



The record of proceedings

Section 1

Setting the scene

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Editor's introduction

The Health Summit took place at the Sandton Convention Centre in Johannesburg from 18 – 20 November 2001 with more than 600 participants. Many were drawn from the public health sector, with the emphasis on provincial, district and institutional representation. But there was also a strong presence of representatives from research and training institutions, from professional and statutory bodies, from trade unions and non-governmental organisations. And there was a relatively small but nonetheless significant contribution from the private sector – practitioners, health care institutions and funding organisations.

This book is a compilation of speeches, papers, articles and recommendations relating to the Health Summit and it bears a resemblance to a patchwork quilt: It is mix of elements with different texture and colour.

Each major theme – Human Resources, Communicable Diseases, Public-Private Interactions and Quality of Care – is covered from three perspectives. We hope that this approach gives you a sense of where the debates started, how they developed and what the conclusion was.

The discussion papers bear the professional stamp of their authors, who are academics and architects of policy. We have not tried to change the fundamental style adopted by these writers. It would have been impossible to reduce the four contributions to a single bland formula.

The overviews on major theme debates were written by four journalists specialising in health. Although quite varied in tone, the overviews all have the brevity and directness that characterises journalism. Each writer strove to give an authentic and representative account, but individual judgment inevitably plays its part. I hope that readers will enjoy this individuality rather than see it as a flaw.

The summaries of debates and recommendations presented almost in “telegraph” form are based on the summaries produced by theme group rapporteurs for the plenary sessions. In a sense, they constitute the “official” record of the outcome and, although they have been slightly edited, their origins as presentation outlines are quite evident.

Of course, the major speeches are simply reproduced as they were delivered.

The publication concludes with a section on key recommendations and the Minister of Health’s indication of the way forward. In the Appendix you will find an analysis of the evaluation forms filled in by about one-third of participants.

Our intention was to produce a document that would be accessible to many who were unable to attend – particularly health workers and students. The real value of the Summit was the extensive interaction that took place. It’s quite hard to recreate that. But – at the risk of some repetition in the book – we thought a variety of perspectives would take you part of the way there.

Jo-Anne Collinge
Department of Health

Minister of Health's opening address

Reflections: The road travelled and distance ahead

It is my great pleasure, as host of the Health Summit, to welcome you here today. I hope you will quickly settle in and feel comfortable and, in particular, that every individual here will feel free to contribute fully and honestly to the deliberations of the next few days.

We are honoured to have with us the Health Minister of Swaziland, Minister Dlamini, and several representatives from the SADC Health Sector, including the Nurses' AIDS Network. We are happy to have you join us at this significant meeting.

A special welcome to representatives of the media who are invited to attend all discussions at this Summit. We trust that you will make full use of this transparency and ensure that the public has the benefit of truly representative reporting of the debates that take place here.

Anyone glancing at the programme for the Summit would draw the conclusion that this event is in the hands of all the participants -- not in the hands of a few performers standing under bright lights on a platform. In organising a Summit on this scale, the Department of Health was driven by a strong impulse to consult -- a sense that those of us who make decisions of national consequence need to be guided by the thinking of colleagues working closer to the rock face of health service delivery.

In this assembly, therefore, ideas and opinions are all equally valued. Their importance does not derive from the rank of their owners or the field of their experience. And there are no holy cows, no areas of intellectual terrain that cannot be crossed. No debates that are closed off by signs that say: Beware -- Do not enter -- We have made up our minds!

In this open engagement, I believe, the central project of transforming our society will point us in a single direction and will ensure coherence in our deliberations. For this reason, I would like to spend a few minutes reviewing the course of transformation thus far in the health sector.

Let me take you back to the publication of our White Paper on Transformation of the Health System in 1997. The mission that we then set ourselves, as Government, was "to provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa and to provide caring and effective services through a primary health care approach".

There were seven goals that marked this road.

- The first was to unify fragmented health services into a single comprehensive National Health System.

- Secondly, we aimed to promote equity in provision of services, good access and utilisation.
- The third goal was to ensure the appropriateness of health services to our social realities.
- Fourthly, we asserted the need to develop health promotion activities.
- We also identified the development of human resources for health as a particular priority.
- We aimed to foster community participation across the health sector.
- And the goal of improved planning and monitoring completed the set.

These then were the core concepts of transformation: a unified system; equity and access; appropriate services; health promotion, development of human resources; community participation; and planning and monitoring.

In 1999, the Department conducted a review of the public health system with the intention of reflecting on the impact of interventions undertaken in the five years since the landmark election of 1994. In many ways, this review highlighted the successes and shortcomings of our transformation initiatives.

At the risk of over-simplifying, the review pointed to substantial achievement in terms redesigning the health system and putting new structures on the ground; in terms of increasing access to services for the poorest in our communities and in the worst served localities; and in putting bold progressive laws on the statute books – laws such as:

- The Medicines Control Amendment, which became a global rallying point in the fight for affordable medicines.
- And the Tobacco Products Control Act, which has positioned this country as a significant player in developing the international Framework Convention on Tobacco Control.

However, the five-year review presented a less positive picture when we looked beyond the structural and institutional changes. Concerns about the quality of care remain real and persistent. Anecdotal evidence of professional behaviour that goes beyond neglect into the realm of outright abuse crops up too frequently for us to dismiss it as unusual. By this I do not mean to suggest that sub-standard practice is the norm – that is certainly not the case. But it occurs too often for us to be complacent.

