency of therapeutic activities and treatment program in which the patient will be participating; staff responsible for the patient's treatment and their individual counselor; as well as the patient's responsibilities and commitment to the rehabilitation process. One of the PPP facility's only written individual treatment documentation included a listing of

staff responsible for the patient's treatment. They did not include a clear and concise statement of patient's current strengths and needs as well as short and long-term goals the patient is attempting to achieve. Nor did they include the type and frequency of therapeutic activities and treatment program in which the patient will be participating. It was vague as to whether the patient's responsibilities and commitment to the rehabilitation process was included in the written individual treatment plan. One of the private registered facilities listed patient needs but not their strengths. At the same facility, the nurse said that a statement of the short and long-term goals the patient is attempting to achieve is written however the counselor said they are not.

At no facility was there a written treatment plan which was dated and signed by both the individual counselor and patient with a copy for each. At five facilities including the public, one PPP, one private registered and both private unregistered, the counselor signed and dated the plan then kept it on file with no required patient signature or copy given to the patient. At one PPP and one private registered facility, the written plan was not dated and signed by anyone.

Each client at all facilities had a case manager. Case managers fulfilled their roles including assisting patients to develop their treatment goals, providing regular documented support and motivation, acting as a liaison person for families/caregivers/role players; meeting weekly with patients for a minimum of 30 minutes and being reasonably accessible to patients for support and crisis intervention. At one of the private registered facilities, the nurse indicated that the case manager's role does not include assisting patients to develop their treatment goals, providing regular documented support/motivation and for acting as a liaison person for other families/caregivers/role players. However, the counselor at this same facility stated that case managers do have this role.

Structured treatment programs and daily activities

Treatment providers were interviewed regarding the treatment programs at their facilities. All treatment centers met the 40 hour per week treatment program requisite. Only one treatment center did not regularly review and update their treatment program in accordance with internationally accepted standards. This was a PPP center.

All treatment programs had structured weekly and daily activities including individual,

group and family counseling as well as organized group activities such as sport, health education, recreation and creative activities. Each center had documented policies and procedures which are implemented to guide daily activities including waking and sleeping times, phone use for private conversations, visits from family, friends, religious leaders and legal counsel and outings.

Quality Assurance

Quality assurance was assessed by speaking to the facility manager. As demonstrated in table 5 below, all facilities made an effort to investigate whether patients were satisfied with their addiction care.

Table 5: Quality Assurance

	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7
Orientation	Public	PPP	PPP	Private Registered	Private Registered	Private Unregistered	Private Unregistered
Review patient satisfaction with addiction care assessment	Sort of, it seems	Yes	Yes	Not formally	Yes	Yes	Yes
Change in counselor option	Yes but seldom allow it. Patient needs a very good reason.	Yes will consider but reluctant if no substantial grounds.	Yes but want to know why. Written request required.	Yes but unusual. Would have to be well motivated.	Yes	Yes	Yes but not considered lightly.

In accordance with the MNSITCs, patients at all facilities have the option of changing counselors should they provide sufficient motivation. What follows is a more detailed description of how facilities seek feedback from their patients. If quality of care is

assessed in any other way at the facility, it is also included.

The public facility uses the patient progress evaluation, a questionnaire as well as informal verbal and written methods in order to obtain feedback from patients. The patient receives an evaluation of their progress at the fourth week of treatment. At this time, the patient is given the opportunity to state any feedback for the treatment center. Patients use this method sometimes. The treatment center will sometimes randomly administer a questionnaire to patients at the end of the treatment program. There is a high response rate when this occurs. The manager walks around the treatment center every day. Patients frequently give verbal feedback to both the general manager as well as other management staff walking around. The patients are told to put feedback in writing however they almost never do.

Facility 2 PPP uses weekly feedback meetings, exit meeting with patients, informal verbal contact and personnel meetings in order to obtain treatment program feedback. Currently, there is a weekly meeting with patients so that they have the opportunity to discuss any problems. This is because the manager wants to resolve the problems while the patient is still in house rather than only asking for feedback once they leave. The manager has a group meeting with the exit group of patients so they can give feedback knowing that nothing will be held against them because they are leaving. The manager finds that the patients often give valuable suggestions e.g. biokineticist in morning not evening. Patients have the option to approach the manager or their counselor with verbal feedback. If a patient is unhappy with the way the manager handles their complaint then they are to approach the CEO of the overarching church organization. Personnel meetings enable the staff to comment on each other's performance as well as the treatment program itself.

Facility 3 PPP uses milestone days, one on one meetings with the manger, an exit forum, lecture time and staff meetings to obtain treatment program feedback. There are milestone days celebrated at the ten, fifteen and twenty day marks within the program. A public forum is held during which patients are given the opportunity to provide feedback. The manager has a one on one meeting with each patient once a month regarding whether they are happy. Patients are welcome to make an appointment via their counselor in order to see the manager. Counselors are aware that this is encouraged. Upon completion of the program, there is a forum where each staff member gives feedback to the patient. It is also an informal opportunity for

the patient to give feedback to the staff. When the manager leads the 12 step lectures, sometimes they turn into feedback meetings. Patients often use all of these methods to give feedback. If ever there is a patient complaint, the manager will investigate thoroughly. Every morning the staff meet to discuss patients.

Questionnaire, verbal and written methods are used to obtain feedback at Facility 4 Private Registered. All patients receive a follow-up questionnaire with space for additional comments three months post-treatment. The response rate is sometimes. While still a patient, patients can speak to a counselor, the nursing staff or the administrative team regarding the facility or any aspect of care. This is used sometimes. There is a notice posted outside the manager's office which invites patients to submit a grievance. This entails filling out a form and submitting it to their counselor. Ultimately, the manager will investigate. This mechanism is used almost never.

Patients have numerous feedback mechanisms at Facility 5 Private Registered. These include community meeting, patient survey and treatment outcomes. These methods are used often. A community meeting takes place every Monday and a business meeting occurs every Wednesday. Patients are welcome to state their views at these meetings. Alternatively, they can consult with their counselor or speak to the clinical director/CEO. A patient survey is conducted three days prior to patient departure, which includes questions on the facility, nurses, counselors, treatment program, administration and transport. The response rate is 100%. The clinical director has laid out nine treatment outcomes. The clinical director assesses these weekly by looking at patient files and the discharge report. Input from referring doctors and psychiatrists regarding how the patient is doing is taken into consideration.

Facility 6 Private Unregistered conducts a community meeting for fifteen minutes every day. Patients can verbalize any complaints or submit them in writing. Alternatively, patients can speak to the nurse, counselor or receptionist and will be listened to. The information is then passed on to the counselor who will ensure it is portrayed to the right person. Patients often use these feedback mechanisms. Once a week, an external psychologist is on site to do case management and staff supervision. The daily unit coordinator and weekly external psychologist look for anything that needs to be tightened up regarding each patient's process and treatment. If a counselor is battling due to patient overload, the unit coordinator will

take over a life skills lecture or a focus group so that counseling quality is not compromised.

There is a community group with no staff present held once a week at Facility 7 Private Unregistered. Patients give feedback and results are fed back to staff. During the first couple of weeks, clients complain often. It is usually the same pattern of complaints regarding food and menial things outside themselves (typical of addict i.e. focus outside self to avoid internal). After the first couple of weeks, complaints drop off to almost never. Patients can ask their counselor any questions they have. If the counselor cannot resolve things then they will refer the patient to the manager. This method is used often. There is a grievance form in place for serious things. This is used almost never. The operations manager examines systems on an ongoing basis. There is a management meeting once a week. This is a place for staff to bring concerns. Anything that the manager notices throughout the day is addressed e.g. a staff member reprimanded a patient in front of her so she approached the staff member as to how to handle the situation better. A ward round is conducted twice a week. There are two feedback sessions daily as the day shift passes over to the night shift and vice versa. A five page questionnaire is filled out the day before patients leave with a 100% response rate.

Follow-Up Procedure

Nurses and addiction counselors were asked about patient follow-up. Only one treatment center formally traces whether patients relapse or not. This is a private unregistered facility.

The public addiction treatment facility only accepts patients that are recommended by an external social worker. Therefore, only the external social workers can apply for readmission of a patient. For example, if referred by the magistrate, if the family asks for help or if the patient approaches the social worker asking for further treatment.

