KEYNOTE ADDRESS
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Good morning South Africa. Mr President allow me to ride on the protocol that you have been establishing the last two days and I thank you for this invitation. I am from Kenya and that should be obvious from my height. So, we run long, you South Africans run short.

I am reminded, and I keep pinching myself since I arrived two days ago, that I am in the land of great people, Mandela, Biko. I keep reminding myself that I am in the land that I read about in Cry the Beloved Country, and I still remember vividly the description of a bird of the veld, called the Titihoya. Do you know that bird? There is a bird of the veld called the Titihoya, that is described in Cry the Beloved Country as having a forlorn cry, but I am reminded too that because of environmental changes that bird is fast disappearing, so its forlorn cry is no longer heard as loudly, but another cry is replacing it, of women and children, because they die, they do not see the fifth birthday.

I am reminded too that health is a human right and that when people fight for human rights as long as you South Africans have done you treat health differently from all of us, so when I sit here for two days and I hear the arguments that are coming out on your NHI I wonder what happened to your quest for human rights, but I am also reminded yesterday in your slides sir that nobody takes medicine on behalf of another person, you take medicine for yourself. So whatever South Africa does in this area of health must be purely South African, it must be yours and nobody else's.

We are in Africa faced by a triple jeopardy: ignorance, disease and poverty. This is something that is not South African, it is African, and it is for this reason that our elders fought so much for the independent that we now enjoy. You will be surprised historically that in health the WHO African Region was actually established in 1956, WHO itself was established in the forties after the war. And that the first members of the African region WHO were South Africa, Rhodesia, I am glad Zimbabweans are

here because there was that Rhodesia, the other three members were Great Britain, Belgium and France. Those were the members of WHO Africa Region. A few months later they were joined by Ghana because Kwame Nkrumah had just gotten Ghana towards independence. Nigeria was not there, Kenya was not there, because we did not exist, but you people existed, you can argue on who sat there, but South Africa was there.

Interesting the first director of the African Region was a Dutch Army doctor and it is not until the sixties that you first find the first black person heading the African Region of WHO. The headquarters were established in Congo, Brazzaville. Many of you do not even know where Brazzaville is, and many people ask why it was there, because later on when it became too unstable they moved their headquarters temporarily to Harare, but it went to Brazzaville because Brazzaville was a French colony, and the French offered the headquarters to be built in one of their colonies, that is why it was there. There is a reason why things happen and that is why I am starting this from where I am, because when you do not know the context then you start climbing the tree from the top, but you do not know the routes, and of the routes is this, that you as you decide on your fate your history ...[indistinct] will be part of your decision, but let it not blind you to what you can do and must do, because there are decisions as I heard yesterday that are detrimental but can be defended by where you come from.

I will give you one, if you look at the medical schools that supply the bigger number of graduates in the United States of America, of the top five three are South African, Wits, Pretoria and Cape Town. The only one that beats you is Ibadan in Nigeria. There is a reason why you supply more doctors to America than any other medical schools in this Continent and you continue doing so, but when I asked yesterday why you have only nine or so medical schools and that between Medunsa and the next one it took forty years before you built another one I was told in a whisper that it is because you do not want the private sector to build any medical schools, because when they do it will only admit white students, so you are stopping the development of medical schools because you are afraid and if the history of Africa is that since independence in the past forty years or sixty years of our independence, Africa was building one medical school every fifteen years, but our population was doubling every fifteen years, so we were doing nothing in terms of improving the ratio, but that – the next 20 years, the

last 20 years we have improved on that not because our governments are building more, because we are open to the private sector to put them up there, so that our kids can go to the schools, because there is an honour in our kids who matriculate, going to India and Pakistan to medical schools which are private, but we do not allow them to train here in private ones because we are afraid that only the rich will go there.

Regulation can make it possible for the poor to go to those schools too, so why can we not use regulation to say but three quarters must be from Limpopo, or do not build in Johannesburg, go and build in the corner of Mpumalanga. This is regulation being used by us positively to move forward.

Addressing you at a time when you seem to feel from the discussion that you are struggling to offer universal health coverage, but I want to tell you that the struggle for universal coverage is not starting now, it has been there all along, before Mandela too over we had in WHO something called Health for All by the Year 2000. I know that things changed here, but before things changed here it was Health for All by the Year 2000, and I keep reminding people that Health for All means universal coverage, so the year 2000 arrived and we are not there, we did not provide it to everybody.

