DISCUSSION REPORT

University of Johannesburg, Faculty of Health Sciences - Médecins Sans Frontières /Doctors Without Borders (MSF) Dialogue Two / 19 October 2010

DECENTRALISED TREATMENT, CARE, AND SUPPORT FOR INTEGRATED HIV/TB PROGRAMMES: OVERCOMING FINANCIAL BARRIERS

In the last decade, South African civil society led by People Living with HIV/AIDS defeated AIDS denialism, a dogma that fuelled a global public health crisis and claimed between 400,000 and 500,000 lives per year.

However, in South Africa today 5.7 million people are living with HIV. In Sub-Saharan Africa, only 44% of the total number of people who need ARVs are receiving treatment - three 3 out of the 6.7 million who should have access. Furthermore, South African has the world's highest HIV/TB co-infection rate in unit numbers. TB is currently the number one killer disease in the world and as a result, the World Health Organisation has declared TB a global emergency.

South Africa has reached the 1 million mark for the number of people on ARVs. This is despite the international community reneging on its commitment to fund HIV/AIDS and TB programmes in developing countries. South Africa is ready to take on its responsibilities to address the epidemic, despite cuts in international funding. However, now, more than ever, a global response is required to ensure that every person needing ARVs accesses and stays on treatment.

Discussants

Dr Aaron Motsoaledi – Minister of Health, South Africa
Advocate Adila Hassim – Head of Litigation and Legal Services, Section 27
Professor Francois Venter – Deputy Executive Director, RHI (Wits Institute for Sexual & Reproductive Health, HIV and Related Diseases) Associate Professor, Department of Medicine at Wits University; and Head of the HIV/AIDS Clinicians Society
Dr. Eric Gomaere – Head of HIV/AIDS and TB, MSF in South Africa
Facilitator: **Professor Adam Habib**, Deputy Vice Chancellor, University of Johannesburg

Summary

Médecins Sans Frontières/Doctors without Borders (MSF) and the University of Johannesburg's (UJ's) Faculty of Health Sciences have partnered to raise awareness and encourage discussion on public health-related issues through a series of high-level debates. In the second of this series, the panel addressed critical issues from challenges hampering the ability of the public health system to provide treatment, care and support, to legal frameworks and opportunities such as innovative financing mechanisms for global health.

The discussion, which took place at the UJ Doornfontein Campus, was an interesting, honest and lively debate. It was an opportunity that many from the activist community have longed for: to engage with government on problems of delivery and outreach, beyond the science of HIV/AIDS.

The Minister of Health spoke at length and frankly about the state of the health care system in South Africa. He engaged vigorously with the panellists, who were equally forthright about problems, while acknowledging progress made under the current leadership.

A key point raised was the need for proper management. Debate facilitator Prof. Adam Habib catalysed a critical look at the powerful individuals and groups with significant financial backing who have a vested interest in stalling work towards a comprehensive decentralised primary health care service.

The systemic failure of the TB programmes came under attack from medical personal in the audience, an argument put forward by Professor Francois Venter. There was agreement that treatment literacy work has empowered patients living with HIV and has played a central role in progress achieved so far. It should now be extended to the TB epidemic which affects approximately 75% of all people living with HIV in South Africa.

Welcome

Prof Adam Habib**,** *Deputy Vice Chancellor, Research and Innovation - UJ and dialogue facilitator opened the discussion.*

The partnership between UJ and MSF is extremely important. UJ aims to become an engaged university because as a public institution paid for by taxpayers, it is crucial that the ideas and people at the university foster a national public discourse. Health is particularly important and MSF is a natural partner, with its global track record of health operational assistance and engagement with policy, care, national/international lobbying of governments, and its global reach.

> '***The question the panellists are addressing is how to ensure that citizens living in resource-poor settings have access to ARVs in a transformed society'.***

Having the Minister engage in this way brings accountability and creates opportunities for political leaders to engage with citizens. Thank you for your leadership and the fact that you are willing to engage in this way**.**

A Government Perspective

Dr Aaron Motsoaledi, Minister of Health *discussed the challenges – systemic, structural and financial - to providing treatment, care and support within a regional context of competing needs.*

The National Strategic Plan 2007 - 2011(NSP), adopted by the South African government had lofty ideals – to reduce new infections by 50% and ensure that 80% of people needing treatment had access. The weaknesses of this plan were clear from 2007, with no clear milestones set up either by the Department of Health (DoH) or civil society.

