The broken thread: Primary Health Care, Social Justice and the Dignity of the Health Worker

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This paper is dedicated to the memory and work of Dr Mervyn Susser a great South African health rights activist who died on 14 August 2014. The paper argues that the heart of the health systems crisis currently being experienced in SA is an acute shortage of health workers and the deteriorating conditions under which they are employed. Unless a plan and adequate budget to rectify this social injustice is seen as the Department of Health's first priority the prospect of equitable and improved health care under a National Health Insurance scheme is a pipe-dream.[i]

The Promise of the Right to Health

Soon after South Africa's first democratic election in April 1994 the ANC published its *National Health Plan for South Africa* (National Health Plan*).*[ii] This radical new vision for health was consistent with both the 1955 Freedom Charter[iii] and the Reconstruction and Development Programme (RDP).[iv] As illustrated in the diagram below the National Health Plan envisaged a 'national health system' that would have at its base a primary health care system (PHC), such as that endorsed in the 1978 Declaration of Alma Ata[v]. The National Health Plan stated that its fundamental underlying principle was to achieve "social and economic justice" in health.

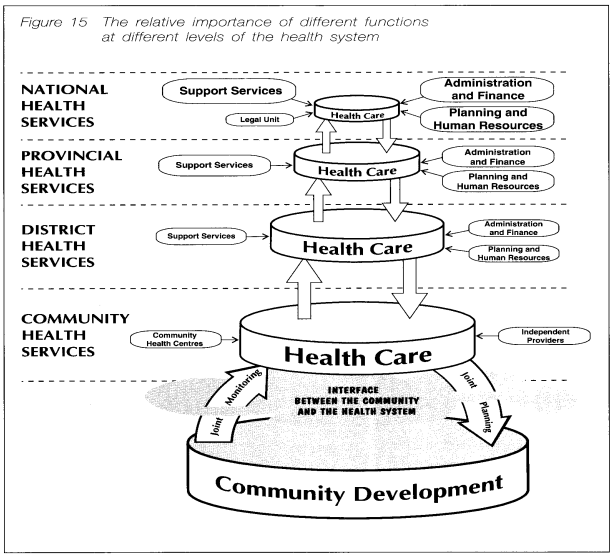

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Diagram 1: ANC depiction of the health system in its 1994 Plan

'Traditional' health systems cannot achieve social justice: they focus on individual access to curative health services and are inherently unjust because they are biased towards urban areas and the monied. In contrast Primary Health Care builds a health system based on societal interest: the greatest good health for the greatest number of people. It holds a better prospect of achieving social justice because it locates a group of essential health services and personnel within communities, ie, at the place where they are most accessible to the largest number of people. Greater resources are directed towards preventative health care and health education thereby preventing illnesses that become a cost to both the individual and to society. Smaller numbers of people need to ascend the ladder to access more specialized and expensive care.

The National Health Plan proposed to turn away from a model of health based primarily on access to curative specialist health services to one that was premised on equality of access, accountability and community participation. It would necessitate a retrained and expanded workforce to meet all health needs and also promised respect and dignity for the health care worker.

The Plan was not an ideological or idealistic policy developed by a movement that did not understand health. It was conceptualized with the expert assistance of the WHO and UNICEF, and was finalised in consultation with democratic health organisations that had emerged to fight apartheid, such as the South African Health Workers Congress (SAHWCO).

The model it proposed broke fundamentally with the shape of the health system that had evolved under successive colonial governments, the Union and finally under apartheid. For 300 years healthcare services had been planned and provided primarily to serve the white minority.[vii] Whilst there was an important medical tradition established through mission hospitals and by a small number of maverick white health professionals, as a matter of policy the health of black people was only a consideration if it affected the labour supply or if infection posed a risk to white public health. But, after the 1913 Land Act provided a relatively limitless supply of black labour, the epidemics of Silicosis, Tuberculosis (TB), and sexually transmitted diseases (STDs) were allowed to develop relatively unchecked.[viii]

Few black people were trained and educated as doctors. Although more black women were trained as nurses, the main stimulus for this was a shortage of nurses during World War II. In addition, as medicine and medical technology developed during the 20th century the bent was increasingly towards curative and hospital care in urban areas.

In 300 years there was only one fleeting exception to this. After a decade of debates within the medical profession about the best form of health system for SA, in 1942 Dr Henry Gluckman was appointed the Chairperson of a National Health Services Commission (NHSC).[ix] In 1944 Gluckman's Commission published a report that recommended creating a unitary national health service that would provide free services to *all* people regardless of race and would be financed by a national health tax. Anticipating Minister of Health Motsoaledi's proposal for District Health Teams

by 60 years, it recommended that primary health care services should be delivered by teams of doctors, nurses and auxiliary personnel.

The Smuts government rejected most of Gluckman's recommendations. However, the training of medical personnel for an envisaged network of 400 health centres did commence, including the establishment of the first ever Institute of Family and Community Health in 1946.

