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EXECUTIVE SUMMARY

Introduction
The Western Cape Department of Health has developed a Health Care 2030 document for comment and discussion. The process of developing the 2030 strategy has already begun to energise, excite and engage our staff and strategic partners.

The document sets out the vision, values and principles guiding the Department to 2030. The document also presents a strategic framework for the Department together with a set of planning parameters and tools that will be incrementally applied. The 2030 strategy represents the third wave of health reform in the Western Cape since 1995. Comments on the first version of the 2030 strategy document were incorporated into the second version and are contained as an Annexure. This document is divided into 8 sections and each section is discussed briefly below.

Background Context
Development of the 2030 strategy took into account changes in the external environment, which include demography, socio-economic determinants of health, burden of disease and its associated risk factors, climate change, advances in technology, and limited resources.

The changing policy environment and policy imperatives such as the Millennium Development Goals (MDGs), the 2030 National Development Plan (NDP), the priority National Health outcomes and the provincial strategic objective to improve wellness were also taken into account. The full implications of the National Health Insurance (NHI) policy have not been detailed to date and the 2030 strategy will need to be adjusted accordingly over time.

The Department will build on the strong foundation, direction and many other achievements of the Comprehensive Service Plan (CSP) and learn from the lessons in its planning and implementation towards 2030.

Approach to Wellness:
The WHO framework is used to think about our approach to Wellness. The five pillars of this framework include socio-economic context, differential exposure to risk factors, differential vulnerability, differential health care outcomes and differential consequences.

The Department will strengthen its advocacy role through wide engagement with other departments and stakeholders outside of government.

The Priority focus areas for intervention include:
1. Reducing Infectious diseases such as HIV/TB
2. Improving healthy lifestyles
3. Preventing injuries and violence
4. Improving maternal and child health
5. Strengthening women’s health
6. Improving Mental Health
From Health Service Delivery to Patient-Centred Care

The crux of a re-imagined future in 2030 is the focus on patient centredness. The four conceptual pillars of patient-centred care are: a person-centred approach, integrated provision of care, continuity of care, and a life course perspective.

Vision

The 2030 vision for the Western Cape Department of Health is: Access to patient-centred, quality care. There are multiple perspectives to this vision. These perspectives include those of patients, staff, the community, the Department, spheres of government and strategic partners.

Values

The values of the Department are caring, competence, accountability, integrity, responsiveness and respect. The challenge of the Department is how to make these values a living reality for each staff member across the Department as we move towards our vision for 2030.

Principles

The principles underlying our vision and values are as follows:

1. Striving for patient-centred quality of care
2. Adopting an outcomes-based approach
3. Commitment to the primary healthcare (PHC) philosophy
4. Strengthening the districts health service models
5. Promoting equity
6. Operating with efficiency
7. Developing strategic partnerships

Leadership and Governance

Leadership

2030 requires transformational leadership from the ranks of managers and clinicians. Leadership must be collective and distributed across all levels of the organisation. Steps to strengthen leadership and facilitate transformational action will be taken.

Leadership will demonstrate and embody prevailing organisational values, have highly developed inter-personal skills, encourage innovation, draw on the capability of all employees and be visibly collaborative with staff and partners.

Governance

According to the United Nations Development Programme, good governance is accountable, transparent, responsive, equitable and inclusive, effective and efficient, participatory, consensus oriented and follows the rule of law.

There is a rich legal and policy architecture that underpins the provision of public sector services in general and health services in particular. This includes the Public Finance Management Act, the National Health Act, the Western Cape Facilities Board Act and the Western Cape District Health Councils Act.

Greater effort will be made to make the statutory structures more functionally effective as conduits of community perspectives. This will include more effective communication and information sharing, capacity development within these structures and deepening of the trust and respect between them and the Department.

Transparency, responsiveness and information sharing are important prerequisites for accountability. Greater effort will be made to communicate departmental plans and reports to the public, in a user-friendly format.

Clinical accountability will be embedded within the Department in line with the departmental clinical governance policy framework.

Principle 6, which was initially listed as “affordability” in draft one, has been changed to “efficiency” after consideration of the comments received.

The development of a shared meaning and a rich, common understanding of these principles will evolve through a series of dialogues with staff and partners over time.
Service Platform

The shape of the envisioned 2030 service platform retains the original configuration of 2010 with a strengthening of community-based services (CBS), primary health care (PHC) and district hospitals. The essence of the change is on how we do business within this service platform. The focus is on patient-centred quality care, integrated provisioning, and continuity of care throughout the life course of the patient.

This strategic document focuses on the general health service platform and does not deal with any specific disciplines or sub-specialities. Special reference is made to tuberculosis (TB), rehabilitation, mental health and oral health in order to provide context to the re-alignment of these services from specialised hospitals to the mainstream health service.

Primary Health Care Services

The PHC service component of the health system is the most critical component, as it serves as the entry point into the care continuum, and it caters for the vast majority of patient contacts. It comprises two distinct but inter-related service delivery platforms:

a. Community-based services (CBS), which includes home and community-based care (HCBC), and intermediate care; and

b. Primary care services (PCS) at health facilities as well as non-medical sites.

Community-based services

Community-based services (CBS) are geared towards prevention and health promotion, with a complementary capacity for curative, rehabilitative and palliative care. It will support the actions people take to maintain health and well-being; prevent illness and accidents; care for minor ailments and long-term conditions; and recover from periods of acute illness and hospitalisation.

CBS is envisaged to have two service elements in the form of home-and community-based care, and intermediate care. The core primary care team in HCBC comprises community health workers (CHWs) and a clinical nurse practitioner (CNP). The service model is population-based and organised per electoral ward in the metro and per sub-district in rural areas. These teams will be entrusted with the responsibility of the health of a defined population. It does not depend on individual- or community-initiated access, thus maximising opportunities for preventive care and health promotion.

Intermediate care

Intermediate care refers to inpatient transitional care enabling patients to regain skills and abilities in daily living, with the ultimate discharge destination being home or an alternate supported living environment. Intermediate care involves post-acute-, rehabilitative- and end-of-life care. It allows for a seamless transition between acute care and the living environment, particularly where the person’s ability to self-care is significantly compromised. Intermediate care is essential to alleviating the pressure on acute hospital beds.

Intermediate care teams will work in close collaboration with home-based care teams. Rehabilitation care workers (RCWs), working under the direction and clinical supervision of professional therapists, will deliver the bulk of required therapy. The introduction of a rehabilitation care worker is a major development in this service and will significantly improve access to rehabilitation.

Rehabilitation will be available for all impairment groups, including mental ill health and intellectual disability. Support groups, adult day care facilities, supported living environments and occupational enrichment programmes are all part of the fabric of wholesome rehabilitation.

Primary care services

A comprehensive range of curative and preventive services are provided for with a complementary capacity for rehabilitative and palliative care at primary health care facilities.

The CNP, supported by a medical, officer will provide the core of this frontline service. There will be additional capacity to target maternity care, eye care, oral health, nutrition, rehabilitation and chronic diseases. The spe-
specific circumstances within a geographic area – such as the burden of disease, access, economies of scale and efficiencies – will need to be considered to determine the provision of after-hour emergency services and labour ward facilities for the delivery of babies.

PHC services rendered in schools, crèches, old-age homes, the workplace and prisons will be governed by service level agreements between the Department and the custodian of these sites.

**Acute hospital services**

A well-functioning CBS and PHC service, as well as an efficient patient transport system, are critical to the efficient functioning of acute hospitals.

A home-grown set of norms for admission rates and average length of stay have been developed by using the experience of the four established district hospitals in the metro. The landscape of service provision will be dramatically different from the current reality after modernising and commissioning fully functional Khayelitsha-, Mitchells Plain-, GF Jooste-, Victoria-, Karl Bremer- and Helderberg hospitals.

The district hospital will provide a family-physician-driven service. The larger district hospitals will also provide a varying quantum of general specialist services depending on, amongst other things, the burden of disease and available infrastructure. These specialist services will not be departmentalised by clinical discipline in district hospitals.

The regional hospitals will be general-specialist-led services that will also provide a district hospital service to the population in the immediate vicinity.

The central hospitals will be sub-specialist led, but will also provide a general specialist service to the population in their immediate vicinity. There will also be an enhanced capability to render specific rehabilitative care activities, psychiatric care and specific oral health service activities in the regional and central hospitals.

**Specialised hospitals**

**Mental health and psychiatric hospitals**

The introduction of the Mental Health Care Act has created a statutory obligation to improve access to mental health care by mainstreaming and integrating mental health services in the general health services. The key components of the package of care to be provided at all levels of the service are summarised. This section must be read in conjunction with the rest of the service delivery platform sections of the document. The bed plan for the Department that will be developed after the 2030 framework has been adopted, will include beds required for psychiatric services across the service platform.

The Department believes that the majority of people living with intellectual disabilities require supported living arrangements and not medical institutionalisation. The medical treatment should be provided on a needs basis by the Department of Health. The supported living arrangements should be the responsibility of the Department of Social Development (DoSD).

**Rehabilitation services and Western Cape Rehabilitation Centre**

In line with the departmental approach to improving the patient experience and to providing integrated health care, rehabilitation services will be accessible at all levels of care. Acute services will be provided in health facilities such as district hospitals and PHC facilities, whereas non-acute services will be provided from a community-based platform. The major investment towards 2030 is to mainstream and strengthen these services within the general health service platform.

The Western Cape Rehabilitation Centre (WCRC) will continue to provide high-intensity-, specialised comprehensive, and multi-disciplinary inpatient and outpatient rehabilitation services. It is an important training site for clinical teaching and training of therapists. An integral aspect of the rehabilitation service will include the provision of the required mobility- and other assistive devices, orthotics and/or prosthetics, to facilitate full reintegration of persons with disabilities back into the community. The provincial orthotic and prosthetic centre will be relocated to and managed by the WCRC. The ethos of the centre will shift from the production of devices to being patient-centred and enhancing strategies to reduce the waiting lists for assistive devices.
Tuberculosis services and TB Hospitals

Ninety percent of TB is currently managed within the PHC platform and strengthening CBS and PHC services will improve efficiencies within TB hospitals. A PHC-based model for the treatment of multi-drug-resistant TB has been successfully piloted and will be rolled out.

A TB hospital will make provision for acute, sub-acute and chronic care beds for the proportion of patients who will be transferred from acute hospitals. The patient information system will also be improved to allow for the efficient continuity of care and referrals across the service platform. This will be a critical success factor in the effective management of the TB patient.

Oral health and oral health centres

The main oral health conditions include dental caries, periodontal disease, mal-occlusion and co-morbidity with other conditions such as HIV and diabetes.

The oral health service platform will be strengthened across all levels, with the largest investment in CBS and PHC services. The focus will to shift from curative care to integrated health prevention and promotion – including education, advocacy for tooth brushing and fissure sealant programmes. Specialised services for complex conditions will be provided at the central hospitals and the oral health centres, which will also provide outreach and support to the district health services.

Specialised services

Emergency medical services

Access to emergency care is a constitutional right in South Africa and is prioritised within the 2030 vision for patient-centred quality care. Emergency medical services has set ambitious targets for 2030, which may have to be reset within the available resources.

Call taking and dispatch are central components of an efficient EMS operation. The province is geographically divided into six districts, each with an emergency contact centre, which also doubles as a disaster risk management centre in the rural districts. The communication centre will receive modernised software application to enhance its operations.

This will also enable better management reporting in real time and improved communication with the emergency centres in hospitals. A bed bureau will also be developed to monitor the availability of acute beds in all the major hospitals.

The aeromedical service will continue to play a vital role in the emergency transfer of complex patients to the referral hospitals.

The non-acute patient transport service will also be strengthened as a key component for access to services (especially for rural patients) and will improve efficiencies of acute hospitals by facilitating only those patients that have difficulty with transport out of these hospitals.

An innovative emergency first aid response (EFAR) programme will be implemented to recruit volunteers from the community.

Forensic pathology services

The forensic pathology service (FPS) is a specialised service rendered by forensic pathologists, supported by forensic pathology officers. Access is also required to other sub-specialists such as histo-pathologists, odontologists and toxicologists. The FPS will continue to be provided via 18 forensic pathology laboratories and two departments of forensic medicine supported by a central management and administration component. The laboratories are graded between M1 to M6 depending on the workload capacity and complexity to be managed.

A model has been developed that considers a number of factors including population estimates, burden of disease and its impact on caseload, workload, case mix, case complexity, direct case contact time as well as the optimal configuration of services. Affordable targets and staffing levels will be developed through the application of the model within defined budget allocations.
Quality of Care

The amended National Health Act, the National Core Standards and the establishment of the Office of Health Standards Compliance provide a legislative framework and mechanisms to ensure quality improvement. In parallel to the statutory obligation to comply with the national core standards, the Department intends to build sustainable commitment to continuous improvement through its local patient-centred experience (PCE) strategies.

The vision for quality of care within the 2030 strategy can be divided into three dimensions:

» An individual dimension as seen through the eyes of the patient;
» A health system dimension, which includes coverage, access, meeting standards, efficiency and effectiveness; and
» A population dimension, which includes increased life expectancy, reduced burden of disease, optimal outcomes, wellness and quality of life.

Caring for and engaging staff is central to achieving optimal PCE and is a theme that is picked up in several parts of the 2030 strategy.

Support Services

Optimal service delivery is enabled by a range of key support services, which includes human resources management, financial management, appropriate infrastructure, medical technology and information management and information and communication technology. The substance and form of these support services are centrally informed by the service delivery imperatives.

Building and strengthening the capacity at various levels is an important prerequisite to effective decentralised management and distributed leadership. Over the next few years, the focus is going to be on developing the clinical and administrative leadership and management capacity at institutional level that is directly responsible for service delivery and quality of care.

Support services will be strengthened at various levels of the platform by ensuring a coherent, integrated, systems approach in particular to policy development, integrated planning, resource allocation, implementation support, and monitoring and evaluation.

The organisational culture of working together and continuous improvement will be entrenched.

Strategy and support

Strategy and support have a key role in:

» Building cohesion and ensuring alignment between structures, policies and processes;
» Providing the organisational intelligence to support strategic planning and priority setting;
» Developing health policy;
» Ensuring good-quality information and robust monitoring and evaluation (M&E) processes;
» Embedding risk management practices in the Department; and
» Promoting a culture of learning and continuous improvement.

Human resources

The 2030 Strategic Human Resources (HR) Framework has three focus areas:

a. Workforce planning
b. People management (the “human” in HRM)
c. Operational HR management

The Department will be developing its capability in HR analytics and research to provide the workforce intelligence that informs workforce planning, development as well as monitoring and evaluation against a set of metrics to assess progress in achieving key strategic objectives. A range of strategies will be developed to address the scarce skills in certain categories of staff. An integrated training and development plan that ensures
the appropriate numbers and competency mix of staff per level of care is imperative for achieving the desired outcome.

The Department will also strengthen its internal HR development capacity – including formal and informal training, mentoring and support.

The biggest challenges to achieving the objective of a patient-centred service are: re-energising the staff and building renewed commitment to the principles and vision of 2030; creating an organisation where staff have a deep sense of belonging; developing an environment where staff feel stimulated, listened to and supported in creatively addressing their challenges. A change management programme will be embarked upon to address these issues.

Given the changes envisaged in the 2030 framework, the priority areas requiring the greatest focus will be the CBS, PHC and larger district hospitals, as well as the sub-district management and district management tiers. The Department is committed to decentralised management. The HR delegations and HR capacity at each of the levels from institutions (clinics to large hospitals) and sub-districts and districts need to be reviewed in this regard. A further priority for HR is to develop leadership and management skills at facilities, sub-district level and district level.

Financial management

There are on-going financial pressures in the light of limited resources and huge demands on the service. Choosing budget priorities and improved financial management within this context remains an on-going annual challenge.

Finance will focus on the following areas:

1. Budget allocation:
   a. Improved budget-allocation methods that fund cost-effective interventions and address inequity.

2. Financial management:
   a. Decentralised management and accountability, including the functional business unit system in large hospitals.
   b. Strengthened financial management processes.
   c. Improved procurement and stock management.
   d. Clean audit practices and strengthening controls to ensure clean government.

3. Value for money

Infrastructure and technology

The approach to health infrastructure and technology management will continue to be governed by the 5L’s agenda:

a. Long life (sustainability);

b. Loose fit (flexibility and adaptability);

C. Low impact (reduction of the carbon footprint);

D. Luminous healing space (enlightened healing environment); and

e. Lean design and construction (collaborative and integrated).

The management of information has become an increasingly prominent component in the running of health care facilities. Hence, clinical, safety and security and other communication systems will be part of the infrastructure design from the inception phase.

Continuous improvement will be ensured by the implementation of the post-occupancy evaluation process, from both a technical and functional point of view. This will allow for future improvements in the design, construction and commissioning of infrastructure.
Information communication technology

Information communication technology (ICT) will be mainstreamed within the generic processes of planning, budgeting, risk management, implementation, monitoring and evaluation in the Department.

The potential ICT opportunities in the areas of engaging with the citizenry, providing services in CBS and health facilities and strengthening and integrating support services within health, will be explored.

Harmonisation of e-Health initiatives, which refers to the agreement, synchronisation and coordination of e-Health initiatives in the Department for enabling more effective inter-operation, will be undertaken. The goal behind this inter-operation is “improving wellness” and quality health service delivery in the province.

The business intelligence project will amalgamate financial and clinical aggregated information for management reporting. This will be taken down to patient-level data, which will enable better and integrated clinical management of patients and the use of integrated information for research and health services management.

The Department will be revising its ICT strategic plan for 2014 to 2016 in this year, which will identify ICT priorities for implementation that emanate from the strategic direction of 2030.

There are exciting innovations in the field of ICT that will require robust systems and technical capacity within the Department to optimally exploit these opportunities.

Monitoring and Evaluation

The Department will apply the Triple AIM framework, which identifies key dimensions for “optimizing health system performance”. These dimensions include population health outcomes, health services (acceptability, appropriateness, access, quality, equity, effectiveness, and patient-centeredness) and cost efficiency in service delivery. A set of potential indicators to measure each of these dimensions is proposed.

The culture of monitoring and evaluation and continuous improvement will be strengthened through improving the quality of information, deepening capacity, ensuring leadership and accountability and the widespread sharing of good practices.

Conclusion

The second draft of 2030 is a substantial piece of work built on the preliminary thinking, vision, principles and values of 2030 expressed in the first draft. This second draft is also the result of the extensive and valuable input received from staff and external stakeholders and the further evolution of conceptual thinking and technical work to date.

The thinking and principles of 2030 have begun to infiltrate daily language use and conversations in the Department. The journey to 2030 has begun in parallel to the process of finalising the 2030 framework.

This document will also be accompanied by facilitated conversations to allow for meaningful engagement and comments. Effective implementation provides the litmus test for any plan.

The Department will then finalise the 2030 framework, which will be tabled at the provincial cabinet. The work will then shift to converting this broad strategic direction into more specific details by applying the models and approaches to specific services and geographic areas. This will include, amongst other things, developing hospital bed numbers, finalising staffing requirements and identifying the priorities for incremental implementation.
SECTION A:
CONTEXT OF 2030 STRATEGY DOCUMENT
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SUMMARY POINTS

1. This is the third wave of health reform in the Western Cape since 1995.
2. The Department appreciates the comments on the first draft of 2030, which were generally positive and the criticisms constructive. They have been summarised as Annexure A.
3. Given the uncertainty of the environment and the need for flexibility to adapt, the Department has chosen to develop a high-level strategic framework that provides the vision, values and principles of 2030 with a set of planning parameters and tools that can be locally and incrementally applied within specific contexts.
4. The 2030 planning process is as important as the end product. It has already served to energise, excite and engage our staff and strategic partners.

Introduction and Background

2030 is about plotting the path over the next two decades to a re-imagined future health service. This framework has been developed after having considered three main areas:

- Changes, including opportunities and threats in the external environment;
- Distilling key lessons from the Comprehensive Service Plan (CSP) of 2010; and
- Fresh thinking about a re-imagined future.

These areas have provided a compelling context for change and created an exciting opportunity to take the Department to new heights in this third wave of health reform in this province since the 1995 Health Plan and the CSP of 2010.

The Department’s preliminary thinking was shared in a draft document circulated for public comment in 2012. Facilitated dialogue sessions were convened with a range of external stakeholders and staff through specially convened sessions by the geographic service area management structures. Forty-two written submissions were received and colleagues raised interesting, relevant and creative ideas during the dialogue sessions. All comments were considered and the written comments were individually responded to.

Comments and criticisms have been summarised as an annexure to this document. The values, vision and principles of 2030 were generally supported with some suggestions for amendments. The absence of a formal evaluation of the 2010 plan was noted and a substantial section has been included in this document to remedy this for 2030. Some of the major omissions from the first draft, such as the impact of climate change and the potential role of advances in information and communications technology (ICT) in health, have been addressed in this version. Many of the specific technical comments have either been addressed in the service delivery platform or support services section or will be addressed when the 2030 framework is further developed in detail.

The Department recognises the high levels of uncertainty and complexity associated with planning for the medium- to long term. Examples of these include: the size of the financial envelope available to provide health services beyond the medium term; the cost of human and other resources required in health services; and the potential impact of the National Health Insurance (NHI) on the organisational, functional and service delivery arrangements between the public and private sectors. The Department has therefore chosen to develop a high-level strategic framework that provides the vision, values and principles of 2030 with a set of planning parameters and tools that can be locally and incrementally applied within specific contexts. This approach will allow flexibility to adjust for the kind of changes mentioned above.

The 2030 planning process is as important as the end product. It has already served to energise, excite and engage our staff and strategic partners. Work has already begun to embed the principles, vision and values of 2030 within the language of the Department and plant the seeds within the hearts and minds of our staff.
It is well documented that socio-economic conditions are important upstream determinants of health. The National Development Plan identifies poverty, inequality and unemployment as the key triad of socio-economic challenges facing South Africa. Notwithstanding the higher level of development and living standards in the Western Cape, these challenges are as relevant to the Western Cape as they are to the rest of the country. According to the Provincial Economic Review (PERO), in quarter two of 2012, the Western Cape had an unemployment rate of between 24.9 percent and 33.5 percent depending which definition was used. The Gini coefficient, which is a measure of inequality, was 0.63 for the province in 2008 with one representing complete inequality and zero representing complete equality. Also in 2008, 22.3% of the population lived below the poverty line of R6 302 per annum. Associated socio-economic challenges are a lack of basic services such as clean water and sanitation, electricity and housing. These challenges are compounded by the pace and scale of migration and urbanisation in relation to the ability of government to provide these services. The situation is aggravated by the low levels of numeracy and literacy and other skills within significant sections of the population. This situation exists notwithstanding the significant gains made by government in the delivery of basic services to date.

Demography The Census 2011 data was released in November 2012. According to the State of the Cities report, the City of Cape Town had the highest growth rate at 20.91% between 2001 and 2007. Migration and urbanisation are important factors in this regard. The Western Cape population is estimated to be 5.8m currently. Some of the important trends are: life expectancy slowly increasing; population growth continuing until 2030; population ageing, a changing racial mix; and the continuation of urbanisation and migration.

Burden of disease The provincial population is afflicted with a quadruple burden of disease that has been well documented. A more detailed summary is found in Annexure B. The level of trauma from inter-personal violence and road traffic accidents, the escalating burden of chronic diseases (including mental ill health and its associated risk factors), the twin burden of HIV with TB and the conditions associated with maternal and child health form the bulwark of the quadruple burden that the health service must effectively respond to. There are also changes in the cause of mortality that must be taken into account in the way we respond. For example, HIV that used to be the number one cause of death of children under five years several years ago has been significantly addressed through the prevention of mother-to-child transmission (PMTCT) and antiretroviral (ART) programmes.

External Environment

Account has to be taken of the on-going changes in the environment. These include, amongst others, demography, socio-economic determinants of health, political contexts, burden of disease and the associated risk factors, advances in technology, and the global, national and provincial policy environment. Some of the main determinants of this context are described below.

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Health outcomes Despite the fact that the WC provincial health outcomes are good, they still lag behind what is required by the MDG targets. Notwithstanding the 2015 deadline for the MDG goals, achieving these targets has now become one of the key drivers of the strategy for 2030 and the revised targets will continue to drive our vision in a post-2015 development agenda.

Public expectations and accountability There is a growing awareness and demand for the right to good-quality health care. Public expectations are high and there is an increased demand for public accountability and responsiveness of government.

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Public expectations and accountability There is a growing awareness and demand for the right to good-quality health care. Public expectations are high and there is an increased demand for public accountability and responsiveness of government.
**Sustaining and improving good practice** While the Department currently performs well on many fronts and has consistently achieved an unqualified audit, there is a need to embed and institutionalise good practice to sustain and improve its performance. The culture of organisational learning and continuous improvement and capacity to change will be improved to raise the performance bar higher.

**Limited resources** Tension between limited resources and growing health needs is inevitable and requires that the Department constantly stretch and optimise the value of the health rand. It is important to ensure that the priorities are identified and that scarce resources are allocated to the most cost-effective interventions. Productivity and operational efficiency must be addressed on an on-going basis. Assumptions will be made with regards to the available funding envelope to plan for in the medium to long term. This is difficult to predict and will be impacted upon by factors such as the growth of the economy and the pooling of resources through the National Health Insurance.

**Climate Change** Climate change is predicted in some quarters to be the biggest global health threat of the 21st century. The increased emission of greenhouse gases and the consequent climate change effects are significant and growing realities that must be addressed. South Africa contributes about 39 percent of the greenhouse gases (GHG) on the African continent. From assessments of other countries, health services are an important contributor to greenhouse emissions.

Climate change policy and adaptation plans have been developed by the National Department of Health and the Western Cape Government (WCG). These provide a useful framework within which the Department will develop and action its strategies.

The impact of climate change is predicted to be wide ranging and will, amongst other things, include: water scarcity and food insecurity; extreme events such as fires, floods and disasters; and the outbreak of infectious diseases. The poorest communities remain the most vulnerable.

The health service thus needs to be in a state of readiness to address the public health consequences of climate change. This will include improved surveillance and disease outbreak management capacity, better disaster management and rescue responsiveness in collaboration with other departments and strengthened emergency services within health.

The Department will put in place tools to measure its own contribution to GHG, set targets and implement cost-effective mitigation measures to systematically reduce its GHG contributions. This will include a range of interventions from better infrastructure design to more environmentally friendly operational policies such as the Green Procurement Policy of the WCG. The four focus mitigation areas are currently water usage, electricity consumption, waste management and distances travelled.

The Department has created a climate change committee (CCC), convened by a senior manager, to systematically start to address both the mitigation and adaptation aspects. Work is currently in its infancy. Disaster preparedness in the Department is being systematically supported by the emergency medical services. The CCC will also be the liaison point for engaging with other sectors and spheres of government in this regard. Khayelitsha and Lentegeur hospitals have been identified as flagship projects as part of the Premier’s 100% Green campaign. Local initiatives by institutions in the Department are being encouraged and the expertise, technical knowledge and research within the Higher Education Institutions (HEIs) are being harnessed by the Department.

**Medical Technology and Information and Communication Technology** Rapid advances in technology raise unlimited opportunities in improving patient care, increasing efficiencies and doing business differently. These opportunities must be optimised within our available resources and obtaining best value for the health rand.
Legislative and Policy Environment

This section provides an overview of the national legislative and policy framework within which the Department functions.

Table 1 Summary of key policy and legislative frameworks guiding development of Vision 2030

<table>
<thead>
<tr>
<th>International</th>
<th>Millennium Development Goals</th>
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<tbody>
<tr>
<td></td>
<td>In September 2000 South Africa was one of the 189 countries to commit to the Millennium Development Goals to reduce global poverty at the United Nations Millennium Summit. A table that summarises the goals, targets and indicators of the MDGs is contained in Annexure C. The specific health-related MDGs are goals four, five and six, which relate to child mortality, maternal mortality and HIV/TB/Malaria respectively.</td>
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<tr>
<td></td>
<td>The rendering of health services is a national and provincial legislative competence in terms of Schedule 4, Part A of the Constitution of the Republic of South Africa, 1996. The Constitution places the following obligations upon the Department:</td>
</tr>
<tr>
<td></td>
<td>» Section 27(1)(a) obliges the Department to provide access to health services, including reproductive health care;</td>
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<tr>
<td></td>
<td>» Section 27(3) provides that no-one may be refused emergency medical treatment; and</td>
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<tr>
<td></td>
<td>» Section 28(c) prescribes that every child has the right to basic health care.</td>
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<tr>
<th>National</th>
<th>Negotiated Service Delivery Agreement (NSDA)</th>
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<tbody>
<tr>
<td></td>
<td>The National Government continues to follow an outcomes-based approach and has identified 12 targeted outcomes against which the respective national ministers have signed performance agreements with the President. The health outcome is: improve healthcare and life expectancy among all South Africans. The key outputs of the NSDA between the National Minister of Health and the President are:</td>
</tr>
<tr>
<td></td>
<td>1. Increasing life expectancy;</td>
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<tr>
<td></td>
<td>2. Decreasing maternal and child mortality;</td>
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<tr>
<td></td>
<td>3. Combating HIV and AIDS and decreasing the burden of disease from tuberculosis;</td>
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<tr>
<td></td>
<td>4. Strengthening health system effectiveness, with a particular focus on:</td>
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<tr>
<td></td>
<td>» Revitalisation of primary health care;</td>
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<tr>
<td></td>
<td>» Health care financing and management;</td>
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<tr>
<td></td>
<td>» Human resources for health;</td>
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<tr>
<td></td>
<td>» Quality of health and the accreditation of health establishments;</td>
</tr>
<tr>
<td></td>
<td>» Health infrastructure; and</td>
</tr>
<tr>
<td></td>
<td>» Information, communication and technology and health information systems.</td>
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</tbody>
</table>
Western Cape Government : Health | Healthcare 2030

National Development Plan (NDP)

The NDP charts a new path for South Africa and seeks to eliminate poverty and reduce inequality by 2030. In terms of the plan, by 2030 the health system should provide quality health care to all, free at point of service, or paid for by publicly provided or privately funded insurance. The NDP identifies the following areas in the public health system for reform:

» Improved management, especially at institutional level;
» More and better trained health professionals;
» Greater discretion over clinical and administrative matters at facility level, combined with effective accountability; and
» Better patient information systems supporting more decentralised and HBC models.

The section on health also identifies the following key targets and actions

» By 2030, life expectancy should reach at least 70 for both men and women;
» The under-20 age group should largely be an HIV-free generation;
» The infant mortality rate should decline from 43 to 20 per 1 000 live births and the under-five mortality rate should be less than 30 per 1 000 from the 104 it is today;
» Maternal mortality should decline from 500 to 100 per 100 000 live births;
» All HIV-positive people should be on treatment and preventive measures such as condoms and microbiocides should be widely available, especially to young people;
» Non-communicable diseases should reduce by 28% and deaths from drug abuse, road accidents and violence by 50%; and
» Everyone should have access to an equal standard of basic health care regardless of their income.

National Department of Health

National Health Act No. 61 of 2003

This Act provides the framework for a structured uniform health system taking into account the obligations imposed by the Constitution and other laws within the national, provincial and local governments spheres with regard to health services.

Ten Point Plan

This is a key policy document which serves as a roadmap to consolidate Government’s response to health system challenges. It includes:

1. Provision of strategic leadership and creation of a social compact for better health outcomes.
2. Implementation of a National Health Insurance (NHI) Plan.
3. Improving quality of health services.
4. Overhauling the health care system and improving its management.
5. Improving HR planning, development and management.
6. Revitalisation of physical infrastructure.
7. Accelerated implementation of the HIV and AIDS and sexually transmitted infections National Strategic Plan 2007-11, and increased focus on TB and other communicable diseases.
8. Mass mobilisation for better health for the population.
10. Strengthening of research and development.

This strategy deals with the supply of health professionals and equity of access; education, training and research; and the working environment of the health workforce. Eight priorities were identified which form the framework for the HRH strategy: leadership, governance and accountability; health workforce information and health workforce planning; re-engineering of the workforce to meet service needs; upscaling and revitalising education, training and research; creating infrastructure for workforce and service development - academic health complexes and nursing colleges; strengthening and professionalising the management of human resources and prioritising health workforce needs; ensuring professional, quality care through oversight, regulation and continuing professional development; and improving access to health professionals and health care in rural and remote areas.

Green Paper on National Health Insurance (NHI)

NHI will be introduced to South Africa over a 14 year period and reforms will focus on:

- Strengthening of district health structures, not only in terms of the re-engineered PHC approach but establishing the District Health Authorities that would need to contract with the NHI Fund and with accredited private providers;
- Comprehensive quality improvement, assurance and compliance by all providers;
- Increasing human resources in the health system (including increasing the capacity of training facilities for various health professionals);
- Piloting the system in 10 selected health districts (initially funded by an NHI conditional grant);
- Completion of an assessment of existing health infrastructure;
- Implementing hospital management reforms in relation to governance reforms, financial management, autonomy and accountability;
- Developing the necessary purchasing and procurement processes;
- Developing processes for population registration;
- Refinement of the “financial resource envelope” and the “revenue mobilisation strategy and pooling systems” (including alignment with the Road Accident Fund, Compensation for Occupational Diseases and Injuries, Compensation Commission for Occupational Diseases and the Occupational Diseases in Mines and Works Act);
- Refinement of the “provider payment mechanisms”;
- Development of an integrated health information system; and
- Review of existing legislation and creation of an enabling legislative framework (including legislation to establish the NHI Fund, initially at a national level and later at sub-national levels).

Footnote: The Western Cape Government supports elements of the NHI policy and has concerns with others that will be addressed with the National Minister.
Primary Health Care Re-engineering

A major policy development which aligns with the 10 Point Plan objective of overhauling the health care system and improve its management. PHC re-engineering is key to the success of the NSDA implementation process and seeks to shift the PHC system from a largely passive, curative, vertically and individually oriented system to one with a more proactive, integrated and population-based approach. The core principles of PHC re-engineering are:

» to attain a population-orientation to health care, focused on meeting priority health needs of geographically coherent populations in a comprehensive manner, including prevention, promotion and good quality, essential care;
» to focus on health outcomes aimed at reducing mortality and morbidity from the major causes of ill-health;
» to develop integrated, efficient and well-supported PHC teams, guided by and accountable to communities;
» to establish a well-functioning DHS; and
» to pay closer attention to those factors outside of the health sector that impact on health, namely the social determinants of health.

Three PHC streams are envisaged:

» multi-disciplinary teams of clinically competent professionals in which nurses play a critical role;
» community municipal ward-based multi-disciplinary health teams with nurses again playing a critical role; and
» effective implementation of national school-based PHC system led by nurses.

Footnote: The Department has adapted the PHC re-engineering strategy to local conditions in the Western Cape.

Office of Health Standards Compliance (OHSC)

Once this office will come into effect through the passing of the National Health Amendment Act. Once established, the OHSC will ensure that complaints received from health care users or the public (patients and families) are properly and independently investigated. The Office will be headed by a qualified Executive Director and supported by competent personnel including Health Officers. The OHSC is also expected to pave the way for the implementation of the National Health Insurance as the provision of quality care will be one of the core requirements for the NHL.

The Provincial Strategic Plan

The Provincial Strategic Plan has 11 strategic objectives that have been identified to facilitate the achievement of the vision of creating an 'open opportunity society for all'. These objectives are closely aligned with the national outcomes, particularly in relation to concurrent functions such as health. The health-specific strategic objective for which the Department takes the lead is increasing wellness.

One of the mechanisms to give effect to the achievement of the strategic objectives is the Provincial Transversal Management System (PTMS), which provides political support for effective inter-sectoral collaboration within the provincial government.
**Provincial Strategic Objective: Increasing wellness**

Upstream factors contributing to the burden of disease are frequently the result of socio-economic deprivation, such as unemployment, poverty, poor housing and sanitation.

The wellness of the people of the Western Cape is undermined by the growing burden of disease. The strategic objective of increasing wellness has adopted a two-pronged approach to address this.

Firstly, the Department has a responsibility to manage the burden of disease through disease prevention, health promotion, and early detection of disease, treatment and rehabilitation – i.e. the provision of comprehensive health services.

Secondly, the Department is working with stakeholders, such as other departments, academia and non-profit organisations, through the mechanism of the PTMS to address the upstream factors that contribute to the burden of disease.

Aligned with the quadruple burden of disease and the MDGs, the Department has formed the following focus areas within the PTMS, in order to address:

» Violence and road traffic accident injuries prevention;
» Healthy lifestyles;
» Women’s health;
» Maternal and child health;
» Infectious diseases (HIV and TB); and
» Mental health.

**Universal Health Care for All**

The Western Cape Government has concerns with the NHI proposals as stated in the Green paper. These include, amongst others,

1. The private sector is not responsible for the low-quality outcomes of the public health sector
2. NHI does not fix the real problem, which is low-quality provision in the public sector
3. NHI does not adequately attend to accountability and management structures
4. Centralisation of healthcare funding will be bureaucratic and inefficient
5. We lack the human resources to implement the NHI
6. The true cost of NHI is unclear
7. NHI may be unconstitutional, as it threatens provincial authority

Its position as stated in Universal Health Care for all proposes High-quality health care that is accountable, affordable and efficient based on the Western Cape experience:

1. The National Department of Health must create an enabling environment for quality healthcare through setting of norms and standards
2. Provincial Departments of Health must be strengthened for better delivery
Internal Environment

**Comprehensive Service Plan 2010 – Lessons learned and achievements**

The 2010 Comprehensive Service Plan (CSP) has guided the health reform process in the last decade.

The detailed engagement that preceded the development of the CSP paid many positive dividends. The technical work for the CSP was undertaken in-house, which ensured the ownership of the process and the product. There was robust engagement between the Department and stakeholders, significant interaction between clinicians and management, and extensive formal and informal comment that was individually considered. These elements of the planning process contributed to the intellectual rigour and a greater understanding of the complexities and challenges in reforming the health service. Flexibility in the translation of a strategic plan into an operational reality was an important lesson.
Achievements

A formal evaluation of the achievements and challenges in the implementation of the CSP has not been undertaken. This is acknowledged as a serious limitation. However, at a departmental review session in July 2010, there was general agreement that the overall shape of the health service proposed by the CSP remained sound and that the major building blocks envisaged by the 2010 CSP have been, or are being, implemented.

Some of the main achievements of the CSP over the past few years include:

a. District Health Services

   Implementation of the district health system, including the unbundling of the Metro PHC service into more manageable substructures;

   » Strengthening the district health service by the appointment and training of family medicine specialists and expansion of the CNP cadre; and

   » Improvement in access to health care by expansion of the community-and home-based services.

b. Acute hospitals

   » General specialist services in rural regional and central hospitals have been strengthened.

c. Mental hospitals

   » Chronic psychiatric and intellectually disabled patients have been dehospitalised;

   » Several mental health care policies have been developed and a Mental Health Review Board that provides oversight is well established; and

   » The Mental Health Care Act required the mainstreaming of the management of mentally ill patients. While there were and continue to be significant challenges in implementing the Act, significant progress has been made, especially at district and regional hospitals.

d. Infrastructure

   » Major progress in the revitalisation of the physical infrastructure of the rural regional hospitals, some district hospitals, several ambulance stations and forensic mortuaries;

   » Upgrading and building of a number of PHC facilities;

   » Constructing a state of the art Western Cape Rehabilitation Centre (WCRC) to replace an out-dated rehabilitation service facility at Conradie and Karl Bremer hospitals; and

   » Commissioning of the new Khayelitsha Hospital and construction of the new Mitchells Plain Hospital is at an advanced stage.

e. Emergency medical services (EMS)

   » The communication centres in EMS have been modernised, a significant number of vehicles in the ambulance fleet have been replaced, the staff complement has been expanded and strengthened and ‘one man ambulances’ have been done away with. Infrastructure at ambulance stations is being incrementally upgraded.

f. Provincialisation

   » A range of services was transferred to the provincial Department of Health: those provided in the provincially aided hospitals; PHC services provided by local government in rural districts; TB hospital services provided by SANTA and local government; forensic pathology services from SAPs; and EMS provided by local government.
Lessons Learned from the CSP 2010

The successes listed above do not fully reflect the rich experience and valuable lessons learnt through the implementation of the CSP. There were certain aspects of the CSP that proved to be over-ambitious and could not be successfully implemented.

