1. Minister of Health Budget Vote speech & responses by DA

2. Briefing

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Minister of Health, Dr Aaron Motsoaledi, gave his Budget Vote speech on the 10 May 2016

Madam Speaker/Deputy Speaker/House Chairperson
My Colleague Deputy Minister of Health, Dr Joe Phaahla
Cabinet Colleagues
Chairperson of the Portfolio Committee on Health, Honourable Lindelwa Dunjwa and
Honourable Members of the Portfolio Committee on Health
Honourable Members
Representatives of UN agencies
Representatives of development agencies and Donor Partners
Distinguished guests
Ladies and Gentlemen

Good Morning!

It is a great honour for me to present the 2016/17 budget of the National Department of Health for consideration and approval of this House.

It is during moments like this that we need to remind each other that South Africa has a plan – a plan of where we should be by 2030 – hence Vision 2030 or the National Development Plan (NDP).

Equally, the World, through the United Nations (UN) does have a plan – the Sustainable Development Goals (SDGs).

These plans have objectives, goals and targets and it is extremely important for us to work within the framework of the SDGs in order to achieve the main aim of the Department of Health – i.e., *A Long and Healthy Life for all South Africans*.

We know by now that there are four (4) highways along which South Africans are marching to their graves. We call these four highways the four colliding epidemics or the quadruple burden of disease.

Just to remind you again because it is extremely important for South Africa not to forget this. The four highways are:

- A huge burden of HIV and AIDS and TB – this is the biggest highway of them all with many many lanes;
- A burden of Maternal and Child Mortality;
- An ever exploding burden of Non-Communicable Diseases (NCDs) or diseases of life style which is threatening to get out of control globally; and
- Injury, violence and trauma, especially on our roads – this also seems to be getting out of control with mass funerals from motor vehicle accidents becoming the order of the day.

The NDP clearly spells out that we need to decisively deal with these highways. In simple language, we must markedly reduce this burden of disease because it is too high a burden for the Nation to carry.
In order to design new plans on how to go about reducing this burden, we need to first take stock of where we come from and where we are at the present moment.

As you know, the country is implementing the world’s biggest HIV and AIDS treatment programme, which started with the launch of the world’s biggest testing campaign in 2010 – i.e the HCT Campaign that ended up testing 18 million South Africans for HIV and AIDS within a period of 18 months. Today, 10 million South Africans test on an annual basis.

AIDS deaths in South Africa declined from 320,000 in 2010 to 140,000 in 2014, and mother-to-child transmission of HIV reduced from 70,000 babies in 2004 to less than 7,000 in 2015.

As you can see, these are remarkable successes. But you will notice that the successes are largely due to Biomedical Interventions.

When it comes to the area of socio-behavioral interventions, it is an uphill battle – especially in the age group 15-24 year old girls and young women. In this age cohort, there are 5,000 new infections per week in 14 Southern and Eastern African countries – but half of these occur in South Africa alone.

Hence to meet the NDP objective of reducing the burden of disease, to have life expectancy of 70 years by 2030 and to have an AIDS-free generation of under 20’s, we wish to announce two major plans:

1. In September this year, we will remove CD4 count as an eligibility criterion for ARV treatment; It means we shall move to test and treat in line with the new guidelines released by the World Health Organisation (WHO) in December last year!

2. In addition, we will provide PrEP (Pre Exposure Prophylaxis) to sex workers in 10 sex worker programmes from June this year. With regard to providing PrEP to young women we will start by learning lessons from demonstration projects on how best provide PrEP to them before offering this intervention to all vulnerable young women.

These new programmes will cost us an additional R1 billion in this year’s budget and we are happy that the Treasury has made this amount available, despite the harsh economic climate in which we find ourselves.

3. The second major programme I wish to announce is a plan to deal with the young generation.

I wish to announce that next month – June (youth month), we shall launch a 3-year campaign focusing on girls and young women, in the age group 15-24 years, and the men who are infecting and impregnating them. This campaign will have five objectives, namely –

- Decreasing infections in girls and young women;
- Decreasing teenage pregnancy;
- Decreasing sexual and gender-based violence;
- Keeping girls in school until matric; and
- Increasing economic opportunities for young women to try and wean them away from sugar-daddies.