The introduction of a parallel PHC approach created a ripple of enthusiasm in the progressive medical profession but it was short-lived. In 1948, the National Party (NP) was elected to power. Its legalised the already existing practice of racial discrimination in access to health care services. According to anti-apartheid pediatrician and health activists Dr Louis Reynolds:

> "the multi-racial health teams embedded in the health centres were antithetical to the NP's programme of apartheid. Staffing problems became endemic … and many of South Africa's most progressive doctors emigrated."[x]

As the two tables below reveal, the result, in 1994, was a grossly unequal health system characterized by:

- inequality in access to health care workers between black and white people, rural and urban areas, the public and private sector;
- gross racial inequality in the numbers of health care workers trained;
- gross inequality in the conditions of employment between black and white heath workers.

Table 1: Percentage of graduating doctors belonging to each population group, 1968-1977[xi]

	Medical graduates: population group	%	Population distribution
	Annual range	Annual mean	
White	84.3 – 86.7	85.4	17.3
Indian	7.9 – 9.3	8.4	2.9
Coloured	1.1 – 4.8	3.4	9.4
African	1.3 – 4.8	3.0	70.4

Table 2: Per capita spending by race, 1985 and 1987[xii]

	1985	**1987**
Africans	R115	R137
Coloureds	R245	R340
Indians	R249	R356
Whites	R451	R597

All this had to be overhauled.

In 1997 the vision for Primary Care that had been set out in the National Health Plan was transformed into official policy in the *White Paper for the Transformation of the Health System in South Africa*.[xiii] A year later "comprehensive" Primary Care was also endorsed in the final report of the Truth and Reconciliation Commission (TRC) which recommended that "All legislation pertaining to health focus on primary health care".[xiv]

The sturdiest reinforcement of this vision, however, came with the proclamation of the 1996 Constitution, which made "everyone's right of access to health care services, including reproductive health care" a fundamental right. It bound this right to an express duty on the state to "take reasonable legislative and other measures within its available resources to progressively realize" access to health care services.[xv]

The new government's policy decision to prioritise Primary Health was reinforced by two other health rights in the Constitution: (i) "every child's" immediate and unqualified right of access to "basic health care services"[xvi] and (ii) the right of everyone to an environment "not harmful to health or wellbeing". Both these rights can only be realized by comprehensive primary health services provided through a district health system.[xvii] They require access to health services at a community level, as well as co-operation between different departments of government in order to protect people from the harm of environmental, industrial and other threats to health.

However an excellent policy and the support of SA's supreme law are not in themselves sufficient to guarantee everyone's right of access to health care services. This is because, in the words of the World Health Organisation (WHO):

> "At the heart of each and every health system, the workforce is central to advancing health. There is ample evidence that worker numbers and quality are positively associated with immunization coverage, outreach of primary care, and infant, child and maternal survival."[xviii]

Health systems are a complex eco-system. They require physical infrastructure, medical technologies, medicines, information systems. But access to, and the functionality of, each part depends absolutely on the presence of sufficient numbers of appropriately trained health workers. The backbone of a PHC system, which is more low-tech than tertiary care but no less life saving, is its personnel. Its success depends on the qualitative interactions of staff in the system with patients and the population of each district. This requires the calculation of appropriate ratios of doctors, nurses and community health workers linked to community clinics, their equitable geographical distribution and efficient systems for managing and monitoring them.

In 1994 a process to quantify the country's unmet needs for different categories of health workers, a plan to train them and then to locate them equitably across the country, as well as costing and budgeting for this plan, should have been the starting point for health system transformation and commenced immediately.

Numbers matter. But experts in health provision also stress the need for policy makers to appreciate that "health care is a human system, and that reforms have to address themselves centrally to the personnel staffing the service."[xix] This required planning to improve the living and working conditions faced by black health workers. Social justice for users of health systems depends on respect for those who work in them, and health workers' trust in the system in which they work. This entails a reciprocal social contract with the state, a commitment to protecting and advancing their fundamental rights.

The Betrayal of the Right to Health

Twenty years have passed since the National Health Plan was published. Sadly, during that time an extensive and depressing academic literature records the missed opportunities for health transformation. Instead of charting the rise of a Primary Care system, the renewal and equitable distribution of a health workforce, the literature records its demise. Failure to act on the volume of academic and research articles pointing out the human resource challenge, and particularly the looming shortages of doctors and professional nurses, creates political culpability for the suffering that is now being experienced by health system users and providers alike.