It also tends to overshadow the truly outstanding work and singular commitment of some of our health workers. Last night I had the pleasure of attending the Denosa function to honour distinguished members of the nursing profession. Just a week ago, in Kimberley health workers across the board were recognised for their commitment to service and in October the third Khanyisa Awards ceremony of the Gauteng Health Department signalled a deepening concern with quality of care.

In contrast to this, various studies have produced a finding that many health workers feel exploited, abandoned and unable to work in the idealistic spirit in which they entered their respective professions. This situation raises a host of questions about the effectiveness of management and communication particularly in the public health sector.

These and other insights gained from the review were put to use in developing the Health Sector Strategic Framework for 1999 - 2004. The document was jointly produced and agreed by national and provincial leadership in the public health sector. It was discussed with the health committees of legislatures across the country and members strongly endorsed the strategic direction the document outlined.

Each of you has a copy of the Strategic Framework in your Summit folder. You will realise that there is strong continuity with the White Paper but that there are also new emphases.

- Restructuring reaches a little deeper, focusing on rationalising support services and decentralising authority, largely to local government.
- Quality moves firmly into focus along with a stronger assertion of human rights and clear standards.
- When it comes to human resources we add the notion of better management to the challenge of HR development.
- Hospitals become an arena for major renewal.
- Several important new goals relate to management processes, such as effectively mobilising resources and using them efficiently, improving communication and consultation with stakeholders.
- The notion of health promotion is replaced with a richer, more complex goal of reducing mortality and morbidity rates. HIV/AIDS and STIs demand a separate national strategy that cuts across all sectors and this is realised in 2000.
- Legislation continues to feature as an instrument of reform and international co-operation joins the priority list.

You might be finding it difficult to keep this checklist of strategic goals in focus. But I'm sure you will have got the message that, after five years in Government, we had come to appreciate the complexity of transformation. In addition, we had begun to pose the questions not only in terms of "*what* is to be done" but also in terms of "*how* do we get it done".

Of course, this shift in focus was consistent with the whole approach of the African National Congress to its second term in office where the question of improved delivery of services to the people of our country was one of three overriding concerns.

As we moved beyond the first five years of democratic government, analysts in independent think tanks began to take the view that the policies of the ANC were sound - the real difficulties lay in the ability of government departments and agencies to implement these policies.

Over the next two days we want to hear *your* views about how we can take forward our mission of building a health system that truly answers to the needs of all our people.

From the point of view of both government and those who elected us, it is an appropriate time to pause and take stock. We are mid-way through this second term of the democratic dispensation and it seems fitting to elicit the recommendations of our stakeholders. Clearly, some important constituencies in the health sector have felt a similar need for collective stocktaking -- earlier this year we had the SA Medical Association's Summit on the Future of Medicine and the Nursing Summit. Fairly recently the ANC held a major consultation of health. The work done at these important meetings will certainly contribute to a clearer analysis of problems and a bolder formulation of potential solutions at the present gathering.

We expect more than 600 delegates to take their seats and raise their voices within this convention centre. We do not expect that you will sing one song -- or even that you will all sing in tune. We are committed to consultation and we fully accept that dissent and criticism are part of the deal.

But we do expect that every delegate will approach our joint undertaking with seriousness, with a feeling of joint responsibility for a constructive outcome and with an appreciation that health care delivery is critical both to the development of our country and to the consolidation of democracy.

There is a degree of hypocrisy in the commentary about why democracy often falters and fails in developing countries. Little is said about how poverty erodes the goodwill between government and the governed as the state struggles to deliver the basics of a decent life to its people. But we know that to be true and we need to be aware how fragile democracy can be and how we need to protect it. The development of a caring, effective health care system is one way to safeguard the democratic society that the people of our country won through tremendous sacrifice and suffering.

I feel absolutely confident that a commitment to preserving our young democracy is something we all share and that we will express this through our honest engagement here and our determination to contribute to solutions.

Many of us will also readily acknowledge how difficult the transformation of this society is, scarred as it is by racism and exclusion. The agenda for change is huge, the pressure of legitimate expectations is intense and the economic climate is tough. Although there are some indicators of general direction, in many ways we are traversing uncharted waters.

Most of us who arrived without too much warning in positions of leadership and responsibility carried very personal memories of dispossession and discrimination. The imperatives of equity and redistribution of resources were not simply principles of administrative justice, they were demands that burned inside of us -- and yet they have not proved easy to achieve.

We would be the first to acknowledge that we have made mistakes in our attempts to rebuild the health care system. At times we have not been sufficiently sensitive to the pressures our decisions have placed on those responsible for implementing them in our

hospitals and clinics. Not all of our interventions have had the beneficial impact we intended and sometimes there have been unintended consequences.

However, it is not in the interests of our country for any interest group to celebrate these shortcomings or to withdraw and sulk about them. The challenge is to recognise the problem, to learn from mistakes and to have the courage to change course when this is necessary. It is important to distinguish whether the policies themselves are correct or whether we have chosen inappropriate methods to achieve them or whether both the goals and strategies are entirely valid and well matched – but perhaps we don't have the means to carry them through successfully.