This campaign must be a whole of government and whole of society campaign and led by young people. I am pleased that 6 young people are my guests in the gallery today. I will ask them to stand so that you can all see them!

This campaign will cost R3 billion and will be made possible by funding from PEPFAR, Global Fund, the GIZ (German Development Agency) and government departments.
Honourable Members, 16 years ago, in the year 2000, the World’s largest conference on HIV and AIDS, the International AIDS Society Conference (IAS) was held in the City of eThekwini. We recall the images of the brave and sadly departed Nkosi Johnson who made an impassionate plea for greater global attention to be paid to AIDS. This was also the Conference that called for ARV treatment to be made affordable and available in poorly resourced countries. 16 Years later we are very happy to note that we live in a world in which millions of people are on treatment – with the largest number by far in our own country.

I wish to announce to the House that in July this year, the World is returning to eThekwini after a 16 year period, for the IAS Conference. There will be about 20 000 people in attendance, including Heads of States. This time around, we have a different story to tell.

I would like to urge Honourable Members to consider attending the Conference.

As you heard earlier, the highway of HIV and AIDS also contain TB in it. Although TB deaths have declined from 70 000 in 2009 to less than 40 000 in 2014, TB still remains the biggest killer of all infectious diseases in our country and indeed globally.

Since the screening campaign was launched on World TB Day on 24 March 2015 by Deputy President Cyril Ramaphosa, I am happy to announce that we have successfully screened thousands of people in the vulnerable sectors of correctional services, mining and peri-mining communities.

This year we are focusing on 8 metros with the aim to screen 1.3 million people.

In this instance, we wish to welcome the R4,2 billion grant from the Global Fund to support our HIV and TB responses.

Honourable Members, as you may recall, together with the Right Honourable Nick Herbert, a member of the UK Parliament, I co-chair the Global TB Caucus which is a forum of Members of Parliaments around the world to join a global advocacy effort to eradicate TB.

I wish to announce that the African Regional TB Caucus will be launched in July in eThekwini and urge every member of the House to join the Caucus and also to support the launch of the African Region of TB Caucus.

Honourable Members, as I have said earlier, only 16 years ago it was unthinkable to put so many people on treatment with ARVs as we are doing now. The price of ARVs was exorbitant. Lest we forget it used to cost $10 000.00 just to put one person on a year’s treatment in the year 2000. If that was not strongly challenged, it means in South Africa today, for our 3.4 million people on ARVs the country would be paying R510 billion, that is half the country’s budget. It would have been totally unaffordable to treat people. Imagine how many would have died. Imagine the collapse of the economy with so many people dying – imagine the collapse of the education system, the health system and social systems.

However, this horrible scenario was averted when civil society activists in both developed and developing countries, joined by UN agencies, Philanthropies and governments, ensured that prices were drastically reduced!! Of course large volumes and generic competition also contributed to the reduction. Today, instead of $10 000.00 per annum it costs only $67.00 per annum to put one person on ARVs.

Unfortunately Honourable Members, that horrible scenario that was averted more than a decade and a half ago, is back to haunt us!

The horror scene is back but not in the HIV and AIDS arena – but in the new arena of Non-Communicable diseases, i.e., NCDs as well as for the treatment of Drug Resistant TB.

You are aware of the exploding prevalence of Cancer around the world and in our own country. We have just moved in a circle. Just as the price of ARVs were unaffordable then, Cancer drugs are
devilishly unaffordable today. If no drastic action is taken today, we are going to be counting body bags like we are at war. Two years ago, I was regarded as exaggerating or outright insane by some, when I spoke openly against Pharmaceutical companies that were planning a price onslaught against us. Today, that onslaught which I had foreseen is here with us.

If you have breast cancer and you need treatment with Trastuzumab, known commonly as Herceptin you must part with close to R500 000.00 for a year’s treatment,

R396 613.00, for colorectal cancer;
R960 000.00 for metastatic melanoma;
R204 000.00 for MRD-TB; and
R832 000.00 for XDR-TB.