A staff member of PPP facility two attends external addiction recovery meetings. They informally report back to the facility as far as how ex-patients are doing. Unfortunately, there are not resources available to do this on a large scale. Also, relapsers cannot be forced to return for more treatment should they be struggling. It has to be of the ex-patient's own initiative. Patients know that they are welcome to return. PPP facility three states that only if the alcoholic sincerely tried to maintain

sobriety/recovery while they were out can they apply to come back.

Private registered facility four offers a two week relapse program should the patient initiate to return. They often hear via word of mouth as to how ex-patients are doing, however, they do not formally trace them. Private registered facility five does not trace relapsers in general. However, in 2004 they paid for a study to be conducted which provided them with valuable results as to patient relapse rates.

Private unregistered facility six stated that they trace relapsers. They are a primary addiction treatment facility which is part of an organization which also owns both secondary and tertiary facilities. Therefore, between the three clinics, patient progress is tracked. The facility offers a once a week for six months aftercare program. Should patients choose not to attend, they are not traced. Post-aftercare, patients are not tracked. The initiative to return for treatment post-relapse rests with the patient. Private unregistered facility seven does not formally trace relapsers. Through word of mouth, they informally hear about how ex-patients are progressing. For example, referral sources, those who attend meetings and the clients themselves can offer feedback. Another factor is that most patients come from overseas. Therefore, referral sources are most likely to provide feedback. Patients are welcome to readmit themselves into the facility.

In conclusion, Health care managers provided very similar results to the nurses and counselors interviewed in terms of quality of care provided. It is notable that there were few differences in the quality of care reported by public, public-private mix, private registered and private unregistered facilities.

Access to primary care inpatient alcohol addiction treatment in Cape Town

The third objective investigated equity in terms of geographic, cost and wait-time access for PCIAAT. Managers were asked to approximate the racial, gender and socio-economic status composition of their treatment centers. Table 6 below presents the geographic, cost and wait-list time findings.

Table 6: Geographic, Cost and Waitlist Time Access for alcohol addiction inpatient treatment

Primary Care Treatment Centers serving Alcohol Addicts (not exclusively)	Geographic Location	Cost to patient	Average Waitlist Time
Facility 1: Public	Northern suburbs characterized by low and middle class, low and mid socioeconomic status and mid-high unemployment.	Free	30 days
Facility 2: PPP	Northern suburbs characterized by low and middle class, low and mid socioeconomic status and mid-high unemployment.	1.Full cost = R16,920 2.Sliding scale that works according to income 3.If sponsored = patient pays R5,250 4.Take one person/month at 0 cost to patient	No waitlist
Facility 3: PPP	Northern suburbs characterized by low and middle class, low and mid socioeconomic status and mid-high unemployment.	Cost = R16,500 Or a contribution based on what patient can afford	No waitlist
Facility 4: Private Unregistered	Southern Suburbs characterized by upper-middle class and upper class, low unemployment and high socio-economic status.	Detox four days = R4,000 28 days primary care = R28,000 Total = R32,000	No waitlist
Facility 5: Private Unregistered	Southern Suburbs characterized by upper-middle class and upper class, low unemployment and high socio-economic status.	Private room = R125,400/month Twin room = R62,700/month	Few days
Facility 8: Private Registered	Northern suburbs characterized by low and middle class, low and mid socioeconomic status and mid-high unemployment.	R39,350	No waitlist
Facility 9: Private Registered	Southern Suburbs characterized by upper-middle class and upper class, low unemployment and high socio-economic status.	R36,000	1-2 days
Facility 4: Private Registered	Southern Suburbs characterized by upper-middle class and upper class, low unemployment and high socio-economic status.	3 weeks for local patients = R53,350.13 4 weeks for international patients = R70,579.50	2 days
Facility 10: Private Registered	Southern Suburbs characterized by upper-middle class and upper class, low unemployment and high socio-economic status.	R18,000	No waitlist
Facility 11: Private Registered	Northern suburbs characterized by low and middle class, low and mid socioeconomic status and mid-high unemployment.	R5,000	1 day
Facility 5: Private Registered	Southern Suburbs characterized by upper-middle class and upper class, low unemployment and high socio-economic status.	R59,288	No waitlist.
Facility 12: Private Registered	Southern Suburbs characterized by upper-middle class and upper class, low unemployment and high socio-economic status.	R71,400	7 days

The public and PPP facilities were all located in the Northern Suburbs of Cape Town which are characterized by residents who have low and mid socioeconomic status and mid to high unemployment. Both private unregistered facilities were located in the Southern Suburbs which are characterized by individuals who have low unemployment and high socio-economic status. Five of the seven private registered facilities were located in the Southern suburbs and two were located in the Northern suburbs.

Alcohol addiction treatment at the public facility is provided free of charge. Treatment cost at PPP facilities was R16,500 at one and R16,920 at the other. However, one facility has a 7 week program duration where as the other has a 12 week program duration. Cost was flexible according to income status at both PPP facilities. Both private unregistered facilities had high costs for treatment (exceeding R30,000). Five of seven private registered facilities had high costs for treatment (exceeding R30,000). The remaining two private registered facilities charged R18,000R and R5,000 for treatment respectively.

The public sector had a one month wait list. Neither PPP had a waitlist. According to the results, private sector patients rarely have to wait more than a few days to be admitted for treatment.

Managers responded to questions around service delivery and access. Their responses may be found in Table 7 below.

Table 7: Service Delivery and Access

	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7
Orientation	Public	PPP	PPP	Private Registered	Private Registered	Private Unregistered	Private Unregistered
Main groups in the community served by this clinic (race, gender, socio-economic status)	75-80% Colored 10-15% White less than 5% Black/African Gender defined by 80:20 male:female ratio Socioeconomic status = low strata	White, Colored primarily minority Black/African Gender= mostly men Socioeconomic status = many unemployed, not subeconomic but not middle-class, just below middle class	70% Colored 15% Black/African rest=majority White Men only Low socioeconomic status (majority from townships)	White 50% Colored 45% Black/African 5% 60:40 male/female Socioeconomic status = middle class and working class	White 80% Colored 15% Black/African 5% 60:40 male/female High socioeconomic status	White 60-70% Colored 30-40% Black/African less than 1% 60:40 male/female Middle to high socioeconomic status	8% Indian/Muslim 2% Colored rest=White 60:40 male/female High socioeconomic status
Can everyone be treated here? If no, what are the main obstacles?	Yes. Even white professionals can come without paying.	Yes.	Evaluated first regarding whether they are willing to accept help. If so, yes.	No. Financial resources of either money or medical aid that will cover the cost is required.	No. Financial requirements.	Yes e.g. have some sponsored beds. Possible but not probable that everyone could be treated there.	No. Financial requirements. Do not accept medical aid therefore big barrier.
Are there people living in this area who do not come to this treatment center to seek care for their alcohol addiction?	Doubts it	Don't know.	Not that manager is aware of.	Yes	Yes	Not that manager knows of.	Yes
If no, why? Where do they go to seek treatment for their alcohol addiction?	n/a	Could go to state or more expensive facility. Perhaps they don't know about them.	n/a	Financial reasons therefore go elsewhere. Or similar facility=competition.	Financial and growing choices of other facilities	Some people want help but don't want inpatient care therefore there are other options e.g. 12 step, therapy, CTDC	Other treatment centers

There was a definite racial divide according to the treatment center orientation. Colored patients made up the majority of public and PPP patients where as White patients made up the vast majority of those admitted to private registered and unregistered clinics. The Black/African population was virtually non-existent in all of the facilities.

The socio-economic status was low for the public and PPP facility patients and ranged from middle class to upper class for private facility patients. The most prevalent male female patient ratio was 60:40. The major obstacle to obtaining treatment was financial. This was present at all private facilities. Competition and lack of awareness were the two reasons listed for patients not seeking care at a particular facility.

Results Conclusion

This chapter presented the results for objectives one through three. In general, there was uniformity in the views of all health care providers including managers, nurses and addiction counselors. The description of Cape Town area primary care inpatient alcohol addiction treatment revealed that private facilities are much more plentiful than public and PPP facilities. However, they serve a comparable number of patients. The length of treatment program, services offered and capacity was described. Secondly, quality of care was investigated. It is notable that there were few quality of care differences between public, public-private mix, private registered and private unregistered facilities. Finally, the extent to which inpatient alcohol addiction treatment is accessible was examined in terms of geographic, income and waitlist times. Limited access due to lack of financial means was the most prevalent barrier. The following chapter discusses the findings.

