

A DESCRIPTIVE ANALYSIS OF HOW PRIMARY
HEALTH CARE SERVICES HAVE DEVELOPED
IN THE CAPE METROPOLITAN AREA FROM
THE PERIOD: PRE – 1994 TO POST – 2000
ELECTIONS

by

ANTHONY ANDILE ZIMBA

Assignment presented in partial fulfilment of the requirements for
the degree of

MASTER OF PUBLIC ADMINISTRATION

at the University of Stellenbosch

Study Leader:

PROFESSOR E. SCHWELLA

December 2002

Declaration

I, ANTHONY ANDILE ZIMBA, hereby declare that this is my own original work and that all sources have been accurately reported and acknowledged, and that this document has not previously in entirety or in part been submitted at any University in order to obtain an academic qualification.

OPSOMMING

Die Primêre Gesondheidsorg benadering geniet tans wereldwyd erkenning as 'n meganisme om doeltreffende openbare gesondheidsdienslewering te versker. Die konsep, wat ontwikkel en gegroei het uit die Alma Ata-konferensie van 1978, is reeds deur verskeie regerings ge-implementeer ten einde die doelwitte van beskikbaarheid, toeganklikheid en bekostigbaarheid van gesondheidsorg vir alle landsburgers te verseker. Die voorsiening van omvattende Primêre Gesondheidsorgdienste word erken as 'n noodsaaklike middel om gesondheidsorg te verbeter. Die Distrikgesondheid-stelsel is geïdentifiseer as 'n ideale model vir die implementering van omvattende Primêre Gesondheidsorgdienste in Suid Afrika.

Publieke Gesondheidsdienste in die Kaapse Metropolitaanse-gebied word gekenmerk deur die feit dat dit funksioneel gefragmenteer is. Twee publieke owerhede, te wete die Provinsiale Administrasie van die Wes Kaap en die Kaapse Stadsraad lewer Primêre Gesondheidsorgdienste, wat aanleiding gee tot swak koördinerings met die gevolg dat dienslewering daaronder ly. Primêre Gesondheidsdienste in die Kaapse Metropolitaanse-gebied, soos in die res van Suid Afrika, het op 'n onlogiese, skewe manier ontwikkel.

Hierdie werk is 'n poging om die gevolge en implikasies van die onlogiese, skewe gesondheids-ontwikkeling te konseptualiseer. Daar is gepoog om die uiters gekompliseerde gesondheidsdiens-stelsel in Suid Afrika krities te analiseer met spesifieke verwysing na die kenmerke van ongelykheid, ontoeganklikheid en onbillikheid. Dit sluit die historiese en huidige ontwikkeling van gesondheidsorg in die Kaapse Metropolitaanse gebied en die strukturele kenmerke in wat deur die loop van jare as gevolg van verskeie invloede en neigings sigbaar geraak het.

Die ontwikkeling van Primêre Gesondheidsorg in die Kaapse Metropolitaanse-gebied word ge-analiseer ten einde bogenoemde teorie in die praktyk te bevestig. Die analise beklemtoon die invloed van verskillende politieke rolspelers op die ontwikkeling van Primêre Gesondheidsorgdienste en bevestig die struikelblokke en beperkings wat

deurentyd opgeduik het. Transformasie van gesondheidsdienste soos dit tans daaruit sien, gegrond op die beginsels van Primêre Gesondheidsorg, vereis dat die ongelykhede van die verlede aangespreek word. Die integrasie van die twee gesondheidsdiensowerhede sal die beginsels van die Gesondheidsdistrik-stelsel verwesenlik, wat daartoe sal aanleiding gee dat omvattende Primêre Gesondheidsorg 'n werklikheid word.

ABSTRACT

Primary Health Care (PHC) approach is currently receiving tremendous attention worldwide as a mechanism to ensure effective and efficient public health services. The concept has evolved from the Alma Ata conference (1978). Since then many countries began to reorient their health services to achieve the goals of availability, accessibility and affordability of health care for all citizens and a number of management issues came to the forefront. Therefore, the provision of comprehensive PHC services is the key aspect to improving health services. A district health system has been identified as an ideal model for comprehensive PHC services to all the citizens in South Africa.

Public health services in the Cape Metropolitan Area are characterised by functional fragmentation. Two public authorities render Primary Health Care services, namely the: Provincial Administration of the Western Cape through CHSO, and the Municipal Health Department. The fragmented nature of the public health services, which result in poor coordination of service delivery between the two health authorities, compromises the quality of service delivery.

Historically, PHC services in the Cape Metropolitan Area – and indeed in the whole South Africa – have developed in a skewed manner. This work is an attempt at conceptualising the implications and consequences of this skewed health development. South Africa is presently undergoing fundamental reform, which has brought the PHC into disarray of fundamental change. Since the South African health care system is a highly complex institution, attempts have been made to critically analyse those aspects and features of inequality, inaccessibility, and inequity. Among these is the historical and present development of Cape Metropolitan Area health care and the structural features it assumed with the passing of time, trends and characteristics.

In order to examine the theory in practice, the evolvement of PHC in the Cape Metropolitan Area will be analysed. The analysis highlights how different political formations have affected the development of PHC services and points out obstacles and

limitations throughout the process, which had to be dealt with. Transformation of the existing health services, based on the principles of PHC, requires the redressing the imbalances of the past. Therefore, the integration of the two health authorities into one entity would best achieve the principles of district health system and will ensure comprehensive PHC.

ACKNOWLEDGEMENTS

I sincerely wish to thank the following people to whom I am indebted:

My family for their patience and understanding while I was working at my desk;

My study leader, Prof. E. Schwella, for his valuable academic support and guidance;

My typist, Cebisa, for her understanding and assistance.

TABLE OF CONTENTS

Declaration	i
Opsomming	ii
Abstract	iii
Acknowledgements	v
List of abbreviations	vi
List of tables	vii

CHAPTER 1 INTRODUCTION AND CONTEXT SETTING

1.1	Introduction	1
1.2	Research problem	2
1.3	Purpose of the study	3
1.4	Aims and objectives of the study	4
1.5	The research methodology	4
1.6	Scope and limitations of the research	5
1.7	Outline of the study	6
1.8	Duration of the research	6
1.9	Design of the research	6
1.10	Summary	7

CHAPTER 2 LITERATURE REVIEW

2.1	Introduction	9
2.2	Conceptualisation	9
2.1.1	Health concepts	10
2.3	The development of the South African health system	12
2.3.1	Historical context	12
2.3.2	Economic context	13
2.3.3	Political context	14

2.4	A district health system approach	21
2.4.1	The provincial option	22
2.4.2	The statutory district health option	23
2.4.3	The local government approach	23
2.5	Legislative framework: Post 1994	23
2.6	Assessment of primary health care in the Cape Metropolitan Area	25
2.7	Summary	26

CHAPTER 3 DEVELOPMENT OF PRIMARY HEALTH CARE SERVICES IN THE CAPE METROPOLITAN AREA DURING 1995 TO POST 2000 ELECTIONS

3.1	Introduction	28
3.2	Health services in the Cape Metropolitan Area: interim phase (1996- 2000)	28
3.2.1	City of Tygerberg	28
3.2.2	City of Cape Town	30
3.2.3	South Peninsula municipality	31
3.2.4	Blaauwberg municipality	31
3.2.5	Oostenberg municipality	32
3.2.6	Helderberg municipality	32
3.2.7	Cape Metropolitan Council	32
3.2.8	Provincial Health Department	32
3.3	Amalgamation process of the Unicity	33
3.4	Summary	33

CHAPTER 4 CRITICAL ANALYSIS OF PRIMARY HEALTH CARE SERVICES IN THE CAPE METROPOLITAN COUNCIL

4.1	Introduction	35
4.2	Lack of clarity on national process	35
4.3	Fragmented primary health care services in the Cape Metropolitan Area	37
4.4	Service delivery	37
4.5	Quality and accessibility of service	38

4.6	Pharmaceutical Services	39
4.7	Management	40
4.8	Equity	40
4.9	Summary	43

CHAPTER 5 CURRENT DEVELOPMENTS ON THE IMPLEMENTATION OF PRIMARY HEALTH CARE SERVICES

5.1	Introduction	45
5.2	Bi-ministerial task team report	45
5.3	Obstacles to implement a district health systems based on primary health care	47
5.4	Recent agreement on the implementation of primary health care service	49
5.4.1	Service level agreement	49
5.4.2	Interim governance	51
5.4.3	Joint management	51
5.4.4	Interim financial arrangements	52
5.4.5	Primary health care core-package	52
5.5	Summary	54

CHAPTER 6 FINDINGS AND RECOMMENDATIONS

6.1	Introduction	55
6.2	Findings	56
6.2.1	Fragmentation of health services	56
6.2.2	Inaccessible health services	57
6.2.3	Quality of service	57
6.2.4	Lack of policy direction and planning in relation to health needs	57
6.2.5	Legislative uncertainty	58
6.2.6	Status of current services relationship	58
6.2.7	Structural growth in service demand and costs	59
6.2.8	Transfer of risk	59
6.3	Recommendations	60
	OPTION A: Municipal- based district health system	

6.3.1	A single health authority	60
6.3.2	Integrated primary health approach	61
6.3.2.1	Equity	62
6.3.2.2	Comprehensiveness	62
6.3.2.3	Implementation of national health directives	63
6.3.2.4	Strategic planning and management	64
	OPTION B: Provincial government option	64
CHAPTER 7 CONCLUSION		
7.1	Conclusion	66
	LIST OF REFERENCES	68

LIST OF ABBREVIATIONS

CBOs	Community Based Organisations
CHC	Community Health Care
CHW	Community Health Workers
CHSO	Community Health Service Organisation
CNP	Clinical Nurse Practitioner
DHS	District Health System
HBC	Home Based Care
HIV	Human Immuno-Deficient Virus
MINMEC	Minister and Member of the Executive Committee
MEC	Member of the Executive Committee
MLCs	Metropolitan Local Councils
MOU	Maternity Obstetric Unit
NGOs	Non-Governmental Organisations
PAWC	Provincial Administration of the Western Cape
PHA	Public Health Authority
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
SMT	Strategic Management Team
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TLCs	Transitional Local Councils
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

LIST OF TABLES

- | | |
|--|----|
| 1. Facilities where municipal health and community health service organisations are rendering health services in the same building | 41 |
| 2. Primary Health Care expenditure by the City of Cape Town and Provincial Administration of the Western Cape | 43 |
| 3. Comprehensive Primary Health Care Services Package in the District | 53 |

CHAPTER 1

INTRODUCTION AND CONTEXT SETTING

1.1 INTRODUCTION

The health care services in the Cape Metropolitan area, and indeed, in all of South Africa, have developed in a disjointed and haphazard manner through the apartheid era. This can be illustrated by the manifestation of different authorities rendering Primary Health Care (Van Rensburg, Fourie and Pretorius, 1992: 61-62). The provision of health care services was strongly focused on a certain population group and resources were not fairly distributed, and, therefore, this necessitated major restructuring (Barron and Zwarenstein, 1992: 1). It is consequently universally recognised that the Western Cape health sector needs an overall restructuring.

The manifestation of communicable diseases in the Western Cape can be attributed to social and economic conditions such as poverty, unemployment and rapid urbanisation. In order to prevent diseases and promote the maintenance of healthy individuals and society, it is imperative to have a comprehensive Primary Health Care (hereafter called PHC) service to address these discrepancies within the health service fraternity. The current provincial and municipal health system is strongly criticised by the community, patients and health care personnel as a result of its fragmentation.

The Draft Provincial Health Plan (1995:2) envisaged to address the following important issues within a district health model, namely:

- The fragmentation of health services.
- The move towards a comprehensive PHC service.
- The need for a new organisation and structure for health services.
- The need to decentralise the management of health services.