> ***'The President's World AIDS Day speech last year was the first major step in the right direction**.'*

Now, the Department of Health has one year to introduce new treatment protocols so that all pregnant women are treated when their CD count is 350, not 200, and, to bring about integration of services for those who are co-infected with HIV and TB..

73% of people living with HIV in South Africa are co-infected with TB – by far the highest in the world , in unit numbers, with Zimbabwe a distant second. Other countries with a significant TB load such as China have co-infection rates of less than 5%. The focus is now on treating TB and HIV in an integrated way.

Previously, clinics had to be accredited to provide ARVs but out of 4000 health facilities in South Africa only 490 clinics were accredited at end March 2010. This must change so that citizens can go into any facility and be tested. There is also a need for trained staff. Human resources are a challenge as are financial resources.

South Africa's focus on HIV/AIDS and TB has been questioned, and suggestions made that other diseases are neglected. The reality is that South Africa is grappling with four ongoing pandemics at once:

The HIV/AIDS and TB pandemics – prevalence in South Africa is 23 times the global average. 22 countries are carrying 80% of all TB patients worldwide – and South Africa is the highest in terms of infection per unit population. People who are HIV-positive are four times more likely to get TB.
The maternal, infant and child mortality pandemic – in South Africa 22,000 children die each year before the age of one and 75,000 children die before the age of five. 6,000 women a year die during pregnancy, with HIV often the cause.
The non-communicable diseases pandemic - these include diabetes, high blood pressure, cancer and chronic respiratory diseases – which are frequently linked to the HIV pandemic. Sub-Saharan Africa is transmuting from an epidemiology of communicable diseases to non-communicable or lifestyle diseases. Diabetes is now seen as so serious that it must be taken to the United Nations.

> ***'Our current healthcare system is a destructive, unsustainable, curative health care system: we need primary healthcare to win this battle**.'*

When did you last see a nurse in a school? Now we wait till the child gets ill and goes to hospital. Nurses used to prevent children from getting sick by immunizing and doing health checks. It was embarrassing having an outbreak of measles in Pretoria last year. National health insurance will go hand in hand with primary healthcare.

> ***'We must do massive immunisation campaigns, and overhaul the healthcare system focusing on primary and preventive healthcare. We need to visit all the schools, churches, villages, and the farms. If we can do these four areas, we will already make a huge impact.'***

Preventive measures include: HCT testing and condom promotion, preventing the birth of 70 000 HIV positive infants annually through prevention of mother to child transmission (PMTCT) campaigns, nationwide medical circumcision programmes aimed at reaching 10m males across the country by 2015, the treatment of sexually transmitted infections (STIs), massive education campaigns and the testing of 12 million school children. Safe blood transfusion is one of our early victories.

A Practitioner's Perspective

Prof Francois Venter *argued that the failure to manage TB is primarily a failure of scientists and epidemiologists to understand the epidemic, and that in South Africa integrating HIV and TB programmes is not enough.*

TB is a catastrophe in South Africa. You are more likely to die of TB than in car accident or from crime. TB kills most people with HIV and a significant number of people without HIV. The numbers are absolutely terrifying. It is true that it is a disease of poverty- it strikes the most vulnerable in society and is seen as global emergency by the World Health Organisation

TB epidemiologists and scientists do not seem to see it this way – which is having a huge impact on the way it is treated. TB drugs used are archaic; drug supplies run low and patients are turned away because they do not have ID books!

In Southern Africa our actions are not sufficient to respond to the crisis. Some say we do not have the resources but in Botswana where TB treatment is done by the book the numbers are still going up.

> ***'The fact is, the rhetoric on conventional TB control is not enough: the treatment paradigm is wrong from the outset.'***

Our understanding of TB/HIV co-infection has been a failure. The way it spreads is greater than we imagined. The transfer of TB in schools is far higher than originally thought. There are poor outcomes despite the massive resources being poured in.

In Hillbrow, 80% of people living with HIV are diagnosed and 90% of those remain on treatment within the healthcare system. Only 50%of diagnosed TB patients remain on treatment and in many cases they are the same HIV patients. This constitutes a systemic healthcare failure which must be addressed.

