HEALTH CONSULTATIVE MEETING REPORT

12th to 13th November 1999

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Introduction

Purpose and Goal

The consultative meeting was convened after discussions between the Minister of Health and the Director General and Chairpersons of legislative Health Committees in the National Assembly and the National Council of Provinces (NCOP). The meeting was held on 12th and 13th November 1999, at the Days Inn, Cape Town.

The main goal of the meeting was to identify strategies for developing a collaborative and co-ordinated working relationship between the Health Department and legislative committees, nationally and provincially.

Specifically, the meeting sought to address the following objectives:

- Discuss the functions of the Health Department and legislative committees
- Discuss mechanisms for co-ordinated interaction between the Legislative Committees and the Health Department
- Share information on progress and achievements in health sector restructuring since 1994; the health sector's strategic vision for the next 5 years; and key challenges still facing the health sector
- Discuss and plan ways for collaborative and co-ordinated interaction between the Health Committees and the Health Department.

Format of the meeting

The format used to conduct the meeting combined both plenary and small group discussion sessions. The opening sessions were each opened by presentations followed by general discussion by participants. Session 1 outlined the purpose of the meeting and intended outputs at the end of the 2 days. Session 2 set the scene informed by the strategic direction for the health sector (developed by the Ministry and Department of Health). During Session 3, a number of case studies were presented. The case studies gave concrete instances of interaction in the past and highlighted success factors, problems, and weaknesses with implementation. Session 4 mainly focused on the role of the national and provincial legislative committees.

Issues requiring in-depth discussion and analysis from the first 4 sessions were identified by a small technical group and presented during Session 5. These were subsequently addressed by small discussion groups (4) during Session 6. Recommendations from the small groups were considered at the end of Session 6. Session 7 considered a way forward based on the decisions from preceding sessions.

This has not been compiled as a verbatim account of what transpired in the various sessions. The report gives an outline of the main papers presented (some summarised), a synthesis of the main discussion points agreed to, and the suggested way forward.

Welcome Address and Opening

Dr Manto Tshabalala-Msimang, Minister of Health

In my first briefing to the Portfolio Committee of the National Assembly on the 24th August 1999, I categorically and unambiguously committed myself to a constructive partnership with all of you across the political divide. I further suggested that to give true meaning to this, that we hold a national consultation before the end of November 1999.

Today marks an important step towards the realisation of that promise and must surely stand as an encouraging sign of our maturing democracy.

Let me repeat once more that my colleagues the MECs and myself – all of us without any hesitation, stand ready to work together and with you to ensure the true fulfilment of the promise of a better life for all.

Today we meet here in Cape Town – representatives of the Legislative and Executive arms of our government - to come and share ideas on how to work together and in what direction over the next 4 and a half years. This act in itself must surely stand as an important affirmation of our common commitment to our country and her people.

We must build on this commitment and let it at all times be the foundation for our interaction. We must at all times remain seized with the singular objective of building a better life for all our people in their diversity.

Over the past 5 months, the MECs and myself have tried to objectively reflect on the nature of the challenge before us. As many of you know, seven of the MECs and myself had responsibilities outside the health sector before our second democratic elections. In this regard, I wish to thank Drs. Mkhize and Sefularo – MECs of KwaZulu Natal and North West respectively, who are the only ones amongst us who have continued in the same responsibility. They have constituted an important link between the present MINMECs ensuring a fuller comprehension of the decisions previously collectively taken.

Added to this, we had the benefit of an informative review of public health service delivery, which had been commissioned by my predecessor Dr. Nkosazana Zuma. We have also consulted extensively with key stakeholders across the country. These, together with our own observations both as citizens as well as incumbents in our new responsibilities have contributed to a rapid assessment of where we stand and consequently what priority interventions we see necessary.

Some of the key conclusions we have reached are:

- That overall our public health system remains strong but can do even better.
- That whilst the majority of our health workers are giving their best, there are serious threats emanating from a minority that challenge the integrity and the very essence of our health system. We need multi-pronged interventions to decisively deal with this cancer of betrayal.
- There have been impressive gains towards equity over the past 5 years. These achievements are in some instances under threat largely due to budgetary pressures. We need to remain vigilant. Equity is the cornerstone of our health reform agenda.

- We need to do more to align the activities of the public, private and NGO sectors so as to optimise use of our limited national resources.
- We need to spur communities into greater involvement as true and legitimate custodians of our institutions and the service we render.
- The scourge of HIV/AIDS threatens to undo a lot of our gains. We need to strengthen partnerships with all sectors in our interventions. But more importantly, no matter how uncomfortable, we need to aggressively target our 9–15 year olds.

Colleagues, over these 2 days we shall be sharing these with you, importantly trying to elicit from you how you see yourselves as elected public representatives contributing to the successful execution of interventions aimed at ensuring an equitable, caring and more responsive health care delivery system. We have come to you with open minds on the role you may wish to play. Our only plea is that it be constructive and in the best interests of our nation.

I sincerely wish that we have a fruitful consultation. I look forward to hearing your ideas.

Setting the Scene

Keynote Address by Dr Manto Tshabalala-Msimang, Minister Of Health

Introduction

I have referred to the Review of public health service delivery, which was carried out between October 1998 and June 1999. I now wish to highlight some of the key findings of that Review. As indicated, the purpose of the Review was to take stock of the achievements and weaknesses of the public health service during the first term of democratic government and to guide health service developments during the second term. The Review focused on service delivery issues and not individual programmes.

Trends in public health expenditure

Let me begin by looking at key trends in public health expenditure as reflected in the Review.

The Review showed that real public expenditure rose by 10% between the 1995/96 and the 1996/97 financial years. This however masks considerable inter-provincial differences.

Between 1997/98 and 1998/99, after adjustment for inflation, the total spending by national and provincial government declined by 5.4% in 1999 prices. Given the continuing rise in population figures, this trend of falling real expenditure is accentuated when viewed in per capita terms. For South Africa as a whole, public health expenditure per person rose from R572 in 1995/96 to R614 in 1996/97 and then fell to R601 in 1997/98. Real per capita expenditure fell again during 1998/99 and indications are that per capita expenditure is likely to fall further during 1999/00, although once adjustment budgets have been voted the scale of this decline is likely to be less severe than current estimates show.

Thus, after the "bumper" year of 1995/96, real public health expenditure has been declining since 1996/97. This trend is even more marked on a per capita basis.