These include the following:

- Much was learnt about the complexity of implementing service shifts across institutions. The health system consists of inter-connected parts. Change in one area of the health system has ripple effects across a range of institutions in the system.
- The complete physical separation of level 2 services from level 3 services within the central hospitals proved challenging. The services, resources and processes were so closely intertwined that they proved over ambitious to separate.
- While some of the historically classified regional hospitals were reclassified as district hospitals under the CSP, we have recognised that these hospitals provide a quantum of specialist services that adds important value and it makes service sense for the specialist services to remain in these hospitals. This has therefore become the norm for large district hospitals and will be more systematically addressed within the 2030 framework.
- The CSP made provision for critical care beds only in the central hospitals. In practice, from a service perspective, the serious need for critical care beds across regional hospitals and at times in the larger district hospitals was recognised. This will be reviewed within the 2030 framework.
- The effort required for the development of detail in planning for a medium- to long-term horizon needs to be balanced against the uncertainty and the need for flexibility to adapt to changing circumstances. For example, the detailed staff numbers developed in the black book of the CSP in many instances was unaffordable within the allocated budgets. The introduction of the Occupation-Specific Dispensation (OSD) was unforeseen and significantly raised the cost of hiring health professionals and rendered the staff numbers in the CSP unaffordable.
- The CSP was useful in laying the foundation of the organisation of health services within the Department, including detailed staff establishments and infrastructure. The human side of the service, which is often regarded as comprising softer issues, both within staff and between staff and patients, families and communities was not adequately focused upon in the CSP.
- The organisational structures we created have unintentionally fragmented the Department and promoted silos and divisions. The national budget programme structure has also entrenched these divisions. This has undermined the effectiveness of the health service from functioning as a cohesive health system.

From this brief analysis it has become clear that the province can build on the strong foundation, direction and many other achievements of the CSP and learn from the lessons in its planning and implementation towards 2030.

Quality of care

The National Department of Health has produced a comprehensive set of core standards to assess quality of health services. Notwithstanding the teething problems in the development and application of the tools, the baseline assessment identifies several areas for improvement. These are more significant in the PHC facilities. An analysis of patient complaints identifies waiting times and staff attitudes to be major challenges.

The staff satisfaction surveys identify a sizable proportion of staff that do not feel valued or listened to in the organisation. A survey of metro doctors identified staff burnout in a stressful working environment as a major challenge. The Barret’s surveys conducted over the previous two years had identified the limiting values to be, amongst others, cost consciousness, bureaucracy, hierarchy, and confusing messages.
SECTION B:
OUR APPROACH TO WELLNESS
Introduction and Background
The approach to increasing wellness in the Western Cape is based on the framework developed by the WHO Commission for social determinants. The basis for this framework is that the structural issues and conditions of daily life such as income distribution, education access and quality, environmental conditions such as housing, social spaces, urban vs. rural areas, access to health services, and work and leisure directly influence health outcomes and wellness. Wellness is defined as not merely the absence of disease, but instead the ability to fulfill one’s potential in all spheres of life. The WHO framework highlights the five factors of importance that are described below.

Socio-economic context and position
People’s social class, gender, ethnicity, education, occupation and income levels are a critical risk factor in wellness. These issues are often driven by policies outside of the health sector, yet are central to ensuring wellness. In South Africa, for example, IMR of those in the poorest quintiles is three times more than of those in the richest quintiles; twice as much in children of mothers who do not have matric compared to those with matric; and twice as much in those from rural areas compared to urban areas.

Differential exposure
The exposure to most risk factors (behavioural, societal, and environmental) is inversely related to the socio-economic position and position results. It is, for example, more difficult to have a healthy lifestyle if you are from a poor community because healthy foods are more expensive there and less readily available. There is also limited access to open and safe open spaces to exercise. Similarly poor communities tend to have unhealthy houses and live in unhealthy environments with poor water and sanitation and thus are more likely to contract infectious diseases like diarrhoea, pneumonia.

Differential vulnerability
The social, cultural and economic environments influence the vulnerability of people in such a way that the same level of exposure could have different outcomes. For example, high access to cheap alcohol has very different consequences if clustered with social exclusion, low income, malnutrition, poor housing and poor access to health services. The high levels of mental ill health in South Africa result in very high mortality and morbidity compared to some developed countries.

Differential health care outcomes
The attainment of health outcomes and wellness is influenced by the socio-economic context and the resulting differential exposure and vulnerability to disease as discussed above.

Differential consequences
Poor health outcomes may have social and economic consequences such as inability to work and earn a living and the resulting poverty, and loss of health insurance or disposable income to pay for transport to access health services. Social exclusion may further increase vulnerability to ill health, loss of earnings, loss of ability to work and social isolation or exclusion. Further, sick people often face additional financial burdens that render them less able to pay for health care and drugs. While advantaged population groups are better protected – for example, in terms of job security and health insurance – for the disadvantaged, ill health might result in further socio-economic degradation, crossing the poverty line and accelerating down a downward spiral that further damages health. Figure 1 below uses alcohol to further explain this framework.
It must, however, be stated that the provision of biomedical interventions also improves health outcomes. For example, the provision of ARV to pregnant women has decreased the transmission of HIV from mother to baby. In 2000 in the Western Cape, more than 1 in five children under five years were dying of HIV; in 2009 only about 7 percent died from HIV.

Thus wellness could be increased by preventing disease before it happens by addressing the social determinants of health to reduce exposure and, in particular, vulnerability to disease and addressing the so-called “upstream factors”. Managing the existing burden of disease can be done through interventions that focus on “downstream” issues such as biomedical interventions. The Department of Health is mandated by the National Health Act to provide quality health services that address mostly downstream issues focused on the individual. As such, HealthCare 2030 is a health-system-transformation strategy that is focused on delivering a superior patient experience of quality health services that result in the desired outcomes. To achieve both the prevention of disease and reduction of the current burden of disease comprehensive strategies that address socioeconomic factors such as education, poverty, and housing together with improved health services are required for improved outcomes. However, the required joint planning across departments, municipalities and sectors to ensure calculated, coordinated, targeted interventions to deliver superior health outcomes is lacking. The approach, therefore, that the province has taken to address this challenge is to create the Provincial Transversal Management System.

The Provincial Transversal Management System (PTMS)

The PTMS provides a structured opportunity to mobilise role players outside of the health department to address social determinants of health. This system has been prioritised by the provincial cabinet, giving political weight to inter-sectoral collaboration through this initiative. The philosophy is that of thinking and acting in a united and coordinated way around a common set of objectives as a “whole of society” and a “whole of government”.

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1. WHO. Equity, social determinants and public health programmes / editors Erik Blas and Anand Sivasankara Kurup, 2010
The strategic objectives for the PTMS are clustered into three sectors – human development; economic and infrastructural; and administrative and inter-governmental. Each of the strategic objectives has a steering group that co-ordinates the work groups that function within the strategic objective.

The following are the 12 strategic objectives prioritised for inter-sectoral collaboration:

**Table 2: Twelve provincial strategic objectives**

<table>
<thead>
<tr>
<th>Strategic Objective 1:</th>
<th>Creating opportunities for growth and jobs</th>
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<tbody>
<tr>
<td>Strategic Objective 2:</td>
<td>Improving education outcomes</td>
</tr>
<tr>
<td>Strategic Objective 3:</td>
<td>Increasing access to safe and efficient transport</td>
</tr>
<tr>
<td>Strategic Objective 4:</td>
<td>Increasing wellness</td>
</tr>
<tr>
<td>Strategic Objective 5:</td>
<td>Increasing safety</td>
</tr>
<tr>
<td>Strategic Objective 6:</td>
<td>Developing integrated and sustainable human settlements</td>
</tr>
<tr>
<td>Strategic Objective 7:</td>
<td>Mainstreaming sustainability and optimising resource use efficiency</td>
</tr>
<tr>
<td>Strategic Objective 8 &amp; 9:</td>
<td>Promoting social inclusion and reducing poverty</td>
</tr>
<tr>
<td>Strategic Objective 10:</td>
<td>Integrating service delivery for maximum impact</td>
</tr>
<tr>
<td>Strategic Objective 11:</td>
<td>Increasing opportunities for growth and development in rural areas</td>
</tr>
<tr>
<td>Strategic Objective 12:</td>
<td>Building the best-run provincial government in the world.</td>
</tr>
</tbody>
</table>

In line with the quadruple burden of disease and the MDGS, the Department has formed six priority areas for increasing wellness:

a. Decreasing the incidence of infectious diseases (HIV and TB);

b. Preventing violence and road injuries;

c. Advocating healthy lifestyles to address non-communicable diseases;

d. Emphasising women’s health;

e. Emphasising antenatal- and child health; and

f. Emphasising mental health.

**The Strategy to Address the Six Priorities to Increase Wellness**

The WHO defines wellness as an optimal state of health of individuals and groups. This definition focuses on rights and responsibilities. The right to realise one’s physical, psychological, social, spiritual and economic potential, together with the individual’s responsibility to fulfill their expected roles in the family, community, place of worship, workplace and other settings.

The success of the 12 strategic objectives referred to in Table A.2 will result in a significant improvement in the socio-economic status of people and, in this way, will reduce individual vulnerabilities and consequences of the burden of disease and improve health outcomes and wellness. The Department of Health, therefore, will be strengthening its capacity to advocate for the six priority areas within the strategic objectives in order to understand health implications of interventions. For example, it is important to understand the health and social implications of minimum standards for low-cost housing that include the materials used in the houses and how they impact on disease burden, the urban design and how that facilitates or discourages living healthy lifestyles like increasing physical activity, the design of roads and how they influence road traffic injuries.

In addition, the Department of Health will work with other sectors to design, pilot and evaluate key interventions to increase wellness.

**Strengthening the Advocacy Role of the Department of Health**

The advocacy role of the Department of Health includes:

» The ability to provide mortality and morbidity information that identifies the communities most affected by
the burden of disease and its associated risk factors;

» Providing the evidence that shows the interventions that have been proven to successfully work elsewhere or in similar contexts;

» Establishing early warning systems for important risk factors;

» Working with other role players to support the design of these interventions locally; and

» Providing a system to monitor and evaluate progress towards addressing all (down-, mid- and upstream) risk factors and the associated diseases and providing recommendations on further action to be taken.

To perform this role the Department has invested in a Strategy and Health Support Chief Directorate that includes planning, health impact assessment, IT and M&E to provide the intelligence to the department and other role players. This unit consists of both technocrats and academics and has strategic partnerships with local universities and research institutions such as the Medical Research Council (MRC) and the HSRC.

**Wide Consultation**

On 8 November 2011 the Premier hosted a summit on reducing the burden of disease, which focused on infectious diseases, child health, woman’s health, violence and road injuries, and non-communicable disease. The summit was attended by over 250 people from government, the private sector, civil society and academia, and succeeded in:

» Reviewing the latest available data on the burden of disease;

» Providing the space for multi-sectoral dialogue on the technical strategy to respond to the burden of disease by all levels of government and role players outside of government in the private sector and civil society;

» Identifying an action agenda for implementation, designed to advance the collective effort of all role players to reduce the burden of disease;

» Getting a broad range of delegates to commit to undertakings in the Cape Town Declaration on Wellness.

The Declaration came up with the priority actions for all sectors. (See Table A.3)
### Table 3: Cape Town Declaration on Wellness priority actions

<table>
<thead>
<tr>
<th>Priority Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inter-sectoral action to address the root causes of ill health, injuries and inequity</td>
</tr>
<tr>
<td>2. Gender equality and the education of all children, as well as adult education</td>
</tr>
<tr>
<td>3. Creating safe &amp; stimulating environments that promote wellness for children and adults</td>
</tr>
<tr>
<td>4. Address the structural, legislative and behavioural constraints and mobilise whole society to make the right choice to:</td>
</tr>
<tr>
<td>» Eat healthy foods</td>
</tr>
<tr>
<td>» Promote breastfeeding</td>
</tr>
<tr>
<td>» Increase physical activity</td>
</tr>
<tr>
<td>» Stop smoking and not smoking in the first place</td>
</tr>
<tr>
<td>» Not do harmful drugs</td>
</tr>
<tr>
<td>» Test for HIV and having safe sex</td>
</tr>
<tr>
<td>» Drink alcohol safely</td>
</tr>
<tr>
<td>» Drive safely</td>
</tr>
<tr>
<td>» Stop violence</td>
</tr>
<tr>
<td>» Immunise against infectious diseases</td>
</tr>
<tr>
<td>» Responsibly use medicines</td>
</tr>
<tr>
<td>5. Take responsibility for the wellness of our children</td>
</tr>
<tr>
<td>6. Maximise the wellness of pregnant women and give special attention to the care of newborn babies</td>
</tr>
<tr>
<td>7. Promote early childhood nutrition through breastfeeding and effective early childhood development</td>
</tr>
<tr>
<td>8. Support long-term adherence to medication and chronic disease management at individual and community level.</td>
</tr>
<tr>
<td>9. Ensure interventions are informed by evidence and appropriate research</td>
</tr>
<tr>
<td>10. Ensure a strong health system to detect and manage disease and their risk factors early and treat it effectively</td>
</tr>
</tbody>
</table>

### Priority Interventions

#### Decreasing the incidence of infectious diseases (HIV and TB)

There are five main priority areas to reduce HIV and TB:

1. Promote HIV testing through the HIV counselling and testing campaign (HCT);
2. Promote the use of condoms in males and females;
3. Promote male medical circumcision.
4. Change behaviour to:
   » Reduce early sexual debut, concurrency, multiple partners, alcohol misuse and drug abuse and increase condom use
   » Social mobilisation to encourage Male Medical Circumcision, HIV testing and counselling.
5. Be more active in TB case finding and promote adherence to treatment until completion.

The strategy to deliver on the priority areas will be:

» Maximising the very wide network of partnerships fostered in HIV and AIDS within other departments in the public sector, the many civil society and community organisations and groups, and academia etc. to promote uptake of interventions and change behaviour.

» Strengthening the multi-sectoral Provincial AIDS Council (PAC) to provide strategic leadership and monitoring and evaluation for the multi-sectoral response through the establishment of a secretariat office.

» Establishing a technical committee of PAC to coordinate the evidence-based joint planning,
implementation monitoring and evaluation of the multi-sectoral response, including the big funders like PEPFAR.

» In the future establishing district Inter-sectoral committees that are technical committee for the DHS that coordinate district level inter-sectoral interventions for wellness and not just for HIV and AIDS.

**Preventing violence and road injuries**

Alcohol is one of the key risk factors for injuries and we know that this risk is concentrated in areas of high deprivation, with 50% of alcohol-related deaths occurring in five areas. The objective is thus to reduce alcohol-related injury harms. In the Western Cape, 60% of all deaths caused by road traffic injuries and homicide were alcohol related. Nearly 80% of these injury-related deaths occurred among males, particularly in the 20 to 34 year age group.

The following interventions are thus being implemented:

High Five: A focus on the five high-risk areas to deliver inter-sectoral alcohol-related violence-reduction interventions.

This focus will comprise:

» **Reducing supply of alcohol** and creating safer drinking environments through the implementation of the Western Cape Liquor Act led by the Department of Economic Development and Tourism

» **Reducing alcohol demand** through Booza TV campaign based on BoozaTV, which is an entertaining and provocative documentary mini-series consisting of six 24-minute episodes, which challenge the misperceptions that South Africans have about alcohol, alcohol abuse and how to reduce alcohol-related harm.

» **Piloting brief motivational interviews** in two trauma units aimed at testing the feasibility and effectiveness of conducting brief interventions for alcohol and drug abusers at a ‘teachable moment’ in the trauma wards.

**Violence prevention policy**

Because the causes and risk factors for violence and injuries are so multifactoral, an integrated provincial violence and injury prevention policy is required to institutionalise a consistent, long-term commitment to safety promotion and violence and injury prevention. This is consistent with international best practice, as echoed at the 5th Milestones Meeting in the Global Campaign for Violence Prevention that was hosted by the PGWC Health in Cape Town on 6 to 7 September 2011 in collaboration with the World Health Organization and the national Health Department.

The aim of the integrated provincial violence and injury prevention policy will be to ensure:

» Adherence to the key attributes of successful violence and injury prevention approaches, namely:
  » An intervention approach driven by an accessible evidence base and reliable injury surveillance data;
  » The strategic and systematic deployment of prevention resources to target high-risk times, places and groups at-risk;
  » The on-going monitoring of outcomes and risk factors for refinement and improvement; and
  » Balancing programmatic and policy interventions likely to reduce violence in the short term (such as those that reduce access to lethal means, e.g. firearms, and the use of drugs associated with violence and aggressive behaviour, e.g. alcohol) Making use of interventions that affect sustained long-term change to the social environment and societal norms that support violence (such as infrastructure for improved early childhood development and positive parenting);

» The establishment of a review and consultation process across relevant departments to align existing performance priorities and deliverables;

» On-going consultation with state- and non-state actors across the political spectrum as well as community organisations and stakeholders; and

» The institutionalization of an inter-sectoral framework that supports and sustains multi-dimensional prevention strategies over a long period to protect them from political vicissitudes.

The strategy to deliver on the priority areas will be:
To advocate for the adoption of the integrated violence and injury prevention policy by the provincial government and ensure sustained multi-dimensional prevention strategies that include:

- Investing in early interventions;
- Increasing positive adult involvement;
- Strengthening communities;
- Changing cultural norms;
- Reducing income inequality; and
- Improve criminal justice and social welfare.

In addition to providing quality emergency medical services, the Department of Health will strengthen screening for risk factors (especially alcohol misuse), provide brief motivational interventions, health promotion using Booza TV and rehabilitation services.

To establish a robust injury surveillance system in the emergency and forensic pathology services and provide geocoded data to influence decision making for targeted multi-dimensional prevention strategies such as the City of Cape Town Mayoral Urban Regeneration Initiative and the DEADT high streets model where an economic hub would be developed and shebeens strongly encouraged to move their businesses there.

To strongly align to the City of Cape Town Mayoral Urban Regeneration Initiative aimed at uplifting former neglected, dysfunctional areas that are regressing rapidly, and to improve safety, quality of life and the socio-economic situation, with a particular focus on the shared/public environment. This initiative is implemented using the strategy from the organisation Violence Prevention through Urban Upgrade (VPUU), the elements of which include a baseline survey and a prioritisation process in cooperation with community members and their representative bodies. The Department would provide the evidence for effective interventions and support the development of a community-level observatory to provide outcome data that can support targeting of interventions by government, civil society and communities.

Promoting a healthy lifestyle

The key priorities in promoting healthy lifestyles that affect cardiovascular diseases in particular include:

- Encouraging healthy eating
- Increasing physical activity
- Reducing smoking

This will be done using a settings approach, targeting three key settings:

1. The school
2. The workplace
3. The community

A school health programme is currently under development that will include the following:

1. Advocacy and capacity development of school leadership;
2. Baseline audit of current healthy-lifestyle interventions in schools;
3. Collaborative development of an appropriate intervention that promotes wellness using the integrated school health policy;
4. Piloting and evaluation of the intervention
   - A workplace programme for provincial government staff in collaboration with the employee wellness sub-group in strategic objective 11: building the best-run provincial government in the world. Advocating for all workplaces in the province to have workplace wellness programmes
   - Establishing wellness centres aimed at increasing awareness of chronic disease and availability of information and resources (not financial) to access treatment and change behaviour.

The key principles for these wellness centres will be:

- Providing free health checks;
- Prioritising people living in under-resourced communities;
- Positioning outside of the health services within communities;
» Locating in well frequented places in communities such as shopping centres;
» Establishing strategic partnerships with local pharmacies and other groups;
» Targeting younger people (25 to 54 years);
» Ensuring strong referral linkages with the health sector; and
» Conducting M&E.

The strategy to deliver on the priority areas will be:

» Supporting the implementation of the Western Cape Integrated School Health Implementation Framework within the departments of health and education, which includes ensuring schools are health promoting;
» Establishing partnerships with academic institutions to support the design, implementation and M&E of healthy lifestyles interventions in schools, workplaces and communities;
» Establishing partnerships with private and non-governmental organisations to use their infrastructure to deliver the aforementioned interventions, which include wellness centres; and
» Exploring and piloting innovative communication and behaviour change methods such as behavioural economics strategies.

Improving Woman’s Health (WH)

MDG goal 3 aims to promote gender equality and empower women. There is evidence that gender inequality increases the vulnerability of women and children to ill health. Intimate Partner Violence (IPV) is a proxy indicator for gender inequality and results in high levels of mental health problems – especially depression, anxiety, post-traumatic stress disorder and substance abuse. Teenage pregnancy, school completion, economic empowerment, crime and violence are also exacerbated by IPV and rape. The summit recommended:

1. The development of a policy on responding to gender-based violence (GBV) within health care settings;
2. Incorporating anti-gender-based violence programmes into specific WH services (sexual, reproductive, maternal health, HIV);
3. Providing IPV screening and services;
4. Training and support of health care workers to improve the quality of care of birthing practices (addressing abuse of women in labour and re-igniting caring and compassionate health care workers);
5. Developing effective models of psycho-social counselling to address the huge mental health burden and improving the quality of counselling services (standards, training level); and
6. Investing in programme/projects that work with young boys and young girls to address gender and social norms by working in close collaboration with the Department of Education.

To implement recommendation 2 to 5 the Department is piloting the IPV project in PHC facilities in the Cape Winelands and Northern/Tygerberg substructure.

The strategy to deliver on the priority areas will be:

» Integrate IPV screening, acute management and referral into the health services;
» Partner with the Department of Education through the Western Cape integrated school health implementation framework to work with young boys and young girls to address gender and social norms;
» Advocate for GBV interventions in the mayoral urban regeneration initiative; and
» Advocate for gender economic empowerment initiatives in strategic objectives 1, 8 and 9.

Improving maternal and child health

The summit recommended that a life course approach to child health be taken, especially since the social and health status of the mother influences child health. In addition to the wide range of clinical services provided for maternal and child health, the summit recommended that the following interventions be implemented:

» Engaging parents to promote a “well family concept”;
» Focusing on perinatal area (health of child begins from pre-conception’);
» Promoting exclusive breast feeding;
» Investing in the CHW (quality and coverage) programme; and
Investing in Early Childhood Development (ECD): SO8.

The strategy to deliver on the priority areas will be two pronged. The first will be to focus on health sector interventions that include:

- Prioritising perinatal and maternal health within health services;
- Ensuring all health facilities are mother-and-baby friendly and encourage breastfeeding;
- Strengthening the CHW programme to move towards geographic coverage;
- Undertake research to develop an evidence-based breastfeeding restoration policy that takes into account social determinants and provides recommendations for inter-sectoral action; and
- Continuing to improve the quality and universal coverage of child health services such as immunisation.

The second prong of the strategy is that of advocacy and collaboration. The Department will:

- Continue to collaborate with SO8 and advocate for an approach that strengthens families and promotes a “well Family concept” through the provision of the evidence to inform this;
- Continue to collaborate with SO8 on ECD and particularly around nutritional support; and
- Advocate for particular vulnerable communities with adverse child and maternal health outcomes on the basis of the mortality and morbidity surveillance system.

Strengthening Mental health

The life course approach needs be employed to address mental health and focus on the following four periods:

- **The perinatal period**
  
  Improving perinatal mental health has been shown to yield very high returns in health outcomes of women and children. These outcomes are very sustainable with long-term effects on the child in particular that can be identified even in adulthood. Currently there is very high coverage and frequency of contact for the antenatal period. Intervening at this stage is likely to yield a very high impact over the medium- to long term.

- **Childhood**
  
  ECD also has a very high return on investment and has been shown to be effective even up to 27 years post-intervention.

- **Adolescence:**
  
  Mental health programmes in schools indicate that nearly half grade 10 to 12 year olds have mental health problems, with substance abuse – particularly alcohol – being the major problem.

- **Adulthood**
  
  Mental health integration into PHC, HIV and chronic disease health services will address about half the adults with these co-morbidities.

The strategy to deliver on the priority areas will include:

- Integrating screening, acute management and referral into perinatal, PHC, chronic and HIV services;
- Collaborating with the substance abuse workgroup to strengthen community-based adolescent services to prevent mental illness; and
- Collaborate with the DSD and DoE for
SECTION C: FROM HEALTH SERVICE DELIVERY TO PATIENT-CENTRED CARE
SECTION C: FROM HEALTH SERVICE DELIVERY TO PATIENT-CENTRED CARE

SUMMARY POINTS
1. The crux of a re-imagined future in 2030 is the focus on patient-centredness.
2. The four conceptual pillars of patient-centred care are:
   a. Person-centred approach
   b. Integrated provision of care
   c. Continuity of care
   d. Life course perspective

**Introduction and Background**

In this third wave of health reform in the Western Cape, the focus will be on the patient experience and outcomes – i.e. patient centeredness. This re-imagined future is described in the vision and principles of 2030 and requires conceptual clarity on the elements of being patient centred. This attempt at defining the elements will be further refined through the comments we receive on this version of 2030, as well as the facilitated dialogues that will be held to develop a shared vision of 2030. This section should be read in conjunction with the section on quality that explores this area even further and provides more detail on how the Department intends to give effect to these concepts. The four elements of this approach are shown in Figure 2.

**Person/Patient-centred Approach**

The organisation of care that has a patient perspective instead of an organisational perspective requires patients to be treated with dignity and respect, to be listened to and provided with information that they can understand, and to be involved and empowered in making informed choices and determining their treatment options. In this context, clinical staff manage their patients holistically, by locating the illness within a broader personhood, family and community context, understanding the socio-economic and other contextual factors, and refraining from adopting a technocratic clinical approach to the management of the patient.

Understanding and addressing a patient’s concerns enables appropriate and effective management of the condition. A patient-centred approach, built on a relationship of trust, leads to increased compliance, improved quality of care and, ultimately, better health outcomes.

**Life Course Perspective**

The health provider needs to develop a trusting relationship with the patient that takes into account the past history as well as the future relationship with the service. The availability of patient records is important for this purpose. Each episode is like the single brick in the life course path of the patient. From a departmental perspective, it is also important to plan and manage the health service from a life course perspective: from antenatal care to neonatal care and child health to adolescence and adulthood to the final stages of life. Each of these stages has specific needs that the Department needs to be responsive to.

**Integrated Care Provisioning**

Multidisciplinary teams will be deployed to develop care pathways for specific patient groups that reference all aspects of care. Existing guidelines and protocols applicable to individual professions will be included in care plans to ensure a patient-centred approach, efficiencies, improved communication, and improved clinical outcomes.

All stakeholders need to work with a single assessment and care planning process as the patient’s journey crosses the entire service platform. There will be shared authority in care provisioning as a result of inter-professional collaboration.

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**Figure 2: Key conceptual pillars of patient-centred care**
**Continuity of Care**

The aim of the continuity of care processes is to provide seamless care in a consistent manner. There needs to be continuity of care for patients who need to utilise services from more than one level of care or facility if they are to achieve the desired health outcomes and goals. The referral and discharge processes are key opportunities in the patient’s journey where health care providers can contribute to continuity of care. An effective process of discharge planning or referral from hospital has the potential benefits of reducing re-admissions and the average length of stay and empowering patients with useful information for self-care.

Comprehensive record keeping, access to medical records, efficient transfer of medical information between health care professionals and adequate provision of suitably skilled staff are essential to ensuring that patients receive a continuum of care. Strengthening the relationship between health professionals within and between institutions also helps the smooth referral of patients and continuity of care.

**SUMMARY POINTS**

1. The vision for 2030 is: *Access to patient-centred, quality care*.
2. A narrative that captures multiple perspectives of this vision is described. These perspectives include those of patients, staff, the community, the Department, spheres of government and strategic partners.

**Introduction and Background**

The Department is excited about developing a shared vision of a re-imagined future health service with the staff and our strategic partners. This is a meaningful and energising process that has already started and will continue over the forthcoming period.

The strategic planning process provides an opportunity to redefine the departmental vision for 2030. The objective is to deliver an improved, quality patient experience to the people of the Western Cape within a world-class public sector health service.

The vision should motivate the population of the province, in partnership with the provincial government, to take responsibility for their health and for the Department to achieve amongst the best health outcomes in the world.

At the heart of the vision for 2030 lies the concept of access to patient-centred, quality care. To bring the vision for 2030 to life, we have described in detail what achievement of the vision will feel like for a range of role players, from patients to other stakeholders.

In order to change behaviour, the expanded vision statement seeks to resonate with audiences on a physical, intellectual and emotional level.
The Expanded Vision Statement

Preamble

Access to health care is a constitutional human right in South Africa that needs to be progressively realised. Achieving optimal health outcomes of the population requires robust upstream interventions by the whole of society and a high-quality, comprehensive health service. We will strive to achieve excellence in delivering health care by 2030. This will be achieved in partnership with caring, competent and committed staff, aided by modernised health systems, infrastructure and technology and in collaboration with all stakeholders and partners.

The narrative below describes what the experience of the Western Cape Department would be like in 2030 if the vision were achieved.

What does it mean for patients?

A patient comes to the health service because he or she has an appointment (unless this is an emergency) and is greeted on entrance by a staff member, who is friendly, helpful, empathetic and caring. The staff are equipped to respond to any queries of the patient or family member and to direct the patient to the necessary sections of the facility. Patients will not wait longer than is reasonably acceptable, as their file will be available because the patient will have an appointment for a planned visit. Patient files will be stored electronically, which reduces the incidence of lost folders and production of duplicates, reduces the physical space for storage of folders and, most importantly, reduces the waiting times for patients at facilities. The electronic record will be available across facilities and will help in the communication and referral between health professionals and the provision of continuity of care in the life course of patients.

The patient will move smoothly through the well-signposted facility without unnecessary delays at any service point. The one-to-one relationship between the patient and staff will build trust and confidence. Patients are respectful of health workers and the facility. Further, patients will be able to take responsibility for treatment compliance and assume responsibility for their health by leading a healthy lifestyle.

Facilities will be well maintained, clean and neat at all times. In addition, through appropriate design and construction, the facility will be environmentally friendly and efficient.

The patient will leave the facility satisfied with the service received and the clinical treatment provided. They will feel that they have been accorded dignity, respect and care. Patients will express confidence in the Western Cape Health Department.

What does it mean for staff?

Staff will be proud of what they do and to be employed in the public health service. Staff are recognised, respected and appreciated for their service by both patients and communities.

Staff are motivated and exercise initiative. The attitude and actions of staff towards patients is one of caring and clinical competence. Staff are empathetic, not only towards the immediate illness that the patient faces, but also to the broader context and challenges faced by patients, their family and community. Clinical staff will endeavour to develop a meaningful relationship with patients based on trust and understanding. Staff will feel a part of the local community and will be encouraged to participate in local activities.

Staff will be fully engaged and will feel valued, will feel empowered to use their judgement to make the lives of their patients better, and will be willing to go the extra mile in their jobs. They feel supported by their peers, supervisors and management. Staff will work together as coherent teams to provide an optimal service. They will feel ‘heard’ and their problems will be efficiently addressed. Staff will feel safe in their workplace.

Systems will be created to ensure that staff have access to knowledge networks. They will be eager to learn and improve their knowledge and skills on an on-going basis.

Patients will leave the facility satisfied with the service received and the clinical treatment provided. They will feel that they have been accorded dignity, respect and care. Patients will express confidence in the Western Cape Health Department.

Staff will be fully engaged and will feel valued and empowered to use their judgement to make the lives of their patients better, and will be willing to go the extra mile in their jobs.
What does it mean for the Western Cape Department of Health?

The Department will have a reputation as the best health department on the continent, rendering a health service that is regarded as amongst the best public sector health services in the world. This reputation will be built primarily on the delivery of good quality health services that are accessible to all in the Western Cape. The Department advocates for a healthy and responsible lifestyle amongst the population both through direct engagement with patients and the community as well as through mobilising other sectors to mitigate the social and economic determinants of health.

The Department is responsive to the needs of the population; it is a learning organisation, and is innovative in developing new models of care. The Department operates a well-functioning health system that is coherent, co-ordinated and focused on the delivery of a superior patient experience and optimal health and organisational outcomes.

Over and above the personal health care that is rendered within the health service facilities, the Department will be pro-actively engaging families and communities through community-based services and other mechanisms. This is a significant development to address population health more broadly. Building resilient mechanisms between the health service and the community will stand the province in good stead to address eventualities such as disease outbreaks and the consequences of climate change including floods and fires. Good intersectoral collaboration at various levels with other stakeholders will be strengthened.

The organisation operates efficiently within its budget and renders a service that is financially sustainable. It receives unqualified and clean audits as a matter of course. The Department has clear strategic and operational plans, with definitive targets and is publicly accountable for results that are based on accurate and reliable information. The Department has institutionalised efficient systems and processes.

It is a corruption-free and well-governed organisation. The Department is sought after by employees as an employer of choice, because people see health workers as inspiring, well rewarded and respected. Employees are recognised and have opportunities to grow with the organisation. The leadership and staff of the Department live the values of the organisation in their daily practice, which is: caring, competence, accountability, integrity, responsiveness and respect.

The community takes responsibility for its health by adopting healthy lifestyles. Opportunities will be available to promote wellness and for the community to be screened for the early detection of chronic diseases. Patients will also feel supported as community members will help them take their medication and attend their health facility when required.

Access to the public health service provides a strong social safety net for the poorest of the poor and prevents catastrophic health spending that plagues poor families into deeper poverty. The public confidence in the Department’s health service is an important contribution to strengthening social capital in the province.

The community is healthy and happy and levels of unemployment are low. There is good-quality housing with electricity, clean water and sanitation. The schools provide effective education; roads are well lit and local businesses create wealth and economic opportunities. People feel it is safe to walk on the streets during the day or night because there is little or no crime. Good recreational and sporting facilities and libraries with Internet connectivity raise the quality of life. Public transport is affordable and accessible.

What does it mean for the community?

The health service operates in a way that ensures that the community trusts and has confidence in the service and in health workers.

Communities are well organised and can represent their interests by engaging with health management. The community takes ‘ownership’ of health facilities and services. There will be efficient structures to enable effective communication with the community. The Department, as part of a developmental state and through its intention to give stronger voice to the community, will endeavour to build capacity and deepen this relationship and the mechanisms of communication and accountability through the legislative provisions of the district councils, facility boards and clinic committees. These structures should be strengthened to monitor the performance of the health service.

There is a full team of community health workers (CHWs). They have access to every household in the community. They are a direct link between the family, community and the health service and carry the message of healthy living to the people. They ensure that pregnant mothers attend the antenatal clinic, babies are immunised and patients take their medication regularly and correctly. They also provide health care advice on a range of issues including health prevention and promotion. Patients are referred to the clinic when necessary or managed at home. CHWs identify social problems and liaise with local social services, when necessary. CHWs live in the same area in which they work and have a good working relationship with the staff of their local clinic. CHWs will develop a solid relationship with each of the families they are responsible for and will form a critical bridge based on trust and empathy between the health service and families in the community.

The community takes responsibility for its health by adopting healthy lifestyles. Opportunities will be available to promote wellness and for the community to be screened for the early detection of chronic diseases. Patients will also feel supported as community members will help them take their medication and attend their health facility when required.

The community takes responsibility for its health by adopting healthy lifestyles. Opportunities will be available to promote wellness and for the community to be screened for the early detection of chronic diseases.
What does it mean for our stakeholders and strategic partners?

We enjoy strong, vibrant, mutually respectful relationships with our partners, who share the common goal of providing better healthcare for the population. There is open and regular communication with all of our partners.

There is a strong co-operative relationship with local government, particularly within the district health service.

Our staff, as members of well-organised unions, consider their interests as workers to be protected. There is a good relationship between organised labour and the Department, which results in labour stability and promotes good-quality essential patient care.

A synergistic relationship with universities is intrinsic to delivering an effective health service. Well-trained, competent and caring health professionals with a shared vision and value system are essential to providing a quality, patient-centred experience. The training provided by our partners as well as within the Department must be aligned to meet the skills required by the health service. Research is necessary to better understand the complex health service and improve clinical care. Interventions need to be evaluated so that lessons can be learned. Best practices will be shared. The relationship with universities will be used to access the technical expertise and knowledge to improve the performance of the Department in an on-going manner. This relationship will extend beyond health sciences to supportive disciplines like social sciences, information and communication technology, medical technology and architecture.

The Department will have all of its fixed health facilities connected and provided with the basic information systems that enable better patient care and auditable and effective monitoring, reporting and evaluation of performance. Electronic content management systems will enable better patient record management throughout the Department. The availability of mobile technology amongst the general public provides great opportunity to interact with patients and the community differently. The Centre for e-Innovation (CEI) within provincial government and SITA will provide effective leadership and support to facilitate progress in this regard.

The future vision is that the Department of Transport and Public Works is an effective implementing agent, which will consequently provide and promote modernised, well-constructed and maintained facilities that are adequately equipped.

There will be a strong contractual relationship with non-profit organisations (NPOs) to improve access to basic health services, especially at a community level and based on an agreed funding formula.

The partnership with the private sector is essential in the interests of improving access to and the quality of patient care. The Department will also have other mechanisms such as a Health Foundation that will enable the private sector to meaningfully contribute to the development of the public health service. The Department is one of the largest procurers of goods and services from the private sector and remains in a strong position to give effect to the policies such as Black Economic Empowerment and Green procurement policies. Suppliers are paid on time and the mutually dependent relationship is strong.

What does it mean for government?

The provincial government is responsible for mobilising all the departments, other spheres of government, civil society and the business sector to improve the wellness of the whole of society.

The provincial government has appropriate and effective strategies and mechanisms for inter-sectoral action for health and wellness. This will be extended from provincial level to district level.

Health is regarded as an important prerequisite for development within the province and is consequently adequately resourced.

The Western Cape Department of Health will give tangible effect to delivering a superior patient experience, optimal health outcomes as per the Millennium Development Goals and effective and efficient health system performance. While the provincial department will operate within the legislative and policy parameters of the national department, it will also be a laboratory for innovation and a testing ground for proof of concept and learning lessons from implementation within the South African context.

The province will provide leadership in health development. It will also be strongly collaborative with sister provinces and the national department as a two-way learning and support process.

At a local level, district health management will liaise and work with local government to ensure co-ordinated planning and delivery of services. Inter-sectoral collaboration is most effective at the local level.
VALUES

Summary Points
1. The values of the Department are caring, competence, accountability, integrity and responsiveness.
2. The challenge of the Department is how to make these values a living reality for each of the staff members throughout the Department as we move towards our vision for 2030.

Introduction and Background
The Department renders a large and complex service every day of the year and the clinical environment is often stressful. Staff attitudes are a common source of complaints. A key issue is how greater commitment and engagement from our staff can be promoted on a daily basis, so that we can move towards a more patient-centred service with a greater focus on quality improvement.

Values are important in building a cohesive organisation. The provincial government has adopted a values-driven approach.

The five core values of the provincial government have been identified as caring, competence, accountability, integrity and responsiveness. After an internal reflection the Department has also added “respect” to the list.

Potentially limiting departmental values were identified as bureaucracy, hierarchy, control, long hours and confusion. There was a general consensus among all staff on the desired set of values for the department.

The challenge of the Department is how to make these values a living reality for each of the staff members across the Department as we move towards our vision for 2030. The Department will be embarking upon a change management exercise to engage staff in this process.

