SA's health system is ill, but the Minister is not the cause

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SOUTH Africa's health system is sick. In fact, a trauma doctor would probably log a patient with such severe symptoms as a code red. One sees evidence of system trauma from the Free State to Gauteng and beyond. Unusually, this trauma is infectious because it is often passed on to patients who encounter it. However, one of our best remedies to treat this sick patient remains to support Health Minister Aaron Motsoaledi in his efforts to build an equitable and accessible health system that benefits the poor as much as it benefits those on medical aids. He is not the cause of the disease. Supporting him does not equate to blind loyalty or praise singing. But it requires taking a healthy dose of realism and frankness on what some of the real hurdles are that he faces. Recently BUSINESS DAY published distressing findings about the state of public health facilities. Given that much of the information was obtained from the Office of Health Standards Compliance (OHSC) there is no gainsaying them. However, it is a misdiagnosis to red-card the Minister. It is equally misplaced to ask him to give up the policy of a more equitable health system. The aetiology of the problem is not to be found in the Minister of Health. Dig a little deeper and you will find that the root of the problem is actually rampant corruption, mismanagement and incompetence in the top structures of the provincial health departments. This mismanagement takes place with the tacit approval and protection of President Jacob Zuma and his Premier League leaders.

Section27 and the Treatment Action Campaign (TAC) worked closely with Motsoaledi and his predecessor Barbara Hogan since 2008. Both Ministers are visionary and committed; Motsoaledi particularly so, given his long tenure in a difficult portfolio. However, it has been clear to us for a long time that their hands are tied because provinces call the shots. In the constitutional eco-system governing health, the provinces control budgets, tenders, positions and other lucrative access points. The Constitution's drafters intended this design to bring health delivery close to communities. It would be fine except that it has led to a situation where corrupt or disinterested Premiers protect often useless and/or corrupt health MECs. We have a long list of such former and current MECs. Another important contributory factor to the crisis is entrenched inequality of access to healthcare services. This would make the Minster's task difficult even in the best of worlds. Remember his mandate is to ensure the progressive realisation of "everyone's right of access to healthcare services". By persisting to try to build a health system which serves the poor and rich equally, the Minister is fulfilling his constitutional duties. Universal access to healthcare systems is promoted by the World Health Organisation and is an object of the sustainable development goals. But to achieve this requires accountability, good governance and adequate budgets. Let's make a turn to the Free State. In the

Free State, things first fell seriously apart in December 2008 when the provincial health department, because of poor fiscal management and corruption, ran out of money. The solution by those in charge? A devastating and unannounced moratorium on the initiation of new HIV- positive patients onto ARVs and the suspension of scripts for many who were already on the lifesaving medicines. Over 15 000 patients were placed on waiting lists, many died. Hogan intervened, helped end the moratorium despite many hurdles and then investigated the causes of the crisis by setting up an integrated support team (IST) that considered the financial management of all nine provinces. For some reason, unknown to us, Motsoaledi did not take forward the recommendations of the IST. That was a mistake. Fast forward seven years and health systems mismanagement with its consequent death and dying is still the order of the day in this province. There is rampant corruption, hospitals and clinics have haemorrhaged 25 percent of health workers, patients are faced with high levels of drug stock-outs, Community Health Workers have been dismissed and bullied.

Despite all the evidence of mismanagement and corruption presented by the TAC and Section27 directly to the ANC leadership (Gwede Mantashe and Jessie Duarte listened intently and then did nothing) and the Minister, the Premier kept his incompetent and corrupt MEC, Benny Malakoane, in charge until two months ago. Let's move to Gauteng, the health system's most populous province. Here health MEC Qedani Mahlangu is sitting pretty despite a litany of failures. Most recently over 2 000 patients with various mental health challenges were dumped, many in backyard dwellings posing as places of care. This was after the MEC and her managers decided that the Life Esidimeni care facility was too expensive and lied to court when they claimed that the facilities to which they were moving patients were of a high quality. In December 2015, director-general Precious Matsoso attempted to pre-empt this crisis after a complaint from Section27. In response, the MEC and her team agreed in writing to ensure patients would be placed in good facilities experienced in dealing with these complex issues. Instead they discarded them.

Accountability? Not yet and not likely, although we await the report of the health ombud, Professor Malegapuru Makgoba, and the police investigation into the deaths in the hope that truth and justice will emerge. Hence our question: how do you start to build a health system that is universally accessible, in these rutted playing fields? The health systems crisis in the Free State, Eastern Cape, Mpumalanga have been repeatedly brought to the attention of those at the highest levels in government and the ANC. They turn a blind eye. The Health Minister uses the little sway he seems to have over provinces to try and intervene. But how does he even start to try and build an equitable health system with such unaccountable MECs in charge? Tragically, this is not the only front the Minister faces. His is a perfect storm. Public health budgets are totally inadequate for most areas of healthcare. The health workforce is dwindling far faster than it is being replaced. Research done by

Section27 and Corruption Watch in 2012 suggested that corruption top-slices up to 10 percent of public funds that are available, and another 10 percent in the private sector. Although we have only one Minister of Health, responsibility for poor population health must be laid at the door of many Ministers. For example, high rates of teenage pregnancy and HIV among young girls are linked to the terrible state of public schools and continued resistance to providing quality sexuality education and condom access. Poor sanitation and water reticulation contributes to water-borne illness. High youth unemployment is in part behind the violence exhibited by young people against each other and their growing substance use. There appears to be no co-ordination between departments when it comes to health. Motsoaledi's is an ever-moving target. Add to this the aggressive and litigious private healthcare sector who profit from the public systems' collapse. Their resistance has delayed the Competition Commission's health market inquiry. Reasonable efforts at medicine and hospital price control have been resisted for ideological reasons. Drug companies, tobacco and sugar merchants rush to the courts to protect their golden eggs, this despite the evidence of the ill health caused by these substances and the growing burden it places on public and private health systems. These are the real issues needing attention. Unless we have more leaders like Motsoaledi, people's doctors and competent healthy system managers, a universal healthcare system that serves the poor will be a pipe dream. While this is the state of play, we would all be better to red-card the dirty players on the field, not the one honest one.

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