

**A CRITICAL ASSESSMENT OF THE QUALITY OF DECENTRALISED
PRIMARY HEALTH CARE SERVICES IN THE CAPE METRO DISTRICT
OF THE WESTERN CAPE**

By

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ABSTRACT

A critical assessment of the quality of decentralised Primary Health Care Services in the Cape Metro District of the Western Cape

The complex and multi-facet decentralisation process of Primary Health Care services in the Cape Metro District of the Western Cape will be critically assessed in this thesis. Primary Health Care is the provision of promotive; preventative; curative and rehabilitative services within the community setting. South Africa initially adopted the Primary Health Care strategy in 1978 as a member state of the World Health Organisation but this was during the Apartheid regime which did very little about implementing the strategy. In 1994 the Government of National Unity (GNU) came into power and there was a renewed commitment to implementing Primary Health Care in order to render health care services to the previously underprivileged masses. The GNU set an eight year time frame for the full implementation of this process from the date of commitment. Now more than ten years later an assessment of the process is necessary to determine if the objectives of the process has been achieved. An independent organisation such as the Health System Trust has in 1998 and 2003 provided some form of evaluation of the process and this will also be discussed in thesis.

The District Health system is part of a unitary Provincial Health System that is decentralised to enable the centre (Provincial Management) and the periphery (District and Sub-district Management) to function more effectively and cooperatively. The District Health System is the management structure for primary health care services as this system allows for interaction of all the role-players involved in delivering health care at district level as it puts in place a decentralised Health Management team who is responsible for the planning, managing, implementing and monitoring of the Primary Health Care Package of care at district level. In summary the district is the place where community needs and national priorities are reconciled. This thesis will therefore show the disjuncture that exists

Abstract, acknowledgements and table of contents

between the Primary Health Care policy intent, the policy implementation and the service delivery outcomes on the ground level.

The general objective is to do a critical assessment of the Quality of Decentralised Primary Health Care Services in the Cape Metro District of the Western Cape. More specific objectives for the research include: Defining and discussing the Primary Health Care Approach and the District Health System using the target indicators currently used by the City of Cape Town and the Provincial government of the Western Cape Health department to assess the impact of this process. To document the implementation process of the District Health System in the Cape Town Metro District as a case study while analysing the findings in terms of successes, constraints, challenges; and make recommendations for the way forward.

The methodology of the study is of a qualitative and descriptive nature. The research design is a case study of the Cape Metro District. The target population will be all those accessing primary health care services in this district. The sample technique is selected by convenience. Data will be gathered directly and indirectly by doing observation and semi – structured interviews and the administration of questionnaires. The framework criteria for assessing the quality would for example include key indicators such as for example the ratio of Professional Nurse to patient; number of health services per three kilometre radius as per the Comprehensive Service Plan 2007 goals and the availability of essential drugs as per primary health care protocol. This directly relates to the key elements that underpin the District Health System namely: equity, access, quality, effectiveness, efficiency, sustainability, overcoming fragmentation, intersectoral approach and community participation.

The main findings indicate that not enough resources have been allocated to the decentralising process causing much delay in its implementation. Shortages of health professionals, infrastructure constraints and poor adherence to legislation also contribute to the delay in implementation. This is why to date the four health districts of the Cape Town Metro District is not fully functional and the quality of the service they provide do not fully adhere to the 2010 Health Care Plan Model.

KEY WORDS OR PHRASES

1. Primary health care
2. District health system
3. Public sector service integration
4. Health care service delivery
5. Nursing work load
6. City of Cape Town
7. 2010 health care plan
8. Metro health district services
9. Comprehensive service plan
10. Decentralisation of health services



DECLARATION

I declare a critical assessment of the quality of decentralised primary health care services in the Cape Metro District of the Western Cape is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.



Signed:

.....September 2008

Neshaan Peton

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Abstract, acknowledgements and table of contents

ACRONYMS

CHC	Community Health Centres
CSP	Comprehensive Service Plan
DHS	District Health System
DMT	District Management Team
LA	Local Authority
MDHS	Metro District Health Services
COCT	City of Cape Town
MTEF	Medium Term Expenditure Framework
GNU	Government of National Unity
DOH	Department of Health
NGO	Non Governmental Organisation
PHC	Primary Health Care
SLA	Service Level Agreement
RMR	Routine Monthly Report
PDR	Plan Do and Review
PGWC	Provincial Government Western Cape

TABLE OF CONTENTS

ABSTRACT	II
KEY WORDS OR PHRASES.....	IV
DECLARATION.....	V
ACKNOWLEDGEMENT	VI
ACRONYMS	VII
TABLE OF CONTENTS.....	VIII
TABLE OF TABLES.....	X
TABLE OF FIGURES	XI
CHAPTER 1: PRIMARY HEALTH CARE AND THE DISTRICT HEALTH CARE SYSTEM	1
1.1 INTRODUCTION.....	1
1.2 BACKGROUND AND CONTEXT.....	2
1.3 PROBLEM STATEMENT.....	6
1.4 OBJECTIVES AND SIGNIFICANCE OF THE STUDY	8
1.5 METHODOLOGY, DESIGN, OPERATIONALISATION AND LIMITATIONS OF THE STUDY	9
1.6 CHAPTER OUTLINE AND STRUCTURE OF RESEARCH REPORT	12
CHAPTER 2: LEGISLATION AND PRIMARY HEALTH CARE.....	14
2.1 INTRODUCTION.....	14
2.2 THE ROLE OF THE WORLD HEALTH ORGANISATION IN DEFINING PRIMARY HEALTH CARE AND THE DISTRICT HEALTH SYSTEM.	14
2.3 INFLUENCE IN HEALTH POLICY	18
2.3.1 The Constitution of the Republic of South Africa, Act 108 of 1996.....	18
2.3.2 National Health Act, No .61 of 2003	20
2.4 THE ROLE AND RESPONSIBILITY OF GOVERNMENT	22
2.4.1 The BI-Ministerial Task Team Recommendations	23
2.4.2 Spheres of Government and the Health District.....	23
2.4.3 Institutional Agreements.....	27
2.4.4 Service Level Agreement	28

Abstract, acknowledgements and table of contents

2.5 IMPLEMENTING HEALTH CARE 2010	29
2.5.1 <i>Setting Target Indicators for the District Health Care System</i>	29
2.5.2 <i>The 2010 Health Care plan 3A3E Model as an Indicator.....</i>	30
2.6 SUMMARY.....	31
CHAPTER 3: THE CAPE METRO DISTRICT AS A CASE STUDY	32
3.1 INTRODUCTION.....	32
3.2 THE CAPE METRO DISTRICT	32
3.2.1 THE KLIPFONTEIN SUB-DISTRICT.	34
3.3 REVIEWING THE PROGRESS IN METRO DISTRICT HEALTH SERVICES ORGANISATION	35
3.4 THE STRATEGIC CONTEXT FOR SETTING TARGET INDICATORS.....	38
3.4.1 <i>The Millennium Development Goals 2015</i>	38
3.4.2 <i>The priorities of the National Department of Health</i>	38
3.4.3 <i>Health Care 2010 Targets.....</i>	39
3.4.4 <i>Strategic Objectives of the District Health Services and Programmes Western Cape Department of Health</i>	39
3.5 THE DISTRICT HEALTH SYSTEM IN THE CAPE METRO: NEXT STEPS.....	40
3.5.1 <i>The road to decentralising health</i>	41
3.5.2 <i>Why decentralisation has been an option for health in South Africa.....</i>	42
3.5.3 <i>Health Planner Implementation</i>	45
3.5.4 <i>Joint City of Cape Town and Provincial Government Western Cape Plan Do and Review Results as per targets set for 2007/8.....</i>	48
3.6 SUMMARY	49
CHAPTER 4: QUALITY OF DECENTRALISED PRIMARY HEALTH CARE.....	50
4.1 INTRODUCTION.....	50
4.2 HEALTH CARE 2010: A PLAN TO ENSURE THE DELIVERY OF QUALITY HEALTH CARE IN THE WESTERN CAPE.....	50
4.3 DEFINING QUALITY:	54
4.4 BARRIERS TO PROVIDING QUALITY HEALTH CARE.....	57
4.4.1 <i>Communication</i>	57
4.4.2 <i>Financial Constraints.....</i>	58
4.4.3 <i>Shortage of staff.....</i>	58
4.4.4 <i>Staff morale</i>	59

Abstract, acknowledgements and table of contents

4.5 SPECIFIC QUALITY INDICATORS FOR KLIPFONTEIN.....	59
4.5.1 Results of waiting time survey.....	60
4.5.2 Consumer Perceptions	62
4.5.3 Staff perceptions.....	70
4.6 SUMMARY	79
CHAPTER 5: ANALYSIS OF FINDINGS CHALLENGES AND CONSTRAINTS OF PROVIDING A COMPREHENSIVE DECENTRALISED PRIMARY HEALTH CARE SERVICE.....	80
5.1 INTRODUCTION.....	80
5.3 HEALTH SYSTEM TRUST REPORTS: ANALYSIS OF FINDINGS.....	82
5.4 SUCCESSES, CHALLENGES AND CONSTRAINTS AND LESSONS LEARNT.	87
5.5 SUMMARY	89
CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS	91
6.1 RESTATING THE OBJECTIVES	91
6.2. FINDINGS AND RECOMMENDATIONS	91
3.4.2 The priorities of the National Department of Health.....	<i>Error! Bookmark not defined.</i>
3.4.4 Strategic Objectives of the District Health Services and Programmes Western Cape Department of Health	<i>Error! Bookmark not defined.</i>
3.4.4 Strategic Objectives of the District Health Services and Programmes Western Cape Department of Health	<i>Error! Bookmark not defined.</i>
6.3 CONCLUSION	93
REFERENCES.....	95

TABLE OF TABLES

TABLE 1: DISTRICT HEALTH FACILITIES STATUS.....	37
TABLE 2: HEALTH CALENDAR 2007 TARGETS	46
TABLE 3: JOINT CITY AND PROVINCIAL GOVERNMENT TARGETS 2007/8	48
TABLE 4: NUMBER OF PATIENTS SERVICED	60
TABLE 5: NUMBER OF PATIENT'S DEFERRED	60
TABLE 6: WORKLOAD OF STAFF AT MANENBERG.....	61
TABLE 7: WORKLOAD OF STAFF AT MASINCEDANE	61

Abstract, acknowledgements and table of contents

TABLE 8: MODES OF TRANSPORT	62
TABLE 9: AVAILABILITY OF HEALTH CARE	83
TABLE 10: MEASURING HEALTH CARE STANDARDS	84
TABLE 11: MONITORING THE AVAILABILITY OF HEALTH SERVICES	85
TABLE 12: MEASURING PROGRESS OF HEALTH SERVICES	86

TABLE OF FIGURES

FIGURE 1: DURATION OF ATTENDANCE.....	63
FIGURE 2: REASONS FOR PATRONAGE OF HEALTH FACILITY	63
FIGURE 3: BEST FEATURES OF FACILITY	64
FIGURE 4: DEFERRALS.....	65
FIGURE 5: AVAILABILITY OF ESSENTIAL DRUGS	65
FIGURE 6: RECOMMENDATION OF SERVICE	66
FIGURE 7: SERVICE DELIVERY CONSULTATION	67
FIGURE 8: KNOWLEDGE OF LOCAL HEALTH COMMITTEE EXISTENCE	67
FIGURE 9: KNOWLEDGE OF WARD COUNCILLOR.....	68
FIGURE 10: PERIOD OF EMPLOYMENT	71
FIGURE 11: REASONS FOR WORKING AT FACILITY	71
FIGURE 12: REASONS FOR STAFF CONTINUING TO WORK AT FACILITY.....	72
FIGURE 13: STAFF SHORTAGES	73
FIGURE 14: CONSULTATION OF SERVICE DELIVERY	74
FIGURE 15: PERSONAL RECOMMENDATION OF SERVICES.....	74
FIGURE 16: PERCEPTIONS OF REMUNERATION	75
FIGURE 17: OPINION OF PRD SYSTEM.....	76
FIGURE 18: FACILITY PERFORMANCE FEEDBACK.....	77
FIGURE 19: KNOWLEDGE ABOUT DHS SYSTEM.....	77
FIGURE 20: KNOWLEDGE OF PHC.....	78

CHAPTER 1: PRIMARY HEALTH CARE AND THE DISTRICT HEALTH CARE SYSTEM

1.1 Introduction

This thesis critically assesses the quality of Primary health care (PHC) services after the decentralisation process was commenced in 1994 in the Western Cape. The adopted National, Provincial and Local Government legislation and policies will be discussed in relation to the decentralisation process. The Government of National Unity (GNU) envisaged that implementing the District Health System (DHS) would result in the delivery of the comprehensive primary health care package reaching the masses which were previously disadvantaged. Restructuring the public health system therefore became a priority in 1994.

South Africa is a racially diverse country and the inequalities and fragmentation of the Apartheid era health system will be discussed to assess the difference between the now and the then. This paper will highlight the many challenges in implementing the DHS successfully in the Cape Metro District (CMD) and why the masses have not felt the full effect or benefit of the process to date. The various role players in the process and their contribution will be discussed. The health information, monitoring and evaluation systems of government will also be reviewed as these play a fundamental role in attaining the objectives of the decentralisation process.

The reasons for the fragmented and parallel service delivery at health facilities in the Cape Metro District despite the commitment on paper by all spheres of government will be explored in relation to set targets for the process. The proxy indicator - number of health facilities in the Cape Metro District offering the full package of Primary Health Care Services will speak to this.

“According to Noll, 1998 The ambitious ideas of using social indicators to contribute to a rationalisation of the political process, to establish goals and priorities, to evaluate political programs, and develop an early warning system have proven to be too far from reality. In this regard, social indicators have suffered a similar fate as

Chapter 1: Primary Health Care and the District Health Care System

other scientific instruments of political decision making, such as cost-benefit analysis.” (Shah 2005:46)

The quality of decentralised PHC will therefore be evaluated considering the implementation, management and operational (service delivery) constraints of the 2010 Health Care Plan also known as the 3A3E Model. Primary Health Care is fundamental in the health care setting as this is the first point of contact the patient/client has with the system and it is within the familiar environment of the client. It is provided in the community that the client resides in and at this level individual needs shape service delivery.

This chapter is organised into the following sections: The introduction which speaks about the decision to implement the DHS in South Africa. The background and context of the thesis describes the South African history and puts into context the diversity of the South African nation. The problem statement introduces the decentralisation process and the legislation pertaining to it. The objectives of the study describe the reasons for undertaking this research. The methodology discusses the type of research that will be conducted and the limitations of the study.

1.2 Background and context

This chapter looks at the history of South Africa dating back to the 1600's giving a broad overview of our history and why public health services today are still being accessed by the underprivileged black majority of South Africa. This puts into context the restructuring of our Health System since 1994. It outlines the reasons for undertaking this study, its objectives, its significance and methodology to be used.