So, the International Community came up with a new slogan called the Millennium Development Goals and it was by 2015. 2015 came and we did not achieve those goals. The only two countries in Africa that achieved their MDGs in health were Rwanda and you do not even know this country, Eritrea.

Those are not two countries that are known for their riches, if anything they are known for their poverty, but that should not surprise you because if you look at the map of Africa the richest part of Africa in natural resources are also the places where the health indicators are poorest. So, the riches that are six feet deep never percolate to affect the lives of people who are on the ground.

Go to DRC Congo, go to Sierra Leone, go to Guinea, countries that are so rich that you do not even have to dig to get diamond this size. The only country that is rich in natural resources that has reasonable health indicators is yours, but you have another big problem, that you also have the biggest disparity, so your health indicators are not driven deeply by the wellbeing of your poorest, because the wellbeing of your poorest is no different from the wellbeing of the poorest in Kinshasa or in Nairobi or in Legos.

Khayelitsha is the same as Mathari, slums in Nairobi where I come from. So, when we start talking about universal coverage and I sit in the front row here and I hear that there is a murmur in the background, there is noise that when we cover all these people it will make us wait longer for our health care, waiting time will increase. When I hear that your fear is that when you do it your doctors will migrate, and you will lose jobs and I go back and I say but you are already supplying more doctors to America than anybody else, so why is migration suddenly going to be an issue, now when you start covering poor people, but it was not when that was not happening. It worries me. It worries me because when we did not reach the MDGs in 2015 the International community does what it does best, they created yet another set of things and they called them the SDGs. SDGs are not their friend from the MGDs the only thing that the MGD was for the menial but now it is sustainable development goals and they gave us 2030. Colleagues 2030 is ten years from today, so if 2030 is ten years from today and you have not even agreed on your National Health Insurance and you want to debate for another five years, then 2030 will come and we had better look for another thing, MGDs, SDGs and do not know what you will call it next time but this time let it be as Swahili wording, not English because if it is done in English it just never happens.

So, when we look at the SDGs we have SDG3 that focuses on health and it does not focus on anything that is big, it is small little things because the health of our people, for it to improve does not require the registration of robots. It does not require an oncologist like me, in fact, it does not even require the doctors, MDs, it requires a lot more of these people that we call nurses and allied health workers. The day we put nurse at the centre of health, then quality will be defined because in my 40 years of practice I have never seen a hospital, a surgical operation, a post-operative care management that a patient walks out in appraisal if nothing is not done properly.

It does not matter how good your stitching is and yet in all the meetings that we go to, in all the WHO things, it is about this ratio of the physician to the public. We have to think because this medicine that we must take we must take it for ourselves, not for anybody else, and I want to predict one thing, because it has happened to every country that I have worked in and I have worked in each and every African country that as you go through these parliamentary debates you will start doing the trips to go to London to how energies works.

You will go to Brazil, you will go to Columbia, you will be in Korea, you will be in Thailand, you will be everywhere, but you know they do not have Khayelitsha in London. And if you who is born in Khayelitsha has to go to London to find out to cover your people then we be damned. There has to be a level of confidence in us who are born here, trained here, breastfed here to know how to make ourselves not have diarrhea.

This is not from science, people are landed on the moon and come back, with technologies which, looking at it 50 years later you cannot believe that those guys went to the moon, but here we are with technologies that can make everybody stay alive and healthy today and we are not even using it. It is here on the palm of your hand for as we are born in countries that are less fortunate than you South Africans, 40 years ago when I finished and went for internship, when you are sent to the district, you did not go to the district there because the hospital was well equipped, and it had everything. You are the one to build that hospital, there was none but you made a difference because you went there to make a difference because I tell you, you can now have all the equipment in the world but if the will to do things I have never seen a theatre that operates on its own. So the SGDs is about something else that one the SGDs were put there this SGD3 was still floating there, because the question was if we did not get it under MDG how come you will get it under MGDs and that is why the clever thinkers in those international institutions, one of which I work for, decided that let us call it UHC and the moment our leaders go to New Your or Geneva and they are given these documents and they are treated to the kind of reception that you treated as to yesterday, they come back with this document and say that we are now doing UHC and they come and let everybody think that in 2030 you will be okay because you are now doing UHC. But the question that we have to ask ourselves is that what

is this UHC, is it anything new or is it doing the same things we are doing before. Is it doing more, doing better or doing what.