- The shift of resources from expensive level hospital-based care to primary and secondary levels of care.
- The need to improve accessibility and quality of health care in the province.
- The need to build on the strengths of the personnel so as to effectively utilise human resources.

In the light of the above the Draft Provincial Health Plan (1995) proposed that the new provincial health system should be based on geographically coherent and contiguous health districts within which all public sector health personnel would be employed by a single authority and within which single multi-disciplinary health management teams would be responsible for attending to the comprehensive health and health care needs of the residents within the district.

1.2 RESEARCH PROBLEM

Primary Health Care services in the Cape Metropolitan Area have developed in a skewed and distorted manner because of apartheid policies. These services are rendered by two authorities, namely the Provincial Health Department and Municipal Health Services. The central government policies are not effectively coordinated and implemented because of the current fragmentation. This has resulted in poor management and coordination of PHC services. In addition, this has caused major duplication of services and poor utilisation of limited resources within the health sector. Health personnel from the two authorities are disgruntled because of salary disparities and different conditions of services offered by the two authorities.

This research focuses on the evaluation of the current state of health services and the most recent developments in this regard. For this purpose a number of sub-problems will be addressed as research questions:

- Are health services fragmented? If so, in which way and what caused this fragmentation?
- Are health services accessible or inaccessible? How has this situation changed over the period?
- Are health resources inequitably distributed? If so, how have these changed over the period?
- What are the levels of health services in terms of:
 - Affordability?
 - Acceptability?
 - Availability?
- How are health policies and strategies coordinated?
- How is health services managed?

1.3 PURPOSE OF THE STUDY

As proposed by Barron and Zwarenstein (1992: 5), a district health system is regarded as an ideal system to overcome fragmentation of those health services that were based on the apartheid policies. It is thus important to investigate the underlying reasons that hamper the implementation of a primary health services based on a district health system so as to obtain a better understanding of the limitations, problems and challenges faced by the Cape Metropolitan Area. The White Paper for the transformation of the health system in South Africa (Department of Health, 1997:13) stipulates that public health services could be developed through a district health system and that this could be a cornerstone for rendering comprehensive primary health care services.

The following principles aim at overcoming the existing fragmentation, namely promoting equity, providing comprehensive, effective and efficient quality services, access to services, local accountability, community participation, decentralisation and inter-sectoral collaboration. It is the intention of the

researcher to investigate the mechanism to expedite the implementation of primary health care services operating within the ambit of a district health system.

1.4 AIMS AND OBJECTIVES OF THE STUDY

The aim of the study is to describe how PHC services have developed in the Cape Metropolitan Area. Towards achieving this aim the following objectives will be pursued:

- To outline the various phases which PHC services have undergone in the Cape Metropolitan Area;
- To identify the extent of duplication of services caused by the fragmentation of PHC services rendered by the provincial and municipal health departments;
- To explore and identify the obstacles and limitations in terms of the management of comprehensive PHC;
- To identify elements of PHC services that can be rendered in a comprehensive manner, and
- To give recommendations as to how PHC services can be improved.

1.5 THE RESEARCH METHODOLOGY

The provision of comprehensive PHC services in the Cape Metropolitan area – and indeed in South Africa at large – continues to face major challenges. A need exists to take a more detailed look at how comprehensive the health system is and how effective and efficiency these services are. It, therefore, becomes meaningful and feasible to analyse these services and whether they meet the needs of the population.

The methodology to be followed will be focusing on historical and current

patterns through which PHC services have evolved, as found in the descriptive features of the research methodology.

- Factual data will be gathered and, based on these, conclusions will be drawn which will serve as a basis for comparing of the PHC development in the Cape Metropolitan area. Therefore, a literature study will be embarked upon to achieve this aim.
- Historical and current patterns of PHC provision will be scrutinised by consulting the latest texts, briefs and available literature.
- Analysis of principles of primary health care approach with regard to the implementation of a district health system.
- A comprehensive study of how fragmented services re, how accessible are health services, extent of duplication of services and how resources are equitably distributed.
- Investigation of obstacles and limitation that hampers the implementation of effective PHC services.
- Analysis of current policy developments to implement PHC services.

Based on the information gathered, own conclusions and critique will be developed to support and serve as a basis for recommending how a PHC approach can be implemented.

1.6 SCOPE AND LIMITATIONS OF THE RESEARCH

This research has been confined to within the Cape Metropolitan Area, to the Provincial Health Department, City of Tygerberg, City of Cape Town, Helderberg Municipality, Oostenberg, South Peninsula and Blaauwberg Municipality and the new City of Cape Town. The following limitations are envisaged in this study: There is limited literature available with regard to district health systems in South

Africa and the possible threats posed by the forthcoming strategy of the Unicity in the Cape Metropolitan area.

The current political uncertainty that prevails in the Western Cape also poses as a major stumbling block because of the inconsistency in policy implementation by the political parties.

1.7 OUTLINE OF THE STUDY

A historical and descriptive study has been embarked upon to indicate how PHC services have developed in the Cape Metropolitan area. This will enable the researcher to reconstruct a chain of events and identify those events that have retarded progress with regard to the consolidation of PHC services to be rendered by a single authority. A critical review of existing literature in the form of texts, briefs, reports, documents and bulletins will be analysed to enable the researcher to develop an in-depth understanding with regard to the subject under discussion.

1.8 DURATION OF THE RESEARCH

The study was conducted in the period from 2000 to 2002. During this period the local government was undergoing restructuring which had three phases, namely pre-election (1994 - 1995), interim (1995 – 2000) and final phase (post-2000 elections). All the data in this research will reflect the position prior to the local government elections up until 2002.

1.9 DESIGN OF THE RESEARCH

Chapter 1 contains the background and serves to introduce the topic of the research. Furthermore, the chapter deals with the aims and objectives for deciding on the problems regarding the development of PHC in the Cape Metropolitan area, the sub-problems and research methodology, as well as the limitation of the study.

Chapter 2 focuses on a study of the literature in the field of PHC services. Because there is such a wide volume of literature available on PHC in general, an attempt was made to search for factual data on the topic.

Chapter 3 deals with the development of PHC services in the Cape Metropolitan area from the review of literature. This is discussed in relation to the interim phase of local government development, which established various municipalities that rendered health services. Furthermore, an attempt to coordinate health services by the Unicity amalgamation process will be discussed.

Chapter 4 dwells on the critical analysis of PHC services in relation to the adherence to a PHC approach, such as overcoming fragmentation, and the duplication in the accessibility of services, equitably distribution of resources and availability of services.

Chapter 5 outlines the current attempts that have been made to implement an ideal PHC services in the Cape Metropolitan area. Obstacles, which hinder the implementation of PHC, will be explored. The present service agreements that have been entered between the Provincial Health Department and the new City of Cape Town will be outlined.

Chapter 6 gives a summary of conclusions and recommendations reached and will include some critique on the present system followed. Finally, this chapter outlines recommendations, which are twofold, namely a municipal based district health systems option or a provincial government option.

1.10 SUMMARY

In view of the above, the pressure to realign the PHC system in the Cape Metropolitan Area along the lines of a district health system has come from local managers and the community at large. Their efforts have been frustrated by the

lack of a single authority and management system. Taking into account the current restructuring process of local government that is underway, the progress on the implementation of a district health system, which is based on the principles of PHC, has been retarded.

Numerous attempts have been made to implement PHC services in the Cape Metropolitan Area and have been hampered by rigid structures from two different authorities rendering this service. Due to a lack of corporate governance in the Health Department, the principles of PHC (Department of Health, 1997:13) that aim at overcoming fragmentation, promoting equity and accessibility of services, cannot be attained.

CHAPTER 2

THEORETICAL PERSPECTIVE ON PUBLIC HEALTH

2.1 INTRODUCTION

This chapter explores the theoretical framework on public health, and the development of the South African health system. To be able to follow the evolution of the South African health system, it is imperative to understand the events and processes that led to the present health care system. According to Barron and Zwarenstein (1992:1), the goals of most governments worldwide are to strive for health for all, a concept that commits them to seeking an equitable and acceptable approach to attain a level of service for all people within their borders. This allows them a full participation in the life of the community and society.

Several events and processes have influenced the development of health services in South Africa, such as the epidemics that occurred at various stages in history that compelled the government to adopt a different stance in rendering health services. In addition, features such as the historical, economical, political, demographical and geographical factors, had a direct influence on how health services developed South Africa. In addition, the current literature on a district health system indicates that this model for effective PHC. Thus South Africa, in common with a number of other countries, has begun to reorient the health services to achieve the goals of availability, accessibility and affordability of health care for all citizens.

2.2 CONCEPTUALISATION

Language usage often results in problems of interpretation. It has thus been deemed necessary to clearly define specific terms and concepts in this study that

otherwise may lead to terminological ambiguity. Therefore, the following terms and concepts will be defined.

2.2.1 Health concepts

Acceptability implies that health services should be acceptable to beneficiaries, be of high quality service at all levels and responsive to the needs, rights and dignity of patients, staff, and clients.

Accessibility: Communities should not be denied access to public sector health services on the grounds that they may be resident outside the area of the health authority. Provision must be made for cost recovery mechanisms between authorities for inter-district health service delivery (Owen, 1995:5)

Affordability refers to health costs, which are affordable to the community, and costs that are reasonable

Primary Health Care refers to the health services that must be acceptable, accessible, and affordable to the beneficiaries.

Intersectoral Collaboration: The health system must promote health and prevent ill health. It must empower individuals and communities to take responsibility for the promotion and maintenance of their health. This requires that the health system be based on a developmental and intersectoral philosophy, drawing on all the various elements required to build healthy individuals and communities (Owen 1995:6).

Equity: Every person should have access to services of comparable quality between different areas and communities in the province.

Comprehensive services: This implies an integrated (promotion, preventive, curative and rehabilitative) and multi-disciplinary approach to

health and health care provision services between the districts (Owen, 1995: 4).

Sustainability implies self-reliant and cost-effective development, facilitating access to health, shelter, clean water and food.

Community Participation: All users should have active participation, as well as their political representatives in the planning, provision, control and monitoring of health services.

Decentralisation implies a transfer to authority and responsibility from the central level of government to the district and local levels, which are strengthened (WORLD HEALTH ORGANISATION 1992:81- 83).

Deconcentration is defined as administrative decentralisation, such as the transfer to a peripheral office of clearly defined duties and responsibilities, including some local discretionary authority e.g. a district-level office of a Department of Health (WORLD HEALTH ORGANISATION 1992:81- 83).

Devolution is the transfer of powers and functions to semi-autonomous sub-national political authorities, such as local and regional governments.

Delegation: As defined by Rondinelli (1981:133-145), this is the transfer of managerial responsibility for defined functions to organisations that are outside the central government structure and only indirectly controlled by Central government.

Privatisation involves the transfer of government functions to voluntary organisations or private enterprises (Rondinelli, 1981:145).

2.3 THE DEVELOPMENT OF THE SOUTH AFRICAN HEALTH SYSTEM

According to Van Rensburg et al. (1992:7) national health care systems do not execute isolated functions within closed vacuums. They are open systems, each component embedded in its environment and each in a constant input-output interaction with that environment. The researcher intends to include the whole spectrum of determinants such as historical, economical, political, as well as the geographical and demographic factors when discussing the evolution of South African Health Care Systems.

2.3.1 Historical Context

The following events, amongst others, represent prominent historical factors which had a significant role in the development of health care systems worldwide, namely the creation of the World Health Organisation and the convening of the Alma Ata Conference in 1978 whereby all countries were expected to conform and adhere to the aims and objectives of this organisation. As outlined by Van Rensburg et al. (1992:8), the following historical factors and events shaped the specific nature and development of the South African health care system. The European settlement since 1652, and the subsequent colonial era, brought about its influences in health services. The health legislation in 1807 paved the way for the introduction of formal health policies and this can also be attributed to the role played by overseas missionary societies. The unification of South Africa in 1910 resulted in the formation of provincial health systems. This was soon followed by the flu epidemic of 1918 that killed a large number of people. As a result this compelled health officials to re-prioritise their strategies and plans to curb this epidemic. The health legislation of 1919 was a milestone in shaping health services as a consequence of which the focus was on both prevention and curative

services. The Gluckman Commission of 1944 played in a significant role by exposing the limitations and shortfalls of health services of the period.