Due to the history of South Africa it has a multi-racial, multi-cultural society. This is largely due the number of immigrants that settled at the Cape after Jan van Riebeeck set up a refreshment post in Cape Town in 1652. Following this the discovery of diamonds and the Industrial Revolution in the late 1860's and 1870's. This resulted in European immigrants being recruited as skilled labour and slaves imported from

Chapter 1: Primary Health Care and the District Health Care System

West Africa, Madagascar and China for unskilled labour. In 1913, the Natives' Land Act divided South Africa into 'white' and 'black' forming the cornerstone for Apartheid.

In 1948 Afrikaner nationalism was adopted and a series of restrictive laws were introduced to benefit the white minority and ensure inferior amenities for Africans, Asians and Coloureds. Later in 1950 the Population Registration Act classified people according to race and the Group Areas Act defined where people could or could not live. The non-urban 'homelands' were then created to separate the different ethnic groups.

The origin of the so called coloured population stems from this time period as many inter-racial marriages and relationships stems from this era. This time period is also known for causing the division of the rich white minority and the poor black majority as people were paid according to their race and skill. South Africa's white population descends largely from the colonial immigrants of the 17th, 18th and 19th centuries while the coloured population stems from slaves brought in from the East and Central Africa and also the Khoisan, Bantu and Nguni people who lived in the Cape at the time (<http://www.capecapegateway.gov.za>).

When the National Party came in power in 1948 they implemented the policy of racial apartheid entrenching socio-economic inequality. This was due to Separate labour - related legislation being adopted for blacks - the Black Labour Act 48 of 1943 and the Industrial Conciliation Act 28 of 1956. At the time the demography of South Africa indicated that more than half the population was black. However when it came to employment opportunities, service delivery (housing, education, and health care), career advancement and tertiary studies it was the white people who were favoured and the blacks oppressed.

According to Benatar (1991), 'South African health services were used as an instrument of apartheid to uphold the social, economic and political institutions structured along legally defined racial categories. Access to health services were unequal as were the health status differentials between ethnic groups: in 1985 infant

Chapter 1: Primary Health Care and the District Health Care System

mortality rates were 61 per 1,000 for blacks and 9.3 per 1,000 for whites' (in Walt, 1996:11)

Overwhelming evidence exists which testifies to the injustices of the past such as the race relations survey 1994/1995. This survey indicated that the educational level of the population was unsatisfactory and it estimated that 11, 3 million equalling 29, 5% of the South African population at the time had no education. In 1994, with the government of National Unity, it was found that 40, 9% of all households in South Africa lived below the minimum subsistence level. Of this 69 % was African households, 38% Coloureds, 18% Indians and 6.7% White households. This brought the poverty level for the Western Cape at the time to 26 % (Cloete 1996: 3).

Since 1994, however South Africa has been through a process of political and social transition and apartheid was abolished and replaced by democracy.

'According to Walt(1996:77), in countries with multi-party systems most of the power for policy making lies with the executive.

The question to which extent politics determine public policy and affect health outcome in South Africa will later be discussed. This is due to the South African government being a government of National Unity with a democratic order and given its history should be slanting towards a social democratic order. Currently the government is under criticism – from the unions – Congress of South African Trade Unions (COSATU) for being a Neo-liberal order pandering to the whims and fancy of the business sector in fear of losing investments opportunities.

The Government of National Unity (GNU) came into power with three parties gaining ministerial seats in cabinet (African National Congress – 20 seats, National Party - 6, Inkatha Freedom Party -1), and because the ANC won such an overwhelming number of seats it could enforce the acceptance of it's policies which lead to the introduction of the National Health Bill. The White Paper for the Transformation of Health Services developed by the Department of Health (DoF) is an attempt to address the inequalities of the past. The focus generally in South Africa

Chapter 1: Primary Health Care and the District Health Care System

as in the department of Health is improved service delivery and the development of systems to achieve economic growth and sustainability.

1994 also saw South Africa engaged in a social transformation process of all sectors of society, with the constitution aiming to ensure a health system that is capable of delivering quality health care to all citizens of South Africa. Chapter two of the constitution makes reference to the right of the South African citizen to access quality health care while our economic policy also speaks about improving the welfare of the population. However, the challenge that faces this government is balancing the inherent intricacies of the past while stimulating the economy and today we are experiencing the effects of how this challenge is been managed.

The focus of the late 1990's was the restructuring of the existing health system according to the DHS. It is believed that the DHS was the most appropriate vehicle for the delivery of PHC. The international Conference on Primary Health Care held in Kazakhstan in 1978 was a milestone of the twentieth century in the field of public health and the district health system and primary health care concepts emerged from this Alma-Ata Declaration. This conference was well attended by the member nations of the World Health Organisation and UNICEF, it spoke strongly about;

“The existing inequalities in the health status of the people, particularly between the developed and developing countries as well as within countries and the political, social and economical reasons for this;

The right of people to participate both as individuals and collectively in the planning and implementation of their health care;

Better use of the world's resources as a genuine policy of independence, peace, dente and disarmament should release additional resources that could well be devoted to the acceleration of social and economic development of which Primary Health Care should be allocated its proper share.”(World Health Organisation, 1991:45)

This conference was also fundamental not only as the foundation event in the history of public health but also for its contributions to the concept of 'Health for All' along

with PHC as its focus. South Africa adopted both of these concepts and this is discussed in greater detail in the chapters to follow.

1.3 Problem statement

Post 1994 new policies were adopted to address the inequalities of the past and the PHC strategy was one such policy. The decentralisation of PHC Services started in 1994 with the ANC National Health Plan and National Health Bill being passed. Since then the decentralisation of PHC Services has been guided by the Constitution, The White Paper for the Transformation of the Health System in South, the White Paper on Transformation of the Public Service, the Municipal Structures Act, the Municipal Systems Act and the Public Finance Management Act. These policy documents serve as the written commitment of government to the process.

During 2001 and 2002 a service task team was set up consisting of both provincial and the City of Cape Town Senior Health Management members. This task team made the recommendation to decentralise management structures in the Cape Metro District and implement service level agreements between the provincial government and the City of Cape Town (Health Systems Trust 2002:78). However in the MDHS Strategic Plan (2004-2007), it is clearly stated that “*the Municipal Based district Health System in the Cape Metro District (adopted by Provincial Cabinet in October 2001) could not be implemented due to legal and financial obstacles*” (MDHS, 2004: 9).

This caused much confusion as PHC services which according to legislation and the above recommendation is a provincial function continued to be managed by the City of Cape Town along side the provincial Department of Health (DoH). Over the last few years several dates have been set for the provincialisation of PHC services but to date this has not happened and the absence of provincial district structures appears to be a major stumbling block in the process. This has lead to large number of health professional staff leaving from the DoH both provincially and at the local authority level as they are unsure about their futures.

Chapter 1: Primary Health Care and the District Health Care System

Service delivery has been negatively affected by this as there is now less staff to attend to more people. Budgetary constraints in terms of infrastructure, stock, equipment and maintenance have also impacted on service delivery. Therefore despite the commitment on paper to decentralise health care services, leading to improved quality of care, effectiveness, efficiency, improved accessibility and availability of these services. This remains a commitment on paper as little change is visible on ground where people are making use of our public health facilities. Some of the reasons for very little decentralisation taking place is that even though the national cabinet decided in 2001 that Municipal health services will be defined as only environmental health and that primary health will be a function of the Cape Metro District the implementation date set initially for the 1 July 2004 has not taken effect more than ten years later.

According to Cloete (1996), it is accepted that in a democratic state the public institutions exist to provide essential goods and services needed by its citizens to promote their general interest. However, it is when members of the legislature and government officials fail to make contact with the citizens that they can only assume what these needs are. Another obstacle to service delivery is that outputs in service delivery do not equal inputs. This is mainly due to lack of work dedication and work ethic. The aspect of worker motivation cannot be over looked. Motivation is the workers willingness to carry out his/her duties and change within any organisation affects the worker psychological especially when the organisational culture, reporting structures and channels of communication change. Worker motivation is also affected by the public or type of community they serve.

In 2007 we have had many media articles discussing the unhappiness with service delivery where people have had various marches to service delivery points due to poor service delivery and government inability to deliver on its promise. On the 29th July 2007 eTV News broadcast Presidents Mbeki responded to the cries of poor service delivery when he stated that it is due to colonialism and apartheid that today the effects of poor service delivery are still felt as budgetary constraints are holding up the processes. At present in the country there is general unhappiness with services

delivery in the public sector and staff on the ground often feels they are abused as public dissatisfaction is voiced at this level.

According to Shah (2005:48 – 49)

“A public sector orientation plays an important role in public sector performance. This is lacking in some developing countries where the civil service pursue power and influence through command and control. Decentralised countries are more responsive to citizen preferences in service delivery and strive harder to serve than centralised countries.”

Post 1994 South Africa can be said to be public service orientated. Change is often painful but it provides opportunities and with the political change in South Africa at the time it opened up the policy environment.

Recognising what our president has said about the inequalities of the past for the majority of the Western Cape’s population living in poverty and relying on the public sector health care system for their health needs, improvement in the quality of health care remains a priority as it will improve their lives and also decrease the burden of disease on the current health system. This is also why the Batho Pele Programme – ‘putting the client first’ was developed.

1.4 Objectives and significance of the study

The main and general objective of the mini-thesis is to assess the quality of decentralised primary health services in the Cape Metro District of the Western Cape.

The more specific and secondary objectives include;

1. Defining and discussing the DHS and the PHC approach in terms of the legislative framework governing the process.
2. Documenting the progress of the implementation process of the DHS in the Cape Metro District.
3. Conduct a consumer perception survey of service delivery in terms of the 2010 Health Care model (ie 3A3E model)

4. Using the plan do and review (PDR) monitoring and evaluation tools of the City of Cape Town and Provincial Departments of Health to assess the progress of primary health service delivery in the Cape Town Metro District, including the proxy indicator for offering the comprehensive PHC service package at all health care facilities in the Cape Metro District.
5. Analyse findings in terms of constraints and challenges; and make recommendations for the way forward

The significance of the study is that bottlenecks in the DHS will be identified and implementation obstacles of the process will be discussed. This information can be used by the Management of both the City of Cape Town and Provincial DoH to formulate strategies to improve the implementation process and flow of information about the decentralisation process to their staff at ground level and the consumers of the service. These results can also be used to address the issues which are causing staff and patient dissatisfaction with the health system and service delivery, while also addressing gaps in the implementation of national legislation.

1.5 Methodology, design, operationalisation and limitations of the study

This study will have a qualitative and quantitative aspect. The qualitative research aspect will allow the researcher to conduct interviews and make extensive observations in the participant's natural environment which for the purposes of this study is the clinic health facility. The researcher will conduct two interviews as discussed later in this section

The quantitative research aspect allows the researcher to use the questionnaire as a research tool from which numerically analysis of the data collected can be made. The researcher will distribute seventy questionnaires in total at the two health facilities identified during the sampling process. The questionnaire will allow for the

Chapter 1: Primary Health Care and the District Health Care System

researcher to explore the cause and effect of the decentralisation process of PHC services on health care service delivery.

A descriptive case study method was chosen as this allows subjects to be selected through randomization procedures while also allowing for data to be statistically analysed. This method also allows for information gathered from the sample group to be generalised to the target population. The case study will give the researcher the opportunity to discuss the decentralisation process of PHC services in the Cape Metro District in great detail. A case study also allows for this real time event to be investigated and this will allow for the observations made during this study to be discussed incorporating various viewpoints especially that of the participants. This method as with using the questionnaire also allows for the 'How' question to be answered, exploring the cause and effect. The how question this study aims to answer is - How has service delivery for the consumer in the public health sector been improved by the decentralisation of Primary Health Care Service in the Cape Metro District? The results of the questionnaires will be quantified and expressed in percentages and graphs.

According to Baumgartner, Strong and Hensley (2002:47) delimitations refer to the scope of the study. The scope of this study is limited to the Cape Metro District (case study area). The population for this research is all the clinic health facilities in this district. The sample due to time-constraints will be the clinic health facilities of the Klipfontein sub-district only. The Klipfontein sub-district was selected as the sample area on the basis of convenience and also because it represents the race, socio-economic and burden of disease factors representative of the Cape Metro District. Two clinics from this sub-district were selected on the basis of head count; burden of disease and for the purposes of fair race representation of the population of the sub-district. This sub-district has four boundaries –the N2 (north), M5(west), Lansdowne Road (south) and New Eisleben Road (west). As part of the City Of Cape Town restructuring boundaries was realigned in 2005 and the old Nyanga and old Athlone sub-districts had its boundaries amalgamated to form the Klipfontein sub-district. According to the 2001 census this sub-district has a population of 373 413 and although geographically it is the smallest of the eight City of Cape Town healths sub-

Chapter 1: Primary Health Care and the District Health Care System

districts it is not the smallest in terms of population density and burden of disease. The Klipfontein sub-district has an estimated population of 28.285 per clinic for 2010 and the headcount for each clinic facility is 1.174.326 (Comprehensive Service Plan 2007: 59).

Choosing only two clinic health facilities did limit the sample size. However these facilities represent the halves of the sub-district, one clinic from the old Athlone sub-district was chosen and the other from the old Nyanga sub-district.

The old Athlone sub-district predominantly has a coloured working community living in brick houses with water and sanitation services while the old Nyanga sub-district has predominantly a black community of a lower socio – economic status mostly living in shacks. This is important to note as the socio – economic status of a community has direct bearing on its health status and its service delivery needs. Grouping the clinic health facilities in the sub-district into large, medium and small according to the actual head count per month over the last financial year ensures that the population is well represented in the sample.

The researcher conducted two interviews with two experts, implementers of the DHS at an executive management level. They were selected on the basis that both these individuals are extensively involved with the decentralisation process of PHC services in the Cape Metro District and have been so from the inception of the process. Observations and questionnaires were administered at the clinic health facilities over a period of one week. Thirty Five Questionnaires were administered at each health facility and for purposes of confidentiality the patient's identity (name, surname and address) was not disclosed. The researcher had information session with patients in the main waiting area of these clinic health facilities every morning for the duration of the week explaining the research purpose and obtaining their consent before assisting patients with completing the questionnaires.

The writer will look at what has evolved since 1994 in the Health Care System in terms of service delivery, focusing on the quality of health care. Walt, 1996:207, states that a government with new leadership can expect change but this does not mean that it will not be threatening. The South African government of the day had to

put health policy in place which was in line with international standards but within a resource thin environment. The constraints of this will be reviewed.

The limitation of this study is that the health facilities for the sample only included the City of Cape Town (Local Authority) clinics. The Metro District Health Facilities – the Community Health Centres and the Maternal and Obstetric Units in this sub-district are still in the process of setting target indicators for some of components of PHC services which they are offering eg. target indicator for number of pap smears per month therefore they are excluded from the sample. These targets are all in place in the local authority clinics and they have monthly PDR (plan do and review) meetings at sub-district level to monitor and evaluate the achievement of these indicators. These are still lacking for the MDHS facilities. This study is also limited to only one sub-district of the Cape Metro District therefore the sample size is small.