PRINCIPLES

Summary Points
1. The principles of 2030 are:
   a. Patient-centred quality of care
   b. Outcomes-based approach
   c. PHC philosophy
   d. District health services model
   e. Equity
   f. Efficiency
   g. Strategic partnerships
2. The evolution of a shared meaning and rich, common understanding of these principles will happen through a series of dialogues with staff and partners over time.

Introduction and Background
Each of the principles that inform 2030 are described in detail below to ensure that the meaning of each principle is fully understood and interpreted in the same way. The evolution of a shared meaning and rich, common understanding of these principles will happen through a series of dialogues with staff and partners over time.

Patient-centred Quality of Care
The quality of care, with a focus on patient experience, lies at the heart of 2030. Excellence in clinical quality of care and the need for superior patient experience must inform every effort of the public health sector in the Western Cape. Patients must be treated with dignity and respect within a safe and clean environment. Waiting times should be acceptable and essential drugs must be available at all times. The Department will strive to meet the core standards developed by the National Department of Health.

A Move Towards an Outcomes-based Approach
The Department will focus on improving health outcomes, which will include improving life expectancy and reducing maternal and child mortality. Targets will be guided by the MDGs. Evidence-based interventions that have the largest impact on the desired outcomes will be prioritised. This also implies a more rigorous approach to disease prevention and promotion. A strong culture and system of monitoring, evaluation and learning will be embedded at all levels of the organisation to ensure we deliver on these targets.

The Primary Health Care Philosophy
The PHC philosophy refers to the provision of a comprehensive service that includes preventive, promotive, curative and rehabilitative care. The primary care service is the point of first contact for the patient. These primary-level services are supported and strengthened by other levels of care, including acute and specialised referral hospitals and an efficient patient transport service. The philosophy is also premised on the understanding that wellness cannot be promoted in isolation from the social, economic and political environment. A central tenet of the PHC philosophy is...
community involvement in health. This implies that the community not only takes ownership and responsibility for its own health care at a personal level but, as a community, is also actively involved in the decision making and governance of health services.

**Strengthening the District Health Services Model**

The DHS model gives a district manager and his or her team responsibility and authority for achieving the health outcomes targeted for a specific geographical area that is a health district. All health services (public and private) provided within the area will be co-ordinated by the district health management team. The district manager will be accountable and play a stewardship role in securing and accessing the support of other levels of the service. Health will be delivered within well-defined sub-district boundaries and district boundaries in the province. All public sector health services will be provided by a single authority. This is already the case for the rural districts. The district model will be further strengthened to ensure the desired health outcomes of 2030.

**Equity**

Serious inequity continues to exist in post-apartheid South Africa as confirmed by the NDP. These inequities exist between provinces and in the province of the Western Cape. Inequity exists between rural and urban areas, within the urban areas between formal and informal communities, as well as between the public and private health sectors. Equity is an internationally recognised principle of social justice. While this is a broader issue for government, the Department will need to address equitable allocation of resources, supervise the provision of services and monitor health outcomes.

**Efficiency**

The Department will advocate for adequate resources for the provision of health care. However, once the budget has been allocated the Department will need to operate responsibly within its budget allocation. Cost-effective priorities will have to be set and regularly reviewed to address the mismatch between escalating health needs and limited resources. The Department will strive to optimise efficiencies to obtain best value for the health rand. The Department will plan and function in a cost-effective and sustainable manner for the future.

**Building Strategic Partnerships**

It is essential that the provincial government seeks out and builds creative partnerships with role players in the private sector, civil society, higher education, labour movement, other spheres of government and internationally.

Improving the health status of the population requires a ‘whole of society’ approach and the capacity and resources within the private sector need to be engaged, given the disparity between what is spent versus the population coverage in the public and private sectors.

The production of competent and caring health professionals is an essential requirement to enable the Department to deliver on its 2030 mandate. Research will play an important role in improving the performance of the Department. It is important that the partnerships between the Department and universities are strengthened.

Labour stability is vital to the efficient and effective delivery of health services. Good structural arrangements already exist at both local and provincial levels to foster a healthy working relationship. This will be sustained.

The provision of environmental health is an important component of PHC and both spheres have to work together to ensure a cohesive approach.

The promulgation of the Districts Health Councils Act in the province provides a statutory framework for working with local government.

Over recent years, NPOs and community-based organisations (CBOs) have become increasingly important as providers of community-based services. There will be major expansion and strengthening of these services towards 2030. Good structural and contractual arrangements and strong collaborative management are key to success in this area.

The WC Ministry of Health has already started an exciting engagement with the private sector, which has shown a willingness to invest in the public sector. Commercial opportunities are being investigated that can be mutually beneficial. A public-private health forum exists and a Health Foundation has been recently created, which provides a structured opportunity for engagement with the private sector.
SECTION D:
LEADERSHIP AND GOVERNANCE
SECTION D: LEADERSHIP AND GOVERNANCE

LEADERSHIP

Introduction and Background

The re-imagined future requires a range of change agents (inside and outside the Department) to lead the required health system transformation process towards vision 2030. The Department will need to invest in building strong transformational leadership alliances with its strategic partners.

The Department recognises that it requires a strong focus on transformational leadership in light of its hierarchical and bureaucratic nature. The intention is to develop managers and clinicians who:

» Embody organisational values in the behaviours;
» Depend on interpersonal forms of power, as opposed to power based on a position in the hierarchy;
» Nurture creativity to enable innovation;
» Draw on the inherent and potential capabilities of all employees in the Department; and
» Are visibly collaborative in their relationships with staff and external stakeholders

The key challenge will be to create a work environment that harnesses the relationships and the skills and capabilities of individuals in the system. Managers at all levels need to be visible at thecoalface to support the frontline staff, listen to their issues and needs and address problems with creative solutions. Frontline staff need to be acknowledged and recognised for their efforts, dedication and commitment to patient-centred care. Managers need to be receptive to constructive criticism and be accountable when they fail to accept such input.

Leadership should be both designated (i.e. someone must be formally in charge of the change process) and distributed (i.e. professionals and other employees must share responsibility for mobilising the change efforts). Distributed leadership does not necessarily require an individual who can perform all of the essential leadership functions. Some leadership functions may be shared by several members of a group, some leadership functions may be allocated to individual members, and different people may perform a particular leadership function at different times. Such collective leadership provided by different employees of the Department will be essential.

There will have to be a focus on the practices and relationships involved in leadership and developing shared and evolving leadership through purposeful mentoring strategies. In our current health system, the complex layering of both the system and the multiple levels of professionalised autonomous practice means that distributed leadership is not only optimal but also necessary for the envisaged large-scale transformative change to take place.

‘Top-down’ leadership alone will not achieve whole-system change because (a) health systems are complex; (b) power is distributed among professional groups; (c) care is necessarily multidisciplinary; and (d) professions have their own norms and hierarchies.

External change management consultants will be contracted to:

» Facilitate individual behaviour change towards patient-centred care;
» Embed reciprocal accountability and assertive communication to achieve values alignment in the Department; and
» Initiate a process of leadership development amongst middle- and senior management members.
The concept of reciprocal accountability is a major shift from the convention where higher-order structures in the Department hold the facilities that deliver services accountable for results to where the facilities also hold the higher structures accountable for the enabling support they need to provide to the facilities.

The Department will invest in developing the prerequisite capabilities of managers and clinicians to manage in the increasingly complex and challenging environment.

The competing values framework is a useful management model, as it is designed to develop the capabilities of managers and clinicians to lead and manage effectively. The application of the model is a balancing act that must be context- and situation specific. The Department will use this framework to improve its organisational effectiveness.

The competing values framework draws on the four domains of organisational effectiveness. Each domain has a perceptual opposite. The “people domain” stands in contrast to the “results domain”. In the “people domain”, people are inherently valued, but in the “results domain” people are of value only if they contribute greatly to the attainment of targets. The “innovation domain” runs counter to the “rules domain”. While the “innovation domain” is concerned with adapting to the continuous change in the environment, the “rules domain” is concerned with maintaining stability and continuity inside the system.

**Figure 3: Competing values framework**

Source: R E Quinn et al.; 2010
GOVERNANCE

SUMMARY POINTS

1. The Commission on Global Governance defines governance as “the sum of the many ways individuals and institutions, public and private, manage their common affairs. It is a continuing process through which conflicting or diverse interests may be accommodated “through compliance and/or cooperation and through formal or informal means”.

2. According to the UNDP, good governance is accountable, transparent, responsive, equitable and inclusive, effective and efficient, participatory, consensus-oriented and follows the rule of law.

3. There is a rich legal and policy architecture that underpins the provision of public sector services in general and health services in particular. This includes the PFMA, National Health Act, the Facilities Board Act and the District Councils Act.

4. Greater efforts will be made to make the statutory structures more functionally effective as conduits of community concerns. This will include more effective communication and information sharing, capacity development within these structures and deepening of the relationships between them and the department, based on trust and mutual respect.

5. Transparency, responsiveness and information sharing are important prerequisites for accountability. Greater effort will be made to communicate these plans and reports to the public, in a user-friendly manner.

6. Clinical accountability will be embedded within the Department in line with the departmental clinical governance policy framework.

Introduction and Background

The Commission on Global Governance defines governance as:
the sum of the many ways individuals and institutions, public and private, manage their common affairs. It is a continuing process through which conflicting or diverse interests may be accommodated and cooperative action may be taken. It includes formal institutions and regimes empowered to enforce compliance, as well as informal arrangements that people and institutions either have agreed to or perceive to be in their interest.

According to the United Nations Development Programme, good governance is accountable, transparent, responsive, equitable and inclusive, effective and efficient, participatory, consensus-oriented and follows the rule of law.

Figure 4: UNDP principles of good governance

Source: UNDP; 1997

The outcome of good governance will be a public health system in the Western Cape that produces the desired outcomes, especially in terms of meeting the expectations of the people it serves. The 2030 vision narrative describes multiple perspectives and implies the roles and responsibilities of various parties in striving to achieve this vision. The Department commits itself to the UNDP principles of good governance. It is therefore imperative to create the enabling conditions to allow for good governance, which should be contextualised within our local setting and conditions. We therefore require effective mechanisms for meaningful oversight of the policy development, institutional arrangements, authority- and decision-making arrangements in the provision of health services in the Western Cape. Some of these mechanisms are elaborated on below as well as under the section on 2030 principles.

Legislation and the Rule of Law

There is a rich legal and policy architecture that underpins the provision of public sector services in general and health services in particular. The National Health Act is the main legislation that provides the overarching legislative framework for health services.

The District Health Council Act and the Health Facility Boards Act provide the legislative framework for governance structures in the Western Cape health system. The Health Facility Boards Act will be amended to make provision for PHC facility committees.
It is imperative that the legislative framework allow for effective oversight at individual facility level and decentralised geographic areas, as much as at centralised levels.

**Public Participation**

Public participation and true local community involvement are integral parts of the 2030 principle of the PHC philosophy. Greater efforts will be made to make the statutory structures more functionally effective as conduits of community concerns. This will include more effective communication and information sharing, capacity development within these structures and deepening of the relationships between them and the Department, based on trust and mutual respect.

2030 envisages public participation and local community involvement with the Department to improve the health status of the population. This could range from an active role in the governance of health facilities to encouraging community campaigns around healthy lifestyles. The extensive network of CBOs and NGOs will be supported and engaged as part of this process.

The investment in community-based services and the fact that community care workers are engaging with families within their homes provides a basis for increased understanding of the many inter-related factors impacting on health. The interaction between health workers and patients must be seen as opportunities to build trust, confidence, and the sharing of information.

Patient satisfaction surveys and complaints and compliments from patients will be important sources of feedback to the health service and used as a basis for continuous improvement.

**Accountability**

Transparency, responsiveness and information sharing are important prerequisites for accountability.

The Public Finance Management Act (PFMA) and the Public Service Act (PSA) provide the legal framework for the efficient management of resources and ascribes accountability to officials at various levels within the Department. There are statutory processes for the tabling of annual plans and reports on performance to the legislature by the executive authority (provincial Minister of Health) and the accounting officer (Head: Health). Greater effort will be made to communicate these plans and reports to the public, in a user-friendly manner. District health councils and facility boards provide important local vehicles for communication and accountability.

The formal audit process and the Office of the Auditor-General, who reports independently to the legislature, ensure compliance with legal prescripts.

Clinical accountability will be embedded within the Department in line with the departmental clinical governance policy framework.
SECTION E:
SERVICE DELIVERY PLATFORM
SECTION E: SERVICE DELIVERY PLATFORM

SUMMARY POINTS

1. The structure of the envisioned 2030 service platform retains the original configuration of 2010 with a strengthening of CBS, PHC and district hospitals.
2. The essence of the change is how we do business from this service platform.
3. The focus is on patient-centred quality care, integrated provisioning and continuity of care throughout the life course of the patient.
4. This section focuses on the general health service platform and does not deal with specific disciplines or sub-specialities.
5. Special reference is made to TB, rehabilitation, mental health and oral health to provide context to the realignment of these services from the specialised hospitals to within the mainstreamed health service.

Introduction and Background

2030 centres on the re-orientation of the health system toward patient-centred care; it recognises patients as partners in managing their own health and that of the broader community. It aims to create a health system that is designed around the needs and expectations of the people it serves, ultimately creating care that is more socially relevant and responsive. This requires a service delivery model oriented towards health and wellness rather than disease, which necessitates a rethink of how services are offered and the development of new ways of working that would enable patient centredness, comprehensiveness, integrated care provisioning and continuity. The intention is the development of a delivery model with close-to-patient interdisciplinary teams responsible for a defined geographical area, with greater capacity for prevention and health promotion. It is important that the delivery model is able to keep pace with the varying needs of patients as they progress along their life course trajectory.

The service delivery platform as envisaged in the 2030 document retains its 2010 structure, but has two important differences. There will a significant focus on expansion and strengthening of community-based services (CBS) and the manner in which we render services. We will move from a mind-set of delivering services mechanistically and often impersonally to patient-centred care at all levels of the service. The planning methodology used in developing the 2030 strategy, has been included as Annexure E.

In the 2030 envisioned delivery model, PHC will be rendered in an array of sites, from the home to facilities like clinics and Community Day Care Centres (CDCs). Acute care will be predominantly rendered from the hospital platform with three levels of care, in the form of the district hospital (L1), the regional hospital (L2) and the tertiary and central hospital (L3). In addition there are hospitals with more targeted specialist services like TB, psychiatric care, rehabilitation and dental care. EMS is integral to facilitating access to emergency medical care and patient transitioning between levels of care. The intention to have ninety percent of contacts occurring within district health services (i.e. CBS, facility-based services (FBS) and district hospitals) remaining as we deliver the “right care, at the right time, in the right setting, every time” a reality.

The 2030 envisioned delivery model retains the original configuration of 2010, where PHC is rendered in an array of sites, from the home to facilities like clinics and Community Day Care Centres (CDCs). Acute care is predominantly rendered from the hospital platform with three levels of care, in the form of the district hospital (L1), the regional hospital (L2) and the tertiary and central hospital (L3). In addition there are hospitals with more targeted specialist services like TB, psychiatric care, rehabilitation and dental care. EMS is integral to facilitating access to emergency medical care and patient transitioning between levels of care. The intention to have ninety percent of contacts occurring within district health services (i.e. CBS, facility-based services (FBS) and district hospitals) remaining as we deliver the “right care, at the right time, in the right setting, every time” a reality.

2030 is inherently concerned with the health of everyone in the province, and thus requires a delivery model that enables a more dynamic continuum of care, particularly if it is to keep pace with the varying needs of patients as they progress along their life course trajectory. Significant investment is made in the re-organisation of CBS as we bring care closer to where people live. The re-organisation of the health services will need to take into account the changes of one section and its impact on other sections of the platform.

Figure 5: Service delivery platform for 2030
Planning Methodology

The planning parameters and methodology for the health service in general used for 2030 is a major advance on that used for 2010 and is based on four major tenets:

» Using a population base and the notion of a dependent population;
» Using the smallest geographic entity for which reliable health and socio-economic data is available;
» Using an equity measure with household income as a proxy that weights the distribution of health resources towards the poorest households; and
» Establishing norms and creating planning tools for different aspects of the health service that allows for its application to specific geographic areas. The tools used in one section of the health service take into account the impact of developments in other sections of the service; in this way the health service is viewed as an integrated health system.

The general tenets are further described in Annexure E and the specific application to various aspects of the health service is described under the service components.

Primary Health Care Services

Introduction and Background

The primary health care (PHC) service component of the health system is the most critical component, as it serves as the entry point into the care continuum, and caters for the vast majority of patient contacts. It comprises two distinct but inter-related service delivery platforms:

1. Community-based services (CBS), which includes:
   » Home-and community-based care (HCBC); and
   » Intermediate care.

2. Primary care services (PCS) at health facilities, as well as non-medical sites.

For a diagram displaying these inter-related services, see Figure 5.

The social dimensions of disease create the need for continuity, coupled with more comprehensive and person-centred approaches to care. These necessitate PHC services that:

» Cater for a range of health risks and illnesses;
» Recognise people as partners in managing their own health and that of the broader community; and
» Re-orientate care around people’s needs and expectations, making care more socially relevant to producing better health outcomes.

The 2030 principles require the PHC services to have significantly greater operational capabilities, especially for increased access to services that meet a range of patient needs. A significant investment in CBS will allow for the increased PHC service coverage that will be required. Areas of particular expansion are in health promotion and preventive and rehabilitative care.
SUMMARY POINTS

1. Community based care (CBS) is embedded in the local context and is innately designed to foster stable, long-term personal relationships with households, which build understanding, empathy and trust. The service model is population based and organised per electoral ward in the metro and per sub-district in rural areas.

2. The HCBC model provides for poorest households having greatest access to CHWs. There will be 270 households per CHW and 10 CHWs per professional nurse. CHWs will work an eight hour day. The model provides for 30 minutes per household visit on average and allocates fifty percent of the CHWs’ employed time for direct patient care.

3. Intermediate care, which involves post acute, rehabilitative and end-of-life care, is essential for alleviating the pressure on acute hospital beds.

4. Intermediate care teams will work in close collaboration with HCBC teams. Rehabilitation care workers (RCWs), working under the direction and clinical supervision of professional therapists, deliver the bulk of required therapy.

5. Rehabilitation on the CBS platform will be available for all impairment groups, including mental ill health and intellectual disability. Supported living environments and occupational enrichment programmes are all part of the fabric of wholesome rehabilitation.

An enduring relationship between the provider and the people served is crucial to being able to plan care pathways that take into account their individual values, the family’s values, and their lifestyle and life perspectives.

2030 Service Configuration for PHC services

Community-based services (CBS)

Introduction and background

Community-based services are rendered in the living, learning, working, and social and/or play spaces of the people we serve. They are geared towards prevention and health promotion with a complementary capacity for curative, rehabilitative and palliative care. CBS is embedded in the local context and is innately designed to foster stable, long-term personal relationships with households that build understanding, empathy and trust. This is pivotal to continuity and person-centred care. CBS is envisaged to have two service elements:

a. Home and community-based care (HCBC); and
b. Intermediate care.

These are elements of particular investment in strengthening the care continuum towards achieving vision 2030.

Description of service

Home and community-based care

HCBC recognises people’s capacity for self-help and involves a comprehensive range of context-sensitive interventions that positively influence environmental and personal factors such as psychosocial abilities, coping abilities, lifestyle issues, behaviour patterns and habits. It is a collection of activities that support the actions people take to maintain health and well being, prevent illness and accidents, care for minor ailments and long-term conditions, and recover from periods of acute illness and hospitalisation. A complementary capacity for rehabilitative and palliative care will be introduced into HCBC to further enhance the comprehensiveness of the care provided on the platform.

There is a need to introduce pro-active steps to strengthen the capability for early detection and treatment, the reduction of risky behaviour and addressing underlying social determinants of health. The delivery model for HCBC is therefore population based and organised in accordance with the geographical boundaries of the electoral ward (urban context) or sub-districts (rural context). The core primary care team in HCBC comprises CHWs and a CNP who are responsible for a specified number of households per ward, bringing care closer to people and making primary care directly and permanently accessible. The model entrusts these teams with the responsibility of the health of a defined population in its entirety, the sick and the healthy, those who choose to use services and those who do not. It thus does not depend on individual- or community-initiated access, maximizing opportunities for preventive care and health promotion. HCBC is designed to create an interface between the population and their health services that builds an enduring relationship. This is not merely a question of establishing trust in the health system and improving patient satisfaction but an investment proven to enhance quality and better health outcomes.

Health activities on this platform are concentrated around the aspects of the package that enable primary and secondary prevention. An example would be the screening initiatives that identify children for immunisation or people who display early signs of a mental health condition. 2030 encompasses a particular focus on tertiary prevention such as:
» Provision of accessible information on the relevant chronic conditions, treatment options, medication and crisis management (e.g. electronic access, group education, crisis plans for people with a psychiatric condition);
» Equipping individuals and the families with strategies to prevent relapse and hospitalisation;
» Mobilising support networks that enable living, learning, working and socialising arrangements that support wellness (e.g. support groups for parents of children with an intellectual disability);
» Mechanisms that enhance coping with persistent symptoms and stress; and
» Enabling health-promoting lifestyle choices (e.g. motivational interviewing and coaching). As shown in Figure 7.

The focus of rehabilitation interventions in the CBS platform will be on the human functioning that relate to difficulties in executing activities (activity limitations) and problems in involvement in life situations (participation restrictions). Disinterest in meal preparation, poor self-care and grooming when clinically depressed are all examples of activity limitations. A participation restriction refers, for example, to the challenges a child with juvenile arthritis would experience as a learner in the absence of appropriate assistive technology and/or the necessary reasonable accommodation. Intermediate care is designed to address recovery from a human functioning perspective and is more concerned with clinical recovery. While HCBC expands on this by including strategies that support personal recovery, more specifically the development of self-management strategies to mitigate likely secondary complication of an impairment (tertiary prevention); and the mobilisation of agency at an individual, household and community level (health promotion).

Intermediate Care

The second element refers to in-patient transitional care for children and adults, which facilitates optimal recovery from an acute illness or complications of a long-term condition; enabling users to regain skills and abilities in daily living. The ultimate discharge destination is home or an alternative supported living environment. It involves post-acute-, rehabilitative- and end-of-life care, which includes comprehensive assessment, a structured care plan, active therapy, treatment and/or an opportunity to recover.

Intermediate care allows for a seamless transition between acute care and the living environment; particularly where the person’s ability to self-care is significantly compromised a supported discharge becomes crucial to a successful recovery process. The focus of this service element is on improving people’s functioning so that they can resume living at home and enjoy the best possible quality of life.

Recovery can be viewed as being clinical and personal in nature. Clinical recovery is associated with rehabilitation and focuses on objective intervention outcomes such as symptom reduction and return to previous levels of functioning. It aims to avoid relapse and re-admission, reduce risk and shorten hospitalisation. Personal recovery involves a subjective, non-linear journey of developing illness self-management strategies based on active choice, self-empowerment, hope and a search for meaning. These initiatives are identified by the person who needs to recover and are based on his or her current life circumstances, opportunities and aspirations.
Introduction and Background

A comprehensive range of curative and preventative services are provided with a complementary capacity for rehabilitative and palliative care.

Primary care services are ambulatory in nature, rendered in a combination of generalist primary care centres (i.e. clinics (including mobiles and satellites)), community day centres and community health centres). There is sufficient evidence available to demonstrate the benefits of generalist ambulatory care in terms of the prevention of ill health and death, and improved health equity. It is particularly the case where services are organised in a dense network of small close-to-patient service points. To this end flexibility is created to enable the provision of a range of preventive interventions at non-medical sites.

PHC services are also rendered in schools, crèches, old age homes, the workplace and prisons. The intention is to establish a policy framework and governance arrangements that provide the necessary parameters to clearly define and manage health activities performed by the Department in these establishments. The relationship will be formalised by a service level agreement between the Department and the custodians of the non-health entity. These activities are factored into the resource allocation tools designed for facility-based primary care services, as the bulk of the resources will stem from this platform.

The proposed 2030 service configuration facilitates the rendering of a core set of curative, preventive and health promotion activities that are nurse driven. To give effect to a comprehensive PHC service there will be an enhanced capability for rehabilitative- and palliative-care activities. An inter-disciplinary team will further augment the capacity for diagnoses, treatment and recovery, in line with the reviewed primary health care package as illustrated in Figure 8.

Description of service

Primary care services

Primary care services build on the CBS platform – particularly as it relates to diagnosis, treatment and recovery. The care provisioning is concentrated around prevention; likely activities include infant hearing screening in the midwife obstetric units, immunisation, counselling for victims of trauma and violence, psychotropic medication maintenance and the management of clients with unstable diabetes or hypertension. Curative care such as the diagnosis and treatment of TB also forms part of the package.

Currently the midwife obstetric units provide a cost-effective and vital service. Almost fifty percent of the deliveries in the metro are carried out at these units. A decision has been made to link the management of these units to the attached CHC for better synergies and efficiencies. The specific circumstances within each geographic area will have to be taken into account when making a decision on the provision of facilities for mothers to deliver their babies. The provision of antenatal and post-natal care will be widely available at clinics.
The professional nurses responsible for the co-ordination and supervision of home-based care will play a prominent role in determining the care pathways of patients.

To improve access and efficiency the intention is to optimally allocate the following health professionals to clinic level:

» Medical officers
» Professional nurse: mental health
» Professional nurse: maternity

Emergency services will be provided at fully equipped and adequately staffed emergency centres in acute hospitals. The specific circumstances within each geographic area will have to be taken into account when a decision is made on the provision of emergency services at PHC facilities. This will be mostly for minor emergencies. Some facilities will have extended after-hour services.

Rehabilitation thus encompasses activities that deal more with problems in body structure and function (impairments) that are ideally treated in a generalist ambulatory environment (See Figure 9). A typical example is the patient who presents to physiotherapy with “sprains and strains” which are resolved relatively quickly with no long-term functional loss. Clinical recovery is the focus of rehabilitation services on this platform with the expressed purpose of minimising activity limitations and participation restrictions for those patients with functional loss. This often takes the form of providing assistive technology like mobility aids.

**Care Co-ordination in PHC**

**Care pathways**

The focus in 2030 is on strengthening the primary care providers’ role as co-ordinators of patient care pathways across the health system, which has specific implications for the capacity of CNPs, as they become the key mediators between the community and the other levels of care in the health system. The CNP takes on the role of gatekeeper, helping patients navigate the labyrinth of care continuums in the system. This coordination function provides an institutional framework that enables collaboration with the broader health and social care networks beyond the boundaries of the Department itself, which is particularly relevant to the CNPs operating on the CBS platform. Care pathways are of particular value where people have multiple morbidities and an array of interventions is required to support self-management.

**Continuum of care**

Care pathways are individualised, non-linear and are a combination of service elements that are unique to a specific patient and cut across levels of care and sectors. Continuums tend to be more linear and represent how care is organised for a particular condition or group of conditions at each level of care within the health system. The co-ordination of a care continuum is vested in clinicians with the relevant expertise in a particular area; for example, the mental health nurse and the psychiatrist for psychiatric conditions, the midwife and the obstetrician for maternity care and the dietician for nutritional care. The family physician will play a critical co-ordination role in the care continuum in conjunction with the general specialist heads of the general specialities.
Service Modelling

Home-and community-based care (HCBC)

The allocation of CHWs is subject to the following three parameters:

<table>
<thead>
<tr>
<th>Application of the equity measure:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Differentiated coverage: % of households (HH) covered by HCBC programme</td>
<td></td>
</tr>
<tr>
<td>Households earning &gt;R307 201</td>
<td>5%</td>
</tr>
<tr>
<td>Dependent households earning between R76 801 and R307 200</td>
<td>40%</td>
</tr>
<tr>
<td>Dependent households earning between R19 201 and 76 801:</td>
<td>75%</td>
</tr>
<tr>
<td>Dependent households earning &lt;R19 200:</td>
<td>90%</td>
</tr>
<tr>
<td>Number of dependent households per CHW:</td>
<td>10</td>
</tr>
<tr>
<td>Number of CHWs per professional nurse:</td>
<td>270</td>
</tr>
</tbody>
</table>

The Department has used its discretion in the percentage of households covered by the HCBC programme. The norm of households per CHW and the ratio between the professional nurse and CHW are consistent with national norms, as well as the technical work undertaken by the University of the Western Cape. The application of the model to a sub-district is shown in the Table 2.

Table 4: Worked example showing application of above model to a sub-district

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent HH Below R19 200</td>
<td>Dependent HH Between R19 201-76801</td>
<td>Dependent HH Between R76 801-R307200</td>
<td>HH Above R307 201</td>
</tr>
<tr>
<td>Distribution of 2001 population</td>
<td>70.1%</td>
<td>26.7%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Households 2030</td>
<td>91 045</td>
<td>34 709</td>
<td>3 659</td>
</tr>
<tr>
<td>HCBC coverage</td>
<td>90.0%</td>
<td>75.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>HHs per CHW</td>
<td>270 = Input variable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of CHW required</td>
<td>303</td>
<td>96</td>
<td>5</td>
</tr>
<tr>
<td>Number of prof nurses required</td>
<td>30</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

A workload calculator has been developed that enables the model to quantify the number of home visits that can be managed per day aggregated per annum. The model assumes that there will be full-time CHWs working eight hours a day for five days a week and that each visit will take 30 minutes on average and that each CHW will spend about fifty percent of their time directly in the homes of clients. The remaining fifty percent allows for travel between homes, which usually happens on foot, and administrative tasks such as reporting, problem solving with other agencies and consulting the professional nurse. These variables are adjustable and will have consequent resource implications.

The professional nurse will be responsible for the overall supervision and support, mentoring and on-the-job training, quality of care and problem solving – including navigating referrals through the system. The professional nurses will spend forty-five percent of their time directly doing home visits for the more complex clients and undertaking some of the abovementioned tasks.

Administrative support for each of the teams of 10 CHWs and a professional nurse in the ward is also provided to prevent the carers and nurses from inappropriately being consumed with administrative work and having their time diverted from seeing clients. (See Table 3.)
Table 5: Worked example showing application of workload calculator to determine the HCBC teams allocated to a sub-district

<table>
<thead>
<tr>
<th>Post description</th>
<th>Working days per FTE per annum</th>
<th>Minutes/day</th>
<th>Direct patient care factor</th>
<th>Minutes/direct patient contact</th>
<th>Contacts per FTE/day (221 days)</th>
<th>Contacts per FTE per annum (221 days per FTE per annum)</th>
<th>FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Worker (CHW)</td>
<td>221</td>
<td>450</td>
<td>50%</td>
<td>30</td>
<td>7.5</td>
<td>1 658</td>
<td>405</td>
</tr>
<tr>
<td>Prof Nurse: Co-ordinators/ Supervisors (CBS)</td>
<td>221</td>
<td>450</td>
<td>45%</td>
<td>30</td>
<td>6.75</td>
<td>1 492</td>
<td>41</td>
</tr>
</tbody>
</table>

Total visits by CHWs per annum by 2030 671 490
Total visits by professional nurses per annum by 2030 61 172

Appropriate adjustments to the model may be required for rural districts. For example, the distances to travel between homes may be larger and, therefore, the time for direct patient care will be adjusted accordingly.

Intermediate care

The model for intermediate care is based on the following assumptions:

» Differentiated admission rate per household income;
» Bed occupancy rate of 90%; and
» Average length of stay of 42 days.

The implementation of rehabilitative home-based care should contribute significantly towards shortening the length of stay within intermediate facilities.

Table 6: Admission rate to intermediate care weighted according to household income

<table>
<thead>
<tr>
<th>Household income</th>
<th>Admission rate per 1000 dependent persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;R30 7201</td>
<td>2.00</td>
</tr>
<tr>
<td>R76 801-R307 200</td>
<td>2.40</td>
</tr>
<tr>
<td>R19 201-76 801</td>
<td>2.88</td>
</tr>
<tr>
<td>&lt;R19 200</td>
<td>3.46</td>
</tr>
</tbody>
</table>

Given the lifespan of hospitals, the model can use the above assumptions and estimated population growth to project the intermediate beds required for 2030 as well.

The assumptions applied in determining the workload and full-time equivalents (FTEs) of rehabilitation workers and therapists required to render services in intermediate care facilities are listed below. These assumptions can be adjusted and will have the necessary consequent effects on staff numbers. This service may be provided by NGOs and the roles and responsibilities between the Department and the NGO will be defined through a service level agreement.

Each patient will receive a 45 minutes therapy session for 5 days per week (total of 225 minutes):

1. RCW will provide 60% therapy support;
2. Physiotherapists will provide 17% support;
3. Occupational Therapists will provide 17% support;
4. Speech therapists will provide 6% support;
5. Total therapy days (=normal working days) 250 per annum;
6. Social worker: 45% of patients will receive therapy once a week; and
7. Doctors are required on a part-time basis to address medical problems.

The introduction of an RCW is a major development in this service. A pilot is underway to develop a curriculum for the training of RCWs. RCWs will expand the access to rehabilitation services and create efficiencies through the optimal use of therapists.
Because of the close collaboration between the home-based care teams and the intermediate care teams, a ratio between CHWs and RCWs was used to calculate the number of RCWs require for home-based care:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CHWs per RCW:</td>
<td>8</td>
</tr>
<tr>
<td>Number of RCWs per therapist (occupational therapy and physiotherapy only):</td>
<td>6</td>
</tr>
</tbody>
</table>

Audiologists, speech therapists and dieticians are regarded as PHC-facility-based services and are therefore excluded from the home-based care teams.

**Primary care services**

In the district health services model applied in the Western Cape each clinic is linked to a community day centre or a community health centre. These centres also provide clinical and administrative support to clinics. A hub and spoke approach will be applied to configure the layout of community centres with their supporting mobiles, satellites and clinics. In the City of Cape Town, all the clinics are well within 2.5km walking distance for the population they serve.

In determining the optimal staff establishment to deliver the full package of PHC services, the aim was to create a balance between the various categories of staff and their optimal utilisation. The ratios between categories of staff must therefore be such that all staff are optimally used. Another important consideration was ensuring that sufficient management, administrative and pharmacy staff are provided so that clinical staff can use their available time optimally for clinical work. The high population density in the urban areas enhances opportunities for economies of scale. An example is the expansion of the catchment area of a clinic to 30,000 people without compromising access.

To ensure that socio-economically deprived communities receive proportionally more resources to address the higher burden of disease, allowance was made for weighted utilisation rates. This results in a greater allocation of health professionals to serve more deprived communities. In the example below the equity measure is applied to a sub-district in the Cape Town metro with regard to the utilisation of services rendered by CNPs. (See Table 5)

**Table 7: Sub-district application of the equity measure regarding clinical nurse practitioner services**

<table>
<thead>
<tr>
<th></th>
<th>Dependent Below R19 200</th>
<th>Dependent Between R19 201-76 801</th>
<th>Dependent Between R76 801-R307 200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilisation rate</td>
<td>2</td>
<td>1.6</td>
<td>1.28</td>
</tr>
<tr>
<td>Headcount</td>
<td>102 780</td>
<td>98 021</td>
<td>10 224</td>
</tr>
<tr>
<td>CNP FTEs required</td>
<td>15.57</td>
<td>14.85</td>
<td>1.55</td>
</tr>
</tbody>
</table>

**The PHC workload and utilisation calculator**

An electronic PHC workload and utilisation calculator was developed to integrate utilisation and workload variables. A description of this process and methodology is contained in Annexure F.

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The abovementioned services are currently rendered at community day centres or community health centres. The feasibility and affordability of providing a specialised professional nurse in mental health and midwifery will need to be examined. Currently there is a significant shortage of these skills in the system.
ACUTE HOSPITAL SERVICES

SUMMARY POINTS

1. A well-functioning PHC community and facility-based service and an efficient patient transport system are critical to the efficient functioning of hospitals providing acute services.

2. A detailed metro- and rural hospital plan will be developed after the 2030 framework has been adopted.

3. International trends point to a decreasing dependency on hospital beds with a strengthening of CBS, PHC and intermediate services and the use of advances in technology.

4. A home-grown set of norms for admission rates and average length of stay have been developed using the experience of the four established district hospitals.

5. The district hospital will provide a family physician-driven service. The larger district hospitals will also provide a varying quantum of general specialist services depending on, amongst other factors, the burden of disease and available infrastructure. The specialist services will not be departmentalised by clinical discipline.

6. The regional hospitals will provide general specialist-led services. They will also provide a district hospital service to the population in the immediate vicinity.

7. The central hospitals will be sub-specialist led but also provide a general specialist service to the population in their immediate vicinity.

8. There will also be an enhanced capability to render specific rehabilitative care activities, psychiatric care and specific oral health service activities.

9. Strategic parameters are identified to guide the planning of acute hospitals. Spatial planning considerations such as human settlements, transport routes, and economic activity, also influence the mapping of catchment areas and siting of hospitals. The rural hospital planning will be further weighted for the disadvantages of distance.

10. The technical model weights variables such as the admission rates and average length of stay in favour of the wards with the poorest households.

11. The detailed planning by clinical discipline will be a process that follows the adoption of the strategic direction of 2030 and will involve local clinicians and management.

Introduction and Background

A well-functioning PHC community and facility-based service (home community-based care, intermediate care and facility-based PHC service) and an efficient patient transport system are critical to the efficient functioning of acute hospitals, as a vital component of the care continuum for patients.

The acute hospitals include district-, regional-, tertiary- and central hospitals. The planning model adopts a similar approach to all of them but, more importantly, the inter-dependency between these hospitals is significant. There is also the current and proposed reality of regional and district beds being housed within the same institution and regional and tertiary beds being housed within the central hospitals.

Given the life span of hospitals and lead-time required to construct new hospitals, the long-term vision extends to 2030.

International trends point to a decreasing dependency on hospital beds – mainly linked to improving technology and the strengthening of associated services outside of acute hospitals. Whilst the complexities of managing large hospitals are recognised, there is no consensus on the optimally sized hospital.

Planning Considerations

The following factors were taken into consideration in the proposed technical modelling process:

Change in hospital utilisation trends

Internationally the trends in hospital utilisation are changing as a result of:

» Decreasing average length of stay;
» Reduced hospital admissions;
» Increased admissions as day cases, day surgery and increased ambulatory care;
» Improved technology;
» Complementary use of associated service platforms such as home community-based care, intermediate care and facility-based PHC; and
» The increased need for intensive care and high-care beds.

Optimal size of hospitals

Economies of scale vary between different types of hospitals. While there is recognition of the complexity involved in managing very large hospitals, there does not seem to be consensus on the optimal size hospital. Given the range of factors that need to be considered, it would be safe to assume that one size does not fit all situations.
Sizes of hospitals in terms of the Regulations published in terms of the National Health Act are:

<table>
<thead>
<tr>
<th>District hospitals:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>50 – 150 beds</td>
</tr>
<tr>
<td>Medium</td>
<td>150 – 300 beds</td>
</tr>
<tr>
<td>Large</td>
<td>300 – 600 beds</td>
</tr>
<tr>
<td>Regional hospitals</td>
<td>200 – 800 beds</td>
</tr>
<tr>
<td>Tertiary hospitals</td>
<td>400 – 800 beds</td>
</tr>
<tr>
<td>Central hospitals</td>
<td>maximum 1,200 beds</td>
</tr>
</tbody>
</table>

**Strategic Parameters**

The strategic parameters informing the 2030 technical planning process included the following principles:

» District and regional hospitals should optimally provide a comprehensive package of care.

» District hospitals should be most accessible and available within each of the sub-districts in the province, where feasible. Not only will this address accessibility to first-line acute hospital services, but it will also maintain the coherence of the district health services model.