Chapter 4: Discussion

Introduction

This thesis explored the public-private mix of alcohol addiction treatment in South Africa. It examined quality of care and access at public, PPP, private registered and private unregistered facilities. Differences between various orientations of facilities were highlighted. The literature review in Chapter two identified the need for addiction treatment research in South Africa. There is evidence of a high burden of addiction-related harm and a growing need for addiction treatment services in Cape Town (Parry et al., 2005; Myers & Parry, 2005). Gossop et al. (2001) concluded that the international evidence supports the premise of positive addiction treatment outcomes. Chapter four presented the quality of care and access data from seven PCIAAT centers including one public, two public-private partnership, two private registered and two private unregistered. The data suggested that quality of care amongst the PCIAAT centers is in line with the MNSITC standards; however there are issues with access. This is the first study to investigate quality of care of PCIAAT in the South African setting. The following section considers the study methodology's main limitations and then goes on to discuss the results. First, quality of care is explored, addressing the second objective of the thesis/paper. Second, there is a discussion on the inequities of access to PCIAAT which is related to the third objective.

Limitations

This study used an interviewer administered questionnaire for service providers. These interviews allowed the researcher to request information regarding quality of care and access for alcohol addiction treatment. Providers shared valuable information but there were also limitations. They are as follows.

The primary weakness of the study is that process and outcome quality of care as well as some of the socio-demographic distribution of patients was assessed using provider self-reports. Relying on provider self-reports poses significant implications regarding the validity of the conclusions reached concerning quality of care. This is supported by the fact that there was little difference in quality of care findings across the various provider groups.

Patients were not interviewed due to the large sample size that would be required in order to draw conclusions from the results. The researcher gained rich data from

PCIAAT providers who were the sole respondents. This study, however, would have been enriched by patient perspectives thus broadening insight.

Non-randomized purposive sampling was used to identify alcohol addiction treatment centers representing the various orientations. It was extremely difficult to create a list of private unregistered alcohol addiction treatment centers. Both of the private unregistered facilities studied were functioning relatively well. The purposive sampling may have led to the identification of better-functioning private unregistered facilities which may have led to optimistic results. In a study conducted by Myers (2007), key informants spoke about the existence of small addiction treatment facilities which serve people from historically disadvantaged communities. The key informants said that these facilities are known to use unethical and punitive treatment approaches with few using any form of evidence-based models of care (Myers, 2007). Unfortunately, the researcher was not able to locate these facilities for her study. Further evidence of unethical and punitive practices for addiction treatment in South Africa was demonstrated in a study by Louw (2006).

A limited number of study sites were investigated (i.e. 2 sites per orientation). This restricts the extent to which the findings may be used to make policy recommendations. Reasons for choosing seven sites include: Significant time and petrol expense was necessary to travel to each site; It made sense to gain a deeper understanding of a limited number of sites rather than a more superficial understanding of numerous sites; The rigor of individual site investigations could be increased by choosing a small sample of sites.

The researcher used a qualitative data collection approach. Interviews had strengths and weaknesses. Strengths were a high response rate and the ability to clarify questions and responses when there was confusion. The primary weakness was the question of the influence of the interviewer's own role in the research process and how it could have affected the study's findings. Another weakness is that qualitative data, including interviews, does not result in empirical data which can be statistically generalized to the whole population. Therefore, it would have been beneficial to include a quantitative component of investigation.

Though there are limitations to the methodology used by the researcher, she believes that a rigorous study took place. The results will be discussed in the following section.

Discussion of results

The review of theoretical and empirical literature in Chapter two provides a foundation upon which public, PPP, private registered and private unregistered inpatient alcohol addiction treatment can be assessed in terms of quality of care and access. According to the literature, there are two alternative roles for the public sector. One role is to finance and ensure the provision of essential services. Essential services are defined to be primary and selective hospital care. The alternative role is to protect the population from catastrophic costs by providing 'insurance' where insurance markets fail. It is impossible for governments in resource-strained countries to effectively take on both of these roles. The literature review laid out the background and context of South Africa's public-private mix. As discussed, South Africa's public sector is still mired with the apartheid legacy of fragmented services, inequity and a weak human resource base. The public sector is therefore inadequate for addressing the alcohol addiction treatment needs of the population without drawing on both the private sector and PPPs. The alcohol addiction treatment private sector is large and well resourced. Due to the high prevalence of alcohol addiction, the public sector is dependent on the private sector to meet demand for treatment services.

The poor population is one of the groups most seriously affected by alcoholism in South Africa. The public sector provides access to treatment free of charge. However, there are three other groups which also provide addiction treatment. These include the private registered sector, the private unregistered group and finally, public-private partnerships between government and the not-for-profit sector. The current study investigated the quality of care and access between the various orientations. The findings, in terms of quality of care and access, are discussed below.

Quality of care performance of each orientation

Public, PPP, private registered and private unregistered facilities all scored highly in terms of process quality of care. This reflects high compliance with the MNSITCs. Outcome quality of care was not formally assessed by providers in all but one treatment center studied. This was a private unregistered facility. The relatively good process quality of care most likely resulted in fairly positive outcome quality of care; the lack, however, of treatment center patient follow-up means that this cannot be confirmed. Alcohol addiction treatment outcome is influenced by many factors in

addition to the quality of inpatient addiction treatment quality of care. It is therefore difficult to measure outcome quality of care.

Public

The public model of provision of addiction treatment received a high quality of care indicator. The literature indicates that the South African public health care sector offers poor quality of care in comparison to the private sector (Sinanovic, 2004). Three reasons which explain why the quality of care in the public sector tends to be poor include: government focus on access over quality, resource shortages and problems with the institutional framework of government. A government focus on access means that the number of people who receive care is more important than the quality of care these individuals receive. It is frequently the case that there is a link between resources available and quality of care. The public sector is renowned for resource shortages (e.g. human resources, amenities, and convenience), however, the public alcohol addiction treatment facility has maintained quality of care. This is perhaps due to the fact that rather than stretching resources for multiple facilities, there is only one government addiction treatment facility in the Western Cape province. Finally, government is slow to respond or unresponsive to patient demand and preferences due to the bureaucratic structure the government operates within. One example is the historic setting of budgets rather than acknowledging current rates of addiction. Perhaps the reason that the quality of alcohol addiction treatment is so high is because of the center's close contact with the Department of Social Development, the developer of the MNSITCs. If the government objective is for the standards to be adhered to then it is important that the government facility itself sets an example.

PPPs

Due to the shortage of public PCIAAT, PPPs have proven to be key players in the Cape Town provision of alcohol addiction treatment. Government funding of these NGOs enables them to offer alcohol addiction treatment care to those in need.

In addition to providing quality treatment, one of the PPP facilities played a major role in the development of the MNSITCs. Therefore, there is the potential for the PPP sector to continue to participate in formulating, developing and revising information, education and communication materials that are appropriate for the Cape Town context.

Private Registered & Private Unregistered

As supported by the literature (Sinanovic, 2004), the private PCIAAT facilities provided good quality of care. It was surprising to note that private unregistered PCIAAT facilities also provided good quality of care. The managers at both private unregistered PCIAAT facilities have applied for registered status. However, both noted that it is a long wait before registered status is awarded.

One theme across all PCIAAT center orientations was that no facility provided the patient with a signed copy of their recovery contract for their own records. This could impact the patient's commitment to the recovery process.

In summary, the provider interviews indicated that the Minimum Norms and Standards for Inpatient Treatment Centers are mostly adhered to in all orientations of facilities. Three possible explanations for this include: 1) the standards are low and easily adhered to; 2) the providers did not give accurate responses; and 3) excellent compliance with good policy.