To test the reliability and validity of the research a pilot study was conducted to determine the stability, consistency of the participants responses as well as the extent to which the questionnaires measure what it is supposed to measure. What was discovered is that the literacy level of the participants was a challenge in completing the questionnaires. Participants also did not respond well to open ended questions and since the questionnaires were only printed in English this was even more problematic. This pilot study allowed the researcher to redesign the questionnaire based on the participants responses.

1.6 Chapter outline and structure of research report

This research paper will consist of five chapters. Chapter one serves as the introduction which outlines the reasons for the study, the background and context, the problem statement, objectives, significance and limitations of the study. Chapter two discusses the legislative framework of primary health care and the district health system. The role of the World Health Organization in defining primary health and the South African health policies such as the National Health Act are also discussed. Chapter three will discuss the Cape Town Metro District of the Western Cape as a

Chapter 1: Primary Health Care and the District Health Care System

case study. The strategic context for setting targets for Primary Health Care Services is also discussed in detail. In chapter four the Health Care 2010 plan is discussed. The concept of quality in terms of health care is defined and the barriers to providing quality health care are listed. Lastly this chapter focuses on the specific health indicators for the Klipfontein sub-district and this includes the results of the most recent waiting and service time surveys as well as the results of the fieldwork for this thesis. Chapter five presents the analyses of the fieldwork .Chapter six focuses on the conclusion, recommendations and way forward.



CHAPTER 2: LEGISLATION AND PRIMARY HEALTH CARE

2.1 Introduction

The purpose of this chapter is to introduce the concepts of PHC and the DHS, while also giving a broad overview of the decentralisation process of Primary Health Care Services in the Western Cape since 1994. The writer will do this by introducing, reviewing and discussing the relevant legislation pertaining to this process since the National Health Bill by the ANC in 1994. The role and responsibility of the two spheres of government in providing Primary Health Care Services in the Western Cape are also discussed.

This chapter is divided into the following sections – the introduction which introduces the chapter and its significance. The second section describes and discusses the role of the WHO and the importance of member states like South Africa conforming to international policy set by this organisation. The third section discusses the influences in health policy. Within the South African legislative context the Constitution and the National Health Act is summarised as it relates to Primary Health Care. The fourth section discusses the various roles of government, the Bi-Ministerial Task Team recommendation, Institutional agreements and the Service Level Agreement the City of Cape Town and the Western Cape Provincial Government has entered into. The fifth section discusses the implementation of the 2010 Health Care Plan and the broad targets it has set in terms of decentralising PHC.

2.2 The role of the World Health Organisation in defining Primary Health Care and the District Health System.

In May 1977 the member states of the WHO adopted the goal of *Health for all by the year 2000*. The first international conference on Primary Health Care (PHC) was held the next year in Kazakhstan where the call for urgent and effective national and international action to develop and implement PHC was made (Alma Ata

Chapter 2: Legislation and primary health care

Declarations, 1978:1). At this conference on PHC the following definitions were conceived,

“Primary Health Care is provided by delivering promotive, preventative, and curative and rehabilitative services. These services should include sanitation, provision of clean water, Nutrition and Maternal and Child Care: Reproductive Health (family planning); immunisations against communicable disease; Health Education; the treatment of minor/common diseases and emergency care.” (White Paper for The Transformation of Health Services, 1997: 11).

Or

“Primary Health Care is the first level of contact for individuals, the family and the community with the National Health System bringing Health Care as close as possible to where people live and work, and constitutes the first element of a continuation of the Health Care Process.” (<http://www.gov.pe.ca/infopei>).

Or

“PHC is a component which forms an integral part of a country’s Health System and the overall economic and social development without which it is bound to fail, it therefore has to be coordinated on a National basis with the other levels of the Health System as well as the other sectors that contribute to a country’s total development strategy.” (World Health Organisation 1991:45).

These definitions clearly indicate the importance of national, provincial and local management of PHC in order to achieve a healthy well developed population. This speaks to the services being managed by one health authority avoiding fragmentation of the system. Primary Health Care has eight elements:

1. Treatment of common diseases and injuries.
2. Maternal and child health.
3. Immunization.
4. Communicable disease control.
5. Provision of essential drugs.
6. Health education.

Chapter 2: Legislation and primary health care

7. Food supply and nutrition.
8. Adequate supply of safe water and basic sanitation.

The above elements of PHC is what is used by the City of Cape Town and more recently by the Metro District Health Services in their Plan Do and Review (PDR) sessions as target indicators for monitoring and evaluating their delivery of PHC services. For PHC services to be efficiently and effectively rendered and in order for targets of the PHC programme to be achieved the management roles of the national, provincial government as well as regional and the district level management in the Western Cape has to be clarified. The City of Cape Town and the Metro District Health Services are having joint Plan Do Review sessions and setting targets for the PHC programme jointly, as both are rendering these services and working within a joint cooperative framework but this agreement is not unifying PHC management completely.

It has been established that PHC is the first level of patient contact with the health care system therefore any inefficiency at this level will affect the rest of the health care system adversely. Most South Africans had previously been denied access to Primary Health Care services due to apartheid policies but it is the key to an acceptable level of health for all, helping people contribute to their own social and economic development and should therefore be an integral part of the overall development of society.

The DHS is the management structure for PHC and is therefore responsible for ensuring that these services meet service delivery targets. According to Tarimo (1991), the district is a geographically compact unit of which every part can be reached within a day while the unit is small enough for the staff to know each other and understand the major health problems and socio-economic constraints. The DHS is a health system which,

Chapter 2: Legislation and primary health care

“Comprises first and foremost of a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural.” It is an organisational framework for a country’s health care system and has been accepted worldwide as the most appropriate vehicle for the delivery of the PHC approach. PHC in more or less self contained segment of the national health system” (Metro District Health Services Strategic Plan 2004 -2007,2004:68-69).

This system allows for interaction of all the role-players involved in delivering health care at district level as it puts in place a decentralised health management team who is responsible for the planning, managing, implementing and monitoring of the primary health care package of care at district level.

The DHS makes effective management possible by having well defined catchments populations not exceeding 500 000, having a district hospital in each district and by ensuring the furthest clinic can be reached within three hours of the district office. This system is also defined as a system which exist as part of a unitary provincial health system that is decentralised in such a manner that it enables the centre (provincial management) and the periphery (district and sub-district management) to function effectively and cooperatively’ (Metro District Health Services Annual Report 2003/04, 2004: 22). In summary the district is the place where community needs and national priorities are reconciled.

Dr. Ivan Toms the Executive Director of Health City of Cape Town and South African Local Government Association (SALGA) representative discusses the benefit of a unified comprehensive plan to address the health needs of the sub-district and in his opinion this is what the DHS will ensure. He lists the following principles of the DHS:

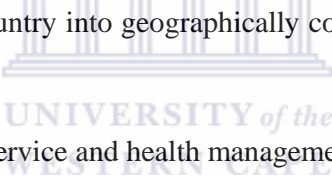
- Equity
- Access to services
- Quality
- Overcoming fragmentation

Chapter 2: Legislation and primary health care

- Comprehensive services
- Effectiveness
- Efficiency
- Local accountability
- Community participation
- Developmental and intersectoral approach
- Sustainability (Toms, 2006)

From the above it is clear that the principles of PHC are derived from the principles of the DHS.

Toms (2006) also list the following goals of the DHS as follows,

- 
- To divide the country into geographically coherent, functional health districts and sub-districts
 - A single health service and health management team for each health district
 - And boundaries which coincide or are coterminous with those of the Local
 - A health team accountable to a single authority
 - A single employer of the district team
 - Uniformed salary and service conditions for staff

2.3 Influence in health policy

2.3.1 The Constitution of the Republic of South Africa, Act 108 of 1996

Chapter 2: Legislation and primary health care

Following the ANC health plan the Constitution of 1996 in chapter two (s) 27.1 – Bill of Rights makes reference to the health care, food, water and social security rights of every citizen. It states that “ *everyone has the right to have access to health care services, sufficient food; water and social security.*” The Constitution spells out the legislative authority of the provincial legislature in initiating, preparing and passing legislation for its particular province in line national legislation. The public is however to be consulted throughout this process as this organ of the state is to conduct its business in an open manner. It is from among the members of the provincial legislature that a premier for that province is elected which has some functions and responsibility relating to passing legislation and policy. Within the Western Cape Province in particular the changes in the premier and majors’ office has contributed to the delay in fully decentralising PHC services in addition to the financial constraints of the provincial government in taking over complete management of the services.

The functions of local government, municipalities and their right to an equitable share of the national revenue and any additional revenue raised by them are also discussed in chapter seven of the constitution. This is important as it is later mentioned by the Executive Director of the City of Cape Town, that as a municipality it uses a significant portion of its revenue to fund their rendering of PHC service in the Cape Metro District.

Now that the above roles for passing health legislation have be described. Who influences health policy? The role of the health arena specifically the medical profession in influencing health policy is historic. This profession set the agenda for health policy which does not necessarily reflect the interests and concerns of front line staff while policy changes impact on the work of more than just the medical profession. This is currently a problem in South Africa as PHC is a nurse driven service which has resulted in an increase of workload for professional nurses. Government has tried to address this more recently with the Comprehensive Service Plan and the scare skills policy but this is only applicable to nurses working for provincial government and not those in the service of the City of Cape Town, who run or implement PHC services in the Cape Metro District.

Chapter 2: Legislation and primary health care

The criticisms by the Congress of South African Trade Unions (COSATU) that the South African government is slanting towards a neo-liberal order can be justified by the following explanation as discussed by Homedes and Ugulde (2004). During the late 1980's the World Bank became a major international lender assisting countries to prepare for health reforms based on neo-liberal economic principles.

“One of the objectives of the health reform was to free central government to pay for the huge debt thereby shifting the financial burden of the public service from central government to provinces was an expedite way to accomplish this.”(Homedes and Ugulde, 2004)

In 1993 the World Bank devoted its World Development Report to the health sector reinforcing decentralisation strategies for health emphasizing the need to improve equity and efficiency through guaranteeing universal access to a basic package of services, determined according to what each country could afford and based on cost-effectiveness principles. Governments and the rest of the population would subsidize the provision of the services (Homedes and Ugulde, 2004).

This was the position that South Africa found itself in post 1994 and looking back one could use this explanation for being one of the reasons South Africa renewed its commitment in 1994 to the PHC strategy.

2.3.2 National Health Act, No .61 of 2003

On the 10th of April 2008 at the Birchwood National Consultative Health Forum Declaration of Primary Health Care held in the Gauteng, Province the implementation of the Alma Ata declaration globally including improving access to PHC services in South Africa and the equitable allocation of resources was again discussed. This forum recognised that many challenges including the availability of adequate human resources for health and strengthening the District Management System still exist. These are some of the reasons why the National Health Act (2003) was legislated, so that clarity for the provision of health service at all levels could be reached. The constitution gave Local government the right to govern PHC services

Chapter 2: Legislation and primary health care

and Toms (2006) makes reference to the article, local government view of progress to DHS – A case of the powerful deciding not to consult with regards to this decision.

This Act differs to the constitution and provides the framework for establishing a health system based on a decentralised management structure. Chapter four of this act discusses Provincial Health Services and the functions of the provincial departments. Section 25 sub-section 2 states the head of Provincial Department, in accordance with National Health policy and the relevant provincial health policy in respect of or within the relevant province should;

- Provide and manage the provincial health information system
- Plan, coordinate and monitor health services and evaluate the rendering of health services
- Plan, manage and develop human resources for rendering of health services
- Control and manage the cost and financing of public health agencies
- Control the quality of all health services and facilities
- Provide and maintain equipment, vehicles and health care facilities in the public sector
- Consult communities regarding health matters
- Promote community participation in the planning, provision and evaluation of health services.

What this means for the Cape Town Metro District is that it will be managed per four health districts. Finance will be decentralised to district level and coordinated centrally but human resource will remain centralised at the level of the Chief Director and will only be coordinated at district level.

In 2006 the Executive Director of the City of Cape Town, Dr. Ivan Toms discusses the District Health System in a document - Building a District Health System in the City of Cape Town. In this document he states that “*the benefits of a District Health*

Chapter 2: Legislation and primary health care

System is a more manageable unit, which is closer to the community it serves and a district only needs one unified comprehensive plan to address the needs of that district.” This has been echoed by many before as well as has the benefit of belonging and reporting to only one single authority.

Toms (2006), discusses the confusion experienced by the patients where two health authorities render services in one facility. This also leads to duplication and fragmentation of services as well as an inappropriate and inequitable resource allocation. The principles of the District Health System speak to overcoming fragmentation, delivering comprehensive services, quality of care and local accountability. The ultimate goal being a unified national health system based on the DHS.

According to Toms (2007), the current situation in the Metro is that the total PGWC health budget is R 3.5 billion. Of this 10% forms the PHC metro budget of which R259 million is provided as a direct cost to C.H.C facilities and R 87 million is local government Transfer. The City Of Cape Town contributes a significant R128 million from its own revenue to the PHC services, even though by definition it is only responsible for the environmental aspect of this service. The way forward is therefore not as cut and dry as it is stated in so many documents and in legislation.

According to Baron (2000)

“The bulk of funding for primary level services comes from tax revenue and is allocated to the provinces as part of the large provincial block grant. In the metros’ a significant amount of the funding for health services come from rates raised by the local authorities” (<http://new.hst.org.za/news/index.php/20000415>).

This speaks to what Dr. Ivan Toms has said is happening in the Cape Metro District and as funding of services play a significant role in the delivery thereof it clearly is an issue that affects the effective date of provincialisation of PHC services in the Cape Metro District of the Western Cape.

2.4 The role and responsibility of government

2.4.1 The BI-Ministerial Task Team Recommendations

In April 2000, the decentralisation of PHC in the Western Cape was recommended by the bi-ministerial task team on the implementation of a municipality based DHS. This task team recommended that PHC should be decentralised to local government based on the rationale that local government is near enough to communities to respond to their practical problems and needs yet equally near enough to the central administrative level to translate government policies to practice.

The shift from doctor driven health services (medical era) to nurse driven health services was now initiated. Centralised health services was now to be decentralised but due the absence of a National Health Act and a lack of clarity on financing municipal health services and other functions delegated to local government a temporary suspension was put on the decentralisation process (Health Systems Trust 2002: 78).