It is not necessarily the radical overhaul of policies that will make the biggest differences. Sometimes it is the practical genius of being able to achieve seemingly small changes that adds enormous value for the service user. It takes no great intellectual ability to recognise that you cannot have quality health care without clean linen on the beds, reliable stocks of drugs; and personnel who treat patients with compassion and respect. But managing our services in a way that ensures precisely these results demands an approach that often eludes us.

Four broad theme areas have been defined for you to apply your collective experience and wisdom to. They are:

- Quality of care -- which includes issues of clinical effectiveness and issues of good service.
- Human resources for health -- which spans recruitment, development and management processes.
- Communicable diseases, and particularly the challenges of HIV/AIDS and TB
- Interactions between the public and private health care sectors, within a transformation agenda.

The themes have been selected because of their significance to the overall performance of our health system and because there exists within each of them a bundle of unresolved issues or problems that have not yielded to existing solutions.

Discussion papers were developed not to restrict debate, but to ensure that we address the most critical questions in each theme area. The authors have not hesitated to place contested issues on the table in the hope that we may forge a new consensus here or, through collaboration, produce solutions that could not exist through unilateral action.

No health gathering of this significance on the African continent could fail to address the challenges that are presented by emerging and re-emerging diseases, particularly HIV/AIDS, tuberculosis and malaria. I need hardly remind you that we rank among 22 nations worldwide with the most serious tuberculosis problem and that the malaria threat along our northeastern border has demanded a concerted tri-nation strategy.

HIV/AIDS has without any question become the most contested area of health care and it has a significance that is felt way beyond our sector. Given the numbers of our people

who are affected and given the particular impact on young people, it was perhaps inevitable that HIV/AIDS would become a focus for social action and not be regarded simply as an infection or illness.

I would like to say quite simply that this Government is committed to meeting the challenges of HIV/AIDS. We will continue to strengthen and expand our programmes across the country and we will participate vigorously in international initiatives – such as the Global Fund to Fight HIV/AIDS, TB and Malaria – to obtain maximum benefit for our people.

At this Summit, consultation on HIV/AIDS responses will be as open and as serious in the quest for solutions as any other. The discussion paper does not shrink from the tough questions and we feel sure that there is much to be gained from pursuing them with an unusually broad group of health stakeholders.

In all the theme areas we are searching for proposals that will result in improved health service delivery to the people of this country. It is left to the critical judgment of the discussion groups whether their recommendations are in the area of fundamental policy changes or creative implementation strategies. My guess is that we will see a mixture of the two, but given my remarks earlier in this address about the relative strengths of our policies and our capacity to deliver, it seems clear that the greatest challenge will lie in the latter area.

The question of creating a suitable mechanism to carry forward the range of proposals made by participants will be addressed on the last day of the Summit. I would like to say unequivocally that we view the Summit as part of a process, in which periodic consultation and accountability become more pronounced features of our relationship with stakeholders.

In addition to the four theme areas, we have three panel discussions which:

- Re-examine the concept of equity and its impact on service provision.
- Highlight the significance of non-communicable health conditions, including mental health.
- Throw open to examination the state of our public hospitals.

The panel discussions are really there in order to round-out the programme and to remind us that there is significant life outside the four theme areas. We are not asking you to apply the same problem-solving energy to the subjects for panel discussion, but we are encouraging a critical awareness of the issues involved.

It remains for me to thank you for being here and treating the challenge of continued transformation of the health system with the dedication it demands. We all approach this Summit carrying a wealth of experience. Sometimes it feels more like a burden of experience, so heavy with frustration and fatigue that we are tempted to dump it. To do so would not only be to betray our selves but to betray the vision of a free society. Our liberation struggle will not truly be won until we have built a nation where every person lives in conditions that are consistent with human dignity. Social transformation is simply

another phase of struggle and we can no more abandon it than we could submit to the insult of apartheid.

If we need inspiration we need only look to the outstanding leaders of the freedom movement – leaders like Nelson Mandela, Albertina and Walter Sisulu, Govan Mbeki, Solomon Mahlangu, Lilian Ngoyi and Joe Slovo. For all of them, life has been an unremitting quest for a more humane world, a quest that continues until time or strength runs out. May this spirit of perseverance, generosity and selflessness be the hallmark of this Health Summit and may South Africa reap the benefit of our collective effort.

Dr Manto Tshabalala Msimang
Minister of Health

President's address to gala dinner

Transformation: Not yet past the crossroads

Thank you very much for affording me the privilege to address this unique and critically important Health Summit.

As I understand it, the purpose of this Summit is to review the transformation of the health system over the last seven years and to seek ways to strengthen the process so that the people of our country have both better services and a better quality of life. I am happy to pledge the full support of our Government for this initiative and to undertake that we will study very closely any proposals you make to ensure that we achieve these objectives speedily.

In 1994, we set out on a path intended to lead to fundamental change in the nation's model of health care delivery.

In the first instance, we committed ourselves to building a unified health system.

- Unified in striving for organisational coherence, with a seamless co-ordination of effort across all spheres of government.
- Unified in its expression of our common humanity and in its proud contrast to the racism of the past.
- And unified in its ability to bring the public and private health care sectors within a common framework of social and professional values and objectives.