Demand for affordable addiction treatment services is not currently met, and as a result, there has been a mushrooming of small community-based addiction treatment providers which are not registered (Bateman, 2006). According to Myers (2007), many of these "mom and pop" outlets operate out of people's homes in historically disadvantaged communities. Myers' (2007) key informants expressed concern about these service providers who they perceived to be unskilled and untrained in the complexities of addiction treatment. Staff knowledge and experience is an important contributing factor to service quality (Grosenick & Hatmaker, 2000). Additionally, service quality has been found to exert an important influence on addiction treatment use (Gallon, Gabriel & Knudsen, 2003). There is therefore concern that these unregulated centers may result in negative beliefs about the quality and effectiveness of addiction treatment (Myers, 2007). Myers (2007) suggests that access to poor quality services may be more harmful than access to no services because negative treatment experiences may lead to individuals being unwilling to seek addiction treatment services in the future.

Access

This study focused on potential access which refers to the degree to which health services are available and the opportunity to access these services when required (Gulliford et al., 2002). Findings from the document review and the interviews

confirmed that there is inequity in potential access to alcohol addiction treatment in the Cape Town region. This may mean that need is not the determining factor for whether alcohol addiction treatment is sought. For example, Myers states that *“results found that need for alcohol and other drugs treatment was not the principal determinant of alcohol and other drugs treatment use among people from historically disadvantaged communities. For these population groups, enabling/restricting barrier variables accounted for the largest proportion of the variance in access and were more strongly associated with access than indicators of alcohol and other drugs treatment need. These barriers included affordability considerations, geographic access barriers and awareness barriers. This finding paints a picture of horizontal inequity, where individuals from historically disadvantaged communities with the same treatment needs do not consume alcohol and other drugs treatment equally”* (Myers, 2007, p. 217). There is limited availability of affordable services within Cape Town’s PCIAAT structure. As discussed in the literature review, non-need barriers are key components to issues of access. The results of this study demonstrate there are still horizontal inequities in access to PCIAAT in the Cape Town region. Non-need barriers to access must be addressed in order to decrease the horizontal inequities so that those in need can obtain the required services.

Despite a) the high prevalence of alcohol addiction in South Africa (Parry et al., 2005); b) reports of the growing need for addiction treatment services in Cape Town (Myers & Parry, 2005); and c) international evidence of the benefits of alcohol addiction treatment (Gossop et al., 2001), this study found that those in need are faced with barriers to obtaining treatment. This section discusses the author’s access findings in terms of race, gender, geographic, wait-time and income.

Race

During the era of apartheid in South Africa, race was the key determinant of access to health services such as alcohol addiction treatment. Health services were concentrated in urban areas where Whites were the primary inhabitants. Pass laws restricted movement of Black/African and Colored people into these areas. Due to the unequal distribution of treatment facilities and pass laws preventing access to urban services, Blacks/Africans and Colored people had access to few alcohol addiction treatment services. The alcohol addiction treatment services that were offered to Black/African and Colored populations were of poorer quality and less comprehensive as compared to those offered in White neighborhoods (Parry, 1997; Parry and Bennetts, 1998). Due to sociopolitical factors, the Black/African and

Colored populations were denied access to equitable treatment and quality of care for alcohol addiction treatment as compared to their White counterparts.

South Africa's first democratic elections took place in 1994. The newly democratic state sought to redress health and social sector inequities. The National Department of Social Development took responsibility for improving access to alcohol addiction treatment services. They developed a policy framework including a National Drug Master Plan and an amended Substance Abuse Bill which prioritizes service provision to previously underserved population groups. Unfortunately, there are few studies demonstrating systematic evidence of improved access to alcohol addiction treatment in South Africa. Despite comprising the vast majority of the South African population, this study found a clear absence of the Black/African population at PCIAAT facilities. The White and Colored populations made up the vast majority of inpatients. White was the predominant race in the private registered and unregistered facilities where as Colored was the predominant race in public and PPP facilities. This raises the question of whether and where the Black/African population seeks alcohol addiction treatment. Studies have shown alcoholism rates to be rampant in the townships, which is where a large percentage of the Black/African population reside. Yet, the treatment facility managers all reported extremely low Black/African participation rates. This finding is in line with "*recent findings from the South African Community Epidemiology Network on Alcohol and Drug Abuse (SACENDU) (Myers et al., 2004; Myers & Parry, 2005; Pluddemann et al., 2007) and audits of alcohol and other drug treatment facilities in Cape Town (Myers & Parry, 2003) and Gauteng (Myers, 2004a). The race profile of clients at alcohol and other drugs treatment facilities does not reflect the demographics of the general population. Specifically, there has been an under-representation of Black/African and an over-representation of White South Africans in treatment. The pattern seems entrenched in Cape Town, where the proportion of Black/African clients in alcohol or other drugs treatment declined from 12% in 2000 to 7% in 2004 (Myers & Parry, 2005). This is cause for concern as Black/Africans comprise roughly 32% of the general population in Cape Town (Smith, 2005). The high levels of alcohol use among Black/African and Colored communities (mentioned previously) suggest that this pattern of service use reflects the limited extent to which Black South Africans have access to alcohol or other drugs treatment, rather than lower levels of alcohol or other drugs use among these population subgroups*" (Myers, 2007, p. 14).

Due to the importance of equity in post-apartheid South Africa, this is a concern because there is the potential that addiction treatment services are not reaching a population in need.

One possible explanation is financial barriers. A study by Sawyer, Wechsberg & Myers (2006) found that a higher proportion of Black/Africans had competing financial priorities as compared to Colored study participants. They noted the documented evidence that Colored communities are less socially disadvantaged than Black/African communities. However, both Black/African and Colored people experience racial inequities as compared to the White population in terms of income, employment and access to basic services (Myers, 2007). The result is poor Black/African and Colored people facing more obstacles to accessing PCIAAT than the White population even in the case of equal unmet treatment need.

Greater awareness of PCIAAT services will lead to a greater likelihood of individuals accessing services (Myers, 2007; Hser et al., 1998; Lennings, Kenny & Nelson, 2006; Porter et al., 2002). In a South African study on the Cape Town region conducted by Myers (2007), Black/African participants knew of fewer addiction treatment centers than Coloreds. Low awareness of where to get help serves as a barrier to the Black/African population. The Colored population has been targeted by addiction awareness and prevention programs in the Cape Town region (Sawyer et al., 2006). This may explain the differences in awareness. The assumption behind such targeting was that Black/African communities have low levels of alcohol addiction (Sawyer et al., 2006). The Black/African limited awareness of how and where to access treatment is a problem as far as equitable access to services for Blacks/Africans. There should therefore be a service provider and policy focus on increasing information on addiction treatment services to the Black/African population.

Myers found racial disparities within the alcohol addiction treatment sector. The current study found further evidence of the underutilization of PCIAAT service facilities by the Black/African population. Myers found “stronger associations between awareness and geographic access barriers and treatment use among Black/African persons from historically disadvantaged communities relative to their Colored counterparts” (Myers, 2007, pg. 218).

Gender

Women have unequal opportunities as compared to men when it comes to accessing alcohol addiction treatment from a historically disadvantaged community. Myers (2007) reported that stronger associations were found between affordability barriers, competing financial priorities, awareness barriers, geographic access barriers and treatment use for women in historically disadvantaged communities relative to men living in these communities. These findings imply that women are more vulnerable to barriers of alcohol addiction treatment use. This means that women experience greater horizontal inequity than do men when it comes to accessing alcohol addiction treatment from a historically disadvantaged community setting.

Studies have shown that alcoholism rates amongst women are on the rise. It is a concern that some treatment facilities have a set number of beds per gender. There is the potential that these centers are not keeping abreast of alcohol addiction rates between the genders. Equity means fair but not equal treatment. Because men have been known to be the more frequent sufferers of alcohol addiction in the past, though the bed ratios are unequal, they may be equitable. One question here is that perhaps women's alcoholism rates have remained the same throughout history but rather it is more socially acceptable for them to be open about needing help today.

As compared to men, women were found to consistently comprise a smaller proportion of the client population at PCIAAT facilities in the Cape Town region. Two facilities excluded women from treatment entirely.

Income will be discussed in detail in a later section however there are some links to gender. Affordability barriers and competing financial priorities are a stronger barrier to access for women than for men (Myers, 2007; Gelberg et al., 2000; Schober & Annis, 1996). One explanation may be the patriarchal structure of African society which involves male control of women's incomes (Tolhurst & Nyonator, 2006). Another reason may be South African women not having an independent income (Tolhurst & Nyonator, 2006).