As evident from the Diagram 1, the foundation of a PHC system was to have been a network of community health centres; to the government's credit many hundreds of new clinics have been constructed. But unfortunately it is at this level that one can now see most clearly the extent of staffing shortages. The 2012 *National Heath Facilities Baseline Audit* for example reported on a survey of 3,356 clinics and community health centres and found that:

> Although the majority of clinics have facility managers, a significant 21% do not. Nearly half of the clinics (47%) report no visit from Doctors…. 84% of clinics have no input from a pharmacist or Pharmacy Assistant .. 11% of clinics report not having any lay counselors, 57% have no administration support and 79% have no information management staff.[xx]

These statistics reveal that the chronic shortage of health care workers inherited from Apartheid has become an acute and catastrophic shortage. This portends very badly for the planned National Health Insurance (NHI) System.

For example, in March 2012 the National Department of Health (NDoH) announced 11 districts where different NHI innovations would be piloted.[xxi] However, because of the unresolved shortage of doctors in rural areas one aim of the pilots was said to be "to assess the feasibility, acceptability, effectiveness and affordability of engaging private GPs" to work at clinics in these districts. Three years later the NDoH reports that only 114 GPs out of a target of 600 have been recruited.[xxii] Not surprisingly therefore very few on the pilot districts have recorded progress in the delivery of health services or improved health outcomes.[xxiii]

What went wrong?

What has impeded the transformation of the health system?

Three significant areas of failure are identified and discussed below.

1. Failure to plan according to the Constitution and law:

A right to health care services was not included in the interim Constitution.[xxiv] It could be argued therefore that its inclusion in the 1996 Constitution indicated the intent of the Constituent Assembly to prioritise health transformation by placing express duties on the state. This may also have been considered necessary given the dependence of other fundamental rights, including bodily autonomy, well-being, dignity, equality and life, on health.

But what did this actually mean? What power and obligations did it give to the government? The first seminal judgment of the Constitutional Court (CC) setting out what these duties entailed was handed down in 2001. Although it concerned the right to access to adequate housing,[xxv] the *Grootboom* judgment has direct bearing on the right to health. The Court explained that whilst not every dimension of a socio-economic right could be realized immediately, the state was under a legal obligation to develop a 'plan' that is objectively capable of realization, and which targets those with the most 'desperate needs' first.[xxvi] Subsequent CC judgments have elaborated more on these duties, including the duty to budget for and identify the resources that are available for implementation of a plan[xxvii] and to communicate the plan to all those who work in or use the health system.

To put it bluntly, without a plan to increase and retrain the health workforce there can be no progressive realisation of access to health care services, no road-map, no quantification of resource needs, no monitoring.

Unfortunately, evidence indicates that the governmental response to meeting the human resource needs of the health system has been characterized by a lack of planning. In fact in the Preamble to the 2012 HRH Plan the current Director-General, Malebona Matsoso, admits that up to that point policy had been "ad hoc and reactive" and "failed to correct workforce imbalances". [xxviii]

The first significant measure to locate more health workers in underserved areas was the introduction of Community Service for doctors in 1998. But this took place in the absence of an overall strategy or framework for human resources. It has remained an important but isolated and largely unsupervised policy. It is also insufficient to meet the health needs being experienced in rural areas.[xxix]

In 2003 the National Health Act (NHA) came into effect. For the first time this law provided substantial detail on responsibility for human resource planning; it made it clear where the duty to plan for human resources lay. Unfortunately it spread this duty across a number of bodies and officials, including the Minister, the Director-General, the MECs, the National Health Council and the Forum of Statutory Health Professions Councils (FSHPC). Thereafter the first 'Framework' for a Plan was not

finalized until 2006. A final 'Human Resources for Health strategy' was only published in 2012.[xxx]

Problems caused by this delay were compounded by the fact that even after the passing of the 2003 Act there was a failure to comply with and implement its provisions. For example, Chapter 7 of the NHA said that it "hereby establishes" a Forum of Statutory Health Professionals Councils (FSHPC) which, amongst other functions, was given significant responsibility for human resource issues, including to advise the Minister on "targets, priorities, norms and standards relating to the equitable distribution of health care providers". However, the FSHPC was not established until 2012 – and it is not clear what it has done since then.

Throughout this period, however, the need for health care workers increased dramatically mainly as a result of the HIV epidemic and a growth in the population of over 10 million people. The need to fill the health-care gap created by AIDS led to the recruitment of tens of thousands of community health care workers to provide home based care, Voluntary Counseling and Testing (VCT), and to observe TB treatment protocols (DOTS) etc. But although community health workers had been identified as a crucial part of a primary health care workforce in both the National Health Plan and the White Paper, their employment took place in a manner that was ad hoc, uncoordinated and often unsupervised.

Finally, a number of further measures have exacerbated rather than ameliorated the HR challenges. For example, the introduction of an Occupation Specific Dispensation (OSD) for doctors and nurses in 2007 was intended to help retention of scarce skills in rural areas, yet it led to a doubling of public sector expenditure on the existing health workforce - from R28bn pa in 2006/07 to R58bn in 2010/11 -[xxxi] without improving health outcomes. It also consumed resources available for other essential cadres of a primary health care workforce including, arguably, community health workers.