We need to ask the question: Has there been progress in achieving inter-provincial equity in public health expenditure during this period? A review of relative per capita spending of the provinces shows that over this period Mpumalanga had the lowest health expenditure per person. In 1995/96 Western Cape (with the highest spending) spent three times more per person than Mpumalanga. This ratio narrowed to 2.5 times in 1996/97 and again to 2 times in 1997/98.

However, this trend of reducing inequalities between provinces in expenditure per capita, seen each year since 1995/96, has slowed down since 1998/99, with variations between provinces in actual expenditure per capita in that year increasing slightly. Now, the Western Cape once again spends closer to 2.4 times per person relative to Mpumalanga.

If we examine spending and allocation on key Health Service Delivery Programmes, we see that nationally, actual expenditure on the district health system (DHS) as a proportion of the total has increased consistently between 1996/97 and 1998/99, as most provinces have sought successfully to increase the share of resources allocated to DHS. On the other hand, actual expenditure on Academic Health Services as a proportion of total spending in the country has decreased marginally from 22.9% in both 1996/97 and 1997/98 to 22.3% in 1998/99.

A look at allocations vs. spending on these three key health programmes reveal differences that may be attributed to either over-budgeting, but most probably a continuing tendency to shift resources from the DHS when over-spending occurs. Some provinces still have trouble ensuring that budgeted funds actually reach district services, rather than being consumed by other levels.

Having said that, more provinces had achieved or were close to achieving their budgeted targets for DHS in 1998/99 than in previous years, marking real progress in reallocation of resources. Gauteng, and to a much lesser extent Western Cape, had still spent a higher proportion than they had budgeted for on Academic Health Services.

District health systems for primary health care services

In our strategic framework we propose the development of a package of services for the primary level of care with a commitment to incrementally provide this over this term of government. We believe this is critical if we are to protect these basic services from the insatiable pressures posed by the hospital sector. We need to work together to argue for the protection of primary health care (PHC) budgets within the provincial allocations.

We shall also build on the recent momentum built by the work of the demarcation board to speed the development of the DHS. As we do so we shall continue to be guided by the firm belief that it is in the interests of the health sector that we have multi-sectoral districts. After all, the major determinants of health lie outside the health sector. We shall therefore be prepared to adjust the boundaries of our existing interim districts to facilitate such multi-sectorality.

Convinced as we are about the critical role of districts as the pillar of our unitary but decentralised system, we should ensure that we do not overstretch our management capacity. Of course this includes the capacity within existing local government. I argue therefore that we should not bite off more than we can chew. I say so not out of hesitation but more to ensure efficient and effective execution of our decentralisation programme. In short - where capacity exists let us proceed with great speed and where none exists let us rather invest in an interactive process of building, driven by a genuine desire to further advance the continuing evolution of our National Health System.

A more worrying picture also emerges when we look at the current MTEF projections. The MTEF budgets for 2000/01 suggest that real spending per capita is likely to recover somewhat from its projected decline in 1999/00, but will stabilise slightly below the 1998/99 actual expenditure levels. Nonetheless, the pressure placed on budgets by population growth and the HIV/AIDS epidemic is likely to be substantial. Between 2000/01 and 2001/02, total real spending across all of the nine provinces is projected to rise by 2.87%, almost R700 million (1999 prices) - but this overall increase is diluted by population expansion to growth of 0.4% (or only three Rands) per capita, from R552 to R555 in 2002! Add to this the pressure of HIV/AIDS and it becomes clear that we have more difficulties ahead of us.

A compounding factor in this scenario is the relative inflexibility of the personnel component of our budget. A significant cause of the 10% increase in the overall budget between 95/96 and 96/97 was the conclusion of the bargaining chamber negotiations which led to significant upward salary adjustments for the health sector. However, consistently in the subsequent years the allocations for the ICS (Improvement of Conditions of Service) have never adequately compensated for the carry through costs of that agreement.

The net effect is that money destined for services has had to be diverted to pay salaries - a statutory obligation. This has resulted in our salary bill increasing from 58% to 65% between 1995/96 and 1998/99. This clearly is not sustainable especially when you consider the continuing upward pressures that still exist.

We are of course working closely with DPSA to ensure introduction of a more appropriate remuneration policy throughout government. We are also unequivocal in our view that practices such as the current automatic rank and leg promotion have no place in a performance driven system.

We argue therefore that we have a collective responsibility, particularly as we are charged by the executive and legislative arms respectively with the health of this nation, to work together to highlight these difficulties. Of course we all know that there are no easy solutions - resources overall are limited. But I am certain that our collective voice across the political divide will be louder than that of the MECs and myself alone.

On our part we are not going to pretend that we cannot do better with the resources already available. In that regard we have committed:

- To strengthen our financial management systems
- To integrate better service planning and budgeting.

So as to further help us monitor our expenditure patterns and share best practices, we shall be:

- Standardising our budget programme definitions
- Speeding up the work currently underway leading to the introduction of a system of National Health Accounts.

Quality of care

A second major problem highlighted by the Review is related to the issue of quality of services. More importantly, the Review pointed to:

- Weaknesses in data availability to track national policies
- Low morale and negative attitudes of health workers.

This manifested as indiscipline and absenteeism which are widespread as well as negative attitudes towards patients. More worrying for us is that whilst we should at all times stress that by far the overwhelming majority of health workers work with extreme dedication, sometimes under difficult conditions, however, we should note that the problem of uncaring attitudes is more than that of the occasional "bad apple". Further worrying is that the most vulnerable patients were women, the poor and the illiterate.

I am sure that as public representatives, we shall all agree that this has the seeds that could undo the sacrifices of so many. Let it be said clearly and loudly that our common humanity as citizens is the fundamental pillar of our new democracy. Whatever the reasons none even amongst us has the right to vent their anger against the most vulnerable in our society.

We must therefore surgically excise this cancer which makes the road to some of our facilities to be travelled only by the most desperate indeed.

Of course some reasons cited for the low morale need our urgent attention and we have committed ourselves to do precisely that. These include staff shortages, some nurses feeling unqualified for some of their new roles; physical insecurity and lack of support.

In this regard, we have charged the Director-General and the provincial Heads of Health to provide us with a comprehensive framework for Human Resource Development and Management by the middle of next year.

Recently on the 2nd November, we also launched the Patients Rights Charter as a specific intervention to reinforce other ongoing initiatives under the banner of "Batho Pele". We shall be working hard to make sure that this charter becomes a living document. I am certain that you will agree that its success requires all round mobilisation of our communities for them to reclaim (in a positive way) what essentially are their institutions. As we partake in this exercise we should also not shirk our responsibility of highlighting that with rights come responsibilities. We should remember too that health workers are also human. They need the occasional pat on the shoulder when things are well done. They also need our protection both physically and emotionally.