Three weeks ago, I was part of a panel in Kampala of 30 so-called eminent African health thinkers. There were 30 of us and we put to ourselves one question, how come we just never delivered to our people and if you were given a bag of Rands and an opportunity for good governance, which one would you take that would make it possible for us to reach UHC by 2030?

We debated for two days and unanimously agreed that we will leave the bag of Rands, we will take governance. That the governance in this sector is our biggest problem and our biggest challenge. If we do not do it well, you can pour all the money that you want into it, but you are not going to get anywhere, and I want to bring that in. in the context of UHC because UHC is about three pillars. Pillar number one is access, pillar number two is quality, pillar number three if affordability, those three access, physical geographical access.

Most of South Africa has attained what the WHO call as reasonable access within five kilometers of a health facility. That is not your problem. The question is what happens when you go to that health facility. Do you really get care? Do you get what is promised over there? Most of Africa is there too, we are within five kilometers of facility, but facts have it that right now our health facilities work at between 20 and 40% of efficiency. If they were a factory they would close, totally inefficient, staff still time, medicines are stolen, infrastructure is stolen and never maintained.

So, the idea that you have a new health centre built near you for the African mother and child that does not mean that, that life is now going to be easier or better for you and yet one of the biggest investments that we continue doing in Africa is building. We build new one and it is good because you name it after somebody and there is a big ceremony of opening, after the opening ceremony none – I have travelled through Africa and you should see the plaques that are there, they are brass waiting to be

cleaned, so nonchalance opening this thing in 1983 but go inside and even a spider cannot survive.

This is something that we have to start asking ourselves, what does access mean, in UHC terms access is that there is a promissory that there is a package of care that you will be able to get in the hands of somebody with appropriate qualification to give it. That person could be a nurse because they give most of it, it could be immunization only, it could be hygiene, it could be dressing the wound, that is it. Just do that, imagine if we raised that efficiency from current 20% and doubled it, from current 40% and doubled it. Imagine, just imagine what that would do to our people. The second one is quality our problem with quality is that there is a lot of myth around it that quality is expensive. If it is try poor quality, it is more expensive.

Two, is that quality is good in private sector it is therefore for the rich, no absolutely none. That you cannot get quality in a rural area you must come to an urban area, no. That you only get quality when you have people with three medial degrees, no. That I not it, being able to define quality based on the standards that HPCSA must make sure or adhered to is the key thing. Unfortunately, we have a problem with the regulation in the continent that in most countries, the regulator is the most underfunded part of the health sector, they do not even have a vehicle that will take them to inspect. Some of them employ retired policemen as inspectors, it is fact in health sector is not about policing it is a different game. The date, most of them are not digital yet in the 21st Century. So, this is not taken seriously, and I believe that for so long as the regulator is not serious, we are not serious about quality. Let us take the role of the regulator for one, is a protector, protector of the public, protector of the health professional and the protector of the profession, three areas. Do we believe in, where you sit that your regulator is your protector? If you do not then you have a problem, do you believe that your protector protects the public, do we believe that the protector protects the profession because when the answer is not an obvious, yes, yes, yes in all of them then we have work to do in those area and that work must be done by nobody else but yourself. For the same reason that has been said here, that we are one of the profession areas that ought to regulate. So, you have no reason to go and blame anybody but yourselves. You cannot auto regulate; the option is let somebody come and regulate you and you can be sure there is a lot of people who would want

to come and regulate you and they were taking over if you do not allow it to happen. So that becomes a problem for us but in the 21st Century, there is something else that we have to deal with, that unlike the other centuries we are now in the fourth industrial regulation, so IT and technology is at a totally different place. Two is that the role of the private sector has to be acknowledged with more acceptance than resistance because it is there and that is why I believe that the future of health in this continent is both public and private.

In 2010 five years into the conclusion of the MGDs my team at the bank did a study did a study to find out why was Africa not moving towards achieving the MGDs and one of the most significant findings was that until Africa learns how to utilize the resources lying in the non-state area it will not reach the MGDs, government alone cannot do it but private sector alone also cannot do it so in the spectrum in things that must happen in health, there are things on this side that only government can do. There are things on this end that only the private sector can do must most things here in the middle takes both of them to do. You do not want government to start manufacturing vaccines or doing all that research, but you do not want private sector setting the rules on this side, but they come together here in the middle where the bulk of the things are.