These are figures out of this world which even those with medical aids can hardly afford, but it is the reality that ordinary South Africans are faced with everyday.

Today, we have no option but to call for HIV and AIDS-like solidarity of all the progressive forces to force significant decreases in the price of these medicines.

The global situation is so out of control that the UN Secretary General, Mr Ban Ki-moon has established a High Level Panel on Access to Medicines. Due to the role South Africa played in the fight for affordable ARVs, the Director-General of Health, Ms Precious Matsoso has been selected as a member of this Panel. Hence she is not attending this Budget vote today because she is at the UN dealing with these issues.

Last month Pope Francis entered the fray and convened a meeting of stakeholders to discuss this issue at the Vatican. He was worried about the morality of allowing people to die through uncontrollable prices, i.e., uncontrolled commercialization of healthcare. This is what he said: "These patients, in fact, often are not given enough attention because the idea of profit prevails over the value of human life. It is fundamentally important to promote greater empathy in society, so that nobody remains indifferent to our neighbor’s cry for help, including when he or she is suffering from a rare disease."

Honourable Members, the examples of pricing of healthcare I have given above is just but a tip of the iceberg to indicate how impossible it is going to be or already is for many people to survive major illnesses. Anybody who is desperate to remain alive and tries to obtain treatment at current costs will end up in poverty. Alternatively, governments will end up bankrupt trying to meet the health needs of their populations. This disaster of unaffordable healthcare unfortunately affects people unequally. Those of higher socio-economic status are better protected and the unfortunate ones of lower economic status are left to perish.

In this context the World Health Organisation (1978) noted that:

“The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries”.

Hence Honourable Members, the world of healthcare provision around us is changing very fast and is changing radically. Those of us given the responsibility to take care of our people around the whole world, are in a fighting mood to change our healthcare systems. In this fighting mood, we are driven by a spirit of no compromise and no surrender.

We want fair, just and equitable healthcare systems that will provide access to good quality affordable care to individuals regardless of their socio-economic status.
We are no longer prepared to tolerate very costly healthcare systems that take care of only the elite, the famous and the powerful members of society and ignore the poor and the down trodden as if they have no right to exist.

Hence with the powerful push and influence of the World Health Assembly, the United Nations has adopted the concept of Universal Health Coverage as part of the 17 Sustainable Development Goals (SDGs).

In its preamble, it says this is an agenda of “unprecedented scope and significance ….”

In South Africa, our Universal Health Coverage is called NHI (National Health Insurance).

Honourable Members, politically, economically and socially, how do we continue to justify a healthcare system where 16% of the population which in essence is the cream of the Nation, have pooled their funds together in their own corner away from the masses in the form of medical aid schemes only for the elite? Pooling these funds together for the cream of the nation means substantial resources including human resources are sitting in that corner alone, hiding away from the rest of society. Hence today we have 80% of the medical specialists of the country being available to only 16% of the population and leaving the remaining 84% of the population to struggle in long queues with only 20% of the remaining specialists. Today, we have some life-saving health services being accessed by this 16% of the population only. The poor are not even allowed to dream about them because they are not meant for them.

How do we continue to justify that you and I here Honourable Members, who call ourselves the representatives and humble servants of our people, together with the judges of our courts who are defenders of the constitutional rights of our people, benefit from resources in a very expensive medical scheme of our own – for us and us only?

The same applies to all professionals – teachers, doctors, nurses, policemen and women, engineers, lawyers, accountants, financial gurus, and all other crème-de-la-crème of the nation, including those working in the private sector. Remember that this system is heavily subsidized by employers and the taxpayer to the exclusion of the masses of our people.

We can no longer continue to defend these unsustainable positions with flimsy arguments like claiming that there are a few taxpayers in our country, conveniently and deliberately forgetting that the poor pay heavy tax through VAT on an everyday basis. We need to urgently change this state of affairs and hence we want Universal Health Coverage – we want NHI where we will be forced to pool together funds for all South Africans and “all” means “all” – not just a selected few.

