

THE TRANSFORMATION OF MEDICAL EDUCATION IN SOUTH AFRICA

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Abstract

This paper examines the policy components of higher education and health that address medical education, within the context of the enormous inequalities in health care in South Africa. The broad intentions of the transformation of higher education and the transformation of the health system as envisaged in the 1990's are revisited, together with a discussion of the intersection of health and human rights as it relates to education. The specific policies that direct medical education, and the mechanisms by which they are enacted and implemented, are then examined. It is concluded that there is a structural disarticulation of purpose and a dilution of the original intent from higher education policy through to educational practice with regard to medical education, to the extent that the transformation agenda is dissipated in the process. Unless these issues are explicitly addressed in the regulations relating to the National Qualifications Framework Act of 2008, which are still in progress, another opportunity will be lost to correct the inequities arising from our collective past.

Keywords

Medical Education
Higher Education Policy
Transformation
Health System

INTRODUCTION

It is becoming clear that there is a growing gap between rich and poor, in health status, access to care, quality of care, and choice, both globally and nationally. The World Health Organization's 2008 World Health Report outlines the increasing disparities between countries in terms of access to services, as well as health outcomes. Tudor Hart (1971) in the United Kingdom coined the phrase "the inverse care law" referring to the observation that the least number of health providers are often found in the areas where they are needed the most, and vice-versa.

"The availability of good medical care tends to vary inversely with the need for the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. "

The Joint Learning Initiative (Chen 2004), an independent network of more than 100 global health leaders who landscaped the field of human resources for health and identified strategies for strengthening workforce development, noted that:

"Nearly all countries have maldistribution, which is worsened by unplanned migration. The urban concentration of workers is a problem everywhere. Improving within-country equity requires attracting health workers to rural and marginal communities—and retaining them. There is also a maldistribution between public and private sectors in many countries. And international equity is worsened by unplanned international migration, with the loss of nurses and doctors crippling health systems in many poor sending countries. "

More recently, the World Health Organization issued guidelines to increase access to health workers in remote and rural areas through improved retention (World Health Organization 2010). They note that:

"approximately one half of the global population lives in rural areas, but these areas are served by only 38% of the total nursing workforce and by less than a quarter of the total physician workforce. "

In line with these inequalities in many countries, the South African situation is complicated by the divide between public and private sector inequities, and its troubled history under apartheid. However the country is in the process of major social transition and "transformation" away from the inherent injustice of the previous regime, towards a more egalitarian and fair society in which citizens are respected and free to exercise their human rights. In all sectors, including the education and the health sectors, this transformation process has been guided and shaped by the majority-elected government, in the form of legislation at many levels to ensure that these goals are realized. "Transformation" in the different sectors has been variously interpreted to include greater access for those to whom it was previously denied, for example to education or health facilities, as well as improved quality, and also the individual freedom to act as a democratic agent in an open society. In the light of these broad principles, this paper aims to review the policy and its implementation regarding the education of medical practitioners, and to analyze it from a critical perspective.

In the context of higher education, the broader societal movement was translated by the National Commission on Higher Education (1996) into three main imperatives: greater access for those previously disadvantaged, better quality of education, and the production of critically engaged citizens for the new democracy. The term "responsiveness" of higher education institutions has been used to denote the need for them to engage with the problems in the broader society, "that of a developing and

modernizing African country in a period of transition from racial discrimination and oppression towards a democratic order with constitutional provisions for justice and equal opportunity".

President Thabo Mbeki (2004), posed the question of whether our universities have sufficiently transformed:

"on the issue of curriculum content which would simultaneously prepare students adequately for the challenges of the world of modern technology, science and commerce while not losing their identity, their history, their culture and their responsibility to their African countries. Are we able to say, without any hesitation, that these centres are not enclaves of our colonial and apartheid past, but have instead embarked on the important path, in the words of Ngugi wa Thiong'o, of decolonising our collective mind?"

In a graduation address at the University of Zululand in 2005, Minister Naledi Pandor (2005), asked what "pedagogy of transformation" would drive the teaching practice of university teachers. She continued:

"Will they offer quality education to all our children or will they perpetuate the moribund philosophy of fundamental pedagogies and remain stuck in the rut of apartheid education ?.... I am hoping for much more from our institutions. I am banking on them to put South Africa first, to place transformation at the heart of the education process."