A series of apartheid legislations brought about homeland health policies, which resulted in the fragmentation of the Health Department. All the facets of health services, such as prevention, curative, promotion and rehabilitation, were incorporated in the 1977 health legislation and this piece of legislation is still in operation. Undoubtedly, all these historical events shaped the South African health care system, and gave it a unique character distinct from the systems of other countries. The economic context will be discussed in the following section.

2.3.2 Economic Context

The prevailing economic climate, the economic systems of countries and specific economic factors, such as the inflation rate, are among the most powerful extraneous determinants of any national health care system. Low paid employment is clearly linked with a high rate of reported ill health. Poor health is often associated with low paid work. According to Amonoo-Lartson, Ebrahim, Lorel and Ranken, (1994:8-9) such work is often dangerous, providing another source of reported ill health through accident and injury and generates a level of income which is insufficient to command an effective presence in the housing market.

Neither does it give command over further resources which may bring about a better job, house, or more varied social and educational provision to be brought within reach. In addition, the relationship between access to a satisfactory means of transport and the ability to find and retain employment is a crucial link, which determines general well-being. Unemployment as a particular severe form of low-income, linked with difficulties of personal self-evaluation and status, is closely related to problems of ill health.

Inflation erodes the value of money and thereby wears away the ability of money to play its proper role as a means of exchange, as a store of value and as a common denominator. Furthermore, inflation leads to an unequal, and unfair, redistribution of wealth, income and health needs. Rich individuals are in a position to protect themselves more easily against inflation with such results as such as high medical costs, than poor people are able to do. Persons in higher income brackets have more opportunities to benefit from inflation than low-income people. As indicated by van Rensburg et al. (1992:8), these economic determinants noticeably affect all dimensions of the health care system, and they also determine what proportion of the Gross National Production (GNP) is spent on health care. These determinants also influence the country's ability to generate and provide resources and the manner in which such resources, facilities and personnel will be distributed. Finally, the broader economic framework and climate determine to a great extent the demand, supply, consumption and cost patterns with regard to health care, and the availability, distribution and quality of services and facilities.

2.3.3 Political Context

The health care system of this country has been influenced by the prevailing political, government systems, the constitutional and statutory dispensations, political ideologies, pressure groups and political revolutions. The establishment of the Union of South Africa in 1910 heralded a totally new era in the country's history. At the time of unification the responsibility of the previous four British colonies with regard to health care was simply transferred to the four provincial administrations, while local authorities continued with the task entrusted to them in prior colonial and even the days of the Boer republics. Each of the four provincial administrations autonomously continued to provide public curative services, while environmental and preventative health

services were still provided by local authorities under the jurisdiction of the Department of Internal Affairs. There was also a marked fragmentation of authority over and little coordination of health matters. This resulted in a rigid structure, which gradually became resistant to fundamental change. (Zwi and Saunders, 1985:28-29).

Health care in South Africa in the 20th century was characterised by the spreading and legitimating of both modern Western medicine and the dominance of the medical profession in health matters and supplanting of traditional and alternative forms of care. This also resulted in the total shift in emphasis towards primary preventative and community health. Segregation on the basis of race and colour in South African health care was eventually confirmed as a structural feature. Racial fragmentation of the South African health care system expanded to various areas, especially after 1948 in the era of so-called grand apartheid. Apartheid affected the health care system when legislation was passed on, for example, the homelands, in terms of which each received its own separate Health Department.

In 1983 so-called own affairs Departments of Health for whites, Indians and coloureds were introduced. And so the pluralistic nature of the health structure developed especially after 1910, and become more complex. An ever-increasing and more differentiated structure also came into existence in the private sector around the mines, industries, insurance companies, charitable organisations and other numerous private entrepreneurs. (Zwi and Saunders, 1985:16)

The process of urbanisation, which was introduced in the latter part of the 19th century by the discovery of diamonds and gold, changed South Africa from a rural to an industrial society. In health care the rural-urban differentiation brought about similar structural results in that health services were increasingly concentrated in urban areas. As a result rural

areas were left underprovided and understaffed. The more urbanised population groups i.e. the Whites and Asians, accordingly reaped greater benefit from the urban-based health services, since health facilities and health care provides were concentrated mainly in urban areas.

However, the disastrous influenza epidemic of 1918 can be attributed to the reorientation and reorganisation of South Africa's health care. It alerted people to the fact that the state had to assume responsibility for public health care. This epidemic brought about a new dispensation, such as the Public Health Act, 1919, Act 36 of 1919, which reformulated and amended some of the obsolete colonial Health Acts with a view to establish uniform control of preventative health services. This Act also established an additional and separate Department, namely the Department of Public Health. The latter was at the first tier of government, while the Provincial Administrations and local authorities were responsible for public health services at the local level. The Department of Public Health acted chiefly a financing agent for the local authorities.

Due to the high socio-economic health problems from which especially the black population suffered, such as the desperate housing situation, overcrowding, illiteracy, unhygienic living conditions and widespread malnutrition during the 1930s and 1940s, the Gluckman Commission was established in 1944 to look into the shortcomings in the organisation of South African health care.

According to the Gluckman Commission (1944:8) the following shortcomings were revealed:

Firstly, a lack of coordination. The Commission condemned the existing health services as "disjointed, haphazard, provincial and parochial." As an example it cited seven role players responsible for the control and

provision of health care, namely local authorities, Provincial Administrations, the Department of Public Health, the mines, missionary societies, charitable institutions, private hospitals and private practitioners.

Secondly, it cited the lack of services which were acute in black areas in terms of both personnel provision and facilities and also the unsatisfactory quality of both.

Thirdly, the Commission's criticism was levelled at the curative disposition and profit motive of private practices, which brought about a situation in which care was not administered according to need, but according to the individual's ability to pay. Consequently doctors established themselves where the wealthy lived and not where the ill lived, and as a result health services were not equally available and accessible to all sectors of the population.

Fourthly, the Commission also found that there was an excessive emphasis on curative services and institutional care, and not enough on either the prevention of disease or community based care. In addition the Commission criticised the inadequate environmental measures and the critical shortage of medical services needed for preventing illness. (Gluckman Commission, 1944:8-10).

Prior 1948 South African health services developed in a manner that the segregating and inequality engendering effect of colonisation and racism manifested itself in numerous discrepancies and inequalities. Therefore, in the field of health care, apartheid likewise existed long before 1948 in the form of separate hospitals, wards, clinics and consulting rooms for whites and non-whites. However, after 1948 apartheid acquired a new look which was declared official policy, was legitimised through legislation, acquired numerous new dimensions and was implemented on a

much grander scale, especially in the homeland policies. Thus a leading characteristic of South African health system is that it is dominated and controlled by whites and is deeply permeated by the structure of apartheid. Its own professionals were trained in different institutions according to their skin colour (Savage, 1979:149).

The homeland policy brought about enormous problems in the scale of the already existing fragmentation. Furthermore, structurally and administratively, the homeland policy gradually added to the existing South African Department of Health ten additional State Departments of Health at the first tier of government with one Department of Health for each homeland. It is thus clear that homelands were shining examples of the further racial fragmentation of South African health care, since each homeland – with its own Department of Health – was after all created for a specific black ethnic group, irrespective of the squandering of resources, manpower and money incurred.

According to Zini (1984:10), homeland policies exacerbated another negative dimension of health care, namely the denial of responsibility whereby the presence of “independent” health authorities in the homelands created an intermediate level of responsibility and administration which put the South African government in a position to negate its own responsibility in respect of poor health services in the homelands and then blamed the homeland authorities.

The constitutional reforms of 1983 culminated in the tricameral parliament and the three "Own Affairs" Departments of Health. The tricameral parliament made provision for separate representative councils for coloureds, and Indians. Blacks were specifically excluded from this dispensation because their “political development” had to be realised through the homelands. There was furthermore a clear distinction between Own Affairs and General Affairs. Own Affairs would denote

matters which specifically and exclusively concerned a particular group, and General Affairs were designated as affairs that were of national importance and concerned all population groups. This perpetuated racial differentiation in health care services that were affected in various ways by this constitutional dispensation. It became evident that certain dimensions of health care were accommodated by Own Affairs, and for this purpose three additional Departments of Health Services and Welfare, and also three additional health bureaucracies – for whites, coloureds, and Indians respectively – were established. This constitutional dispensation led to greater inefficiency and cost, and the threat of deterioration of already inadequate health services (Cloete, 1988:112–113).

In 1977, the National Health Act, (Act 63 of 1977) was introduced, consolidating health related legislation promulgated since 1919. The aim of this Act was to address anew the uncoordinated division of responsibilities and functions among the different health authorities at the national, provincial and local levels of government, the escalating degree of inefficiency and overlapping resulting from this division, and the lack of a uniform national health policy. It also aimed at the rationalisation of services in the spirit of sincere and imaginable cooperation, namely in terms of what would best serve the national interests. This was in contrast to a climate where each authority sought to gain as much as possible in terms of sectional interests and autonomy (De Beer, 1976:431-432). The 1977 legislation was a major step in delineating the three areas of authority and stipulating their duties, functions and responsibilities. It also took concrete steps to effect greater coordination between the three levels of government. In addition, it clearly aimed to set in motion a process to shift the emphasis in South African health care towards the prevention of illness and promotion of health.

Though the Act attempted to address some of the problems, it fell short in some of its stated aims, such as the fragmentation and inaccessible health services. The national health services facilities plan was introduced in 1980 to coordinate health care provision nationally to expand PHC by means of a network of community responsibility in illness and health. Furthermore, a national health plan of 1986 was introduced and its basic principles were to centralise responsibility for overhead planning and policy decisions, with decentralised, executive responsibility transferred to the second and third sphere of government. It also envisaged the optimal use of available resources by means of the elimination of fragmentation and duplication. It also encouraged private initiative and input in the field of health. Finally, it attempted to rectify the division between preventive and curative services and arriving at responsible integration of these rehabilitation and environmental health measures (Health Act, Act 63 of 1977:12).

After 2 February 1990, when the then State President F.W. de Klerk announced the unbanning of the ANC and the liberation of Mr Nelson Mandela from prison, there have been some attempts by the government to bring about fundamental reforms in the South African health care. This brought about the National Policy for Health Act of 1990 and the National Health Services Delivery Plan for the Republic of South Africa of 1991 which makes the state's intention clear, namely to establish in an affordable way a comprehensive health which will effectively provide priority needs of the entire population and contribute to the progressive improvement of health status and quality of life of all the people of this country, based on the principles of accessibility, effectiveness, affordability, equity and acceptability.

2.4 A District health system approach

Following the Alma-Ata declaration on Primary Health Care (PHC) in 1978, most developing countries committed themselves to the development of a PHC system based on a district health system. This approach has been the philosophy which influenced health systems around the world. A district health system is a more or less self-contained segment of the national health system, based on PHC. It comprises of a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all the institutions and individuals providing health care in the district, whether government, social security, non-governmental, private or traditional. A district health system (DHS), therefore, consists of a large variety of inter-related elements that contribute to health in homes, schools, workplaces, and communities by means of the health and other related sectors. It includes self care and all health care workers and facilities, up to and including the hospital at the first and referral level, the appropriate laboratories, and other diagnostic services. The principles of a district health system stipulate that the boundaries of the health district should not cross boundaries of other administrative sectors, or of local governments, or of magisterial districts (i.e. they should be coterminous with these other boundaries). These boundaries do not need to be permanent and should be subject to change over time ("soft" boundaries) as the need arises so as to improve the management of the district. This would happen particularly if local government boundaries change or as health management capacity increases and a large district can be divided into smaller health districts.