> ***'While we give HIV patients adherence counselling and proper support, we treat TB patients like cattle. We see TB is a public health problem we tell them to take their drugs for the community. If you individualise therapy with the patient at the centre, they'll take their drugs. People who design the TB programs are public health specialists and policy makers, not clinicians. They have no idea what it means to be treated for TB: the stigma of health professionals, the tablets that turn your urine red and make you feel like hell for weeks.'***

During the health sector's strikes this year, it was the TB patients who stopped taking treatment, while the HIV patients understood the importance of staying on treatment. It is about educating the patient. If we explained things properly to our TB patients rather than treating them like children, we would get better results. So while we need to address the science, we must urgently address the systems and start valuing patients.

Furthermore, we have to start investing in TB. There are funding shortfalls and 10th rate drugs and diagnostics. The TB patients do not toytoy for treatment as do HIV patients. Yet the drugs are terrible and only used because they are cheap.

> ***'At a TB conference I asked why we don't pay people to finish their treatment. If we gave them R100 per month it would be in everyone's interests. The***

response was that it's too expensive. This goes to the heart of the problem with the leadership; it is about how to save money, not how to improve human life.'

People need individualised treatment and must feel valued in the system. Decisions cannot be based on what suits the system. The Department of Health must access the resources it needs to deal with this crisis.

'I think that the TB programme should be given to the HIV programme – the reality is that HIV programmes have fought for resources, have delivered outcomes. They have made many mistakes, but they are making a big impact; while TB programmes across the street are catastrophically failing.'

A MSF Perspective

Eric Gomaere, MSF *spoke about the issues around access to funding and how South Africa should engage the Global* Fund (Global Fund to Fight AIDS, Tuberculosis and Malaria).

In Khayelitsha 11 years ago, there was already an 18% antenatal HIV prevalence rate but no one was talking about HIV. I had to fight with the nurses to get agreement on starting an HIV programme. The nurses said '*you will attract patients and we'll all get infected'*. I say this to remind you that that is where we have come from. At that time we were forced to set up a selection committee to decide who to treat. At the time it was 1 in 4 patients with a CD4 count lower than 50 - that's the kind of rationing we had to do. Countries were saying they could not afford to respond to the HIV pandemic.

The question now is how to continue. Today, 4.2 million people are on treatment worldwide, with over 1 million in South Africa. In South Africa, 25% of all people needing treatment have access. This is remarkable. Now there are ambitious targets and there is the political will to reach them.

However, internationally the 2006 promises to fund universal access have been forgotten. Possibly PEPFAR (US President's Emergency Plan for AIDS Relief) is seen as former president Bush's initiative, so president Obama feels the need to make his own mark.

South Africa managed to fund 80% of its HIV programme, (treating 1 million people) independently, but surrounding countries such as Lesotho rely on the international community for 80% of their funds. I attended the International HIV Conference in Vienna this year, where I heard remarks that we used to hear 10 years ago like '*treatment is not sustainable: we must prevent, not treat*'. I was on a panel with the US advisor who said '*we need more results for our bucks'*. So the Global Fund, the most fantastic funding mechanism which encourages countries to set their own priorities and encourages programmes to be ambitious and make a difference, might disappear.

The last replenishment was $13 billion for the next two years (current pledges stand at only $11 billion). Once there is a shortage, infighting begins. South American countries start comparing their budgets to Lesotho, questioning South Africa's wealth and whether they really need Global Fund support. International funding remains extremely important.

SA must engage more proactively with the Global Fund to set the rules of engagement – there are currently no rules. Anyone can submit proposals regardless of their programme results. The Global Fund must be transformed from a charity to a sustainable funding mechanism. This could be achieved through regular contributions from different countries according to their capacity. South Africa contributed $1.5 million in effect making them shareholders in the Global Fund. This example should be followed by all African countries.