In the health sector, the White Paper for the Transformation of the Health System in South Africa (Department of Health, 1997) set out the changes that were envisaged, including specific recommendations for the education and training of health professionals. Medical professionalism is primarily focused on the relationship of the individual patient who consults a medical practitioner, and only secondarily with the relationship of the practitioner to the society within which he or she practices. To what extent are health professionals and health professional educators contributing to this national agenda, or are we stuck in a "moribund philosophy" that merely replicates previous injustice and exclusion ? Sixteen years into the new democracy, is Health Science education "transformative", or is it merely "reproductive", replicating the medical model without challenging it? Are we producing critical and engaged doctors, who are advocating for their patients or their community, beyond the consulting room? Doctors who are prepared with the skills and attitudes to see and act through the individual patients who present themselves, into the home and community situation which gave rise to the presenting illness in the first place ? Or to choose to practice in areas of greater need, such as the public service in rural and periurban areas ? If these are some of the challenges of a transformed health system in a fairer and more just society, what are the implications of such an outcome for educational policy, curricular and professional development? The priorities for curriculum revision and accreditation of medical education programmes need to be developed in relation to policy, practice and theory within the South African context.

THEORETICAL CONSIDERATIONS

To assist us in this task at a conceptual level, Boelen (2001) writes from a pragmatic perspective of tensions between quality and equity on the one hand, and between relevance and cost-effectiveness on the other. Equity and relevance are major components of the social responsibility of medical schools to the societies that they serve. Medical schools differ in the extent to which they prioritize one or other of

these aspects, which are related to the others: greater equity for example, is sometimes obtained at the expense of quality, and the more relevant the programme, the more expensive it is.

From the perspective of social philosophy, Barnett (1994) depicts a triangular relationship between knowledge, society and higher education, in which these three elements are in mutual tension. He asserts that modern society tends to favour forms of knowledge of an instrumental and operational kind, as opposed to those leading to broad educational and personal development. He describes this 'operationalism' as one-dimensional, in the sense that higher education is becoming a technical business, producing graduates for the global industrial market. *"The humanities turn to information technology and quantification while programmes directed at the caring professions seek to derive an academic legitimacy by allying themselves to scientific and positivistic forms of knowing. Terms such as insight, understanding, reflection, wisdom and critique are neglected in favour of skill, competence, outcomes, information, technique and flexibility"*. To a certain degree, the student's decision to study medicine represents a commitment to those disadvantaged by illness. But this implicit commitment is undermined by the extremely reductionistic and curative-orientated approach to health care that constitutes the current hegemony in medicine, as well as by the global market context which turns medical care into a commodity that can be bought and sold.

Barnett (1994) also expands on the issues of vocation and vocationalism, in a discussion of the place of skills and competence in our society. He asserts that we have lost something of the value-laden connotations of the word 'vocation', as being honourable and implying commitment, and replaced it with the word 'vocational', which is apparently value-free, in order to serve the interests of corporatism, economy and profit. He contrasts two rival conceptions of competence, one which he terms 'academic competence' referring to discipline-bound cognitive understandings in an intellectual field, and the other 'operational competence', referring to practical abilities to be effective in a pragmatic way in a particular situation.

Samuel (2005) describes professional education as holding these two poles in tension, as they are "internally related" in that the theory and the practice cannot be learned in isolation of one another. He further describes professional knowledge as practical knowledge harnessed to an ethical ideal, which is distinct from academic and technical knowledge, while drawing on both. In the case of health services, the health professional gains certain technical competencies which are used for the benefit of individual patients. But the ethical principles that guide the treatment of the individual must extend to the context in which it is given and received, which in South Africa dictates that certain individuals have access to health care whereas others do not, fulfilling the "inverse care law". The understanding of medical professionalism as inclusive of social justice, is described in American Charter on Medical Professionalism (Brennan 2002) as follows:

Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography, and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession.