Following this recommendation the consolidation of City Health and Department of Health (MDHS) services and assets into one comprehensive PHC service under one authority is mentioned in the Metro District Health Services Strategic Plan 2004 – 2007, where it is stated that the resources and opportunities arising out of this consolidation will be used to fully decentralise the sub-districts at no extra costs to the DOH. This gives the impression that the bi-ministerial task team recommendation even though accepted by cabinet, was not adopted by the provincial government and that the management of health services as stated in the New Health Act 61 of 2003 will become or remain a provincial function. This means the City of Cape Town Health Department currently manages the PHC services as an unfunded mandate.

2.4.2 Spheres of Government and the Health District

The national government should play a supportive role to the provincial government in terms of legislation, policy development and implementation. This sphere of

Chapter 2: Legislation and primary health care

government is responsible for monitoring and evaluating the progress provincial government makes with implementing the DHS. The provincial government is responsible for the decentralising process, setting targets for the system and allocating the resources to ensure service delivery.

“The District Health Services Chief Directorate’s role is to provide district health services – it is responsible for establishing public health services, Level 1 hospital services and health support in the Metro” (<http://www.capegateway.gov.za> 1/8/2008).

In the Western Cape, however, the implementation is hindered as the Metro District Health Services still do not have its core district health management teams in place in all its districts and full decentralisation cannot take place without this component. The core function of this district team is the management of the District Health system.

In August 1994 the National Health Systems committee was established to develop a District Health System for South Africa. A policy document in its draft form was compiled and edited by Professor C. Powen in 1995 and was sent out for public comment by the National Department of Health. According to Powen (1995:2), the aim of this policy document called – ‘*A policy for the development of a District Health System for South Africa*’ was to develop a DHS that will provide a preventive, health and wellness – orientated approach of PHC instead of the curative and fragmented approach of the past. This document speaks about the shift from medical care to PHC health.

It is often said that the health district is where top down planning meets bottom up realities and within the public sector the reality is targets are set without attention being paid to the resources required to implement activities that will enable the district to reach the set targets (Health District Development and Performance Assessment tool 2007: 3). This is evident in every public sector health care facility where masses of people are waiting to be attended but staffing levels are insufficient and the infrastructure not accommodating. Health care at these facilities are however free and the target indicators for the various programmes and projects are set. Does quantity then compensate for quality? Does management then feel they are adhering

Chapter 2: Legislation and primary health care

to the principles of Batho Pele and is performance then more important than quality of care or client satisfaction?

This policy document by Powen proposes that the DHS must be structured in such a manner, *“that no-one in need of it is prevented from accessing any level of care that they require, rapidly and efficiently, and in such a manner that all will receive the highest quality of care at all levels.”* (Powen 1995:2)

This document discusses 12 principles that underlie the development of a DHS for South Africa. For the purposes of this thesis the following four are relevant in terms of rendering quality PHC services:

- Comprehensive services: must be planned, managed and delivered in a comprehensive, integrated manner. This includes both comprehensive community health services as well as non-specialist district hospital services.
- The practice of local government authorities rendering preventive PHC while the provincial staffs provide curative PHC services must not be continued.
- For quality to be achieved local needs and resources should be taken into account.
- For successful decentralisation: it is vital that sufficient powers are devolved to the managers of the districts and their facilities, especially with respect to personnel and financial controls. This will increase both the accountability and the efficiency but is also important as a means of boosting staff morale and encouraging local initiative and flexibility in the light of local and changing circumstances.

This document also discusses the move to a single health service and management team, which is not to far to be responsive to staff and local needs. The health team in each district will be accountable to a single health authority and this authority will be the employer of the team, where uniform salaries and the same conditions of service for all public sector personnel will exist.

Chapter 2: Legislation and primary health care

In April 1996 the DoH issued an official policy document – Restructuring the National Health System for Universal Primary Health Care. This document speaks about the restructuring of the National Health System of South Africa under two major sections: policies and funding of the national health system and the proposed regulatory reforms in the private health sector. This policy set out to achieve:

“Substantial visible and sustainable improvements in publicly funded primary health care services; Improvements in funding efficiency and governance of the public hospital system and Improvements in the equity and efficiency of the private system and the relationship between the public and private sectors.” (Restructuring the National Health System for Universal Primary Health Care, 1996:1)

According to this document the implementation of the restructuring process will take eight years and within eight to ten years the core set of target primary health care services listed above will be provided at district level. This document refers to the district management team as the District Health Authority and it is this team that will be responsible for the management of Primary Health Services at district level. This team will be specific to the district needs but must consist of medical practitioners, PHC nurses, community health nurses, rehabilitation workers, oral health workers, health promotion officers, radiographers, laboratory technicians, pathologists and environmental health officers. This document makes no reference to the role of local government in rendering PHC services and speaks only from a provincial point of view. However according to legislation environmental health is a function of only the Local government. This is interesting as the time frame for the restructuring process has been set but the role of Local government omitted. Since the start of the restructuring process discussed in this document more than ten years has passed and its objectives as set out then has not been achieved in this time period.

It is only since 2007 that much progress towards establishing the district health management team has been made in the Cape Town Metro of the Western Cape. Joint meetings between MDHS and Local government sub-district management known as the Integrated Sub-district management meetings are held at sub-district level to discuss operational, service delivery and integration matters. The

Chapter 2: Legislation and primary health care

MDHS advertised the director level post for each of its four districts in the metro in February 2008 after their management structure was finalised in October of 2007. The directors started their term in office on the 1st June 2008.

This was done so that the move to incorporate maternal health services currently under the management of the secondary level maternity hospitals, into the district and the move for the national laboratory services to be extended to the district level could be addressed. Maternal health services was to be incorporated into the district as of 1 April 2008 but this time line has now been extended pending the progress of the DMT'S. Also level one district hospitals needs to managed by the DMT and for some districts, like Khayelitsha and Mitchells Plain, these hospitals still need to be built therefore the NHLS move to the districts is also put on hold. This will allow for the comprehensive package of PHC services to be available and managed at district level.



2.4.3 Institutional Agreements

According to the National Health Act (No 61 of 2003) the responsibility for provincial primary health care (PPHC) services has been designated to the Provincial Department of Health. In March 2005, Health Minister Pierre Uys announced that, *“the Western Cape Health Department will assume responsibility for PPHC services currently provided by the municipalities outside of the Cape Town Metropolitan area with effect from 1 April 2005.”* (<http://www.capegateway.gov.za>). This however meant that they will be taking managerial responsibility for this service and only eleven months later, on the 1st March 2006, the PGWC DoH assumed operational responsibility for PPHC services in the non – metro districts of the Western Cape.’ (Metro District Health Services Annual Performance Plan 2007/08, 2006:45). For the City of Cape Town the MDHS was also to assume responsibility on the 1st of March 2006. This was postponed for one year and again until the date has now been set for the 1st July 2008. The cost implications for this amalgamation is probably the reason why the service level agreement has to date not been signed.

2.4.4 Service Level Agreement

This document, in its fourth draft discusses the transfer of staff, assets and liabilities from the City of Cape Town (COCT) to the MDHS; it is not however endorsed with the signatures of the two parties and therefore remains in this draft form. This agreement is better known as the memorandum of agreement (operational control and transfer) and although its name might not be well known to staff its content is. The intended operational control date is stated to be the 1st March 2006, but to date the municipality is still managing its primary health services as before.

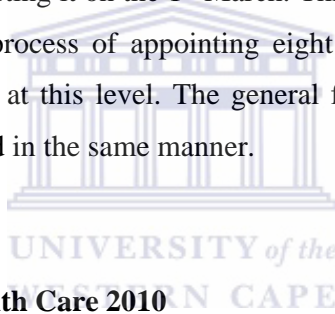
This is what has caused much debate and confusion at ground level as the staff is uncertain of their futures leaving them feeling disillusioned and causing low morale. At present conditions of service and remuneration packages differ for these two spheres of government and the staff is not prepared to perform the same functions at different remuneration rates. This has already caused disputes in many combined facilities and has led to COCT or province having to take the decision to move out of certain combined facilities.

The transfer process has also been delayed by the political change in the mayoral structure of the Cape Town, since no mayor or premier has served out their term in the last ten years. On the 31 July 2008 the new Premier for the Western Cape – Ms Lynne Brown announced that Mr Pierre Uys will no longer have the portfolio for health. It is these political changes which effect the progression of full DHS implementation. Other delays are due to the City of Cape Town having its sub-district boundaries and management team in place where the provincial department of health in the first part of 2007 only put in place its interim management structure. This structure was then finalised on the 1st October 2007. The provincial management of health is still very much centralised. Currently the provincial health service is managed by a combination of a central head office in Cape Town and decentralised Regional offices in Bellville, George, Worcester and Malmesbury. (MDHS Annual Performance Plan 2006/07, 2006:28)

Chapter 2: Legislation and primary health care

On the 29 July 2007 MDHS and COCT had its first combined monitoring and evaluation meeting to discuss the flow of data and time frames for data submission. Data is still submitted to the provincial offices from both these organisations often causing duplication and fragmentation of data. Following this meeting on the 2nd August 2007 the Klipfontein and Mitchells Plain sub-districts which forms one MDHS district with Dr. Rob Martell as the PHC coordinator had its first monitoring and evaluation meeting. This was a combined meeting and the COCT version of reporting on targets –Plan Do and Review (PDR) was adopted and MDHS facilities were asked to set target indicators for those PHC services not yet having targets at facility level.

A remarkable difference is that COCT starts its financial year on the 1st July compared to MDHS starting it on the 1st March. This affects the data reporting cycle. MDHS is also in the process of appointing eight sub-districts Health information officers to capture data at this level. The general feeling is that services should be monitored and evaluated in the same manner.



2.5 Implementing Health Care 2010

2.5.1 Setting Target Indicators for the District Health Care System

According to Professor Craig Househam

“The implementation of Health Care 2010 and ultimately the Comprehensive Service Plan will require discipline, dedication and resolve. Hard decisions need to be taken now to yield positive results later; and these positive results will benefit the patients who come to us for good quality health care”. (Department of Health, Western Cape Healthcare 2010, 2003: 8-9)

The strategy for reshaping public health services in the Western Cape to focus on primary level services is multi-pronged and include: The service delivery plan, which will define and quantify the health services required per district; The infrastructure

Chapter 2: Legislation and primary health care

plan; this will provide buildings, equipment and maintenance in line with service requirements; The human resource plan; this will enable facilities to be staffed appropriately and will require a revision of the existing staff establishments; and The financial plan; the allocated budgets will be linked to measurable, time bound objectives for the medium-term expenditure framework period and beyond to give effect to the restructuring of the health services.

The plan to implement this will include: An evaluation of all jobs; Determine packages of health services per level and location; Match services with the necessary facilities and equipment; Shift services according to the identified need; Equip staff facilities with the appropriately qualified staff; and Link funding to services to ensure sustainable quality services.

2.5.2 The 2010 Health Care plan 3A3E Model as an Indicator

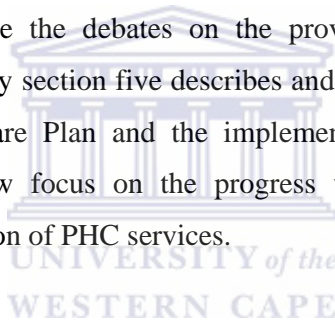
The health care plan highlights indicators such as:

- Accessibility.
- Affordability.
- Appropriateness.
- Equity.
- Effectiveness.
- Efficiency.

According to Dr. Joey Cupido, Chief Director of District Health Services at the time of the 2010 Health Care Plan was initiated, now the Director General for health, aiming to adhere to this model will allow for PHC services being available twenty four hours a day, seven days a week and fifty two weeks a year.

2.6 Summary

In summary the first section of this chapter focused on introducing the international and local definitions of Primary Health Care and the District Health System. The second section discusses the first international conference on PHC in 1978 by the WHO and relates to the origin of the concept of PHC. The third section discussed the importance of National Health Act and to what extent its principles as legislated are conformed to. This section also made reference to the Constitution as this bit of legislation outlines which sphere of government is responsible for the management of Primary Health Care Services. In the fourth section bi-ministerial task team recommendations, the institutional and service level agreements between the City of Cape Town and the Provincial Government of the Western Cape were discussed as these agreements is what governs Primary Health Care Service in the Cape Metro District currently, while the debates on the provincialisation of Primary Health Services continue. Lastly section five describes and discusses the broad targets as set in the 2010 Health Care Plan and the implementation strategy is finally listed. Chapter three will now focus on the progress within the Cape Metro District regarding decentralisation of PHC services.



CHAPTER 3: THE CAPE METRO DISTRICT AS A CASE STUDY

3.1 Introduction

This chapter focuses on the shift in health services from a centralised to a decentralised level. Specifically focusing on the District Health System (DHS) and the progress made in the Cape Metro District from 1994 to date. Progress reports and reviews will be discussed in detail as well as set deadlines and targets. The reasons why decentralisation has been considered as an option for South Africa is also explored.

Information is organised in the following five sections: section 1 the Introduction which introduces the shift to decentralization. Section 2 discusses the demography of the Cape Metro District and the Klipfontein sub-district. This section also discusses the vision of the City of Cape Town and the Provincial Government of the Western Cape Health Department. A number of annual and strategic reports are also discussed in this section. Section 3 reviews the progress in the Metro District health Services Organisation. Section 4 presents the strategic context for setting target indicators. Section 5 discusses the district health system and why this system was chosen as a health management system in South Africa.

3.2 The Cape Metro District

South Africa is situated at the southern tip of the continent of Africa, covering 1.2 million square kilometres. South Africa is a middle-income country with the largest economy in Africa. Since 1994 when the Government of National Unity (GNU) entered office economic growth has been at a level of about 2 percent per annum this however is still not enough to address the high levels of poverty and unemployment rate of the country.

South Africa has a population of 47.9 million people of diverse origins, cultures, languages and beliefs according to the mid 2007 estimates from Statistics South Africa. Africans are in the majority at just over 38 million (79.6%), the white

Chapter 3: The Cape Metro District as a case study

population is estimated at 4.3 million (9.1%) the coloured population at 4.2 million (8.9%) and the Indian/Asian population at just short of 1.2 million (2.5%). In South Africa PHC services are free and since 1994 more than 500 clinics have been built, bringing health services closer to around six million people, 2298 clinic have been upgraded and given new equipment while 125 new mobile clinics have been established (<http://www.capegateway.gov.za>). The State contributes about 40% of all expenditure on health but the public sector is under pressure to deliver services to about 80% of the population. Public health consumes around 11% of the government's total budget, which is allocated and spent by the nine provinces. This causes the standard of health care delivered to vary from province to province depending on resource allocation and access of health services by more poor people in some provinces compared to others. Therefore the Western Cape is seen to be a wealthier province in respect to this and its total population accessing public health services. In general the public sector is under resourced and over used (<http://www.capegateway.gov.za>).

The Western Cape is situated on the south – western tip of the African continent and covers an average of 129 386 square kilometres and has a population of 4.7 million (Statistics S.A, 2005). The majority of the population are Afrikaans speaking and the other official languages of the province are English and Xhosa. The Western Cape makes the third-highest contribution to the country's GDP. According to the South African Yearbook 2002/2003 the province has an official unemployment figure of 18.4% which is lower than that of most parts of the country (<http://www.capegateway.gov.za>).