Geographic Access

Distance and travel time are two barriers to geographic access. These variables are strongly correlated and therefore the researcher focused only on distance. Distance is also reflective of transport availability barriers (Rossler, Richer, Loffler & Fatkenheuer, 1991). Myers (2007) found that geographic access was one of the

strongest determinants of addiction treatment use. She found that as travel time to treatment increased, the probability of seeking addiction services rapidly declined. One issue related to travel time is affordability. This is supported by Myers' (2007) finding that travel time has a stronger negative association with treatment use when affordability barriers are high than when affordability barriers are low.

The overwhelming majority of private facilities were located in the Southern Suburbs of the Cape Town region. The Southern Suburbs are a high-income region of Cape Town. It is therefore most likely a profit incentive that motivated facilities to locate there. Demand for expensive services in low-income regions would be low. The public and PPP facilities were all located in the Northern Suburbs. This is most likely because that was the region determined to have the most need for affordable addiction services.

Addiction spans the socioeconomic spectrum. However, the concentration of Cape Town's low-income population is in the Northern Suburbs. The problem is that there are low-income groups in the Southern suburbs whom are unable to afford the addiction treatment services offered there. Some managers indicated that their facilities will arrange for pick-up. The researcher believes that for public and PPP facilities, where affordable transport would be important for poor clients, this is not well known. In fact, low-income populations living in the Southern Suburbs may not be aware of the affordable PCIAAT services offered in the Northern Suburbs. Therefore, location of these facilities may restrict the access to alcohol addiction treatment services for low-income people in the Southern suburbs.

The Northern Suburbs location of public and PPP PCIAAT facilities is positive because treatment is offered close to low-income people, travel costs are reduced and awareness of services in the area is increased. This study confirmed that PPP involvement in the provision of addiction treatment improves access to services.

Previous research has shown a negative association between distance and travel time to treatment (both relating to geographic access) and how it impacts upon addiction treatment use (Myers, 2007; Beardsley et al., 2003; Fortney et al., 1995; Schmitt et al., 2003). The transport system in South Africa is unreliable and costly (Naude & Krugell, 2003; Tanser, Gijsbertsen & Herbst, 2006). Distance, travel time, unreliable transport and cost are barriers to geographic access. The spatial distribution/geographic location of PCIAAT services is therefore important. The

public and PPP facilities are located where the poor are concentrated. However, it is a concern that there are no affordable facilities located outside of this region. It is known that geographic access barriers reduce addiction treatment service use and therefore there is an equity problem for the poor living outside the Northern suburbs region, which is where the affordable facilities are concentrated. When planning for new addiction treatment services, the issue of geographic access should be taken into consideration.

Wait-Time Access

All private facilities had minimal wait times. The public and PPP facilities had substantially greater wait times. This is because they had limited treatment slots as compared to demand. As discussed in the literature review, wait-time is an essential factor for addiction treatment because the addict may only have the willingness to seek help for a window of time. There is evidence that people with addiction do not tolerate treatment delays (for example, loss of treatment motivation) (Carr et al., 2007; Hser et al., 1998; Tucker et al., 2004). Waiting lists can therefore result in a missed opportunity to treat an addicted individual (Carlson, 2006). For this reason, it is a concern that individuals struggle to access PCIAAT services at public and PPP facilities in a timely manner. This is supported by the literature which shows that private for profit addiction treatment facilities do not often have delays in access. Though these facilities had greater availability, they are not accessible to people with low income and no medical insurance (Edelstein, Weber & Pillay, 1997; Mills et al., 2004).

Income Access

Myers (2007) found that affordability barriers are negatively associated with addiction treatment use. She investigated the relationship between addiction treatment use and low employment status, income, access to medical insurance, as well as high treatment costs and concluded that there was a negative correlation. The current study supported her findings.

The private registered and unregistered facilities were well out of reach to the majority of the Cape Town region population due to the high fees. In terms of income access, the purely public model was the most affordable from the patient's perspective. There were no patient costs associated with treatment in the public sector with the exception of indirect costs such as transport.

The cost to the patient in the PPP facilities was substantially lower than the vast majority of private facilities. PPP facilities had a few free slots for the poor: one facility then ranked according to income/insurance while the other facility accepted whatever the individual could donate. By forming PPPs, the government has improved access to alcohol addiction treatment.

Those with money and/or insurance can afford to attend PCIAAT centers which have in-house detox services. Therefore, they don't need to detox at a hospital first. The public and one of the PPP PCIAAT facilities did not offer detox services. This puts those requiring affordable public and PPP PCIAAT services at a disadvantage.

The poor experience competing financial priorities such as the need to pay for food and shelter. According to both South African and US research, competing financial priorities are a significant barrier to one seeking alcohol addiction treatment services despite need (Myers, 2007; Appel et al., 2004; Gelberg et al., 2000; Hser et al., 1998).

The poor disproportionately experience difficulties in accessing PCIAAT services as compared to those who have the ability to pay for private detox and PCIAAT services. This is inequitable. Therefore, action should be taken in order to better serve the poor specifically. One way is to broadly increase services. The issue with this approach is that it takes time for the benefits to trickle down to the poor population. It is often relatively better-off individuals who benefit before the poorest sectors of communities (Raine, Hutchings & Black, 2003).

Access General

Myers (2007) reported a perception that there is limited availability of state detoxification and mental health services as well as non-profit inpatient alcohol and other drugs treatment facilities. Geographic location and waitlist times suggest that difficulties in accessing inpatient treatment care were disproportionately experienced by poor people. Those who could afford to pay for private hospital detoxification and private inpatient addiction treatment did not have to wait. These circumstances point to issues with horizontal and vertical inequity because they qualify as non-need barriers. Vertical equity occurs when individuals with different levels of need consume appropriately different amounts of services (Morris et al., 2005). A non-need barrier refers to a factor which is not based on a patient's need for treatment standing in the way of them obtaining services. Non-need barriers to access must be

addressed in order to assure equitable access to those in need of treatment.

There are not enough PCIAAT services in Cape Town in order to meet the need of the poor population. Yet, service appropriateness is strongly related to treatment outcomes (Ball, 2007; Gossop et al., 2001; Schmidt, Greenfield & Mulia, 2006). Myers (2007) found that people were appropriately using addiction treatment services to meet genuine addiction treatment needs in the Cape Town region. Since services are being appropriately used and there is a demand for more services, it means that there is a need to put more PCIAAT services in place for the poor. One solution is to build more public PCIAAT facilities. Another idea is to form partnerships with the private sector. From a prevention perspective, in future, earlier identification of alcohol problems will decrease the need for PCIAAT as outpatient services will be appropriate.

The access findings demonstrate that more resources are needed in order to increase affordable addiction treatment. The quality of care section showed that the public and PPPs are currently practicing quality of care according to the MNSITCs. Access to services may be improved by better funding those that are available and by adding more.

In summary, the access findings point to issues of both horizontal and vertical inequity when it comes to accessing alcohol addiction treatment in Cape Town. This is despite post-apartheid efforts to transform addiction treatment services, including equity-oriented policy. Greater effort is required to ensure that these policies are working in practice. PPPs improved access to PCIAAT services. PPPs are therefore beneficial to both providers and patients because they improve affordability and geographic access while decreasing waitlist times for the public (and possibly private) facilities. This is because though PPPs are more expensive than the public sector, they do offer an alternative to high priced private options. PPP facilities maintain quality of care.

Public-private mix arrangements

As discussed in the literature review, PPPs have the ability to improve health care access, quality of care, service delivery and health promotion. PPPs can be a method of maximizing the use of existing resources. Due to the aforementioned reasons, there are benefits to establishing and improving relationships between the public sector and private providers. The South African health system has a

significant history of public-private partnerships. This study has revealed that through the public and private sectors working together in the form of PPPs, Cape Town inpatient addiction treatment has seen increased access while maintaining quality of care.