NHI is a political decision of a nation hungry for justice and equality. It is based on political will and should not be subjected to obstacles driven purely by greed and self-interest of a selected few.

NHI is a reflection of the kind of society we wish to live in – a society that will be based in values of justice, fairness and social solidarity.

NHI is not a beauty contest between the private and the public sectors as many who belong to this selected 16% like arguing, but it represents a desire to share so that the population can best utilize what both systems have to offer rather than segmentalised in a way not consistent with our Constitution.

We are aware that those who wish to discourage the population from embracing NHI are spreading a narrative based on an assumption that we are going to implement NHI under the present system of healthcare with everything based on exorbitant prices in private healthcare sector, and lack of quality in the public healthcare system.

Let me give a strong warning, we shall not implement NHI under the present health platforms – both public and private, NO!
We are going to have to change everything drastically – the mad pricing in the private healthcare sector and the disconcerting challenges of quality in public healthcare, all these must change and give way to NHI. As Pope Francis said, we can no longer continue to being indifferent to our neighbours’ cry for help.

Hence the second paragraph of the NHI White Paper deliberately states that NHI represents a substantial policy shift that will necessitate massive reorganization of the healthcare system, both public and private. Honourable Members, brace yourselves for massive legislative and structural alterations to both the private and public healthcare systems, in order to prepare for NHI.

Those who like claiming that it is only the public healthcare system that needs any changes, and that the private sector needs no changes, I challenge them to go and listen to inputs by various stakeholders, especially patients at the Health Market Inquiry being conducted by former Chief Justice Sandile Ngcobo since February this year.

Let me give a brief report about some of the programmes that are already in the pipeline in order to help to strengthen and reorganize the healthcare system in preparation for NHI.

The huge burden of disease in our country is causing us serious challenges of sometimes running out of drugs – a phenomenon called drug-stockouts. We have been battling with this problem for some time now.

We have now implemented a stock visibility system known as SVS in our Primary Health Care clinics. This is a mobile Application (App) that healthcare professionals use to scan medicine barcodes and enter the stock levels for ARVs, anti TB medication and vaccines. This information is in real-time and is availed at any geographic location, via the web. Six provinces have the SVS covering 1 900 or 60% of our clinics. We plan to have 100% of all Primary Health clinics reporting medicine availability into a national medicine surveillance centre within the next three months.

We have also implemented an innovation called Central Chronic Medicine Dispensing and Distribution programme known as CCMDD.

This programme makes it possible for stable patients to collect their medication from a pick-up point near their home or work – saving both in time and money. It also reduces waiting times at clinics by reducing volumes of patients who have to come to a clinic.

We currently have 400 000 patients enrolled into this programme accessing their medicines from over 1 000 pick-up points including adherence clubs, occupational health sites, GPs and private pharmacies.

We plan to reach a total of 800 000 patients by the end of this financial year.

We also need to ensure rational use of medicines. To this end, we have standard treatment guidelines referred to as STGs. On the 25 November last year we launched a mobile Application (App) to disseminate these guidelines, starting with the Primary Health Care STGs. This Application is freely available from all app stores and also works offline to assist health professionals in remote areas with poor or no connectivity.

The Application helps decision-making at the point-of-care. It also has a function to report any stock-outs of essential medicines. What it means is that any doctor in any health facility, on prescribing any essential medicine and told that it is out-of-stock, can press a button which will report such a stock out directly to Pretoria. It means the doctor does not have to struggle with the management of the hospital or clinic who in the first place should have reported the stock out if there was good management in that facility.

This Application has already been downloaded 15 000 times in South Africa.
It is a home grown App developed by our own Medical Research Council (MRC). Guess what? The World Health Organisation is very interested in it and is informing countries about it and it has already been downloaded 1,000 times by international users.

What is brilliant about the system is that it is not only doctors and nurses who may use it. Even you as a patient and member of the public can download it and use it. It can give you a phone number and physical address of any public health facility in the country as well as directions to the facility, which is linked to your google map. You can inform us about side effects of any medication you are on, using this App from anywhere in the country.

