Address to the National Health Summit

19 November 2001

Minister of Health, Dr Manto Tshabalala-Msimang;
MECs;
Distinguished participants at this important Health Summit.

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 for sophisticated curative interventions enjoyed mostly at academic hospitals. This was a far cry from the health promotion, preventive programmes and early interveon 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 inseparable 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 manner 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 becomes 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.

These allies 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.

Among them are to be found 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, women 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 pipe dream.

But we know that much 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 our 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 face of it, 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, as we must be, 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. The challenge to each one of us is to break the bounds of racial and class isolation, to challenge the 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 the 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 patriot 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 that 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 aware that, however seemingly 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 be right that more of our heroines are 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 exceed 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 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 better understanding of the 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, and 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 with the rest of our 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 marginalised 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 to reinforce old patterns of social privilege.

While our preventive 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 health 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 by unscrupulous people of drugs and medicines, hospital apparel, equipment and food.

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 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 necessary sacrifices. I make this call to you and to this Health Summit because 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 tested front-line fighters for the building of a humane South Africa and a world of health and happiness for all. I know that you will not disappoint us.

Thank you.