South Africa spends 8.5% of GDP on health care which ranks as high. Yet, its health status ranks poorly as compared to countries spending similar amounts or less (McIntyre et al., 1995; McIntyre & Gilson, 2002). This study has demonstrated that public and private sectors can work together in the form of PPPs in order to treat alcohol addiction and in turn meet health system performance goals. PPPs may be one solution to avoiding the duplication of resources and maximizing the use of resources which are already in place. This could then improve patients' access to services by reducing the cost of private alcohol addiction treatment services. The private sector inpatient alcohol addiction treatment sector can only expand to a point. Public sector resources are limited. It is therefore beneficial to overall health system performance for the two sectors to interact.

Health economists traditionally view public and private sector relationships according to their service delivery responsibilities including financing and/or provision functions (Donaldson & Gerard, 1993; Bennett et al., 1997). One view is that the state should take primary responsibility for alcohol addiction because it is a public health concern. Another perspective is that the private sector should be the key player in alcohol addiction treatment because the state should be spending money in other priority areas. In addition, it is the overall tendency for increasing private provision and financing of health care services to characterize health sector reform in developing countries.

Overlapping and sharing of functions including service provision and financing is not uncommon with public and private sector relationships. Both PPP facilities investigated provided private services with the aid of public financing. The PPP arrangement was complex because the financing role was shared between public and private sectors. In each case, the government provided a fixed amount of funding (25% of total operating costs for one and approximately 65% for the other). The NGOs were expected to cover the balance of expenses through raising funds. In terms of service provision, public-private relationships can also be blurred. For example, though addiction treatment services are provided by the private sector, it is the public sector who is responsible for subsidizing the training and certification of

private sector addiction treatment practitioners including nurses, doctors, counselors, occupational therapists, etc. The addiction treatment industry illustrates the intricate public-private interactions which frequently include overlapping financing and provision functions.

Conclusion

This chapter has discussed the research findings from the various alcohol addiction treatment center orientations evaluated, and also the limitations of the data and the methodology used. All three orientations provided good quality of care. Public and PPP facilities provided superior access in terms of income. Private facilities had the shortest wait-time. Geographic access was a pronounced issue for the poor population that resides in the Southern suburbs, far from affordable PCIAAT services. Horizontal (and vertical) inequities were identified in terms of access to PCIAAT services in the Cape Town metropole. Service planning and resource availability were explored as potential ways to improve geographic access. The study pointed out that women and Black/Africans are likely facing access barriers to treatment as these groups were not represented in treatment centers. This study had a particular focus on quality of care and access at various treatment center orientations in the Cape Town region. Though there are some limitations, this study has generated new evidence on quality of care in the PCIAAT sector. It has also confirmed issues of PCIAAT access in the Cape Town setting.

Despite the Department of Social Development's alcohol addiction treatment policy changes, there still appears to be inequitable access to alcohol addiction treatment services in the Cape Town region. Good policies are now in place. Going forward, the focus should be on developing the services themselves. The following chapter discusses recommendations to develop services that are responsive to need.

Chapter 6: Conclusions and Recommendations

Introduction

This study aimed to redress the lack of empirical data on alcohol addiction treatment in developing countries by evaluating various treatment center orientations. The literature review provided an overview of addiction treatment including an exploration of quality of care and access. Previous South African research on addiction treatment has mainly focused on describing service use (Myers & Parry, 2005). This study moves beyond that and is the first study to examine addiction treatment quality of care in South Africa.

The US is the country that the majority of health service use research has been conducted in (Chou et al., 2004). Examining access within the South African context is beneficial to understanding within a specific country and cultural context. One example is Myers' finding that South Africans experienced a weaker association between access to medical insurance, availability of services and affordability barriers as compared to other study contexts (Myers, 2007; Appel et al., 2004; Tucker et al., 2004). Myers determined that limited availability of affordable services, widespread poverty and a low proportion of the population having health insurance were contributing factors to this weaker association with access (Myers, 2007). This demonstrates that though research undertaken within different settings may be useful for advising policy, country-specific research is vital to understanding local barriers.

This chapter begins with a summary of the study methods. The results section addressed the objectives of the study by providing an overview of quality of care and access in the South African setting. Based on the literature review and results of the study, conclusions are drawn. The utility of the study findings is explored and the study contribution to knowledge is discussed. The fourth objective of the study is to make recommendations on how policy-makers in South Africa and elsewhere could best improve quality of care and equity with regard to the provision of inpatient addiction treatment. These recommendations are discussed below. The chapter concludes by suggesting future research directions within the field of addiction.

Summary of the methods used

This thesis addressed the four study objectives using document review and

interviews with health care providers. Objective 1 used document review to provide an overview of the PCIAAT services available in the Cape Town region. This included orientation, services offered and capacity.

The literature review provided background and context regarding the public-private mix and the various levels of addiction treatment available (primary/secondary/tertiary). Public-private partnerships were explored in terms of financing and provision.

Objective two investigated quality of care in terms of process and outcome. Qualitative data on treatment methodology, patient assessment/treatment, individualized treatment planning, structured treatment programs and daily activities, quality assurance as well as follow-up procedures was generated through semi-structured interviews. Results were compared according to the treatment center orientation: public, PPP, private registered, private unregistered.

Objective three used a combination of document review and semi-structured manager interviews to explore access in terms of geography, wait-time and income. Gender and racial access barriers were also explored.

Thesis conclusions

This research therefore can conclude the following:

Structure of Cape Town's addiction treatment delivery

The Cape Town metropole has high rates of alcohol addiction and a significant underprivileged population in need of treatment. Only one public PCIAAT center exists in the Cape Town region. It has limited treatment capacity. Two PPP facilities exist. Both were non-profit. Each consisted of private provision of care and a dependence on some public funding. PPPs are viewed to be part of the public sector's service delivery strategy. PPPs are a relatively new type of arrangement for South Africa. A multitude of private facilities exist. While public and PPP treatment centers exist, it is the private sector that is the predominant provider of alcohol addiction treatment. Purely private sector providers who provide alcohol addiction treatment may be classified into two groups: (1) private facilities which are registered with the Department of Social Development and (2) private facilities which are not registered with the Department of Social Development. The public facility does not offer detox services. Patients are required to undergo detox at a public hospital prior

to admittance. One of the two PPP facilities does not offer detox. Again, the expectation is that patients undergo detox prior to admission. The majority of private facilities offer detox services. All facilities offer a multidisciplinary approach. Treatment capacity varies.

Quality of care for the treatment of alcoholism

Unlike previous research, this study explored South African quality of care within an alcohol addiction treatment context. According to the findings, the quality of care is good across all orientations of addiction treatment facility. This indicates that the MNSITCs are being generally complied with. Quality of care can be affected by many different factors across facility orientations. The public sector and PPPs are frequently challenged with insufficient funding, poor working conditions and the flight of skilled workers either to the private sector or overseas.

Access to primary alcohol addiction treatment

This study confirmed some of Myers' work (2007) by demonstrating that the socio-political context has shaped the structure of alcohol addiction treatment services. The current Cape Town region inpatient alcohol addiction treatment system has structural, contextual and population level barriers to treatment access.

The researcher's findings coupled with published literature on the subject points to access to PCIAAT services being relatively more inequitable for women and Black/African persons from historically disadvantaged communities than for men, White and Colored persons.

The findings indicate that individuals with no medical insurance and limited financial resources will struggle to access PCIAAT services in the Cape Town region. This is because the majority of services require the patient to pay. There are limited slots for free PPP and public services resulting in waiting lists. Current research on addiction treatment has identified direct costs associated with treatment and the indirect costs associated with transport to treatment as barriers to using addiction treatment services (Myers, 2007; Hser et al., 1998; Tucker et al., 2004).

Interventions are needed which reduce patient out-of-pocket cost for PCIAAT. Addiction treatment is provided free of charge at the public facility in order to provide access to poor people. PPPs also offer affordable services as compared to the private sector. The issue is the limited capacity at these facilities resulting in limited availability of PCIAAT standing in the way of access. The expansion of public and

PPP addiction treatment centers is one solution. According to Myers (2007), "...interventions should target competing financial priorities (such as the need to provide food and shelter) that take precedence over the need for alcohol and other drugs treatment. Interventions that provide tangible support (through the provision of food, clothing or economic assistance) to persons wanting treatment might reduce the impact of competing financial priorities on AOD treatment use".