Balancing the needs and demands of the individual patient against those of a large community or population in a situation of limited resources, poses specific challenges. Gruen et al. (2004) provide a useful model for the level of engagement of medical practitioners in health issues in the public arena. They identify a number of boundaries and domains of professional responsibility, diagrammatically represented by a number of concentric circles, with the innermost circle being that of individual patient care. Successive levels of responsibility, working outwards from this core obligation, include firstly access to care, then direct socioeconomic influences on health, broad socioeconomic influences, and finally global health influences. They argue that doctors are professionally responsible, beyond individual patient care, for access to care by those who do not have care. In addition there is a professional responsibility for those socioeconomic influences that have a direct impact on the health of their patients. Beyond this level, where these links are less well defined and the feasibility or efficacy of interventions by medical practitioners is less clear, they advocate a more elective approach, depending on the interests and situation of each doctor. Access therefore becomes the key issue. This conceptual model has obvious relevance to medical education, as well as the development of policy in this field of practice and research.

HIGHER EDUCATION TRANSFORMATION

The historical shifts in higher education since the apartheid era have been succinctly captured in a Council on Higher Education (CHE) paper entitled “Higher Education and Social Transformation” (Reddy 2004). Tracing the development of this theme through the National Commission on Higher Education report (NCHE 1996), the White Paper on Higher Education (1997) and the National Plan on Higher Education (2001), the author highlights the tension between a “narrow” concept of higher education, as producing workers for the needs and demands of the economy, as contrasted with the “humanist” emphasis which would have universities produce *“active agents of a democratic society”*. The NCHE proposals were focused on the three principles of participation, responsiveness and governance. It is the second of these, the concept of “responsiveness”, that is most closely aligned to curricular transformation, while recognizing that access to higher education and governance are also vital components of structural transformation. As the NCHE report explains, the idea of responsiveness refers to the need of higher education institutions to engage with problems in the broader society, *“that of a developing and modernizing African country in a period of transition from racial discrimination and oppression towards a democratic order with constitutional provisions for justice and equal opportunity”*. This engagement should be reflected in course content, pedagogy, and programmes. However it would appear that there is as yet no clear approach to a “pedagogy of transformation”, as the Minister noted in her speech, and specifically not in health science education.

The White Paper on Higher Education (1997) identified among others, the following goal for higher education: *“To contribute to the socialization of enlightened, responsible and constructively critical citizens.”* It mentions the need to *“support a democratic ethos and a culture of human rights by educational programmes and practices conducive to critical discourse and creative thinking, cultural tolerance, and a common commitment to a humane, non-racist and non-sexist social order”*.

The White Paper further stressed that higher education must be internally restructured to face the challenge of globalization, in particular, the breaking down of national and institutional boundaries which removes the spatial and geographic barriers to access. This is particularly relevant in the health

sciences, where it is estimated that up to 40% of health science graduates leave the country after their year of obligatory community service (Reid 2003), drawn by the comparatively enormous salaries in the United Kingdom and Middle East, and unrestrained by either local regulations or international boundaries. The 2004 Accra Declaration on the General Agreement on Trade and Services (GATS) and the Internationalization of Higher Education in Africa (Association of African Universities) warns of the threats to higher education in developing countries posed by GATS, and calls on Africa governments and other African role players to exercise caution on further GATS commitments in higher education until a more informed position is arrived at.

The National Plan on Higher Education (Department of Education 2001), outlined the practical steps that needed to be taken in order to reach the aims of the White Paper. However, the tension between the so-called “reproductive” tendency of universities, and the transformation agenda of government, remains. Reddy argues that the universities since 1994 have indirectly contributed to social transformation through the creation of a black elite and a black middle class, which is beginning to stabilize the institutions of democracy. Student activism, however, waned in the late 1990’s, in line with broader civil society activism, which has been sporadic.

Lansink (2002) in a paper entitled “*The More Things Change the More they Stay the Same: Higher Education and the Fallacy of 'Transformative' Politics in South Africa*”, argues that the issues of equity and redress in the National Plan have been eclipsed by the imperatives of the market economy, in which rationalization, mergers, efficiency and managerialism prevail. As a result, she argues that the plan fails to transform and overcome the legacies of apartheid in the education system.