Another example was the programme that started in 2008 to train 'mid-level health workers' (referred to as clinical associates). Several hundred ClinA's have graduated since 2012 but they express enormous frustration because of the fact that three years later they remain with out a scope of practice approved by the HPCSA or clear policy governing the role they are expected to play in the health system.[xxxii]

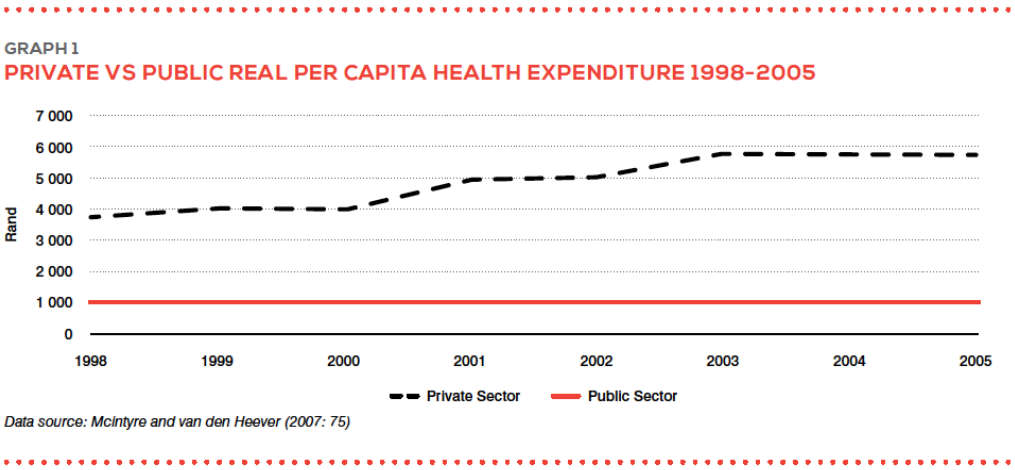
2. *Failure to allocate resources necessary to grow and retrain the health workforce*

The right of access to health care services is subject to progressive realization 'within available resources'.

In the early 1990s it was obvious that the recruitment and retaining of thousands of health workers would necessitate a massive additional investment of funds in the health system.

But unfortunately fiscal decisions made did not prioritise health. The government was able to find R30 billion for the arms deal but similar resources could not be found not for increasing the health workforce. As the table below shows, per capita public expenditure on health remained stagnant.

Table 3: Private vs Public Real per capita expenditure on Heath, 1998-2005[xxxiii]



During the late 1990s a number of nursing colleges were closed that led to a contraction in the nursing profession over several years, before numbers began to increase again in the mid 2000s.[xxxiv] The number of doctors remained static. In fact, as already explained, the only real growth was amongst extremely low paid community health workers.

As a result between 1997 and 2006 significant categories of the health workforce have shrunk. In recent years nursing colleges have re-opened and there has been an instruction to medical schools to increase intake. However what is troubling is the aging of the nurse population together with the fact that fewer professional nurses are qualifying.[xxxv] Similarly, although medical school intake has increased the numbers remain far from sufficient.[xxxvi]

Ironically given the very poor quality of management of many health facilities, as can be seen in the table below, the only growth area was in management and administration.

Table 4: Health Professionals Employed in the Public Sector, 1997 - 2006[xxxvii]

Professional category	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Administration & management	28,676	27,435	27,188	25,884	27,629	27,253	26,622	28,935	32,052	37,419
Ass health professionals	13,786	13,779	13,598	13,524	13,824	16,955	18,307	19,363	22,470	23,349
Hospital & health support	81,097	77,603	72,849	67,172	67,209	65,614	62,330	60,397	60,388	60,030
Management	420	381	379	342	555	620	700	800	1,314	1,091
Medical	15,554	15,593	14,875	14,256	14,759	14,980	13,752	14,219	14,659	16,006
Nursing	111,102	105,757	101,982	99,473	99,618	100,079	101,090	103,387	107,762	113,153
TOTAL	**250,635**	**240,548**	**230,871**	**220,651**	**223,594**	**225,501**	**222,801**	**227,101**	**238,645**	**251,048**

Source: Adapted from NDoH Review of National and Provincial Human Resource Public Health Expenditure 2008

Unfortunately, linked to this stagnation in production, were growing "push" factors from the public sector and "pull" factors into the private sector caused by deteriorating conditions of service that I will discuss in the next section.[xxxviii]

There is now recognition that health care worker shortages blight health service delivery. But despite this the targets that are set out in the 2012 HRH Strategy to increase the number of health workers in 8 'major categories' by 2025 and to increase personnel spending by 3-5% per annum is not accompanied by a corresponding budgetary commitment. To the contrary, the HRH plan baldly states that increases in health spending are unlikely and that:

> "the health sector must demonstrate allocational and operational efficiency (optimal spending between different categories of health workers and productivity of the existing workforce) in the management of human resources before additional spending can be motivated."[xxxix]

This approach to budgeting will be self-defeating. Under-investment in crucial categories that are not even listed in the HRH plan, such as community care workers whose 'stipends' range from R500 to R1600 per month[xl], is adding to the burden of disease that must be managed by clinics and hospitals and causes poor outcomes of a number of priority health programmes. Unfortunately, even if NHI pooled all the public and private health workers in SA the number would be insufficient to meet health needs. Current patterns of inequality would continue.