Generalisability of results

The extent to which findings can be generalized is an important factor in determining their relevance. This study evaluated quality of care and access among various orientations of primary care inpatient alcohol addiction treatment centers in the Cape Town region. Though the South African Cape Town region has a specific context, there are countries worldwide which are experiencing the alcoholism epidemic, and have the potential for private providers to form partnerships with the government. On the African continent there is a key difference between South Africa and other African countries. That is, South Africa has a much greater availability of formally trained and registered private health providers. There is a dearth of formally trained and registered private health providers in the remaining African countries. Another pertinent point is that other African countries' health sectors are dominated by non-profit providers such as NGOs and church-related facilities with a minority of private for-profit providers. In contrast, South Africa has many for-profit health care providers.

The level of socio-economic development, degree of social mobilization for alcohol addiction treatment among other health activities and the cultural setting all contribute to determining how inpatient alcohol addiction treatment is implemented within a particular setting (Maher et al., 1999).

Service delivery design and implementation may be specific to particular settings; quality of care principles, however, are generalizable.

This study examined only the Cape Town region therefore one may question whether the findings can be generalized to the rural setting and other urban centers in South Africa. The Western Cape province (Cape Town is the capital) is known to be well resourced as compared to other provinces with regard to health and social services (Statistics South Africa, 2005). With regard to access, there is therefore the possibility that those in need of inpatient alcohol addiction treatment in other

provinces face more structural and population-level barriers.

The MNSITCs are a national document meaning that PCIAAT policy is the same across urban/rural settings, from province to province and from city to city. However as stated above, resource allocation may differ and there may be variations in treatment practices.

Thesis contribution

This study addresses some of the crucial research gaps and unanswered questions regarding the public-private provision of alcohol addiction treatment in the Cape Town region. First, this study documents the nature of alcohol addiction treatment provision in Cape Town, focusing on the various providers, their services offered, their capacity and the interaction between public and private providers. The four main providers of alcohol addiction treatment were: public, PPP, private registered and private unregistered facilities.

Second, the study offers a set of data about the quality of care offered in each treatment center orientation. The data in this thesis do not include the patient perspective on quality of care, but rather contributes insight from the provider's perspective. The study shows that quality of care performance is similar across the various orientations. This study demonstrates that alcohol addiction treatment in public and PPP facilities performs better than the developing country research usually indicates (Sinanovic, 2004).

Third, the study documents access to alcohol addiction treatment according to geography, income and wait-time. As stated in the literature on access to treatment, there are major geographic, income and wait-time barriers for the public and PPP facilities as compared to private facilities.

Overall, the results have contributed to the growing knowledge on alcohol addiction treatment in the Cape Town area. This study provides empirical information which can be used as a basis for policy-making.

Policy recommendations

This section makes recommendations to South African policy-makers regarding how inpatient alcohol addiction treatment quality of care and access could be improved based on the findings of the study. Suggestions are made regarding individual,

contextual and systematic barriers. These recommendations may also be applied to other African countries and elsewhere.

1. Increase role of public-private partnerships as a component within the health system in order to improve the availability of PCIAAT

This study demonstrates that PPPs can improve access while maintaining quality of care for inpatient alcohol addiction treatment. The public sector budget is limited. Implementing or improving partnerships with existing private facilities (which serve foreigners) could therefore improve access in terms of affordability, geography and waitlist time. Greater availability of affordable PCIAAT will mean reduced waiting-times for affordable treatment. Private PCIAAT infrastructure is already in place therefore PPPs have the potential to maximize the use of existing resources across sectors. It would be beneficial to make better use of existing resources. PPPs are one way of achieving this objective. Factors which could influence the choice of PPP relationship decided upon include: socioeconomic conditions, including insurance coverage; size and distribution of private providers; as well as government institutional and financial capacity (Sinanovic, 2004). Partnerships may be a good short term solution to providing addiction care because partnerships make fewer demands on government than building more purely public facilities.

2. Government should monitor and evaluate public, PPP and private providers according to their adherence to the MNSITC national guidelines.

Incentives may motivate private providers to improve access to quality inpatient addiction treatment services; however it is the responsibility of the public sector to maintain control by ensuring adherence to the national guidelines. Quality assurance is vital to achieving long-term health objectives. Due to the government capacity, resources and information processing required for regulation, providing appropriate incentives may be the best long-term plan.

3. Non-need barriers to access should be addressed.

Previous studies have shown that interventions to improve access frequently reach individuals who are relatively better off first, and then later reach the poorest sectors of communities (Raine, Hutchings, & Black, 2003). Providing improved and additional services does not trickle down to those in need immediately. Therefore, when strategizing to address issues of access, the poor should be targeted directly.

4. Interventions should target geographic access in order to increase the number of those in need who are served.

Findings suggest that there are geographic access barriers to PCIAAT in the Cape Town region. One solution is to cover transport costs by providing shuttle services or reimbursing the provider of transportation (Beardsley et al., 2003). This would address issues of facility proximity to public transport, travel cost, travel time, and travel distance to the PCIAAT center. In future, new treatment services should be located in areas of high need which are near transport hubs so that they are easily accessible by public transport (Beardsley et al., 2003; Gruen et al., 2001).

Another possibility is to form PPPs with Southern suburbs providers so affordable treatment is offered in that region. Subsidized treatment in the Southern Suburbs would result in a more even geographic distribution of affordable services. It is important to note that PPPs require regulation and financing, and therefore they are not the solution to poor capacity. Rather it is an institutional re-organizing technique.

In a broader sense, the government should focus on lifting the socioeconomic status of its population by providing affordable housing and employment opportunities. With increased affluence, people could better afford PCIAAT services. Long-term structural interventions are necessary in order to address poverty. Interventions which focus on affordable housing, creating employment opportunities, and implementing feeding schemes are needed. PPPs are a good interim solution because they offer low cost services to those in need.

Agenda for future research

Research is needed in order to determine effective incentive mechanisms for PPPs in the addiction treatment setting. For example, how for-profit and not-for-profit providers respond to various incentives. Research on how partnerships can be effectively monitored would also be useful.

For a scaled-up response to alcohol addiction, the South African government will have to make a commitment of resources. In order to determine the service coverage and resources required to provide PCIAAT, estimation of current coverage as well as both public and private current expenditure on PCIAAT would be helpful. The government can then make informed decisions on financing and provision. This will help planning efforts for the appropriate public-private mix of services in the short, medium and long term.

This study provides valuable insight into the quality of care of alcohol addiction treatment in the Cape Town region. Based on the researcher's literature review, this is the first study to investigate addiction treatment quality of care in the South African setting. Future studies should further explore quality of care in addiction treatment including how best to monitor and evaluate the quality and effectiveness of PCIAAT.

Further research that examines both need and non-need factors associated with PCIAAT access in terms of gender, race and socioeconomic status is essential. This research could incorporate both rural and urban settings as well as a representation of the country's various provinces.

This author recommends that research on alcohol addiction treatment within the South African setting continues in order to widen the body of evidence and improve understanding. A number of research directions were suggested.

Conclusion

This thesis investigated Cape Town's alcohol addiction treatment center public-private mix in terms of quality of care and access. The performance of different orientations of treatment centers was evaluated using the MNSITCs. The researcher used document review and semi-structured interviews. Provider reporting on quality of care and the limited number of sites interviewed were the main research limitations. Nevertheless, the thesis reached its objectives and contributed to the limited information on alcohol addiction treatment public-private mix, quality of care and access in South Africa. The main study findings are that the quality of care is good across the PCIAAT facility orientations and that access needs to be greatly improved.

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Appendix 1: Interview Schedule for Health Care Providers

Date:

Facility: public/private/PPP

Position of interviewee: addiction counselor/nurse

Characteristics of provider

1. What is your most recent qualification? Year?
2. How long have you worked here?
3. Where did you work before this job?
4. Are you registered with an official professional or accrediting body? E.g. Health professions council of SA, SA nursing council, addiction counselors approved accreditation and registration body.

Knowledge of diagnostic criteria and diagnostic procedures followed

5. How would you describe addiction?
6. What are the symptoms of addiction?
7. How do you diagnose addiction?

Treatment Methodology

8. Do you follow the South African *Minimum Norms and Standards for Inpatient Treatment Centers*?
9. Is there a copy of the Guidelines available for staff in this facility?