If you have downloaded this App and you go to any health facility as a patient and experience a drug stock out, you can press a button and it will inform us in Pretoria and we will investigate and take corrective action.

Please note that whenever you download this facility and use it, we will be able to know who you are. I am just warning those who may be tempted to play games with us on such an important tool!!

Honourable Chairperson, to strengthen the quality of our public health facilities, we need an Ideal Clinic. As part of this Ideal Clinic model, we will among other interventions deal with poor administration of patients records and data, as well as to drastically reduce patient waiting times. We have started the process of installing dedicated computer hardware for the rollout of the Patient Health Information System in our clinics.

In each dedicated computer we are installing software for a patient registration system in accordance with paragraph 364 of the White Paper on NHI. This system will be able to trace any patient within the system, i.e when and which clinic have they visited before, what medication did they receive and what amount of medication was dispensed.

Gone will be the days, when some patients move from clinic to clinic collecting medicines, resulting in overuse of services.

Out of the 700 Primary Health Care facilities in the NHI Pilot Districts, we have already covered 657. A total of 1,400 additional facilities will be completed in this financial year with the remaining facilities completed in 2017/18.

Patients are being loaded on this system as they visit health facilities. Next month, we will officially launch this system after we have loaded one third of the uninsured population.

Honourable Members, together with CEOs of private sector companies operating in health, in 2012 we launched a Public Health Enhancement Fund to help strengthen the human capital of our country. The following companies contributed handsomely to the establishment of this Fund:

- United Pharmaceutical Distributors
- Alcon Laboratories
- Clinix Health Group
- Joint Medical Trust
- Mediscor
- Roche Diagnostics
- Aspen Holdings
- Dis-Chem
- Life Healthcare
- Medscheme
- Roche Pharma
- Abbott Laboratories
- Bausch + Lomb
- Discovery Holdings
A total of R40 million was collected and we agreed to produce 1000 PhDs in the field of HIV and AIDS research over a period of ten (10) years.

Honourable Members I am happy to announce the first PhD produced by this collaboration. He is Dr Simon Nematandani – who is with us in the gallery today, and I am also happy to announce that 76 more students are already in this scholarship and we are awaiting the day they obtain their PhDs like Dr Nematandani.

I wish to heartily thank the participating companies for the foresight in helping to build the human capital of our country which as we all know is a very important component of nation building and economic development.

Honourable Members will recall that our icon, former President Mandela was instrumental in facilitating the building of a children’s hospital in Gauteng not only for South Africa’s children but for children of the whole region. I am very happy to announce that his vision is being realized. The Nelson Mandela Children’s Hospital is scheduled to be officially opened in December 2016.

Finally, I wish to announce that in further strengthening and reorganizing the healthcare system, South Africa has now got its first ever Health Ombuds. He was appointed last week. He is Prof Malegapuru Makgoba!! He will commence work as an Ombuds on the 1st of June 2016!! His function will be to investigate and dispose of the complaints laid by patients and the public in general against health establishments and health workers. He will act as the public protector of health.

In conclusion, I wish to thank my colleague, Deputy Minister Joe Phaahla for a very warm and fruitful working relationship.

Let me finally thank my team of officials, ably led by the Director-General Ms Precious Matsoso in absentia, the DDGs all present today and other senior officials of my Department, for their hard work in our effort to improve our healthcare system. I also wish to thank my colleagues the MECs, for their support and commitment.

Honourable Members, may I request the House to approve the Budget of the National Department of Health in the amount of R38,563 billion.

I thank you for your attention!

Responses

4. The Health budget does not honour our Constitutional commitments: Wilmot James DA  
Shadow Minister of Health
Health Minister Aaron Motsoaledi’s greatest contribution to the nation’s health is the HIV/AIDS antiretroviral programme.

Since he took office, Black lives in particular have been extended by multiple years. Credit is not his alone.

Former President Kgalema Motlanthe’s moral judgment in 2008 ended the long night of HIV/AIDS denialism by appointing former Minister Barbara Hogan who first set our policies on the right course.