» All large district hospitals will provide some specialist services. The type and quantum of specialist services at large district hospitals will depend on the local burden of disease and the available infrastructure, technology and human resources.

» Regional hospitals are referral hospitals and should be optimally distributed and accessible along the major transport routes to facilitate emergency inter-facility transfers.

» Some regional beds have also been located within the larger district hospitals. The number of regional beds has varied according to the available infrastructure in current hospitals or the potential opportunity in new ones. The package of care to be provided at these hospitals will be determined by the needs of the local population and the pragmatic feasibility of services within the available beds.

» The co-ordination of district health services and regional hospital services will be managed through the geographic service areas (GSAs) structures.

» Central hospital beds will be planned within the affordability envelope of the conditional grants.

» The future of small district hospitals needs to be reviewed.

**Description of Services**

The Western Cape Department of Health L1/L2/L3 acute hospital packages of care, 2009 provide the framework for the clinical services to be provided in district-, regional- and central/tertiary hospitals.

**District hospital**

District hospitals provide first-line hospital access and geographical ease of access for patients is important. District hospitals will optimally provide patients’ full package of care. This will correct an important historical anomaly for several hospitals and local communities: such as Victoria Hospital not providing obstetric services; GF Jooste not providing paediatric and obstetric services; and Karl Bremer not providing trauma and orthopaedic services.

The proposed 2030 service configuration allows for a family-physician-driven L1 acute hospital package of care. In response to the burden of disease, and in the interest of patient-centred care, provision to varying levels will be made for a range of generalist specialist services (across the eight general specialist disciplines and the minor specialities), especially in the larger district hospitals. The general specialist services will not necessarily be configured in separate specialist departments. In certain instances general specialists will render these services on the establishment of the district hospitals. There will also be an enhanced capability to render rehabilitative care activities, psychiatric care and specific oral health service activities. To give full effect to this package of care, an appropriate multi-disciplinary team (with the prerequisite skills mix) will be provided. (See Figure 10)
Development of district hospital norms

A home-grown set of norms for admission rates and average length of stay have been developed, by using the experience of the four established district hospitals that provide services to almost forty-three percent of the population of the metro. The hospital model uses differentiated admission rates and average length of stay in favour of the most deprived populations to address equity. This approach is used for district, regional and central hospitals.

The location, size and classification of Khayelitsha-, Mitchell’s Plain-, GF Jooste- and Eerste River hospitals will be a fait accompli by 2030, with very limited scope for change by that date. For modelling purposes, it was assumed that the three new hospitals would accommodate 300 beds each by 2030, resulting in the following availability of beds:

**Table 8: Four hospitals used in developing district-hospital bed norms**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>2013</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khayelitsha Hospital</td>
<td>230</td>
<td>300</td>
</tr>
<tr>
<td>Mitchell’s Plain Hospital</td>
<td>230</td>
<td>300</td>
</tr>
<tr>
<td>GF Jooste Hospital</td>
<td>230</td>
<td>300</td>
</tr>
<tr>
<td>Eerste River Hospital</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>810</td>
<td>1,020</td>
</tr>
</tbody>
</table>

» The four hospitals referred to in Table 6 serve a cluster of socio-economically deprived settlements, which comprise forty-three percent of the total population of the City of Cape Town;

» By applying the principle of equitable access, adjustments were made to the spatial development areas based on the location of the hospitals;

» The available beds in these four hospitals on the Cape Flats by 2030, i.e. 1,020, was used as the baseline for determining the allocation of district-hospital beds;

» The equity measure was applied to each ward to determine the admission rate and average length of stay weighted for each income group and, therefore, the number of beds required;

» In essence a home-grown set of norms for admission rates and average length of stay have been developed by using the experience of the four established hospitals.

There will be additional weighting built into the rural bed planning parameters to allow for distance and population dispersion.

**Table 9: Weighted admissions for district hospitals**

<table>
<thead>
<tr>
<th></th>
<th>Persons with income below R19 200</th>
<th>Persons with income between R19 200-R76 801</th>
<th>Persons with income between R76 802-R30 7200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions/1000</td>
<td>65.60</td>
<td>55.76</td>
<td>49.20</td>
</tr>
<tr>
<td>ALOS</td>
<td>2.90</td>
<td>2.61</td>
<td>2.47</td>
</tr>
<tr>
<td>Bed utilisation</td>
<td>0.85</td>
<td>0.85</td>
<td>0.85</td>
</tr>
<tr>
<td>Beds required/1000</td>
<td>0.61</td>
<td>0.47</td>
<td>0.39</td>
</tr>
</tbody>
</table>

Regional hospital

The proposed 2030 service configuration allows for a general specialist-driven L2 acute hospital package of care. In specific regional hospitals, provision will be made for the delivery of the L1 acute hospital package of care for the population in the immediate geographic drainage area that does not have access to a district hospital. The services
will be configured in distinct and separate specialist departments (See Figure 11). There will also be an enhanced capability to render rehabilitative care activities, psychiatric care and specific oral health service activities. To give full effect to this package of care, an appropriate multi-disciplinary team (with the prerequisite skills mix) will be provided.

Regional and central hospitals are less geographically accessible than district hospitals and weighted admission rates. There will be additional weighting built into the rural bed planning parameters to allow for distance and population dispersion.

Table 10: Weighted admissions for regional hospitals

<table>
<thead>
<tr>
<th>Persons with income below R19 200</th>
<th>Persons with income between R19 200-R76 801</th>
<th>Persons with income between R76 802-R307 200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions/1000</td>
<td>26.24</td>
<td>22.30</td>
</tr>
<tr>
<td>ALOS</td>
<td>3.9</td>
<td>3.51</td>
</tr>
<tr>
<td>Bed utilisation</td>
<td>0.85</td>
<td>0.85</td>
</tr>
<tr>
<td>Beds required/1000</td>
<td>0.33</td>
<td>0.25</td>
</tr>
</tbody>
</table>

Table 11: Weighted admissions for central hospitals

<table>
<thead>
<tr>
<th>Persons with income below R19 200</th>
<th>Persons with income between R19 200-R76 801</th>
<th>Persons with income between R76 802-R307 200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions/1000</td>
<td>16.00</td>
<td>13.92</td>
</tr>
<tr>
<td>ALOS</td>
<td>6.00</td>
<td>5.40</td>
</tr>
<tr>
<td>Bed utilisation</td>
<td>0.85</td>
<td>0.85</td>
</tr>
<tr>
<td>Beds required/1000</td>
<td>0.31</td>
<td>0.24</td>
</tr>
</tbody>
</table>

Central/tertiary hospital

The proposed 2030 service configuration allows for a sub-specialist driven L3 acute hospital package of care. It also allows for the provision of a general specialist-driven L2 acute hospital package of care for the population in the immediate geographic drainage area that does not have access to a regional hospital.

The central hospitals are an integral part of the overall service platform. The Department will continue to advocate for adequate funding through the conditional grants for these hospitals. There will also be an enhanced capability to render specific rehabilitative care activities, psychiatric care and specific oral health service activities. To give full effect to this package of care, an appropriate multi-disciplinary team (with the prerequisite skills mix) will be provided.

Figure 11: Regional hospital package of care

Areas such as intensive care are recognised as high-pressure areas in the service and will require a separate technical process to make recommendations. Consideration is being given to provision of critical care beds in regional and certain large district hospitals.
The Department has historically had specialised hospitals for psychiatry, rehabilitation, TB and dental services. The future of these hospitals towards 2030 cannot be looked at in isolation from the broader general health service. 2030 explicitly intends to strengthen the general health service at all levels based on a PHC philosophy and the DHS model. Thus the mainstreaming and integration of mental health services, rehabilitation and dental and TB services will be the key focus towards 2030. The success of these processes will result in a significant strengthening of these specific services.

### Mental Health and Psychiatric Hospitals

#### Introduction and Background

There is strong evidence that the burden of mental illness is on the increase both globally and locally. This is further supported by the national and provincial mental health summits held in 2012 and the Ekurhuleni Declaration.

The burden has been aggravated by high levels of co-morbidity with the epidemics of substance abuse, chronic diseases and HIV, as well as the other stressors, which include challenging socio-economic conditions of the majority of the population and the high levels of violence. In the country at large and within the province specifically, neuropsychiatric disorders are ranked third in their contribution to the overall burden of disease in South Africa, after HIV and AIDS and other infectious diseases. A total of 16.5 percent of adults have experienced a mood-, anxiety- or substance-use disorder in the past 12 months (SASH study). Research shows that the 12-month prevalence of child and adolescent mental disorders in the Western Cape was reported to be seventeen percent. Most mental disorders have their origins in childhood and adolescence. Approximately fifty percent of mental disorders begin before the age of 14 years. Mental illness remains highly stigmatised in society generally. Studies have shown significant proportions of unmet need in the population at large. Mental illness has historically been managed through custodial care in large psychiatric hospitals.

The introduction of the Mental Health Care Act has created a statutory obligation for the mainstreaming and integration of mental health services within the general health services to improve access. This is a global trend. This is further supported by the national (and provincial) mental health summits held in 2012 and the Ekurhuleni Declaration.

The bed plan for the Department that will be developed after the 2030 framework has been adopted will include beds required for psychiatric services.

The Department believes that the majority of PLWID require supported living arrangements and not medical institutionalisation. The medical treatment should be provided on a needs basis by the Department of Health. The supported living arrangements should be the responsibility of the Department of Social Development.

### Specialised Hospitals

**SUMMARY POINTS**

1. There is strong evidence that mental illness is on the increase. This is further aggravated by societal stressors such as socio-economic deprivation and violence, as well co-morbidity with chronic diseases, substance abuse and HIV. There are large proportions of unmet need.

2. The introduction of the Mental Health Care Act has created a statutory obligation for the mainstreaming and integration of mental health services within the general health services to improve access. This is a global trend. This is further supported by the national (and provincial) mental health summits held in 2012 and the Ekurhuleni Declaration.

3. The bed plan for the Department that will be developed after the 2030 framework has been adopted will include beds required for psychiatric services.

4. The Department believes that the majority of PLWID require supported living arrangements and not medical institutionalisation. The medical treatment should be provided on a needs basis by the Department of Health. The supported living arrangements should be the responsibility of the Department of Social Development.

The mainstreaming and integration of mental health services, rehabilitation and dental and TB services will be the key focus towards 2030.

### Mental Health & Psychiatric Service Platform

The focus of Health Care 2030 for mental health is the integration of mental health services into community-based, PHC- and acute hospital platforms and service delivery. Only those services requiring a more specialised level of intervention will be treated within the specialist hospital platform.

#### Description of Services

**Community-based Service Platform**

The CBS platform will include home care programmes, residential care programmes, group homes as well as day centres. The intention of all of these services is to provide support to patients within their communities. This support will include treatment adherence support, family support, as well as attending to appropriate psychosocial rehabilitative support as needed. Patients will also be able to participate in peer support groups and learn how to improve their adherence.
The CHWs and rehabilitation care workers who will be functioning at this level will be supported by professional nurses and community mental health nurses.

The Department has also established Assertive Community Treatment (ACT) teams which have played a role in the reduction of in-patient admissions and length of stay among people with severe mental illness, as well as improved user-, family-, and staff satisfaction. This approach will be reviewed and strengthened in the light of the HCBC programme as we move towards 2030.

The intermediate psychosocial rehabilitation service will be a part of the CBS platform. The aim of this service will be to:

- Relieve pressure in the acute psychiatric services by providing a continuum of care from acute hospital settings to community-based residential services;
- Provide within these facilities an intensive psychosocial rehabilitation service for residents requiring a longer stay in a semi-institutional, structured environment where the resident is seen as an equal partner in his or her rehabilitation process; and
- Complement and assist the functions of the assertive team in optimising the management of high-frequency mental health users by either facilitating step up directly from the community or step down.

It is envisaged that the intermediate service would be part of the recovery-based rehabilitation care pathway of patients and would play a crucial role in ensuring that patients receive high-quality service.

Phases of the CBS platform

Mental health promotion and prevention programmes are also critical aspects of any community-based intervention. There is an increasing body of evidence that supports the efficacy of mental health promotion and prevention programmes, focusing on childhood and adolescence stages of development. This is where most of our preventive efforts should be targeted as we move towards 2030.

PHC-based service platform

The PHC-based service platform, together with the CBS platform forms the basis of the health care system. These levels will be supported by the district hospital within each sub-district. Mental health services will therefore form part of this integrated comprehensive PHC system.

Preventive measures for mental disability are therefore also included in all PHC services such as antenatal-, infant-, child-, reproductive health- and curative care services.

It is envisaged that the community mental health nurses at the larger centres, will support the PHC team of nurses, medical officers and allied health professionals on the service platform. The PHC team, including the mental health nurse will provide outreach support to the smaller clinics and the CBS platform.

Services provided at this level of care will include: assessing new patients; reviewing chronic stable patients; and the early detection and appropriate management or referral of patients at risk for relapse to the nearest district hospital. The services will also provide treatment for psychiatric conditions that do not require a higher level of intervention.

District hospital psychiatric services

The provision of psychiatric services will be significantly strengthened through the strengthening of the district hospital services. The strengthening of the DHS should result in eighty percent to ninety percent of psychiatric services being provided at the community based, PHC or district levels of the service platform. The remaining ten percent to twenty percent of services will be provided on the specialist service platform.

Patients will be assessed within the emergency centre of the district hospital and, once organic causes for a suspected mental illness have been excluded, will be referred for a 72 hour assessment. Given the high burden of psychiatric morbidity being experienced at the moment, most of the larger district hospitals will have attached and dedicated units to assist with the 72-hour assessments of patients.

District hospitals in general will provide care for those people with severe psychiatric morbidity, including: the evaluation and management of attempted suicide; the management of substance intoxication, withdrawal and delirium; the admission and initial treatment of patients with psychoses; as well as the referral of medium-term admissions to psychiatric hospitals. In addition district hospitals should be able to: screen for, diagnose and
manage acute mild to moderate, uncomplicated psychiatric illness; exclude medical causes of psychiatric symptoms; manage all aspects of acute and ongoing violent, agitated or disruptive patients; and screen, diagnose and manage patients presenting in other disciplines with co-morbid psychiatric conditions.

District hospitals will have mental health nurses as part of the mental health team, with district psychiatrists providing the specialist-level support to the medical officers and family physicians.

The district team should also provide support and outreach to the PHC service platform.

**Specialist-hospital-based psychiatric service platform**

The specialist psychiatric hospitals will provide the full range of treatment for the following: general adult psychiatric services; substance abuse and addiction treatment; child and adolescent services; neuropsychiatry; old-age psychiatry; forensic psychiatry; as well as intellectually disabled services.

The specialist psychiatric hospitals will have the full team of dedicated professionals that will include general nurses and mental health nurses, physiotherapists, occupational therapists, social workers, psychologists, medical officers, registrars, psychiatrists, as well as psychiatrists trained in specific areas such as forensic psychiatry, psychogeriatric care etc.

**Psychiatric services at designated units within general specialist and central hospitals**

Patients entering via the emergency centre of a general specialist hospital would follow a similar journey to the one described for a district hospital. In addition the designated regional units would be able to manage those patients referred for more specialised interventions, as well as continuing involuntary care beyond 72 hours when clinically appropriate.

Each general specialist hospital would provide psychiatric services in line with the general psychiatric package of care. These services would include the following: diagnose and manage complicated general psychiatric conditions that cannot be managed at district hospital level and require a general psychiatrist; diagnose and manage acute moderate to severe or complicated psychiatric illness; exclude and manage medical conditions that may be co-morbid or may cause or exacerbate psychiatric illness; manage all aspects of acute and on-going violent, agitated or disruptive patients; admit involuntary psychiatric patients for 72 hour assessment and continue treatment beyond 72 hours; provide appropriate ambulatory services; provide appropriate child and adolescent services; and provide appropriate old-age psychiatric services.

Psychiatric services at general specialist hospitals will be provided by mental health teams including mental health nurses, medical officers, registrars, psychiatrists, psychologists, psychiatric social workers and psychiatric occupational therapists.

The general specialist hospital team should provide support and outreach to the district service platform. Each general specialist hospital will have a designated mental health unit, which would provide a spectrum of specialist services in line with a general specialist package of care for adult psychiatric services.

There will also be a quantum of specialist services that cannot be accommodated on the specialist psychiatric hospital platform. These services will be accommodated within the central/tertiary hospitals and will include, for example: services for patients with medical conditions and co-morbid psychiatric illness; managing the more complex old-age psychiatric conditions; as well as managing the more complex child and adolescent psychiatric illnesses.

**Intellectually disabled services**

The intellectually disabled services (IDS) service has historically been a sizeable portion of the service within the specialised psychiatric hospitals. A firm strategy within the CSP has been to de-institutionalise these patients. This was an ambitious objective and, in reality, most of the patients were de-hospitalised into more cost-effective institutions.

The Department believes that the majority of PLWID require supported living arrangements and not medical institutionalisation. The medical treatment should be provided on a needs basis by the Department of Health.
the main require supported living arrangements and not medical institutionalisation. The medical treatment should be provided on a needs basis by the Department of Health. The supported living arrangements should be the responsibility of the Department of Social Development.

However, the Department recognises that this is a complex discussion and process that transcends departments, legislative provisions and policies, historical practice, patient-, family-, and community expectations.

**Considerations in developing a normative bed model for the psychiatric service platform**

The Western Cape Province has already significantly reduced the specialist hospital platform from a starting point of 3,500 beds in 1998 to a 1,843 bed platform that includes 145 designated intermediate care beds.

Despite the strengthening of the acute hospital platform, it has not been able to cope with the increased demand for acute psychiatric care necessitated by the explosion of the substance epidemic, including methamphetamine (TIK) and the general increase in the mental health burden of disease. If one adds to this the increasing levels of violence and poverty in our society on the whole, it is clear that the current bed numbers are inadequate for dealing with the mental health needs of the population. Looking forward to 2030, one of the key enabling factors, however, is the expanded district and general specialist hospital platform. This is a critical factor in ensuring that the mental health needs of the population are met.

The remaining mental health needs of the population that require more specialist input will be accommodated in the specialist psychiatric hospitals. In developing an approach and methodology for determining the specialist psychiatric bed needs, a similar approach will be followed as with developing the norms for the acute hospital needs of the population. Whilst national norms had been developed in 1997 by the National Department of Health, this work needs to be reviewed in light of the changing mental health burden of disease.

Further technical planning in this regard needs to be completed by the 2030 technical team in order to ensure that the appropriate number of beds is available at the various levels of the service platform.

The following factors should be taken into account in developing a normative-based model for acute psychiatric inpatient and outpatient needs:

- The same modelling norms and assumptions proposed in developing the acute hospital bed platform will apply to psychiatry as well – i.e., population-geographic-based modelling based on socio-economic factors and taking into account future population growth;
- The exploding substance abuse epidemic, including alcohol and illicit drugs such as cannabis, TIK, heroin, cocaine and designer drugs would need to be built into any modelling framework. However, it must be borne in mind that we may very well find that this pattern might change over the next 10 to 20 years;
- The increased need for inpatient adolescent services with the alternative rehabilitation placement where return to home is increasingly difficult;
- The increasing psychiatric burden of disease over the next 10 to 20 years. Neuropsychiatric disorders alone are ranked third in their contribution to the overall burden of disease in South Africa, after HIV and AIDS and other infectious diseases;
- The model of service delivery in the Western Cape with a strengthened DHS will ensure that most of the mental illnesses will be manageable from the acute hospital platform. Only a relatively smaller quantum of mental disorders will be managed from the specialist psychiatric service platform;
- As community mental health services are scaled up, so the need for hospital admissions should decrease. This will include a decrease in the bed need at specialist psychiatric institutions;
- A strengthened focus on treating mental health disorders on an out-patient basis will imply less need for inpatient treatment facilities;
- Outreach programmes will be strengthened, thus decreasing the need for acute psychiatric hospital beds;
- Community based intervention rehabilitation programmes will further lessen the need for acute in-patient bed requirements; and
- In-patient units at district and general specialist hospitals will be developed.
SUMMARY POINTS

1. In line with the departmental approach to improving the patient experience and to providing integrated health care, rehabilitation services will be accessible at all levels of care. Acute services will be provided in health facilities such as district hospitals and PHC facilities whereas non-acute services will be provided from a community-based platform.

2. The Western Cape Rehabilitation Centre (WCRC) will continue to provide high-intensity, specialised comprehensive, multi-disciplinary inpatient and outpatient rehabilitation services. It is an important training site for clinical teaching and training of therapists. The centre also provides outreach and support to other levels of the service platform.

3. An integral aspect of the rehabilitation service will include the provision of the required mobility- and other assistive devices, orthotics and/or prosthetics, to facilitate full reintegration of people with disability back into the community.

4. The provincial orthotic and prosthetic centre will be relocated to and managed by the WCRC. The ethos of the centre will shift from production to patient centredness. Strategies to reduce the waiting lists for assistive devices will be enhanced.

These factors are not an exhaustive list and could be further strengthened as the acute service platform is developed and the intermediate-, rehabilitation- and community-based platforms play an increasingly important role in service provision.

Rehabilitation Services and Western Cape Rehabilitation Centre (WCRC)

Introduction and Background

In line with the departmental approach to improving the patient experience and to providing integrated health care, rehabilitation services will be accessible at all levels of care.

Acute services will be provided in health facilities such as district hospitals and PHC facilities, whereas non-acute services will be provided from a community-based platform.

In order to improve the accessibility to rehabilitation services, use will be made of RCWs who will provide home-based care as part of the home-based and intermediate care teams.

Audiologists, speech therapists and dietician services will be provided as part of the facility-based PHC services and will not be part of the home-based care teams.

Complex patients requiring specialised physical rehabilitation services will be referred to the WCRC. The stronger the rehabilitation capacity within the DHS platform, the earlier the patients could be discharged into their communities for follow up at a local PHC facility or through the home-based programme.

Figure 11 describes a model for rehabilitation services in acute hospitals. The key focus of rehabilitation services in acute hospitals is on body structure and function (impairment) and their impact on the patient’s ability to execute a task or action (activity limitation).

The attention of rehabilitation in acute hospitals is on problems in body structure and function (impairment) and their impact on the patient’s ability to execute a task or action (activity limitation). Examples of impairments include thought disorder, psychomotor agitation and blunted affect. Participation restrictions and the recovery aspects that link to environmental and personal factors are important considerations in addressing impairments and its consequent activity limitations; they are however not the focus of clinical recovery in this service component. Currently rehabilitation services are concentrating on the L3 service platform and are predominantly outpatient based. A limited capacity for rehabilitation exists on the L1 platform. This situation raises questions around the accessibility of rehabilitation services on the acute platform. The 2030 principles necessitate a re-think on how necessary rehabilitation services are rendered on this platform. Due consideration needs to be given to enhancing the capacity at district hospital to provide rehabilitative care as this would significantly increase access for people with impairments.

Figure 12: Rehabilitation in acute hospitals
**Acute hospital and rehabilitation service platform**

In line with the departmental approach to improving the patient experience and to providing integrated health care, the health system’s capability for rehabilitative care is being strengthened. The main area of development is in the PHC service with the introduction of rehabilitation in HCBC and intermediate care on the CBS platform. New operational capacity is being created in the form of the RCW as part of an inter-disciplinary primary care rehabilitation team.

The focus in PHC services are on addressing the elements of human functioning that relate to activity limitations and participation restrictions, taking into account the implications of environmental and personal factors.

At L2 and L3 facilities the multi-disciplinary team, including physio-, occupational- and speech therapists, will add value to the work of general medical specialists, rehabilitation nurses, clinical psychologists and social workers. The patients have complex conditions and long-term (permanent) disabilities that require a high level of competence, clinical expertise and experience and the support of medical specialists is required. Examples of such services are provided in:

- Burns/ intensive care units;
- Spinal cord injury units;
- Acute psychiatric units;
- Departments of orthopaedics, neurology, cardiovascular-, maxillo-facial and hand surgery;
- Memory clinics;
- Specialised rehabilitation units;
- Stroke / neurological-rehabilitation units;
- Work assessment units; and
- Cochlear implant units.

Patients requiring a higher level intensity of rehabilitation (i.e. four to six hours of rehabilitation per day) will generally attend the specialised rehabilitation facilities (including at L2 and L3 and WCRC). These centres should have enough staff for assuring that patients receive appropriate treatment.

**Specialised rehabilitation services**

The 156-bed Western Cape Rehabilitation Centre will continue to provide specialised comprehensive, multi-disciplinary in-patient rehabilitation services to persons with physical disabilities. Primary reasons for admission include rehabilitation management of people with long-term, permanent disabilities, such as:

- Spinal cord afflictions (quadriplegia/paraplegia), due to trauma, TB or HIV and AIDS, other neurological causes;
- Cerebrovascular accidents due to hypertension, HIV and AIDS;
- Traumatic brain injury;
- Amputations;
- Neurological conditions (Guillain Barre, multiple sclerosis, motor neuron disease, Parkinson’s, cerebral palsy etc.);
- The WCRC will provide high-level rehabilitation expertise, consultancy services and support to other levels of care to facilitate the provision of quality rehabilitation services for people with physical disabilities;
- The WCRC, in turn, will be supported by specialists from the tertiary hospitals, e.g. plastic surgery, orthopaedics, while other specialists are employed by the WCRC on a sessional basis (urology/radiology);
- The WCRC rehabilitation programmes focus on clinical outcome levels 1 to 3 (primarily); i.e. the aim is to achieve physiological (medical) stability, physiological maintenance (outcome of basic rehabilitation) and eventually home or residential re-integration (outcome of intermediate rehabilitation outcome); and
- In select, good prognostic cases (and especially in the case of children, youth and employed adults) the WCRC will manage patients through Outcome levels 4 to 5 to facilitate a return to work or school.

**Provision of assistive devices**

An integral aspect of the rehabilitation service will include the provision of the required mobility- and other assistive devices, orthotics and/or prosthetics, to facilitate full reintegration of people with disability back into the community.
The greatest possible independence for persons with disabilities will be achieved through the provision of affordable, quality mobility aids, devices and assistive technologies. Facilitating training in mobility skills to patients and to specialist staff working with people with disabilities will continue to be provided by the WCRC.

Seating services in the province are currently structured in three levels - basic, intermediate and advanced. Though relatively synchronous with the PHC model of health care in the province, this service orientation does not lend itself to efficient, accessible, patient-centred comprehensive care. The conceptual plan of a district-based dedicated seating service will improve accessibility to a comprehensive seating service, which is outcomes based and not dictated to by the cost of the device or its availability linked to only specific levels of services.

The time required to do a comprehensive assessment for wheelchair/buggy seating can vary between 90 minutes to a full day, depending on the complexity of the disability, the availability of expertise (trained personnel), and the availability of resources (from devices to simple consumables such as glue and foam). Advanced seating may often require the additional skills of a trained technician with an appropriately equipped workshop (over and above the rehabilitation professional).

A variety of mobility devices and accessories (various sizes and types) needs to be on hand in which to “trial” a patient. This requires adequate secure onsite storage facilities.

**Provision of orthotic and prosthetic services**

The orthotic and prosthetic service for the province, excluding the Eden and Central Karoo districts, which are outsourced, is managed by the WCRC and is currently located on the Conradie Hospital site at the Orthotic and Prosthetic Centre.

It is intended that the service be relocated to a custom-built facility on the WCRC site. A key challenge towards 2030 is to change the organisational culture of the Orthotic and Prosthetic Centre from that of a mechanical-production-type facility to that of an integral part of the rehabilitation team providing services with a patient-centred focus.

Various strategies are being implemented to reduce the waiting lists for patients waiting three to six months and six months and longer for orthotic and prosthetic devices, such as:

» Strategies to improve productivity;
» The appointment of medical orthotists and prosthetists; and
» The development of clinical guidelines and standard operating procedures for the prescription of orthotic and prosthetic devices.

**Tuberculosis Services and Hospitals**

**Introduction and background**

The role of the TB hospitals needs to be located within the context of the projected burden of disease, the vision and principles of 2030 and the focus of overall health system strengthening. The majority of the TB workload will be managed in the DHS.

The Western Cape has always had a TB burden that is disproportionately large compared to other provinces in South Africa. Nevertheless, the burden and nature of TB has changed considerably since TB hospitals were first designed and built.

Approximately 52 000 people were treated for TB in the Western Cape in 2011. Of these, approximately 44 000 were adults, of whom about forty-five percent were HIV infected. Of the approximately 8 000 children treated, about nine percent were known to be HIV infected, with a further twenty-three percent having no HIV status recorded. Between 2007 and 2010, the number of diagnosed multi-drug resistant TB (MDR TB) cases increased by seventy-one percent, from 764 to 1 310. Over the same period diagnosed extensively drug-resistant (XDR TB) cases increased by sixty-five percent, from 764 to 1 310.
Drug-resistant TB has increased from one percent to three percent in new patients and from four percent to seven percent in retreatment patients. Eighty percent of MDR-TB is acquired through transmission from other infected patients. In the 2011/12 financial year there were approximately 4,000 discharges recorded from TB hospitals.

The most significant change in TB disease burden in recent years, therefore, is the contemporaneous increase in co-morbid HIV infection and the rise of MDR TB and XDR TB. The HIV-infected patients with TB are much more severely and acutely ill and more complex to diagnose and treat than their HIV uninfected counterparts. A significant proportion of these patients are sputum negative, which has been the main method of diagnosis in pulmonary TB to date. These patients and those suspected of extra pulmonary TB require more sophisticated and expensive modes of investigation such as gene sequencing technology, blood cultures, ultrasound, X-rays and biopsies to make the diagnosis.

Drug-resistant TB necessitates stringent infection control measures and specialised drugs and drug delivery strategies. The severity of the clinical condition of these patients varies from being quite well and ambulant to acutely ill. These patients have prolonged lengths of stay, are expensive to treat and often have a poor prognosis. The co-morbidity is further aggravated by other chronic diseases such as diabetes and hypertension, chronic obstructive airways disease, malnutrition and substance abuse.

The increase in drug-resistant TB cannot be sustainably managed through the admission of all patients to TB hospitals. Models of care in which drug-resistant TB patients have been treated through a community-based treatment delivery system have been piloted with success in recent years. A proportion of drug-resistant patients is clinically stable and well and can be managed on an ambulatory basis. The biggest challenges in this group of patients are, one, compliance with treatment over a prolonged period given that they feel well and, two, the risk of transmission to family and community.

**TB management on the CBS platform including MDR/XDR**

The responsibilities of the CBS platform are three-fold: raising community awareness of TB, case finding and case holding. Community awareness means ensuring that simple messages about TB are widely disseminated – the signs and symptoms of TB, the transmission risks, what to do if one suspects one has TB, etc. Also, engagement with relevant role players in high-risk areas and situations – like taxis and taxi ranks, shebeens and schools.

Case finding implies active case finding and refers both to contact tracing of known TB cases (especially known drug-resistant TB cases) as well as more general out-of-facility screening in high-burden areas.

Case holding refers to adherence support for people on the ambulatory (PHC) TB programme as well as those TB patients who have been discharged from hospital but who need on-going ambulatory treatment.

The health service needs to create community “safety nets” into which a hospital clinician will feel comfortable discharging the drug-resistant (and drug-sensitive) patient. Such “safety nets” will need to borrow from existing models of community care for drug-resistant patients and, as such, will likely include a dedicated professional nurse and a team of CHWs, as well as home visits and home “infectiousness” assessments. Making these links to care is seen as an increasingly important part of driving down the TB epidemic.

The relationship between the TB hospital and the receiving sub-district/facility can be facilitated by simple changes to existing networked software, so that a discharge from the TB hospital is automatically registered as an “expected case” at the appropriate facility and loss-to-programme is minimised. In an ideal world it is even possible to imagine the drug-resistant TB patient being introduced to their community care worker prior to discharge, such is the importance of this relationship.

**TB management on the PHC platform**

The period of individual infectiousness within a community must be reduced. Delays in diagnosis and time to initiation of treatment must be addressed. These can be achieved through the widespread adoption of newer diagnostic technologies and improving health system efficiencies. Systems must be instituted so that HIV-infected people, who are at particular risk of acquiring TB, routinely receive high-quality screening for TB. Particular attention must be given to early identification of drug-resistant cases and appropriate channelling of such cases to the correct treatment regimens and strengthened community adherence support.

**TB management in acute inpatient services**

With the increasing risks of drug-resistant TB, care must be taken to prevent health institutions from becoming
sources of nosocomial infection – both for health care workers and other patients. Infection control strategies will be reviewed and improved. All acute admitting institutions must have appropriate infection control measures to the extent that they would be comfortable to retain a drug-resistant case for 24 to 72 hours – since this duration of stay is a reality of being a first-line admission point. Diagnostic delays must be reduced through the use of appropriate technology.

**TB management in specialised hospitals**

TB hospitals need to be resourced according to their needs and this will require being able to manage the acutely complex patient. TB hospitals themselves will also need to become centres that attract and retain the right kind of staff. Ways of doing this might include making TB hospitals:

1. Centres of inquiry at the “cutting edge” of the epidemic;
2. Centres of training, outreach and skills transfer; and
3. Nodes for community involvement.

The first and second points can be facilitated by improving the individual patient information captured at hospital level. The TB hospital in 2030 will be able to provide the health system with individualised data for each patient with regard to, at the very least: demographics, reason for admission, interventions, investigations and treatment received, and health outcome. Such data if it were routinely available would transform knowledge about the state of the TB epidemic in the province. (See Figure 13.)

**Figure 13: A TB patient’s care pathway**
Oral Health and Oral Health Centres

Dental Hospitals have historically provided a high-end oral health service within the province and in the main have been responsible for the training of dental professionals and research. A review of their role and recasting their future within the context of 2030 cannot happen in isolation from examining the broader oral health strategy towards 2030.

Introduction and Background

Poor oral health contributes to problems with general health and for this reason the high prevalence of early childhood caries is a serious concern to this province and the country as a whole. Most oral diseases are not life threatening, but affect almost every individual during his or her lifetime. Poor growth, cognitive and general development, poor appetite, interference with sleep, poor school behaviour including absenteeism, and negative self-esteem may result from oral diseases. Oral conditions are important public health concerns because of their high prevalence, their severity, their impact on the quality of life and the public demand for services.

The key oral health problems in the Western Cape are described below.

A national survey conducted in 2003 showed that the dental caries rate for certain specific age groups in the Western Cape was double that found as a national mean. The decayed, missing, filled teeth score was almost double that for the age groups between five and 15. This survey clearly indicated that the WC was the worst province as regard dental caries experience in the country.

The gingivitis-calculus complex is high. This is indicative of neglected oral hygiene. Prevalence levels in the Western Cape are in line with national figures.

Various studies have shown a marked association between periodontal diseases and cardiovascular disease. For this reason patients with severe periodontal disease could be regarded as high cardiac risk patients.

Approximately thirty percent to forty percent of 12 year olds in the Western Cape need definitive orthodontic treatment. This is in line with the national figure.

The prevalence of partial and complete edentulousness is the highest in the Western Cape compared to the rest of the country. This affliction has been implicated in Quality of Life (QoL) studies internationally.

Certain general health conditions have an impact on oral health and vice versa. Patients with HIV and AIDS present with candidiasis (thrush) in the mouth and various types of ulcers. The dentist could be the first to pick up these observations during oral examinations. The dentist could also pick up early signs of cancer in the mouth. Diabetic patients have been shown to be prone to mouth ulcers, as well as periodontal conditions. The escalating epidemic of chronic diseases including cancers will increase the burden of oral conditions.

Oral health service platform

Community-based services and primary health care

An integrated health prevention and promotion approach includes:

» Life skills in primary schools;
» Promotion of good oral health habits with a focus on mothers and children;
» Antenatal clinics and completion of the oral health section in the Road to Health booklet;
» Supervised daily tooth brushing with fluoride toothpaste programmes at early childhood centres, crèches and selected primary schools;
» Selected pit and fissure sealant programmes for especially permanent first and second molars;
» Integrated school health programme in partnership with the Department of Basic Education;
» CHWs carrying the basic message on oral health and even demonstrating the correct and essential use of a toothbrush during home visits; and
Water fluoridation as a very cost-effective way to reduce caries, but subject to a national legislative problem being resolved.

Primary health care

The basic oral health package that will be available at primary health care facilities includes the following:

- An examination;
- Bite-wing radiographs;
- Relief of pain and infection via dental extraction;
- Fissure sealants;
- Simple fillings (one to three surfaces) and atraumatic restorative treatment;
- Limited endodontics (anterior or single-rooted teeth);
- Emergency denture repairs; and
- Referral for further treatment.

The community-based and PHC service platforms have been designed to cope with the envisaged primary oral health service needs of the population within each sub-district.

District hospitals

District (L1) hospitals will normally receive referral from and will provide general support to CHCs and PHC clinics. Oral health professionals will be dental practitioners. There will be no resident specialist at district hospitals.

The following is a summary of the oral health services that will fall within the scope of the district health services:

- Maxillo-facial trauma – basic stabilisation and referral;
- Provision of theatre to offer general anaesthetic and conscious sedation for dental extractions for preschool children and patients with special needs;
- Services at specialised institutions such as those for intellectually challenged people; and
- Services at prisons: A service level agreement is in place that governs the provision of very basic dental services at these prisons. It is envisaged that the Department will continue to render these services in the future. It should be noted that the Department of Correctional Services pays for these services.

Regional hospitals

Regional (L2) hospitals will offer specialised oral health care for the treatment of severe diseases and trauma. The care also focuses on reconstruction and rehabilitation. Most care will be led by a rotating specialist.

Services to be provided are as follows:

- Maxillo-facial and oral surgery (complex jaw fractures and pathological lesions);
- Complicated oral health rehabilitation; and
- Medical patients who have co-morbid oral health disease and pathology.

Specialist oral health services

Specialist oral health services will be provided within the health service platform at appropriate facilities. Highly specialised services – such as maxillo-facial and orthodontic sub-specialist care – will continue to be provided at appropriate facilities within the health service platform.

Specialised services to be offered include:

- Maxillo-facial and oral surgery;
- Oral medicine;
- Complicated periodontology;
- Oral pathology;
» Orthodontics;
» Prosthodontics;
» Forensic odontology;
» Complicated fractures;
» Difficult impactions; and
» Oral oncology.

Outreach and support:

A consultation service will be provided to regional and district hospitals, which includes:

» Interceptive orthodontics;
» Development of minor oral surgery skills of clinicians at designated clinics and regions in order to facilitate local treatment of simple fractures and impacted third molars;
» Registrar rotation to regional hospitals for maxillo-facial surgery; and
» Training, which will continue to be provided by the oral health centres and central and tertiary centres.

Emergency Medical Services

SUMMARY POINTS

1. Access to emergency care is a constitutional right in South Africa and is prioritised within the 2030 vision for patient-centred quality care.

2. EMS has set ambitious targets for 2030, which may have to be reconsidered within the available resources. These include:
   a. All 10177 calls from the public to be answered within three rings
   b. Ambulance response time for Priority 1 calls in urban areas is ninety percent within eight minutes and rural areas ninety percent within 40 minutes.
   c. Medical rescue response will be ninety percent within 15 minutes in urban areas and ninety percent within 60 minutes in rural areas.
   d. Non-acute patient transport requests will be responded to on the same day if booked before 10 am and within 24 hours if booked after 10 am.

3. EMS district managers will closely support district health managers by providing EMS-related data for monitoring and evaluation and, by their availability, for immediate problem solving. Management of EMS is divided into strategic management in Cape Town and tactical management in health districts.

4. The province is geographically divided into six districts each with an emergency contact centre. In the rural districts these centres double as disaster risk management centres.

5. A model to calculate the fleet and staffing requirements for the ambulance service has been developed. The model assumes that ten percent of the population will use the service.