Against the above background on district health systems, the provincial health plan proposes that a health district should be large enough to have the financial and management capacity to provide all essential care, including environmental health services, emergency services and first level hospital care. In essence it must contain all the elements required for comprehensive PHC. On the other hand it must be small enough for efficient management and meaningful

community involvement in terms of participation and accountability. Because of its size and closeness to the people it serves, it has the potential to allow for structured and meaningful community involvement at all levels of its management system. In order to enhance intersectoral collaboration, a health district should coincide with similar areas of service delivery of other sectors.

Furthermore each health district should contain one or more district hospital, community health centres, clinics and smaller facilities, such as mobile units, and it should be part of a well defined referral network both within the province and as part of the overall National Health System. There should be single health service and health management teams for each district that will be accountable to a single authority within a provincial and national framework. Therefore, a provincial health authority, which is accountable to the National Health Department, will be responsible for monitoring, evaluating and supporting district health services. Basically, the health district is not a separate, completely autonomous unit: it forms an integral part of the National Health System. Owen (1995:19-21) has proposed the following options of DHS:

2.4.1 The Provincial Option

Because of the insufficient capacity and infrastructure at the district level to take on independent responsibility for comprehensive health service in certain areas, a Provincial Administration would retain full responsibility to render all health services. This implies the integration and absorption of local authority personnel currently rendering selective services in these areas. The province would determine the health districts into which the province is divided, appoint all district health personnel, and delegate appropriate powers within the area. It is also proposed that provincial legislation should establish a District Health Council, with representation from the population residing in the district, and assigned certain powers and function (Owen, 1995:20).

2.4.2 The Statutory District Health Authority Option

This option is ideal for those parts of the country where there are proposed health districts which have the capacity and infrastructure to allow the devolution of full responsibility to the district level, and where there is no single local authority (with the capacity to render comprehensive services) whose boundaries correspond with those of the health district. In such circumstances an independent authority can be established. This structure will be governed by a District Health Council, which will have full governance powers for the provision and management of district health services. Each statutory District Health Authority should establish an independent administrative infrastructure that will ensure that it is accountable to the population of the district and would have autonomous powers with respect to personnel and finance (Owen 1995:20).

2.4.3 The Local Government Approach

Owen (1995:21) proposes that there should be an establishment of a district based system of local government, in which a single district based local authority could be responsible for the provision of all services within a defined area, and which is accountable to the people of that area. In view of the great diversity of situations in South Africa, it remains possible that the boundaries of certain local authorities may well correspond with those of functional and viable health districts.

In addition, Owen (1995:21) suggests that the Metropolitan Local Councils can be divided into functional and viable health districts. Therefore, in such cases, it would be logical and feasible to give to a single local authority the responsibility to render comprehensive district health services to its population. The Local Council of that Local

Authority would then delegate powers and functions to its District Health Council.

The primary objective was to create an integrated district health system capable of delivering comprehensive PHC. Various structures were formed in November 2001 by the Provincial Department of Health and the City of Cape Town to coordinate and oversee the transfer of services, functions, facilities, and staff from the then City of Cape Town. A central steering committee consisting of senior management from both authorities was established. In addition, a health services task team (2002:1) was constituted to package services to be rendered by the municipality and to drive the process of designing the new integrated PHC service. In addition the newly appointed Director of Health in the City of Cape Town was mandated to develop an operational plan, while eight health sub-districts were established, based on equity, population size and the geographical set up of the Metropolitan Unicity.

2.5 LEGISLATIVE FRAMEWORK: POST - 1994

The Cape Metropolitan Area was established in terms of the provisions of the Cape Metropolitan Enactment, namely Proclamation No 18 of 1995. The new Transitional Metropolitan substructures were established by the Western Cape Minister of Local Government by virtue of the powers vested in him by Section 10 (1) and 10 (3) which should be read with Section 8 (2) and 8 (3) of the Local Government Transition Act 1993 (Act 209 of 1993). As from 1 July 1997, nineteen (19) old Administrations – amongst them the former Black Local Authorities – were replaced by seven (7) new administrations. These seven new administrations were called the City of Cape Town (Central), Oostenberg Municipality (Eastern), Helderberg (Northern), Southern and Tygerberg Municipality. Each Metropolitan Local Council had to employ new Chief Executive Officers supported by Senior Management whose job it was to steer

their municipalities towards a brighter fiscal future and to take on the greater responsibilities conferred on local government by the new Constitution. Through the Metropolitan Restructuring Forum and the Metropolitan Labour Forum, the staff, assets and liabilities, rights, obligations and duties were transferred and relocated to the new Administration in terms of the Proclamation (27 of 1996).

The Cape Metropolitan Council plays a coordinating and facilitating role, redistributes resources where needed, is also responsible for the bulk services which can be more effectively rendered on a Metrowide scale. It is funded by business levies. The six (6) Metropolitan Local Councils are autonomous bodies which render basic services, such as health services, directly to communities and they are funded from rates and services charged on property owners (Cape Times, 12 January 1998).

In the light of the foregoing, an overview of health services in the Cape Metropolitan Area will be discussed with specific reference to the six (6) Metropolitan Local Councils.

Furthermore, the proposed implementation of the District Health System in the Cape Metropolitan Area will be discussed with specific reference to current patterns of service delivery, management and organisation, legislative and constitutional courses of fragmentation, the Local Government option, and also the financial, personnel and service implications of the Local Government option.

2.6 ASSESSMENT OF PRIMARY HEALTH CARE

Primary Health Care is rendered in a specific context, which is social, economical, cultural and political. It encompasses a wider field than health care alone and has special development implications. PHC emphasises health care at a local level, and it promotes mother and child health services, including immunisation and nutrition. In addition, it provides a comprehensive system of care, prevention, treatment, community development, management and

organisation. A district health team is the key element to successful PHC. Furthermore, a district health team is the nerve centre and a powerhouse for overseeing the work of the district and carrying out the functions of planning, developing, maintaining and evaluating services, supporting, building and developing staff and systems of work, and maintaining links between the local situation and other government agencies rendering health services (Amonoo-Lartson et al., 1994; 19).

Contrary to the above, the PHC services in the Cape Metropolitan Area are rendered by two authorities, namely the Provincial Health and also by the Municipal Health Departments. This is a clear manifestation of fragmentation, duplication, overlapping of health services. PHC services are planned at central level and no district health teams are in place. As stated above, district autonomy is essential to local accountability. This autonomy needs to be balanced against the need to ensure that the entire population receives the minimum basic health package (Barron and Zwarenstein, 1992:3)

2.7 SUMMARY

The above discussion leads to the conclusion that the historical development of public health services in South Africa has historically developed in a skewed manner. Several events and processes contributed to this development, and hence the government was compelled to adopt different approaches to address this problem. The district health system was proposed as the vehicle through which the delivery of PHC should take place. As PHC is the foundation of the health system, it is critical for the overall functioning of the system that there should be a well-functioning district health system in place. Various approaches to district health system are being proposed and it is incumbent upon the Authorities to establish as to which is the best approach that should be followed. In terms of improving service delivery under the DHS, an enabling legislation is needed to

pave the way for the introduction of a DHS, which will ensure the effective implementation of PHC services in South Africa.

CHAPTER 3

DEVELOPMENT OF HEALTH SERVICES IN THE CAPE METROPOLITAN AREA DURING THE INTERIM PHASE (1997 – 2000)

3.1 INTRODUCTION

In this Chapter the development and current policy of health services in the Cape Metropolitan Area will be discussed. This is based on the 1994 election, whereby changes in the Health Departments were affected, as proposed by the Constitution. In addition, this Chapter also outlines the current situation, including the structure and functioning of the health delivery system. An evaluation of these services will also be given in order to establish the necessity of further transforming health service delivery according to the district health system.

3.2 HEALTH SERVICES IN THE CMA: INTERIM PHASE (1995-2000)

The following is the current situation in terms of health services development in the Cape Metropolitan Area.

3.2.1 City of Tygerberg : Health Department

The then City of Tygerberg was one of the seven (7) Metropolitan Local Councils which was formed during the second phase of Local Government transition process which took place in July 1997.

The Health Department of City of Tygerberg is constituted of a majority of previous Cape Metropolitan Council Health Department staff, as well as staff from the previous City of Cape Town Health Department. The 1 July 1997 “unbundling” process of the previous Local Authorities, led to the Health Department staff of the Western Cape Regional Services

Council (which was later changed to Cape Metropolitan Council) to be transferred to a single functional department that could continue to deliver all the services. So the City of Tygerberg was left with the responsibility of filling one post only in the micro-organisational structure, namely Head of Health Services.

The new Head of Health Services had to restructure or realign the health services. In September, 1997 Council approved the division of the City of Tygerberg in three health districts, namely the Tygerberg Eastern District as proposed by the National Health Plan, as well as the Provincial Health Plan which divides the Cape Metropolitan area into a total of eleven (11) health districts. The criteria and parameters for setting the size of a health district include that the population should not exceed 500 000, facilitate community participation and the district should be a manageable size which allows for efficient and cost effective services planned and managed by a district management team. These parameters were deemed appropriate to restructure this Council's Health Department in order to meet the local needs (City of Tygerberg, 1997:1)

The Health Department used the following guiding principles in developing the micro-organisation structure: the structure had to be flat with a wide span of control; the structure had to encourage empowerment of all levels of staff and equity to prevail and historical imbalances corrected. In order for this process to be successful, the Health Department used its participatory management structures to involve all staff in the process of developing the abovementioned micro-organisational structure. This process culminated in a departmental workshop at which all the proposals were presented and the group attempted to reach consensus on principles and an appropriate structure (City of Tygerberg, 1997:1-2).

The following structure was proposed: Three generic Area Managers who are health professional from any one of the health professions (Nursing, Doctors and Environmental Health), a technical support for the specific disciplines through technical support services which will help to support quality technical services without direct line accountability from the operational staff who work in the three health districts. The new Health Department of the City of Tygerberg is made up of a majority of previous Cape Metropolitan Council Health Department staff, as well as staff from the previous City of Cape Town Health Department. This newly formed municipality comprises of the following areas, Belhar, Bellville, Delft, Durbanville, Goodwood, Bothasig, Parow, Mfuleni and Khayelitsha. (Delpont, 1997)

Currently the city is divided into three health districts, namely Khayelitsha, Tygerberg Eastern District and Tygerberg Western District. This division is in line with the National Plan, as well as the Provincial Health Plan, which divides the Cape Metropolitan area into eleven health districts. The parameters for setting the size of a health district include that of a population and the district which should be of a manageable size, allowing for efficient and effective services, planned and manageable by a district management team (City of Tygerberg, 1997:3).

3.2.2 City of Cape Town

The new City of Cape Town Health Department consists of old staff and few staff members who were unbundled from the Cape Metropolitan Council. Currently, a Director heads this Department of Health Services as from May 1999. The new head of health had to realign the health services. A flatter structure was adopted and four districts were established in terms of which four acting District Managers were employed to coordinate and start to introduce district health principles as

proposed by the National and Provincial Health Departments (Delpport, 1997).

This municipality comprises of the areas of Sea Point, Camps Bay, Cape Town, Woodstock, Salt River, Observatory, Mowbray, Ndabeni, Pinelands, Kensington, Langa, Gugulethu, Philippi, Nyanga, Crossroads, Mitchells Plain and Mandalay.