One of the main components of the National Plan concerns the quality of higher education. The CHE has a mandate to promote quality assurance in higher education, audit the quality assurance mechanisms of higher education institutions, and accredit programmes of higher education. The CHE quality assurance framework is based on the following definitions from the previous work of the HEQC:

- Transformation – meaning “the extent to which students develop cognitively during the course of a programme”, enhancing the capabilities of individual learners for personal development, as well as the requirements of social development, and economic and employment growth.
- Fitness for purpose – meaning internal quality assurance in relation to specified mission within a national framework that encompasses differentiation and diversity.
- Fitness of purpose – meaning absolute quality judgements on the basis of pre-defined, generic and standardized criteria based on national goals, priorities and targets.

Fitness of purpose has gained an increasingly important place in this discourse, as we seek to address persistent national imbalances and inequities in health. Although this is the most significant concept from the CHE that needs to be applied to the particular case of medical education, the initial indications are that the new quality framework will be more concerned with fitness for purpose than with fitness of purpose.

Whereas the Council on Higher Education has sought to bridge the gap between the education sector and the labour sector through the South African Qualifications Framework, it has left the professions and the trades somewhat isolated as special cases. In the context of higher education, the transformation imperative is translated by the Council on Higher Education into three main imperatives: greater access for those previously disadvantaged, better quality of education, and the production of critically engaged

citizens for the new democracy. These progressive elements need to be translated into educational programmes that can be measured and monitored through appropriate accreditation procedures, particularly in the education of health professionals.

The National Qualifications Framework Act 67 of 2008, promises to facilitate this process, with objectives inter alia, to (a) accelerate the redress of past unfair discrimination in education, training and employment opportunities, and (b) contribute to the full personal development of each learning and the social and economic development of the nation at large.

The Higher Education Quality Committee (HEQC) since 2007 has included community engagement as one of the criteria to be assessed when it audits institutions. The expectation is that each institution is able to show that: *“quality-related arrangements for community engagement are formalised and integrated with those for teaching and learning, where appropriate, and are adequately resourced and monitored”*

It remains to be seen how these objectives will be translated into policy for medical education, as well as educational practice, since it is still a work in progress (Council on Higher Education 2010)

HEALTH AND HUMAN RIGHTS

No-one gives us rights. We win them in struggle. They exist in our hearts before they exist on paper. Yet intellectual struggle is one of the most important areas of the battle for rights. It is through concepts that we link our dreams to the acts of daily life. (Sachs, 1999)

The attainment of the highest possible level of health is laid down in the World Health Organization (WHO) Constitution as the principal objective of the organization, and the enjoyment of the highest attainable standard of health is cited as one of the fundamental rights of every human being. Health is defined as *‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’*. However, the exact meaning of “well-being” has been the subject of much debate, as has been the issue of access to health services as a right to health. In 1978 the WHO Health for All Strategy explicitly articulated the global commitment to health for all. The Declaration of Alma-Ata proclaimed in its preamble *‘the need to urgent action by the world community to protect and promote the health of all the people of the world’*. But no binding rules have been laid down to start reversing the “inverse care law” described above. The major demand embodied in WHO’s Health for All, namely *“preferential allocations of health resources to the social periphery as an absolute priority”*, has not happened (Tomasevski 1995). It is widely acknowledged that the national government has the responsibility for the health of a country’s population, but how far this responsibility should reach is continuously debated, while national practices vary.

The South African constitution is now held to be one of the most progressive in the world, entrenching basic human rights and civil liberties in law (Constitutional Court of SA 1997). Everyone has the right to have access to:

- a) health care services, including reproductive health care
- b) sufficient food and water

c) social security, including, if they are unable to support themselves and their dependants, social assistance

With regard to health and other social rights, however, there is an important clause which states that *“The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights”*. This allows the state to negotiate individual and collective rights to health services in the light of available resources, but does not guarantee immediate access to all health services by all citizens.

The Human Rights approach to health issues gives us a social and legal framework for addressing the issues of justice, fairness and equality in health. It has a particularly strong resonance in post-apartheid South Africa as a result of the Truth and Reconciliation Commission (TRC) which heard submissions in the health sector that documented atrocious violations of patients’ and health workers’ rights (Baldwin-Ragaven et al, 1999).

“The health sector in South Africa has a particular role to play in the process of national transformation.....As advocates for human rights in health, the authors believe that health professionals are uniquely placed to ensure that social justice, human rights and professional ethics become integral to the transformation agenda.”