The Western Cape has six districts of which the Cape Town Metro district is the largest with a population of 3,324,209 (64%). It has four provincial health districts and eight Municipal health sub-districts. The remaining districts are the Cape Winelands with a population of 656,455 (14%); the West Coast district with a population of 295,503 (6%); the Overberg district with a population of 213,580 (5%), the Eden district with a population of 475,785 (10%) and then lastly the Central Karoo district with a population of 63,569 (1%) (Department of Health

Chapter 3: The Cape Metro District as a case study

Comprehensive Service Plan, 2006: 59, Provincial Departmental projections for Census 2001, Directorate: Information Management).

Cape Town Metro covers 2.500 square kilometres and its population constitutes approximately 9.9% of the National population. It is estimated that in the Cape Town Metro District alone, 64% of the Western Cape's total population resides, although it only covers 2% of the province's surface area (Metro District Health Services Annual Performance Plan 2007-2008). The size and population of this Metro is definitely significant in comparison to the other districts of the Western Cape. Of this population only 32.734 is in a walking distance of 3km radius (access to health care facilities) that was set by the 2010 Health Plan (Department of Health Western Cape Comprehensive Service Plan ,2006:59).

3.2.1 The Klipfontein sub-district.

This sub-district has a population of 381,150 for 2007 of this 133403 is the private population and 242718 the uninsured. According to the Comprehensive Service Plan (2006; 2), a clinic has been allocated for every 30,000 people in the Cape Town Metro District, such a facility will have 18 staff allocated using the clinical staffing model. and the average walking distance to the facility should be a radius of 3-4 km Each of these clinics' will be linked to a CHC which will vary in serving between 30,000 to 120,000 people depending on the size of the CHC and each CHC will be linked to a district hospital. The allocation of the clinics per sub-district is done on the population density of the sub-district. The Klipfontein sub-district has nine City Of Cape Town/municipal clinics, three CHC of which two facilities namely Guguletu and Hanover Park is a 24 hour facility, two MOU Guguletu and Hanover Park and one district hospital – G.F Jooste hospital.

Within this sub-district the link between CHC and clinic has not yet been established. Clinics and CHC operate independently while neither offers the full package of PHC services. Family physician posts at CHC level are vacant and the workload calculator as described below is not applied. All health facilities in this sub-district are also not located within a 3-4km radius as per the Comprehensive Service Plan

Chapter 3: The Cape Metro District as a case study

recommendations and certain parts of the community only has access to mobile facilities.

The City Of Cape Town is the municipality with the most number of COHSASA accredited PHC facilities and in the Klipfontein sub-district three of eight the facilities namely Guguletu, Hanover Park and Lansdowne have been accredited while a fourth facility Vuyani is the process of receiving accreditation for service delivery.

3.3 Reviewing the Progress in Metro District Health Services Organisation

The provincial DoH has a vision of equal access to quality health care and it also shares a joint vision with the City of Cape Town, “Together we can deliver better Health Care for the greater Cape Town” (Metro District Health Services Strategic Plan 2003:10). In June 2003, as part of the Provincial Health Departments’ restructuring, the MDHS was formed. This was as a result of the amalgamation of the Community Health Service Organisation, District and Specialised Hospitals and the Metropole Health Programmes Departments. The directorate of this organisation aimed to strive to deliver a quality, affordable, accessible, efficient health service to all the people in the metropolitan region. (<http://www.capegateway.gov.za>). At the same time, due to the MDHS and the City of Cape Town functioning within a joint cooperative agreement, the District Health Plan was developed.

The MDHS Strategic Plan 2004 – 2007 has been said to be the blue print and road map for the Cape Town Metro Region. This plan was drawn up taking into consideration the future governance and amalgamation of the district health services into one unified DHS. Primary health care PHC services have been declared a Provincial competence by the National Health Bill and this will have implications for the future funding and governance of the District level Health services. The Metro District Health Service (MDHS) and COCT continue to function within a joint cooperative framework agreement, based on joint principles and decision making structures. This is formalised through a service level agreement (Metro District

Chapter 3: The Cape Metro District as a case study

Health Services Strategic Plan 2003: 9). These two spheres of government also have a cooperative working relationship which enables functional integration.

This plan noted the many challenges in providing PHC services and the following was noted during a rapid assessment of the clinical PHC staff at the time:

1996 – 1.8 million visits managed by approximately 2000 staff

2003 – 3.9 million visits managed by the same staff compliment

In this document MDHS admits that the people management challenge remains a key factor in delivering PHC services. Other challenges exist in the Pharmaceutical services, namely periodic stock outs of medication and the shortage of pharmacists, because of the poor working conditions and remuneration packages. The problems with equipment was also mentioned as at the time there was no asset management in place and an audit indicated that essential PHC equipment was old, poorly maintained and needs replacement. Regarding transport the poor EMS response to emergencies and life threatening situations in PHC facilities are discussed. The long waiting times of patients due to many of the above was also discussed and ironically this situation still remains to day. This plan stresses that there is a need to implement a new sub-district management structure to facilitate the effective move to proper decentralisation of management within the MDHS.

In the plan Annual Performance Plan of 2006/2007, Professor K.C. Househam, Head of Health speaks about the additional funding that has been allocated to strengthening both the management and the service delivery of Personal Primary Health Care. Management and support structures will be aligned with the district and sub-district boundaries of the Western Cape.

Actual service delivery will be strengthened by the appointment of family physicians at the larger CHC'S and the filling of vacant nursing posts, the provision of extended hours of service at CHC'S and by allocating additional funding to enhance the response to HIV/AIDS/TB.

Chapter 3: The Cape Metro District as a case study

The nurses, which are said to be the backbone of the Health services are amongst the category of health professionals with highest shortage rates and therefore the current shortages of experienced nurses which is 12% for professional nurses and as high as 26 % for specialised categories presents a fundamental problem. Particular attention is being given to the recruitment and retention of these skills and the intention is to establish a nursing directorate during 2006/07 to manage nursing issues across the province.

Table 1: District health facilities status

2003 District Health Facilities Status in the Western Cape was as per the 2010 Health Care Plan	District Health Facilities as per Annual Performance Plan 2007/8 for the Mitchells Plain and Klipfontein Substructure
Fixed clinics – 242	Fixed clinic – 228
Mobile clinics – 130	Non-fixed – 135
Community Health Centres – 64	Community Health Centres - 60
District Hospitals - 21	District Hospitals - 28

Source: The Department of Health, Healthcare 2010: A Plan to ensure equal access to quality health care (2003) and Annual Performance Plan 2007/8 for the Mitchells Plain and Klipfontein Substructure (2008)

Table 1 above indicates a comparison between district health facilities from the year 2003 to 2007 financial year. It indicates an increase in mobile clinics and hospitals this suggests an increase in first level facilities. In the 2007/2008 Annual Performance Plan the continuation of jointly offered services by the City of Cape Town and PGWC DoH within this district is discussed. The Cape Town Metro has 152 service points and 22 of these are jointly managed by these two service providers. This has caused many problems as these service providers have separate organisational contexts (managerial and administrative structures). This eventually led to the eight most problematic facilities being consolidated to a single service during the 2005/06 financial year. The City manages - Durbanville CHC, Ikwezi CHC and Ocean View CHC. The Provincial Government Western Cape Health Department manages – Vanguard CHC, Site B CHC, Delft CHC, Gustrow CHC and Hout Bay CHC.

3.4 The Strategic Context for setting Target Indicators

3.4.1 *The Millennium Development Goals 2015*

The millennium development goals (MDG) include:

- Reducing child mortality: Under five child mortality should be reduced by two thirds
- Improving maternal health: Maternal mortality ratio to be reduced by 75%
- Combating HIV/AIDS and other diseases: Halve new infections
- Ensuring environmental sustainability: Halve the proportion of people without access to safe drinking water and proper hygiene
- Eradicating poverty and hunger: Halve the proportion of people suffering from hunger
- Achieving universal primary education: All children to complete primary schooling
- Promoting gender equality and empower women: Eliminate gender disparity in all education
- Developing global partnerships for development: Deal comprehensively with the debt of poor countries. Provide access to affordable, essential drugs in developing countries.

3.4.2 *The priorities of the National Department of Health*

Many of the above mentioned goals inform the priorities of the national DoH. These priorities include:

Chapter 3: The Cape Metro District as a case study

- Improving governance and management of the national health system
- Contributing towards human dignity by improving quality of care
- Strengthening primary health care services
- Preparing and implement legislation
- Strengthening international relations

3.4.3 Health Care 2010 Targets

Similarly the Health Care 2010 targets include:

- Treating 90% of health contacts at primary care level
- Delivering high quality PHCare services within the DHS
- Allocating R40 Million for prevention/promotion education

Again many of these goals and priorities have been translated and adopted to the local district level.

3.4.4 Strategic Objectives of the District Health Services and Programmes Western Cape Department of Health

The following are the strategic objectives:

The development of the DHS: Provincialise Primary Health Care Services; Implement decentralised management structures; Implement district and sub-district governance structures; Implement PHC infrastructure; Institutionalise monitoring and evaluation of these services (monthly data collection/collation/verification and quality control while on a quarterly basis analysing, interpreting and taking corrective action- PDR)

Chapter 3: The Cape Metro District as a case study

Within this framework the MDHS intends to improve service delivery on the PHC platform, by providing improved access to services, implementing the comprehensive service plan completely while consolidating the provision of PHC services to a single service provider and mainstreaming performance reporting of these services. (Annual Performance Plan 2007/8 for the Mitchells Plain and Klipfontein substructure (2007:9-10). This will facilitate a better understanding and planning of resources used to provide effective and efficient services. Improving on the quality of services by improving the documentation of supervisory visits and ensuring that information gathered during these visits is used to improve service delivery. Also more efficiently implementing the computerisation and networking project – which is the installation of the PHC information system called clinicom and for the City of Cape Town this system is implemented as well but called PREMIS. Finally providing new infrastructure and building two district hospitals in Mitchells Plain and Khayelitsha by 2010.

3.5 The District Health System in the Cape Metro: Next steps

The Comprehensive Service Plan of May 2007 speaks about the accessibility of services and the achievement of a service point for every 30 000 population, the Model Clinic and its 18 staff members, the attachment of every clinic to a Community Health Centre (CHC), the extended clinic hours of at least one CHC per sub-district, the consolidation of the nine trauma units to having trauma services only available at the district hospital so as to reduce the number of non emergencies accessing doctor care at these trauma units and it speaks about the fact that these services will be nurse driven. This services plan is in alignment with the priorities of the national DoH and Health Care 2010. However it is necessary to realistically review how much progress has been made with implementing the DHS in the Cape Metro since 1994.

After the government of National unity came into power in 1994 a series of documents in the form of policies and White Papers were published all speaking of the implementation of the DHS and PHC been the vehicle of implementation. Firstly the national health systems committee is established in 1994. This is followed by the

Chapter 3: The Cape Metro District as a case study

policy document in 1996 by the national DoH discussing the restructuring of the national health system. In 1997, the Minister of Health releases the white papers on the transformation of the health system in South Africa which describes the decentralisation of the health system and the White Paper on the transformation of the public service which speaks about public health service delivery. (nineties focused on passing legislation for the implementation of the DHS).

Then in the Western Cape the sub-district initiative was launched in 1997 which intended to ensure that decentralisation and service delivery improvements are implemented. The bi-ministerial task team recommendations of 2000, municipal systems; structures and finance Acts all fundamentally shape transformation of the Western Cape Health System during this period but it is the National Health Act 61 of 2003 that gives clear guidance as to which sphere of government is to govern the DHS and PHC services. MDHS is formed in 2003 and Health Care 2010 is also launched simultaneously in the Western Cape. In 2005 Provincial government take over the management of PHC services in the five rural districts of the Western Cape, but still an unsigned service level agreement is the basis for delivering PHC services in the Cape Metro district and this is how services are rendered to date in this district.

3.5.1 The road to decentralising health

Decentralisation describes the transfer of various properties and functions of government management from the national (central) level to 'sub-national level'. These properties include power, authority, functions, resources and responsibilities. The sub-national level usually refers to lower levels of government.

In contrast, deconcentration is the transfer of resources, responsibilities and authority to an organisation or administration. It shifts power from central offices to peripheral offices of the same administrative structure. Devolution refers to the existence of legitimate sub-national levels of government. It shifts responsibility and authority to peripheral bodies that are legally or constitutionally independent. It is the transfer of

Chapter 3: The Cape Metro District as a case study

functions or decisions-making authority to legally incorporated local governments, such as districts or municipalities (Hall, Haynes & Mc Coy 2002: V)

Silverman (1992: 1-2) discusses the five types of decentralisation as: Deconcentration, Delegation, Devolution, and Top – Down Principal Agency and Bottom – Up Agency. His definitions are similar to the above by Hall, Haynes & Mc Coy, however, he defines delegation as the form of decentralisation where responsibility is delegated to another organisation. The Top-Down Agency is defined within the contexts of local governments as exercising responsibility on behalf of central government, whereas the Bottom – Up Agency acts as agents of lower levels of governments or directly as agents of the client.

3.5.2 Why decentralisation has been an option for health in South Africa

There are three main reasons for decentralisation being an option for South Africa, the first reason pertains to improved economic and managerial efficiency or effectiveness.

- Reduction of overload and congestion in the channels of administration and communication.
- Timely reduction to unanticipated problems that inevitably arise during implementation.
- Improved technical capacity to deliver services at field levels, and
- Improved administrative and managerial capacity.

The second reason concerns improved performance - improved information about local or regional conditions for more effective and appropriate economic development planning, decision making and increased monitoring. A third reason involves political interest - improved equity in the allocation of government resources for the investment and delivery of services (Silverman 1992:4). Finally the national

Chapter 3: The Cape Metro District as a case study

government may want to escape the responsibility for service delivery and shift the blame for poor service delivery through the process of decentralisation.