3.2.3 South Peninsula Municipality

The following areas fall under the jurisdiction of the South Peninsula Municipality, namely Constantia, Fish Hoek, part of old Cape Town and Simons Town. There are four districts in the Directorate, namely Environmental Health – which provides a preventative/promotive service regarding environmental health standards – secondly Community Health – whose clinics provide a promotive, preventative and limited curative health service. Thirdly the Directorate of Services include aspects such as Child Health, Community Development – provides a social development service and health support services – which support the above divisions in their operations. Services include aspects such as a health information system, medical depot, x-ray service and administration. Currently there are seventeen fixed clinics, five satellite clinics, three environmental health site offices, four community centres and one nursery school. The overall staff complement of this Department is 137 (Delpport, 1997:12).

3.2.4 Blaauwberg Municipality

Blaauwberg Municipality covers areas such as Atlantis, Belhar, Bloubergstrand, Mamre, Melkbosstrand, Milnerton, parts of Brooklyn, Pella, Rugby, Sanddrif and Tygerhof (Delpport, 1997:474). The overall staff complement is thirty-five. There are three clinics operating in the

municipal areas of jurisdiction. The district management team is not in place as yet, though this area is envisaged to be a district in the new health dispensation when the unicity is in place (Delpont, 1997:14).

3.2.5 Oostenberg Municipality

This Municipality is constituted of the following areas – Brackenfell, Kraaifontein, Kuilsriver, Melton Rose, Blue Downs and Scottsdene. There are six (6) clinics serving this municipality. To date there are forty-three (43) nursing staff, environmental health officers, and twenty-four clerical staff. The municipal Health Department is head by an Assistant Director: Health Services with two managers (i.e. Environmental Health and Nursing Services). A district with a district management team has not been established, though it is anticipated that this area will form one district in the forthcoming unicity dispensation (Delpont, 1997).

3.2.6 Helderberg Municipality

The Helderberg Municipality comprises of the following, namely Somerset West, Gordon's Bay and Strand. There is a staff complement of about eighty in the Health Department, which is constituted by environmental health services, curative (nursing services) and administrative support services. The district management team is not yet in place, but it is envisaged that this area will form a district, as proposed in the district health system.

3.2.7 Cape Metropolitan Council

The Cape Metropolitan Council was established in 1995, and it was in essence the successor in law to the former Western Cape Regional Services Council, which in turn was the successor in law to the Divisional

Council of the Cape, Stellenbosch and Paarl. Presently, this Council is playing a coordinating role with regard to coordination and funding the Metropolitan Local Councils through grants (Delport, 1997).

3.2.8 Provincial Health Department

Personal health care services in the Western Cape are provided by the public sectors, private sector and various non-governmental organisations. The Department of National Health has a regional office in the Western Cape, responsible for monitoring health status of the population, for environmental health services in the posts for aspects of health promotion, for supporting, monitoring and evaluating the health services rendered by local authorities, for monitoring of private hospitals and for primary level curative and rehabilitative services. The total staff establishment of the hospital and health services branch of the Provincial Administration of National Health amount to 1371 posts, while a further 2045 health personnel posts are assigned to the regional office of the Department of National Health. (Draft Provincial Health Plan, 1995:29 – 30).

3.3 AMALGAMATION PROCESS OF THE UNICITY

Subsequent to the 2000 local government elections, the new Director for City Health was appointed. It became incumbent upon him to implement an effective PHC care service based on the district health system. In order to maintain and improve the health status of all communities in the City of Cape Town, the Health Department was divided into eight districts with health facilities/clinics to ensure the promotion of health services, preventive health service, appropriate curative services, environmental health services and specialised health support services (City of Cape Town Business Plan 2001:1)

This obviously demands close cooperation on many fronts and if these weaknesses cannot be solved, the alternative may well be return to some of the known strengths and pitfalls of vertical programmes. In view of the foregoing, a district level is considered to be ideal for rendering of health services in the Cape Metropolitan Area and is the appropriate method of overcoming fragmentation and promotes decentralisation. The district level must ensure that there is the necessary amount of central government control, support and supervision as well as a high degree of local flexibility. Considerable authority should, therefore, be delegated to certain staff members near the periphery of the health services.

CHAPTER 4

CRITICAL ANALYSIS OF PRIMARY HEALTH CARE IN THE CAPE METROPOLITAN AREA

4.1 INTRODUCTION

The National Health Department's vision is that the population should experience seamless care from primary to tertiary health level, and that they will access this care through integrated, comprehensive PHC services within a district health system. PHC within a district is the foundation for a comprehensive health care service. The goal is to have 53 health districts in the country, each ultimately characterised by the provision of comprehensive district health services; a district health plan; a structure and processes to ensure cooperative governance; a single budget and Management structure; and all staff to be part of a single Public Service (Department of Health, 1997:8)

In the following discussion the obstacles, limitations and difficulties experienced by the Health Department on the provision of PHC services in the Cape Metropolitan Area will be outlined. In the author's opinion the following critique could be levelled against the development of PHC services in the Cape Metropolitan Area:

4.2 LACK OF CLARITY ON NATIONAL PROCESS

In February 2000, the National Health Department established a committee comprising of the National and the Provincial Minister/MECs of Health. The task of this committee was to facilitate the district health system. It was declared that each metropolitan and district municipality area would constitute a health district. Each province was mandated to establish a Provincial Health Authority, which would be composed of councillors responsible for health from each metropolitan

and district municipality and would serve as an advisory body to the MEC with regard to PHC services. However, the PHC services that are not part of the definition of Municipal health services were to be delegated to metro and district municipalities. Such delegations would be by agreement and be regulated by means of a service level agreement. The task team proposed that there should be cooperative governance of all public health services in the proposed health districts. Therefore, the District Health Authority and the service level agreement between the MEC for Health and the local Executive Mayor were proposed as mechanism to achieve this cooperative governance (Minutes of the Health MinMec, 2001:1). The Western Cape Department of Health has been unable to delegate PHC services to the Cape Metro Council (Unicity) despite agreeing to do so in July 2002. The major problems are:

- The Western Cape Provincial Treasury vetoed the Provincial Department of Health's proposal that if the staff at the provincial level rendering PHC services is transferred to the municipal-based PHC level, it will fund improvements in the conditions of service of provincial personnel transferred to the municipalities.
- There is lack of clarity whether it is appropriate to transfer staff if the PHC service is being delegated to the municipality.
- The committee of Ministers of Health adopted a broad definition of municipal health services that could include environmental health, preventive, promotive and curative services. In practice it is very difficult to separate even those preventive and promotive services that should be rendered by municipalities. In essence, the Constitution (1996:65) define municipal health services as environmental health services. The major problem with a narrow definition of municipal health services is that huge amounts allocated for municipal health could be used by municipalities for

other services and this would compel Provincial Health Departments to increase their funding for PHC (Minutes of the Health MinMec, 2001:3).

4.3 FRAGMENTED PHC SERVICES IN THE CAPE METROPOLITAN AREA

PHC services are currently rendered by two authorities, namely the Provincial Health Department and the Municipality. The above has resulted in the fragmentation of service, lack of equity, services are not comprehensive, economically ineffective and inefficient, services are not accessible and are of a low quality. There is clear evidence of fragmented service delivery in the Cape Metropolitan Area. The Municipal Health Department renders preventive and promotive health services such as the treatment and prevention of Tuberculosis (TB), Sexually Transmitted Diseases (STDs), immunisation, health education, family planning, curative services to children under six years, mother to child health and environmental health services. The CHSO renders curative services, school health services, specialised psychiatric services (mental health), antenatal, delivery and post-natal care. The Maternity Obstetric Unit (MOU) falls under PAWC and renders antenatal, post-natal and delivery services (Mtwazi, 2000:29-30).

4.4 SERVICE DELIVERY

According to the study conducted by Leon (2002:4) on the joint facilities (PAWC and municipal authorities) in all of the eight joint facilities, there is one record room, which is shared. When a new patient is admitted, whether the patient seeks a municipal or provincial service, one file will be opened. The clinic road to health baby card is usually inserted into a standard folder to ensure a unified system for adult and children. Although the reception area, the record room and the filing system are all shared, the reception service itself is not always shared. The personnel in reception do not work as a unit. For example, the PAWC clerk will serve PAWC patients and the municipal clerk serves only municipal patients.

In more instances than not, patients are aware that there are different kinds of services offered when they report to the reception. Patients who seek a service for their babies, would report to the "baby clinic" hatch and put their cards in a clearly marked box. To demonstrate the inconvenience experienced by patients, the following can be illustrated: If a patient seeks an adult service, there is no indication at reception to where the patient should go. Once referred to the municipal service for TB and STI follow-up, patients would then report to the municipal reception area. And so the differentiated reception service reflects that the core clinical services have remained separate in these facilities.

4.5 QUALITY AND ACCESSIBILITY OF SERVICE

In the majority of joint facilities, the patient assessment, preparation, treatment and medication is done separately for the two health authorities. There is little cross-over of staff or of functions between authorities in these facilities. Parallel clinical services are rendered. The community health services organisation has one or more full-time doctors on its staff establishment and the municipal health service use sessional doctors for a weekly TB and STI treatment. The doctors at the provincial section do the bulk patient diagnosis and treatment, with nurses doing preparation, injections and dressings. But in the municipal health section, the Clinical Nurse Practitioner (CNP) performs the diagnosis and treatment of sick children under 5 (five) years, instead of a doctor doing such work. On the whole there is very little cross-over of staff or functions and the sharing of staff in the event of staff shortage (Barron and Zwarenstein, 1992:19).

The accessibility of health service is referred by Van Rensburg et al. (1992:30) as the extent to which services and facilities are open to the clientele. In most of the municipal health facilities, the opening time is 08:00 until 16:45 and they operate 5 days a week (Mondays to Fridays), meaning that the patients cannot access

these facilities over weekends. On the contrary, most of the CHSO facilities operate on a 24 hour basis and these include the MOUs. As indicated by Mtwazi (2000:33), the working population of whom the majority leave their homes before 06:00 and return after 18:00 cannot be able to access the health services during the week. Furthermore, Harrison (1997:43) revealed that patients are turned away untreated in health facilities because of staff shortages.

4.6 PHARMACEUTICAL SERVICES

The existing pharmacy service in the clinics is provided by PAWC, and the service is not integrated. These pharmacies only dispense medicine for PAWC staff, while the municipal nurses keep medication in their consultation rooms and directly dispense to their clients. This dual system can be attributed to the fact that the PAWC pharmacies are overloaded to take on a full municipal service. The staff shortage from PAWC pharmacies result in long waiting times for patients (Leon, 2002:3).

4.7 MANAGEMENT

There are 48 public health care facilities in the Cape metropolitan area that are rendering a PHC service. Presently, the management of these facilities shows fragmentation, though eleven are jointly managed by a system of dual or parallel management (See Table 1). Some of these facilities share the same ground, the layouts are similar and others are built in close proximity. The CHSO and municipal services each have a facility manager and a deputy facility manager who are responsible only for their own service and staff. In certain (Delft and Bellville South clinic) facilities with integrated clinical services, there is a single facility manager who holds this position informally. As indicated by Leon (2002:5), the CHSO and municipal health manager, with the support of staff, arrange that one of them would fulfil the managerial role for both services, whilst the other would act as deputy and do clinical work. However, in a larger joint facility such as Vanguard

clinic, a coordinator was appointed to oversee the two facility managers from both authorities. Therefore, the coordinator is in charge of the overall management of the joint facility. To overcome fragmentation and foster good governance, district management teams have been established by CHSO and municipal health management, and they meet on a regular basis to discuss ensuing problems in these various facilities (Kane-Berman, 2000:4). All the maternity obstetric units are managed by PAWC staff.

4.8 EQUITY

Equity is the distribution of health resources based on health needs. Demography (age), health status, HIV/TB/tuberculosis/infant mortality rate, socio-economic conditions such as housing type, access to water, access to electricity, income, adult educational status, and unemployment jointly or severally determine or impact on the population's health needs.