I agree with Francois Venter's argument on the integration of TB/HIV treatment. Rather than talking about returns on investment, we must talk about long-term, patient-centred efficiency. It makes sense to treat TB co-infected patients, and PMTCT, but we should be more ambitious as follows:

- Treat people with *CD4 counts up to 350*
- *Decentralise healthcare services* as per the expanded accreditation from the DoH.
- Implement sound cost-saving measures for co-infection that will not disadvantage the patient.
- Develop *outreach programmes*, and target those who do not present to health facilities unless they are very ill.
- Re-negotiate prices and ensure there is transparency in the *pricing process*.
- *Remain focused as in the past*. There is still a need for an emergency intervention integrating HIV and TB. The debate should not become an either/or scenario.
- *Be aggressive in our approach to reduce HIV incidence* – this is important to win the political battle and the debate around treatment.
- Save time and money through *task-shifting.*

A legal perspective

Adila Hassim, Section 27, *spoke about the need for more funding, within the context of the constitutional right to health.*

In South Africa, the legal starting point is the Constitution, which includes the Right to Health in Section 27, while recognising availability of resources under the '*progressive realisation'* of this right.

Health is the government's obligation, even while working under financial restraints. The Constitutional Court has emphasised that a mere claim of '*lack of resources'* is not sufficient: the National Treasury must explain why there are no resources. Through the courts, the Treatment Action Campaign (TAC) forced a re-adjustment of the budget to a conditional grant for HIV of R 6 billion, excluding provincial contributions. This changed the way budgetary decisions were made and led to the NSP and the integration of HIV/TB programming.

But there are problems. The aim is to test one million people per month. This has been successful and 2,5 million people were tested between April and September 2010 leading to 500 000 newly diagnosed infections, and 75 000 new people on treatment. Obviously the more we do well, the more money we will need to respond. I agree with Francois that we need the science and decent programmes, but equally, without the money we cannot solve the problem.

We need money from national government through treasury allocation, using concrete evidence to make sure decisions are rational and relate to health needs. We need to know how budgets are being managed and spent. Transparency and efficiency in budgetary processes are legal obligations – including declaring any anticipated deficits, proposals for financing deficits, etc. that stem from section 215 of the Constitution and the Public Finance Management Act.

> ***'We are currently not meeting these constitutional standards and we are in debt. How can we meet new or growing demands when financially we are already failing?'***

South Africa needs the Global Fund and has already benefited from it. However, the R12 billion requested recently has not been met, which has financial and therefore a life-and-death implications. It also has an ideological implication, leading to in-fighting about whether funding should be disease-specific rather than health system strengthening. This is clearly not the case; if HIV had not been tackled with such focus, the health system would be further under pressure than it already is. The vertical focus on HIV has improved the system and improved people's health who would otherwise have burdened the system.

Many initiatives are on the table especially from civil society. We must explore how to support our government in sustainable international financing. Various proposals exist and are not

mutually exclusive. We need to talk more about the models. If we don't, we'll never be able to deal with the financial burden.

Tobin tax / Robin Hood Tax: a nominal tax on financial transactions such as trade in currency (currency trade amounts to approximately $ 1.8 trillion per year. This redistributes wealth from the excessively rich tothe poor. The tax is used for socio-economic priorities..
Health Impact Fund whereby government provides incentives to pharmaceutical companies to develop drugs that make financial sense. Rewards are based on the health impact of the drug (ie access by people to the drug, etc). This requires an initial investment from government, but leads to a drop in drug prices (ie benefit outweighs cost)
Patent pools

POSSIBLE FUNDING MODELS

> ***'Section 27 has been working with Oxford and Georgetown Universities to develop a Framework Convention, a global architecture to determine what national and international responsibilities are regarding health and to define what the essential content should be - what is the service of a right to health'.***

On a practical level, we must push our government to ratify the International Covenant on economic and social rights.

Open Discussion

Question: 'Regarding TB's poor diagnostics and lack of government sourcing: While new equipment may be purchased, sustaining them can become a white elephant; at the Orange Farm health facility, we have a new expensive radiograph machine, but patients aren't benefiting because there are no films or it was not serviced. It is a waste of money and people must still be transferred to Baragwanath Hospital.'

MoH: This is about the mismanagement of equipment. But as Professor Venter has rightly mentioned, we have not invented new methods and drugs in at least 15 years. We believe that in the next three years we will develop new drugs.
FV: How much does it cost to treat someone for HIV in the state sector? It costs R5-6000 to save someone's life – it could be done on less than 10% of SA's health budget. The Minister of Health is getting a good deal. We need costing standards for all diseases, including TB, so that decisions on spending are evidence-based. Our ARV programme is almost exclusively funded by government, the only one in Africa that is self-sustaining in this way and runs through treasury. It is something to be proud of. Treasury has a high interest in what it costs.