On the 16 April 1997 Dr. Nkosazana C. Dlamini Zuma, Minister of Health states in the White Paper for the Transformation of the Health System in South Africa, Notice 667 of 1997 the intent of decentralising the Health System of South Africa to bridge the fragmented apartheid health system of the past. The mission statement of the health sector;

“To provide leadership and guidance to the national health system in its efforts to promote and monitor the health of all people in South Africa and to provide caring and effective services through a primary care approach”(White Paper for the Transformation of the Health Systems in South Africa,1997:13)

Other legislative documents such as the Bi-ministerial task team report before this document also speaks about a single unified health system with the district being its administrative units and a comprehensive PHC package being available at the first point of entry for the client. It intends to do this as stated in its seven objectives:

1. To unify fragmented health services at all levels into a comprehensive and integrated national health system
2. To promote equity, accessibility and utilisation of health services
3. To extend the availability and ensure the appropriateness of health services
4. To develop health promotion activities
5. To develop the human resources available to the health sector
6. To foster community participation across the health sector
7. To improve health sector planning and the monitoring of health status and services

Chapter 3: The Cape Metro District as a case study

With this the restructuring of the South African health services commenced. Powers were now devolved according to the constitution to the various levels of government – national, provincial and district. The national department assumed the responsibility for policy formulation, strategic planning and management of resources, capacity building for provincial and district health departments and development of a coordinated information system. The provincial department has the broad responsibility of monitoring the health of the people in the province while the district has the responsibility for the management of its budget and the provision of the comprehensive PHC package (White Paper for the Transformation of Health Services in South Africa, 1997:17-31)

Another document which speaks about transforming the public sector is the White Paper on the transformation of the public service. This document with the meaning service to the people focuses on service delivery within the public sector in meeting the basic needs of the South African citizen who due to circumstances has no choice but to make use of these services within this sector. Furthermore the White Paper for Transforming Public Service Delivery (1997:15) suggests the transformation of this sector based on the following eight principles: Consultation, service standards, access, courtesy and transparency, information, openness, redress and value for money.

These values are drawn from and elaborate on sentiments expressed in the Constitution of 1996, namely that:

- A high standard of professional ethics be promoted and maintained;
- Services to be provided impartially fairly, equitably and without bias;
- Resources be utilised efficiently, economically and effectively;
- People's needs be responded to;
- The public be encouraged to participate in policy-making; and

Chapter 3: The Cape Metro District as a case study

- The public health sector is accountable, transparent and development orientated.

This document also addresses the issue of service standards at national, provincial and intra-departmental level. It clearly states that, ‘service standards must be relevant and meaningful to the individual user. Standards must also be measurable so that users can judge for themselves whether or not they are receiving what was promised. In health care for example standards might be set for the maximum time a patient should have to wait for a service at a primary health care facility or how long a patient has to wait for an ambulance to be transferred between health institutions. (White Paper for Transforming Public Service Delivery 1997: 17). This paper also speaks about the regular review of standards. Factors which influence the performance of these standards are addressed in Chapter 11 of this white paper which requires that plans for staffing, human resource development and organisational capacity building be tailored to service delivery and that financial plans link budgets directly to service needs and personnel plans. Yet it is well known today that public health services are under staffed and struggling to recruit personnel due the poor working conditions, the stressful working environment and low salary incentives for the public health sector.

3.5.3 Health Planner Implementation

The Comprehensive Service Plan was approved by Provincial Cabinet in October 2006. The goal of this plan is to, “*ensure that all clients of the public health care services in the province have better access to a high quality of treatment and support at the level of care most suited to their needs*” (Department of Health Western Cape Health Planner 2007: 1). The focus of the plan is to strengthen primary level services. This planner also speaks about the evidence which indicates that 90% of patients could be successfully treated at district level within district hospitals, Community Health Centre’s and clinic’s with the support of community based services. This plan goes on to say that the main beneficiaries of the comprehensive service plan will be

Chapter 3: The Cape Metro District as a case study

the more than 3, 5 million people using the health services in Western Cape, and that staff to will benefit from a strengthened primary level service.

“Better service at well-maintained and properly resourced and staffed facilities will undoubtedly improve job satisfaction through quality time spent with patients as well as through the improved health outcomes” (Department of Health Western Cape Health Planner 2007:1)

The specific targets set as per The Comprehensive Service Plan 2007/8 for the Cape Metro District

Table 2: Health calendar 2007 targets

INDICATOR	BASELINE	ACHIEVED	SET TARGET
Number of District Management structures created	4	4	4
Number of CHC's with functional extended hours	9	9	9
Number of CHC and clinic offering the full package of Primary Health Care service	152	0	All health facilities within the Metro (Total of 152 service points in the Metro)
Number of Family Physicians employed	12	9	12

Source: Department of Health Western Cape Health Planner (2007) also see annexure Health Calendar 2007.

Table 2 above indicates the progress made in achieving its target indicators. The information above was received via personal correspondence from the office of Dr.Keith Cloete – Chief Director Metro District Health Services. Although the table indicates that none of the community health centres offer the full PHC package other indicators suggest that some progress is made with regard to the availability, access and equity of PHC services in the Cape Metro District.

3.5.2 Health information systems

“Health information systems provide management with information on which to base decisions on change, in order to meet the goals of the health system. The main purpose of this system is to monitor the district health systems’ progress towards primary health care and therefore the objectives for which data is collected should include the primary health care objectives used by the World Health Organisation and adapted for the specific district level use in many countries.”
(Zwarenstein and Barron 1992:23)

The City of Cape Town and Metro District Health Service Organisation prior to 2007 used different reporting health systems causing duplication of health information being sent to the national DoH. The validity and accuracy of this information was also questionable as the population denominators used in calculations were at times different or overlapping. Now with clear sub-district boundaries this has been addressed. Comparable data is necessary for situational analysis at national and provincial levels as this allows for performance management comparisons between facilities, sub-districts, sub-structures, districts and regions. Comparative performance also allows for progress monitoring towards the principles of PHC and when individual feedback at meetings like the Plan Do and Review meeting of the City of Cape Town are held it is a forum which allows managers to actively engage with the data from their facility. Measures to improve service delivery at these facilities then stem from this meeting. The meeting of set performance indicators are used when resource allocation for services and staff are done at all levels therefore understanding health information and having an appropriate health information system in place is ultimately a cornerstone to the successful management of the DHS.

Chapter 3: The Cape Metro District as a case study

3.5.4 Joint City of Cape Town and Provincial Government Western Cape Plan Do and Review Results as per targets set for 2007/8

Table 3: Joint City and Provincial Government targets 2007/8

KEY RESULT AREA	INDICATORS
Establishment of district management structures	<ul style="list-style-type: none"> • Number of district management structures created • Number of sub-districts/sub-structure management structures created • Formalisation of Interim Sub-District Management Teams (ISDMTs)
Establishment of Community based accountability structures	<ul style="list-style-type: none"> • % Fixed Primary Health Care Facilities with functioning community participation structures • Number of sub-districts with functioning Health Forums
Improve Information management systems	<ul style="list-style-type: none"> • Number of PHC facilities computerised and with access to Primary Health Care Information System • % PHC facilities with monthly data submitted to Province within 30 days
Improve clinical governance in the District Health System	<ul style="list-style-type: none"> • Number of Family Physicians employed at CHC's
Improving access to emergency care	<ul style="list-style-type: none"> • Number of CHC's with functional extended hours service • Number of clients seen during extended hours • Number of PHC facilities per 100,000 uninsured person
Provision of Primary Health Care Services	<ul style="list-style-type: none"> • Professional nurses in fixed PHC facilities per 100,000 uninsured • % Sub-districts offering full package of PHC Services • % of facilities with Clinic Supervisors manual implemented
Ensuring efficient use of Primary Health Care Health Services	<ul style="list-style-type: none"> • Total head counts for PHC • Headcounts under 5 years • Provincial PHC expenditure per headcount at provincial PHC facilities • Expenditure per headcount at public PHC facilities

Chapter 3: The Cape Metro District as a case study

Source: Joint City of Cape Town and Provincial Government Western Cape Plan do and Review Results as per targets set for 2007/8. Also see annexure Joint PDR

Table 3 above is an example of the joint indicators for the City of Cape Town and the Metro District Health Service organization. It is important for these organisations to have joint target indicators as they are both responsible for the governance and rendering of PHC services in the Cape Metro District. They have a common goal - the full implementation of the decentralised PHC package at all health facilities in this district and therefore it makes sense to monitor progress using the same indicators.

3.6 Summary

This chapter reflects on the reasons for full provincialisation of PHC services in South Africa. The chapter presents the information in the following sections: section one is the introduction to the chapter. In section two the geographics of the Cape Metro District and the Klipfontein sub-district are discussed to put into context the area of this research study. In section three the Metro District Health Services Organisation role in the decentralisation process is contextualised. Section four lists and discusses the millennium development goals (MDG), the priorities of the national department of Health, the 2010 Health Care targets and finally the strategic objectives of the District Health Services. Section five discusses the process and reasons for decentralisation PHC services in South Africa.

CHAPTER 4: QUALITY OF DECENTRALISED PRIMARY HEALTH CARE

4.1 Introduction

The aim of the decentralisation process was to bring primary health care closer to where the people live and make the services more accessible further enhancing the quality of life of communities in South Africa. The realignment of boundaries has organised the DHS into geographically smaller units referred to as districts and sub-districts. The division makes the management of these services more effective. The move to a single health authority managing the District Health System (DHS) was based on these principles. This chapter discusses how decentralised Primary Health Care (PHC) improved the health of our people.

This chapter organises the findings into four main sections. The first section introduces the chapter. The second section discusses Health care 2010 and provides a working definition of Quality Health care. The third section discusses the barriers to providing quality health care. The fourth section presents the main outcomes of the questionnaires in terms of the main indicators pertaining to waiting time, patients and staff perceptions. These questionnaires were administered at two clinic facilities in the Klipfontein sub-district (sample area) of the Cape Metro district (case study area).

4.2 Health Care 2010: A plan to ensure the delivery of Quality Health Care in the Western Cape

This is a plan to ensure equal access to quality health care in the Western Cape. It was produced by the DoH in 2002 as a way to improve the quality of health care in the Western Cape and was finally launched in July 2003 after it's approval by cabinet on the 26 March 2003 (Metro District Health Services Annual Performance Plan 2006/07,2006;23). This plan emphasises primary health services through its core values: integrity, openness and transparency, honesty, respect for people and commitment to high quality service.

However as said by the then Provincial Minister of Health Western Cape, Mr Piet Meyer in his message of 2010, '*things are difficult in Health*'. They have been so for a long time, and they will continue to be so for a long time. Unfortunately he was not

Chapter 4: Quality of Decentralised Primary Health Care

time specific with this statement. The Head of Health in the Western Cape Province, Professor Craig Househam also acknowledged then “*the reality that the health needs of our people outweigh the resources available to meet those needs.*” (Health Western Cape, 2003: 9). The 2010 plan was implemented with this as background knowledge and the logo ‘*Better Care for Better Health, All Day, Every Day*’. This plan has now evolved into the Comprehensive Service Plan for the PGWC.

Interestingly it is said that this plan focuses on service delivery, ‘it is service driven and not budget or infrastructure driven and aims to determine the required resources to deliver an acceptable package of healthcare services’ (Comprehensive Service Plan; 2006; 32). Now the question arises what is acceptable and to who is what acceptable?

Many of the facilities in the Klipfontein sub-district need infrastructure changes to accommodate the services they are delivering today. The inadequate TB departments and constraint of HIV consultation space are at the top the list as the number of patients in need of these services in this sub-district in on the increase and the co-infection rate of these diseases are further contributing to the problem. This presents quite an intrigue problem as some buildings are owned by PGWC but the City Of Cape Town are rendering PHC services in it or the building is owned by the City Of Cape Town and PGWC/MDHS are rendering services along side the City of Cape Town in it .To the greater public this is irrelevant as they come to these facilities for care and the politics in delivering these services are a management battle. The Health Act (2003) requires all health facilities to establish health committees as this is a forum for the community to participate in the decisions concerning service delivery. For Klipfontein sub-district two representatives from each health committee attends the sub-district monthly meeting The Klipfontein Health Forum was established in 2003. The current chairperson is Mr Kamaar and this forum meets monthly to discuss service delivery issues. This forum is also attended by PGWC Facility Managers as well a representative from the district hospital and the non-government organisation from the sub-district. In turn two representatives from this forum attends the Metropole Health Forum meeting which takes place quarterly. At this meeting the Executive Director of Health for the City Of Cape Town and the Director of Health

Chapter 4: Quality of Decentralised Primary Health Care

for the MDHS (top management of health) interact with the community on service delivery issues especially regards to complaints received by the health committee from the public. The informal powers of the health committee should not be underestimated as they can influence management in many decisions because of the political role they play.

Currently government is advocating for community based services for continuum of care versus the public call for specialist care in the field of district and school nursing. However the non-profit organisations rendering this community based services are not yet all South African Quality Assurance (SAQA) accredited and these health workers will be generic community based workers (not specialist) and due to this many a scholar or a terminally ill patient will slip through the cracks. This is one example of public interest that the health committee has raised with government.

Similarly the public is constantly complaining about the long waiting period for a secondary and or tertiary care appointment, while patient waiting list for hospices is so long that family members are taking on the role of the primary care givers. Yet the underlying principles of Health Care 2010 as outlined by the Annual Performance Plan (2006/07, 2006:23) are: quality of care at all levels, accessibility of care, efficiency, cost effectiveness, collaboration between all levels of care and de-institutionalisation of chronic care. The reality is then contradictory to these principles as accessibility to the appropriate level of care even though promised is limited.

In less than two years it is 2010 and the achievement of service delivery as set out in the service plan is questionable. The Cape Town Metro Districts which is only one of the six PGWC districts was previously managed by a Chief Director for District Health Services and a Director Metro District Health Services. Then on the 1st May 2007 an interim MDHS management structure was put in place. Finally on the 1st October 2007 the management structure was finalised and in terms of the National Health Act, Act 61 of 2003 a Deputy Director General: District Health Services and Programmes, a Chief Director: Metro District Services with four directorates each

Chapter 4: Quality of Decentralised Primary Health Care

with its director has been put in place. The change of sub-district boundaries which took place in 2005 in the Cape Town Metro District has led to the Klipfontein and Mitchells sub-district being combined to form one district. The Primary Health Care Manager for this district is Dr. Rob Martell and his core function is to manage PHC services within this district. He reports directly to the Director – Dr. James Claassen for this district who was appointed on the 1st of June 2008 along with the Directors for the three other provincial health districts. This is due to the remaining six sub-districts having been paired to form the three other MDHS districts. This has been based on the population density and geographic's of the sub-districts. This is another fundamental step to implementing the District Health System in the Cape Metro District.

For the Klipfontein Sub-district the District Manager was Dr. James Claassen until end May 2008 when he took up the District Director post for the Klipfontein and Mitchells Plain Sub-structure with the provincial government of the Western Cape. The City Of Cape Town (local government) has a different management structure to that of the provincial government who is currently in the process of finalising this structure according to the comprehensive service plan which speaks to the district health system. Therefore the appointment of the directors as mentioned above. The sub-district manager reports directly to the Executive Director for Health: This post is currently being occupied by Dr. Ivan Bromfield after the sudden death of Dr. Ivan Toms in April 2008. Dr. Toms was known to be instrumental in the development and implementation of the DHS and set strict targets in order to achieve the goals of the system.