Colleagues, honourable members, I believe you have a duty as you interact with your constituencies to convey this approach so that together we build our nation.

In the coming year we shall also work on other elements of a quality management system. These will include the introduction of clinical audits and peer review systems. We shall also be interacting with the Health Professions Council and other statutory councils to ensure that there is a dynamic link between the recently introduced system of continuing professional development and identified weaknesses within the service environment.

The issue of quality of care, and the inculcation of a caring ethos amongst health workers is perhaps one of the key challenges that will define our success as a nation to create a caring society. Consequently, it cannot be a product only of goodwill by health workers but rather to have true meaning and be sustainable, it will have to be a product of a dynamic relationship between the providers and the users of health facilities.

Hospital restructuring and management

Another key problem identified by the review is the inefficiency within our hospital sector. Many of our hospitals are in need of rehabilitation. Government has clearly signalled its intention to tackle this disturbing inheritance from our past. We budgeted R100 million last year, R200 million this year and a further R900 million over the next two years for the rehabilitation process. A key challenge is to ensure that as we carry the rehabilitation programme, we also reshape our hospital portfolio. We are currently hard at work to finalise comprehensive provincial hospital plans to inform this investment. This work will be completed by June 2000.

Besides refurbishing our hospitals we need to ensure that the management systems and skills at our hospitals are improved. We have begun to appoint general managers (who need not be medical doctors) as chief executive officers and are in the process of developing performance agreements with them. We have received assistance from the British NHS to support our process of decentralised management.

We are confident that as we increase the skills of hospital managers and empower them to make decisions, the quality of care and efficiency of our hospitals will increase. We are already seeing gains

from the process of decentralised management in some of our public hospitals. We are currently in discussion with the treasury to agree on an appropriate mix of incentives to underpin this initiative.

One such measure is revenue retention. We regard the revamping of our management culture and systems as critical also in the attainment of better quality. We do not underestimate the enormity of the task ahead in this area. Appropriately prepared human resources are limited. Consequently the pace may not be as we would wish. It is also clear to us that at times we shall falter. But we are convinced that change we must. The alternative, which is to continue as we are, can only spell death for the public hospital sector.

We are encouraged by recent agreements between the Health Departments and Treasuries in Gauteng and Western Cape on revenue retention. In essence the treasuries have accepted that a portion of the revenue generated in health facilities be kept within the sector. Combined with our management reforms, this offers a challenge for innovation by our hospital managers. Those who make their facilities more attractive will have the ability to generate more income over and above budgeted amounts to further effect improvements in the work environment.

We also appeal for your support in appreciating the cost of some of these reforms. One of the tragedies of the tight fiscal environment we operate in is that in the effort to balance books year to year, we become more short-term in our thinking and extremely risk averse. Both are no solutions at all. We need to realise that treasuries at times may benefit more by spending more money today in order to save millions tomorrow.

There are other concerns raised by the review such as:

- Poor communication
- Need for Primary Care Nurses
- Role of Primary Care Nurses
- Dilemmas of participatory management
- Heavy-handedness of Unions
- Need for rationalisation of hospital beds.

As already indicated, together with my colleagues, we have examined these critically and built on them amongst others to suggest a way forward for the health sector over the next few years. We have developed a 10-point plan to consolidate the gains made and to strengthen the health system.

10-point plan

The 10 priority areas are:

- Improving the quality of care rendered in the health sector
- Revitalisation of the hospitals
- Delivery of a comprehensive package of primary health care services through the district health system
- Decreasing mortality and morbidity rates for priority diseases

- Strengthening human resource development and human resource management
- Transforming certain support services
- Improving resource generation, allocation and management
- Legislative reform
- Improving our communication within the Department of Health and between the department and our partners and
- Strengthening our international relations.

We need to consolidate the major achievements of the past 5 years in improving access to PHC services for all our citizens. Over the next few years, we shall now place less emphasis on the further roll out of our physical infrastructure but concentrate more on ensuring that our primary care infrastructure is functioning optimally and providing a service of high quality. In particular we shall focus on the following:

- Ensuring an incremental delivery of the PHC package
- Many childhood diseases can be eliminated through immunisation. We are doing well with respect to the elimination of polio. We expect to be able to be declared "Polio Free" by next year. We also have done well in reducing the burden due to measles. We are now planning to consolidate this by carrying out a combined Polio and Measles campaign in June 2000. However, despite mass immunisation campaigns our full immunisation coverage stands at 63%. This is not acceptable and we plan to implement strategies to increase this to 90% by 2004 (no province should have immunisation coverage of less than 80%). We plan to introduce immunisation programmes in hospitals as well to ensure that we use all opportunities to vaccinate children.
- Ensuring 100% availability of drugs in the EDL for PHC in all facilities. To achieve this, we need to both popularise and train health workers on the EDL, improve stock management and ensure reliability of pharmaceutical distribution to all our facilities. We will deal decisively with the theft of drugs. For example we have agreed with the pharmaceutical industry on the differential marking of drugs destined for the state sector.
- Ensure appropriately trained personnel are available in all our PHC facilities
- Reduce maternal mortality and improve reproductive choice
- Ensure full implementation of IMCI
- Provision of assistive devices for those with disabilities.

Immunisation

Recently, there were widespread reports of problems with the BCG vaccine. We are happy to note that we are now trying to catch up with the backlog. We are currently, however, discussing a possible shift in our BCG vaccination policy - a switch over from pecutaneous. We will receive a report and take a final decision on this matter in our MinMEC scheduled for the 2nd and 3rd December 1999. There are however other possible problems due to worldwide shortages of DTI due to the closing down of DTI plants in Europe and a batch failure at the major supplier (Pasteur Marieux Connaught). There were also batch failures internationally for measles. We are however dealing with this to avoid negative consequences.

As you know, South Africa has 2 facilities that have been involved in vaccine production. Task teams were put together by my predecessor to advise on the future of these assets. The conclusion of those teams was that we continue to be players in vaccine manufacture but that to have any success, significant investments will have to be made. Cabinet approved this recommendation and tasked our department and DTI to further suggest a concrete plan of action. I am due to meet my colleague Alec Erwin for us to reflect on preliminary recommendations from our officials.

Needless to say we are keen to conclude these discussions soon so that real work can begin.

South African Demographic and Health Survey

In the last two months two significant events have taken place. We announced the results of the first ever South African Demographic and Health Survey - the most reliable baseline of health status that we have ever had. This has laid a solid platform for us to reliably monitor the impact of our policies and interventions. This survey will be repeated every 5 years to enable us to track progress made in reducing mortality and morbidity in South Africa.