3. Failure to Respect or Fulfill the Right to Dignity of health workers

I have pointed out that health is a human system. Good health care relies on a contract between the state and the health care worker. However, shortages combined with appalling conditions of service have demoralized and demotivated large parts of the health workforce. In particular health workers complain of:

- Managing a huge increase in the burden of disease, caused by HIV and TB primarily.
- Their increased vulnerability to occupational infection.

- Their lack of involvement or consultation in health planning.
- The weakness of statutory bodies, medical associations and trade unions to consistently advocate for health or health workers.

There is much anecdotal information about the increase in morbidity and mortality caused by HIV and TB in HCWs. But surprisingly there is very little monitoring or collation of information about levels of occupational infection. According to one health worker union, HOSPERSA, occupational infections are under-reported and poorly managed. DENOSA is the largest nurses' union. Its Project's Co-ordinator, Kedibone Mdolo, states that:

> "Many health care workers are infected with both susceptible TB and MDR-TB; but the difficult part is to find statistics from department of health. I have been struggling to get this information as DENOSA needs it to factually debate the issue of compensation and emphasize the crucial need to adhere to Infection Control measures by the employer… the department do have the information but they don't want to share it. ..I wrote letters to all provinces (9) requesting this information but only Mpumalanga responded positively. I even went personally to NDoH Monitoring & Evaluation department, they couldn't assist...."[xli]

The 1994 National Health Plan accepted that involvement of health workers in health planning is essential to successful implementation of PHC.[xlii] Recognizing this the NHA promised a system of "co-operative governance and management … decentralized management" and "to promote a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans."[xliii]

The NHA also mandated the establishment of Consultative Health Forums at National, Provincial and District level, as well as Hospital Boards and Clinic Committees – all involving health workers. But very few of these exist.
The result is that more and more priority health programmes are being piled on a diminishing and demoralised workforce, with little monitoring of quality. There is growing evidence of declining outcomes in these programmes, including now with the AIDS treatment programme.[xliv]

Finally, many HCWs complain that bodies like the Health Professions Council of SA (HPCSA) and the South African Nursing Council (SANC) fail to perform their statutory mandates to represent the interests of the professions.[xlv]

Conclusion: Social justice in health requires social justice for health workers

The NDoH recognizes that "the biggest threat to NHI is the unequal distribution of health professionals between the private and public sector, and between urban and rural areas". It promises that the "NHI Fund will enter into contracts with public and private hospitals, specialists, public clinics and private GP practices to deliver health care services free." [xlvi] In addition it reports that the WHO recommended Workload Indicator of Staffing Needs (WISN) system is now being used to more accurately identify HR shortages.[xlvii]

However this paper has shown that the health worker shortages and demoralization are frequently much deeper than admitted. It is more that just about numbers. It is also about the quality of conditions and support experienced by front-line workers.

Ironically, part of the problem is planning. We have a plethora of plans but little prioritization, monitoring or accountability. In additional plans are often so complex that those responsible for their implementation have no idea where to start. Chapter 10 of the National Development Plan (NDP), for example, is titled 'Promoting Health'. It lists 9 goals towards its 2030 vision for heath; goals 7 and 9 relate to the health workforce and are themselves multi-pronged.[xlviii] It also has 9 priorities, but only priority 6 relates to the workforce.

But unfortunately, for reasons I have tried to argue in this paper, the NDP's catch-all of goals and priorities fails to recognize that the first priority has to be to resolve the crisis that faces the health workforce. And, as with other plans, the NDP suffers fatally from being neither costed, budgeted for or having a Grootboom-compliant implementation plan setting out how and when its priorities will be effected.

My conclusion is that much of our public health policy on the health workforce is unconstitutional because it is failing to utilize all the 'legislative and other measures' permissible by the government or to properly calculate or allocate 'available resources' to health.

It is therefore not compliant with the approach required by the Constitutional Court when it comes to the realization of socio-economic rights.

The result is that whilst the Minister of Health may justifiably claim, in his Health Budget Vote Speech on 23 July 2014, that the number of health programmes and facilities is expanding, access to quality health care (measured fundamentally through equitable access to health care workers) is regressing.

This is an unlawful state.