Introduction and Background

The imperative for emergency care is established through the Constitution of South Africa and the National Health Act both of which ensure the universal right to access to Emergency Care explicit in Chapter 2, section 27(3) of the Constitution and Chapter 2 section 5 of the National Health Act.

Emergency medical services (EMS) in the Western Cape will follow the guiding principles of 2030:

» By providing telephonic access in defined time frames and by responding in tightly measured response times. With well-trained personnel under the clinical oversight of a quality assurance system it will deliver on a patient-centred quality of care.

» By measuring and recording clinical parameters at the start and through the progress of the patient journey and adjusting care based on evidence it will move towards an outcomes-based approach.

» By advocacy for prevention of illness and injury and the institution of Emergency First Aid Response in communities it endorses the PHC philosophy.

» By establishing congruent operational structures and participation in geographic service area service delivery it strengthens the DHS model.

» By geographically well-distributed response units across the province and a full range of communications, patient transport, ambulance, rescue and aeromedical services it will provide equitable access to all communities. Cooperation with the private sector will ensure that our resources are dedicated to the indigent and poor. Distribution of ambulance units linked to hospital dispatch areas with Cape Town addresses distribution geographically and chronologically to match demand with resources.

» By providing acute and outpatient transport to referral facilities and by constant performance management of services and components it ensures affordability.
eighthirty percent of staff will be emergency care technicians and twenty percent advanced life support or paramedics. The basic life support cadre is being phased out by the HPCSA.

6. The aeromedical service will continue to play a vital role in the emergency transfer of complex patients to the referral hospitals.

7. The non-acute patient transport service will also be strengthened as a key component for access to services, especially for rural patients, as well as for improving efficiencies of acute hospitals by facilitating the transport of discharged patients out of these hospitals.

8. Emergency First Aid Response (EFAR) is a volunteer community component of EMS designed to:
   a. Provide First Aid Response in a local community
   b. Provide an informed interface with EMS

9. The communication centre will receive a modernised software application to enhance its operations. Call taking and dispatch is a central component of an efficient EMS operation. This will also enable better management reporting in real time and improved communication with the Emergency Centres in hospitals. A bed bureau will also be developed to monitor the availability of acute beds in all the major hospitals.

By its nature and position in the pre-hospital environment EMS interfaces with health and other emergency services and builds strategic partnerships to ensure patient outcomes.

**Service norms and standards**

**Public access:**

EMS must receive calls for emergency medical assistance through the 10177 emergency number within the following metrics:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call answer time</td>
<td>3 rings</td>
</tr>
<tr>
<td>Call process time</td>
<td>120 seconds</td>
</tr>
<tr>
<td>Dispatch time</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Call abandonment rate</td>
<td>&lt;5%</td>
</tr>
</tbody>
</table>

**Ambulance response:**

Ambulance services must comply with the minimum norms and standards of the Western Cape Ambulance Services Act 3, 2010.

In addition the following metrics must be met:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Priority 1: Urban Response Time</td>
<td>90% within 8 minutes</td>
</tr>
<tr>
<td>Ambulance Priority 1: Rural Response Time</td>
<td>90% within 40 minutes</td>
</tr>
<tr>
<td>Ambulance Priority 2: Urban Response Time</td>
<td>90% within 30 minutes</td>
</tr>
<tr>
<td>Ambulance Priority 2: Rural Response Time</td>
<td>90% within 60 minutes</td>
</tr>
</tbody>
</table>

**Medical rescue response**

Medical rescue services include the medical leadership and control of emergency medical incidents and the provision of access, patient care and extrication of patients trapped in their physical environment.

Medical rescue must meet the following metrics:

<table>
<thead>
<tr>
<th>Metric</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Time Urban Areas</td>
<td>90% within 15 minutes</td>
</tr>
<tr>
<td>Response Time Rural Areas</td>
<td>90% within 60 minutes</td>
</tr>
<tr>
<td>Time to Release Urban Areas</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Time to Release Rural Areas</td>
<td>75 minutes</td>
</tr>
</tbody>
</table>

**Patient transport services**

Patient transport services must meet the booking demands of the DHS and the geographic service area for the transport of outpatient or non-acute health clients between facilities up or down levels of care.

All discharge requests must be met both in Cape Town and rural districts as follows:

» The same day if booked before 10 am;
» Within 24 hours if booked after 10 am; and
» Aeromedical services provide three essential components in support of EMS:
   » All long-distance acute transfers between 200 and 500km are performed by air to reduce re-
ferral time and improve outcome.
» The service maintains ground ambulance availability in small rural towns with one ambulance.
» The winch rescue capacity supports the medical rescue services in Wilderness Search and Rescue.

Fixed-wing and rotor-wing (helicopters) aircraft are necessary components. Two helicopters adequately cover the entire Western Cape during daylight hours. They are based in Cape Town and Oudtshoorn.

One fixed-wing aircraft covers the entire province day and night.

Service plan
EMS includes the following necessary components:

» Management and administration;
» Communications services;
» Ambulance services;
» Medical rescue services;
» Aeromedical services;
» Patient transport services;
» Community response services (EFAR Emergency First Aid Responders); and
» Management and administration.

International benchmarking and best practice establishes that EMS is best delivered as a provincial service rather than a local service.

In this context EMS in the Western Cape is best managed as a provincial service with strong links to the geographic service areas and districts. EMS district managers will closely support district health managers by providing EMS-related data for monitoring and evaluation and by their availability for immediate problem solving and being part of the district management scheduled meetings.

The motivation for a provincial service model is as follows:

» Uniform vehicles and equipment procurement and equity;
» Universal education and training both initially and continuously;
» Uniform fleet management;
» Equitable budget distribution;
» Equitable staffing distribution and skills mix;
» Universal standard operating procedures;
» Universal standard administrative procedures and compliance;
» Equitable patient access and referral to all systems/modes;
» Smooth application and deployment in Major Incident Medical Management System (MIMMS);
» Universal standard information management; and
» Universal and standard management practice.

EMS management structures match governance boundaries for local and district municipalities.

Current administration for fleet, finance, supply chain management and human resource management within EMS is centred in Cape Town.

Management of EMS is divided into strategic management in Cape Town and tactical management in health districts, which matches MIMMS command structures, which require bronze, silver and gold command levels based on a geographic model.

Aeromedical services, medical rescue services, education and training have provincial management com-
ponents while ambulance services, medical rescue and patient transport services (HealthNET) are managed directly at district level. For the second group of services, there will be a close working relationship with the district management teams.

**Communications services**

EMS must receive and process telephonic 10177 requests for assistance from ten percent of the population.

The province is geographically divided into six districts, each with an emergency contact centre as follows:

<table>
<thead>
<tr>
<th>Location of Emergency Contact</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Town</td>
<td>Cape Town</td>
</tr>
<tr>
<td>Eden</td>
<td>George</td>
</tr>
<tr>
<td>Central Karoo</td>
<td>Beaufort West</td>
</tr>
<tr>
<td>Overberg</td>
<td>Bredasdorp (Caledon)</td>
</tr>
<tr>
<td>West Coast</td>
<td>Mooreesburg</td>
</tr>
<tr>
<td>Cape Winelands</td>
<td>Worcester</td>
</tr>
</tbody>
</table>

These centres are emergency contact centres but also double as disaster risk management centres in the rural districts. Traffic services will also coordinate actions from these rural centres and speed-over-distance systems operate from here. An ideal model would see all emergency services (police, traffic, fire, and ambulance) operating from the same public service point.

These calls must be answered within three rings and take 120 seconds to process to dispatch. Each call results in at least three other telephone calls/actions of 120 seconds each. This determines the capacity required to take the calls in respect of call taker numbers.

Dispatchers receive calls from the computer-aided dispatch (CAD) system and manage up to ten resources (ambulances, rescue vehicles) per dispatcher in a defined geographic area, which drains towards a hospital in the centre of the geographic area.

Supervisors are required for each function within a contact centre, i.e.:

» Inbound communication (call taking);
» Outbound communication (dispatching);
» Incident management;
» Shift management; and
» Centre management.

The vision in Cape Town is to collaborate with the City of Cape Town in the traffic management centre to derive maximum efficiency and emergency service coordination.

**Ambulance services**

Ten percent of the population use ambulance services annually as calculated from historical performance. While the ten percent figure is used at a macro level to calculate the resources required in EMS, the allocation of resources to the areas with the greatest need will occur at a daily operational level. In rural areas ten percent of patients delivered by EMS are referred up a level of care to a regional or central hospital. In Cape Town 40 percent of EMS acute transfers are between facilities.

EMS personnel work 12-hour shifts day or night or day shift only (straight shift). The allocation of staff and vehicles will be titrated with the patterns of workload envisaged both in terms of geographic origin of calls as well as time of day.

Response time performance required is:

» 8 minutes for P1 in urban areas;
» 40 minutes for P1 in rural areas (responses to farms);
» 30 minutes to P2 in urban areas; and
» 60 minutes to P2 in rural areas.

Mission times are dependent on the geographic drainage area, but in Cape Town, the measured average mission time is 60 minutes.

The staff mix required is eighty percent emergency care technician (ECT) or intermediate life support (ILS) and twenty percent B.Tech Paramedic or advanced life support (ALS). Basic life support (BLS) training has been discontinued by the Health Professionals Council of South Africa (HPCSA). Attrition will gradually erode the BLS component of the service.

The model for ambulance services in the City of Cape Town uses ten percent of the total population to determine the number of clients that EMS will serve for the specified period. This demand at a macro level has been consistent over the last decade. Notwithstanding the interventions directed at upstream factors impacting on health, the increasing ageing of the population, continued urbanisation within and migration to the province and the escalating epidemic of a spectrum of chronic diseases has made one conservatively use the ten percent figure for modelling. The current percentage proportion contribution for P1 calls are calculated at 36 percent of all calls and sixty-four percent for P2 calls. Table 10 shows the urgent number of calls received by EMS.

<table>
<thead>
<tr>
<th>Sub District</th>
<th>2012</th>
<th>10% of population = Possible clients</th>
<th>P1 Clients</th>
<th>P2 Clients</th>
<th>Calls responded to within 15 minutes</th>
<th>Response performance %</th>
<th>Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Town Total</td>
<td>3 895 123</td>
<td>389 512</td>
<td>140 224</td>
<td>249 288</td>
<td>98 157</td>
<td>70</td>
<td></td>
</tr>
</tbody>
</table>

A mission time of 60 minutes is used to determine the number of hours needed to service the projected number of clients. With the hours calculated the model then calculates the number of vehicles and staff required to service the need for P1 and P2 calls at a response rate of seventy percent within 15 minutes. These targets can be adjusted in the model.

Table 13: Calculating the number of vehicles needed to service P1 calls

<table>
<thead>
<tr>
<th>P1</th>
<th>Number of vehicles to achieve target</th>
<th>Number of hours</th>
<th>Staff needed to achieve set targets</th>
<th>ALS</th>
<th>Cost of staff ALS</th>
<th>ILS</th>
<th>Cost of staff ILS</th>
<th>BLS</th>
<th>Cost of staff BLS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>32</td>
<td>196 314</td>
<td>269</td>
<td>27</td>
<td>R 5 321 700.8</td>
<td>105</td>
<td>R 13 823 207.3</td>
<td>137</td>
<td>R 12 590 461.8</td>
</tr>
</tbody>
</table>

Table 14: Calculating the number of vehicles needed to service P2 calls and displaying the projected increase in staff and vehicles

<table>
<thead>
<tr>
<th>P2</th>
<th>Number of vehicles to achieve target</th>
<th>Number of hours</th>
<th>Staff needed to achieve set targets</th>
<th>ALS</th>
<th>Cost of staff ALS</th>
<th>ILS</th>
<th>Cost of staff ILS</th>
<th>BLS</th>
<th>Cost of staff BLS</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>47</td>
<td>520 435</td>
<td>713</td>
<td>71</td>
<td>R 0.0</td>
<td>278</td>
<td>R 36 645 754.1</td>
<td>364</td>
<td>R 33 377 707.4</td>
<td>277 13</td>
</tr>
</tbody>
</table>

The inter-hospital transfer clients are calculated at forty percent of the projected patient load (ten percent of total population). This proportion may reduce once we have established fully functional district hospitals strengthened by general specialists in certain high-demand disciplines. Within the model, we can increase/decrease the required number of patients transported via IFT to emergency care centres.
Table 15: Projected inter-hospital transfers

<table>
<thead>
<tr>
<th>Sub District</th>
<th>Possible Clients</th>
<th>40% of possible clients = IHT</th>
<th>Total Patients seen in EC</th>
<th>% of IHT total EC headcount</th>
<th>New proposed performance</th>
<th>New number of IHT patients to transport</th>
<th>Proposed increase above 40%</th>
<th>Percentage increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Town</td>
<td>389 512</td>
<td>155 805</td>
<td>237 628</td>
<td>66%</td>
<td>58%</td>
<td>246 172</td>
<td>90 367</td>
<td>58</td>
</tr>
</tbody>
</table>

The model for ambulance services in rural districts presumes a geographic distribution model; i.e., that ambulances are distributed equally in each town (urban area) and then capacity is calculated on the demand in larger centres.

Ambulances are required in the following urban complexes in the Western Cape. (Table 14 – communities with no resident ambulance station are highlighted in bold italics.)

Table 16: Urban ambulance complexes in the Western Cape

<table>
<thead>
<tr>
<th>CAPE TOWN (WEST COAST)</th>
<th>CAPE WINELANDS</th>
<th>OVERBERG</th>
<th>EDEN</th>
<th>CENTRAL KAROO</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWARTLAND</td>
<td>WITZENBERG</td>
<td>THEEWATERSKLOOF</td>
<td>GEORGE</td>
<td>PRINCE ALBERT</td>
</tr>
<tr>
<td>» Malmesbury</td>
<td>» Ceres</td>
<td>» Grabouw</td>
<td>» George</td>
<td>» Prince Albert</td>
</tr>
<tr>
<td>» Riebeeck West</td>
<td>» Prince Alfred Hamlet</td>
<td>» Caledon</td>
<td>» Pacaltsdorp</td>
<td></td>
</tr>
<tr>
<td>» Saron</td>
<td>» Op Die Berg</td>
<td>» Kleinmond</td>
<td>» Thembalex</td>
<td></td>
</tr>
<tr>
<td>» Gouda</td>
<td>» Tulbagh</td>
<td>» Pringle Bay</td>
<td>» Uniondale</td>
<td></td>
</tr>
<tr>
<td>» Mooreesburg</td>
<td>» Wolseley</td>
<td>» Rociois</td>
<td>» Haarlem</td>
<td></td>
</tr>
<tr>
<td>» Darling</td>
<td></td>
<td></td>
<td>» Wilderness</td>
<td></td>
</tr>
<tr>
<td>» Hopefield</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Yzerfontein</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SALDAHNA

<table>
<thead>
<tr>
<th>STELLENBOSCH</th>
<th>OVERSTRAND</th>
<th>MOSEL BAY</th>
<th>LAINGSBURG</th>
</tr>
</thead>
<tbody>
<tr>
<td>» Vredenburg</td>
<td>» Stellenbosch</td>
<td>» Botriver</td>
<td>» Mossel Bay</td>
</tr>
<tr>
<td>» Langebaan</td>
<td>» Cloetesville</td>
<td>» Hermanus</td>
<td>» Groot Brak</td>
</tr>
<tr>
<td>» Jacobsbaai</td>
<td>» Khayemandi</td>
<td>» Gansbaai</td>
<td>» Hartenbos</td>
</tr>
<tr>
<td>» Dwarkersboss</td>
<td>» Jamestown</td>
<td>» Stanford</td>
<td></td>
</tr>
<tr>
<td>» Paternoster</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>» Veldrif</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BERG RIVER

<table>
<thead>
<tr>
<th>DRAKENSTEIN</th>
<th>SWELLENDAM</th>
<th>LANGEBERG</th>
<th>BEAUFORT WEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>» Elandsbaai</td>
<td>» Paarl</td>
<td>» Rivieronderend</td>
<td>» Beaufort West</td>
</tr>
<tr>
<td>» Porterville</td>
<td>» Wellington</td>
<td>» Swellendam</td>
<td>» Riversdale</td>
</tr>
<tr>
<td>» Piketberg</td>
<td>» Franschoek</td>
<td>» Barrydale</td>
<td>» Albertinia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» Bredasdorp</td>
<td>» Still Bay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» Struisbaai</td>
<td></td>
</tr>
</tbody>
</table>

CEDERBERG

<table>
<thead>
<tr>
<th>BREDE RIVER</th>
<th>KNYSNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>» Lamberts Bay</td>
<td>» Worcester</td>
</tr>
<tr>
<td>» Leipoldtville</td>
<td>» Rawsonville</td>
</tr>
<tr>
<td>» Graafwater</td>
<td>» De Doorns</td>
</tr>
<tr>
<td>» Citrusdal</td>
<td>» Touws River</td>
</tr>
<tr>
<td>» Clanwilliam</td>
<td></td>
</tr>
</tbody>
</table>
Medical rescue services

Medical rescue services are modelled on demand in the City of Cape Town and in a geographic proximity model along major traffic routes in rural districts.

Cape Town experiences 10,751 traffic-related accidents annually, with a patient entrapment (patients trapped by the wreckage that then have to be freed with the ‘jaws of life’) rate of 1,018/10,000 accidents and a P1 under-15 minute-performance of eighty-one percent with ninety-two percent of these incidents dispatched within five minutes.

Cape Town therefore requires eight rescue units 24 hours a day, including Atlantis, to create the geographic proximity for response within the necessary response time.

In addition Cape Town supports aquatic rescue through missions with the South African Airforce (SAAF) to provide air sea rescue (ASR) (of medical casualties recovered from ships at sea under the authority of SAMS and MRCC), a diving rescue squad, swift water rescue, National Sea Rescue Institute (NSRI) rescue and inshore rescue with the NSRI through the aeromedical programme. Cape Town must have confined space, trench and collapsed structure capability to support disaster risk-management capacity in the event of earthquakes or major structural collapse.

Disaster medicine and mass casualty response with a mobile medical unit and emergency equipment vehicles (EEVs) with large amounts of medical equipment to treat trauma victims is also provided.

Finally, Cape Town provides resources and support to Wilderness Search and Rescue to perform base management, communications, and technical rope rescue response.

Intermediate motor vehicle rescue units and trailers are required along national routes on the N7, N1 and N2 highways and service approximate regional and municipal routes from those locations. The following units currently exist, including in Cape Town.
Table 17: Motor rescue units along national routes

<table>
<thead>
<tr>
<th>N7</th>
<th>N1</th>
<th>N2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malmesbury</td>
<td>Paarl</td>
<td>Grabouw</td>
</tr>
<tr>
<td>Moerreesburg</td>
<td>Worcester</td>
<td>Caledon</td>
</tr>
<tr>
<td>Piketberg</td>
<td>Laingsburg</td>
<td>Hermanus</td>
</tr>
<tr>
<td>Clanwilliam</td>
<td>Leeu Gamka</td>
<td>Swellendam</td>
</tr>
<tr>
<td>Van Rhynsdorp</td>
<td>Beaufort West</td>
<td>Bredasdorp (trailer)</td>
</tr>
<tr>
<td>Bitterfontein (trailer)</td>
<td>Murraysburg (trailer)</td>
<td>Riversdal</td>
</tr>
<tr>
<td>Vredendal</td>
<td>Prince Albert (trailer)</td>
<td>Mossel Bay</td>
</tr>
<tr>
<td>Vredenburg</td>
<td></td>
<td>George</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knysna</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plettenberg Bay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oudtshoorn</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ladismith (trailer)</td>
</tr>
</tbody>
</table>

Aeromedical services

Aeromedical services are operated on a contracted-out model to an aviation medical service provider.

The services provided include acute primary scene response for mainly traffic accidents and Wilderness Search and Rescue (WSAR) incidents and acute inter-facility responses up to 200km and from 200km to 500km.

One fixed-wing aircraft adequately services inter-facility transfers from locations between 200km and 500km from Cape Town.

Helicopters in Oudtshoorn and Cape Town service a radius of 200km from those bases and drain towards George Regional Hospital, Worcester Regional Hospital, Paarl Regional Hospital and the three central/tertiary hospitals (including Red Cross War Memorial Children’s Hospital).

Patient transport services

HealthNET provides outpatient transport locally within sub-districts, regionally within geographic service areas (GSAs) and provincially along national routes to Cape Town.

Each geographic unit must have the capacity to book transport electronically, schedule patient movement and provide transport in suitable vehicles. Each District HealthNET component needs dedicated management.

The configuration of vehicles includes seats, stretchers and wheelchair capacity. Seated vehicles have a capacity of up to 23 seats; wheelchair vehicles are configurable to two wheelchairs and four seats; stretcher vehicles are configurable to two stretchers or one stretcher and six seats.

HealthNET operates five days a week for incoming referrals and seven days a week for outgoing repatriations. HealthNET takes patients only to their personal residence if they are in a wheelchair, on a stretcher, on renal dialysis or over 60 years old. HealthNET collects renal dialysis and wheelchair patients from home only. Vehicles travelling greater than 200km to a referral centre need two drivers for safety reasons.
Forensic Pathology Services

Introduction and Background

The forensic pathology service (FPS) is a specialised service rendered by forensic pathologists, supported by forensic pathology officers. Access is also required to other sub-specialists such as histo-pathologists, odontologists and toxicologists.

The forensic pathology service is mandated to perform the medico-legal investigation of death in all cases where death is or appears to be due to unnatural causes.

Since the transfer of the service to the Department of Health in April 2006, the provincial post-mortem rate per 1 000 population has varied between 1.8 post-mortems per 1 000 population and 1.63 per 1 000 population, with a greater variance experienced at district level. The post-mortem rate projected for 2030 is 1.74 per 1 000 population.

As a scarce resource the service is configured to ensure access, whilst at the same time ensuring the quality of the medico-legal investigation process. Forensic pathology facilities are historically classified according to caseload. The classification ranges from M1 to M6, dependent on the number of cases managed at the facility.

Planning methodology and principles

In planning the forensic pathology service the following guiding principles are considered:

1. The forensic pathology service provides a 24/7; 365 day service;
2. One full-time equivalent (FTE) is available for 221 days;
3. The service provides a 365-day service with regard to scene attendance and a 250-day service with regard to post-mortem service; and
4. It is also required to consider “critical mass” to provide service.

In planning towards 2030, a planning modelling tool was developed that considers a number of factors including population estimates, burden of disease and its impact, on caseload, workload, case mix, case complexity, direct case contact time as well as the optimal configuration of services.

The population estimate used in the modelling is that of the midway scenario using the Dorrington 1999 population data. The estimated caseload has been projected on the basis of historic information (post-mortem/1 000 population) and then adjusted year on year to allow for changes in population. The provincial post-mortem rate as an indicator of burden of disease or injury is projected for 2030 at 1.74 per 1 000 population.

The impact of various interventions on the burden of disease and injury is unknown. The forensic pathology service contributes to the provincial strategic objective 3 (increasing access to safe and efficient transport), provincial strategic objective 4 (increasing wellness), strategic objective 5 (increasing safety) and strategic objective 8 (increasing social cohesion) by providing expertise and information in terms of mortality to the burden of disease project. This information is important for informing policy, planning services, as well as targeting interventions and monitoring the impact of interventions. The modelling tool is sufficiently robust to allow for adjustments year on year.

In developing staffing norms and a staffing model it is clear that the modelling cannot be done merely on case-load or cases admitted to the forensic pathology service, but that the actual “case contact time” has to be considered.
It should further be noted that the ‘care-pathway’ for a forensic pathology case begins when the call for response is received and ends when the case is concluded by the judicial system. Case contact time defines per facility the amount of time spent per case and includes the following factors:

- Death scene attendance;
- Death scene investigation;
- Facility admission and receipt;
- Identification;
- Autopsy travel time;
- Autopsy;
- Referral;
- Release;
- Forensic pathology administrative processes;
- Management of general enquiries; and
- Specimen and exhibit management.

When case contact time is determined, scene travelling is based on the actual median response time using historic data. This modelling was used to confirm the current forensic pathology officer staffing requirement and also to project staffing needs by 2030.

The only existing norm for the determination of pathologist staffing requirements is that of ‘NAME’, which indicates a criterion of 250 cases to pathologist per annum. The current caseload of a forensic pathologist is 539 cases per annum. From the modelling, it is clear that the norm of 250 cases per annum would most probably not be achievable by 2030 in a resource-constrained environment. Affordable norms will be developed through application of the model within defined budget allocations.

**Service provision model**

The forensic pathology service is a specialised service rendered by forensic pathologists and forensic pathology officers with a quantum of level 1, 2, 3 and 4 activities being provided. The forensic pathology facilities are classified according to the package of care (level determinator) provided at such a facility as well as the caseload (M1 to M6). The operational geographical service is largely aligned with that of the South African Police Services (SAPS) and National Prosecution Agency (NPA) as key strategic partners, with an operational forensic pathology service manager responsible for each area, while clinical unit managers have the responsibility of ensuring clinical governance in each of their respective drainage areas.

The service will continue to be provided via 18 forensic pathology laboratories and two departments of forensic medicine supported by a central management and administration component. The facilities will over time and according to priority be relocated off existing SAPS premises and be replaced with fit-for-purpose facilities.

The forensic pathology service area managers and responsible pathologists (clinical unit managers) will closely support district health managers by providing forensic-pathology-service-related data for monitoring and evaluation and by being available for immediate problem solving and being part of the district management scheduled meetings. The forensic pathology service will further report on trends with regard to burden of disease and hospital case management as managed by the service without impacting on the medico-legal investigation of the death process.
### Level 1

The package of care provided at a Level 1 holding facility is the following:

- Call taking;
- Property management;
- Scene management;
- Specimen management;
- Death scene investigation;
- Evidence and exhibit administration;
- Admission; case administration (including chain of evidence); and
- Visual Identification and final release.

The following facilities are defined as holding facilities:

- Swellendam
- Riversdale
- Laingsburg

### Level 2

The package of care provided at a Level 2 facility includes in addition:

- Death scene attendance and comprehensive reporting;
- Dissection, including specialised dissection techniques;
- Special investigations;
- Consultations;
- Court appearances;
- Inquests; and
- Provision of docket opinions.

The following facilities are classified as Level 2 facilities:

- Paarl (referral centre)
- Vredendal
- Vredenburg
- Malmesbury
- Stellenbosch
- Worcester (referral centre)
- Hermanus
- Wolseley
- George (referral centre)
- Knysna
- Mossel Bay
- Oudtshoorn
- Beaufort West

### Level 3/4

A Level 3/4 service is defined as an academic referral centre (according to caseload) with additional specialised support services.

The package of care provided at a Level 3/4 facility includes in addition to that listed above:

- Neuropathology;
- Histopathology;
- Paediatric pathology;
- Odontology;
- Toxicology;
- Molecular science;
- Entomology; and
- Anthropology or any other functions related to case admission.

The following facilities are classified as L3/4 services:

- Salt River
- Tygerberg

The forensic pathology service in the Cape Town metro district will be strengthened by the commissioning of the Observatory Forensic Pathology Institute, which will replace the Salt River facility, and by the expansion of the Tygerberg facility to enable the facility to manage the Helderberg caseload.
Inspector of anatomy

The inspector of anatomy / health officer component provides a transversal function to the Department of Health, which has been further expanded by the promulgation of Regulations relating to Chapter 8 of the National Health Act. The health officer’s responsibilities include ensuring compliance with Chapter 8 of the National Health Act in relation to: health establishments; tissue banks; blood transfusion services; fertility clinics; undertakers; university departments; transplantation; human tissue donations; tissue importation and export permits; exhumation requests, as well as provision of consultation and support.
SECTION F: QUALITY OF CARE

Introduction

Delivering quality health services is both a national and a provincial priority. The Batho Pele principles of consultation, setting service standards, increasing access, ensuring courtesy, providing information, openness and transparency, redress and value for money provides a national guide of the key elements of quality service delivery in the public sector more generally.

The amended National Health Act, the National Core Standards and the establishment of the Office of Health Standards Compliance provide a legislative framework and mechanisms to ensure that quality of health service standards are met. The main purpose of the National Core Standards as articulated in the national policy is to:

1. Develop a common definition of quality care, which should be found in all health establishments in South Africa as a guide to the public and to managers and staff at all levels;

2. Establish a benchmark against which health establishments (public and private) can be assessed, gaps identified and strengths appraised; and

3. Provide for the national certification of compliance of health establishments with mandatory standards.

In parallel to the need to comply with the national core standards, the Department wants to build sustainable commitment to continuous improvement in patient-centred experience (PCE) and quality.

The vision for quality of care within the 2030 strategy can be divided into three dimensions:

- Individual dimension
- Health system dimension
- Population dimension

The Department’s patient-centred experience framework has prioritised five focus areas:

- Reception services
- Clinical services/clinical governance
- Continuity of care
- Staff wellness
- The patient’s voice

Caring for and engaging staff is central to achieving optimal PCE.

A set of potential indicators will measure the success of implementing 2030.

These three dimensions are inter-related and interdependent and not discrete as some of the elements can be classified in more than one dimension. It is, however, useful to consider these three dimensions in determining the vision for quality in the Western Cape Department of Health.

The **individual dimension** relates to the vision of patient-centred care where the Department aims to provide optimal health services as perceived through the eyes of the patient. This is based on the following principles:

- Effective treatment delivered by staff patients can trust;
- Involvement in decisions and respect for patients’ preferences;
- Fast access to reliable health care advice;
- Clear, comprehensible information and support for self-care;
- Physical comfort and a clean, safe environment;
- Empathy and emotional support;
- Involvement of family and friends; and
- Continuity of care and smooth transitions.

The **health system dimension** relates to the vision of a health system that provides access to effective health services that have the required coverage and are delivered in the most efficient manner that minimises wastage and is compliant with national standards.

The **population dimension** relates to the vision to ensure that the burden of disease at a population level decreases and life expectancy, health outcomes, quality of life, and wellness increase.
**THE INDIVIDUAL DIMENSION**

**Patient-centred Care**

The Department has developed a framework to guide the establishment of a patient-centred health service in the Western Cape. This framework in particular complements the first four domains of the National Core Standards. This framework enhances the national core standards by placing the patient at the centre of everything to result in not only the desired health outcome but also one accompanied by a superior experience of a complete patient journey.

**Reception Services**

It is recognised that the manner in which a facility ‘presents itself’ to a patient and the manner in which the patient’s needs are efficiently identified and handled play a large role in the patient’s perception of the quality of that service. The patient’s clinical folder that is neat and tidy, well annotated, up-to-date and always accessible is considered inviolable and is symbolic of respect for the patient’s dignity during their journey through the health services.

The following has been prioritised for action.

1. **A welcoming protocol** that ensures patients and their families feel welcome in the facility from when they enter the premises and through their entire journey of the facility.

   This will include the courteous attitude of security guards at the gates of facilities, even if they are from outsourced companies. They should also have assistance to direct them to where they need to be either through a patient service officer or manager and/or very clear signage of where the services patients require are situated. Staff should also be identifiable with nametags, and facility organograms with photographs and contact details of the managers should be visible. Information on patient rights and responsibilities, the service charter and compliment and complaints procedures should also be visible.

2. **Environmental ambience** is related to clean facilities including toilets, availability of adequate seating in waiting areas, availability of drinking water, and an environment that is safe and minimises the transmission of diseases. In addition, there is adequate natural light and ventilation, minimum noise, especially in inpatient wards and the setting is generally aesthetically pleasing and environmentally friendly.

3. **Triaging and risk profiling** ensures the sickest patients or those that have limited mobility are prioritised and seen by the most appropriate health worker.

4. **Patient registration** that ensures each patient has a unique patient number that can be accessible at any provincial or City of Cape Town health facility and that can be retained throughout their life course.

5. **Folder management** that ensures folders are managed effectively with all the required and updated administrative and clinical information that can be easily retrieved when required. The most essential data should be captured for monitoring and evaluation purposes.

6. **Appointment system** that ensures patients do not wait for unnecessarily long periods to receive services

**Clinical Service and Clinical Governance**

The Department has developed a policy framework for clinical governance. In this policy framework clinical governance is defined as: “a framework through which organizations are accountable for continuously improving the quality of their services and safeguarding high standards, through creating an environment in which excellence in clinical care can flourish”.

The departmental patient-centred experience has five focus areas:

1. Reception services
2. Clinical services/clinical governance
3. Continuity of care
4. Staff wellness
5. The patient’s voice
Clinical leadership and technical expertise are central to facilitating clinical governance. This leadership will ensure that:

» Comprehensive service packages are defined for various level of care;
» Clinical effectiveness results from the implementation of evidence-based clinical interventions;
» Clinical risk management is achieved through continuous monitoring and improvement of
  a. individual health outcomes,
  b. adverse incidents and
  c. adherence to clinical standards and guidelines;
» Clinical accountability is established with clear clinical and professional standards against which actual performance of health workers is measured;
» Effective teamwork emphasises multidisciplinary co-operation; and
» Continuous professional development needs are identified and addressed.

In addition to health workers providing effective health services, the manner in which they interact with patients must subscribe to the key principles of a patient-centred experience which aims to ensure:

» Empathy and emotional support to patients;
» The involvement of patients in decisions and respect for patients' preferences;
» Involvement of family and friends where appropriate; and
» Integrated health care provisioning to minimise wastage and inconvenience for patients.

Management plays an important role in ensuring that clinical governance remains central to clinical service delivery by partnering with clinical leaders to ensure that the required resources to perform clinical governance processes are provided for. In addition, both managers and clinical leaders have to instill a management culture based on on-going learning and development that ensures delivery of clinical results together with measurable credibility of clinical services by patients, families and other stakeholders.

The creation of functional business units within larger hospitals will also allow for decentralised management and local responsibility and accountability for quality health services and efficient use of resources.

**Continuity of Care**

The “care pathway” for patients in the health system describes the patient’s journey through the health system which is planned to meet the needs of the individual patient and takes into consideration the patient’s goals, needs and lifestyle as they progress through the various stages of life from birth to death.

As part of enhancing the patient-centred experience, there will be continuity of care for patients who need to utilise more than one package of care from more than one level of care at different stages of the life course to achieve the desired health outcomes and goals. The referral and discharge processes are key opportunities in the patient’s journey where health care providers can contribute to continuity of care and the achievement of the desired outcomes and goals, as well the recording and capturing of vital information about the patient encounter, such as the international classification of disease (ICD) codes that are essential for evaluating the impact of clinical interventions and ensuring that desired population outcomes are attained.

An effective process of discharge planning or referral from health services will have the potential benefits of reducing re-admissions and the average length of stay and empowering patients with useful information for self-care.

*The aim of the continuity of care processes is to provide seamless care, as if it were provided by the same carer and ensures that there is shared effort throughout the care pathway to jointly deliver the patient’s desired health outcomes and goals.*
In order to achieve this, there are two critical elements that the Department will be focusing on:

**Hardware issues that ensure effective referral**

- A standardised patient record and record management system that can maintain records throughout the life course from birth to death;
- A standardised continuity of care record for discharge and referral;
- Service point and drainage area directories for ease of referral;
- Geography-specific resource materials for continuity of care that are used for all inductions for new staff and regularly updated by all staff (old or new);
- Institutionalised ICD-10 coding guidelines, tools and standard operating procedures to capture burden of disease information;
- Availability of integrated appointment systems;
- Easily accessible communication tools such as telephones, faxes, and e-mail; and
- Closed loop communication that ensures that referring health providers receive communication that the patient they referred was received successfully and what the outcome of the referral was.

**Software issues that ensure effective referral**

Through a values-based culture change in the Department, there will be a strengthening of positive values and an addressing of limiting values to foster positive relationships between staff and patients, and amongst different cadres of staff at different levels of care. This is to ensure the shared responsibility for attaining the patient’s desired health outcomes and goals.

**Improved Staff Experience**

Staff play a critical role in PCE as they are responsible for the patient and provider interaction that is at the centre of PCE. It is would impossible to provide patient-centred quality care without a high-quality workforce and there is increasing evidence that staff satisfaction is directly related to improved patient satisfaction. Thus part of the 2030 strategy is geared to ensure that employees are engaged, empowered and happy to be at work that will in turn generate better outcomes for patients and improve the efficiency of the service through a reduction in hospitalisation days and re-admission rates. Staff will be encouraged to be more innovative and to look for ways to be more effective and efficient.

In a recent staff satisfaction survey, staff in the Department were reported to be dedicated to their profession, committed and keenly engaged with their actual work. They also reported, however, that they experience dissatisfaction with the people-management skills of their line managers and do not believe that they are valued, feel listened to or cared for by the organisation and thus have limited engagement with the organisation. Furthermore high levels of burnout have been identified in staff as a result of heavy workloads and a stressful working environment.

The key interventions to improve staff experience, in addition to the broader human resources strategy, include:

- A facilitated change management process that will assist in the transformation of organisational culture to be in line with 2030 values of “Caring, competence, accountability, integrity, responsiveness and respect”. The key focus here will be on the development of a performance league table, improved communication with staff, identification and development of change agents in the front line staff, and improved leadership at all levels;
- Making staff part of the solution through the implementation of lean projects to improve service delivery and the provision of innovation awards to drive continuous improvement through the development of new ideas to reach departmental goals;
- A staff recognition system which will acknowledge and reward excellence through a variety of financial and non-financial rewards;
- An employee wellness programme in line with a Safety, Health, Environment, Risk and Quality Management (SHERQ) policy and the Occupational Health and Safety Act (OHSA). Support and counselling
» Conducting staff satisfaction surveys to constantly monitor staff engagement with the organisation.

The Voice of the Patient

The aim of PCE is to place the patient at the centre of service delivery. The Department has institutionalised an annual patient satisfaction survey and will be implementing regular rapid surveys to hear the voice of the patient. This will be used as a key yardstick to measure how well the Department is meeting expectations of patients with regard to patient centeredness.

This also involves meaningfully engaging the patient during each visit to the health service, listening to the concerns, needs and perspective of the patient.

Illness can cause anxiety and fear in patients and it is important to recognise that patient perspectives are dependent on values, beliefs and culture, informed by family, friends and community. These factors influence health-seeking behaviour, adherence to health care advice and interventions and self-care.

As deemed appropriate by the patient, there will be collaboration between communities, patients, family members and providers to ensure that appropriate support is given to the patient to ensure appropriate health-seeking behaviour, adherence to interventions and appropriate self-care. Patients will therefore be provided the opportunity to involve family and friends in their health-related decisions and plans.

In instances where patients require long-term support from family and friends, non-governmental organisations will be encouraged to provide support to the caregivers.

THE HEALTH SYSTEM DIMENSION

Building a Culture of Continuous Quality Improvement

The seven domains of the National Core Standards provide the minimum legislated standards set for the health system to deliver quality health services that result in the desired health outcomes. The National Core Standards have seven domains, as shown in Figure below.

Figure 14: The seven domains of the National Core Standards
In addition to progressively moving towards National Core Standards compliance, the Department has also prioritised the manner in which we deliver services in ways that minimise waste, are effective and patient-centred. The Department will develop incremental internal capacity to implement process re-engineering strategies such as lean management to reach these objectives.

Managers will be encouraged to “manage by walking about” and get first-hand experience of service challenges by observing and listening to staff and patients and to respond to them as quickly as possible. Interventions to minimise waste, improve outcomes and the patient experience will be systematically monitored and evaluated and incremental targets will be set to ensure continuous improvement. System efficiency will be further evaluated as described in the monitoring and evaluation section of this document.

THE POPULATION DIMENSION

The Burden of Disease

The last dimension of quality pertains to the ultimate aim of reducing the burden of disease, increasing life expectancy and improving the quality of life. This is determined by both the delivery of quality health services and the realisation of a developmental agenda that addresses the social determinants of health. These determinants result in the differential distribution of disease, differential vulnerability to disease, and the realisation of differential health outcomes and consequences.