Confidential Inquiry into Maternal Deaths

On the 15th October we announced the results of the Confidential Inquiry into Maternal Deaths. We have been able to identify the most important causes of maternal deaths in each province and each province has committed itself to develop a plan to prevent avoidable deaths. We believe that implementing these provincial plans will ensure that we are on track to reduce the current high levels of avoidable maternal deaths. Our maternal mortality rate is an unacceptable 150/100 000 births.

This enquiry, of major concern to us, has once more forced us to confront the major challenge posed by HIV/AIDS. AIDS is now the second leading cause of death amongst pregnant women. Later on today we shall have the opportunity to listen to a presentation by the Chairperson of the National Committee on Confidential enquiries into maternal deaths.

Violence against women and children

Women and children are especially vulnerable to violence, with men often being the perpetrators. With our partners in and outside government we plan to implement strategies to reduce these high levels of violence against the most vulnerable. Strategies include the development of protocols for the management of survivors of rape and the hosting of workshops for men in order to also focus on preventive actions. We have started a pilot programme for the training of forensic nurses in the Northern Cape. Early results from this are encouraging. We shall then roll out this programme to other provinces. This programme aims to significantly strengthen the effectiveness of our criminal justice system.

TB

South Africa ranks amongst the first 22 countries with the highest incidence of TB in the world. The HIV epidemic is contributing greatly to the increasing incidence of TB. In the absence of HIV infection, the risk of developing TB is about 10% during a lifetime. But for individuals co-infected with HIV, the risk ranges from 5-10% per year. In 1998, there were more than 114 000 reported cases

including 65 000 that were sputum smear positive (infectious). Incidence rates in 1998 in the nine provinces ranged from 98/100 000 in the Northern Province to 538/100 000 in the Western Cape. An estimated 40% of cases are co-infected with HIV.

In 1996, the South African Government launched the revised National TB Control Programme (NTCP). In establishing the NTCP, the Government signalled its adoption of the WHO DOTS strategy (Directly Observed Therapy Short-course) and set about the task of standardising procedures related to TB case diagnosis, treatment, and reporting. The DOTS strategy is an organisational framework that consists of five key elements, namely:

- Government's commitment to the National TB Programme
- Identifying TB cases through smear microscopy
- Standardised treatment of TB cases via directly observed treatment
- Regular, uninterrupted drug supply
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- To achieve smear conversion rates of at least 85% of all new smear positive cases and 80% of retreatment cases
- To cure at least 85% of all new smear positive cases
- To contain the rising incidence of TB related to co-infection with HIV
- To prevent the emergence of drug resistance.

The expansion of the DOTS strategy is measured by the number of health districts adopting the elements of the DOTS strategy and being designated as Demonstration and Training Districts (DTDs). Districts that undertake to become DTDs receive intensive training support and management development from the national and provincial TB programmes and indicators such as laboratory turn-around time, smear conversion and cure rates are assessed quarterly.

By the end of 1998, a total of 63 DTDs had been established; 24 were achieving targets.

Since the beginning of 1999, an additional 22 new DTDs have been established, resulting in a total of 85 DTDs. By March 2000, the Programme aims to have facilitated the establishment of 114 DTDs covering two-thirds of all health districts in South Africa.

Challenges of our TB control programme are:

- More rapid implementation of DOTS as a priority programme within integrated district-based primary health care
- The increasing HIV/AIDS epidemic
- Need for more aggressive strategy to educate communities about TB
- Persistently high rates of treatment interruption and inconsistent defaulter tracing
- MDR TB, which is the legacy of weak TB control structures and fragmented services

- Surveillance: Efforts are underway to simplify the TB Recording and Reporting Systems to reflect the evolving district-based DOTS strategy and to facilitate cohort analysis at district level
- Lack of information on provincial rates of MDR TB
- Training and implementation of administrative controls aimed at reducing the risk of nosocomial transmission
- Extension of services and quality assurance of TB services in special populations, e.g. prisons and mines
- Poor involvement of tertiary hospitals in ensuring proper diagnosis, treatment, and referral to community clinics
- Persistent over-reliance on chest x-rays as basis of diagnosis in many tertiary facilities.

The Department of Health is committed to TB control. Services are available in all primary health care services and treatment is available free of charge to ensure cure. We thus need to mobilise other key partners and advocate for a more integrated approach to TB control.

HIV/AIDS

On HIV - key directions of our actions include promoting:

- Greater co-ordination at all spheres of government
- Strengthening of the partnership against HIV/AIDS - hence proposal for a National AIDS Council
- Voluntary counselling and testing
- Provision of care and support, including for those orphaned as a result of HIV/AIDS
- Retain the focus on Primary Prevention as the priority intervention of our HIV/AIDS Control Programme
- Participation by South Africa in the international effort of searching for an affordable vaccine
- Management of opportunistic infections
- Working closely with SADC members states and the Africa Region of WHO as exemplified by the recent meeting on 4-5 November 1999.

Human Resources Development

With respect to improving our human resource capacity we plan to have a national human resource plan by June 2000. This plan will link our current human resources to our needs.

We have increased access to medical doctors through the country-to-country agreements we concluded with the Cuban and some European governments. We are very grateful to these countries and the doctors who volunteered to come to South Africa to assist us. However, a more sustainable intervention is to get our locally trained health personnel to work in the public health sector. We have introduced community service for medical doctors, which despite minor implementation problems is proving to be a huge success. We will be expanding this to include pharmacists and dentists in the next two years. We are also exploring a further expansion of this programme to include physiotherapists,

occupational therapists, speech therapists and psychologists. Overall, we have been heartened by the positive response of these young South Africans. What better example can we hope for our call for a New Patriotism!

One of the major issues that we need to confront is the transformation of our training institutions. We must ensure that these institutions, which are largely funded by public funds, train the right categories of health personnel in ways that facilitate the implementation of policies. For example if the policy is to increase access to PHC services especially in rural areas, then our training institutions must train people who are able to render PHC services in rural areas. This remains a challenge that we will confront together with the Department of Education in the next 5 years.

Besides the need to build the required capacity, we need to strengthen our human resource management systems and skills. This will be done in terms of the legislation and policies of the Departments of Public Service and Administration and of Labour. This is critical in order to generate greater efficiencies and to ensure a more responsive civil service.

Currently we have tabled before Parliament an amendment to the Pharmacy Act to make provision for performance of community service by pharmacists.