However, injustices and inequities persist in more pernicious forms into the new South African democracy and seem to defy political transformation. The TRC recommended that:

“Training in human rights should be a fundamental and integral aspect of all curricula for health professionals. This training should address factors affecting human rights practice, such as knowledge, skills and attitudes and ethical research practices”

So we have a constitutional imperative to ensure dignity, fairness and equity in the health system as far as possible through education that promotes social justice, human rights and ethical behavior by health professionals. A legal perspective however, is not sufficient in itself to induce the degree of change required for real transformation. Changes in the health system itself, as well as in higher education, are the mechanisms by which such transformation will occur.

EDUCATION OF HEALTH PROFESSIONALS

One of the strongest means for retaining health professionals in the country, against the prevailing forces that drive them away from areas of need and out of the country, is in the educational domain, while they are busy with their training and developing their values and attitudes about the world of work ahead of them.

In parallel with the transformation of higher education, plans for the transformation of the health system in South Africa took a similar course using a different set of parameters. The 1997 White Paper for the Transformation of the Health System in South Africa (South African Department of Health 1997) states with regard to the training of health professionals, that curriculae need to be more community oriented, with an emphasis on generalist as opposed to specialist training:

Health sciences curricula should be restructured to reflect community needs more accurately, and teaching should place greater emphasis on community and outcome-based programmes. The fundamentals of a community needs-based health sciences curriculum are primary health care,

social sciences, health promotion, ethics, basic management, community participation, conflict resolution and communication, basic counseling, epidemiology, research methodology and information use, and first aid (emergency care).

International standards, as captured in the Global Minimum Essential Requirements in Medical Education (Institute for International Medical Education 2000), prescribe a number of broad educational outcome-competence domains, one of which is population health and health systems. A specific outcome is stated as “*an understanding of the need for collective responsibility for health promoting interventions which requires partnerships with the population served, and a multidisciplinary approach including the health care professions as well as intersectoral collaboration*”, and another is “*an understanding of the mechanisms that determine equity in access to health care, effectiveness, and quality of care*”. While the intention of these policy documents are clear at an international and national level, their implementation by educational institutions through the various agencies is more complicated than it would first appear.

The Health Professions Council of South Africa (HPCSA) assumes the role of regulating not only the profession, but also medical education. It is governed by the Health Professions Act, No 56 of 1974, in terms of which it is empowered to control the training and registration of health practitioners. Section 16 (3) states that:

The professional board concerned may prescribe such conditions and requirements as it may deem fit subject to which the training in question may be provided.

Despite recommendations of the Health Sciences Working Group (Shear et al 1997) that there be a separation of powers of the HPCSA such that independent bodies be established to accredit professional educational programmes, separate to those that certify practitioners fit for practice, the HPCSA remains in control of this process. A HPCSA sub-committee of the Medical and Dental Board (MDB) on undergraduate education and training is responsible for the accreditation of the eight medical schools in the country on an ongoing basis. In this process, it applies an array of criteria that resemble the accreditation criteria of the Department of Education.

In 2003 the Standards Generating Steering Committee for the MDB of the HPCSA produced a document for SAQA which stipulated the minimum standard for education and training of medical practitioners (Health Professions Council of SA 2003). According to this document, the purpose of the medical qualification is to equip learners with, amongst others:

- Knowledge of and insight into of health care, its promotion and the prevention and management of the pattern of diseases specific to South Africa.
- Ability to serve all the communities of South Africa and to function independently in the community at a primary health care or general practice level.
- The awareness of the health needs of South Africa and the ability to serve communities optimally.

The document also states that “*It is also the task of medical practitioners to act as advocates and watchdogs for the poorest and most marginalised members of our society; to help people identify and cope with problems specific to South Africa.*”

In terms of exit level outcomes, a whole section is devoted to “Population and Health Systems” in line with the Global Minimum Essential Requirements, which includes specific reference to, inter alia:

- 4.2 Interaction between the patient and their physical and social environment.
- 4.3 Graduates should understand their role in protecting and promoting the health of a whole population.
- 4.6 Recognise important life-style, genetic, demographic, environmental, social, economic, psychological, and cultural determinants of health and illness.
- 4.7 The ability to use the required public health skills to conduct a community health "diagnosis", develop an appropriate management plan and evaluation thereof, relevant to disease, injury and accident prevention.
- 4.12 An understanding of the mechanisms that determine equity in access to health care, effectiveness, and quality of care.

