EDITORIAL

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Hearts in sight – A pretty picture of collapse and excellence

A surprising number of serious decisions in the history of nations and populations have been firmly based upon generalisations, speculation, popular opinion and unproven theories. It is very much like guessing the weight and height of a patient and then calculating his body surface area to the second decimal, like old perfusionists did, and then basing the required pump flow rates on this calculation. The funny thing is that the patients were mostly fine. So, I trust that most of you will survive the generalisations and opinions expressed in this editorial.

Cardiac medicine, and medicine in general, in South Africa is in many ways going through a transitional period, whatever that means. What is however self-evident is that when one contemplates a country's disease profile it includes the entire population, which in turn includes the state-dependent as well. The state or public sector also controls training facilities and standards by and large. The challenge is to try and understand the direction of and drivers which impact upon this process. It is probably worth asking ourselves, as participants, and from a purely selfish point of view, what do we want ourselves and, in our more altruistic moments, what should we be doing?

South Africa, with our now world famous income gap between rich and poor, is still facing the same "unique" challenges we faced ten years ago. At various meetings over the last decade, well-intentioned, well-designed and focused studies have been presented discussing the changing epidemiology of cardiac disease in South Africa. The potential prevention of a massive wave of cardiovascular disease sweeping our country by timely preventative strategies, the impact of the lack of cardiologists in the public sector, the implications of effectively disinvesting in tertiary training institutions and the seemingly impossible impasse between national health policies and how things pan out at provincial and district levels have all been pointed out and discussed.

In the schizophrenic world in which public sector cardiac practitioners live, the National Health Department regularly declares that, through the National Health Insurance project and other programmes, massive investment in tertiary service is happening, both in terms of resource allocation and quality of management. This is supposedly restoring the once proud academic centres to their former grandeur as centres of excellence and service centres of choice, competing with, if not out-performing, private sector. On the other hand, balancing the scales, is the reality of resource depleted training institutions nationwide in a state of near collapse, underfunded, under-supplied, under-equipped and understaffed (in the majority of cases) as managed by the Provinces. It remains a challenge for employees to constantly switch (at very short notice) from expanding services and developing units of excellence, to closing beds, losing theatre lists and having no access to medicine or disposables.

The private sector, on the other hand, thrives upon the graves of our once mighty training institutions, with no competition and largely unrestrained by regulatory organisations and the stern professors of

yesteryear in a profit driven frenzy, supported by the private hospital groups and funded by the ever innocent and well-meaning funding giants who somehow still manage to generate billions in profits out of generosity. Of course, all these units proclaim to be - you guessed it - units of excellence, serviced by an ever-aging group of cardiac practitioners. As the moratorium on the development of new hospitals, or extra beds in existing ones, is largely in place (except for those lucky few exempt players), the state thus ensures, through legislation, that an undersupply of beds continues to exist in the private sector. This effectively kills any free market incentives to drive prices down and so no real competition exists between hospital groups. It is, however, also noteworthy to mention that the bulk of interventional procedures and surgery at this stage is performed in this sector at competitive costs when compared to international standards.

Like in any other epoch, there are a few people who are really worried about the state of affairs. As elsewhere in the world, they have embarked upon a number of studies and also quote widely from existing literature in support of programmes for the detection of congenital heart disease, the prevention of rheumatic heart disease, echocardiography screening programmes in district and regional hospitals, cross-sectional population studies to demonstrate the requirements for services within populations and support of the development of cost-effective services. These would probably be based on case mix models, matching required expected service delivery demands and facilities.

Essentially, the scientific evidence gathered and quoted concludes that it makes sense to try and prevent disease, to detect it early, refer it to the appropriate service center and then ensure that services are provided by well trained personnel in well-stocked and appropriately equipped facilities, matched to the population served by the specific facility. Real rocket-science; hence the lack of references to support this editorial.