'Regarding the failure of TB programmes leading to XDR TB: The research behind DR TB and XDR TB has hardly started and we know little about the epidemiology. Most XDR drugs used are older than I am (45). I work in a hospital and I can see we're sitting on a time-bomb. In my lifetime only one drug has been proposed to be registered for XDRTB.'

MoH: Every sentence Professor Venter said in his speech is true. TB is an emergency, particularly in the SADC. One out of every 100 people has TB. I am on the board of the Stop TB Partnership. We are 34 members globally. I represent the high-disease burden countries. We had a meeting last week. One decision taken was that the Minister of health and the mining/minerals industry must work together, as there is high prevalence in the mining sector. Regarding TB drugs, we thought there was a vaccine and now have a pandemic. There has been a public outcry about HIV drugs but not TB. We are discussing how to do the same for TB. Of the MDG targets we are doing badly on three, none of which will be achieved without drastically combating HIV/AIDS and TB, namely, reducing infant and maternal mortality; and HIV/AIDS. If these goals are not met South Africa's life expectancy will fall to figures similar to

1955. We are doing everything in our power. We know all HIV patients are vulnerable to TB infection. 600,000 HIV+ people have been put on a prophylaxis against TB. There should be no either/or debate about treatment or prevention, as treatment provision reduces incidence.

'***I'd like clarity from the doctor. We have a problem because our government continues to buy drugs internationally. This is a waste of money, considering that in rural areas people are still drinking unclean water – how can you take drugs with unclean water? We must focus on our own problems. We can find the cure – we must educate our people. We must not keep borrowing from the World Bank and US/UK.'***

MoH: The US and UK do exist and they run our lives. The world is small – ignoring them will not solve it – we must learn to live together. We are the one country that puts a premium on health financing. South Africa applied for R3 billion for health financing from the Global Fund, but the South African treasury increased last year's budget to R8 billion after the President's World Aids Day speech.
EG: Should South Africa look at its own problem? It is time for SA to be a political role-model in the region. There's a lot of disagreement in the room, we need more debates in future.

'Thank you for giving us this opportunity Minister, it means a lot to people in health that a person in government is prepared to listen. The last press release in Gauteng praised the TB programmes, claiming that we should close our hospitals. What is your response?'

MoH: TB under control in Gauteng? No it's not! Our target is to cure 85%. It is 65%. In Mpumalanga and for KwaZulu/Natal the cure rate is 40%. It has improved but has not reached 85%. One hospital in KZN that is very well-managed has a cure-rate of 85%. It is not just about resources

'***Professor Venter described how well the HIV clinics function and their excellent adherence rates. But a lot of them are not state clinics. The majority of successfully-managed, funded clinics are run by NGOs. My wife works part time for an NGO and gets twice my salary, and has internet etc. Our biggest hospital has no fax machine, staff use my home fax and I pay for printing. There are differences with HIV/TB but we must recognise government is not doing very well with either of the programmes.'***

FV: Yes we need more money and human resources. Botswana has half the number of staff but achieves much more. We can call for resources, but we are managing them very badly. Bad systems management is the reality.
AHassim: This is a very vexing issue, that we lack enough human resources. It is a global issue – often other countries attract/recruit health professionals from South Africa. This requires a global strategy on migration of health professionals. There's a huge workforce of community health workers – who are living in the communities and best-placed to provide prevention and basic care. Currently they provide ad-hoc services, often without support or payment. We should start with them; bring them more formally into the workforce.

'***Adila discussed progressive realisation and available resources. Coming from a social security perspective, I'd like to know what the guidelines are to make resources available for socio-economic rights. I'm convinced by the minister's passion, but it's a disease burden affecting the poor. How does treasury determine fiscal policy? How can civil society call for an expansion of our taxes for those who need them most?'***

MoH: Social security is a big debate but there is another one. The highest budget was for education and health. Now social development absorbs more resources, the number of people on grants has risen from 3 million to 14 million. People are asking if we are becoming a welfare state. Having a low CD4 count qualifies you for a disability grant – a perverse incentive causes people to stop treatment to remain on this allowance. In Brazil, no child is allowed child support unless the mother is on contraception and the child attends school.