Our problem in Africa has been that because of the way health care – modern healthcare came to our countries through the missionary, we still believe that it is the missionary and the government. The way private sectors come to us through traders we still believe that the private sector is a trader and nothing else. So, in every country that I go to, the civil war that exists between the public and the private sector has made it impossible for our people to enjoy the benefits of working together. Unfortunately, it is even bigger here in South Africa than everywhere else because you have an entrenched strong private sector and you have a new government that had come in from the apartheid era with all the baggage that is in it and the battlefield now is the health sector.

May I remind you, ladies and gentlemen that this sector is beginning to be the sector that makes people win democratic elections. The last elections in Ghana who had decided on which party was going to bring the fruits of social health insurance. We are reaching that level in the 21st Century where health has become so important to our people that it will start affecting how they vote and what watch it you ANC, watch it ANC, if you do not do this thing well somebody else will come and say that I am going to offer something to our people that you have not offered and you will not be in power again but just look at it this way, that this is happening and the main players are you people gathered here today, you are the regulators, you are the provider. So, in this field, in your own field decisions are being made that is going to move the country

left, right, up or down and yet, you still sit here as spectators and health is no longer a spectator's sport, you cannot afford to be neutral in health.

So, three weeks ago when I was invited to give the keynote address to the Health Funders conference in Cape Town I kept hearing from them, that the problem was not them, the problem was you, the providers. The last two days I come here, I keep hearing that the problem is not you, the problem is the funders.

Imagine that poor woman in Khayelitsha being the fly on the wall listening to you people disagreeing and hoping that something good will come out of these major, major gatherings that you have here, are we really discussing the real issues, are we really focusing on the things that will make a difference. My answer is no, Mr Chairman the reason my answer is no is this, that on the first day that you are here you were reminded that you South Africans are now seeing this thing as a big thing because it is not splitting the family, remember that example. That this CEO driving probably in Mpumalanga gets an accident, the father and mother and then the children are there, and the helicopter comes and picks them and leaves the father and mother, so he is in a dilemma, but who created that dilemma, can he do nothing about that dilemma? Because the reason is that he has a cover that allows a helicopter to pick him up, but his father has nothing that allows a [indistinct] or a wheelbarrow to pick the father. So, suppose he came up with a scheme where, rather than the helicopter it was just an ordinary road ambulance, but he has picked all of them and it took them to the nearest hospital that could take care of all of them. Would he have given too much for the sake of his father? The reason why I say it is because all of you here sitting here have health insurance scheme something that for some reason has mistakenly in Southern Africa been called medical aid, I do not know why you call it medical aid, it is never aid or is it? But this is the only part of Africa where health insurance is called medical aid. There must be something about this medical aid that you are not telling me, what is it aiding, what are you aiding people with when they pay for you to – it is not philanthropy, so let us change the name and call it what it is.

Now I am saying that because in the study that we did there was another finding that in most of our countries the non-state actor and the state actor provide more or less 50/50 of care. Two, in terms of out of pocket expenditure the biggest proportion of

expenditure comes from people's pockets. Either pocket through the tax to the government or pocket to medical aids to take care of them. None of these two funders, government or medical aid creates their money somewhere in heaven it is people's money.

So, the question here is, if these monies come from the same people's pockets, the poor people who are there, how would you use this money to service them. This is the debate that you should be having, and that debate will tell you several things, one, is that the more people you cover with prevention the less people will come in sick and the less you will spend in hospitals, that is common sense.

Two, that if you want to create a market in health the market place becomes more viable the more people in it who can spend, the more people in the market who have money to spend, the bigger the market. So, the more people you cover and give a card, the bigger the market but we have got a historical precedent in Africa, I see it in Nairobi, I see it in Legos that we have refused to see the 85% of people who currently are not covered as a potential market. We see them as a problem but when you are an acute and responsible business person you will know that if these people have a card then they are no longer a problem. They are people who are coming to bring business to you, so your NHI debate is about how to turn 85% of your population into a marketable, bankable population.