Another bold strategic direction was the decision to introduce primary health care as the founding philosophy of our health system. At the heart of primary health care is the notion of development --which implies recognising the importance of those determinants of health that lie outside the health sector. It also implies recognising the significant contribution that service users can make to health, both as individuals and communities.

It was indeed a radical move to assert that primary health care would become the very bedrock of our health system. Consider where we had come from:

- Our recent heritage was one of dumping grounds and economic exclusion through the pass laws. It was the antithesis of development.
- There was little relationship between the institutions of government and social mobilisation in communities -- they worked on two separate circuits and were usually antagonistic.
- Our public health service was split on apartheid lines and resources were concentrated in sophisticated curative interventions enjoyed mostly at academic hospitals. This was a far cry from the health promotion, preventive programmes and early intervention demanded by primary health care.

We were not ignorant of the fact that it would be an uphill struggle to establish the primacy of primary health care. But, as a government, we believed that there was no other option. We fully understood that the struggle to improve the health status of our people as a whole is inextricable from the struggle against underdevelopment and poverty. This obliges us to locate national health initiatives within integrated, multi-sectoral development programmes for fundamental social and economic change.

This is certainly not an isolated or eccentric approach. One has only to read the analysis and policy documents of the World Health Organisation to appreciate the impact of poverty on the health of the people of the developing world. These conditions contribute to the enormous -- and growing -- gulf between the world's richest and poorest countries. The vicious, descending cycle of poverty, disease, increased marginalisation and perpetual deprivation is painfully obvious.

The notion that development needs to be planned and implemented in an integrated way in order to yield results has been at the heart of government planning since 1999. All Ministries and Departments work within a framework of clusters in which planning is undertaken as a joint exercise and particular objectives of any one member of the cluster become the common property of all other members of that cluster.

In this context the public health service has allies beyond its conventional boundaries. These are the engineers and town planners who lay on clean water and dispose of waste. They include the peacemakers who work to silence the guns and allow people to live securely in their homes, within the reach of functioning clinics. Among them are the teachers who know that health literacy is an extension of basic literacy and the promoters of agrarian reform who work for food security and a high level of nutrition among our people.

The allies of our public health system are also those in government and society who are battling hard to eradicate the amorality and the social conditions that encourage crimes against the person – including murder, rape and the abuse of children and the elderly.

What then is our assessment of our progress to date and the critical challenges that lie ahead?

On the issue of improved access to health care, we can clearly say we have expanded services to many marginalised communities. I am convinced that we have improved the platform for the delivery of basic services, without which the attainment of good health would remain a pipedream.

But we know that a lot more needs to be done, both in the health sector itself and other crucially related areas.

If we misled ourselves into thinking otherwise, this year's cholera outbreak (experienced most fiercely in KwaZulu-Natal) would have served as a salutary reminder of unfinished

work. As a consequence of the outbreak, Cabinet in its mid-year Lekgotla committed government to accelerate the programme for universal access to sanitation and safe water.

On the surface we have deracialised our health care institutions and this too has enhanced access to care. Removal of racial barriers has also eradicated some of the most obvious inefficiencies of the apartheid era and created new opportunities for some of our personnel. But, if we are honest, we will admit that we are still struggling under the weight of various kinds of baggage that we carry from the past. Our attitudes and, at times, the obstacles we place in the paths of others betray the incomplete liberation of our souls.

This is a painful reality. But we need to confront it -- confront it wisely, with the understanding that, in the short space of seven years, nothing short of a miracle could lift the prejudice and insularity that has accumulated over three centuries.

Obviously we are not counting on a miracle, and the challenge to each of us is to break the bounds of racial and class isolation, to challenge the concrete conditions that give rise to racial stereotypes -- in short, to take the risks that allow each of us to inhabit a fully human, trans-racial and non-racial imagination. The opportunities and the challenges exist in every setting -- in the corridors of bureaucracy, the ranks of our professions, the emergency rooms of our hospitals, the lecture halls of our universities and colleges.

I am aware that you have confronted the difficult reality of residual racism in your discussions at this Summit. I am heartened that you have had the courage to do so and hope that others in our society will follow your example.

There are few countries that have greater potential than ours to confront issues of racism and sexism, and few whose history so strongly compels them to strive to vanquish the past in order to attain the future we desire.

I need not remind you that a critical measure of our success as health providers in both the private and public sectors is the extent to which the consumers of our services benefit from our assistance and are satisfied with the quality of care they receive. Research and common experience tell us that we still have some distance to travel before we can say we are satisfied with what has been achieved.

How many of us indulge in interventions and forms of treatment that are driven first and foremost by the benefit that accrues to us as opposed to the good of those we claim to serve?

How many times have we acted to satisfy our own convenience instead of following the dictates of professional responsibility -- and how often has this had unfortunate consequences?

How often do we lord it over those who seek our professional help without attempting to understand their wishes and their fears?

Have we remained true to the oaths and pledges that we solemnly swore when we entered our professions? Do we understand the living link between the Bill of Rights of our country and our practice as health care professionals?

I ask all these questions not simply to highlight the negative, but to focus our thoughts on the task of building the commitment of the huge cadre of health workers, who face constant challenges often under trying conditions, and whose expertise and compassion is the lifeblood of the health service.