We have no such conditions. It is an emotional issue that should be debated – there is no agreement in civil society. In fact there is no accepted definition of poverty.

'In order to fight TB/HIV we need sensible policy, money and wise spending. But we also need much more HR: shocking lack of HR in SA – what are your suggestions? Also a suggestion to the minister: what about compulsory testing for pregnant women to reduce child death rates. Also regarding improving our lifestyle: you may be able to exercise, but what about our food that is genetically modified?'

MoH: we are planning around this. We won't succeed using the HR current model. We need PHC and CHW. Adila is right. Regarding quality of care, HR is a global phenomenon and healthcare workers are in short supply. Every year it features in the World Health Organisation General Assembly. At a meeting in Kigali last year a minister from Africa said South Africa is taking their health workers. Those going to Europe go to South Africa first. Europe takes doctors from us, Canada and the United States from us and Europe. We have signed a MoU to rectify this. But we must also train our medical professionals. Our eight medical universities produce only 1200 doctors annually. That's not enough considering our crisis. Our five new hospitals are all teaching hospitals. We must rebuild them and spend more money on them than on the stadiums!

Compulsory testing sounds tempting, but it doesn't need to be compulsory. 97% of pregnant women attend antenatal clinics. They need to have all services available to them at that point: testing, PMTCT, post-birth care and contraception.

EG: Are we short on HR? Not at all! I just returned from Zimbabwe. I was expecting to find the clinics empty, but they are full of community nurses, they are training them by the thousands. Malawi doubled their workforce in the last five years. What we are short of is creativity and political leadership. In the absence of that, we've been around for five years proving that it is safe for nurses to initiative ARVs. But there are forces that have no interest to see task-shifting happen. Creativity and political leadership will prevent us from the mistake of saying we're doing too much. Then we will be permanently running behind the epidemic and lose the political battle.

AHassim: Regarding compulsory testing: all patients have a right to privacy, informed consent and bodily integrity. There are exceptions in extreme and unusual circumstances such as international outbreaks. It's not something I would advise the minister to implement.

'NSP and where we are today? There is no doubt that the NSP of 2007-11 was a radical departure from previous NSPs. But did we try to do too much? Are we not trying to do too much since Polokwane and your appointment as MOH – circumcision, HCT, PMTCT - considering this context of limited resources? Can we achieve this within the limited resources, irrespective of Adila's comment that we need more money, despite investing money in health and we're not seeing the returns?'

MoH: Are we exaggerating HIV AIDS? In fact, we missed it. We need to go back to PHC, but the disease burden has increased. We must do prevention and cure simultaneously due to the four epidemics. Health is not a commodity; it is a right and cannot be compared to other commodities. Recently a patient was charged R500 000 for a perennial abscess! Then another R700 000 was billed - and the patient died while it was under discussion! Unethical overcharging should go before the Competition Commission. The Health Professional Council has ruled that doctors will only be charged for unethical practice for overpricing by 300% or more. I will change this. Regarding the prescribed minimum benefits (PMBs), the medical aid schemes must follow, but prevention or complications are not addressed. You can prevent diabetes through diet and exercise. But we wait too long, because it is in the interest of the medical machinery.

MoH: Regarding salaries, professors of medicine earn the same as Directors General (DGs). They are not underpaid. The entry point is that of a deputy director. Nobody questions this. There was a professor in Mpumalanga earning R1.2m

per annum, while running his own practice. They are cheating our system and poor people, and reduce the credibility of the health department.

AHassim: We need transparency in the private healthcare system, medical inflation is shocking. They get away with it because the rich are willing to pay. There is a lack of information. Leadership from the health department is needed for the regulation of the private sector to ensure national health insurance (NHI) is effective and cost-efficient.

'Male circumcision: what is the evidence that led us to incorporate it in the campaign and spend such resources on it. I did a Masters degree on Defence Forces on this issue. The scientific evidence is thin (one in Orange Farm, discontinued, and another in Uganda) and yet it's become normalised. I'd like the Minister to justify using resources on controversial evidence.'