It is our view that overall, our pharmacy students support this Bill. There are certainly some areas they raised on implementation. This will be dealt with by the Department in discussion with them.

The availability of pharmacists in the Public Sector is one of the challenges we need to address. Currently the Free State and Gauteng have vacancies of 52% and 46% respectively. The situation is worse in provinces like the Eastern Cape and the Northern Province. We believe that community service will help alleviate this problem and contribute to effective pharmaceutical management in our facilities. At the same time we have been in discussion with the Department of Public Service and Administration for a review of the salary structure of pharmacists in the Public Sector. Ten days ago our Directors-General initiated a process of job evaluation of the pharmacist category. We hope for a positive outcome to this initiative.

A few of our support functions need to be transformed. These include the health laboratory services, taking over of the SAPS mortuaries and the unification of our blood transfusion services. We have already published draft legislation on the transformation of the laboratory services into a parastatal and this will be tabled for your consideration early in the New Year.

The Department is now finalising the regulations on Tobacco Amendment Act. These will be published for comment before the end of this year.

We are working closely with other sectors, especially Welfare, Labour and Finance, towards the establishment of a Social Health Insurance as part of a comprehensive social security system. This would enable those in employment to make a contribution to the cost of their care and enable us to provide better health care for all South Africans. An inter-departmental team has started working on this area. A draft proposal will be available for wider debate by March 2000.

The Review had highlighted the importance of communication both within the health system and between ourselves and our partners. I believe this meeting also signals our intent to respond to this. In addition, I plan subsequent to this meeting to meet with labour organisations, professional associations and statutory councils to discuss the strategic direction that are moving in so that each one of us can define for themselves what role they wish to play. In that way a true partnership can be built.

We also intend working closely with the private sector and do everything possible to blur the artificial divide between the two sectors. For this partnership to work, we would need to tackle the high cost differential between the two sectors. We hope the amendments to the Medical Schemes Act will begin to bring more sanity to the cost spiral. Furthermore we hope that the Certificate of Need initiative will curb the excessive abuse due to over-servicing and bring about more rational use of limited national resources. Some of the areas we shall be working on include:

- Continuing to expand contracting out of non-clinical services where appropriate
- Enter into lease agreements for hospital equipment
- Explore the value of Private Finance Initiatives in the provision particularly of physical infrastructure in the health sector
- Use private sector resources subject to mutually agreed conditions to the benefit of those dependant on the public sector
- Increase the number of private "fee paying" patients seen and admitted in our hospitals. The aim should be to use revenue generated to improve the overall quality for the entire public hospital sector to the benefit of those dependant on this sector.

We are happy that we now have reached agreement on the phasing out of Limited Private Practice (LPP) by 31 December 1999. We hope this brings an end to a sorry chapter which was beginning to erode the integrity of our training institutions.

The final point in the ten-point plan is to strengthen our relationship with our international partners. Here I wish to say that we have already made progress in participating in the development of the SADC Health Protocol (which was endorsed by all Heads of Government in September 1999 and we hope will be ratified by Parliament in the next year). We are committed to strengthening our participation in SADC, the OAU and NAM in particular and in the African Renaissance initiative of Government. I have just returned form a useful meeting of OAU Health Ministers in Egypt.

We have begun to collaborate with our neighbours in our effort to combat malaria. Recently (14 October 1999) South Africa, Mozambique and Swaziland signed an agreement to work together to combat malaria. In addition, we have donated 800 000 doses of the polio vaccine to Angola during their recent outbreak of polio. We will continue to do this within the constraints of our resources and other policies.

May I conclude by thanking you for your support thus far. I shall continue to count on your support.

Discussion

The MECs for health in the 5 provinces present at the meeting highlighted the difficulties inherited from the past, including fragmentation and inequities in distribution and allocation of resources for health. Uneven socio-economic development continued to interfere with proper planning for health care delivery. For example, the Eastern Cape continued to be a reservoir for human resources (labour) for both the Western Cape and Gauteng. Such personnel spend most of their economically active years in these provinces only to return to the Eastern Cape when unemployed, ill and requiring care. This emphasises the need to link health plans to broad socio-economic plans (inter-sectoral planning).

The impact of cuts in budgets was widely felt by all provinces. These are manifest mainly within hospital level of care, as the dilapidation and degradation of some hospitals demonstrate. In this context, the issue of defining an affordable hospital package needed urgent attention.

The strategic plan developed by the Ministry and Department provided the necessary vision and framework for proper health care delivery. It helps to develop long term planning and thereby to shift current focus on short term solutions, mostly on a crisis management basis. What is required is to make the necessary assessments on "financial viability" of what the plan proposes, especially in view of the tendency to allow for "unfunded mandates". It should be noted that decisions at national level have an impact on provinces, especially financial implications.

The implementation of the district health system has gone a long way in bringing services closer to communities. KwaZulu-Natal was now seeing more patients in clinics and fewer in hospitals for primary health care services. However, this has not translated into a decline in hospital costs. The high prevalence of HIV and AIDS will further put strain on resources for health care. In tandem with this, there are increases in TB and malaria infections.

The Department of Health, like all government departments, faces challenges that have come about with the introduction of new labour laws. An overhaul of the current systems of rank promotions is needed.

Local government presents its challenges, with regard to organisation and management of health services through health districts. It's imperative that the organisation of health services is in line with local government organisation (soft boundaries).

Case Studies to Review Practical Implementation of Policies And Strategies

South Africa Demographic and Health Survey, 1998
Dr Lindiwe Makubalo, Department Of Health

The infant mortality rate, a key indicator of a country's socio-economic status, is 45 deaths per 1000 live births for the period 1993-1997, which is within the WHO's target for the year 2000 of 50 deaths per 1000 births.

Immunisation coverage in children 12-23 months being vaccinated against the major childhood diseases is 63%. Three quarters of mothers of children under five could produce a "road to health" card on request.

Breast-feeding among South African women is alarmingly low: Of all children 0-3 months, only 10% receive breast milk exclusively, and of those aged 4-6 months, less than 2% are exclusively breast-fed.

There are generally high levels of primary health care use, and women received antenatal care from a nurse or doctor for 94% of births. However, the maternal mortality ratio remains high at 150 per 100 000 live births.

The survey shows evidence of abuse against women, with one in 8 women (13%) reporting they had at some time been beaten by a partner, although recently released data from the MRC suggest that this may be an under-estimate.

Fertility rates are declining, consistent with increasing education and contraceptive use, and the total fertility rate is 2.9 children per woman for the period 1993-1997. There is almost universal knowledge of modern contraception, and a relatively high use of contraception, with the injection, the pill and female sterilisation being the most popular.