This country is justly proud that it gave birth to health professionals who were towering figures, casting a bright beam of hope well beyond the confines of the health sector. These are patriotic men and women who were actively involved in the struggle to free our country from racist tyranny.

Further, we will never forget those doctors and nurses who, at the height of apartheid oppression, acted in the highest ethical tradition by providing a haven for detainees on hunger strike or requiring psychiatric care. We think of emergency service teams who repeatedly venture into danger and sometimes pay with their lives. We think of Marilyn Lahana who succumbed to Ebola fever contracted from a patient and who symbolises all those health workers who accept that risk of infection with a deadly disease is a reality and part of the conditions in which they work.

These are all heroes and heroines who, unfortunately, are largely unsung.

When I see hospitals named after the giants of our freedom struggle, I would like to think that all who work at these places must be conscious that, however routine their job, they serve a higher purpose. They are there to assert the dignity of life and the significance of human compassion against a tide of deprivation, toil and pain.

Bearing in mind the preponderance of women in the health sector, it would – however -- be appropriate to see more of our heroines remembered in the naming of hospitals and clinics.

I would like to emphasise that I believe that, although the material circumstances of public and private health care providers differ enormously, the fundamentals of professional practice are the same. Furthermore, it is clear that no health professional can afford to run his or her practice as an island, oblivious to the sea of public health problems lapping at the shores.

The gap in health spending between the private and public sectors is enormous and is, inevitably, a reflection of the gulf that exists in terms of income and wealth between the impoverished majority and the privileged minority in South Africa. Only a few countries in the world exceeded this inequality and it represents one of the gravest threats to the stability of our young democracy. Every action that bridges that gap, every measure that

puts the brakes on the further marginalisation of the poorest among us helps to build our future, ensure our future and sustain our democracy.

In this context, principled partnerships between private health care providers and public health services take on a wider meaning. We believe that many of these partnerships should fall into the realm of social responsibility rather than routine business. While there always will be place for straight business transactions between government and the private sector, I must be blunt and say that in health care we are looking for collaboration that goes beyond the profit motive.

We have seen a few pioneering instances of this and I am confident that there is the potential to develop many others. For its part, government is committed to taking stock of its own practices to eradicate needless obstacles in the path of productive partnerships.

The question of partnerships has been brought sharply into focus by the growing burden of disease in South Africa. In common with the rest of Africa, we are experiencing an upsurge in the communicable diseases strongly associated with poverty and underdevelopment -- AIDS, TB and malaria. As a middle income country undergoing rapid urbanisation we also find ourselves heavily taxed by the illnesses associated with "western" lifestyles -- cardiovascular conditions, diabetes, respiratory conditions and cancers. The final component in our infamous "triple burden" of disease is trauma -- accidents, assaults, rapes, murders, suicides.

In the context of globalisation, partnership takes on a whole new trans-national dimension. Few people in this audience will be unaware that South Africa has forged partnerships with SADC member states and more broadly on the African continent so that we can address simultaneously the questions of development and health.

Our common concerns in the African health partnership have been the development of programmes to combat communicable diseases; the overall strengthening of our health systems; challenging trade practices that make essential medicines unaffordable for us; and mobilising increased domestic and external resources for health care on our continent. The New Partnership for Africa's Development (NEPAD) seeks to pursue all these objectives.

By standing in solidarity and speaking with a single voice as African countries, we have been able to project the inherent morality of our position and we have been able insist that assistance for health must answer to our real needs. We have argued that development and sustainability are indispensable features of all future health assistance to Africa.

Overall, our assessment of the past seven years is that health care has undergone some fundamental changes and has begun to record the kinds of achievements that are critical if our target is Health Care for All.

- There is improved access to care and a new sense of hope for some of our most deprived and marginal communities.

- We have developed a much clearer understanding of the nature of inequity and have begun to bridge the gap between the haves and the have-nots with regard to health.
- There is a new emphasis on rationality in health care, on basing our interventions on evidence of need rather than reinforcing old patterns of social privilege.
- While our preventive and promotive programmes still have a long way to go – yet we have made great strides in terms of integrating our initiatives into the school curriculum, building partnerships for health and promoting healthy public policy.
- Some headway has been made in terms of projecting a new ethos of accountability and social responsibility in health care.

Despite these gains there is still the very real sense that we stand poised at a critical juncture. Further reinforcement of the progress we have recorded is critically necessary. Imagination and commitment are required to overcome some of the persistent obstacles to better health care.

We have to fight and defeat crime and corruption within the public health system, which results in the theft of drugs and medicines, hospital apparel, equipment and food by unscrupulous people.

And I believe that the answer lies in the hands of health care workers -- of every rank and occupation, professional and non-professional.

You have the critical power to make this country a truly better place. You can make freedom real for countless of your compatriots who have known nothing but scarcity, drudgery and neglect. I cannot disguise the fact that this will mean hard work – harder than at present. But the historic opportunity exists today and will not come again.

Now is the time to act as one, to call up your deepest reserves and to make the sacrifice. I make this call to you and to this Health Summit because that I know that you have ears to hear, and are capable of the most heroic actions that give meaning to the concepts of the sanctity of life and human solidarity.

I speak to you, our valued health workers, as tried and test frontline fighters for the building of a humane South Africa and a world of health and happiness for all. I know you will not disappoint us.