The mechanism to implement these standards is through an accreditation process, in terms of which visiting panels of peers appointed by the MDB accredit medical schools on a 5-yearly basis. A significant component of this process is the production of a Self-Assessment Report by the faculty before the visit (Health Professions Council of South Africa 2002).

On examining the minimum standards document in detail, it becomes evident that there is a disjuncture between the criteria and the accreditation process, specifically with regard to the primary health care approach. The detail of the exit-level outcomes relating to population and health systems, is entirely absent in the self-assessment report. Only one of the 89 questions in the self-assessment report explicitly alludes to population-based outcomes, under a section of 11 questions on curriculum design, content and organization. By contrast the section on clinical skills includes 14 specific questions. It would appear that very little of the purpose and none of the explicit exit level outcomes stipulated in the minimum standards document are carried through into the accreditation process.

DISCUSSION

Whereas the education sector in South Africa has embraced a more progressive vision, this has not been systematically extended to health sciences education. There is currently no coherent relationship at policy level between the Departments of Education and Health relating to higher education. The pivotal controlling body, the Health Professions Council of SA, which has a public mandate to “guide the profession”, has limited legal responsibility towards the Department of Education, despite the fact that it is empowered to accredit the educational institutions. The responsibility for the accreditation of medical education has been devolved to the professional board without adequate feedback or control mechanisms being put in place, despite the NQF Act of 2008. The transformation agenda is therefore weakly carried through, if at all, into the formal processes for quality assurance of medical education. Consequently the Health Science Faculties are under no direct pressure to transform, except through indirect pressure from the Department of Health through shifts in funding, and they continue largely unchanged by the wider processes of transformation.

There would therefore appear to be two crucial areas of discontinuity of purpose in the process of transforming medical education towards a more equitable and socially responsive system. At the higher level, the lack of communication and articulation between the Departments of Education and Health, and specifically the delegation of the responsibilities of the CHE to the HPCSA as the accreditor of medical schools, is partly responsible for the gap. Secondly, within the HPCSA documentation itself, there is a

clear disjuncture between the intent, as made explicit in the Standards document, and the implementation of this intent, as seen in the accreditation process documents.

Some questions that persist are as follows:

- Are undergraduate medical curriculae contributing to the transformation of South African society, or are they essentially “reproductive”?
- Are the HPCSA Guidelines and Accreditation processes for medical curriculae still appropriate to our current and future context?
- What are the components of medical education that need to be prioritized in the process of transformation?

It is one thing to divorce our policies and institutions from the inequities and colonization of the past, but quite another to create a new modus operandi. The gap between the high ideals of higher education policy, and its actual implementation in the health sector through a professional body such as the HPCSA, is enormous. The purpose for which medical education exists and functions, is the production of medical graduates who are equipped with the appropriate clinical and other skills to serve the medical needs of their society. The selection, curriculum and assessment strategies of our medical schools have continued post 1994 within this “fitness for purpose” without addressing the “fitness of purpose” of medical education within a changed context. Overall, medical education in South Africa has continued in a largely reproductive rather than a transformative mode. Despite the key role of some of the medical schools in the history of the struggle for this country, there exists no recognizable “pedagogy of transformation” in our medical schools, in response to the Minister’s challenge. Individual faculties and schools interpret the agenda in different ways and give emphasis to different aspects of medical education. The task therefore becomes one of identifying and developing the approaches and components of medical education that need to be prioritized in the process of transformation within the national context.

CONCLUSION

It appears that there is a structural disarticulation of purpose between the Department of Education through the HPCSA to the medical schools, as well as a dilution of the intent of transformation from higher education policy through to educational practice. There is not only a gap in the policy itself but also a failure of implementation of higher education policy with regard to medical education, to the extent that the transformation imperative is dissipated in the process. The 2008 World Health Report “Primary Health Care: Now More than Ever” emphasizes this need at a global level, since the equitable distribution of resources for health care is a global challenge as well as a national priority. The high ideals and aspirations of the National Health Plan after 1994 are being diluted at a time when we most need them, and the opportunity for significant change could be lost unless the regulations arising from the NQF Act of 2008 address this perspective.

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