There is extensive awareness about HIV/AIDS, yet awareness does not seem to translate into knowledge, which enables safe sexual behaviour. Condom use is low among teenagers and adults, and only 8% of women reported that their partner had used a condom during their last sexual intercourse. Furthermore, the prevalence of sexually transmitted diseases is high in South Africa, with 12% of men reporting having experienced symptoms of a sexually transmitted disease in the last three months.

About 3.3 million South Africans (11% of all men and 13% of all women) are hypertensive and less than half of them are aware of it. Hypertensive African men, particularly in non-urban areas, are seldom diagnosed, indicating the need to increase screening when they visit health services or at work. Nationally, 7% of men and 9% of women have symptoms of lung diseases including asthma.

The smoking rate nationally is 24%, with 42% of men and 11% of women smoking. This translates into more than 7 million South Africans 15 years and older who smoke regularly. Overall, 10% of teenagers smoke, with the rate being higher among boys (1 in 7 smoke) than girls. The adult smoking

rate is lower than reported in previous, smaller surveys, suggesting that it has declined since 1995/96 when a range of tobacco control activities were implemented.

Twenty-nine percent of men and 55% of women are overweight or obese, with white, educated men being the most obese of all men, and African urban women of low education level being the most obese of all women. In Gauteng and KwaZulu-Natal, more than one-third of the women are obese.

The survey found that 9% of men and 5% of women had experienced work-related illnesses or injuries in the previous 12 months. The highest rates were reported by men living in non-urban areas and men with the least education.

Report On Confidential Enquiries Into Maternal Deaths In South Africa
Prof Jack Moodley, Committee Chairperson

South Africa has a maternal mortality rate (MMR) of 150/100 000 compared to the 122/100 000 live births in the United Kingdom. Clearly, the high MMR in South Africa is not due to global lack of knowledge on how to manage severely ill pregnant women, but due to maternity services in South Africa not implementing available knowledge.

The Confidential Enquiry into Maternal Deaths identified the "big five" causes of maternal deaths to be complications of hypertensive conditions in pregnancy (23.2%), AIDS (14.5%) which was probably significantly under reported, obstetric haemorrhage (13.3%), pregnancy related sepsis (11.9%) and pre-existing medical conditions especially cardiac diseases (10.4%). The "big five" accounted for 73.3% of all the deaths.

Women older than 30 years were found to be significantly at higher risk than women under 30 years. Most deaths occurred among African women (92.6%). The average gestational age at delivery or time of death was 32.6 weeks.

The majority of maternal deaths occurred in level 2 hospitals (35%), level 3 having second highest (29.6%), followed by level 1 hospital (27.3), home deaths (2.8%), community health centres (2.3%), private hospitals (1.8%) and unknown (2.7%).

In almost half of the maternal deaths, there was a missed opportunity for preventing death related to the behaviour of the women or her community. The most common factors were not attending antenatal care and delay in seeking help.

Problems with administration were evenly distributed throughout the levels of care. Delays in transporting patients between institutions was seen in 13.6% of cases requiring transport (an underestimate), lack of intensive care facilities, beds, equipment and personnel was found to be a factor in 15.6% of cases where mothers died in tertiary institutions (an underestimate).

Problems relating to the standard of routine care were poor problem identification (12.4%), delay or lack of referral of problems (16.2%) and not following standard protocols (16.2%) all at the primary level of care.

Report on the Commission of Inquiry into Health Practices in the Gauteng Province
Dr Ralph Mgijima, Superintendent General, Gauteng

Main findings

The Commission found that the most complaints received from patients and other hospital users concentrated on:

- Patients spending an inordinate amount of time waiting to see their health care providers
- The general uncaring attitude of professional and support staff
- The state of cleanliness of hospital facilities
- The shortage of linen resulting in cancellation of surgical operations
- Patients using dirty linen
- Patients requested to bring in their own linen
- The poor quality and the inadequate quality of food received
- The need for the family of the patients to take on the duty of providing basic care such as feeding and bathing, which ought to be provided by hospital staff
- The fact that pharmaceuticals are not available after a particular time requiring patients to return the next day for their medicines
- The poor state of security of both the person and his/her belongings, especially high security risk patient; and
- The poor state of communication at all the levels - between professional staff and the patients, as well as between hospital management and the patients.

The Commission made further findings on a number of factors that impact negatively on hospital patient care. These include issues such as:

- Financial constraints experienced by hospitals due to the overall budgetary limitations under which the Gauteng Department of Health has to operate
- Internal constraints experienced by hospitals at varying degrees due to lack of equipment, medical officers, nursing staff and inappropriate facilities
- Perceived poor working conditions as a result of staff shortages and other inadequate facilities
- Uncaring attitudes of staff including refusal to assist needy patients, arrogance, intimidation, lack of confidentiality and poor communication;
- An unacceptable level of incidences of intimidation and harassment of patients by staff
- Lack of cooperation from some support staff who are not categorised as essential services staff and often leave work to take part in industrial action; and
- The extent to which nurses and doctors have been accused of being negligent and indolent in discharging duties.

Response of the Gauteng Department of Health to the Commission of enquiry into hospital care practices

The Gauteng Department of Health extends its appreciation to the Commission for the extensive and insightful work it undertook in a short space of time.

The Chairperson of the Commission comments in the foreword that "the Commission trusts that its investigation will further strengthen the hands of the health workers and the Provincial Health Department of Gauteng". The Department believes that the investigation has indeed the potential to do so.

The Department agrees with the Commission that all is not well in the hospitals, and feels that the Commission has pin-pointed where the troubles lie and added value to the pool of strategies and ideas on how to resolve these.

By undertaking a general survey of patient's satisfaction with services, the Commission places the complaints of a relatively small number of patients into context. It highlights the fact that a majority of patients feel they receive satisfactory care, while at the same time paying serious attention to the factors underlying the poor care experienced in a minority of cases.

The Commission discusses many issues and/or problems of which the Department is aware and it generally does so in a balanced manner.

In many cases the Department has already introduced initiatives to address the problems the Commission identifies in the hospital sector, and these initiatives are outlined in this response.

At the same time, the Commission offers some valuable fresh insights, provides new emphases and contributes some important ideas on how to deal with the issues.

In its report the Commission looks briefly at patients' complaints and perceptions of services. It then moves on to an equally brief review of the question of budget and resources before considering the impact on patient care of: staff behaviour, level of service usage, facilities and equipment, waiting times, support services (linen, dispensaries and catering), communication, administrative and management systems.