President Thabo Mbeki

Director-General's presentation to plenary session

The vision, the challenges and the debates

Intention of presentation

The intention of this introductory presentation is to build on certain debates raised in the Minister's opening address and the panel discussion on equity and, at the same time, to preview the terrain of the four main theme areas of the Summit.

Point of departure

The selection of major themes has been informed largely by the difficulties we experience in the public sector in answering the health needs of the majority of South Africans. I would like to take a few minutes to explain why we feel justified in pursuing this focus with a group as large and diverse as the participants in this Summit.

Given the levels of poverty experienced in this country – and these are suggested by an unemployment rate of about 30% -- the only hope of the majority of South Africans is a democratic state that is responsive to their plight, their needs and their aspirations.. Every one of us therefore, no matter where we're placed, has a duty to assist the state to fulfil its mandate of improving life for the ordinary citizen. What we do today in health delivery is very important to the sustenance of democracy.

Responsibility for this vests at every level – in the formal processes of the legislature and the executive; in the actions of every public servant; and in civil society – both the non-profit and the business sectors. One does not have to sit in Parliament or in the offices of the bureaucracy to make a meaningful contribution.

Nor does this contribution have to be at the level of making laws and developing major policy. In fulfilling our responsibilities to provide health care for all, the short-term commitment to good service delivery is every bit as important as the development of an appropriate long-term strategy. When we speak of a short term vision, we have in mind putting value on small interventions that may otherwise seem insignificant but make health care truly effective and life-affirming.

A perspective on transformation

It is important to remind ourselves that the scale and the pace of the changes we are attempting in the post-apartheid decade have few parallels anywhere in the world. The sheer magnitude of our task and the ambitious goals that we have set may predispose us to judge our results harshly. It is almost inevitable that we cannot succeed in all respects.

What we need to ask is whether we are still on track and whether, on balance, the score sheet is positive. And I believe that we can say that this is the case. We need to maintain our sense of direction, renew the energy required to pursue our goals and, at all times, guard against defeat by the sheer size of our historic task.

Purpose and place of this Summit

The Department of Health convened this Summit not as a response to a particular crisis in the health system. But we have been concerned with a persistent gap between the policy framework and our ability to translate policies into the kind of action that produces better health care. There are weaknesses in delivery that we simply have not overcome.

The Summit seeks to confront some of these challenges by mobilising on a wide front and focusing the attention of many significant players on a few key problems. We are hopeful that this concentration of energies will achieve the breakthroughs we are looking for.

Four key themes for the Summit

Quality of care

Terrain and issues

The discussion paper on quality of care highlights the multi-dimensional character of quality, that is: the technical standards that indicate high performance and the client expectations that must be met.

It points out that there are quality-related problems in both the public and private sectors, though these are not the same. For instance, in the private sector commercial imperatives may be a threat to quality of care, while in the public sector the shortage of resources is likely to make a significant impact.

The discussion paper also reflects on the different quality challenges that face hospital and ambulatory care.

Having established the distinct nature of quality issues in different contexts, the paper tries to draw out some of the overarching problems. It focuses on the weakness of data on quality; the failure to establish patient-centred services; rigid management systems; underdeveloped mechanisms for seeking redress; and the inappropriateness of many nursing practices.

Quality of care: the challenges

It is suggested in the discussion paper that we should be targeting our efforts on the following:

- Changing the workplace culture.

- Promoting ethical professional practice.
- Transforming nursing, not in a technical sense but in terms of culture.
- Changing health science education.
- Making use of regular, participatory forms of evaluation.
- Developing systems for quality management.

Quality of care: points to debate

The authors of the discussion paper invite you engage with them on their description of the situation: Does it reflect the reality that you, in your diverse settings, have come to know?

They invite you to contribute ideas on improving quality of care, particularly in relation to:

- Producing managers – or perhaps leaders – who can take charge of quality initiatives.
- Including consumer voices in the planning and evaluation of quality programmes.
- Making regulatory mechanisms and financing systems serve the goals of quality.
- Creating governance structures that promote and reinforce quality of care.

Quality of care: some comments

I would like to suggest that training is an absolutely vital dimension of quality health care, that it lays the basis for all other quality assurance measures. And in this regard, questions of selection of health professionals and the appropriateness of the curriculum are paramount. I would argue that ensuring appropriate technical competence is always important. But equally important to training is the process of imparting the values of service, humane practice and professionalism.

Another debate that arises within the quality arena is the relative importance of health workers' rights and service users' rights and expectations. Take for instance the situation of nurses in the public sector and the private sector. They are the same people, broadly speaking. So why is care so poor in the public sector and when we get to the private sector we are treated like gods. The salaries of these nurses are not so different, so clearly there must be some other explanation for their behaviour.

Both patients' and health workers' rights are justly claimed and deserve recognition. They must co-exist and therefore our task (especially in the public sector) is to find a better balance between them than the one that prevails – a balance that takes into account the resources available, the imperative of national reconstruction and the project of transforming the public service.

Lastly, on the question of quality, I would like to make a plea for us to recognise the value of small interventions that may make an enormous difference to the ways in which our clients experience our services. We should not endlessly defer making these immediate changes because we are not able to implement total quality management. I am convinced that we can make substantial progress towards quality of care in a step-by-step fashion if our commitment is strong enough.

