The Charter needed to be more of a 'living document,' the delegates added.

Under *Strengthening the Health System* it was recommended that there be cross-subsidies of health insurance mechanisms, revenue retention policies be standardised across provinces, service gaps be made more visible with more service level audits, accountability be strengthened (ward committees at local health management level) and a 'continuum' of accountability be established, authority be decentralised, standard business-like and service-oriented operating manuals be developed and quality assurance processes be more widely used. Strategic roles of other stakeholders needed identifying and their players enrolled into supporting the national health system. Intersectoral co-ordination outside of the social cluster needed improvement while the private sector needed enrolling into providing support in rural areas.

Under the *Millennium Development Goals (MDGs)* it was recommended that national and provincial custodians of the MDGs be appointed for monitoring purposes, United Nations indicators be used, access to prevention of mother-to-child transmission be improved and children be followed-up on, all child-related programmes be co-ordinated at health facility level, the Enquiry into Maternal Deaths be reviewed, basic training on maternal labour be intensified and voluntary counselling and testing be strengthened. Pregnant women should be prioritised for ART and PMTCT in order to decrease child mortality rates.

Family planning needed to be prioritised, especially for teenagers and co-ordination of directly observable treatment among community health workers improved for the ART programme.

Under *Human Resources* it was suggested that community structures such as health and hospital committees, community-based organisations (CBOs) and NGOs be used to help mobilise and strengthen resources, legislation be more creative to recruit and retain workers, mid-level worker, scarce skill and rural allowance delivery be speeded up, levels at which posts were advertised be reviewed (no recognition for previous experience), professional nurses' career pathing be supported, the entry of foreign health workers into the system be eased, a national human resources database be created including staff expectations, aspirations and skills in order to radically enhance planning and management.

The interpretation of the scarce skills allowance should be standardised across provinces and the application of the rural allowance widened.

Chris Bateman

Editor's note: *Such National Health Summits are an excellent idea. However, serious consideration needs to be given to improved planning and organisation. The present summit informed potential delegates weeks before it was to take place and the agenda was not finalised until days before the meeting. As a result it was difficult for potential delegates to decide if they should attend or to obtain accommodation.*

The South African Medical Journal

100 years ago:

We have had reported to us an incident whicb, unless it can be explained, looks very discreditable. A woman in Cape Town had engaged Dr. A. for her confinement. Dr. B., visiting the same collection of tenement dwellings, but not this woman or her family, noticed her condition, and then told her that he should be glad to attend her, his fee being two guineas. It may be mentioned that the fee of her own medical attendant was three. We cannot sufficiently condemn conduct of this kind as being not only unethical but indelicate. Unfortunately such touting based upon such ocular data is not altogether uncommon... Small wonder that the profession enjoys less public esteem than should be the case. If we do not respect ourselves, we can hardly expect others to respect us. In the SAMJ of the following month: With reference to a passim note in last month's issue referring to a Cape Town medical man "touting" for a midwifery engagement, we have been assured by a gentleman who conceives himself to be the party referred to, that the statement is untrue. He absolutely denies having made any approach to the patient, but says that she did approach him, as he happens to be M.O. to a club of which she is a member, and that, without knowing that the patient had engaged any other practitioner, he simply mentioned the club rate of fees. He imagines that the whole thing was a device on the part of the patient to induce the other practitioner to reduce his fee, and this we think a very probable explanation.

50 years ago: Blood groups and the clinician

In 1950 the authors of a standard work could still observe that, maternal-foetal differences apart, there was no evidence that those of any given blood group were particularly susceptible to any disease... Several recent papers have suggested some of the possible advantages and limitations of belonging to particular ABO groups. Aird and his colleagues showed in 1953 that subjects of group A seemed to be significantly more liable to carcinoma of the stomach than those of group O. But the tribulations of the O subjects are not confined to blood-giving, and in the following year Aird's team showed that bearers of group O were apparently very appreciably more prone to peptic ulcer than those of other groups. Pike and Dickens brought forward evidence to suggest that this was also true of toxaemia of pregnancy. Aird et al. found no relation between the ABO groups and the incidence of carcinoma of the colon, rectum, bronchus and breast. Further work will clearly be necessary... but there seems no doubt that real differences in disease incidence between those of different blood groups have been demonstrated; and that more will be found... Probably it is only one of many factors which act in this way. The blood-group studies now being undertaken are of obvious clinical interest; but they promise also to contribute something, however indirectly, to our understanding of the mechanism of human evolution.