Why then have things not changed in the last ten years? It is really hard to explain and probably, by and large, the result of a lack of political will in both the private and public sector to really affect change. From a cardiac medicine point of view the private sector is surviving, and even thriving, whilst the state is depleted of especially adult cardiologists, under-supplied in paediatric cardiology and is merely ticking along from a cardiac surgery perspective; forcing prolonged training times for surgeons at least. Of course this is a massive threat to the development of cardiac medicine in the future, especially with an ageing cardiac practitioner population in private practice. To date no game-changing programme has come to the fore to address this challenge. The lack of service provision to the most vulnerable part of our population has evoked a stream of media responses, unfortunately not sufficient to curb preventable deaths and suffering. In the case of cardiac medicine, none has ever been as effective as the Treatment Action Campaign for AIDS in producing services.

The recent near collapse of services in some training centres has alerted our community to the vulnerability of our position and maybe we shall now be forced to address cardiac medicine and its future in South Africa. Many of the challenges are the same as in the rest of the developing world.

THE EASINESS OF DIFFICULTY

The world is awash with fix-it books describing the principles of addressing difficult problems in countries, companies and, alas, in medicine. These have been mostly written by well-meaning or successful people, of which an inordinate number seems to reside in business management schools, or by people who have actually built up enormous business empires themselves.

From my decidedly limited exposure to business management it does however seem that a number of things reamain constant. The most important of these constants are leadership and responsibility.

Leadership is expressed through various activities. Most of these successful people agree that one should know what one's market is about (burden of disease), there seems to be agreement that one should know what one is doing at the moment (audit of facilities and services), one should have a very good

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idea of what the actual requirement is (benefit or service package) and how to address the performance gap. All of them measure activity based costing in some format to ensure solvency and/or profitability. They measure outcomes or achievements against set milestones on a regular basis and then introduce remedial, or alternative, plans if there are shortcomings. They all employ the most talented people they can find and rely heavily on expert opinions. They also do things as effectively as possible and are creative in the invention of new services and products to suit an ever-changing environment. They all use economies of scale to drive down prices.

From an entrepreneurial point of view, all these successful people and organisations have a mutually beneficial relationship with their customers, suppliers and funders. They all seem to uphold values that are clearly communicated to all participants in their specific sphere and they also seem to be great sticklers for principles. Most of these businesses impact upon the quality of life of their customers in some way.

Most of these activities are surely possible in cardiac medicine in South Africa. We have had tremendous creativity regarding the development of the funding industry in South Africa, we have an excellent network of private hospitals and providers in the country and so far, by and large, the service providers are of a good quality as well. We also have the largest and best-developed in-hospital cardiac care facilities in the public sector in Africa. The challenge remains the future.

What is clearly required in our environment, or predicament, is leadership. In cardiac medicine, this can either come from the universities and training institutions or our professional societies, advising or participating in government and private sector structures, working towards long-term solutions. There seems to be a unanimous idea regarding what the leadership should do, but we have yet to decide, as a cardiac community, who and where they are. Without a proper mandate, leadership cannot function and thus a mandate is part of the package once the leadership structure has actually been identified. Maybe it is a case of being born great, achieving greatness or having greatness thrusted upon them, but this issue surely needs to be addressed.

THE EMPEROR'S CLOTHES AND ALTERNATIVE FUNDING

It is common knowledge that the public sector is resource-limited or constrained to the point where it cannot conceivably provide everything to everyone all the time within the present funding and cost structures. In order to allow for the expansion of services within the public sector, creative ways of increasing state hospital revenue and co-payments will have to be investigated. It is imperative that alternatives to a single tier NHI system be considered and properly investigated.

It is also important that the use of modern imaging and diagnostic modalities lead to cost effective and evidence-based medicine. The heart team concept is a welcome development and will hopefully contribute to continuing cordial relationships between disciplines, ultimately to the advantage of our patients. I hope that the conference sessions, pertaining to these issues, will have some lasting impact on our practices in South Africa.

I trust that all the delegates to Sun City will enjoy the congress, the sessions on the development of cardiac services and the scientific sessions. Congratulations to all participants whose abstracts were accepted for publication.