The Department's response departs from the conventional cabinet memorandum format and follows the sequence and structure of the Commission's report. This should make it easier for the readers to cross-refer between the documents.

Discussion

A number of issues were raised in response to the case studies including:

- Anonymous HIV testing: is this ethically appropriate?
- What are the factors behind deaths from legal termination of pregnancy?
- How many abortions have been conducted since TOP legislation was introduced?
- Can HIV/AIDS surveillance be extended to the entire population (financial viability)?
- How gender sensitive is the use of ANC testing on HIV/AIDS?

- What strategies are being employed to address the problem of "brain drain", especially among medical doctors and nurses?
- Why are there negligible numbers of women using TOP services in provinces other than Gauteng, especially KwaZulu-Natal and the North West?

Some of the issues were addressed in the small discussions groups (see section on Recommendations from Small Discussion Groups on Critical Issues) while others were left to agendas of future meetings.

Role and Functions of Legislative Committees

Dr Abe Nkomo, Chairperson of the National Assembly Portfolio Committee on Health presented a brief outline on the role and functions of the Legislative Committees. Essentially, the Committees take their cue from the Constitution which separates responsibilities between the Executive, Legislative and Judicial arms of the South African government. The Legislative Committees play an essentially "oversight" and monitoring role, especially over the Executive by scrutinising policy formulation, and the implementation of policy. In the recent past, the committees have focused on policies relating to the production and distribution of health personnel and the use (and abuse) of state resources (e.g. theft of stocks and medicines in hospitals).

A major area of work is also reviewing the national and provincial budgets. Currently, the committees find their involvement in the budget process limited. The introduction of the MTEF however presents more opportunities for meaningful contributions and involvement by the committee. The strength of the framework is also in its emphasis on outcomes-based budgeting. The Money Bills, once enacted into law, will also allow for more participation by the legislatures into the budgeting process.

A major challenge that continues to face the Legislative Committees is ensuring participation of ordinary South Africans in policy formulation and other government processes. More time is needed to allow for this to happen, at least in the form of public hearings.

A number of models are being developed to help enhance the quality of the Legislative Committees oversight work, most notably, the Equity Gauge, a partnership project between Health Legislative Committees and the Health Systems Trust. The project operates on the basis of indicators of equity that are monitored over a period of time, using research and other data management systems.

The Chairpersons of the provincial standing health committees highlighted challenges facing provinces. The North West Committee has decided to focus its efforts on increasing the momentum to extend services to rural communities. Clinics are receiving particular attention, especially with regard to strengthening referral support to them. The committee will also monitor the training of health personnel (particularly doctors) and patients' satisfaction surveys, integration of services and will promote intersectoral collaboration.

The Free State is concerned by the increase of poverty, and would like to see a national response to the problem. It was pointed out that the national government had already endorsed the notion of integrated rural development. The strategy will be linked to the nutrition programme which is being revamped into a more holistic development strategy, incorporating elements of skills training and development. Four rural provinces have been identified and would receive direct support for this. This however will be on condition that the provinces develop sustainable and implementable plans.

Co-ordination with traditional health services is a major issue in the Northern Province. This has been put into sharp focus by the problems relating to "witch-hunts" and deaths associated with the practice. The Department is working in close collaboration with the Department of Safety and Security to try to find long term solutions to the problem.

In KwaZulu-Natal, a council for self regulation by traditional healers is being established. It is hoped that this model will succeed and may even be endorsed on a national basis. The problems of theft of medicines continue to plague the province. Internal agencies are being established to deal with the problem.

Recommendations from Small Discussion Groups on Critical Issues

A number of issues were identified for an in-depth discussion and possible resolution within 4 small groups.

Strategic Plan

There was an overwhelming support for the 10-point strategic plan developed by the Ministry and Department. The following issues were noted:

a) There was concern that the plan did not clarify the role of alternative health services in general, and traditional health care in particular. This issue has remain unresolved for a long time and requires urgent attention.

b) Some of the strategies identified require more thought as they have inherent problems associated with them:

- The code of conduct for health workers
- The problematic role of hospitals within health districts (especially the often tense relationship between hospital boards and district health authorities)
- Inadequacies in current mechanisms and tools for monitoring implementation
- The need to ensure safety for primary health workers as part of the strategy for promoting PHC care
- The need for appropriate communication channels within the entire health sector. Such channels should clarify the link between the Executive (Minister, MECs) to the legislative counterparts (Portfolio Committees). It is important that regular communication takes place between the Minister, MECs and Chairpersons of Legislative Committees. In this regard, a closer relationship should be forged with permanent NCOP delegates to ensure that provincial matters do receive attention. There should be regular briefing sessions by the Minister/MECs to portfolio/standing committees.
- Creative mechanisms for engaging local government and/or district committees should be found.

Policy Formulation and Legislation

There is little interaction between the Executive and Legislators on policy formulation and the development of legislation.

While it is important that the constitutional separation of responsibilities between the Executive and Legislative arms of government is respected, it should however be possible to identify avenues for co-operative governance and co-ordination. Sharing of information is critical in this regard. It should

also be possible to do joint planning on areas of common interest without undermining each other's specific responsibilities and lines of accountability that each arm of government has.

Budget

Legislators were concerned about the limited influence that they have over the development of budgets. They often have limited time to make inputs during the process. They feel uninformed about the budget process. This curtails their constitutionally given responsibility to oversee the development and monitoring of budgets and monetary allocations by the Executive.

There appears to be duplication/wastage across departments on budgetary allocations. This is indicative of lack of interdepartmental overview on budgets.

There is need for more interaction between national and provincial legislators to ensure that provincial budget allocations are in line with agreed national priorities.

Budgets should be linked to policy goals and objectives. The budget formulation framework should therefore be evidence-based or output/outcome based. It must also specify allocations for target groups, including the disabled. Monitoring and evaluation by legislators should be based on such outcomes and policy goals (including the health status of the nation).

Full costs of implementing policy should be assessed as part of policy formulation.

The budget process and cycle are too complex and make it difficult for adequate participation by legislators. Strategies of simplifying the process should be identified.

Health portfolio and standing committees should meet their finance counterparts to agree on a common approach in order to deepen participation of Legislative Committees in the budgeting process.

Local Government

Local government is critical for successful delivery of health services to communities. Closer collaboration with that level of government is critical. Existing channels for communication need to be assessed with the view of strengthening them, or where necessary, making necessary adjustments. In this regard, the channels provided through the NCOP and SALGA require special attention. There are currently 10 observers from local government on the NCOP. Their observer status needs clarification. The Chairpersons of the NCOP and National Assembly health committees should take this matter up. Co-ordination between the health sector and local government is also impeded by the varying provincial structures and organisation. For example, Gauteng uses IPHA while the Free State uses provincial facilitating committees for communication.