The population dimension will ensure that not only is the burden of disease reduced but that quality of life improves and wellness is increased enabling people to fulfil their true potential.
SECTION G:
SUPPORT SERVICES
The core business of the Department is to be responsive to the health needs of the population, with the prime focus being to improve health outcomes and the patient experience in the health service. There are also secondary organisational outcomes, such as being an employer of choice, achieving a clean audit, operating within our budget envelope, and maximising value for money, which we wish to achieve.

Optimal service delivery will be enabled by a range of key support services, which include human resources (HR) management, financial management, appropriate infrastructure, medical technology and availability of consumables, and information management and information and communication technology (ICT). The substance and form of these support services are centrally informed by the service delivery imperatives for patient-centred quality care and improved health outcomes. As shown in Figure 15.

**Figure 15: 2030 Strategic framework of the Western Cape Government: Health**

Support services will be strengthened at various levels of the platform by ensuring a coherent, integrated, systems approach, in particular:

- Policy development to ensure the development of coherent, complementary policies that are aligned with each other;
- Integrated planning that incrementally and progressively moves towards the attainment of the long-term strategic objectives. Integrated planning processes will ensure that service delivery targets are accompanied by appropriate capacities in HR, finance, infrastructure, supplies and ICT to ensure delivery;
- Resource allocation that is based on the principle of equity and ensuring value for money;
- Implementation support that provides guidelines, mechanisms and tools for the efficient and effective decentralised management of services at institutional-, sub-district- or district levels; and
- Monitoring and evaluation that monitors if short-term achievements result in long-term outcomes/impacts and motivate continuous improvement cycles.
Each of the support service components have in the main addressed two areas in thinking through their role within 2030: how does it support various levels of the service delivery platform in practical and innovative ways and how it builds a cohesive approach within support services to achieve optimal impact – i.e. a systems approach to achieve synergies between the various components?

Management mechanisms to enable the coordinated planning, priority setting, service provision, joint problem solving, monitoring and evaluation of all health services together with the support services, across the levels of care within a geographic area, will be strengthened.

Building and strengthening capacity at various levels is an important prerequisite to effective decentralised management and distributed leadership. Over the next few years, the focus will be on developing the clinical and administrative leadership and management capacity at institutional level that is directly responsible for service delivery and quality of care.

STRAgy AND HEALTH SUPPORT

Building Cohesion

Once the framework for 2030 has been finalised, it would be important for the Department to ensure alignment of its structures, policies and practices to give cohesive effect to this strategic direction both from a planning and an M&E perspective. Strategy and support will provide the key interconnectivity between the various support functions and service delivery functions. Strategy and support will ensure structural and functional alignment, a cohesive organisational focus on the patient experience and desired outcomes, appropriate prioritisation and consequent allocation of resources, and the M&E of progress towards achieving the identified outcomes. The integrated functioning of strategic planning, information management and health impact assessment as well as the meaningful engagement with the line function services, health programmes and other support functions (such as finance, human resources and infrastructure) is critical to providing this alignment, co-ordination and cohesion both at a provincial- and district or institutional level.

Strategic Planning and Priority Setting

Strategy and support must also play a key role in obtaining, digesting and processing of organisational intelligence that informs the planning and management of health services in the Department. Scanning of the broader external environment for relevant developments globally and locally and being aware of the dynamics, performance, stresses and strains within the internal environment of the Department are critical to the functioning of Strategy and Support. Organically embedded mechanisms between Strategy and Support and the other support functions, service delivery entities and external partners are critical to enable this functionality. Tapping into the body of knowledge generated by research as well as accessing the technical expertise within higher education institutions (HEIs) and other organisations is also important. Robust forms of surveillance of disease patterns and risk factors will inform the planning and responsiveness of the Department.

Given the reality of limited resources compared to the health needs of the population, the setting of priorities and the targeted allocation of resources become increasingly important. Within this context, 2030 calls for a focus on health outcomes which requires harnessing the most cost-effective interventions based on sound evidence. Steps will also be taken to access the strong research capacity located within the province more effectively.

To address the principle of equity, measures will be put in place to assess the current situation as well as to develop mechanisms to address these. Important parameters to address equity include access to services, resource allocation and health outcomes.

The commitment to a district-based health service in 2030 implies a geographic and population-based approach to planning and the management of health services. The promulgation of the District Health Councils Act makes it a statutory obligation to have district health plans with targets that the district management will be accountable for.
The collection of data from facilities and the building of targets from the bottom will ensure consistency and alignment between district and the provincial health plans. This also lays the foundation for a meaningful monitoring and evaluation process at both levels. The provincial centre will ensure that there is an alignment between district plans and institutional plans and the strategic priorities of national and provincial government.

**Policy Development**

Several areas of improvement will be addressed to optimise the policy process:

- A central repository of all policies which will be digitally available to all in the health services;
- A more systematic and regular process of policy review;
- More effective ways of communicating policies and developing a common understanding amongst staff;
- More effective implementation of policies;
- Monitoring the implementation and evaluating policy outcomes and impact; and
- Involvement of all role players at all stages of policy is an important prerequisite to the successful development and implementation of policies.

The technical capacity to support these processes will be strengthened. This will include building expertise to clearly define the problems to be addressed, source the evidence to support policy options, and cost the resources required to implement these options. Expertise will also be required to evaluate the impact after implementation and to conduct a review of the lessons learned from this experience.

**Information Management**

An important enabler to address the strategic direction of 2030, is the timeous availability of good quality data and information to make decisions that impact on the health service at all levels. This requires the building of an organisational culture that values and uses information and the strengthening of information management systems. The latter requires ensuring proper policies and processes, supportive information technology with optimal use of the opportunities that rapid advances in this area provide, and the strengthening of human resources competency and capacity.

Good-quality information is an important prerequisite for the planning, implementation and M&E of the 2030 plan. Annual institutional, district and provincial plans will be developed that will contain incremental steps and targets to give effect to 2030. A core set of indicators is suggested to measure and report progress. Building the capacity to regularly evaluate health programmes and services will be important in improving overall performance at various levels of the service.

A clean audit on predetermined objectives (Information) is an important organisational objective. Institutionalising system improvements to address the audit findings will result in an overall improvement in the quality of data and information.

**Risk Management**

The Department has recently started to embrace risk management more formally and systematically. The risk management process will be developed and deepened at various levels of the organisation. This process will be institutionalised within the planning and M&E cycles of the Department and all managers will take responsibility for the implementation of mitigation measures in their areas of jurisdiction.

**Culture of Learning**

A culture of learning and improvement will be fostered in the Department. This will be done through the encouragement of on-going, regular reflection on performance and developments and the sharing of lessons and experiences within the Department. In-service training, various management and clinical meetings must become an opportunity for learning, continuous improvement and innovation.

The Department will embark upon a change management strategy, aided by external expertise, to foster the culture of continuous improvement and doing things differently to improve the service. This will include embracing methods such as lean management.
SUMMARY POINTS:

1. The human resources (HR) function is one of the most important, yet most challenging areas in the health service.
2. The 2030 Strategic HR Framework has three focus areas:
   a. Workforce planning
   b. People management (the “human” in HRM)
   c. Operational HR management
3. The Department will develop its capability in HR analytics and research to provide the workforce intelligence that informs workforce planning, development, as well as monitoring and evaluation against a set of metrics to assess progress in achieving key strategic objectives.
4. The biggest challenges to achieving the objective of a patient-centred service are: re-energising the staff and building renewed commitment to the principles and vision of 2030 and creating an organisation where staff have a deep sense of belonging. A change management programme will be embarked upon to address this challenge.
5. For the Department to become an employer of choice, the day-to-day operational management of staff and the role of the HR manager at each level of the service will be re-crafted.
6. The Department is committed to decentralised management. The HR delegations and HR capacity at each of the levels from institutions (clinics to large hospitals) and sub-districts and districts need to be reviewed in this regard. A further priority for HR is to develop leadership and management skills at facilities, sub-district level, and district level.

Introduction and Background

The HR function is one of the most important, yet challenging areas in the health service. The Department will operate within the HR legislative and policy frameworks of the Department of Public Services Administration (DPSA) and the National Department of Health who have published a national framework for human resources in health. Having considered the above, the main focus of the HR function in this document has been to locate it against the strategic direction of 2030 and within a coherent, integrated, systems approach to the provision of support services in the Department.

Workforce Planning

Health workforce planning to ensure the right number of people with the right skills at the right time is required to enable the achievement of health outcomes. Workforce planning addresses demand and supply forecasting through environmental scanning and workforce analysis. Based on the new approved organisational structure and the review of the current staff complement, an analysis will be made to determine the need in HR. Collaboration with internal and external stakeholders, particularly the higher education institutions is pivotal in this regard.

Specific priorities and action plans to address service delivery needs and imperatives through amended staff establishments and the creation of the necessary posts, recruitment, retention, education, training and development etc., will be developed for each of the service areas identified. The HR management capacity, with clearly defined roles and responsibilities at the various levels, will be strengthened and integrated into the broader support service planning process.

The Department has therefore formed an HR planning work group as well as an M&E team comprising senior managers to focus on the strategic HR issues it faces.

To ensure effective integrated planning, HR intelligence to manage demand and supply will be essential. Innovative actions such as task shifting, institutionalising a culture change process, leadership development, training and development will support the ability of the Department to attract and retain staff.

The Department will strengthen its internal HR development capacity and functioning, including formal and informal training, mentoring and support.

This is a key strategic opportunity to ensure alignment between staff development and the values, vision and principles of 2030.

It is also an opportunity to actively engage with the experiences and creative ideas of staff in improving the service.
**HR intelligence**

There is a need for an integrated HR information system to establish a database for health workforce intelligence, which will provide health workforce information, meeting workforce requirements for new and emerging strategies and ensuring an effective health service. In addition the database will provide value-adding HR and management information and the development of an integrated talent framework. Succession planning, talent acquisition and retention and strategies to become the employer of choice will be part of the integrated talent framework.

The Department will be developing its capability in HR analytics and research to provide the intelligence that informs workforce planning, development as well as M&E against a set of metrics to assess progress in achieving key strategic objectives.

**The strategic HR approach to 2030 will be based upon the factors described below.**

### Demand

The demand for health workers for the different categories of staff, the specific skills and staff numbers required will be determined by the health service platform configuration and service delivery levels of 2030, which are required to address the burden of disease and achieve the desired health outcomes, including wellness of the population at large.

The 2030 framework does not include detailed staffing numbers and competencies required for every level of care or institution as appeared in the 2010 planning process. However, planning tools such as workload calculators and service models will be developed to enable the required staffing levels to be quantified. These tools will be then be applied, in consultation with local management and clinical staff, to specific sections of the health service to work out the human- and other resource requirements for 2030. Assumptions will be made about the available funding levels and affordability of staff.

### Supply of health workers

The supply of health workers, especially health professionals, is from three main sources – universities and colleges, from other provinces and countries, and internal training and development.

The demand and supply of health workers is in dynamic flux as there is continuous movement of staff between the various sources and also between the private and public sectors. There is a range of push and pull factors that impact on this movement of staff. Some of the recognised push factors include stressful working environments, breakdown in relationships with immediate supervisors, and broader societal factors such as crime and insecurity. Some of the pull factors include better remuneration packages in the private sector and overseas, better and less stressful working environments, and the opportunity to travel and gain broader experience.

The vision to become an employer of choice by changing the culture of the organisation to be more patient centred and to improve staff engagement will be critical in addressing the pull and push factors.

### Scarce skills

The retention of scarce skills in the areas of specialised nursing, pharmacy, clinical psychology, radiography, prosthetics and orthotics, clinical technology, clinical engineering, forensic pathology and emergency care (technicians and paramedics) continues to compromise the ability of the Department to perform optimally. There is a range of strategies that the Department will continue to use and strengthen, which include:

- The use of bursaries to train staff in identified areas;
- The provision of relief staff to free up individuals for training;
- Implementation of the occupation-specific dispensation to provide better remuneration to attract and retain staff;
- Improving the working environment to retain talented staff with scarce skills;
People Management

The ‘human factor’ in human resources management

The Department is a large organisation with about 30,000 staff that attend to millions of patients annually within a stressful, busy and resource-constrained environment. It is easy to understand how especially staff working at the clinical coalface can become mechanistic in the way they do their work, slip into a mentality of clearing crowds, and treating patients as cases on a daily basis. The biggest unintentional casualty is the human and caring factor in the service.

» Developing a reputation of being the employer of choice and marketing the Department accordingly to attract staff;
» Using innovative ways to advertise posts; and
» Undertaking task shifting to free up the existing staff with scarce skills to be optimally used.

Task shifting

The Department will further its attempts at task shifting as a mechanism to optimally use the health professionals we employ. The training of theatre technicians to overcome the shortage of professional nurses that are theatre trained has recently started and shows promise. The 2030 framework includes rehabilitation care workers and home-based carers who will be able to do some of the basic functions in the homes of patients that have been previously conducted within facilities.

Lay care workers will be employed in hospital wards to assist with basic patient care that can free up professional nurses to do what they are qualified to do. The creation of mid-level workers such as dental assistants must be supported by adequate and appropriate training.

Education and training

An integrated training and development plan, which ensures the appropriate numbers and competency mix of staff per level of care, is imperative to achieve our desired outcomes. The training plan will include strengthening strategic partnerships with HEIs and professional councils to ensure that the Department’s needs in terms of numbers of staff with the right competencies and values are produced on an ongoing basis. The Department will engage with the HEIs to ensure appropriate curriculum content and a close inter-relationship and alignment between training, service and research. The teaching capacity within nursing colleges and the EMS training college will be addressed.

The OSD for health professionals has generally been positive in providing competitive salary packages and retaining staff in the public service within the Western Cape. Skills shortages in certain categories, such as midwives, theatre-trained nurses, mental-health-trained nurses, pharmacists, clinical technologists, continue. The Department will continue to strengthen mechanisms to address these categories, such as bursaries, in-house training, and providing relief staff to allow others to train.

Leadership and management development

Committed and competent leadership distributed at all levels of the organisation is a key prerequisite for the strategic and operational management of staff and other resources in the health service towards 2030.

Health systems strengthening should not only be based on competency development of managers at all levels of health care. The transformative role of management as ‘change champions’ is fundamentally important as well. The role of HR is to develop leadership and management skills at facilities at sub-district- and district level.

The area of clinical leadership has been historically under-emphasised in the Department. With the introduction of functional business units and the centrality of quality in the 2030 vision, the role of clinical leadership becomes very important. Strategies to develop this area will be put in place.
This is going to require a complete re-think on how we strengthen relationships, build trust and confidence and meaningful and effective communication in all directions between clinical staff and patients, between members of the multi-disciplinary teams, between staff at different institutions, between management and clinical staff, between line function and support service staff and between the Department and the strategic partners and stakeholders. There needs to be greater alignment between the values of the individual staff and the stated values of the organisation.

The Department will invest resources in securing expertise to facilitate and implement interventions that address the above-mentioned challenges with the primary objective of becoming more patient-centred in the way we deliver our service at all levels of the organisation. A secondary objective will be to become an employer of choice for staff in the province and beyond.

**Employee wellness**

Effective caring for patients requires caring for the carer. There is an inseparable connection and two-way impact between the working lives and personal lives of employees that is not unique to health.

The Department is committed to developing a safe working environment for staff, employee wellness and the provision of quality care. A Safety, Health, Environment, Risk and Quality Management (SHERQ) policy has been developed within the national legislative framework and international conventions. The provisions of the Occupational Health and Safety Act (OHSA) are also incorporated into the policy. The policy aims to promote a safe working environment and reduce risks, prevent occupational injuries and diseases, and promote healthy lifestyles of employees. There is some overlap between this policy and the infection control and quality of care initiatives, which are being addressed within the Department. The challenge is to now take the required action towards systematic and sustainable implementation of the policy at various level of the health service.

**Operational HR Management**

For the Department to become an employer of choice, the day-to-day operational management of staff will be improved.

The Department has been a long history in the development of pre-scripts and policies and ensuring administrative compliance. At this point in time however, the challenge for the HR function within the Department is to become more responsive to the needs of the service and the staff and to find creative space to function within existing rules, while still responding with greater urgency and flexibility.

The Department has created instruments that have been institutionalised to operationally manage the filling of all posts (permanent and contract). The approved post list (APL) identifies priority posts for filling at the beginning of the year within the allocated budget per entity. The APL is an important control mechanism to manage the personnel expenditure, as no post can be filled if it has not been authorised through the APL. The system allows for any change in the posts to be filled during the course of the year provided that costs of the old post and those of the new post(s) balance each other out and the source of funding can be identified. This allows flexibility yet firm control of the expenditure.

Recruitment processes will continue to be refined and improved. Innovative methods of electronic advertising and web-enabled application processes will be introduced. The Department will continue to reduce the period taken to fill posts over and above current average of 60 days. Tighter targets are being set to further improve in this regard. Creative retention strategies for staff will be explored and developed.

More systematic ways to monitor and evaluate the HR function will be developed. This will include the Barretts and staff satisfaction surveys, a robust analysis of exit interviews to understand why employees leave the organi-
sation to routine indicators such as vacancy rates for different categories of staff, personnel expenditure per outputs such as patient day equivalent and average time to fill posts. Improved HR information systems are also required to better monitor the HR function in the Department.

The role of the HR manager at each level of the service needs to be re-crafted in the light of the philosophy and vision of 2030. HR management needs to become more supportive, enabling and responsive to the needs of line-function managers to enable them to deliver good-quality services. Line function and HR management share a joint responsibility in ensuring the right number of staff with the right skills and values in the right place to achieve this vision of 2030.

Performance management and productivity
Steps will be taken to improve the manner in which the current performance management system is used and applied. This includes finding creative ways of using the existing system, exploring the use of non-financial methods to recognise staff performance and ensuring that there is a stronger alignment between the individual performance agreement of employees and the overall objectives and deliverables of the Department.

FINANCIAL MANAGEMENT

SUMMARY POINTS
1. There are on-going financial pressures in the light of limited resources and huge demands on the service. Choosing budget priorities and improved financial management within this context remains an on-going annual challenge.
2. Finance will focus on the following areas:
   a. Budget allocation:
      i. Improved budget-allocation methods that fund cost-effective interventions and address inequity.
   b. Financial management:
      i. Decentralised management and accountability including the FBU system in large hospitals;
      ii. Strengthened financial management processes;
      iii. Improved procurement and stock management; and
      iv. Clean audit practices and strengthening controls to ensure clean government.
   c. Value for money.

Introduction and Background
There will always be an inevitable tension between effectively balancing the demand for service against financial constraints. Choosing budget priorities and improved financial management within this context remains an annual challenge. In order to address this tension, getting better value from the existing health rand, more effective targeting of resources and improving efficiencies are the major focus areas for the forthcoming period.

A re-alignment of budget and financial management processes of entities according to geographical areas rather than divisions and programmes will be undertaken. This will be relatively easy to achieve as the finance function is currently geographically divided on the hub and spoke principle. This means that the finance sections of the larger hospitals also serve the surrounding smaller facilities. These services are supported by regions, with ultimate control and support provided from Head Office. The structural reorganisation of the Department, therefore, will require only a limited reorganisation of the finance function to support geographical management. This support will be provided in a coherent way that is integrated with all other support functions that work seamlessly to provide for the resources required to deliver on 2030 imperatives.

Budget Allocation
Budget allocation is a powerful form of strategic decision making. The Department will continue to improve its budgeting processes by:

» Ensuring that the most cost-effective interventions that will most optimally impact on “health outcomes” will be prioritised for funding and that funds are equitably divided between and among various levels of care;
» Addressing inequities in resource allocation between districts, sub-districts and entities in terms of service load and population served; and
Improving measures of patient workloads (both from the numbers of patients as well as their acuity). Diagnostic-related groups or equivalent methodologies will be used to facilitate a better understanding of patient profiles.

Financial Management

Decentralised management

Delegations and decentralisation of functions to districts or geographic service areas or entities will be refined to ensure an optimal balance of decentralised authority and accountability. Managers and clinicians will take joint financial accountability.

The aim of the Functional Business Units (FBU) is to delegate authority to manage the budget of a particular FBU to the individuals who make the clinical decisions that incur the expenditure and link these to a systematic process of assessing the outcomes of clinical care through clinical governance processes like mortality and morbidity reviews.

The FBUs in regional and central hospitals will allow for a more refined approach to budgeting and budget management for specific sections within institutions. This includes allowing authority to clinicians in administrative decision making and also encouraging greater financial and operational accountability by clinicians for the financial consequences of their decisions. The FBU’s provision of a well-functioning Business Intelligence (BI) information system and other improvements in automated systems would be a key enabler to achieving these objectives.

Strengthening financial management processes

Various budget administrative and financial management processes will be automated to reduce workload, control and reporting. This includes the complete budget administration process, as well as the APL process. Integration of systems will be improved since systems that are not integrated necessitate that the same data be captured more than once, creating additional work and increasing the risk of error. The Department will therefore investigate the possibility of replacing SYSPRO with a system that is integrated into the government systems.

The Budget Management Instrument (BMI), which is key to the budget management of the Department, will be improved and the APL mechanism, which controls the number of posts available in the system in line with the budget and, will be extensively rolled out.

The recruitment, retention and development of staff in the Finance department are significant challenges. Minimum standards when employing staff will be developed while at the same time ensuring that formal qualifications alone do not outweigh on the job acquired knowledge and skills to assume ownership and responsibility. Ongoing training of staff will take place to ensure standardised operations and compliance with prescripts.

The communication between institutions and financial staff at head office level will be strengthened thereby improving compliance with financial prescripts and ensuring that the centre is better able to support staff at the various service points.

The Department will develop mechanisms for measuring financial performance of institutions based on expenditure control and findings of the various audit and assessment teams.

Unnecessary procedures that do not add value or that add less value than they create will be eliminated.

Procurement and stock management

The existing supply chain management function will be reviewed. This review will include assessing the feasibility of “just-in-time” procurement with direct deliveries from the supplier to the institution, the possibility of bulk ordering of certain items centrally to optimise discounts, and better contract management of suppliers.

The principles of the Essential Drug List will be applied to the procurement of consumables and equipment to standardise the supplies and equipment used in the Department, to reduce the procurement workload and to limit the potential for fraud and irregularities and to obtain cost savings through volume discounts.

Clean audit

The CMI Compliance Monitoring Instrument (CMI), which assists managers with respect to what to manage at institutional level, will gradually be replaced by more extensive “internal assessments” which includes the random

SYSPRO is a materials management system that provides the technology to manage a supply chain from end to end and used in the central hospitals in the province.
Getting Value for Money

The assessment of cost efficiency in the Department, which is extremely complex due to the divergent nature of the services, will be improved. The nature and acuity of patients differ, even at institutions that are intended to render the same service. A system such as that of Diagnostic Related Groups (DRG) is being piloted to address this challenge.

Reports that benchmark unit costs between similar institutions, as well as within the same institutions over time, will be regularly provided to local managers to facilitate the search for greater efficiencies and getting value for money for achieving clinical outcomes.

HEALTHCARE INFRASTRUCTURE AND HEALTH TECHNOLOGY

**SUMMARY POINTS**

1. Health care infrastructure should be conducive to the healing process, while, at the same time, remaining sustainable, flexible, energy efficient and affordable and within the financial and environmental constraints. The delivery of appropriate, well-designed and affordable facilities in the right location facilitates the provision and access to quality health services.

2. The approach to health infrastructure and technology management will continue to be governed by the SL’s Agenda:
   i. Long life (sustainability)
   ii. Loose fit (flexibility and adaptability)
   iii. Low impact (reduction of the carbon footprint)
   iv. Luminous healing space (enlightened healing environment)
   v. Lean design and construction (collaborative and integrated)

3. The following priorities have been identified:
   a. Emergency Centres at Hospitals
   b. District hospital replacements
   c. New Tygerberg Hospital
   d. Focus on maintenance

4. The management of information has become an increasingly prominent component in the running of healthcare facilities. Hence, clinical, safety and security, and other communication systems have to be part of the infrastructure design from the inception phase.

5. Continuous improvement will be ensured by the implementation of the post-occupancy evaluation process, which allows for improvement in the design and construction process and product, from both a technical as well as a functional point of view and, ultimately, informs on how to “do better” in the next project.

**Introduction and Background**

Public sector infrastructure delivery is a complex and multi-faceted set of processes and activities, conducted in an environment characterised by the scarcity of skills within an ever-changing mix of legislation and policies. Effective and efficient performance requires rigorous and well-institutionalised structures, systems, and best practice, based on a consistent, effective, and agreed upon service delivery model, with clearly defined mandates, roles and responsibilities. All of these must be underpinned by appropriate and optimally placed personnel capacity, experience and skills. The Western Cape Government Health (WCGH) infrastructure and technical management component has started the journey for improving the infrastructure and medical technology service through the implementation of the Infrastructure Delivery Management System (IDMS). This IDMS provides tools, systems, and processes for improved management of infrastructure programmes and projects.

Provincial Treasury Instructions 16b – Chapter 16B Supply Chain Management for the Delivery and Maintenance of Infrastructure – was issued on 01 April 2012 to regulate the implementation of the Standard for an Infrastructure Delivery Management System and the Standard for a Construction Procurement System. This is a seminal piece of legislation in that it recognises that procurement of capital and maintenance infrastructure projects requires different rules and regulations from goods and services. The WCGH is currently working in partnership with the Western Cape Government Transport & Public Works (WCGT-PW), towards the implementation of the Infrastructure Delivery Management System (IDMS).

The IDMS is structured around the following three core processes:

» Portfolio management which comprises the iterative process of identifying objectives, planning and grouping projects into infrastructure programmes and monitoring and controlling the roll out of these programmes or projects;

» Project management which involves the implementation of the projects identified in the planning processes; and

» Maintenance & Operations which comprises the maintenance and operation of assets through their life cycle and ultimate disposal.
A control process – the “Infrastructure Gateway System” – provides a number of control points (gates) in the infrastructure life cycle where a decision is required before proceeding from one stage to another. Such decisions need to be based on information that is provided during the infrastructure life cycle.

The provision of infrastructure and technology will also be positioned as part of the integrated support services package to support service delivery aligned to 2030. There will be three main areas of focus: capital projects, maintenance of existing infrastructure and establishment of health technology to support patient-centred quality of care.

Towards 2030

In line with patient centredness, healthcare infrastructure should be conducive to the healing process, while, at the same time, remaining sustainable, flexible, energy efficient and affordable, and within the financial and environmental constraints. The delivery of appropriate, well-designed and affordable facilities in the right location facilitates the provision and access to quality health services. This can be achieved by adhering to various principles during the planning and delivery of new infrastructure and the maintenance thereof.

In the Western Cape, the modernisation, management, and maintenance of health infrastructure and technology continue to remain one of the cornerstones for enabling the health service in 2030. Health infrastructure and technology support productive workflows, operational protocols and procedures, improves staff efficiency and morale, provides a healing as well as a safe working environment, and strives to be “future proof” by allowing for future service delivery changes. The process for the delivery and maintenance of health infrastructure and technology also needs to be economical, efficient, effective, and take cognisance of the continuous development of medical technology. The healthcare space must be used as a resource and not as a territory, efficiently utilised and respected by staff, patients and the broader community. Lastly, infrastructure projects must be delivered through an integrated and collaborative process.

Figure 16: The 5L’s Agenda

The 5L’s Agenda

The Department’s approach to health infrastructure and technology management is, and will continue to be, governed by the 5L’s Agenda listed below:

1. Long life (sustainability)
2. Loose fit (flexibility and adaptability)
3. Low impact (reduction of the carbon footprint)
4. Luminous healing space (enlightened healing environment)
5. Lean design and construction (collaborative and integrated)

Long life

Rigorous health infrastructure and technology planning processes are required for enabling the health service at all levels. This is currently done through the drafting of the User Asset Management Plan (U-AMP), as required in terms of the Government Immovable Asset Management Act. The plan covers two budget cycles (six years) and provides a list of facilities to be built, replaced, upgraded, extended, and maintained. One of the new priorities in Government is to increase the focus on the maintenance of existing facilities and to limit new and/or replacement infrastructure. A considerable portion of the infrastructure budget is therefore to be utilised for the routine, day-to-day, and scheduled maintenance of facilities.

An integral part of sustainable infrastructure management is ensuring its affordability and the application of “green building” technology.
Affordability

One of the primary aims of the IDMS is to create a more informed and capacitated Client Department (WCGH) working with the Implementing Department (WCGTPW). WCGH will ensure a balance between the desire to build state-of-the-art, world-class facilities, and appropriateness in terms of the provincial context and affordability. Standardisation of design, technical specifications, and cost and planning norms are currently under development through the Infrastructure Unit Systems Support (IUSS). The main objective is to optimise the acquisition and management of public healthcare infrastructure throughout its entire lifecycle. The cost of infrastructure will be calculated for its entire lifecycle, with the intention of reducing its operational costs.

Lifecycle costing

Lifecycle costing is the estimation – at the planning stage – of all of the costs of an asset, including the cost of acquisition, operation, maintenance, and disposal of that asset. New health facilities are planned for their entire lifecycle. A building maintenance plan is prepared with the aim of implementing it throughout the entire lifespan of the facility. Accordingly, an appropriate budget for maintenance must be ring-fenced for the facility and approval of new capital investment should only be granted if an appropriate lifecycle budget has been allocated. Balancing once-off capital costs and on-going operational savings is seen as an important factor in determining the value for money of an infrastructure investment. It is important to note that it is estimated that for every R1 spent on design and construction of a building, R5 must be set aside for maintenance through the estimated 60 years of the building’s life – while between R50 to R100 must be for available for operational costs.

Green building

Scientific research has demonstrated that a better indoor quality environment increases work productivity. The focus on green building design is therefore not only required for the reduction of energy and water consumption, thereby reducing operational costs, but also for improving the working environment and patient experience, ultimately leading to better health outcomes. The intention is thus to “retrofit” existing buildings with appropriate green technology. Such green retrofits would form part of all upgrades at existing facilities and would include, for example, improving energy and environment performance, reducing water use, and improving the comfort and quality of the space in terms of natural light, air quality, and noise.

Green building departmental policies are currently being developed in relation to the following:

» Technology for cooling/heating – e.g. use of heat pumps, room motion sensors, geothermal installations;
» Awareness of and education for saving electricity and water;
» Management and usage – e.g. water and electricity meters; and
» Utility project with the aim of reducing the consumption and expenditure for water and electricity in the next three years.

Loose fit

Buildings are systems composed of different components, and each component is made up of different elements. “Flexibility and adaptability” refers to the capacity of a building element, component, or the system itself, to change in response to external stimuli, such as the users, technology and the environment.

Healthcare buildings must be flexible and adaptable and used as space, not as territory. The design of health facilities needs to respond to changing needs, workloads, healthcare policies, protocols, and medical technologies. Spaces must be universally designed to accommodate a range of related functions. As long-term investments, buildings must be adaptable to changes, as replacement is not always a feasible option. This can be achieved by:

» Creating a universal size room to be adapted to different functions;
» Acuity adaptability patient room;
» Standardisation of functional layouts;
» Appropriate technology – e.g. light steel structure;

\ii The IUSS is a structured collaboration between the national Department of Health, the Development Bank of Southern Africa (DBSA), the Council for Scientific and Industrial Research (CSIR) and other stakeholders, provincial health departments included. Further information can be found at http://www.iussonline.co.za
Design of “buffer” zones for allowing future expansion – e.g. adjacent to an imaging department;

Modular design and construction;

Office accommodation in accordance with the National Public Works Guidelines; and

Interstitial floors where feasible.

A hospital is a good example of a facility that continuously requires to be modified to suit changing demands – flexibility and adaptability should therefore be essential aspects to be included as part of their design.

Standardisation will also apply to health technology, which brings the following benefits:

Economical, due to the bulk procurement;

Limited number of consumables and type of medical equipment;

Facilitates maintenance, due to the inter-changeability of accessories and parts;

Reduces usage errors, due to the staff familiarity with fewer equipment types; and

Fewer training requirements.

Low impact

With a “cradle-to-grave” approach, the health infrastructure and technology value chain means considering all aspects of design, construction, usage and disposal, with the aim of reducing the overall carbon emissions. International experience shows that health facilities can be a significant contributor to greenhouse gas emissions. There is no reason to believe that the WCGH situation is any different.

The existing infrastructure portfolio will be assessed and baselines established for green retrofitting projects – aimed to reduce energy consumption – while for new and upgraded infrastructure, the focus will be on the following:

Reviewing the origin and selection of raw materials;

Considering the construction phase emissions; and

Considering the design itself – passive design strategy, use of natural ventilation, use of alternative sources of energy, and energy-efficient equipment.

For health technology, the proposal is to use suppliers that offer low carbon products as well as those that can demonstrate a consideration for both the direct and indirect environmental impact of their products and services. However, it should be emphasised that users’ behavioural change is also a fundamental component in reducing the carbon footprint of facilities (e.g. switching off lights, equipment, air-conditioning units, etc.).

Luminous healing space

Health care staff know that a patient’s sudden interest in the physical environment is the first sign that healing has started; over the past 30 years, scientific research has demonstrated that the physical environment affects the healing process and better medical outcomes can also be linked to the quality of the space where the patient is treated. The physical environment plays an important role in the healing process and ensures the wellbeing of health care workers.

Health facilities can thus be seen as healing environments where the building itself is part of the therapeutic setting and process. Healing environment elements are:

Access to external views;

Natural light and ventilation;

Reduction of noise;

Clear way finding;

Access to nature; and

Environmentally friendly materials.

A luminous healing space is a space where physical stressors for patients and staff are reduced to a minimum.
This is all the more relevant given the stressful working conditions in the public health sector.

**Lean design and construction**

Sustainable and efficient health care infrastructure is only achievable through an integrated and collaborative design and construction process. Lean design and construction are the result of such a collaborative and integrated approach in infrastructure delivery. Lean is a management philosophy based on three tenets: continuous process improvement, reducing waste, and respect for people. Lean design principles are also linked to operational improvements, such as reducing waste, human error and ways to improve quality and efficiency. In the design and construction of health facilities, activities, connections, pathways, and continuous improvements will be carefully considered.

Through the IDMS it will be possible to apply lean design and construction principles in the delivery of healthcare infrastructure. Healthcare facilities will be built to increase patient and staff safety, while eliminating waste, reducing travel and waiting and lowering operational costs.

**Integration with ICT**

The management of information has become an increasingly prominent component in the running of health care facilities. For this reason, clinical, safety and security, and other communication systems have to be part of the infrastructure design from the inception phase. Communication systems must be integrated into the design and construction for improving efficiencies and reducing redundancies, avoiding ad-hoc decisions in choosing between the different available technologies. This requires a more collaborative approach between the ICT component and the infrastructure unit.

**PHC facilities**

New PHC facilities will be designed and built using standardised design and technology, wherever suitable. A well-conceived standard design will cost less to procure and take shorter time to implement, while offering a dignified working environment for staff and patients. The plan is to develop a few design types for PHC facilities, which can then be applied and adapted as required to suit a particular context, such as urban or rural, etc.

Continuous improvement will be ensured by the implementation of the post-occupancy evaluation process, which allows for improvement in the design and construction process and product, from both a technical as well as a functional point of view and, ultimately, informs how to “do better” in the next project. The continuous improvement process will also guarantee the pursuit for innovation in striving for operational efficiency and a better healing environment. The standard design will be regularly challenged and interrogated, and, where appropriate, updated to incorporate new ideas and fresh thinking.

**Hospitals: looking to the future**

Applying lean thinking in a structured way to hospital design can result in an environment that promotes continuous improvement, efficiency, safety, and better flow of information, supplies and services, keeping the emphasis on processes that add value to the patient experience.

Lessons learned from the design and construction of Khayelitsha and Mitchell’s Plain hospitals, through the post-occupancy evaluation process, will be implemented for future projects. Health processes and workflows need to be understood fully, before casting the concrete, for enhancing the patient-centred care approach, as well as for efficiency and value for money. Owing to the current financial environment, the province cannot afford to build one square metre that is not needed or will not be properly utilised.

Finally, using integrated project delivery will ensure that hospitals are built faster, cheaper and are of better overall quality.
**Introduction and Background**

One of the most exciting developments is the realisation of the centrality of information and communication technology (ICT) as an enabler and the opportunities it presents in achieving the vision and objectives of 2030. ICT will play an important role in enhancing the integration of patient data and facilitating the continuity of care of patients across facilities in the system as well as over the life course of the patient. These developments give effect to the overall spirit of the 2030 strategy which is improving the patient experience.

There has been a renewed focus at the highest levels of the organisation to examine the challenges the Department faces in this regard, the opportunities that advance in ICT present for health and develop a roadmap of priorities to 2030. To undertake this exercise, the Department embarked on an ICT strategic planning session involving senior management and technical persons from the Department, partners such as the Centre for e-Innovation (CEI), the State Information Technology Agency (SITA) and the universities.

The Department intends to mainstream ICT processes within the generic processes of planning, budgeting, risk management, implementation, monitoring and evaluation. This is in line with initiatives by the National Department of Health to strategically refocus on ICT.

A national e-Health strategic framework and norms and standards have been developed and provide useful pointers and guidelines to developing the provincial ICT strategy.

The rapid advances in ICT provide opportunities to significantly transform the way we do business in almost every section of the Department and for the broader public in achieving the vision of 2030. One such area is mobile technology.

**m-Health**

m-Health is defined as the use of mobile technology in health. Mobile technology commonly used for cellular communication has evolved considerably over the years and now ranges from smart cellular phones, tablets, iPads, and Personal Digital Assistants (PDAs). The penetration of mobile technology, especially cell phones, within all sections of the South African population is estimated at close to ninety percent. This development has created massive opportunities for m-Health.

Various pilot projects and studies internationally have shown the potential application of m-Health technology in a range of areas. These include, amongst others:

- Creating public health education and awareness through messaging;
- Permitting remote access to health training materials;
- Enabling more efficient data capturing and reporting;
- Enabling patient complaints and feedback in real time;
- Promoting public health campaigns; and
- Sharing of health and patient-related information between health professionals.

The Department looks forward to optimising the use of m-Health in achieving the vision of 2030.
The WCG has conducted a pilot exercise to learn lessons in the management of mobile devices within the public sector and is in the process of finalising a provincial policy in this regard. The policy will provide a framework within which Departments could use this exciting opportunity. It will cover a range of issues such as data security, patient confidentiality, roles and responsibilities, access to government networks, options such as government-owned devices and privately owned authorised for business use.

The Department has already embarked upon pilots and small-scale projects using m-Health and social media. The Department has a Facebook page and Twitter account. More recently, a project has been launched to enable patients to complain about the service in real time to a central line. A substantial proportion of the complaints were satisfactorily resolved within hours and feedback provided to patients. A larger-scale rollout of the project will take place.

**ICT opportunities**

Some of the other main opportunities provided by advances in ICT and e-Health are listed below.

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**Opportunities to become citizen-centric**

» A health services directory that provides basic information on services and facilities throughout the province will be available on the internet and therefore mobile phones;

» A health helpline to assist with basic enquiries and First Aid advice will be explored;

» The emergency call numbers for ambulances, fire, police etc. could be made available more widely and be easily accessible on cell phones;

» The geographic positioning system (GPS) location of the original call could assist emergency services with getting to the address of person requiring help. This is particularly useful in the informal settlements where street lighting, street names and house numbers are often poorly developed;

» The plans and performance reports of the Department could be made available in a user-friendly language to enable broader consultation and accountability; and

» Vacancies and tenders could be advertised on the web and the public could similarly submit their applications electronically.

**Opportunities within home and community-based care**

The CHW could have access to patient records, which are password protected, to be able to effectively engage with the household members. This will also assist with referrals both to and from the facilities where the referral or discharge summary could be available on the mobile. The unique patient number is key to enabling this functionality. This enables the continuity of care across the service platform that is a key element of patient-centred experience.