According to Barron and Zwarenstein (1992:18), the PHC principle of equity implies that services delivered in any district of the country should be available to the citizen in any other district as well. There is a need to distribute resources to presently under-resourced areas in the province. At district level there is a need to redistribute resources to services such as STD and TB services, child health services, and to target groups that have previously received less than their due, e.g. children and elderly. A resource allocation formula should be used to distribute resources as in the budget each year, which should be divided up by district according to the population of the district and a measure of poverty in the area. Table 3 reflects the budget expenditure of the City of Cape Town and the Provincial Health Department of the Western Cape. At present the government's formula measures need partly by reported mortality, which in turn is measured by attendance at clinics and use of services. The formula needs to be well managed; it must have clear, measurable goals with target dates.

TABLE 1

Facilities where Municipal Health and Community Health Services Organisations are rendering Health Services in the same Building.

Community Health Centre	Shared Service		24hr Service		MOU Service	
	Yes	No	Yes	No	Yes	No
1. Belhar (St Vincent)	Yes			No		No
2. Bellville South (Kasselsvlei)	Yes			No		No
3. Bishop Lavis	Yes			No	Yes	
4. Brown's farm		No		No		No
5. Cape Town Station		No	Yes	No		No
6. Crossroads 2	Yes			No		No
7. Delft	Yes					No
8. Dr Abdurahman		No	Yes	No		No
9. Durbanville	Yes			No		No
10. Elsie's River		No			Yes	No
11. Good Hope		No		No		
12. Goodwood (Dirkie Uys)	Yes			No		No
13. Grassy Park		No		No		No
14. Green Point (only 1 CCT PN)			Yes	No		No
15. Gustrouw	Yes	No	Yes	No		No
16. Gugulethu					Yes	No
17. Hannover Park	Yes			No	Yes	
18. Heideveld	Yes	No		No		No
19. Hope St Dental				No		No
20. Hout Bay Harbour	Yes	No		No		No
21. Ikhwezi (Only 2 HSO Pns)		No	Yes	No		No
22. Kensington					Yes	No
23. Khayelitsha (Site B)	Yes		Yes	No		
24. Kleinvlei	Yes				Yes	No
25. Kraaifontein (only 3 CCT staff)	Yes	No		No		
26. Lady Michaels		No		No		No
27. Lotus River				No	Yes	No
28. Macassar	Yes			No		
29. Maitland	Yes			No		No
30. Mamre	Yes		Yes	No		No

31.Mfuleni	Yes	No		No	Yes	No
32.Michael Maphonwana					Yes	
33.Mitchell's Plain	Yes					No
34.Nolungile	Yes			No		No
35.Nyanga	Yes	No		No		No
36.Nyanga Junction				No		No
37.Ocean View	Yes			No		No
38.Parow	Yes			No		No
39.Ravensmead	Yes	No		No		No
40.Reed Street		No	Yes	No	Yes	
41. Retreat		No				No
42. Robbie Nurock		No		No		No
43. Ruyterwacht				No		No
44. Scottdene	Yes	No		No		No
45. Strand	Yes		Yes	No	Yes	
46. Vanguard		No				No
47. Werdmuller		No		No		No
48. Woodstock		No				
TOTAL NUMBER: 48	26	22	9	39	11	37

Table 2

Primary Health Care Expenditure of City of Cape Town and Provincial Administration of the Western Cape: Financial year 2001/2002

Description of the facility	Number of facilities	Expenditure	Municipal Revenue	Provincial Revenue	Clients seen per year	Staff
Municipal clinics	109	R215 m	R128 m	R87 m	7 million	1024
Provincial health centres	35	R114 m	Nil	R114 m	2 million	624
Maternity obstetrics units	12	R181 m	Nil	R181 m	2 million	1262
Total	156	R510 m	R 128 m	R383 m	R11 m	2910

Source: City of Cape Town Business Plan: 2001/2002

4.9 SUMMARY

The lack of integrated health service in the Cape Metropolitan area has been a matter of concern for more than two decades. Attempts have been made by local managers and health care workers to come up with an ideal solution, but because of bureaucratic tendencies their efforts have been frustrated. This situation, inherited from the past, led to duplication of services, and thus effectiveness and efficiency was not achieved, inequitable distribution of resources, quality, and access services are compromised, with the result that the delivery of comprehensive services were not achieved.

The criteria for a successful integration of services include effective central policy making and planning, clarity with regard to structures, responsibilities, authority,

reporting, communication channels, job description, roles and relationships. This also requires skilled managers operating in highly effective administrative components with a clear understanding that their function provides an efficient service.

CHAPTER 5

CURRENT DEVELOPMENTS ON IMPLEMENTATION OF PRIMARY HEALTH CARE SERVICES

5.1 INTRODUCTION

The Management of PHC services in the Cape Metropolitan Area combines an extremely fragmented health authority structure with regard to coverage, comprehensiveness, efficiency, equity and costs. As Barron and Zwarenstein (1992:1) stated, the lack of any system to be based upon future planning can be compounded by an inability to plan or manage urgent change, especially fundamental change. Health services are particularly lacking in national health outcome goals and a coherent information system to monitor health outcomes or the distribution and effectiveness of health care services. With due consideration of the restructuring process currently under way in the local government sphere, the following chapter will elucidate the current developments with regard to managing PHC services.

5.2 BI-MINISTERIAL TASK TEAM REPORT

A bi-ministerial task team was established in 1997 by the Ministers of Health and Local Government in the Western Cape Province to investigate the future governance of all PHC services in the Western Cape. The intentions of the task team was to produce a sound policy framework for the implementation of a municipal based health system in the Western Cape and to addresses all the practical steps that need to be considered in the implementation. In addition, the pressure to realign the PHC system along the lines of the internationally accepted district health system (DHS) necessitated the establishment of this task team, also drawing in local managers and health care workers, whose efforts are constantly frustrated by the lack of a single organisation and management system.

According to the bi-ministerial task team report (2000:1), the task team reviewed the existing patterns of delivery of PHC services and found substantial fragmentation between Provincial and Local Government with inefficiencies and duplication throughout these services. It became evident that PHC services are divided between local authorities and provincial government and this was supported by legislation and constitutional framework. This compromises the integration of PHC services. The bi-ministerial task team report (2000:1-2) further recommended that:

- Local government should carry responsibility for the rendering of all PHC services. Therefore, integration will only be successful if the Province were to transfer its PHC functions to local government with full funding for these transferred functions.
- The PHC service is structured as a public partnership, with the Province providing the bulk of funding and local authority rendering the service.
- The transfer of all PHC services will result in the transfer of approximately 100 provincial facilities and their staff to local government. The bulk of the transfer will take place in the Metropolitan area. Currently the local authorities already operate approximately 400 clinics and small community health centres.
- A personnel subcommittee should review legislation and policy pertaining to the transfer of staff between authorities, and to analyse the differences in conditions of service between these authorities.
- About 2119 staff should be transferred in terms of the provisions of the Labour Relations Act, 1995 (Act 66 of 1995), and a collective agreement of the Provincial Bargaining Chamber.
- A new organisation, which incorporates the transferred services, will need to be developed by the local authorities in consultation with the Provincial Health Department to accommodate both local government and provincial PHC staff in a fair and equitable manner.
- A core-package of PHC services to be provided. This range of services would include inter alia preventive, promotion, curative, rehabilitation

services, school health services, oral health services, community health services, environmental health and basic health services.

- The scale and range of services to be provided would be the subject of mutually-agreed performance contracts that are negotiated annually and are linked to the resources available.
- In order to prevent an unfunded mandate to local authorities, The task team recommended that Provincial Government guarantee funding at a minimum of the current level for at least 5 years. After 5 years funding is to be guaranteed at levels equal to the current proposition of the provincial budget spent on those PHC that have been transferred. Should funding levels be insufficient to maintain the level of services, local government, in consultation with provincial government, may reduce services to the affordable level?
- Hospital services are excluded from the package and will be run by the Provincial Health Department, with the exception of selected smaller district hospitals that may be transferred to local government at a later stage.

5.3 OBSTACLES TO IMPLEMENT A DISTRICT HEALTH SYSTEM BASED ON PRIMARY HEALTH CARE

The National Minister of Health and the nine Provincial MECs for Health in February 2001 took the following decisions regarding the implementation of the district health system and the role of local government in health service delivery (Minutes Health MinMEC, 2001:1).

At provincial level, the district and the metropolitan council areas shall be the focal points for the organisation and co-ordination of health services. The Provincial Department of Health shall be responsible for coordinating the planning and delivery of district health services within the district. Each province was mandated to establish a Provincial Health Authority (PHA) to advise the MEC for Health on health matters and the PHA is to comprise of the MEC for Health and the Councillors responsible for health in a district or metropolitan

council. Furthermore, the head of the Provincial Department is to establish a Provincial Health Advisory Committee and its functions will be to coordinate the planning and delivery of health services and to advise the Provincial Health Authority on health matters. In addition, the MEC for Health was mandated to facilitate the establishment of District Health Authorities (DHA) and community health committees within the district council and metropolitan council areas.

The MinMEC committee also agreed that the delivery of such services should be coordinated with due regard to similar services rendered by the national and provincial departments in which the district is situated, to eliminate fragmentation and duplication of health services and to improve efficiency, effectiveness and equity.

Despite the directives from the MinMEC, the Western Cape Department of Health has been unable to delegate PHC services to the Cape Metropolitan Council. The major problems that could be cited include the following: The Western Cape Provincial Treasury vetoed the Provincial Department of Health's proposal that it will fund improvements in conditions of service of provincial personnel transferred to the Cape Metropolitan Municipality. Unions questioned whether it was advisable or even possible to transfer staff if the service was being delegated in terms of the Constitution of the Republic of South Africa, 1996 (Act 108 of 1996). The lack of national processes to facilitate the transfer of staff from province to local government also posed a problem.

A narrow definition of municipal health services by the Constitution includes environmental and excludes preventive, promotion, and curative services. This is presenting a major problem. In practice it is very difficult to separate those preventive and promotion services that should be rendered by the Province and those that should be rendered by municipal health. With such a narrow definition about R1 billion of municipalities' own revenue may be used to provide health services nationally and could thus be lost to the health system. Therefore, if

municipalities use these funds for other purposes, the Provincial Health Department would have to increase their funding for PHC. Though it seems possible to transfer staff from province to municipalities in terms of section 189 and 197 of the Constitution, this issue still needs to be raised in a joint sitting of the Health and Welfare Sectoral Bargaining Council and the South African Local Government Bargaining Council. (Minutes of the Health MinMEC, 2001:4).

5.4 RECENT AGREEMENTS ON THE IMPLEMENTATION OF PRIMARY HEALTH CARE SERVICE

Recent attempts to integrate PHC services to be rendered by a single authority, caused the Provincial and local authorities to take a decision to establish a service agreement between the two parties. This is based on the acknowledgement of the importance of health priorities set by National and Provincial Government outlined in the White Paper on the transformation of the health system (April 1997) that calls for delivery of a comprehensive PHC package through municipality-based district health systems. This has been also influenced by the Western Cape's Provincial Health Plan that provides for the creation of an integrated district-based PHC service in the Western Cape. After a comprehensive investigation, the Western Cape Provincial Cabinet adopted a resolution on 1 October 2001 containing inter alia, the following key mandates:

5.4.1 Service Level Agreement

The service level agreement entails the following:

- It provides an in principle decision to consolidate PHC services within a municipality-based district health system.
- It grants approval to proceed with the implementation of a municipality-based PHC system initially only in the Metropolitan health region.

- It grants approval to establish an appropriate regulatory platform for rendering PHC services through service agreements in the whole of the Western Cape.