I would want to believe that the first people to welcome will be the vendor, the person who has things to sell and what you would be asking is, do I have goods that these people need or are the goods that I have only good for Fifth Avenue and Oxford Street, that is the big question that is here. And what is happening in Africa right now is because our vendors have been unable to answer this, Africans in their thousands are taking air flights to India and I tell you this, the African patient is now running airlines. Go to Nairobi go to Addis Ababa the Ethiopian airlines and Kenya Airlines, the only two viable airlines in Africa because yours is not.
Do not throw me out I will go back on Kenya Airways, so it is okay. The bulk of the business is East West, it is not South North, you guys you are still on South North, that business died long ago. East West 25% of the East West human movement is a sick African. Sit in Addis Ababa bole Airport and you will the coming out on wheelchairs,

come to Nairobi with me and you will see them. They are going to Nigeria they have come from Dakar and they are going to India and back and what India did, it was very simple, they created a new business model where charge a little for more people with higher profits.

You stayed on this colonial system where charge a lot to a few people and remain comfortable in it, you are dying. This business model that you have here is a business model that is making it impossible for Africa to provide UHC for its people. Change it, because it is not about getting less it is getting more but also covering more people.

In 2016 my team did a study in Nigeria and India, to find out what medical tourism does, we found that in that year Nigeria sent 30 000 patients to India at a cost of one billion dollars, not Rands, dollars. East Africa, Kenya, Uganda, Tanzania and Rwanda every year send patients to India for approximately that amount of money, one billion dollars and a lot of them are going in for the non- communicable diseases, most of it is cancer but because most of our cancers are discovered in stages three and four, they are basically going for palliation and they come back happy because they were nursed well but not cured.

So, anybody with a business sense, and I am sure with the intelligence you have more business sense than most people, how come we are not seeing this? How come we are seeing this thing as such a big challenge that we cannot reach? How come it is a challenge at a time when virtually every African now has a cell phone, cell phone and MTN and Vodaphone know them, can reach them with information? That is why in my country, Kenya, we have forgotten how to use cash, everybody sends money on this, so if you can send money on this in the whole country to everybody it means that, number one, there is confidentiality in it, number two, there is trust in it.

So, people now trust this more than they trust the preacher man, more than they trust the doctor and that is why Google is making it because the information that Google puts through this, somebody reads it before they come to you. So, this is not a regulatory issue, it is a behavior issue and we are going to start asking ourselves as people of Africa whether we want to remain with these models that served us in the last century but will not serve us in this century and move out there. I am not seeing

that argument coming out clearly in the cacophony and the noise that you have about NHI, because you must talk about access, you must talk about quality and you must talk about affordability, all of them must be discussed together. It is not just a money issue.

So, in that study there is something else that came out that the private sector in Africa will not play it is potential role until and unless we address three things. One is regulation, make it modern regulation, two human resource and three is access to capital. I dream of a day when we can put our nurses to work in our communities, right now we do not even know where our nurses are. I will tell you, I am right now leading an ECSA, East Central and Southern African region study on nurse labour market and I am getting data from everywhere and it is scary. I will give you an example, in my country Kenya on the registry, nursing registry we have about 90 000 nurses. The government can only account for 20 000 but we are still building more nursing schools.

I do not know what it is in South Africa, but I know in Swadini in the registry there are about 4 000 something nurses but the government can only account for 1 900. So how can a continent this poor train people so well and not know where they are. If we were to complete our nursing study for South Africa we will find that the biggest supplier to nurses, to Holland and Germany and so on will be you guys here. So just like WITS and Pretoria are number one in the US for doctors, you will also be number one on very many other things. So that you will do very, very comfortably, using public resources to train them but when we start discussing how to use public resources to cover Khayelitsha then you cannot solve it. This is where we are, and our problem then comes down to something very, very simple, I was happy yesterday President Letlape to see Absa here because what we are trying to do is to make the Absas of the continent start seeing health as a bankable business area.

That because our government will never be able to employ all of us, the only way which we can remain to work in this sector if we become entrepreneurs and start providing care as groups for the people who trained us.

Imagine if we had a nursepreneur programme in Africa where all our nurses, by the time they leave school if they do not get jobs and go and start a two-roomed clinic that can provide all the basic primary healthcare and they are earning it on their self, there is a small loan that Absa gives, and we teach them how to do business.