Human resources

The terrain

Turning to the theme area of human resources, I am sure there is no need to dwell on the link between this subject and the issues we have raised under quality of care. The relationship is self-evident.

They are:

- Strengthening the work ethos.
- Scopes of practice.
- Professional migration.
- And representivity – in training and in the workplace.

Human resources: the issues

The discussion paper highlights a number of issues in relation to strengthening the work ethos in the health sector. It challenges some conventional views about the relationship between workloads and low morale. It discusses the relative impact of salary levels and the turmoil of transformation. It opens discussion on some ethical sore points, like the relationship between kickbacks and over-servicing of patients. And it tackles the issue of poor management as a factor in undermining the work ethos.

When it comes to scopes of practice, the paper argues that the present vertical and horizontal definitions of scopes of practice are at odds with the needs of our health system at this particular time. It suggests that existing scopes of practice fit badly with the demands of primary health care and that they retard the move towards employing mid-level workers on a scale that begins to relieve critical staffing shortages. What we really need to ask in relation to scopes of practice is whether we are acting to safeguard the patient or more to perpetuate our own professional interests.

Introducing the debate on professional migration, the paper points out that this has several dimensions: urban/rural; public/private and from South Africa to wealthier nations. It recognises that financial incentives play a significant part in this. But it also suggests that the selection of students may have a lot to do with the migration dynamic.

In terms of creating a representative work force, the paper observes that the public sector has attained substantially better results than the private sector on racial representivity. It notes that specialised medical disciplines have been particularly slow to transform. And it suggests that there are pockets and levels where there is resistance to gender equity. Finally it points out that affirmation of people with disabilities is simply not happening.

Human resources: points to debate

We hope to probe beyond the surface in debating the reasons why the work ethos is so negative in many health institutions. What are the real roots of the problem and what impact have we had in our efforts to tackle it?

Likewise, we are optimistic that the collection of experts we have in this room may result in us pinning down the barriers to changing scopes of professional practice. We are looking to you to define a workable, fail-proof way to rapidly expand the pool of mid-level workers and give them a meaningful future in the health services.

The most critical questions in relation to professional migration are retaining senior professionals in public sector facilities in the rural areas and reducing the irresistible attraction of the private sector.

When it comes to representivity, the biggest challenges lie in the private sector. Black managers of private health care institutions are an extremely rare species. Student admission criteria are obviously a major factor in determining the composition of the professions – and we need to debate how these should change in order to effect broader transformation.

Human resources: some comments

I would like to add another dimension to the human resource debate by asking how much we understand about the relative contributions of understaffing and low productivity to our problems in service delivery. In a way it is more comfortable and easier to blame poor quality of care on staffing shortages. And in some circumstances this is quite clearly the real problem. Low productivity, on the other hand, is the result of a whole number of shortcomings and is not amenable to simple or rapid solutions.

When it comes to professional migration, I would argue a measure of migration is unavoidable in this age of globalisation. Human resources represent a major national asset and a huge public investment. International competition for well-qualified health workers is inevitable and it would be futile – and obviously unconstitutional -- to attempt to prohibit the movement of workers. However, it would be foolish in the extreme if we failed to develop strategies to manage migration, to protect this asset we have produced at huge cost and to harvest some of the fruits to be gained from the international exchange of skilled professionals.

Public-private interactions

The terrain

The discussion paper gives a particular perspective on public-private interactions (PPIs), by setting out up-front the vision, aims and goals of such engagements within the health care environment.

The paper – which draws extensively on the draft PPI policy of the Department of Health – lists as key goals:

- The promotion of equity in terms of access to care and the allocation of resources.
- Efficiency, in terms of getting maximum value from health resources in our country.

- And quality of care – in the sense that it is discussed in the Quality of Care paper.

These goals, I want to believe, are widely shared by all health care providers. Differences are more likely to arise about the terms on which we combine our efforts to achieve them.

It is important for us to understand the inter-dependence of private and public health care sectors and how PPIs can contribute to the sustainability of the health system as a whole.

Public-private interactions: points to debate

Summit participants are invited to examine whether the vision and the goals, as set out in this document, are appropriate and sufficiently specific to provide a useful guide to those of us seeking to build workable PPIs. Do they need reviewing?

Public health services engage with any number of private sector enterprises in a routine commercial manner. Many government services also benefit from outright donations from the private sector. PPIs occupy a middle-ground, somewhere between commerce and philanthropy. What precisely is the range of PPI practices – where does it begin and end?

Principles have been proposed to guide decision-making on PPIs. The appropriateness and usefulness of these are out there for debate. The principles go a long way to defining what the respective roles of government and the private sector would be when they meet in the PPI arena. Are these roles consistent with the health system goals that we want to achieve?

Public-private interactions: some comments

I would go so far as saying that PPIs can be an expression of commitment to democracy. If you accept, as I do, that democratic government is much more stable where the state is able to meet the needs and legitimate expectations of the people, then you would agree that interventions that aggravate existing inequalities endanger the democratic project. Given the difficulties that the public health sector has in coping with the demands on it, we need to be very sure that PPIs always increase the capacity of government services.