Furthermore, the City of Cape Town (Unicity) and Provincial Government of the Western Cape (Health Department) agreed to the creation of an integrated district – based PHC service in the City of Cape Town. The Province agreed to delegate power and duties to the City. It was also agreed to transfer Provincial Metropolitan Health district services, staff and assets. The Province also set to resource all agreed provincial PHC services to the City. The Province would set up accounting and monitoring procedures and systems. Both the City and Province agreed to establish a joint management and political governance structure. In addition agreement was reached to amalgamate Provincial health services, staff and facilities with those of the City. The remaining Provincial PHC duties would be to provide an effective monitoring and support service to the City, and provide for the development and establishment of new integrated PHC service within 5 years (City of Cape Town, 2002:1-2).

However, the following powers were not delegated to the City in terms of the agreement:

- The Province is to retain the legislative authority to approve the budget for the agreed services rendered on its behalf by the City.
- The City may not approve any municipal rates, taxes and levies for the rendering of the agreed services.
- The City may not raise any capital loans in relation to the agreed services.

It was proposed that the implementation should take place in two distinct phases, each with its characteristics, time frames and obligations:

- (i) Phase 1 will be called the “Amalgamation Phase” and will structure the implementation process up to the transfer date.

- (ii) Phase 2 will be called the “Integration Phase” and will structure implementation from the transfer date for the first five municipal financial years thereafter.

5.4.2 Interim governance

The Province has been mandated to establish an ad hoc advisory committee on which equal and proportional representation would be provided for the Provincial Legislature and the Council of the City, under the chairmanship of the Minister of Health of the Western Cape. The ad hoc advisory committee would be the main political negotiating body between the parties. It will coordinate all elements of the transformation process of PHC services. It was also agreed that the ad hoc advisory committee will inform the employers' caucus relating to health matters pertaining to the transfer of staff. It will also provide advice to the Provincial Minister with regard to matters pertaining to the establishment of a district based PHC service in the city.

5.4.3 Joint management

A joint management committee will be formed by the Deputy Director General: Health Operations of the Provincial Department of Health and the Director: City Health to oversee the technical process pertaining to the transfer and amalgamation of the district-based PHC service in the City of Cape Town. Furthermore, the City and Province may agree to implement joint management arrangements at the level of facilities, sub-district and health districts.

5.4.4 Interim Financial Arrangements

The Province will finance the actual expenditure incurred by the City with regard to the following aspects of municipal PHC: approved capital grants,

Protein – Energy Malnutrition scheme, drug costs for tuberculosis treatment, family planning drugs and materials, curative drugs according to the essential drug list for treatment based on the Province protocols, laboratory costs, voluntary counselling and testing for sexually transmitted diseases. On the other hand, the City is expected to submit quarterly reports on its expenditure with regard to the actual cost of performing in accordance with the protocol. The City will take on the maintenance of buildings and equipment which are owned by the Province. The payment of salaries and wages and the funding of employee benefits in respect of health staff employees by the Province are to be managed by the City, and the City undertakes to pay for such services. The above will enable the Province to comply with the provisions of the Public Finance Management Act, 1999 (Act 1 of 1999) and satisfy the Provincial Treasury who vetoed the process due to financial implications. As a result the implementation date has been set to be 1 July 2003.

5.4.5 Primary Health Care Core-package

As indicated by Department of Health (2001:5), the purpose of this package is, in the perspective of equity, to define comprehensive PHC services which within 5 years following implementation will be common to the whole country. This package would help to quantify requirements of staffing, infrastructure, equipment and financial resources. The following is a synopsis of the PHC core-package outlined by Department of Health (2001).

TABLE 3

Comprehensive Primary Health Care services Package in the district.

Category	Service
1. Personal promotive and preventive services	* Family planning * Immunisation

	<ul style="list-style-type: none"> * Health education * Nutritional/dietric services * Screening of common disease
2. Personal curative services	<ul style="list-style-type: none"> * Acute minor ailments * Trauma * Endemic * Other communicable and chronic disease
3. Maternal and child health services	<ul style="list-style-type: none"> * Antenatal care * Deliveries * Post-natal and Neonatal care
4. Provision of essential Drugs	* Prescribed Drugs for PHC
5. PHC level investigative services	<ul style="list-style-type: none"> * Radiology * Pathology
6. School and institutional health services support	<ul style="list-style-type: none"> * Oral health * Audiology * Optometry
7. Health services support	<ul style="list-style-type: none"> * Epidemiology and health information * Health monitoring * Planning and administration

Source: Department of Health (2001)

5.5 SUMMARY

Taking all the above developments into account to implement a municipal based district health system which is in line with the principles of primary health services, there are bottlenecks in the process, such as clarity on governance of the service, definitions of municipal health services, and the

unwillingness by the Provincial Treasury to pay the shortfall which may come about when Provincial staff is transferred to the City. Because of the foregoing the integration process has been kept on hold pending the political intervention and the go-ahead from the Provincial Treasury.

CHAPTER 6

FINDINGS AND RECOMMENDATIONS

6.1 INTRODUCTION

The aim of the research was to explore how PHC services have developed in the Cape Metropolitan Area. The following objectives were followed:

- Outlining the various phases which PHC have undergone in the Cape Metropolitan Area.
- Identification of the extent of duplication of services caused by the fragmentation
- of PHC services rendered by the Provincial and Municipal Health Departments.
- Exploring and identifying the obstacles and limitations in terms of the management of comprehensive PHC.
- To establish elements of PHC services that could be rendered in a comprehensive manner.
- To give recommendations as to how PHC services could be improved.

The research has been largely exploratory and descriptive in nature. The fragmented nature of the public health services, which is further compounded by the poor coordination of services delivery between the authority structures, clearly impacts on the quality of services rendered. It became evident that the disproportionate distribution of resources in the form of personnel, services and facilities, the unequal provision and availability of services and facilities and the differential quality of services all directly contribute to the quality of PHC services rendered.

6.2 FINDINGS

In view of the above, the following findings have been reached:

6.2.1 Fragmentation of Health Services

Health services in the Cape Metropolitan area give rise to an extremely fragmented health authority structure. These services are rendered by two authorities, namely: the Municipal Department and also the Community Health Services Organisation under the auspices of the Provincial Administration of the Western Cape. Municipal health services comprise preventive and promotion health, whereas Community Health renders services such as curative care, school health services, mental health, delivery and post-natal care.

There is a maldistribution of health services that is compounded by the geographical and demographical layout of the area, inaccessibility and inequality of services rendered.

It became evident that there is a gross functional fragmentation and that joint facilities do not necessarily mean that they constitute integrated facilities. Management systems are not integrated and a dual system exists whereby managers from both authorities manage the facilities differently. There is minimal coordination of services between CHSO and Municipal Health which is the reason why there is an overlap in service delivery. Poor coordination of services inconvenience members of the community, who are often sent from pillar to post for treatment of such widely differing conditions as sexually transmitted diseases to minor ailments.

6.2.2 Inaccessible Health Services

A further problem is the inaccessibility of health services. Van Rensburg et al. (1992:30) referred to this as the extent to which services and facilities are open to the clients. Municipal health clinics operate eight hours a day and five days a week, and as a result clients who want to access these services over weekends are not able to do so. In contrast CHSO facilities operate twenty four hours a day and also operate over weekends. The unavailability of the full spectrum of services to the community is exacerbated by this fragmentation of services.

6.2.3 Quality of Services

The quality of services rendered is affected by the poor coordination of services by different authorities. This can be clearly illustrated by inequality with regard to distribution of resources in the form of personnel, and services rendered. In the combined health facilities, patients are compelled to queue twice in order to access the service rendered by two authorities. The lack of a "one stop shop" approach to health care compromises the quality of such care and this is exacerbated by the long waiting times caused by the high workloads in the facilities.

6.2.4 Lack of Policy Direction and Planning in relation to Health Needs

There is a lack of strategic planning and effective management. There has been a rapid expansion of the services provided by both authorities, without adequate resources being provided. These include services such as Voluntary and Counselling, (VCT) of HIV+ clients, and the prevention of mother to child transmission (PMTCT), with no provision of additional personnel. This has resulted in a major increase in the workload for most categories of staff. Because of the parallel management of services in joint facilities, the sharing of staff to overcome staff shortages cannot be

implemented. The expansion of services had a significant impact on the administrative and other support services, without a concomitant increase in resources.

Decision making by both authorities is centralised and this result in indecisiveness amongst the staff and this consequently causes ineffectiveness.

6.2.5 Legislative Uncertainty

The current definition of municipal health services in terms of the new National Health Bill could fundamentally alter the service relationship and allocation of responsibility between the City of Cape Town and the Provincial Administration of the Western Cape. The narrow definition of municipal health services as environmental health, excluding preventive and promotive services, could overburden the province with massive additional funding responsibility of PHC services by the Provincial Health Department. If the definition of municipal health services is to include environmental health services, then the annual financial budget of provincial health districts will increase by R197 million, which is the estimated City contribution minus the cost of environmental health services.

6.2.6 Status of Current Services Relationship

The existing basis of funding or subsidisation and the service relationship between the Provincial Health Department and municipalities remains unclear. The result is that the City of Cape Town does not have a clear mandate to finance provincial aspects of health services from its own revenue, exposing the validity of its budget. The Province cannot comply with the provisions of the Public Finance Management Act and the dispute

on financial shortfalls and deficits increase as the service and funding relationship gets out of touch with the service mandate.

Therefore, the risking of a R7 billion City of Cape Town operating budget would be the result of not addressing the current service relationship with the Provincial Health Department. In all probability this is the most significant risk facing the parties.

6.2.7 Structural Growth in Service Demand and Cost

It became evident that the City of Cape Town was facing the risk that the PHC services would escalate beyond the limitations of the funding budget. Therefore, if the agreement between the Provincial Health Department and the City of Cape Town does not allow for an adjustment for such an occurrence, then the City's exposure will be unacceptable. The following escalations of costs are envisaged: Increased patient load due to the effect of AIDS / HIV, referral of patients from the secondary hospitals, currency deterioration affecting the cost of medicine and the loss of medical aid coverage for middle class people because of the escalation of medical aid fees.

6.2.8 Transfer of risk

If PHC services are moved to the municipal based district health system, there will be no transfer of service risk, since the delegation mechanism in terms of the Constitution (1996:50) is followed. This basically means that the Provincial Health Department remains the legislative authority with full financial responsibility for the service rendered and retains all liabilities.

6.3 RECOMMENDATIONS

Based on the conclusions drawn, the following recommendations will attempt to provide a climate for and a vision of an ideal health service for the Cape Metropolitan area:

OPTION A: Municipal - based district health system

6.3.1 A Single Health Authority

In order to overcome the fragmentation of services, promote comprehensive health services and equity, avoid duplication and foster local accountability, a single health authority should be established in the Cape Metropolitan Area. Therefore, a district health system would be ideal and this district should be able to offer a basic package of services, including all of the preventive and promotive services, and basic curative and rehabilitation services. The present ethnic boundaries should be replaced by socio-economic topographic boundaries which draw together coherent economically functional units. These district boundaries should match those of local administrative structures. The following principles of a district health model, as outlined by the Draft Provincial Health Plan (1995:43), should be adhered to

- District boundaries should be coterminous with administrative and political boundaries in order to facilitate management, administration and accountability to the people within that district;
- District boundaries should be coterminous with the administrative boundaries of other service sectors in order to facilitate multi-sectoral actions and collaboration;
- Districts should be of such a size as to enable the effective participation in the management of the district health service by the people within that district;

- Districts should be of such a size to enable the efficient and effective provision of comprehensive health care services, up to and including the non-specialist level one hospital.
- The district health authority is responsible for the co-ordination of all health-related activities within the district, including those of the public sector, the private sector and health related non-governmental organisations;
- All public sector health services within the district to be the responsibility of a single authority (the district health authority), which has the competence to manage the services in the district with norms, standards and policy guidelines of the National and Provincial Health Authorities;
- The district health authority and its services are monitored and supported (including financial support) by the Provincial health authority and its services. This Provincial monitoring and support may be rendered via the regional offices of the Provincial health authority.
- The district health authority should be situated within the lowest practicable level of government. Ideally, this will mean local government, but this will be dependent upon the local government's areas of jurisdiction broadly corresponding to the requirements outlined above. In particular it is essential, from the point of view of health and health service delivery, that a single authority be responsible for the health of town, rural and farm communities within any given district area.