In July 2007 the first integrated sub-district management team (ISDMT) was held for the Klipfontein sub-district. This integrated management meeting is where the Primary Health Care Manager (MDHS) and his management team meet with the Sub-district Manager (Local government) and his team monthly to discuss the management of PHC services for the sub-district since the funding for these services are jointly provided by these two spheres of government. For the Klipfontein sub-district monthly PDR (Plan Do and Review) meetings are held to discuss the target indicators that have been set for the financial year. Progress is measured in the format

of tables and graphs giving each clinic a good sense of their performance. Following the monitoring and evaluation meeting at Woodstock Hospital on the 29 June 2007 the Primary Health Care Manager for Klipfontein convened a joint meeting to discuss joint targets for this sub-district in the same format as the PDR. Significant differences exist in the monitoring and evaluation of primary health care services. The financial year for MDHS starts in April of every year compared to the financial year of local government which starts in July. The City Of Cape Town and MDHS however had its first combined PDR on the 29 October 2007. These are all significant steps to the full provincialisation of all PHC services in the Cape Town Metro District by 2008. However due to many differences which still exist with monitoring and evaluation of PHC services the focus for this thesis will be the clinic health facilities of the City Of Cape Town in the Klipfontein sub-district.

4.3 Defining Quality:

By quality is meant the degree of excellence, extent to which an organisation meets the clients' needs. Stated differently it is generally 'doing the right thing, right, the first time and doing it better next time' (Muller, Bezuidenhout & Jooste 2006:534). Katz and Green (1997:8), is more specific and defines quality in health care as the *"level of excellence produced and documented in the process of patient care, based on the best knowledge available at a particular facility."*

The City of Cape Town has a policy document on Quality Management-Policy CT 03/06 of 19 June 2006. In this document the 1998 WHO definition of quality is referred to as-*"proper performance (according to standards) of interventions that are to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, disability and malnutrition."* This document also defines quality to be, *'Doing the right thing right, right away.'*

The City of Cape Town has an orientation policy in place and sends all its new appointments at health facilities for the basic courses related to the services they will need to render. The orientation programmes orientates staff to the District Health System, services delivered in the City Of Cape Town, the organogram of the

Chapter 4: Quality of Decentralised Primary Health Care

organisation and human resource related matters. This allows for staff to be well acquainted with the organisation and their role and function in it.

Measuring the quality of a service in the City Of Cape Town is done by using target and performance indicators. According to Muller Bezuidenhout & Jooste (2006:533), performance indicators are tools used to monitor and evaluate the quality of important governance, management, clinical and support functions that affect outcomes.

With quality terms such as standards, performance management and review are synonymous as they all speak to level of service delivery. Standards serves as a measure against which current practice can be compared while target indicators serve as a measure against which services can be measured. There are a number of role players namely government policy makers, health management (national, provincial, regional, district, sub-district), health professionals and the general public such as health committees who are responsible for performance reviews and monitoring and who also play a fundamental role in setting standards. These role players are involved in policy setting, developing strategy for quality of care and drawing up scope of practices. They then periodically review the performance and progress against the set standards and goals of the organisation.

Standards are said to define quality as they clearly state what is to be received, how it is to be received and when. Standards form an integral part of quality assessment. Standards are written value statement of rules, conditions, and actions in a patient, staff member, or the system that are sanctioned by an appropriate authority. For the City of Cape Town that authority is the Council for Health Services Accreditation for Southern Africa (COHSASA). According to Katz and Green (1997: 9) standards have the following features:

- It must be written so people can be held accountable;
- The standard must adhere to current acceptable levels of practice and are presented in a form that is easily understood by those expected to conform to them;

Chapter 4: Quality of Decentralised Primary Health Care

- It should define a set of rules, actions, or outcomes;
- It must be written for consumers, staff members and systems
- It must be approved by an authority that manages the quality

The type of standard should also be appropriate to the needs of the setting. There are three types of standards: Structure standards: define the rules under which the service must be delivered (eg: all clients accessing the facility should have folders opened). Process standards: define how the service is to be carried out (eg: policies and protocols on service delivery).

Outcome standards: define both the desired outcome and undesired results to be avoided. Examples of this type of monitoring are that within the Klipfontein sub-district audits are used to monitor the TB/HIV/STI programme bi-annually. This programme has specific standards written and specific indicators set for this programme which it is monitored in the monthly PDR as well as quarterly in the TB feedback meetings. Any shortfall in this programme is then highlighted and corrective action taken; measures are put in place to reach the set targets. This gives the management of the sub-district a good idea of how they are doing in terms of combating the TB/HIV epidemic in this sub – district. This in turn is reviewed in terms of not only the sub – district business plan but the business plan for the City Of Cape Town and the Provincial plan.

The City of Cape Town also makes use of complaints or suggestion boxes at its health facilities to measure the public's perception of the organisation and externally customer satisfaction and waiting time surveys are done. Complaints about a service should not be viewed as a negative but rather as a way of improving service delivery. To often public servants are set in their ways and change is met with resistance. The public sector has been involved in a transformation process over the last 13 years and the cultural diversity of our clients and the workforce diversity of the public sector employees' have complicated matters. However quality of care in terms of service delivery cannot be compromised. The challenge that faced the Government of

Chapter 4: Quality of Decentralised Primary Health Care

National Unity in the Mbeki era was, balancing enormous expectations of the masses with substandard delivery systems and resource constraints. It will have to uplift the masses; improve service delivery; facilitate a work ethic that boosts productivity; enhance the mindset of people development; retain essential white skill while promoting affirmative action; reduce crime levels without tampering too overtly with hard won human rights' (Erasmus, van Wyk & Schenk, 2000: 128).

The New Health Act (No 61 of 2003), provides for procedures to deal with complaints. Chapter 2 section 18 sub-section (1) refer to the right of any person to complain about the manner in which they were treated at a health establishment and to have the complaint investigated. It also stipulates in section 3(a) that the procedures must be displayed in each health establishment. Despite the efforts described above at ensuring good quality primary health care services, some problems still persists and present barriers to achieving quality health care.

4.4 Barriers to providing Quality Health Care

The main barriers to good quality health care include- poor communication, financial constraints, shortages of qualified staff and low staff morale. Each of these is discussed below.

4.4.1 Communication

Communication is essential for service delivery as this allows for the top down and bottom up flow of information in any organisation. Each employee should know what the vision; mission and goals of the organisation are in order for them to contribute towards attaining this. Communication allows for facilities to be adequately staffed with the appropriate staff mix as vacancy is identified early, recruitment initiated and post filled. Staff resignations are also discussed and management can learn from the exit interviews the reasons for resignations which will aid in future planning. Communication allows for staff needs to be addressed in

terms of training, rewarding good performance/productivity and the promotion of deserving staff. Forums and communication channels where staff voices their concerns are also essential as this allows for staff to feel heard and not suppressed. These communication measures ensure a good flow of information and problems can be identified promptly and corrective actions taken /put in place.

4.4.2 Financial Constraints

Health facilities were not built for specific communities and neither for the delivery of the comprehensive PHC service package. Facility infrastructure therefore does not meet the service requirements. Currently facilities are struggling to find space for rendering certain services such as TB and VCT counselling and the incidences of these diseases are ever increasing. At most facilities the necessary ventilation requirements for the TB department are not adequate but the service is rendered putting staff at risk by compromising their health. Waiting areas for children under five attending the well baby services such as immunisation form part of the general waiting area where TB clients are also waiting. Infection control guidelines in this regard are then not applied. These are the concerns staff has but which even though addressed is not corrected. Other concerns are that hospital admissions for certain clients are delayed due to bed shortages in the system and even though the client poses a risk for staff and the community they are treated at a clinic level until a bed becomes vacant at secondary/tertiary level eg: the admission of multi-drug resistant (MDR) TB clients to Brooklyn Chest Hospital (BCH). These are all due to financial constraints. These constraints cannot be relieved at sub-district or district level as the budgets are set by top management.

4.4.3 Shortage of staff

The occupational specific dispensation has brought some relieve to provincial staff shortages and government has also embarked on the employment of foreign doctors as well as compelling doctors and pharmacists to complete two years community

Chapter 4: Quality of Decentralised Primary Health Care

service in under staffed hospitals and clinics. However language and a lack of experience can be argued to be barriers in this instance. Staff shortages put remaining staff under pressure as they need to consult more patients in less time therefore it becomes quantity versus the quality service delivery.

4.4.4 Staff morale

The above factors impact on staff morale as there no quick fix solutions to the issues affecting the delivery of quality health care to the patient. Staff is also not well informed of changes within the organisation and feel excluded as there are no time for them to discuss the issue of change which will affect them. Patients often also voice their dissatisfaction with the system to ground level staff so much so that staff becomes verbally abused at times due to service delivery issues. Staff is also expected to be multi skilled and to multi task when the need arises which is more often than not and this affects their morale as they often do not have a choice in the matter.

These constraints point to significant concerns which need to be taken into account in any critical assessment and performance management of primary health care services. These concerns were included among the indicators in the questionnaires for gathering data in the Klipfontein sub-district.

4.5 Specific quality indicators for Klipfontein

Two waiting and service time surveys were conducted in 2005 and 2007 respectively by the school of public health in the Klipfontein subdistrict as a monitoring and evaluation exercise. The main results are presented and briefly discussed below.

4.5.1 Results of waiting time survey

Table 4: Number of patients serviced

Total Patients Manenberg 2005 (N)	Total Patients Manenberg 2007 (N)	Total Patients Masincedane 2005 (N)	Total Patients Masincedane 2007 (N)
189	227	221	204

Source: School of Public Health Waiting Time and Service Time Survey (2005)
 School of Public Health Waiting Time and Service Time Survey (2007)

Table 5: Number of patient's deferred

Patients turned away Masincedane 2005 (N)	Patients turned away Masincedane 2007 (N)	Patients turned away Manenberg 2005 (N)	Patients turned away Manenberg 2007 (N)
0	6	0	5

Source: School of Public Health Waiting Time and Service Time Survey (2005)
 School of Public Health Waiting Time and Service Time Survey (2007)

Table 4 and 5 above indicates the total number of patients serviced and deferred at these facilities

Table 6 and 7 below indicates the patient workload per category of staff. These surveys were conducted on the 31st August 2005 and 15th August 2007. These are snapshots of the utilisation of PHC services at these facilities as these surveys were conducted on a one day basis, but for the purposes of this thesis these surveys do provide insight into service utilisation at these facilities. For 2005 the Klipfontein sub-district had a population of 364 913 and for 2007 the population figures are 381 150. This means that over a two year period the sub-district experienced a growth of 16 237. For Manenberg the population figure was at 11250 for 2005 and for 2007 it

Chapter 4: Quality of Decentralised Primary Health Care

was 11745. For Masincedane the population for 2005 was 14914 and for 2007 it was 15570. The 2007 population data is projected from the 2006 data. On interpretation this means the sub-district had an overall growth of 4.4% over two years. For Both Manenberg and Masincedane clinic the population growth over these two years are in line with that of the sub-district as both communities have grown by 4%.

Table 6: Workload of staff at Manenberg

Service Point	2005	Staff	2007	Staff
	Patients seen Manenberg		Patients seen Manenberg	
Reception	117	1.06	118	3.21
Prof Nurse	74	1.81	60	2.55
Doctor	22	0.50	No data	No Data*

Source: School of Public Health Waiting Time and Service Time Survey (2005)
School of Public Health Waiting Time and Service Time Survey (2007)

*on that day no doctor, this service is available once a week only

Table 7: Workload of staff at Masincedane

Service Point	2005	Staff	2007	Staff
	Patients seen Masincedane		Patients seen Masincedane	
Reception	106	1.69	99	2.74
Prof Nurse	87	2.44	69	2.63
Doctor	19	0.44	15	0.91

Source: School of Public Health Waiting Time and Service Time Survey (2005)
School of Public Health Waiting Time and Service Time Survey (2007)

On interpretation of the results patients are being turned away from services, yet patient numbers over the two years have not increased as significantly as staff numbers. A possible explanation for this could be that the disease presentation is

Chapter 4: Quality of Decentralised Primary Health Care

more complex than it was in 2005 therefore patient consultation time is longer. This could be due to the HIV/AIDS problem escalating coupled with the increase in the TB incidence and prevalence of the sub-district. For 2005 the Professional Nurse to client ratio for Manenberg clinic was 1:41. For 2007 this ratio was 1:24. Similarly for Masincedane clinic the Professional Nurse ratio for 2005 was 1:36 while for 2007 it was 1:26. This indicates there are more Professional Nurses available to consult clients.

Table 8: Modes of transport

Mode of Transport Manenberg	Mode of Transport Masincedane	Mode of Transport Manenberg	Mode of Transport Masincedane	Mode of Transport Manenberg	Mode of Transport Masincedane
Walked	Walked	Bus	Bus	Taxi	Taxi
2007	2007	2007	2007	2007	2007
88.9	98.64	0	0	6.89	0.45

Source: School of Public Health Waiting Time and Service Time Survey (2007)

Table 8 above indicate the most frequent modes of transport patient use to access the facility. The above tables are measuring availability, equity and access of PHC services in the Klipfontein sub-district. The majority of patients' accessed services by walking therefore the availability of services within a 3km radius as per the comprehensive service plan are crucial to service delivery and in terms of accessing these services. On interpretation table 8 indicates, that for Manenberg clinic 39, 1% of clients accessed the facility by walking in 2007. While for Masincedane 48, 35 % of clients walked to the facility during the same time period.

4.5.2 Consumer Perceptions

Two facilities within the Klipfontein sub-district were used to conduct this research. These facilities were selected using the RMR (Routine Monthly Report see annexure E) of these facilities over the last financial year. This RMR measures the headcount/workload of the facility for the month. Two questionnaires was administered, one for the clients to assess their opinion of service delivery and the

Chapter 4: Quality of Decentralised Primary Health Care

other to the staff of these facilities to assess their opinion on their service delivery. This method was used to assess both client and staff perceptions on the quality of health care in this sub-district.

A total of seventy questionnaires were handed out at both facilities and forty completed questionnaires were received back. The graphs below reflect the actual numbers of the respondents.

1. How long have you been attending this Health Facility (clinic)?

Figure 1: Duration of attendance

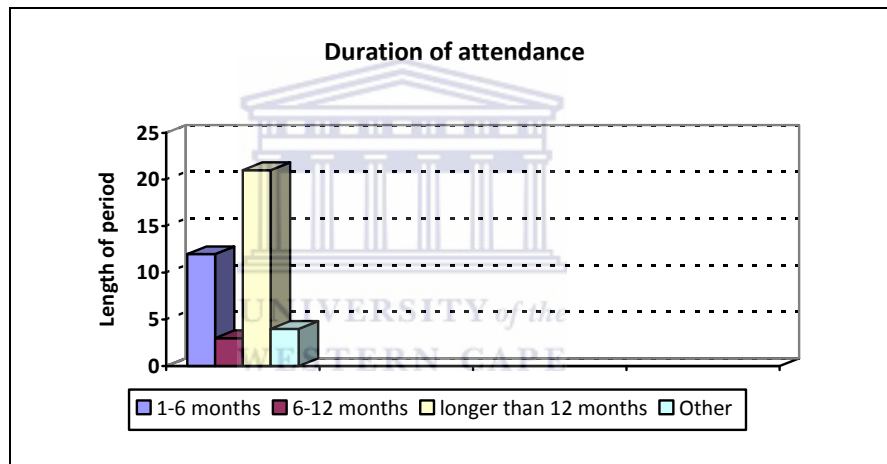


Figure 1 above indicates that the majority of the patients that completed the questionnaire have been attending the facility for longer than 12 months. They should have a more than reasonable insight into the functioning of the facility.