MoH: I completely disagree with you. In South Africa, KwaZulu/Natal has the highest prevalence but in the Eastern Cape it is low despite the poor healthcare system. There is a prevalence link to housing, roads, poverty. High levels of HIV are found where circumcision is not practiced and circumcised males are generally healthier. We should use every weapon that we can.

'Adila talked of government's obligation to fund health. True there's a right to healthcare, but in SA there's a growing culture of entitlement. Introducing the NHI appears like a panacea, but the evidence suggests that health insurance does not reduce medical consumption and can create medical inflation. Minister, how will NHI control the cost to achieve the needs with limited resources?'

MoH: Is NHI a panacea for all our problems? Only the media said that! Our 10-point programme is clear and NHI is part of this. We will implement all points simultaneously. Even before being implemented, NHI is under attack because it's the first time we'll bring equality to the system. We must give strategic leadership, a social contract to mobilise civil society to realise that poor people need NHI more than ever. We are spending more money in health than many other countries with better health outcomes. We need to overhaul our system and improve our outcomes, but we must keep this level of funding in health.

Looking at corruption and development, when assessing if a country will collapse, they look at the judiciary, the banks and security of property ownership. However in South Africa it is the gap between the rich and poor that threatens stability. The NHI is one of the programmes that aim to narrow this gap – it is a part of the solution. Regarding quality of healthcare, we will establish a committee for standards and accreditation. NHI is not a panacea; it is part of a massive initiative.

Take the tobacco companies – everyone knows tobacco kills – but this powerful lobby communicates with ministers of trade and industries across the continent. But the poor must fight this lobby and make sure we don't entertain them!

'I commend the minister on importance of PHC. HIV infection properly-managed isn't a hospital-managed disease. We will never sort this out without proper information systems. Imagine if the banks did their work without computers. It would be chaos. This is the reality of health – we have no way of registering or measuring disease burdens. Are we doing something to get proper health systems for better outcomes?'

MoH:. We must manage the PH system. The president in closing the ANC conference said we have people managing hospitals who do not even know what aspirin is. Our previous MoH said you do not have to be a doctor to manage a hospital. in the United Kingdom there is an MBA in Health Services, which is a requirement for managing a hospital. In South Africa, you have teachers going from classrooms straight to hospitals. There must be incentives; non-performing schools should have their funds reduced. And then they will improve. We have not addressed this in the management of our schools and our hospitals.

FV: No printer ribbons, computers switched off! Budgets do exist. It is a question of management. We need to work better with the resources we have.

Panel Discussion with the Chair

AHabib: What is missing is the issue of power. The fact that the minister should have more money is not disputed. But resources follow the powerful, not the need. To the Minister a shift to a primary healthcare system means that some people will lose out. How do we mobilise alternative stakeholders or allies within and outside the state? How do we make the political and economic elite realise that TB affects them, is important to them too. If TB had been a rich man's disease, new drugs would have been developed. You can allocate significant resources but you need information systems. For 15 years we've allowed this to happen. What are we doing wrong? How do we create incentives and a public service that attracts human resources.. As a university bureaucrat I would say you can build as many training hospitals as you like, but you need people to stay. Generally, we need to build allies to advance the state agenda and make hard decisions in hospitals, make appropriate investments, and build incentives for human resources for health

FV: Civil society comment: the HIV program is not flawless but civil society mobilised people on this issue. People who are standing up for TB now are not infected; it is often HIV positive people making a stand. They know first-hand what the system did in terms of lack of access. Why is it that comrades are all connected to the HIV world?

AHassim: Regarding mobilisation for TB: I think it's inevitable that it is the HIV community that responds. This is because it is where the disease has most impact. At the same the HIV community has become well-versed in the right to health, systems, treatment literacy, financing etc. This must lead to the next NSP integrating HIV and TB.

Closing remarks

AHabib: If we do not get healthcare right, we do not guarantee the fundamental right to life. There is general recognition that there has been a significant improvement and leadership in the fight for health. The criticism that exists is the constructive, it aims to build not destroy.

SE: This has been a useful debate and there are still many issues that must be debated. An important future debate will be around the need for a regional approach to address the problems of health.

For further information on future debates and the work of UJ and MSF, see our websites at:

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