» There would be easier storage and retrieval of their own notes when visiting a household;

» All the data of their home visits could be loaded on directly onto their cellphone and transmitted to their supervisor. This will drastically cut down time spent on administration and free up more time for direct patient care. It will also provide auditable tracking of data and make for easier and quicker reporting;

» Clinical algorithms on their mobiles could assist the CHWs with making decisions in their management of patients; and

» There would be more efficient communication between the professional nurse supervisors and the CHWs.

**Opportunities within health facilities**

A summary of all pertinent patient data will be available in one place to support the continuity of care. At a minimum, the single patient view will include demographics, vital signs, a problem list (including current and past conditions), a medication list, past laboratory- and other diagnostic tests for the patient, vaccinations and immunisations, risk factors, other relevant measures (number of cigarette packs smoked per day), consultations and education, referrals, notes, and reminders. These data items will be densely displayed so that they fit into one screen (without the need to scroll) or onto one piece of paper.
If data have to be entered in manually into one database, it should never have to be entered again. All, or most, health ICT systems will be interoperable across the health platform using the unique patient identifier to enable primary care to connect to emergency medical services, emergency centres, general hospitals and vice versa. There is a clear need for having data from the continuum of care available for the effective management of patients.

The referral and discharge processes are key opportunities in the patient’s journey where health care providers can contribute to continuity of care, as well the recording and capturing of vital information about the patient encounter, such as the ICD codes. A standardised electronic record for discharging and referring patients from hospital will be developed.

An electronic document system namely Enterprise Content Management (ECM) offering clinical documentation including clinical notes, care plans, clinical correspondence, and discharge information will be rolled out. This is intended to provide an electronic version of the historic paper records. This will enable safer storage and easier retrieval of patient folders as well as enable the communication of patient notes between health professionals and different facilities.

Our partners in the NHLS are implementing a new tracker system for laboratory results that will be inter-operable with Clinicom and PHCIS that will enable the efficient digital flow of lab results of a patient across the platform.

The Department will be modernising its radiology and imaging service, starting in the larger hospitals with implementation of the Picture Archive and Communication Systems (PACS) and Radiology Information Systems (RIS). This will enable the efficient flow of digital images across institutions, easier storage of and access to images and doing away with x-ray films and the need for darkroom development. A radiologist could now centrally provide reports to more remotely placed referring institutions.

The pharmacy system is currently built around a stock management system for the pharmacy department. The Department will be testing the feasibility and affordability of electronic patient-level prescribing and administration. The system will, amongst other things, overcome illegible handwriting of prescribers, provide back-up systems to alert the prescriber to potential drug interactions, provide clinical audit trails of who and what was prescribed and dispensed, which will be captured as part of the single view of the patient record described above.

There are a range of other smaller systems operating within hospitals such as theatre management and maternity that will be reviewed to ensure inter-operability and consistency within the broader ICT strategy to enable 2030.

**Opportunities within support services**

Functional Business Units (FBUs) is a system of decentralised management at hospital level within the department. Establishing an FBU system is a strategic imperative of the Department, as is the creation of a central capacitated support structure in order to assist hospital management with the implementation and maintenance of this system. There will be ICT systems that will enable timeous and standardised reports to all relevant FBU managers. Utilising Business Intelligence will allow for reporting of financial, performance and efficiency data in line with the performance plan for the hospitals at FBU level.

Various budget administrative and financial management processes will be automated and decentralised to improve local management and accountability, better efficiency and reporting. This will include instruments such as the Budget Management Instrument (BMI) and the Approved Post List (APL) that will continue to be improved upon and firmly institutionalised to ensure the optimal control of expenditure within the allocated budgets at a decentralised level.

ICT will enable the HR intelligence required for effective strategic human resource management. Collecting, processing, and managing HR data and information will facilitate strategic decisions for forecasting, planning, recruiting, promotion, evaluation, and developing key human resources at all levels of the Department.
Harmonisation refers to the agreement, synchronisation, and coordination of eHealth initiatives in the Department to enable inter-operating more effectively to achieve the goal of “improving wellness” in the province. However, there is a growing concern among senior management in the Department that existing and increasing efforts in eHealth is resulting in uncoordinated systems, duplicated efforts and unrealised potential. Coordination is therefore urgently needed.

A more detailed document that serves as a guide for the development of comprehensive policies and strategies that elaborate measures that seek to harmonise and consolidate eHealth in the Department is being finalised.

The project is built around two teams – financial business intelligence and clinical business intelligence. The two teams are currently working independently, with different interlinked goals set. Clinical business intelligence focuses on aggregated clinical reporting coming from different sources. This will include some operational reports; e.g., throughput (national reporting per institution) and other Clincicom reports.

The Department has aligned the technologies and processes with the provincial ICT and BI strategy in order to achieve the goals set by the business. This means the technology is robust and scalable; this allows us a seamless integration with provincial technologies.

Figure 16 depicts the vision the Department had for BI but it focused mainly on aggregated data. The department has made a decision to incorporate patient-level data into the BI project and looks to refine roles and responsibilities and also merge two BI teams – i.e., finance and services. The details are contained in the BI strategy and data harmonisation working document. Figure 17 depicts the ‘to be’ proposed platform state for all patient-level data that will in essence enable the following reporting structures: clinical care viewer, epidemiological analysis, and routine clinical reporting. All of this will then feed into the BI layer, which is aggregated by a cost centre code for further corporate reporting; FBU, M&E, QPR, Annual Reporting, national data submission, EPM, etc.
IT Governance

The WCG has a provincial IT governance framework and policies within which the Department will operate.

The Department has revised the structure and function of the Departmental IT Committee (DITCOM). The chairperson and deputy chairperson are senior managers who also represent the Department within the central IT committee of the WCG. Senior representatives from the line-function services and strategic partners such as SITA and CEI are also represented. The main focus of the DITCOM is to provide strategic leadership and governance/oversight of the IT function within the health service. The DITCOM will provide regular feedback to the head of department and make recommendations to top management for decision making.

The Directorate: Information Management provides the technical support to DITCOM and manages the operational IT function at a provincial level. This includes management and support of the various IT projects, engagement with the line-function services, as well as liaison with the partners (CEI and SITA).
The district- and facility managers are responsible for the IT function within their jurisdiction.

The Department has developed an ICT strategic plan. This will be amended in light of the vision and principles and priorities of 2030. Given the recognition of the increasing centrality of IT to health services and the ownership by management at various levels, the planning, budgeting, risk management, implementation and M&E of IT in health will be systematically incorporated into these generic processes within the Department. This will ensure that IT secures its due attention and focus towards 2030.

The WCG has an IT governance charter that provides a framework within which the Department will operate and manage its ICT initiatives.

**Technology Refresh**

Computers have become a basic tool to do one’s work at all levels of the organisation. Like all other infrastructure and technology, a systematic and affordable plan to refresh and maintain our computers and associated hardware needs to be developed and implemented. The WCG has adopted a policy position that all PCs older than five years should be replaced.

The Department needs to put in place an integrated system that connects the DITCOM approval, procurement and payment and asset register systems to enable an institutionalised database that identifies the hardware that requires replacement at institutional/section annually and allows for proper planning, budgeting and replacement.

**ICT Human Resource Capacity**

The availability of skilled human resources is a prerequisite for the success of an e-Health project. e-Health is not simply about equipment and telecommunications. It is people who make the difference.

The Department will develop a strategy to ensure adequate human resource capacity and IT technical capability. For new projects being developed and implemented, business analyst skills and IT project management skills are essential. A key function of the project manager, over and above managing all aspects of the project itself, is the ability to manage the interface in a user-friendly manner between the IT vendor or partners such as CEI/SITA and the health providers within the Department.

Development of new programmes and enhancements of current software applications and systems is another critical capacity that requires strengthening within the WCG at large. While client departments are not allowed to employ their own programmers, the ability of CEI to respond to the needs of the health service is important. Existing systems will have a system administrator, controller and owner who manages the maintenance of the system. The Department will explore the possibilities of pooling these resources across systems to acquire efficiencies. An institutionalised system of IT support per district will also be explored with CEI.

Training of staff within the health service on an on-going basis is important to be able to manage the basic challenges and support the systems, especially at local level. All healthcare professionals should have access to basic ICT training facilities to improve their skills and foster positive attitudes towards information technology.

**IT Innovation**

ICT is one of the most rapidly developing fields of our time and has the capacity to transform the way we do business in Health. Innovations are being developed within increasing frequency both within the Department as home grown solutions to service challenges as well as by external parties.
The Department needs to have its vision for the ICT enabled health service consolidated that provides a compass against which innovations can be assessed. Organisational arrangements need to be created that enables adequate responsiveness to these challenges. This should include amongst others, appropriate structures, technical capacity, systems and processes and criteria to screen, assess and make recommendations to the Department on which innovations would be cost effective to adopt.

Important aspects such as security and confidentiality of patient data, implications for the network and bandwidth, cost implications, inter-operability all need to be robustly investigated. Notwithstanding these challenges, innovations will be encouraged within these parameters.
SECTION H: MONITORING AND EVALUATION
SECTION H: MONITORING AND EVALUATION (M&E)

SUMMARY POINTS

1. There is a need to strengthen support for M&E and to enhance the culture of continuous improvement for all levels and components of the organisation so that information is collected primarily to empower staff to continuously improve health outcomes, the patient experience and health-system efficiency.

2. The Triple AIM framework which identifies key dimensions for optimising health system performance will be used by the Department to monitor and evaluate the implementation of the 2030 strategy. These dimensions are:
   a. Population health outcomes;
   b. Health services taking into account acceptability, appropriateness, access, quality, equity, effectiveness, patient-centredness;
   c. Cost efficiency in service delivery;
   d. The culture of M&E and continuous improvement will be encouraged through:
      i. Improving the quality of information collected
      ii. Deepening capacity to use and collect information
      iii. Ensuring leadership and accountability
      iv. Widespread sharing of best practice

MONITORING AND EVALUATION OF POPULATION HEALTH OUTCOMES

Introduction and Background

Vision 2030 describes the health strategy for the province and emphasises the documented changes in health outcomes as the key indicator to monitor the impact of this strategy. The assessment of this impact requires the accurate and timely measurement of changes in population health outcomes and the associated risk factors, including social determinants. Similarly the changes made in the health system in the areas on leadership and governance, human resources, finances, infrastructure, commodity (medicines, tests, supplies) management, information management also require accurate documentation in order for their effect to be assessed.

There is a need to deepen the importance of M&E and enhance the culture of continuous improvement for all levels and components of the organisation such that information is collected primarily to empower staff to continuously improve health outcomes, the patient experience and health system efficiency and, secondarily, for reporting to the next level of authority.

The annual operational planning with specific targets for the incremental realisation of the 2030 objectives will be important to document alongside the documentation of achieved health outcomes, the improvement of the patient experience and the attainment of health system efficiencies.

The Department will use the Triple AIM framework in its monitoring and evaluation processes related to their 2030 strategy.

The Triple Aim framework was developed by the Institute for Healthcare Improvement (IHI) and identifies key dimensions for optimising health system performance as follows:

» Population health outcomes;
» Health services (acceptability, appropriateness, access, quality, equity, effectiveness, patient centeredness); and
» Cost efficiency in service delivery.

The Department will be monitoring mortality, morbidity, quality of life and risk factor indicators, which include social determinants, to identify areas for intervention to prevent disease and the consequences thereof.

A mortality surveillance system that links information from death notification and forensic pathology records has been developed and is being institutionalised. The use of relevant technology will be maximised to improve in particular the quality and timeliness of information. This is expected and is increasing the utility of the mortality surveillance system for the planning of interventions at local and provincial level for health sector and inter-sectoral action to improve health outcomes.

The vision for 2030 is to have a provincial web-based mortality surveillance system accessible to all health practitioners in the public and private sectors who notify deaths. This system will have multiple purposes that include statutory reporting requirements of deaths to the Department of Home Affairs, surveillance, monitoring and evaluation. Accessibility to this data will be protected by strict governance processes to ensure respect for patient confidentiality and will be governed by the principles of the Declaration of Helsinki developed by the World Medical Association.
Morbidity-, risk-factor and quality-of-life surveillance systems will be implemented at the following levels:

» Community-based level through the periodic household profiling by the PHC outreach teams;
» PHC level through the routine collection of national- and provincial indicator data sets;
» Hospital level through the universal coverage of ICD-10 coding and monitoring, in particular the trends for avoidable hospitalisations that could have been prevented by improved health services at primary level or the prevention of risk factors (e.g. smoking); and
» All levels: notifiable medical conditions.

The use of relevant technology that includes mobile devices will also be maximised.

**MONITORING AND EVALUATION OF HEALTH SERVICES**

The modelling for 2030 determines the size and shape of the health service based on the principles of patient-centred quality of care, equity, outcomes, PHC principles, strong district health systems, affordability and cost efficiency. Patient-centred quality of care will be evaluated using the departmental framework as described in this document. A patient-centred quality of care index will be developed, monitored and routinely published to be accessible to the public. Equity in access, quality and outcomes will be monitored for the population at large and, in particular, for vulnerable populations like children, the elderly, the disabled, and the poor based on the prevalent burden of disease profiles; and the DHS and the PHC principles will be evaluated according to the extent to which the set principles are met in line with the World Health Organization definitions.

**MONITORING AND EVALUATION OF COST EFFICIENCY**

The growing burden of disease is not often aligned to the available financial resources. Thus, in as much as the 2030 strategy is to prevent disease and its consequence, it also aims to ensure that the scarce financial resources result in maximum benefit and result in the best value for money. The aim is to balance the inputs provided such as money, people, infrastructure or equipment against either intermediate outputs of headcounts, inpatient days, waiting time, etc. or final health outcomes such as reduction in premature mortality, improvements in the quality of life.

Three areas of efficiency will be measured in the province and these are technical, productive, and allocative efficiency. Technical efficiency refers to the efficient use of particular inputs for a specific outcome – e.g. assessing the extent of rational prescribing of drugs to receive maximum benefit without prescribing unnecessary drugs or incorrect dosages for incorrect periods. Productive efficiency results from alternative interventions being compared that have different costs and produce the same or improved health outcome with less or more of a particular resource. Allocative efficiency refers to the equitable distribution of outcomes within the broader community. It aims to inform resource allocation decisions at a population level.

**INFORMATION AND CONTINUOUS IMPROVEMENT**

**Improving the Quality of Information**

The key steps in improving the culture of M&E and continuous improvement include:

» The identification of key indicators to assess the dimensions of the Triple Aim Framework that is relevant, actionable, valid, easy to collect and sensitive, so that changes in performance can easily be identified;
» The development of data-collection- and data-management processes that make use of the relevant technology to minimise the transactional and opportunity costs that can adversely affect the patient experience and health outcomes;
» The identification and conducting of relevant research to understand why the changes in the Triple Aim objectives are or are not occurring; and
» Robust interpretation and analysis of the information (from all data including research) to provide action-able recommendations for continuous improvement in the dimensions of the Triple Aim Framework
Improving Capacity

The following steps will be taken to improve capacity for M&E and continuous improvement in the system:

a. Ensuring an adequate number of people who are competent in M&E at all levels of the organisation;

b. Empowering staff to be part of the solution and to generate innovations for continuous improvement;

c. Incentivising continuous improvement and the development of innovations throughout the organisation; and

d. Partnering with academic institutions and non-governmental organisations to support M&E and research capacity in the Department, in particular to support process evaluations to understand how implementation could be improved.

Improving Leadership and Accountability

a. The inclusion of specific performance standards for all staff that are aligned with achieving the Triple Aims;

b. Continuing with departmental M&E meetings to review achievement of results and led by the most senior managers at all levels of the system;

c. The dissemination of information using dashboards, league tables to staff, patients and communities;

d. The strengthening of community governance structures (health committees, hospital boards) to engage with M&E information and support the collaboration between the services and communities for continuous improvement.

e. Widespread communication and celebration of successes and innovations both internally and to external stakeholders, with a reflection of challenges and plan of action to address these; and

f. The use of evaluation processes at three to five yearly intervals to evaluate outcomes and the impact of implementing 2030 that will contribute to the understanding why successes occurred when they did and why failures occurred and how these could be addressed.

KEY INDICATORS OF SUCCESS

In addition to detailed M&E processes that will be institutionalised in the Department, the indicators below will be used as proxy indicators to determine the success of Healthcare 2030.

Table 18: Key indicators of success

<table>
<thead>
<tr>
<th>Population health outcomes</th>
<th>Increase life expectancy at birth</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Reduce infant mortality rate</td>
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<tr>
<td></td>
<td>Reduce child mortality rate</td>
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<tr>
<td></td>
<td>Reduce maternal mortality rate</td>
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<tr>
<td></td>
<td>Reduce age-specific mortality rate</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Health services outcomes</th>
<th>Increase patient-centred quality of care index</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reduce waiting times</td>
</tr>
<tr>
<td></td>
<td>Increase positive staff attitudes</td>
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<tr>
<td></td>
<td>Increase level of staff engagement in the organisation</td>
</tr>
<tr>
<td></td>
<td>Increase PHC utilisation rates</td>
</tr>
<tr>
<td></td>
<td>Increase awareness rates of chronic disease status (HIV, TB, chronic diseases of lifestyle and mental health)</td>
</tr>
<tr>
<td></td>
<td>Increase patient retention in care rates for (ART, TB, chronic diseases of lifestyle and mental health)</td>
</tr>
<tr>
<td></td>
<td>Increase in rates of control/cure of chronic diseases (HIV, TB, chronic diseases of lifestyle and mental health)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost efficiency in service delivery</th>
<th>Cost per PHC headcount</th>
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<tr>
<td></td>
<td>Cost per PDE</td>
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<td></td>
<td>Unit cost per diagnosis-related group</td>
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SECTION I: CONCLUSION
SECTION I: CONCLUSION

The second draft of 2030 is a substantial piece of work built on, the preliminary thinking, vision, principles and values of 2030 circulated in the first draft, the extensive and valuable input received from staff and external stakeholders and the further evolution of conceptual thinking and technical work to date.

The 2030 process has started to energise, excite and engage the Department and its partners. The thinking and principles of 2030 have begun to infiltrate the daily language and conversations in the department. The journey to 2030 has begun in parallel to the process of finalising the 2030 framework.

The process of consultation and engagement and coalescing of the multiple perspectives of people within and outside of the Department into a cohesive document is always a challenge.

This document will also be accompanied by facilitated conversations to allow for meaningful engagement and comments. The Department will then finalise the 2030 framework, which will be tabled at the provincial cabinet. The work will then shift to converting this broad strategic direction to more specific details by applying the models and approaches to specific services and geographic areas. This will include, amongst others:

- developing hospital bed numbers,
- finalising staffing requirements and
- identifying the priorities for incremental implementation.

History will judge us by the degree to which we have been able to put in place the various plans and processes we have outlined in this document in order to improve the health and health status of our citizens.
1. **Introduction**

The document “2030: The future of health in the Western Cape: A draft framework for dialogue” was published in hard copy in November 2011 and electronically on the Department’s website. Interested parties were requested to submit their comments on the document by 15 February 2012. This deadline was extended to accommodate late submissions.

Forty-two submissions were received from various stakeholders, both individuals and groups, and with the supporting documentation, the submissions were in excess of 200 pages.

Presentations were also made to various interest groups such as the geographic service area teams, the Metro Health Forum, some facility boards and unions.

The document was generally positively received and supported. The criticisms were generally constructive and included the following:

- There was no formal structured evaluation of the Comprehensive Service Plan (CSP);
- The document was ‘incomplete’ because of the lack of technical information;
- The issue of National Health Insurance was not adequately addressed;
- There should be a greater focus on population health and not just patient care; and
- The focus on upstream factors should be stronger.

A brief overview of the comments is presented per broad section of the November 2011 document.

2. **Principles, Values and Vision**

There was general support for the principles, values and vision identified in the framework and some respondents commended the Department for driving a patient-centred approach.

2.1 Additional guiding principles were proposed, which included adopting:

- A community-centred approach; and
- A holistic approach to urbanisation

2.2 Feedback suggested that the principles do not sufficiently address:

- Training and research;
- The environmental imperative; and
- Parity across the disciplines; e.g. mental health care services.

2.3 Attention should be given to the terminology used; e.g. the term “cost effectiveness” should be used rather than “affordability” and the term “psychiatric hospital” should be used rather than “mental hospital”.

2.4 It was stated that although the Department aspires towards these principles, values and vision that the focus of many of the Department’s activities are on compliance.

2.5 It was suggested that the universities should align their curricula with the core values of the Department.

2.6 There were some suggestions regarding the vision slogan.

3. **Comprehensive Service Plan (CSP)**

3.1 Some stakeholders indicated that the CSP consultation process was not sufficiently inclusive.
3.2 Stakeholders indicated that there should have been a formal evaluation of the CSP and that the monitoring and evaluation of the implementation of the 2030 strategy should be addressed during the formulation process.

3.3 Various issues that were not addressed in the CSP must be addressed in 2030, such as:
   » Multi- and extensively drug-resistant TB
   » The role of nurses in the provision of ART.

3.4 Examples of specific issues that respondents indicated should be addressed include:
   » The impact of the de-hospitalisation of mental patients;
   » What was the impact of the 2010 HR plan and revised organisational structure?
   » What changes should be made to the CSP modelling when applied to 2030. For example, are the 18 members of staff for a clinic serving 30 000 people still appropriate?
   » What was the impact of the reclassification of hospitals in the CSP?

4. Service Platform

4.1 Divisions should be replaced with a flatter geographically based management structure.

4.2 Services for children need to transform into child-friendly services.

4.3 All PHC services in the Cape Town metro district should be delivered by the City of Cape Town, including environmental health.

4.4 Community-based services
   » Roles and skill requirements of CHWs need to be defined.
   » The Community Care Worker Charter should be used to guide the integration of CHWs into the 2030 plan.
   » By 2030 CHWs should be a fully fledged job category with minimum wages and basic conditions of service formalised.
   » The importance of having the appropriate capacity to supervise CHWs is recognised.
   » It was suggested that community care workers should prioritise maternal and child health, given South Africa’s poor performance with MDG 4.

4.5 Primary health care (PHC)
   » PHC services should be fully restructured by 2030 with an integrated community-based service. The reduction of hospital admissions will be a marker of good quality and successful PHC and community-based services.
   » Some facilities are not accessible to communities and serve large drainage areas and have prolonged waiting times.
   » Youth clinic facilities are not patient friendly.
   » The Department needs to form a partnership with the private sector in order to tackle the significant PHC needs in the province.

4.6 Acute hospitals
   » It is difficult to recruit and retain surgical skills in rural areas. It is better to refer patients to surgical centres with the appropriate expertise and transport is cheaper than replicating surgical expertise in each town.
   » There should be no district hospitals in the Cape Town Metro District. The hospitals should all have general specialists who are not more expensive to train than generalists.
   » Building another Tygerberg Hospital is a mistake – replace Tygerberg Hospital with more regional hospitals.
   » Regional hospitals should have intensive care units.
   » There must be a multi-disciplinary approach to oncology in terms of facilities, equipment, rehabilitation, palliation and continued care at local clinics.
4.7 Specialised hospitals
   » More rehabilitation and step-down facilities are required.

5. **Discipline-specific Comments:**

5.1 General paediatrics:
   » General paediatrics is not less important than specialist paediatrics. There needs to be an equitable re-distribution of resources between general and sub-specialist paediatrics.
   » Most patients require general paediatric services – general paediatricians must therefore be developed and trained.
   » Hospital caseloads are increasing and patients present with more complex problems.
   » The strengthening of lower levels of care is dependent on the number of general paediatricians available to support care in the community.

5.2 Mental health
   » Mental health care services must be integrated into all levels of care.
   » Intellectual disability needs to be managed within the broader social network rather than by health services.
   » The burden that de-institutionalisation of psychiatric patients places on families often exceeds their ability to cope.
   » Healthcare 2010 ‘failed miserably’ to ensure that the savings generated by the de-institutionalisation of mental health care patients followed the patients.
   » Provision must be made for facilities for abandoned and abused children with intellectual disabilities.
   » Mental health and, in particular, maternal mental health, must be more substantively included in the document.

6. **Quality: Patient-centred Experience (PCE)**
   » Compliance with the National Core Standards is important.
   » Staff should be trained in customer service.
   » Complaint mechanisms should be more effective and clinic committees should be present when complaints boxes are opened.
   » The impact of staff and patient satisfaction surveys are not addressed and nothing new is identified in quality improvement. This needs leadership and a clear plan.
   » Various issues should be addressed to improve the patient experience. These issues include:
     • Improve waiting times.
     • Provide an after hour service for working people.
     • Add dental services to all clinics.
     • Signage should be in all three official languages of the Western Cape.
     • Staff must wear name badges.
     • Management should be commended for recognising the importance of the patient experience.
     • Poor infrastructure should be replaced.
     • The need to update IT systems exists.

7. **Support Services**

7.1 Staffing
Mid-level- and community-service therapists will require appropriate supervision and cannot replace rehabilitation professionals.

Recruitment:
- The turnaround times for filling of posts need to be shorter.
- The Department should be more innovative and modernise the HR approach; e.g. job sharing.
- Provision should be made for the appointment of relief contract staff during the process of filling the posts.

Attrition: the loss of experienced nursing staff is a challenge.

Training:
- There is no relief staff for those on training.
- There is a concern about the ‘new breed of nurses’ versus the old in terms of training around basic caring and compassion, which is perceived to be lacking.

Performance management: incompetent staff must be appropriately managed.

Caring for the carer:
- There is a high level of low morale and burnout amongst staff.
- The wellness and well being of staff are critical to improving the PCE.
- Staff are not respected and protected by the public.

7.2 Training
- Nurse training schools must be addressed – there will not be enough nurses to work in training schools in five years’ time.
- The responsibility of the Western Cape Government as a partner of the universities needs to be more clearly articulated.
- There is no mention of a plan to address the shortage of nurses.
- The Department should indicate that by 2030 the relationship with the universities will be optimised and much better than now. It should be a “strive for the best-in-the-world type” relationship.

7.3 Health technology
- The Department must harness the power of modern telecommunications and ICT.
- Effective ICT can be the ‘glue’ that holds the system together.
- The use of cell phone technology can potentially improve services.
- Attention must be given to the maintenance of ICT assets.

8. Governance:

8.1 The responsibilities of patients for the role that they play in their own health and well being should be emphasised.

8.2 The role of health committees should be emphasised.

8.3 There should be functional clinic committees at every health facility.

8.4 The National Health Act obliges the provincial government to host an annual consultative forum to ensure community participation.
ANNEXURE B: THE BURDEN OF DISEASE

The Burden of Disease and its Determinants

Figure A.1 below reflects the mortality profile for the Western Cape, estimated from the district-level mortality surveillance, and shows the profile of a quadruple burden of disease consisting of:

» HIV and TB;
» Child and maternal health, other communicable diseases, and maternal, perinatal and nutrition causes;
» Non-communicable diseases; and
» Injuries.

Figure A.1: Age-specific deaths by broad cause and sex, Western Cape 2009

In order to effectively estimate the burden of disease, the profile of morbidity also needs to be considered. A morbidity surveillance system has, however, not been institutionalised into the Department and such estimation is thus not yet possible. The burden of mental illness, largely depicted by a burden in morbidity, is one of the key components of the burden of disease that is underestimated by considering only mortality.

HIV and TB

In 2011, the HIV prevalence amongst antenatal women in the province was 18.2 percent (95 percent CI 14.3 – 22.8); in 2010 it was 18.5 percent (95 percent CI 15.1 – 22.5) and in 2009 16.9 percent (95 percent CI 13.8 -20.5). Even though this appears to be an increase from 2009 the increase is not statistically significant, meaning that in real terms the HIV prevalence in the province has not changed over the last three years. Those aged between 25 and 29 and between 30 and 34 years remain mostly affected. The failure to observe a decline in HIV prevalence in the province may be partly due to declining mortality as a result of access to antiretroviral therapy (ART).

A third of the sub-districts have an HIV prevalence that was greater than the provincial average. These are: Klipfontein, Khayelitsha, Eastern, Western and Northern sub-districts (metro district), Bitou, Knysna and Mossel Bay sub-districts (Eden district) and Overstrand sub-district (Overberg district). Since 2004, Khayelitsha sub-district in the Cape Town metro district has had an HIV prevalence estimate consistently higher than the national average.

Apart from mother-to-child transmission (MTCT), the risk of acquiring HIV primarily involves the practice of unsafe sex and is exacerbated by high partner turnover and partner concurrency. Other related issues are gender disparities and the coercive nature of some sexual encounters. Other contributing causes include poor levels of education, transactional sex, mobility, migration and the socio-economic clustering of poverty, unemployment and overcrowding (Western Burden of Disease Reduction Study, 2007).

The recently released evaluation of the prevention of mother-to-child-transmission (PMTCT) report shows that the Western Cape had the lowest MTCT rate of 1.98 percent compared to a national estimate of 2.67 percent. Even though this is good news, the risk factor for new infections is still prevalent. The Human Sciences Research
Council (HSRC) household HIV study reports that in the province less than half of its adults used a condom at last sex, only about a third of adults have the correct knowledge to prevent HIV and can reject major misconceptions, and less than a quarter had an HIV test in the previous 12 months. Much work is thus still required in the arena of behaviour change.

The ART programme continues to expand rapidly, with approximately 115,087 people on ARVs in 2011/12. Death due to HIV is showing a decreasing trend. The biggest risk factor for TB is concurrent HIV infection. TB is described as a social disease, as it is closely linked to the upstream issues of poverty, unemployment and overcrowding.

The Western Cape has the third highest number of new TB infections in South Africa (909 cases per 100,000) after KwaZulu-Natal and the Eastern Cape. However, the Department is making significant progress in addressing the epidemic through the implementation of the Enhanced TB Response Strategy. The programme achieved a new smear-positive TB cure rate of 81.7 percent in 2011/12. Two districts (Overberg and Eden) achieved the World Health Organization (WHO) target of 85 percent. The provincial TB cure rate is the highest TB cure rate in South Africa.

The TB defaulter rate has decreased slowly over the past few years with the implementation of various interventions and stood at 6.8 percent in 2011/12 in comparison to the 9.4 percent recorded in 2008/09. Although this is a significant improvement, more effort will be required to reach the national and global 2011 target of a defaulter rate of below 5 percent. This is required to decrease the size of the infectious pool in the community and prevent the generation of drug-resistant TB, which requires longer stays in hospital, is much more expensive to treat, and has a very poor prognosis.

**Child health**

Both infant- and child mortality rates are decreasing in all of the Western Cape districts. However, some sub-districts such as Khayelitsha, Witzenberg, Overstrand have rates much higher than the provincial average.

**Table A.1: Infant and under-five mortality rate (per 1 000 live births)**

<table>
<thead>
<tr>
<th>District</th>
<th>IMR (&lt; 1yr) 2007</th>
<th>IMR (&lt; 1yr) 2008</th>
<th>IMR (&lt; 1yr) 2009</th>
<th>U5MR (&lt; 5yr) 2007</th>
<th>U5MR (&lt; 5yr) 2008</th>
<th>U5MR (&lt; 5yr) 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cape Winelands</td>
<td>28</td>
<td>21</td>
<td>24</td>
<td>33</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>Central Karoo</td>
<td>45</td>
<td>43</td>
<td>41</td>
<td>60</td>
<td>58</td>
<td>52</td>
</tr>
<tr>
<td>Cape Town Metro</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>25</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Eden</td>
<td>30</td>
<td>21</td>
<td>21</td>
<td>36</td>
<td>27</td>
<td>25</td>
</tr>
<tr>
<td>West Coast</td>
<td>36</td>
<td>25</td>
<td>26</td>
<td>45</td>
<td>32</td>
<td>31</td>
</tr>
<tr>
<td>Western Cape</td>
<td>32</td>
<td>27</td>
<td>22</td>
<td>38</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td>WC (Mortality Profile 2009)</td>
<td>23</td>
<td>21</td>
<td>21</td>
<td>28</td>
<td>26</td>
<td>26</td>
</tr>
</tbody>
</table>
The provincial mortality systems show the big five causes of death in under five year olds to be neonatal causes, diarrhoea, pneumonia, HIV and injuries, as shown in Figure A.2 below.

**Figure A.2: Causes of death in children under five years, Western Cape 2009**

Diarrhoea, 16%

Pneumonia, 13%

HIV/AIDS, 7%

Septicaemia, 3%

Meningitis, 2%

Tuberculosis, 2%

Injuries, 7%

Malnutrition, 3%

Other, 7%

Preterm, 14%

Severe infections, 6%

Birth asphyxia, 6%

Congenital, 5%

Other, 3%

Neonatal, 35%

The PMTCT programme has been successful and has reduced HIV in children from above 20 percent in 2000 to 7 percent in fewer than 10 years. The pneumococcal and rotavirus vaccines have had a significant impact on reducing the number of pneumonia cases and reducing the severity and mortality of diarrhoea. However, it is recognised that breastfeeding rates in the Western Cape are low and that poor breastfeeding accounts for about 45 percent of the neonatal death burden, 30 percent of diarrhoea and 18 percent of pneumonia. On the basis of studies done between 1997 and 2009, nearly 9 percent of children were acutely malnourished and just 20 percent chronically malnourished, with about 20 percent of teens being overweight.

Social determinants of health (poverty, housing, inequity, unemployment) negatively influence child health outcomes, such as, Infant mortality rates (IMR). Similarly, it is very well documented that downstream interventions, such as the provision of quality health services to increase coverage of immunisation, the early diagnosis and management of diarrhoea and pneumonia, have a profound impact in reducing both morbidity and mortality. Pneumococcal and rotavirus vaccines are good examples, as illustrated in Figures A.3 and A.4 below.

Figure A.3 shows data from the routine health information system where the number of new pneumonia cases of those under-5 years decreased sharply after 2009/2010 financial year. Figure A.4 shows an evaluation done at a national level where during the same time period there was a 60 percent decrease in pneumonia cases in the country. This decrease coincides with the introduction of the pneumococcal vaccine suggesting that the introduction of the vaccine has resulted in a reduction in new pneumonia cases.
Figure A.3: Pneumonia under five years: new cases in the Western Cape: 2008 to 2012

Pneumonia Under 5- New cases, Western Cape 2008 -2012

Figure A.4: Annual incidence of invasive pneumococcal disease

Annual incidence of Invasive Pneumococcal Disease reported by year in children <5 years, by age, 2005 - 2011

Official launch of PCV - 7, April 2009

Reduction: 60%; p<0.001
Maternal and women’s health

The Western Cape enjoys relatively high coverage of antenatal care, which is close to 90 percent, with most women visiting health facilities more than four times during their pregnancy. The key intervention to ensure women present before 20 weeks to health facilities has also been showing some successes. In 2008 just over 40 percent of women were presenting before 20 weeks for antenatal care and in 2011/12 this had increased to 53 percent. Maternal death trends have been erratic over the years but have been on the increase as shown below in Figure A.5.

Figure A.5: Maternal deaths in the Western Cape 2003 to 2010

The leading causes of maternal death in 2008 to 2010 were non-pregnancy-related infections, particularly those due to HIV and AIDS (36.1 percent), hypertensive disorders (16.3 percent), pre-existing medical disorders (11.9 percent), obstetric haemorrhage (8.3 percent). The peak in 2009 was due to the outbreak of H1N1 influenza.

Deaths from complications of the pregnant state or from interventions, omissions or incorrect treatment have steadily decreased. However, deaths from previous existing disease, or diseases that developed during pregnancy and that were not due to direct obstetric causes, but aggravated by the physiological effects of pregnancy increased. This suggests that services to address pregnancy-related conditions (antenatal, perinatal, postnatal) are improving but services to manage the pregnant women with pre-existing medical diseases could be improved. It is also of concern that nearly half the maternal deaths (47.2 percent) were preventable, as different management might have made a difference to the outcome.

Couple year protection rate has been increasing steadily since 2008/9 when it was 40.3 percent it was 42.3 percent in 2011/12. The prevalence of family planning in sexually active women has, however, been decreasing since 1998. In that year in the demographic survey it was reported to be 73.7 percent. Family planning had dropped to 44.6 percent in 2006, when it was surveyed in women on the West Coast. Thus there is significant room for improvement in access and utilisation of family planning services. Cervical cancer screening has had particular success in the province, when it increased from 38.6 percent in 2007 to 66.5 percent in 2011.

Globally gender-based violence is acknowledged as a public health problem and research has shown that women who experience violence are more likely to have poor health and to use health services more often. The Western Cape in particular has much higher rates of woman abuse – e.g. women abused by partner in the previous year were 8.0 percent in the Western Cape compared to 6.3 percent in the country.
Intimate partner violence creates vulnerability for women to engage in risky behaviours such as alcohol use, risky sexual behaviours and poor use of health services. It is well documented that women’s position in the home impacts on her ability to access reproductive services. Similarly food security for children depends on the status of the mother in the house. A more gender-equitable society will thus impact on women and child wellness across their lifespan and thus interventions with a strong focus on improving gender equity would be beneficial.

Community-based interventions for both adolescents and adult men and women aiming to improve sexual health and improve psychological well being through building stronger equitable intimate partner relationships are therefore important.

**Non-communicable diseases and mental health**

Non-communicable diseases consist mainly of cardiovascular diseases, neoplasms (cancers), respiratory diseases and diabetes. Diabetes mortality rates are very high in the Western Cape in comparison to those in developed countries.

Cardiovascular disease includes hypertension, ischaemic heart disease and stroke. It has been well documented that the primary causes of cardiovascular disease, while partly genetic, are largely attributable to environmental factors, specifically an unhealthy lifestyle. The most important risk factors are a lack of regular physical exercise, long-term use of tobacco products and the consumption of an unhealthy diet characterised by a high intake of fat, salt and sugar, and a low intake of fibre, fruit and vegetables. An unhealthy lifestyle may lead to obesity, hypertension and diabetes.

Compared with the rest of the country, non-communicable or chronic diseases account for a much larger proportion of deaths in the Western Cape (58 percent) than nationally (38 percent) and are the third leading cause of premature years of life lost in the province. The Western Cape has the highest prevalence of smoking of all provinces; i.e., 44.7 percent of men and 27 percent of women are smokers.

The National Food Consumption Survey (2005) indicated that 26 percent of women of child-bearing age (16 to 35 years) in the Western Cape were overweight and 32.7 percent were obese. It is of concern that the prevalence of obesity is 8 percent more than the national average for women (24.9 percent). The results of the South African youth behaviour risk survey of 2002 indicated that the prevalence of overweight amongst children is increasing in the Western Cape and the survey confirmed a higher prevalence of overweight adolescents in the Western Cape compared to the national average. Obesity is associated with an increased risk of cardiovascular diseases, hypertension and certain types of cancer of the reproductive system in women and with an increased rate of rectal-, colon- and prostate cancers in men.

Mental health is another key component of the burden of disease. Neuropsychiatric conditions such as depression and anxiety are the third highest contributor to the burden of disease in South Africa. The one-year prevalence of common mental disorders in South Africa is 16.5 percent and the lifetime prevalence is 30 percent. Furthermore, more than 80 percent of South Africans with mental health disorders do not receive the care they need.

In South Africa, some studies found that between 35 and 48 percent of women were diagnosed with postnatal depression, with as many as 12 percent in one study having moderate- to high risk of suicide.

There is also high co-morbidity of mental illness with chronic diseases. About half of all hypertensive, diabetic and cardio-respiratory disease patients in the Eden pilot of PHC 101 had depression.

Mental illness is also prevalent in adolescents. About 41.4 percent of Grade 8 to 12 of Western Cape learners were classified as medium risk and 14.9 percent as high risk for mental health problems; this is so across all the districts.