In order to facilitate proper co-ordination and communication, the structures of local government corresponding to those in the health sector should be identified for local, provincial and national interaction.

The role of traditional structures needs specific attention.

The Minister and the MECs should take up the concerns raised about local government with their respective counterparts.

HIV/AIDS

There is still a need to organise all spheres of government to ensure maximum involvement and interaction on HIV/AIDS activities, including the annual HIV/AIDS week in December. More thought should be given to how best to utilise legislative members to support HIV/AIDS campaigns inter- and intra-provincially. The campaigns normally have specific themes, and members should make themselves available according to the themes that they are best equipped to deal with within and outside their provinces.

In view of the magnitude of the problem, constituency offices (which are normally bases for party political work) should be transformed into satellite centres to provide support to HIV/AIDS campaigns.

HIV/AIDS should become a permanent item on agendas of meetings in the health sector, including future consultative meetings of this nature.

As much as possible, legislative members should seek to complement existing activities including those initiated by the Department of Health and NGOs, and not start new ones.

It appears some members require support in developing relevant and appropriate HIV/AIDS messages.

There was concern about the confusion emanating from reasons that inform current government position on the use of AZT. The Director General should address this matter as soon as possible.

The establishment of a National AIDS Council was considered to be an important development in the fight against HIV/AIDS problem. It was felt that the Council would benefit greatly if Chairpersons of the National Assembly Health Portfolio and NCOP Standing Committees could serve on the Council. The Minister of Health should look into the matter.

Violence Against Women

Violence against women (including sexual harassment), although not identified as a focus area for the meeting, came up several times during discussions, showing the huge concern that participants had on the matter. It appears that members do not have a full grasp of the worrying extent of this problem. There also appears to be limited co-ordination at both national and provincial levels in addressing the problem.

The office of the Status of Women is charged with responsibility of monitoring and co-ordinating strategies to address the problem. That office will benefit greatly from support of legislative committees.

To show the seriousness that the health sector attaches to the problem, the Minister of Health should be the main liaison to ensure the involvement of health legislative members (in the National Assembly, NCO, provincial legislatures and committees) in the campaigns seeking to address this problem. The Minister should also be the hub around which intersectoral and intergovernmental consolidation of strategies to deal with the problem can occur.

Members should actively promote the implementation and understanding of the Domestic Violence Act.

Way Forward

There was unanimous agreement about the usefulness of the consultative meetings as a forum for joint planning, monitoring and evaluation on progress (or the lack thereof) with implementation of policies and strategies. The meeting is also useful as a platform where key stakeholders in the health sector can inform one another on developments in the sector. It also makes it possible for common views to be developed on major issues facing the health sector in as transparent a manner as possible.

The format of plenary sessions combined with small group work was found most appropriate.

It may be desirable to have these meetings replicated at provincial level, where participation by local government can be enhanced. This however will depend on availability of funding.

It was decided that the meetings be held at least once or twice a year with the next one scheduled for June 2000 to be followed by another one in December 2000. The usefulness and need to proceed with the meetings should be reviewed thereafter.

Traditional health authorities should be invited to attend future meetings.

Closing Remarks

Dr Manto Tshabalala-Msimang, Minister of Health

This brings us to the end of 2 days of intense and robust deliberations.

Over the past two days we have had a very constructive interaction. We have every reason to be proud of ourselves. I hope this lays a solid foundation for even deeper co-operation

The health of our nation is too great a prize for us to sacrifice it at the altar of political expediency. I once more therefore appeal for all of us to work together across the political divide in the interest of building a united caring and human society.

When I first made the suggestion for us to meet, I could not have hoped for a better outcome but of course we can always do better. I am sure that in future we shall be able to structure and organise our meetings with the benefit of this experience.

I wish to thank my comrades Abe Nkomo and Loretta Jacobus in particular for ensuring that we walked together at every stage of this initiative. I have taken note of the fact that we could have given more prominence to local government participation in the conceptualisation of this initiative. I am sure that we all agree that we should correct this for the future.

Colleagues, I sincerely believe that we have been able to find a happy balance between our respective roles as the executive and the legislatures respectively. We have tried, I think successfully, to better understand how this constitutional separation can be better used to enhance service delivery. After all there could not have been a different motive for our constitution makers. And above all, that is what ordinary South Africans would expect of us.

Thanks for ensuring that we make this important advance. We have shared with you the key elements of our strategic direction over the next few years. You have also heard that we intend and have begun to move together with my colleagues the MECs. I wish to assure you that I shall do everything possible to strengthen this partnership. I sincerely believe that this would be an investment that is worth every and any effort.

We therefore commit to ensure truly accelerated delivery in the health sector. We have listened carefully to your views on how you wish to execute your oversight function. We respect and value this role. We see it as important in ensuring that we do not betray the confidence of those who have elected us to be their representatives, to be their eyes and ears.

Comrades, colleagues, there are many challenges we need to tackle together. We have discussed some of these – viz TB, HIV, violence against women, STDs and the unacceptably high levels of maternal deaths.

More importantly, today we started to confront the difficult issue of limited resources versus ever growing need and demand. We are at one that this terrain requires painful choices to be made. We need to have a common understanding of these choices because only then can we be catalysts to a truly informed public debate. It is important that we tackle this issue head on. After all, if we truly want our managers to manage and our tens of thousands of health workers to confidently and proudly do their job then we too must be seen not to shirk our responsibility of taking the hard political decision.

I am confident that collectively we are equal to this task. Once more, this is a great beginning. A lot more needs to be done. Let us truly travel this road together.

I wish to thank the Henry J. Kaiser Family Foundation for providing the necessary financial resources that made the meeting possible. I also wish to thank the Health Systems Trust for providing the secretariat support needed for organising the meeting.

We shall be sending all of you the proceedings of this workshop. We shall also be working together to work out what next steps to take based on the recommendations you have made. I wish all of you good health till we meet again!

Agreeing with the Minister of Health, Dr Abe Nkomo, Chairperson of the National Assembly Portfolio Committee on Health, acknowledged the good turnout and the fact that, unlike most meetings, the participants stayed through the sessions for the full period of the meeting. The meeting itself represented another opportunity to encourage team development across the Executive and Legislative arms of government, an important ingredient for ensuring an equitable health system in South Africa.

List of Invited Participants

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