Health’s civil servants, led by the capable DG Malebona Precious Matsoso, reversed the schizophrenic culture that pitted modern medicine against pseudo-science ‘beetroot and garlic’ naturalism.

But it is the Minister’s fighting spirit led the charge against HIV/AIDS, as he has against TB, winning the USAID-TB International Award for the effort recently.

So when the Minister takes aim at an issue, stuff happens.

But Madame Speaker, I am sure the Minister would agree with me that we have not turned the corner in lifting our health burden.

It is a triple burden; to summarise, they are infectious diseases, chronic illness arising from unhealthy habits and the inevitable degenerative conditions of an ageing population.

Firstly, then, we are afflicted with a high incidence of infectious disease – HIV/AIDS and TB in particular – for which there are no HIV vaccines or effective TB vaccines – that show no sign of burning out.

We have between 6.4 and 6.8 million people infected with HIV/AIDS, the world’s highest burden. But 3.26 million are on treatment. New infections have neither stabilized nor declined.

There were 450,000 active cases of TB in 2013 and more than 26,000 drug-resistant ones.

Secondly, the unhealthy habits of our nation are resulting in chronic diseases.

Comparatively speaking we have a high percentage of teetotallers, but those who drink do so excessively.

We eat fast-foods and drink sugary beverages at a rate that make us the most obese people in Africa well on the road to already alarming levels of diabetes, hypertension and heart disease.

25.8% of boys and 52.3% of men are obese or overweight. 35.9% of girls and 81.3% of women likewise.

We are one of the great sporting nations in the world with extraordinary opportunities for exercise, but the majority of people, mainly black, have few safe spaces or accessible gyms to use.

Thirdly, an aging population brings cancer, cardio-vascular and degenerative diseases.

This is an overwhelming burden.

Madame Speaker, health is the second largest budget commitment after education – R157.3 billion (R182 billion if one adds conditional grants) – and our health to GDP spending ratio is higher than the norm for middle-income countries.

But, Madame Speaker, the 2016-17 budgets do not honour our Constitutional commitments as defined in Section 27, which read:
‘Everyone has the right to have access to (a) health care services, including reproductive health care; and (3) no one may be refused emergency medical treatment.’
The Minister should take aim at these two critical issues.

But his budget does not reflect it.

This is because his National Health Insurance (NHI) is all things to all people. Neither does it meet the Constitutional requirement (s.27.2) binding the state to take ‘measures within available resources’.

The DA proposes three cardinal policy measures that would give every citizen and legal resident to health care: First, universal access could be achieved in one year if the Minister dropped the means test, brought the off-budget medical aid credits on-budget and defined a universal subsidy for all. Medical Aid credits are worth R15.9 billion.

Second, the Minister could set up a Maternal and Child Care Fund to finance – as conditional grants – the expansion of maternal and paediatric services at hospitals and clinics. This includes an extension of antenatal services and obstetric care to rural and under-served areas.

Third, the Minister could create a National Emergency Care Fund that would serve as an underwriter of all parts of the health system offering emergency services of any form. The Fund’s purpose is to give equal access to the nearest treating facility regardless of whether the individual is covered by a medical scheme or the public sector.

Madame Speaker, the Minister is not the only one to take aim. We need much more effective collaborations between national and provincial health ministries, civil society and smart non-partisan contestations between political parties that elevate accountability to citizens as highest principle of our land.

Madame Speaker, accountability brings to me to the subject of oversight.

It is a constitutional imperative and duty and should be encouraged.

One cannot do justice to a portfolio especially one such as health unless one goes and sees for oneself.

I once visited Charlotte Mxenge Hospital only to discover that Pickitup’s criminal unwillingness to collect ordinary garbage created a major public health risk.

I alerted a senior official of the Health Department.

The next day the garbage problem was attended to.

In preparation for today’s debate, I visited 2 clinics in Nelson Mandela Bay, 1 in Uitenhage, 2 clinics and a hospital in Durban and 3 clinics in Mangaung.

R.K. Kahn Hospital in Chatsworth had no x-ray machines in casualty.