To remedy this situation requires that we demand a return to the health revolution that was promised in 1994 National Health Plan. In view of the fact that current staff shortages cannot meet the legal obligation to realize access to health care services the government has a legal obligation to revisit and revise the Medium Term Expenditure Framework (MTEF) for health, in order to ensure sufficient finances are made available for expanding, retraining and supporting the health workforce. But in the short term several measures would bring immediate improvements, including:

i. Establishing the consultative and governance structures required by the National Health Act, so that health workers are actively involved in health monitoring and planning;

ii. The finalization and swift implementation of key policies whose delay is causing distress in the health system, particularly policies regarding community health care workers and Clinical Associates;

There are many measures and best practices locally and internationally that could be used to radically and quickly improve the situation. But realising the right to health requires political will from across government, not just the Minister responsible. Finally, I would argue that a new civil society alliance for health worker rights and employment must be created that unites health unions, health activists and academia and which focuses demands on health worker employment and conditions.

[i] I would like to acknowledge the invaluable assistance with information and opinions of the following persons in the research and writing of this paper, Fazeela Feyers (HOSPERSA), Thembeka Gwagwa (DENOSA), Kedibone Mdolo (DENOSA), Adila Hassim, Saul Kornik, Leslie London, Marije Versteeg-Mojanaga, Janneke Saltner, Umunyana Rugege.

[ii] ANC, *A National Health Plan for South Africa*, May 1994, available at: http://whqlibdoc.who.int/publications/1994/0958386714.pdf

[iii] Under the demand that 'There shall be Houses, Security and Comfort' the Freedom Charter proclaimed that in a free South Africa a "preventative health system shall be run by the state" and that "free medical care and hospitalization shall be provided to all".

[iv] The RDP promised: "The government will develop a national health system offering affordable health care. The focus will be on primary health care to prevent disease and promote health, as well as to cure illness."

[v] http://www.who.int/publications/almaata_declaration_en.pdf

[vi] ANC, *National Health Plan*, p 60.

[vii] See: H Coovadia et al, The Health and Health System of South Africa: historical routes of the current public health challenges, *The Lancet*, Vol 374, September 5 2009.

[viii] See: A Digby, *Diversity and Division in Medicine: Health Care in South Africa from the 1800s*, Peter Lang, 2006; K Jochelson, *The Colour of Disease: Syphilis and Racism in South Africa, 1880-1950*, Palgrave Macmillan, 2001; J McCulloch, *South Africa's Gold Mines and the Politics of Silicosis*, Jacana, 2013. Digby quotes research by Jochelson showing how doctors' awareness of syphilis developed during the 1880s as migrant labour moved to Kimberley and the diamond mines. In a relatively short time up to one third of the population of the Northern Cape were affected. Then, as a result of the growth of migrant labour, syphilis spread to Pondoland in the 1920s. Jan Smuts infamously said: "The Africans of this country are becoming rotten with disease and a menace to civilization." Government's racist response included the Contagious Diseases Prevention Act of 1885 where 'coloureds' and Africans were locked up in hope to prevent spread to whites. By contrast the 1919 Public Health Act gave whites voluntary free treatment in municipal clinics.

[ix] See: D Harrison, The National Health Services Commission, 1942-1944 – its Origins and Outcomes, *South African Medical Journal*, 33, Sept 1993.

[x] L Reynolds, Health for All? Towards a National Health Service in South Africa, in *The New South African Review 1, Development or Decline*, Wits University Press, 2010.

[xi] L Baldwin-Ragavan, J de Gruchy & L London, *An Ambulance of the Wrong Colour: Health professionals, human rights and ethics in South Africa*, UCT Press, 1999, p 173.

[xii] A Hassim, M Heywood, J Berger, *Health and Democracy, A Guide to Human Rights, Health Law and Policy in Post-Apartheid South Africa,* SiberInk, 2007, p 13.

[xiii] Notice 667 of 1997.

[xiv] The full recommendations of the TRC in relation to health are set out in *An Ambulance of the Wrong Colour*, pp 215-221.

[xv] Constitution of the Republic of South Africa, 1996, section 27.

[xvi] Constitution, section 28(1) (c).

[xvii] Note on other rights and the legislative intent evident in the difference between the interim and final constitutions.
[xviii] World Health Organisation, *Working Together for Health, World Health Report, 2006*; also, S Anand, T Barnighausen, Human Resources and Health Outcomes: Cross Country Econometric Study, *The Lancet*, 364, October 30, 2004: "Findings: Density of human resources for health is significant in accounting for maternal mortality rate, infant mortality rate and under five mortality rate".
[xix] U Lehmann, D Sanders, Human Resource Development, *South African Health Review 2002*, Health Systems Trust, 2002.
[xx] National Department of Health et al, *National Health Facilities Baseline Audit – National Summary Report 2012*, available at: http://www.hst.org.za/sites/default/files/NHFA_webready_0.pdf
[xxi] According to the NDoH the objectives for the NHI Pilots are:

- Pilots will focus on the most vulnerable sections of society across the country
- Reduce high maternal and child mortality through district-district based health interventions
- Strengthen the performance of the public health system in readiness for the full roll-out of NHI
- Strengthen the functioning of the district health system
- To assess whether the health service package, the PHC teams and a strengthened referral system will improve access to quality health services particularly in the rural and previously disadvantaged areas of the country
- To assess the feasibility, acceptability, effectiveness and affordability of innovative ways of engaging private sector resources for public purpose
- To examine the extent to which communities are protected from financial risks of accessing needed care by introducing a district mechanism of funding for health services

[xxii] GP Contracting Under National Health Insurance, presentation to TAC by R Morewane, Chief Director, NDOH, (available from SECTION27 on request).
[xxiii] An August 2014 article by the health news service Health-e, bears sad testimony to what is happening in the Gert Sibande district of Mpumalanga, available at: http://www.health-e.org.za/2014/08/22/nhi-pilot-district-also-shows-signs-collapse/
See also: MP Matsoso and B Fryatt, *National Health Insurance: The first 18 months*, The National Department of Health, 2012, available at: http://reference.sabinet.co.za/webx/access/electronic_journals/healthr/healthr_2012_2013_a4.pdf
[xxiv] The interim (1993) Constitution did not contain socio-economic rights and health was only referred to in relation to the rights of children and the environment.
[xxv] *President of the Republic of South Africa v Grootboom*, 2001 (1) SA 46 (CC). The duties this judgment created were set out in detail by the AIDS Law Project in a submission made to the NDoH in 2005 on the Draft Strategic Framework for the Human Resources for Health Plan. All the recommendations were overlooked.
[xxvi] These duties were summarized as follows in a submission made by Adila Hassim and Jonathan Berger to the NDoH in September 2005:

- The plan must be comprehensive and co-ordinated, with a clear allocation of tasks and responsibilities at all levels of government.
- The plan must identify (or call for) a funding mechanism that considers the quantifiable gap in the existing capacity of HRH and the health care needs of the population, and is able to deliver on the stated targets.
- "[L]egal, administrative, operational and financial hurdles should be examined, and where possible, lowered over time."
- The plan must be implemented "by taking all reasonable steps that are necessary to initiate and sustain it" and "with due regard to the urgency of the situations it is intended to address."
- The plan must set out how its implementation is to be measured.

In addition to these essential aspects, the relevant case law also identifies the following key requirements of a constitutionally defensible (reasonable) plan:

- It must be capable of facilitating the realization of the right of access to health care services (it must be able to achieve its aim);
- It must be balanced and flexible, making provision for short, medium and long terms needs, as well as including a component that responds to the urgent needs of those in desperate situations;
- Implementation of the plan must be expeditious and efficient, be done in a transparent manner; and
- In order for the optimal implementation of the plan, its contents must be made known to all stakeholders, through "proper communication, especially by government".

[xxvii] See: A Hassim, The Cost of Rights: Is there a Legal Right to Transparent and Efficient Budgeting, *Section27 Review, 2010-2011* where she quotes two important judgments on budgetary duties:

- "It is not enough to make a bald assertion that there is not enough money to fund a plan's activities; the details of the precise nature of the resource constraints must be provided by government (Metrorail) and
- "It is not good enough for the (relevant organ of state) to state that it has not budgeted for something, if indeed it should have planned and budgeted for it in the fulfillment of its obligations." (Blue Moonlight)

[xxviii] M Matsoso, Preamble in National Department of Health, *HRH SA, Human Resources for Health South Africa, HRH Strategy for the Health Sector, 2012/13 – 2016/17*, available at: http://www.ruralrehab.co.za/uploads/3/0/9/0/3090989/human_resources_for_health_doc.pdf

[xxix] By 2003 this policy was later extended to nurses and other health professionals. For an analysis of some of the teething problems of this policy and recommendations on how to overcome them see S Reid, Community Service for Health Professionals, *SA Health Review 2002,* Health Systems Trust.

[xxx] *HRH SA*.

[xxxi] *HRH SA*, p 27.

[xxxii] Rural Health Advocacy Project, Rural Health Update 1, *The Role of Clinical Associates*. See also www.clinicalassociates.co.za. Also, e-mail correspondence with Mark Heywood from Edwin Leballo, chairperson of the Professional Association of Clinical Associates of South Africa (PACASA), August 12 2014 (on file).

[xxxiii] See: D Eagar, *Health Care Financing Reform in SA: Equity, Social Justice and the NHI*, Budget Justice 5.

[xxxiv] See: Wildschut, A and Mgqolozana, T "Nurses" in Erasmus, J and Breier, M (eds), *Skills Shortages in South Africa: Cases studies of Key Professions* (HSRC Press: 2009).