Patient Assessment/Treatment

10. Is an alcoholic's intake assessment undertaken within 8 hours of patient arrival?
11. If yes, is the intake assessment completed by a medical practitioner?
12. Does the initial assessment include: yes/no
 - a. Personal details and brief personal history.
 - b. Mental state examination, including intoxication status and needs.
 - c. Physical examination and history of medical conditions, including tests to facilitate evaluation.
 - d. Brief history of substance abuse (and other mental health problems).
 - e. Provisional psychiatric history and diagnosis.
 - f. Assessment of risk potential (i.e. for suicide and other forms of self-harm) and specifications for detoxification (if offered).
13. Does a comprehensive assessment take place?
14. If yes, when and by whom?
15. Does the comprehensive assessment include:
 - a. Psychiatric and physical assessment and diagnosis, with special reference to any co-morbid conditions.
 - b. Comprehensive psychosocial, developmental and functional assessment including an evaluation of the patient's social situation (e.g. family, employment, housing and legal situation) and vocational and developmental needs (especially in the case of the elderly).
 - c. Referral for a more in-depth psychological, social work, psychometric or physical evaluation, as appropriate.
 - d. Provisional treatment goals and prognosis.
16. Are the results of each patient's comprehensive assessment reviewed by a case manager and the center's multidisciplinary team?
17. Are the assessments recorded in the patients' case records in a timely and accurate manner?
18. Do you give patient/client feedback on the results of the assessment process?

19. How often does the multidisciplinary team formally review the patients' treatment progress?

Individualized treatment planning

20. Is informed consent sought from all patients prior to the onset of treatment?
21. Are patients given the opportunity, as far as possible and appropriate, to make choices regarding their care?
- a. Are they provided with adequate information on the specific treatment (e.g. medication used) and risks, benefits and options of the treatment offered?
22. Does the facility have a patient education program on addiction?
23. Does the facility provide:
- a. Information and practical support to maintain a healthy, alcohol-free lifestyle (e.g. exercise, better nutrition, stress management).
 - b. Information and practical support to prevent the onset and spread of HIV and other sexually transmitted and infectious diseases (e.g. voluntary testing & counseling).
 - c. Access to reproductive health care and support of pregnant patients.
 - d. Access to nutritional support and supplements for chronic alcohol-dependent patients.
24. Are treatment plans individualized?
25. What factors are considered when creating a patient's treatment plan? (yes/no)
- a. Nature of their substance addiction/dependency
 - b. Psychiatric/psychological conditions (symptoms, severity and history)
 - c. Personal preferences, strengths and characteristics
 - d. Social needs and circumstances
26. Does a patient's written individual treatment plan contain the following: (yes/no)
- a. Clear and concise statement of the patients' current strengths and needs
 - b. Clear and concise statement of the short- and long-term goals the patient is attempting to achieve.
 - c. Type and frequency of therapeutic activities and treatment program in which the patient will be participating
 - d. Staff responsible for the patients' treatment and their individual counselor
 - e. The patients' responsibilities and commitment to the rehabilitation process.
 - f. The plan is dated and signed by the individual counselor and the patient; a copy of the plan is given to the patient.
27. Does each client have a case manager?
28. If yes, what is the role of the case manager? (yes/no)
- a. Responsible for assisting patients to develop their treatment goals (and other individual treatment tasks), for providing regular documented support and motivation, and for acting as a liaison person for other families and caregivers and role players.
 - b. The individual counselor meets weekly with the patient for a minimum of 30 minutes.
 - c. The individual counselor is reasonably accessible to patients for support and crisis intervention (i.e. outside of fixed counseling sessions).

Structured treatment programs and daily activities

29. Is your treatment program regularly reviewed and updated in accordance with internationally accepted standards?
30. Do you have a treatment and rehabilitation program which describes structured weekly and daily activities?
31. If yes, what does it include? (yes/no)
 - a. Individual counseling/therapies
 - b. Group counseling/therapies
 - c. Family counseling/therapies
 - d. Organized group activities such as sport, health education, recreation and creative activities
32. What is your program duration?
33. Does the centre have documented policies and procedures implemented to regulate and guide daily activities? (yes/no)
 - a. Waking and sleeping times
 - b. Phone use for private conversations
 - c. Visits from family friends, religious leaders and legal counsel
 - d. Outings

Follow-Up Procedure

34. Do you trace relapsers?
35. What system is in place?
36. How does it work in this practice?

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Appendix 2: Interview Schedule for Facility Manager

Date:

Facility: public/private/PPP

Services delivered at the facility

1. What addiction treatment services are provided at this facility?
2. Are you implementing the South African *Minimum Norms and Standards for Inpatient Treatment Centers*?
3. Please explain how the South African *Minimum Norms and Standards for Inpatient Treatment Centers* work in your clinic? What system is in place?
4. What are the opening hours of this facility?
5. Does this facility intake patients outside of normal hours i.e. evening, weekends, public holidays?
6. Do you have a patient waiting list? If yes, how long on average do patients wait to be admitted?
7. Do you provide transport for patients?

Professional details and management of staff

8. How many and what type of health workers are involved in addiction treatment supervision?
9. Has anyone at this facility received specialized training in management skills and/or supervision of staff?
10. If yes, how many?
11. Are you a member of any professional organization(s)/union(s)?
 - a. Which one(s)?
12. Where did you work before this job, and what are the main differences between working conditions here and your previous job?
13. What do you think are the main problem areas with regard to staff conditions at this facility? (e.g. salary, working environment, privacy for breaks and administration)
14. What could be done to improve them? What are the main obstacles to doing this?

In-service training

15. How many of your staff are trained on South African *Minimum Norms and Standards for Inpatient Treatment Centers*.
16. Is further training necessary? If yes, please specify.
17. Do you feel that you are adequately trained for the job which you are expected to perform?
 - a. If no, what additional training do you think you would benefit from?

Service delivery and access

18. Which are the main groups in the community served by this clinic?
19. Is it possible for everyone who wants to, to get to this clinic and be treated here?
 - a. If No, what would you say are the main obstacles?
20. Are there people living in this area who do not come to this clinic?
21. If no... Why? Where do they go to seek healthcare?

Quality assurance

22. Do you try to assess whether patients are satisfied with the addiction care they receive at this facility?
If yes...how?
23. Is there a mechanism for "consumer feedback"? (e.g. suggestion box)

24. Is it used by patients?
25. Is there a mechanism for patients to ask questions about the facility or any aspect of care? How does it work?
26. Is it used by patients?
27. Is there any other mechanism for patients to complain should they be unhappy with the care they receive or the attitude of a health worker? How does it work?
28. Is it used by patients?
29. Is quality of care assessed in any other way in this practice/facility? If yes, explain how.
30. Does the patient have the option to request a change in case manager if they are not satisfied?

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Appendix 3: Informed consent form for providers

Date
Organization
Address

Dear _____,

I am a Masters student of the Health Economics Unit, University of Cape Town, South Africa. I am conducting a study to evaluate the public-private mix of alcohol addiction treatment in Cape Town, in terms of quality of care, access and equity. Furthermore, it is hoped that the recommendations made from this study are going to form an input into the strategies to improve health care delivery for alcohol addiction treatment in Cape Town.

I would like to interview yourself, the facility manager, and two health care providers including one nurse and one addiction treatment counselor. I am requesting the consent of the aforementioned parties to participate in a 30 minute interview each. The interview will cover issues around quality of care and access to treatment within your facility. Your name and place of work will not be listed. The information collected would be treated with absolute confidentiality. I will provide you with the overall results of the study.

Please note that my research proposal has been approved by the UCT Research Ethics Committee. I have attached both the abstract and full version for your interest.

I hope that you will respond favorably to this request. Thank you.

Sincerely yours,

Laura Fleming

Principal Investigator

Health Economics Unit
School of Public Health and Family Medicine
Falmouth Annex
Medical Campus
University of Cape Town
Observatory, 7925
South Africa

**Consent to Participation in the Study:
Public/Private Mix of Alcohol Addiction Treatment in Cape Town**

Principal Investigator:
Laura Fleming, Student, University of Cape Town

I have read the summary of the research project and I understand what will be required of the organization if we take part in the study. My questions concerning this study have been answered by Ms Fleming. I understand that at any time I may withdraw from this study without giving a reason.

Signed..... Date.....

Name _____

Title _____

University Of Cape Town