It would be solved, one of our biggest problems on our continent at the moment which is the labour relationship at any given time in Africa today, one quarter of the country's nurses and doctors are on strike, in another quarter they are planning to go on a strike. On another quarter they have just come out that strike and in the last quarter nobody knows the difference between when they are on strike and when they are on duty. It is because we believe that it is only government that can employ you, but it does not have jobs, so we now start holding government at ransom. It is the same, same ransom that is now happening in the private sector that when you want to change things, somebody comes and tells you do not change it because jobs will be lost. Jobs cannot be lost in health, health is the only sector that keeps producing jobs even when the economy is at it is lowest because people get even sicker.

We cannot use an argument that when we start covering people a lot of our specialists will move to America, no, let them create the space and let them fill them with a new training programme that allow that training to happen here. Trust becomes the key thing, and I want to finalise this and tell you this, guys all the arguments that we have had on whether UHC is possible or not, the reason why Health for All 2000 did not happen. The MDGs are not happening, SDGs are not happening is because you have failed in upholding the Hippocratic oath that have just been revised here by the chairman. The day you take this thing to heart, you will find that not only will this sector be a comfortable sector for us all to work in and for our children to work in, but it will be a praiseworthy sector for the people that we treat.

In a meeting that I held six months ago with 30 senior nurses in the Eastern Central African Region, in Nairobi, the directors of nursing, the directors of everything, nurses, total cumulative experiences of 1 300 years sitting in one room. I asked them how many of you have a child who has followed your footsteps into nursing? There was silence, then two hands came up, those two, one was an American director of nursing in ...[indistinct] and the other one was a nurse from Zimbabwe. So, I asked them, why

– how come, the senior most nurses you have reached the peak of your profession, none of your kids want to follow. They looked at each other then I heard a whisper somewhere that they saw our pays lip.

That they saw the pay slip of the mother who is director of nursing in a country and they decided this is not a comfort zone for me. It is interesting that when you go to the medical schools in Africa the aforesaid is happening that you find that the sons and daughters of doctors are in the medical schools in even bigger numbers and I do not know it is whether because they see their pays lip or whether it is not the pay slip that makes them survivor, they have another alternative way of survival and they lead a good life. I want to believe, and I know it that it is because we have alternative sources of income, you can do both public and private practice and herein comes the conflict that we have in this profession that is creating the perpetual civil war between the carers that are there, we cannot speak with one voice, between those who are in public and those who are in private and between what we say and what we think.

To a large extent the people whose reputation is being used to fight universal health insurance has been doctors, that they do not want it and in my next visit to South Africa, I hope that it will be a visit, Mr President, that I will sit with South African doctors so that they tell me why they are against people getting cover and I know what I will get because this is what I got in Nigeria, in Ghana and everywhere.

People are not against this, people do not trust the governance of this process and if I was a Minister for Health, God forbid I know nobody will make me one, I would focus on explaining how the new governors will make this thing work for our people because there is no greater dignity for a poor woman and for a poor man that a dignity of having a card that makes you be welcome like a king in a clinic and we must start giving dignity to people who are sick. For far too long have we made people who are sick beggars who come in and are thankful for the few minutes that you give them. This is not a Hippocratic oath this is not what we are trained for and giving dignity, I must say does not mean that it diminishes you neither does it reduce your income, absolutely none.

I want to make a case that actually the income will be higher for everybody and we will be happier. I look back at my 40 years in this profession and I decry those early days when the people who trained us, trained us to be people of good standing of dignity, that is where this trust came from which my brother here is talking about because there is nothing that you can compare with being given the opportunity to get into the confidence and the nakedness of a fellow human being. That is something that money cannot buy and if we believe that it is only money that will make it possible for us to do it then we are wrong.

This sector needs men of character, women of character and people of good standing. The challenge in UHC for the continent is to start counting who are those people in the profession who are of such good standing that they will say it as it is, not because they are being paid, not because of the paycheque, but they are saying the way it is because that is the only way that we can do it. People before you have made sacrifices that are bigger than we are asking you to do because it is not a sacrifice, to be a professional is not a sacrifice but as long as professionalism is peddled, and we cannot come to a meeting like this and talk truthfully because we are afraid that medical aid will exclude you from their list.

Then this is what we have created for us, the elephant in the room is not medical aid, the elephant in the room is you health workers because you are the only people who are trained on public resources to provide, you are the only people who have delegated yourself the responsibility of regulating and you can regulate in a manner that provides for the three things, access, quality and affordability, South Africa wake up, thank you.