6.3.2 Integrated Primary Health Care Approach

Based on the above findings, the municipal-based district health system is proposed as an ideal approach to render PHC services because of the interface between municipalities and their local communities. If this

approach is followed the health system and services will be provided in a manner which ensures that they are caring, high quality services at levels, and also responsive to the needs, rights and dignity of patients. The PHC approach should, therefore, embrace the following:

6.3.2.1 Equity

The Health Department structure must enable the achievement of equity, particularly of access to services of comparable quality. Therefore, equity of expenditure will be achieved when there is equality of public health care throughout the Cape Metropolitan Area, which is currently lacking.

6.3.2.2 Comprehensiveness

The district health system should promote intersectoral actions and collaboration, at community, district and provincial levels, for the achievement of optimal health of the inhabitants of the Cape Metropolitan Area. The structure should ensure a fully integrated comprehensive (promotive, preventive, curative, rehabilitation) and multi-disciplinary approach to health care. There should be provision for an integrated referral and support system, supported by the appropriate training of personnel working at different levels. It is also necessary for the structure to allow for the active promotion of community participation in all stages of health care delivery, planning, implementation and evaluation. Furthermore, the service needs to be accessible, cost-efficient, affordable and sustainable.

6.3.2.3 Implementation of the National Department of Health Directives

The Western Cape Province should implement the proposals of the MinMec – February 2001 meeting which included the following: It is the central Department of Health's responsibility to set broad policy for the country, coordinate and distribute national resources and to monitor the performance of regions and districts. The national committee of the National and Provincial Ministers of Health took a decision that all provinces should restructure their health services. Therefore, each Metropolitan and district municipal area should constitute a health district. A Provincial Health Authority should be established which is composed of Councillors responsible for Health from each Metropolitan and local area. They should serve as advisors to the MEC for Health. PHC services that are not contained within the definition of municipal health services should be delegated to Metro and district municipalities. Such delegation should be by agreement, with the necessary resources and be regulated by means of a service level agreement. There should be cooperative governance of all public health services in the district. Though PHC services will be delegated to municipalities, the Province needs to remain financially responsible for PHC. Management authority should, however, shift to the municipal manager and district health manager through an agreement between the MEC for Health and the relevant Executive Mayor.

6.3.2.4 Strategic Planning and Management

As stated previously, there is a system of dual management of health services in the Cape Metropolitan Area. With the implementation of a district health system, the Metro area should be divided into sub-districts, which are managed by district management teams. This will enable the decentralisation of management functions, as opposed to the current centralisation of management functions. At the sub-districts level, senior management would assess the resources available, the national goals and other procedures, local specific conditions and also the relevant health status. On the basis of the above they would try to optimise resources within the sub-districts. Middle management would design and lower level management would implement plans. All levels would consult with communities, respond to their ideas and incorporate these into their programmes. Financial management and budgeting will be sub-district based. Since one of the principles of PHC is that of participatory management, therefore, the organisational style required of the district system management team is open, flexible and participatory.

OPTION B: Provincial Government Option

Alternatively, if the above recommendations cannot be implemented, the following steps could be followed:

- A political decision by the Provincial Executive Council is required regarding the governance of the district health system. As soon as this decision is taken, detailed planning and negotiation with relevant State and Provincial Departments, with employee bodies and with local

government bodies regarding the transfer of personnel to the relevant employing authority can be initiated. It cannot be emphasised strongly enough that the entire process of establishing functional health districts rests on this political decision being made.

- If, as is recommended in this report, the district health services are to be the responsibility of provincial government, it is recommended that the Provincial Services Commission, in consultation with the National Public Services Commission and with the with the Departments of State Expenditure and of Finance, take responsibility for developing proposals for the transfer of personnel currently employed by local government authorities to the Provincial Health Department, and for the steps which will be necessary to achieve parity in salaries and service conditions within an acceptable time-frame.
- Discussions will also have to be initiated with the relevant local government bodies regarding the possible transfer of the lease of health facilities at present owned by these bodies. In this regard, it should be borne in mind that the great majority of these facilities were initially at least, and in many instances continue to be largely funded with public funds provided by various State Departments.
- It is recommended that, pending the amalgamation of all the public sector health services, a mechanism be established to impose the same moratorium on the filling of vacant local authority health posts as currently exists with regard to Provincial Administration posts.
- It is recommended that, within each of the proposed health districts, a district health working group be established as soon as possible.

CHAPTER 7

CONCLUSION

7.1 CONCLUSION

South African citizens have been faced with a fragmented Primary Health Care services for more than two decades. Historically, the Provincial Administration of the Western Cape has been responsible for curative health services and the local authority for prevention services. But in practice one cannot separate the two services. Hence there is a dire need for the integration of these two levels of authority. The health care system traditionally emphasised curative care that is not effective in improving the health of the whole population. There is a maldistribution of health services along race, place of residence and wealth. Previously patients had to seek treatment from facilities run by the Provincial Administration, the former House of Representatives, two tiers of local government and non-governmental organisations. On the whole the health services were poorly managed and there was lack of planning. The central Department of Health had responsibility for setting broad policy for the country and matching goals, co-ordinating and distributing national resources. It is still the responsibility of the National Health Department to monitor performance in provinces and districts. This ensures equity and brings about rational plans, which are in line with National Government policy and directives.

The major obstacles delaying the implementation of PHC at the district level are multifold, namely the lack of goals, the absence of consensus on what PHC is, and the lack of a proper information system. The prolonged period for the transition of PHC impacts on the moral of the health personnel. New health patterns are needed, as health problems change and communities become older. Furthermore, these new health problems are influenced by the political situation that prevails.

Resistance to change by many professionals and managers is the root cause of the delay to implement the PHC model. Currently, authorities battle to control over shrinking of public sector resources, and the backlog of inequity still has to be resolved. This is further exacerbated by the severe shortage of managerial skills at provincial and local level.

In order to implement an effective and efficient PHC model, it is imperative that a basic package of PHC service should be agreed upon to ensure the equitable distribution of resources, and of a comprehensive and integrated service delivery. Decision making should take place at a district level and tasks should be delegated to the lowest level. Evaluation and information should become central to managing the service.

All PHC services should be integrated under one authority, and restructured along district and regional lines. These services should be horizontally integrated, with most services being available every day of the week. Therefore, a “one stop approach” should be implemented whereby services, such as baby clinics, antenatal and post-natal clinics, family planning, and also adult curative services are rendered on a daily basis. In order to achieve this, an enabling legislation to facilitate the integration process is of paramount importance.

LIST OF REFERENCES

- Amonoo-Lartson, R., Ebrahim, R., Lorel, G.J. and Ranken, J.P. (1994). *District Health Care: Challenges for planning, organisation and evaluation in developing countries*. Macmillan Education, Ltd (pty), London.
- Barron, P. and Zwarenstein, M. (1992). *Managing primary health care in South Africa at the district level: MRC/IUPHC workshop*. Centre for Epidemiological Research, MRC, Cape Town.
- City of Cape Town, (2001). *Health services business plan*. Department of Health, Cape Town.
- City of Cape Town (2002) *Service Agreement on the creation of district based Primary Health Care services between Provincial Administration of the Western Cape and the City of Cape Town*, 25 February 2002, Working document, Cape Town.
- City of Tygerberg, (1997). *Health department proposed micro-organizational structure*. Health department, Cape Town.
- Cloete, J.J.N., (1998). Central, regional and local government institutions in South Africa. JL van Schaik Academic, Pretoria.
- De Beer, J., (1976). A forward view of health services in South Africa. *South African Medical Journal*, 50(1): 431-440. Pretoria.
- Delport, A. (Eds) (1997). *Official South African local government yearbook 1997/8*. Johannesburg.
- Department of Health, (1997). *The white paper for the transformation of the health system in South Africa*. The Republic of South Africa, Pretoria.
- Department of Health, (2000). *The Primary Health Care package for South Africa: a set of norms and standards*. The Republic of South Africa, Pretoria.
- Ministry for Welfare and Population Development (1998) White paper on population policy for South Africa. *Government Gazette*, 7 September 1998, 399 (19230), Pretoria, Government Printers.
- Gluckman Commission, (1944). *Report of the national health services commission*, Department of Health, Pretoria.

- Health services task team report: 4th November 2001. Commissioned by the Provincial Administration of the Western Cape and the City Of Cape Town, Cape Town.
- Health Systems Trust. (2000). *Biministerial task team report on the implementation of the district health system in the Western Cape*. Provincial Administration Western Cape, Department of Health, Cape Town.
- Harrison D. (1997). Saving the system. *Making Primary Health Care work*, 14(1), Medical Research Council/ Institute of Urban Primary Health Care, Cape Town.
- Kane-Berman, J. (2000). *Report on the investigation into the management of the community health services organization*. Provincial Administration Western Cape, Department of Health, Cape Town.
- Leon, N.H., (2002). District Health Systems. Integration at joint Primary Health Care facilities in the metro region. (unpublished report)
- Ministry of Health and Social Services (1995) *Draft Provincial Health Plan*, for public comment. Strategic Management Team Western Cape Province, Cape Town.
- Minister of Health (2001) Minutes of the Health Ministers and Members of the Executive on: *the implementation of the district health system and the role of local government in health system delivery*, 13 February 2001. Pretoria.
- Mtwazi, L.M., (2000). *A district health system for Khayelitsha*. Unpublished dissertation, University of Stellenbosch.
- Owen, C, P. (1995). *A policy for the development of a district health system for South Africa*. compiled by the Health policy coordinating Unit on behalf of the national District Health System Committee, Department of Health, Pretoria.
- Proclamation 18 of 1995. Establishment of the Cape Metropolitan Area.
- Proclamation 27 of 1996. Transfer of staff, assets, liabilities, obligations and duties.
- Restructuring of local authority (1998). *Cape Times*, 12 January 1998.
- Rondinelli, D.A. (1981). Government decentralization in comparative perspective: Theory and practice in developing countries. *International review of administrative science*, Vol47 (2): 133-145.
- Savage, M. (1979). In Westcott, G. and Wilson, F.A.H. (Eds), *The political economy of health in South Africa*. (p140-156). Revan Publishers: Pretoria

- The Constitution of the Republic of South Africa, 1996* (Act 108 of 1996) as adopted on 8 May 1996 and amended on 11 October 1996 by the Constitutional Assembly: annotated version / [Christina Murray, Friedrich Soltau].
- The Republic of South Africa (1977). *The Health Act, 1977* (Act 63 of 1977)
- The Republic of South Africa (1995). *The Labour Relations Act, 1995* (Act 66 of 1995)
- The Republic of South Africa (1993). *The Local Government Transition Act, 1993* (Act 209 of 1993)
- The Republic of South Africa (1999). *The Public Finance Management Act, 1999* (Act 1 of 1999).
- The Republic of South Africa (1919). *The Public Health Act, 1919* (Act, 36 of 1919).
- Van Rensburg H.C. J. Fourie A. and Pretorius E. (1992). *Health in South Africa: structure and dynamics*. J.L van Schaik, Pretoria.
- World Health Organization. (1990). Report of a World Health Organisation review. Local Government focused acceleration of Primary health care. Nigerian experience
- World Health Organization. (1978). Alma-Ata Conference on Primary Health Care, Annual WHO Conference: Geneva.
- Zini, A. (1984). *Piercing together health in the homelands. Second carnage inquiry into poverty and development in Southern Africa*. South African Labour and Development Research Unit, School of Economics, University of Cape Town.
- Zwi, A. B. & Saunders, L. D. (1985). *Towards health care for all*. Namdo Publishers, Johannesburg.