The problem has been sorted out. But in probing I established that the tender process for medical technologies is paralysed and few if any of the life-supporting machines have been serviced at clinics and hospitals in KwaZulu-Natal.

The Minister does not like my visits.

I have news for you Minister, my oversight visits help you.

You appoint the key officials of the Office of Health Standards Compliance. Though they do good work, they are mindful of not displeasing you too much.

Your visits to hospitals, when they happen, are almost always announced.

You are out of touch with what happening at our clinics and hospitals.

I challenge you to join me in a national programme of unannounced visits. The effect will be dramatic.
Finally, our people must take aim. We need an incentive architecture to support our population make smart choices to drink less, eat better, exercise more, reduce high-risk sexual intercourse, drive sober and adhere to norms of hygiene.

The DA will work in a spirit of bipartisanship with the Minister and the Treasury to bring the off-budget R15.9 billion worth of medical aid credits on-budget, reducing members’ medical aid contributions and serving as a cross-subsidy between those who have jobs and are on medical aid to those who do not.

In this way health justice will be served.

5. Minister Motsoaledi, we urge you to take bold action against the HPCSA: Heinrich Volmink DA

Shadow Deputy Minister of Health

Honourable Chairperson,

One of our nation’s most vital resources is its health workforce.

The budget reflects this, allocating R2.5 billion to HRH planning under Programme 5. However, while funding is important, the provision of adequate support to health professionals is just as crucial. Moreover, action needs to be taken against anyone who interferes with the provision of that support, without fear or favour.

It is within this context that we ask the Minister to take bold action on the issue of the Health Professions Council of South Africa, or HPCSA.

The HPCSA is supposed to play a pivotal role in preparing a capable health workforce. Put simply, it has to ensure that professional freedom is balanced with safe practice so that both providers and the public are protected. However, it has failed dismally in its duties.

In November last year, a Ministerial Task Team, led by the highly-respected Professor Mayosi, released a damning report on the HPCSA entitled “A Case of Multisystem Failure.” The findings included:

1) That the COO was implicated in “acts of unauthorised, irregular and/or fruitless and wasteful expenditure” involving an Oracle IT system.

2) That the Registrar had severely mismanaged the HPCSA; this included unacceptable delays in registering professionals and recognizing foreign qualifications.

3) That the General Manager: Legal Services had failed in dealing with professional misconduct complaints, potentially deferring justice for victims of medical negligence in the order of years.

I have been approached by many individuals affected by this. This includes a young South African doctor who trained overseas, successfully completed his internship here, but then was allegedly told, by a Council official, for no justifiable reason, that he should either choose another career or leave the country. This isn’t someone who is unfit for practice; this a skilled doctor who has made every effort to comply with the HPCSA’s prescripts. Yet he has been sitting at home for years now, desperate but unable to provide much-needed medical services.

There are also tragic cases of citizens whose loved ones have been harmed through alleged medical negligence but whose complaints have gone callously unresolved by the HPCSA; this could affect any one of us.
Although the April deadline for an implementation report from the HPCSA has come and gone, the DA will not rest until the Council is brought to account.

While we note the resignation of the Registrar, Dr Mjamba-Matshoba, last month, it is not clear that she faced any consequences for her misconduct. Furthermore, to expect the current Council members to restore the fundamentally damaged image of the HPCSA is unfair to them and the public at large.

So we urge the Minister to act. While the HPCSA has been afforded some independence, the Health Professions Act gives the Minister the power to dissolve the Council. We ask him to take action now, in terms of the MTT report, and:

- 1) Ensure that proper disciplinary action is taken against all those involved in the dismal state of the HPCSA.
- 2) Ensure that an impeccably ethical interim executive team is put in place.
- 3) Replace the now broken HPCSA with the two new Councils recommended in the report.

Furthermore, we call for the setting-up of temporary service centres to deal with the massive backlog of registration and professional misconduct cases that need fair, and urgent, resolution.

As substantial as the HRH planning budget is, its benefit to the health workforce will be obstructed by the albatross that is the HPCSA. We would ask the Minister to step-up, and provide the decisive leadership that our health professionals, and the communities they serve, so desperately need.