Table: Output of all nursing courses, every 4 years between 1997 and 2006:

	4-year programme: South African universities		4-year programme: South African nursing colleges		Nurses				Auxiliaries				Total	
					Public institutions		Private institutions		Public institutions		Private institutions			
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
1997	387	7	2 295	40	881	15	188	3	1 442	25	575	10	5 768	100
2000	408	7	2 086	35	1 217	21	702	12	271	5	1 238	21	5 922	100
2003	453	5	1 108	13	1 352	16	956	12	522	6	3 868	47	8 259	100
2006	534	4	1 493	12	1 442	12	3 374	28	1 166	10	4 256	35	12 265	100
Total	4 211	5	15 975	19	13 205	16	14 696	18	7 462	9	27 059	33	82 608	100
Growth (%)	38		−35		64		1 695		−19		640		113	
Average annual growth (%)	4		−5		6		38		−2		25		9	
Average output (N)	421		1 598		1 321		1 270		746		2 706		8 261	

[xxxv] According to Coovadia *et al,* the closure of many nursing colleges in the late 1990s led to a decrease from 149 registered nurses per 100,000 in 1998 to 110 per 100,000 in 2007. For detailed information and analysis on current and projected shortages of key heath care personnel see Econex, Health Reform Note 8, *The Human Resource Supply Constraint: The Case of Doctors*, November 2010; Health Reform Note 9, *The Human Resource Supply Constraint: The Case of Nurses*, December, 2010. Also, Rural Health Advocacy Project, *Rural Health Fact Sheet*, November 2013.

[xxxvi] See correspondence with Saul Kornik, 15 August 2014, Director African Health Placements (AHP); also Adam Habib, Vice Chancellor Wits University, who helpfully provided a table indicating registration numbers for intake of medical students at Wits University between 2009 and 2014 (on file).

[xxxvii] *HRH SA*, p 25.

[xxxviii] Valuable research of the 'push factors' was conducted by the South African Medical Association (SAMA) in 2003 and a 'retention survey' is currently being undertaken by African Health Placements. Correspondence with Saul Kornik, 6 & 8 August 2014 (on file).

[xxxix] *HRH SA*, p 22. The plan further states that: "the percentage of GDP (or even the public budget) spent on human resources for health may be increased, but this implies one or more of the following:

- An increase in health workforce financing as a share of GDP;
- Revenue generation by the public health sector;

- A shift in public spending towards health;
- A shift in public health spending towards human resources for health;
- Additional private sector financing going towards human resources for health."

In other words these are political choices.

[xl] It is estimated that there are 73,000 CHWs. NDoH, *Community Health Worker Audit Report, 2011*, unpublished but available from SECTION27 on request.

[xli] E-mail to Mark Heywood from Kedibone Mdolo, 13 August 2014. Official statistics provided to DENOSA for 2012 from the Uthungulu district in KwaZulu Natal revealed 66 nurses diagnosed with TB and 3 with MDR TB (on file).

[xlii] According to the White Paper "it is essential to obtain the active participation and involvement of all sectors ... in health and health-related activities".

[xliii] The National Health Act (61 of 2003), Preamble.

[xliv] Some of the major programmes that have been launched in the last decade include the ARV treatment programme, NIMART, the Integrated Schools Health Programme, the HCT testing programme, HPV vaccination of school girls, Medical Male Circumcision, the National Family Planning Campaign, MomConnect and a huge plan to screen 1,250,000 prisoners, mineworkers and peri-mining communities for TB.

[xlv] The Nursing Act (33 of 2005) say that the SANC has amongst its objects to:

- "promote the provision of nursing services to the inhabitants of the Republic that complies with universal norms and values."
- "establish, improve, control conditions, standards and quality of nursing education and training .."

The Health Professions Act (29 of 2007) includes among the objects of the HPCSA:

- "to advise the Minister on any matter falling within the scope of this Act in order to support the universal norms and values of health professions, with greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement;
- "to communicate with the Minister information of public importance acquired by the Council in the course of the performance of its functions..
- "to uphold and maintain professional and ethical standards within the health profession."

There is little evidence that either body fulfills these functions.

[xlvi] National Department of Health, *National Health Insurance, Healthcare for All South Africans*, undated (circa 2012).

[xlvii] Norms for staffing : patient/population ratios remain outstanding. The WISN method is described by the WHO as a calculation "based on a health worker's workload, with activity (time) standards applied for each workload component. The method: determines how many health workers of a particular type are required to cope with the workload of a given health facility; assesses the workload pressure of the health workers in that facility." It might be argued that it is late in the day to be conducting this exercise.

See http://www.who.int/hrh/resources/wisn_user_manual/en/

[xlviii] National Planning Commission, *The National Development Plan - 2030*, http://www.npconline.co.za/MediaLib/Downloads/Downloads/NDP%202030%20-%20Our%20future%20-%20make%20it%20work.pdf