Although we would assert that the central focus of PPIs is to support the state in discharging its duty to the public, this does not mean that there are no benefits for the private sector. All too often the debates on PPIs become a sterile recital of the weaknesses of the legal framework and the shortcomings in the public health sector. The genuine opportunities that exist for mutually beneficial arrangements are often lost. Apart from the specific benefits flowing from each PPI, I want to believe that the private sector benefits substantially when the overall quality of health services in the country is strengthened.

HIV/AIDS, TB and STIs

Terrain and issues

The discussion paper for this theme is based on the HIV/AIDS and STI Strategic Plan for 2000 to 2005. Many of you will be aware that the plan is structured into four priority areas, namely:

- Prevention of new infections
- Treatment, care and support
- Research and surveillance
- Human and legal rights.

It is further underpinned by a number of principles that include:

- A holistic, comprehensive approach to the HIV, AIDS and related infections.
- Participation of people living with HIV/AIDS in the development of policy and the implementation of programmes.
- The development and strengthening of a partnership between the state and civil society.
- Respect for human rights of all who are infected and affected.

The Strategic Plan is the product of a process that was initiated by government and it is fully endorsed by government, but it was developed in a series of consultations and is certainly not the sole property of government.

HIV/AIDS, TB and STIs: the challenges

In relation to prevention, the discussion document highlights particular areas where improved intervention could yield measurable results. For instance, ensuring that the syndromic approach to managing STIs is much more widely used, particularly in the private sector. Increasing the use of barrier methods through better researched, better targeted and more effective initiatives to influence sexual behaviour. Developing an effective programme to prevent mother-to-child transmission of HIV.

When it comes to treatment, care and support, achieving a “continuum” of care features in large print among the major challenges confronting us. The notion that appropriate care should be available to the individual with HIV/AIDS from the point of diagnosis, through a variable period of wellness, then through a stage of declining health into the terminal stage is easy to grasp. So is the concept that this treatment and care involves many different interventions, and that it will require a variety of institutions and types of services provider.

However, the reality is that this continuum is available only to a minority of people affected. In many geographical areas, the required range of services and organisations simply does not exist. And in other areas, where there is a reasonable range of treatment and care facilities, coordination and referral links are often poorly established.

The discussion paper refers to the “aggressive” management of opportunistic infections and examines what it would take to achieve this more effective form of response. Control of tuberculosis is recognised as a particular challenge.

The matter of anti-retroviral drug therapy is raised with a recognition that this is rapidly changing terrain and it is discussed in terms of the need to develop an understanding of appropriate utilisation of ARVs in local contexts.

The document also isolates as a major challenge the expansion of home-based care so that it becomes a meaningful care option, functioning on a large scale to minimum standards of care. This is clearly an area where, despite good intentions, effective implementation has eluded us and where the gap between need and supply is growing.

Under the heading of research and surveillance, the discussion document argues for more research that is attuned to the needs of infected and affected persons. It also focuses on impact studies as an important tool for planning – including planning for the continuity of health services.

And it suggests that securing human and legal rights will depend largely on the extent to which we are able to mobilise across a range of sectors.

HIV/AIDS, TB and STIs: points to debate

When it comes to prevention, the discussion paper urges participants to dig below the surface of the VCT and MTCT debates and to attempt to resolve some of the training and human resource issues that are crucial to building successful programmes.

A similar approach is adopted in relation to the continuum of care, as well as step-down and home-based care.

The discussion paper raises questions about harmonising HIV and TB strategies and considerations in shaping the research agenda

The linkages between this theme group and the other three are quite evident. Indeed, we have often argued that the weaknesses of the HIV/AIDS programme are an expression of inequities and under-development in the health system as a whole. I believe that the debates here will, in part, affirm this.

Panel discussions

In defining the Summit programme, the organising committee deliberated for some time about the number and the nature of major theme areas. In the end, we opted for a relatively narrow focus instead of comprehensiveness. This is because we see the Summit as a springboard for action rather than a talk shop without consequences and commitments.

But the organising committee was not comfortable with the total exclusion of large and very significant areas of health from the agenda. The compromise was to incorporate some of these through panel discussions.

In addition to the equity discussion that we witnessed yesterday, we will have a discussion on the state of public hospitals and on non-communicable diseases, including mental health.

We hope that the discussion on public hospitals will, in a sense, draw together many threads from the theme areas on quality of care, human resources, public-private interactions and HIV/AIDS.

By turning the spotlight for a couple of hours on non-communicable diseases and mental health, we are reminded once again of South Africa's heavy and complex "triple burden" of disease. The World Health Organisation's year-long focus on mental health has almost run its course and at the close of this Summit a copy of the world health report for 2001, which deals exclusively with mental health, will be presented to the Minister.

Concluding comments

At this point the real work of the Summit begins and I can sense that there is no need for me to encourage you to speak your minds and shape the final result.

Before we receive an indication about the practical arrangements for the theme group discussions, I would like to thank the writers of the discussion papers for the considerable effort that they have made in setting the scene for our deliberations. I would also like to express our appreciation – in advance – to the facilitators and rapporteurs who will be taking responsibility for keeping the theme discussions on track.

Dr Ayanda Ntsaluba
Director-General of Health

(Note: this is a reconstruction of a slide presentation given by Dr Ntsaluba, not a verbatim record of his address)