**Injuries**

According to the Western Cape Burden of Disease project, in 2009 injuries that include homicide, transport injuries, self-inflicted injuries and injuries due to fires accounted for 18.1 percent of the burden of disease in the province. This is just less than HIV and TB combined, which accounts for 22.5 percent of the burden. In comparison to the rest of the world violence is a particular problem in the Western Cape, where injuries are ten times more prevalent in Western Cape men than the global average for men and seven times more prevalent in Western Cape women than the global average for women.
In an analysis of mortuary data in the province, it was found that 42 percent of injuries were from homicide and 29 percent from traffic injuries. Nearly 80 percent of these deaths were in men aged 20 to 34 years old.

Substance abuse, particularly alcohol abuse, is one of the most important drivers of the injury burden in the Western Cape, as it fuels both violence and road traffic accidents. Nearly 60 percent of injuries were alcohol related and approximately 50 percent of all alcohol-related violence was found to occur in five areas that correlate with high levels of multiple deprivation and inequity. Alcohol is also a key driver for transport-related deaths. In the same analysis of mortuary deaths, it was found that 66 percent of pedestrian deaths, 61 percent of driver deaths and 38 percent of cyclists’ deaths had a positive blood alcohol concentration.

**Social determinants**

According to the South African Index of Multiple Deprivation, 72% (18/25) of the municipalities in the Western Cape are in the fifth quintile of multiple deprivations; thus they are the least deprived municipalities in South Africa. Prince Albert and Laingsberg municipalities are in third quintile and the most deprived of all municipalities in the Western Cape. Province-specific deprivation indices (StatsSA) show that the most deprived wards within the Western Cape are within the City of Cape Town municipality, particularly the townships on the Cape Flats alongside the N2, and in the Karoo. The Central Karoo comprises approximately one percent of the total population.

More detailed analysis also suggests that approximately half of the 50 most deprived wards in the province are most deprived in four or more of the following domains: income and material deprivation, employment deprivation, health deprivation, education deprivation and living environment deprivation. As discussed above, social determinants play an important role in the distribution of disease and its consequences.
### Table C.1: Millennium Development Goals

<table>
<thead>
<tr>
<th>Millennium Development Goal</th>
<th>Target</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eradicate extreme poverty and hunger.</td>
<td>Halve, between 1990 and 2015, the proportion of people who suffer from hunger.</td>
<td>Prevalence of underweight children under 5 years of age.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of the population below minimum level of dietary energy consump-tion.</td>
</tr>
<tr>
<td>Achieve universal primary education.</td>
<td>Ensure that by 2015, children everywhere, boys and girls alike, will able to complete a full course of primary schooling.</td>
<td>Net enrolment ratio in primary education.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Literacy rate of 15 – 24 year-olds.</td>
</tr>
<tr>
<td>Promote gender equality and empower women.</td>
<td>Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.</td>
<td>Ratio of girls to boys in primary, secondary and tertiary education.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ratio of literate females to males of 15 – 24 year-olds.</td>
</tr>
<tr>
<td>Reduce child mortality.</td>
<td>Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.</td>
<td>Under-5 mortality rate (U5MR).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Infant mortality rate.(IMR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of one-year old children immunised against measles.</td>
</tr>
<tr>
<td>Improve maternal health.</td>
<td>Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.</td>
<td>Maternal mortality ratio.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of births attended by skilled health personnel.</td>
</tr>
<tr>
<td>Combat HIV and AIDS, malaria and other diseases.</td>
<td>Have halted, by 2015, and begun to reverse the spread of HIV and AIDS, malaria and other diseases.</td>
<td>HIV prevalence among 15 – 24 year old pregnant women.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Condom use rate of the contraceptive prevalence rate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Number of children orphaned by HIV and AIDS.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of the population in malaria risk areas using effective malaria prevention and treatment measures. (Prevention to be measured by the percentage of under 5 year olds sleeping under insecticide treated bed-nets and treatment to be measured by percentage of under 5 year olds who are appropriately treated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prevalence and death rates associated with Tuberculosis (TB).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of TB cases detected and cured under the directly observed treatment short course (DOTS).</td>
</tr>
<tr>
<td>Ensure environmental sustainability.</td>
<td>Halve, by 2015, the proportion of people without sustainable access to safe drinking water.</td>
<td>Proportion of people with sustainable access to an improved water source.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of urban population with access to improved sanitation.</td>
</tr>
<tr>
<td>Develop a global partnership for development.</td>
<td>Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.</td>
<td>Official development assistance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of exports admitted free of duties and quotas.</td>
</tr>
<tr>
<td></td>
<td>In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries.</td>
<td>Proportion of population with access to affordable essential drugs on an established basis.</td>
</tr>
</tbody>
</table>
ANNEXURE D: THE EKURHULENI DECLARATION ON MENTAL HEALTH

We, the participants in the National Mental Health Summit held on 12-13 April 2012, consisting of representatives of government departments, non-governmental organizations, the World Health Organization, academic institutions, research organizations, professional bodies, traditional health practitioners, clinicians and advocacy and user organizations, gathered around the strategic theme ‘Scaling up investment in mental health for a long and healthy life for all South Africans’:-


Recognising that health is a state of mental, physical and social wellbeing and not just the absence of infirmity and that there can be no health without mental health; human rights of people with mental disabilities are entrenched in South African and International law; poor mental health and substance abuse is often associated with poverty, violence and other adversities and vulnerability while good mental health is an important contributor to social and economic development; attaining good mental health requires the commitment and practical involvement of a number of government and non-government sectors and partners; users of mental health services are integral to planning and delivery of mental health services; mental health service delivery must be accessible, affordable and acceptable; the right of all South Africans to the enjoyment of the highest attainable standards of physical and mental health must be achieved through increased services for mental health at all levels of the health care system, and that culture plays a key role in mental health.

Noting that mental and neurological disorders account for 13% of the global burden of disease and for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively; in South Africa neuropsychiatric disorders rank 3rd in their contribution to the overall burden of disease - after HIV and AIDS and other infectious diseases; over 16% of adults in South Africa have a 12 month prevalence of mental disorder; around three quarters of people in South Africa that suffer from a mental disorder do not currently receive any mental health intervention; mental and substance use disorders are closely correlated with physical diseases, including both communicable diseases such as HIV and AIDS and non-communicable diseases such as heart disease and cancer; mental and substance use disorders and intellectual disabilities impact on every strata of South African society, men and women, all races, economic groups, urban and rural populations and all age groups; there is considerable inequity in mental health service provision especially between the private and the public sectors and also between urban and rural areas; mental health services within general health care and community based mental health services are underdeveloped; people with mental disorders and disabilities continue to be stigmatised and discriminated against in most aspects of their lives; improved primary mental health care would reduce the number of mental health visits to secondary and tertiary health care facilities.

This national mental health summit was a culmination of an intensive process of consultation in provinces involving over 4000 people.

Realising that primary health care is the foundation of the health care system and that there is a need to fully integrate mental health care into primary health care in South Africa with the view to increasing prevention, screening, self-management, care, treatment and rehabilitation; in order to achieve equitable, efficient and quality health services, South Africa is in the process of implementing a National Health Insurance System and mental health must form an integral part of this system.
Hereby commit to:

1. Promoting mental health as an important development objective;
2. Eliminating stigma and discrimination based on mental disability and promoting the realisation of the United Nations Convention on the Rights of Persons with Disabilities (2006);
3. Full implementation of the Mental Health Care Act, 2002 (Act No. 17 of 2002) and changing the legislation where this is needed;
4. Ensure collaboration across sectors and between governmental and non-governmental organizations, academics and with other stakeholders to improve mental health services;
5. Providing equitable, cost-effective and evidence based interventions and thereby ensure that mental health is available to all who need it, including people in rural areas and from disadvantaged communities.
6. Integrating mental health and substance abuse services into the general health service environment.
7. Providing mental health and substance abuse care to people within communities while referring to higher health care levels where clinically required.
8. Ensuring that all users of mental health services participate in the planning, implementation, monitoring and evaluation of mental health services and programmes.
9. Fostering person-centred recovery paradigm that respects the autonomy and dignity of all persons;
10. Increasing human resources to address mental health needs throughout the country through additional training across sectors, integration into general health care and through the National Health Insurance System;
11. Developing and strengthening human capacity for prevention, detection, care treatment and rehabilitation of mental and substance use disorders and build links with traditional and complementary health practitioners.
12. Providing physical infrastructure that is conducive to the needs and human rights of people with mental disorders and disabilities;
13. Reducing costs and increase the efficiency of mental health interventions, including making medicines more affordable, in order to provide essential health services;
14. Establishing comprehensive mental health surveillance mechanisms, health information systems and dissemination processes to assist policy and planning.
15. Developing and supporting research and innovation in mental health.
16. Using the outputs from the summit to finalise the Mental Health Policy Framework 2012-2016 and to assist with its implementation and monitoring;

And consequently to:

1. Develop and implement a mental health service delivery platform based on community and district based models to ensure that prevention, promotion, treatment and rehabilitation services meet the needs of all;
2. Implement with vigour the Health Sector Mini Drug Master Plan;
3. Establish at least one specialist mental health team in each district;
4. Adequately fund mental health services as per WHO recommendations;
5. Embed and increase mental health human resources within the National Human Resource Plan;
6. Develop a fit for purpose plan for mental health infrastructure at all levels;
7. Revise norms and standards in line with the service delivery platform;
8. Strengthen Mental Health Review Boards;
9. Establish a national surveillance system and appropriate monitoring and evaluation systems for mental health care integrated into the National Health Information System;
10. Establish a national suicide prevention programme;
11. Strengthen links with traditional, complementary and faith-based healers and non-governmental organizations
ANNEXURE E: PLANNING METHODOLOGY

Planning Methodology

The planning parameters and methodology for the health service in general used for 2030 is a major advance on that used for 2010 and is based on four major tenets:

» Using a population base and the notion of a dependent population;
» Using the smallest geographic entity for which reliable health and socio-economic data is available;
» Using an equity measure with household income as a proxy that weights the distribution of health resources towards the poorest households; and
» Establishing norms and creating planning tools for different aspects of the health service that allows for its application to specific geographic areas. The tools used in one section of the health service take into account the impact of developments in other sections of the service; in this way the health service is viewed as an integrated health system.

The general tenets are described below and the specific application to various aspects of the health service is described under the service components.

Population based approach: demographics

The availability of reliable current population data has been a major challenge as a result of the previous census being conducted in 2001. The City of Cape Town therefore published a “Demographics Scenario Discussion Paper” in 2010, which summarises population projection data and trends identified by the Institute for Futures Research (IFR) and demographic trends analyses performed by Professor Dorrington for the City of Cape Town in 2000 and 2005. This useful document also references other sources, e.g. Statistics South Africa and the “State of Cities Report”. Dorrington’s 2000 analysis, which was based on census 1996 data, includes projections up to 2030. His 2005 analysis, which was based on census 2001 data, includes projections up to 2030.

Summary of key demographic trends – South Africa

» Continued population growth is projected until 2030 but will start to decline in absolute size thereafter;
» Fertility rates are declining;
» Life expectancy at birth is slowly increasing;
» The population is ageing;
» Age structures are changing;
» Racial composition is changing; and
» The HIV and AIDS epidemic is projected to continue to have a significant impact on the demography of South Africa.

Although Johannesburg remains the city with the highest population, Cape Town’s comparative growth rate was the highest in the country at 20.91 percent for the period 2001 to 2007. The State of Cities Report refers to the population growth rate for Cape Town as being consistently higher than the total population growth rate for the country.

Key demographic trends – Cape Town 2030

» Cape Town’s population will continue to grow significantly each year because of natural births (although at a slower rate, with fertility levels declining) and migration;
» Average household sizes have slowly decreased from 3.92 in 1996 to 3.72 in 2001, to 3.55 in 2008 (General Household Survey) and are likely to continue decreasing;
» The nature and extent of migration, both internal and trans-national, are the most prominent unknown variables;
» Cape Town will continue to experience significant internal and external migration;
The number of refugees and displaced persons is likely to increase, adding to Cape Town’s population growth through migration;

» A lower mortality rate than originally predicted as a result of HIV and AIDS will also influence the population growth; and

» The population is ageing.

The current estimated population for Cape Town, based on the Statistics South Africa data (General Household Surveys and Labour Force Surveys in particular) and the City’s Urban Growth Monitoring System estimates, is closely aligned with the Dorrington 2000 medium migration projections. (See Table E.1)

Table E.1: High/medium/low projections for Cape Town population

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2006</th>
<th>2011</th>
<th>2016</th>
<th>2021</th>
<th>2026</th>
<th>2031</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>3 186 938</td>
<td>3 646 156</td>
<td>4 008 402</td>
<td>4 292 446</td>
<td>4 538 385</td>
<td>4 769 669</td>
<td>4 976 987</td>
</tr>
<tr>
<td>Medium</td>
<td>3 154 238</td>
<td>3 547 055</td>
<td>3 820 847</td>
<td>3 997 718</td>
<td>4 119 504</td>
<td>4 208 444</td>
<td>4 255 857</td>
</tr>
<tr>
<td>Low</td>
<td>3 121 532</td>
<td>3 447 946</td>
<td>3 633 286</td>
<td>3 702 990</td>
<td>3 700 595</td>
<td>3 647 071</td>
<td>3 534 371</td>
</tr>
</tbody>
</table>

Source: Dorrington; 2000

Owing to the absence of updated or refined population projections, the City of Cape Town has used the medium Dorrington 1999 population data as the best estimate for the Cape Town population for the period 2011 to 2031. The same data set has therefore been used to draft the Spatial Development Framework referenced in the chapter on Drivers of Urban Growth.

However, given the large gap between the medium- and high projections reflected in Table 3, the Department opted to use a midway scenario to allow for a higher migration rate. (See Table E.2)

Table E.2: Midway scenario

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2006</th>
<th>2011</th>
<th>2016</th>
<th>2021</th>
<th>2026</th>
<th>2031</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midway</td>
<td>3 170 588</td>
<td>3 596 606</td>
<td>3 914 625</td>
<td>4 145 082</td>
<td>4 328 945</td>
<td>4 489 057</td>
<td>4 616 422</td>
</tr>
</tbody>
</table>

The midway scenario is the mathematical average of the Dorrington high- and medium projections.

Census 2011

The Department of Health used the 2007 community survey results, in conjunction with the trends displayed in the 1996 and 2001 censuses, as a basis for population projections in the Western Cape. These projections, which focused specifically on the distribution between districts and sub-districts, were published in subsequent annual performance plans.

The preliminary results of Census 2011 were announced in November 2012 and indicate that the total population of the Western Cape is 5 822 734. This is 1.0147 percent higher than the Department’s previously projected estimate of 5 763 653.

A trend analysis of the 1996 and 2001 censuses and the 2007 community survey suggests that the population of Cape Town would constitute approximately 66.1 percent of the total population of the Western Cape, equating to 3 809 735 by 201. However, according to the 2011 Census, the population of Cape Town was 3 740 025, which equates to 64.2 percent of the total population and reflects a difference of 1.83 percent from the Department’s projected estimate. The difference between the census results and the Department’s projected estimates for the city of Cape Town is 4.67 percent. Early indications are that Census 2011 may underestimate the population of Cape Town and overestimate the population in rural districts; e.g. the Central Karoo and the West Coast. Should the Census 2011 population distribution be adjusted so that it reverts to 66.1 percent for urbanised people, this would equate to a population of 3 848 827 for the city of Cape Town – a difference of only 1.02 percent from the Dorrington midway scenario. It is unlikely and contrary to prevailing demographic trends that the urbanised population in the Western Cape would have declined from 66.1 percent to 64.2 percent as advocated by the 2011 Census. For this reason the original population projections, based on the Dorrington midway scenario, have been maintained in the service models for Cape Town.
**Geography-based approach**

The 2030 philosophy is underpinned by a patient-centred, outcome-based approach where patient experience and health outcomes are the primary focus. A geography-centred approach with clear insight into the prevalent burden of disease and understanding of the factors that determine the health-seeking behaviour of people in a specific area, is therefore advocated.

Electoral wards were used as building blocks to demarcate geographic drainage areas for the delivery of specific health services in the Cape Town metro. This enables PHC drainage areas to feed into district hospital drainage areas and district hospital drainage areas to ultimately feed into regional hospital drainage areas.

Socio-economic data, which is available at ward level, can be aggregated to higher levels (e.g. sub-district and district) and can then be integrated with health statistics to determine the burden of disease and population profile for specific areas.

Another advantage of using integrated data sets is that a population profile, based on ethnicity, age, gender, household income, etc., can be compiled for each ward or drainage area, which can then be used to estimate the PHC utilisation rate. This is done by allocating protocols as described in the package of PHC services to specific denominator groups. For example, children under one year of age are a denominator group and immunisation is an important protocol prescribed in the full package of care. Other defined denominator groups that can be associated with specific protocols are: children under five; women between 15 and 49; women 30 to 50; and people with TB, etc. The total PHC utilisation rate per catchment area can thus be estimated, as well as the skills mix of the staff required to manage the relevant burden of disease and workload.

**Table E.3: Geographic profiles of the Western Cape population**

<table>
<thead>
<tr>
<th>Area</th>
<th>Census 2011</th>
<th>% of total population</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laingsburg</td>
<td>8 289</td>
<td>0.1%</td>
<td>Deep rural</td>
</tr>
<tr>
<td>Prince Albert</td>
<td>13 136</td>
<td>0.2%</td>
<td>Deep rural</td>
</tr>
<tr>
<td>Beaufort West</td>
<td>49 586</td>
<td>0.9%</td>
<td>Deep rural</td>
</tr>
<tr>
<td>City of Cape Town</td>
<td>3 740 025</td>
<td>64.2%</td>
<td>Urban</td>
</tr>
<tr>
<td>Western Cape</td>
<td>5 822 734</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

**Summary: distribution**

- Urban population: 64.2%
- Population in high density rural areas: 13.2%
- Population in rural areas: 20.2%
Table E.3 shows that 77.4 percent of the population of the Western Cape reside in high-density areas. In the rural sub-districts with a high population density the same planning methodology and approach that was used for the city of Cape Town can be applied.

However, a different planning approach is required for the rural and deep rural areas where 22.6 percent of the population reside. The smallest geographic planning unit used in these rural districts is a sub-district because many areas are so sparsely populated that it is neither practical nor meaningful to drill down to ward level. Similarly, the application of the income equity measure to relatively small settlements and towns would not yield meaningful results. The rural model is, therefore, based on estimated dependent population per sub-district. Allocation norms – for example, households per CHW – will be weighted, taking population density per catchment area and travel distances into account. The principle of critical mass must be applied in rural areas where the population numbers are too small to allow for the application of population- and workload-based norms.

**Equity measure**

The direct correlation between the burden of disease, poverty and associated deprivation is evidence based and generally accepted. For this reason an equity measure, based on household income and that will ensure that resource allocation is sensitive to income deprivation, has been developed. This will ensure that poor settlements will receive proportionately more resources to address their relatively higher burden of disease. Instead of focusing on the insured versus the uninsured population, wards have been stratified into four income layers. An income analysis was then applied to estimate the percentage of households in each layer that were likely to be dependent on public health services. A dependency profile could then be determined for each ward in the metro and sub-district in the rural districts. For this reason, reference is made to “dependent” population rather than “uninsured” population. The equity measure comprises the income layers set out in Table E.4.

**Table E.4: Equity measure income layers**

<table>
<thead>
<tr>
<th>Household income in 2001 Rands</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>More than</td>
<td>R307 201</td>
</tr>
<tr>
<td>Between</td>
<td>R76 901-R307 200</td>
</tr>
<tr>
<td>Between</td>
<td>R19 201-R 76 801</td>
</tr>
<tr>
<td>Less than</td>
<td>R19 200</td>
</tr>
</tbody>
</table>

It should be noted that the application of the equity measure not only results in a more equitable distribution of resources, but also enhances equitable access to health services.

In line with the broader 2030 philosophy the planning for hospitals is population based. An electoral ward is the smallest unit for which population and socio-economic data is available (Statistics SA). Pending the outcome of the 2011 Census and the availability of detailed census results, the data from the Dorrington scenarios is used to estimate population and a scenario midway between the medium- and high projections is used in order to accommodate migration.

Deprivation was used as a proxy for the burden of disease and health service requirements in order to ensure that the most deprived sections of the population have appropriate access to health services.
Differentiated access to services is therefore provided using household income as a proxy to ensure that more services are provided in lower-income areas.

The following household-income bands were used to determine deprivation:

<table>
<thead>
<tr>
<th>Equity measure: Household income bands in 2001 Rands</th>
<th>Current terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than R307 201</td>
<td>R552 001</td>
</tr>
<tr>
<td>Between R76 801 and R307 201</td>
<td>R138 001 – R552 000</td>
</tr>
<tr>
<td>Between R19 201 and R76 801</td>
<td>R34 501 – R138 000</td>
</tr>
<tr>
<td>Less than R19 200</td>
<td>R34 500</td>
</tr>
</tbody>
</table>

To ensure equitable access to district hospitals it is envisaged that there will be a district hospital for each catchment area. The spatial development boundaries demarcate more functional areas than the current sub-district boundaries across the province. These spatial development boundaries provide a framework for future development in terms of transport routes, human settlements and governance nodes. Sub-district boundaries remain for administrative and managerial purposes but are not optimally useful for technical planning.

The actual location of current hospitals determines the catchment areas in terms of access to the hospitals.

**Development of norms and flexible technical models**

As the technical work progressed, the discussions centred on the required level of technical detail and the approach to target setting. In Healthcare 2010 and the Comprehensive Service Plan specific future targets were set that drilled down to institutional level and staff establishments. Achievement of these targets was dependent on the implementation of service shifts across the platform and institutions. Without intermediate targets and appropriate management tools these shifts proved to be complex and challenging.

Given the lessons learned from Healthcare 2010 and the CSP, it was agreed that norm-based- and flexible technical tools would be developed. These would facilitate the implementation of the 2030 philosophy and service delivery platform within the context of the seven 2030 guiding principles. The tools are focused on the use of appropriate key indicators for which current baselines can be determined and for which indicative interim targets can be set for specific points in time, e.g. 2015 and 2030. Details of the technical models and norms that have been applied are described in Section D: Service Platform.

The technical modelling was guided by the philosophy and principles of 2030. Embedded in the patient-centred care-pathways approach is the understanding that what happens in one sector of the service delivery platform directly impacts on other sectors. This was taken into consideration in the technical modelling. For example, if home-based care is effectively implemented it should enhance early detection and diagnoses of chronic disease. This would lead to the effective treatment and control of chronic diseases and result in fewer emergencies and admissions to hospitals.

The development of flexible technical models enables the Department to progressively move towards the service platform envisaged in 2030. Major service shifts can be achieved through smaller coordinated projects that are easier to manage. The Department would in this way be able to manage effectively the shift of funds within the baseline budget and to table well-motivated requests for additional funding where necessary.
1. **Utilisation variables**

“Utilisation rate” refers to the number of times the average person visits a PHC facility per year and is derived from the following formula:

\[
\text{Utilisation per dependent person} = \frac{\text{Total head count (number of patients)}}{\text{Total population}}
\]

2. **Workload variables**

- Direct patient care factor per category of staff; i.e. the percentage of time spent in direct contact with patients;
- Minutes per consultation per category of staff; and
- Number of contacts of a patient with health workers at different service points during one visit to a facility. A patient contact refers to a consultation or treatment event between the patient and a health care worker. During a visit to a health facility a patient may consult with or be treated by more than one health care worker and may therefore have more than one ‘contact’ per visit to the facility.

3. **To calculate the utilisation rate it is necessary to estimate the average number of contacts that a patient has with health workers during one visit to a facility.**

In terms of the second point under “Workload variables” above, “patient contact” refers to a consultation or treatment event between the patient and a health care worker. During a visit to a health facility a patient may consult with or be treated by more than one health care worker and may therefore have more than one ‘contact’ per visit to the facility.

4. **Application of the workload and utilisation calculator**

In the example opposite (Table F.1) the calculator was applied to calculate the human resources required to render community-based- and clinic services to people in a ward.
<table>
<thead>
<tr>
<th>Post description</th>
<th>Working days per FTE per annum</th>
<th>Minutes /day</th>
<th>Direct patient care factor</th>
<th>Minutes / Patient Contact</th>
<th>Contacts per FTE/day</th>
<th>FTEs (250 days)</th>
<th>Total Patient Contacts per annum (250 days)</th>
<th>Clinical FTEs only</th>
<th>Contact Utilisation Rate per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Counsellor (Mental Health)</td>
<td>221</td>
<td>450</td>
<td>0.80</td>
<td>20</td>
<td>18</td>
<td>2.94</td>
<td>11 692</td>
<td></td>
<td>0.32</td>
</tr>
<tr>
<td>Clinical nurse practitioner</td>
<td>221</td>
<td>450</td>
<td>0.75</td>
<td>11.4</td>
<td>30</td>
<td>6.68</td>
<td>43 705</td>
<td></td>
<td>1.19</td>
</tr>
<tr>
<td>Professional nurse consultations (Minor trauma, Supervise prep and dressing rooms)</td>
<td>221</td>
<td>450</td>
<td>0.33</td>
<td>6.6</td>
<td>23</td>
<td>1.34</td>
<td>6 643</td>
<td></td>
<td>0.18</td>
</tr>
<tr>
<td>Enrolled Nurse / Nursing Assistant: prep, bandages and dressings rooms, etc.</td>
<td>221</td>
<td>450</td>
<td>0.80</td>
<td>4</td>
<td>90</td>
<td>4.58</td>
<td>91 107</td>
<td></td>
<td>2.48</td>
</tr>
<tr>
<td>Medical Officer</td>
<td>221</td>
<td>450</td>
<td>0.70</td>
<td>10</td>
<td>32</td>
<td>1.34</td>
<td>9 300</td>
<td></td>
<td>0.25</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>221</td>
<td>450</td>
<td>0.75</td>
<td>3</td>
<td>113</td>
<td>1.47</td>
<td>36 538</td>
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<td>1.00</td>
</tr>
<tr>
<td>Pharmacy assistant</td>
<td>221</td>
<td>450</td>
<td>0.90</td>
<td>4</td>
<td>101</td>
<td>2.2</td>
<td>49 326</td>
<td></td>
<td>1.34</td>
</tr>
<tr>
<td>Admin Clerk: Admissions</td>
<td>221</td>
<td>450</td>
<td>1.00</td>
<td>5</td>
<td>90</td>
<td>4</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Chief Admin Clerk</td>
<td>221</td>
<td>450</td>
<td>-</td>
<td>30</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Community Health Worker</td>
<td>221</td>
<td>450</td>
<td>0.50</td>
<td>30</td>
<td>8</td>
<td>27.38</td>
<td>54 514</td>
<td></td>
<td>1.49</td>
</tr>
<tr>
<td>Prof Nurse: Co-ordinate / Supervise / Training (CBS)</td>
<td>221</td>
<td>450</td>
<td>0.40</td>
<td>20</td>
<td>9</td>
<td>3.00</td>
<td>7 168</td>
<td></td>
<td>0.20</td>
</tr>
<tr>
<td>Prof Nurse: Unit Manager</td>
<td>221</td>
<td>450</td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Cleaner</td>
<td>221</td>
<td>450</td>
<td></td>
<td></td>
<td></td>
<td>3.00</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Admin Clerk: Information management</td>
<td>221</td>
<td>450</td>
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<td></td>
<td></td>
<td>1.00</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Prof Nurse Specialised: Mental Health</td>
<td>221</td>
<td>450</td>
<td>0.75</td>
<td>20</td>
<td>17</td>
<td>1.00</td>
<td>4 480</td>
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<td>0.12</td>
</tr>
<tr>
<td>Facility Manager</td>
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<td>450</td>
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<td>15</td>
<td>-</td>
<td>1.00</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Rehab Care Workers (RCWs)</td>
<td>221</td>
<td>450</td>
<td>0.50</td>
<td>45</td>
<td>5</td>
<td>3.42</td>
<td>4 543</td>
<td></td>
<td>0.12</td>
</tr>
<tr>
<td>Rehab Care Therapists (OT &amp; Physio)*</td>
<td>221</td>
<td>450</td>
<td>0.40</td>
<td>30</td>
<td>6</td>
<td>0.57</td>
<td>909</td>
<td></td>
<td>0.02</td>
</tr>
<tr>
<td>Help desk (admin person)</td>
<td>221</td>
<td>450</td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
<td>-</td>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Total FTEs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>34.37</td>
<td>FTEs required for Community Based Services</td>
<td></td>
<td>34.37</td>
</tr>
<tr>
<td>*Allocated to CHC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>33.36</td>
<td>FTEs required for Facility based services</td>
<td></td>
<td>33.36</td>
</tr>
</tbody>
</table>
Table F.2: Module 2 of workload calculator – estimation of “head count”

**Module 2 of Calculator: Estimation of number of patients (headcount) that visit the facility based on the number of contacts calculated in module 1**

AVERAGE NUMBER OF CONTACTS WITH HEALTH WORKERS PER PERSON DURING ONE VISIT TO A CLINIC

Assumption:

Consults by clinical nurse practitioners, professional nurses and doctors will be supported by visits to clinical support personnel: prof nurses staff nurses, enrolled nurses and pharmacist.

<table>
<thead>
<tr>
<th>Medical doctors (including dentists)</th>
<th>9 300</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical support: prep room &amp; dressing room: staff nurse &amp; nursing assistant</td>
<td>9 300</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>9 114</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical nurse practitioner</th>
<th>43 705</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical support: Prep room &amp; dressing room: Staff nurse &amp; nursing assistant</td>
<td>43 705</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>39 335</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional nurse (33% consultation; 67% support)</th>
<th>6 643</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical support: Prep room &amp; dressing room: Staff nurse &amp; nursing assistant</td>
<td>4 982</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>5 979</td>
</tr>
</tbody>
</table>

Total number of contacts: 172 065

Number of patients (=headcount) treated during the above contacts (Curative cases): 59 649

Total number of contacts per annum (calculated in module 1): 252 791

Number of patients with one contact per visit (including group sessions): 80 726

Average contacts per person during a visit to a clinic: 1.8

Patients (head count) per annum: 140 375

Dependent population utilisation rate: 3.82

**Home based Care**

<table>
<thead>
<tr>
<th>Total visits per annum by CHWs</th>
<th>54 514</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total visits per annum by Prof Nurse</td>
<td>7 168</td>
</tr>
<tr>
<td>Grand total</td>
<td>61 682</td>
</tr>
<tr>
<td>Utilisation rate</td>
<td>1.7</td>
</tr>
</tbody>
</table>

RCWs: total home visits per annum: 4 543

Rehabilitation care therapists: total home visits per annum: 909

Total: rehabilitation home visits: 5 451

Utilisation rate: 0.15

Total utilisation rate: 5.65

*Support factor: the support required by clinical workers can be adjusted in this column

Note: Tables F.1 and F.2 are selected screen prints of the calculator and therefore do not display all the columns and functions.

Given the close relationship between the PHC service and HBC, the CHW and RCW from HBC and associated professional nurse, therapist and administrative support components based at the clinic are all included in the PHC staff allocation in Table 12 above. The calculator is also used in determining the utilisation and workload of community health centres and community day care services. Therapists currently allocated to sub-structure offices will be allocated to community health centres in the 2030 plan.
ANNEXURE G: DEFINITIONS

Extract from National Department of Health facility definitions

Definitions of characteristics of context

These definitions apply to health services in all cases. That is services that involve patient contact for diagnosis and treatment provided by health professionals. The definitions do not necessarily cover support services such as catering, laundry, estate management, power generation, logistics, information systems, security etc., which are not core business and can be and are routinely subcontracted out to external providers.

Range of services (general or specialised)

General

A unit delivering a range of services usually related to an expected package and within the scope of service of the health practitioners providing the services.

Specialised

A unit delivering a particular type of service relating to a particular patient group, disease or treatment.

Levels of care

(Minimum threshold values – one facility may provide several of these services)

(Note: These minimum threshold values do not imply or require the inclusion of the full target package described in A Comprehensive Primary Health Care Package for South Africa, National Department of Health, September 2001)

Primary care

(Non-admitted care – consultations, interventions, tests)

A set of prescribed services, generally falling within the skill base of a professional nurse, technician, mid-level worker, counsellor, community health worker, midwife and emergency care technician. These services may be the first point of contact or for follow-up care.

Day care

Treatment, observation or assessment that requires an extended stay, usually beyond the treatment or consultation as an outpatient, but with a duration of less than one day. Day care patients do not get counted in the midnight bed count.

In-patient care

Patients are admitted to hospital for at least one night for diagnosis, investigation or treatment.

Level 1 care

Services that are within the skills base of a general medical practitioner and do not require the intervention of a specialist. These include simple surgery requiring a general anaesthetic.

Level 2 care (secondary)

Services that at some time during the intervention are beyond the normal scope of a generalist and required the input of a registered specialist.

Level 3 care (tertiary)

Services that at some time during the intervention are beyond the normal scope of a specialist and require the input of a registered sub-specialist.
Acute, sub-acute and chronic care

Acute care

Care of conditions that may change within a few hours or days and that require prompt investigation, diagnosis and treatment.

Sub-acute care (intermediate care)

Transitional inpatient care that follows or forms the latter part of an acute episode in which the patient has been investigated and diagnosed. The patient is in a stable condition and has a treatment plan but requires on-going inpatient nursing or rehabilitation care for fewer than 90 days.

Chronic care

Long-term inpatient care and or treatment that relates to chronic conditions requiring extended care of over 90 days.

Categories of facilities

Facilities providing predominantly ambulatory care

(Note: The reference to packages or ranges of services does not require or imply delivery of the full target package described in A Comprehensive Primary health Care Package for South Africa, National Department of Health, September 2001).

Health post

A health post is a room in a house or other structure in a community from which a range of elementary primary health care (PHC) services are provided.

Mobile

A mobile clinic is a temporary unit from which a range of PHC services are provided and where a mobile unit/bus/car provides the resources for the service. This service is provided on fixed routes and at a number of points, which are visited on a regular basis. Some visiting points may involve the use of a room in a building, but the resources (equipment, stocks) are provided from the mobile when the service is available and are not maintained at the visiting point.

Satellite clinic

A facility that is a fixed building where one or more rooms are permanently equipped and from which a range of PHC services are provided. It is open for up to eight hours per day and fewer than four days per week.

Clinic

An appropriately permanently equipped facility at which a range of PHC services are provided. It is open at least eight hours a day at least four days a week.

Community day centre

A facility that is not open 24 hours a day, seven days a week, but at which a broad range of PHC services are provided. It also offers accident and emergency services but not midwifery services or surgery under general anaesthesia.

Community health centre

A facility that is open 24 hours a day, seven days a week, at which a broad range of PHC services are provided. It also offers accident, emergency and midwifery services, but not surgery under general anaesthesia.

Specialised health centre

A facility that provides specialised care to particular groups of patients, usually for fewer than 24 hours at a time. There are many possibilities for such units, but the most common are obstetric units (open 24 hours and providing midwifery services) and renal dialysis units.
Units providing sub-acute (step down) services

These provide inpatient care for patients who no longer require acute intervention and can be cared for mostly by professional nurses or allied professions (i.e. they are clinically stable, have a final diagnosis, treatment plan and prescribed medication). They will not generally have been discharged from hospital except where their care can be better managed in a specialist unit as described below.

Convalescent unit

These cater for patients who need on-going treatment requiring supervision in hospital or are recovering from surgery or are in need of respite care. Such a unit will be permanently staffed by professional nurses and will be normally situated in a hospital.

Rehabilitation unit

These cater for patients who require physical or psychiatric rehabilitation or respite care. They will be staffed either by professions allied to medicine (physical rehab) or specialist nurses (psychiatric rehab). These specialised units may be on or off hospital sites. Patients may be discharged from hospital into off-site units.

Hospice unit

These cater for terminally ill patients requiring palliative care or respite care. They will be staffed by allied professions and specialist nurses. These specialised units may be on or off hospital site. Patients may be discharged from hospital into off-site units.

Transit units

These units cater for patients who are awaiting treatment from a hospital but do not require admission, or patients awaiting transfer to a higher-level hospital for diagnosis but not currently requiring admission. They may also cater for patients who have been discharged from hospital but, for social reasons, cannot go home.

Regulations Relating to Categories of Public Hospitals

(IN TERMS OF THE NATIONAL HEALTH ACT, 2003)

The following are the categories of public hospitals used in the 2030 planning, as defined in the regulations relating to categories of public hospitals in terms of the National Health Act, 2003, published in Government Gazette No. 35101 on 2 March 2012.

Categories of public hospitals

The following are categories of public hospitals:

a. District hospital
b. Regional hospital
c. Tertiary hospital
d. Central hospital
e. Specialised hospital

District hospitals

Categories

District hospitals are categorised into small, medium and large district hospitals, according to the number of beds:

a. Small district hospitals with no fewer than 50 beds and no more than 150;
b. Medium-size district hospitals with more than 150 beds and no more than 300; and
c. Large district hospitals with no fewer than 300 beds and no more than 600.
Purpose

A district hospital must:

a. Serve a defined population within a health district and support primary health care;

b. Provide a district hospital package of care on a 24 hour basis;

c. Have general practitioners and clinical nurse practitioners (CNPs) of PHC;

d. Provide services that include in-patient, ambulatory health services as well as emergency health services; and

e. Where practical, provide training for health care service providers.

Support

A district hospital receives outreach and support from general specialists based at regional hospitals.

Specialist services

A district hospital may provide only the following specialist services:

a. Paediatric health services

b. Obstetrics and gynaecology

c. Internal medicine

d. General surgery

e. Family medicine

Regional hospitals

Purpose

A regional hospital must provide on a 24-hour basis:

a. Health services in the fields of internal medicine, paediatrics, obstetrics and gynaecology, and general surgery;

b. Health services in at least one of the following specialties:

   » Orthopaedic surgery;
   » Psychiatry
   » Anaesthetics
   » Diagnostic radiology

c. Trauma and emergency services;

d. Short-term ventilation in a critical care unit;

e. Services to a defined regional drainage population, limited to provincial boundaries and receiving referrals from several district hospitals; and

f. Where practical training for health care service providers

Support

A regional hospital receives outreach and support from tertiary hospitals.

Number of beds

A regional hospital has between 200 and 800 beds.
Tertiary hospitals

Purpose

A tertiary hospital

a. Provides specialist-level services provided by regional hospitals;

b. Provides subspecialties of specialties referred to in point (a);

c. Provides intensive care services under the supervision of a specialist or specialist intensivist;

d. May provide training for health care service providers;

e. Receives referrals from regional hospitals not limited to provincial boundaries; and

f. Has between 400 and 800 beds.

Central hospitals

Purpose

A central hospital

a. Must provide tertiary hospital services and central referral services and may provide national referral services;

b. Must provide training of health care providers;

c. Must conduct research;

d. Receives patients referred to it from more than one province;

e. Must be attached to a medical school as the main teaching platform; and

f. Must have a maximum of 1 200 beds.

Central referral services

These are provided in highly specialised units; require unique, highly skilled and scarce personnel; and are located at a small number of sites nationwide.

National referral services

a. Refer to super-specialised national referral units; and

b. Represent extremely specialised and expensive services (e.g. heart and lung transplants, bone marrow transplants, liver transplants, and cochlear implants).

Specialised hospitals

Purpose

A specialised hospital

a. Provides specialised health services like psychiatric services, tuberculosis services, infectious diseases and rehabilitation services; and

b. Has a maximum of 600 beds.


Rendall D. Standardisation in primary health care facility design in the South African public health sector, Getting the balance right; 2012


Western Cape Department of Health. Policy framework for Clinical Governance in the Health Department in the Western Cape. Cape Town: Western Cape Department of Health; November 2011.