2. Why do you attend this Health Facility?

Figure 2: Reasons for patronage of health facility

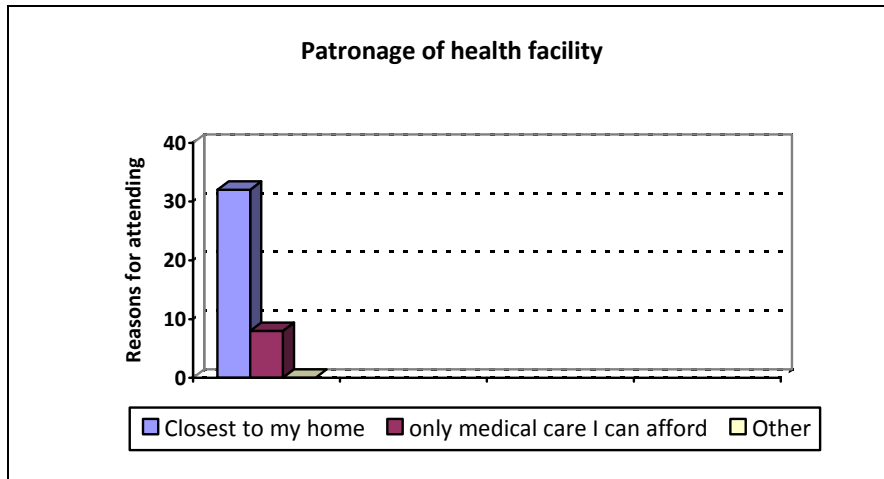
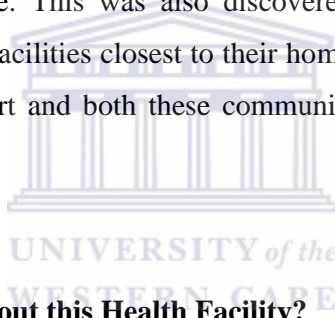


Figure 2 above indicates that the overwhelming majority of the patients attend the facility closest to home. This was also discovered in the previous section, table 8. Clients attend health facilities closest to their homes due to the cost implications of other modes of transport and both these communities have a poor socio-economic profile.



3. What do you like about this Health Facility?

Figure 3: Best features of facility

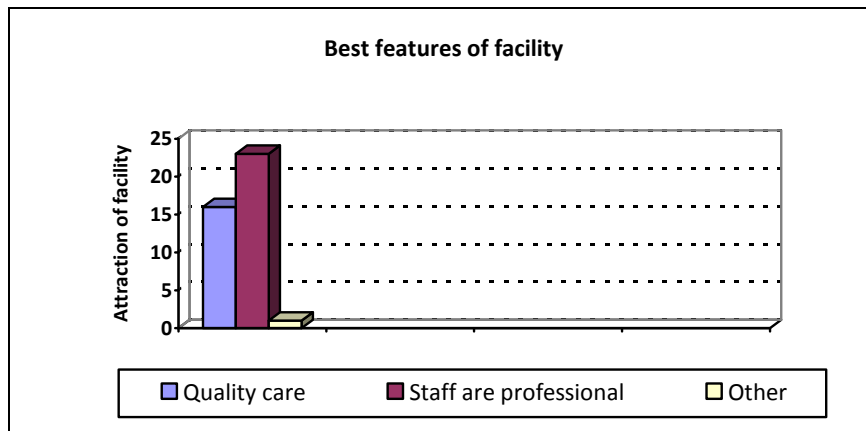


Figure 3 above indicates that the best feature of the facility is the professionalism of the staff in conducting their duties. Clients value being treated effectively, efficiently and by staff who treat them with respect. This relates to the Batho Pele principles.

4. Have you ever been refused health care at this facility?

Figure 4: Deferrals

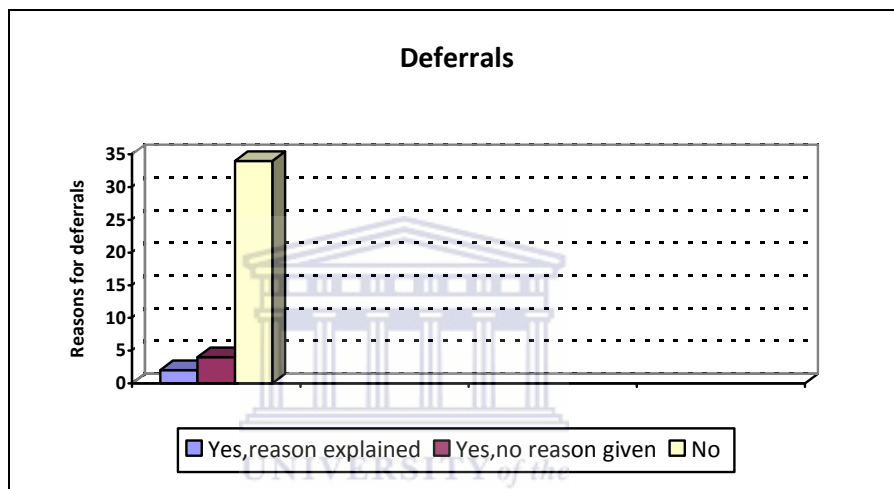
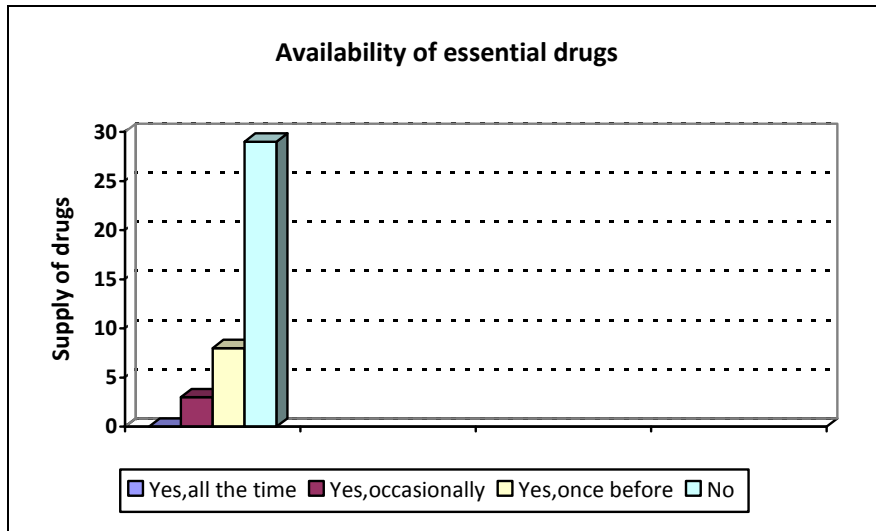


Figure 4 above indicates the overwhelming majority of the patients are receiving services and that deferrals are not frequent. As discussed in table 5, less than 5% of clients have been deferred from these facilities

5. Have you ever been told that this facility is out of stock of medication?

Figure 5 below indicates that a steady supply of essential drugs is available to patients. The supply of medication at these facilities is a proxy indicator for this thesis as clients cannot be treated adequately without the necessary medication being available.

Figure 5: Availability of essential drugs



6. Would you recommend the service received at this facility to your friends and family?

Figure 6: Recommendation of service

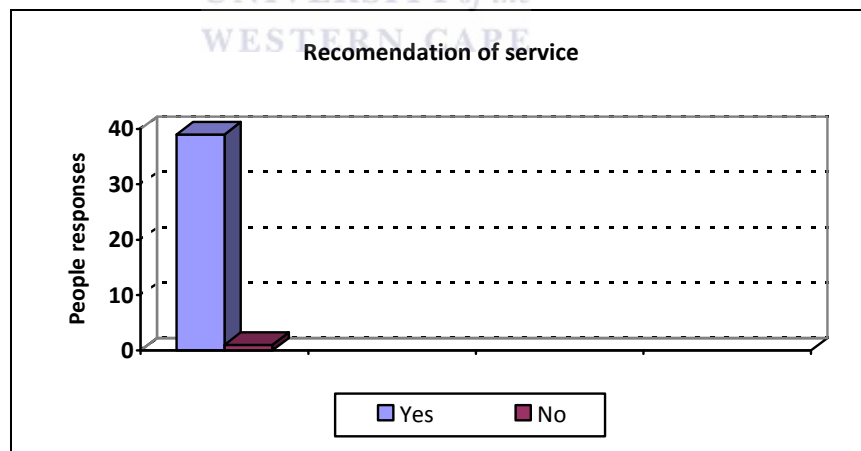
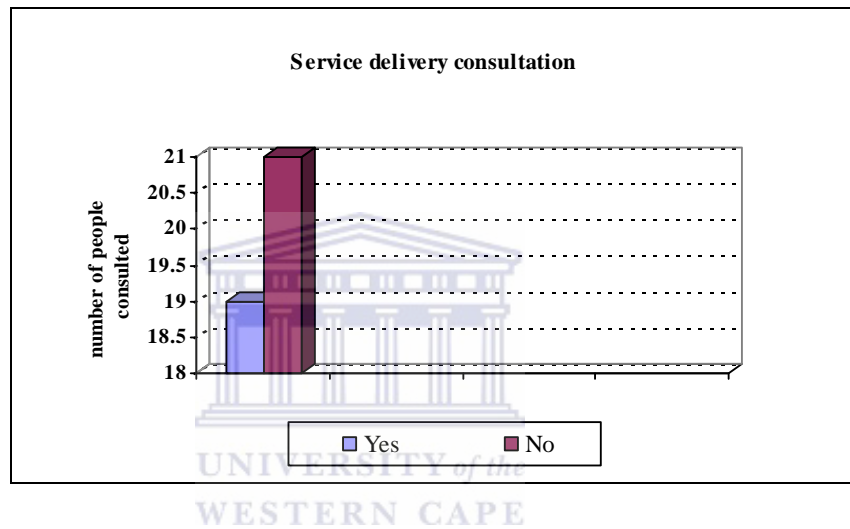


Figure 6 above indicates that most patients would recommend these services to family and friends. Interpretation of this graph indicates that clients are satisfied with service delivery at these facilities and considering the results of figure 1, these clients have attended these facilities long enough to give an informed opinion.

7. Have you ever been consulted about service delivery at this Health Facility?

Figure 7 below indicates that most of the patients are not consulted about services delivery.

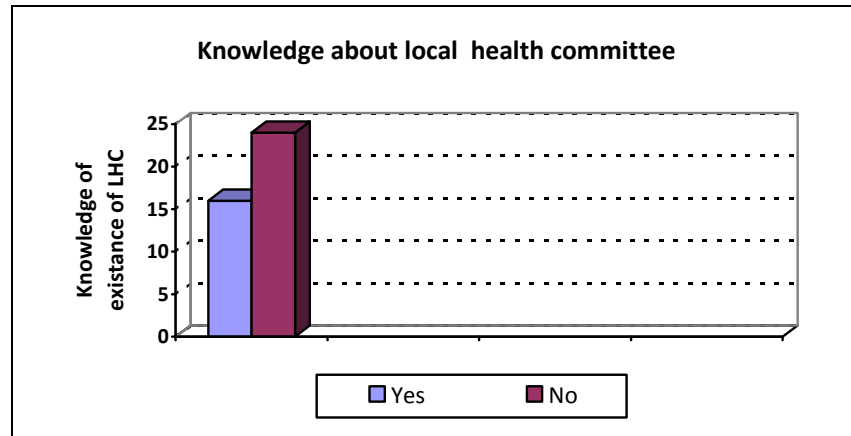
Figure 7: Service delivery consultation



8. Are you familiar with the Local Health Committee?

Figure 8 below indicates that 62.5% of patients are not familiar with their local health committee. This was surprising as unresolved complaints about services delivery can be addressed via this committee. Committee members are also elected from the community by the community.

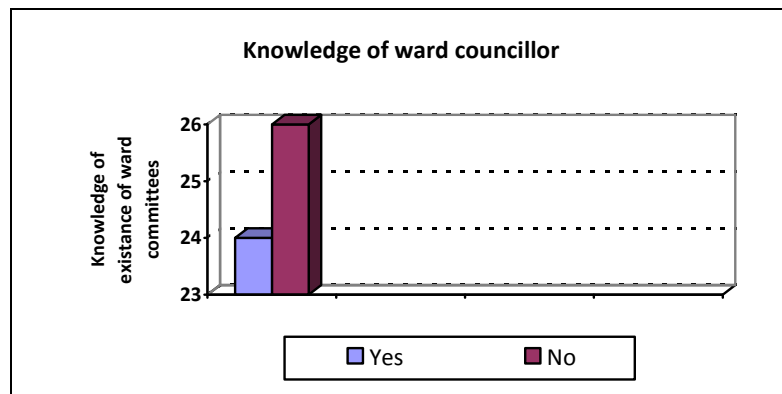
Figure 8: Knowledge of local health committee existence



9. Do you know who your ward councillor is?

Figure 9 below indicates that 65% of the patients are not familiar with their ward councillor. This indicates that ward councillor visibility in the community is lacking. This is also worrying as ward councillors are accountable to the people in ensuring service delivery needs are met.

Figure 9: Knowledge of ward councillor



10. Please give suggestions (at least three) on how service delivery at this Health Facility can be improved?

Chapter 4: Quality of Decentralised Primary Health Care

The following are the patients suggestions to improve service delivery The suggestions are listed according to priority.

- Appoint more nursing staff
- Fast lanes for immunisations and family planning services are needed
- Improve on time management, to avoid long waiting times
- Improve the infrastructure of the health facilities.
- Good communication regarding service delivery changes ,eg staff shortages and medication stock outs
- Health Education/promotion activities for patients while they wait in the main waiting areas.

On analysis of the questionnaire results, respondents report to be happy with service delivery at these health facilities but also report that they are not consulted about service delivery issues. From the results it is also evident that communities are clearly not familiar with the local health committees and ward councillors which are the people elected to address the problems patients experience at health facilities. These are also the individuals that meet with the health management on a monthly basis therefore decisions making power rests with them. Suggestions by the respondents regarding service delivery issues indicate that the following should be prioritised: the appointment of more staff, limiting medication stock outs and improving current infrastructure.

From the observations the researcher made during her time at these facilities the following were observed: Within the main waiting areas neither the clinic nor the City of Cape Town mission and vision statements were displayed, no communication boards are visible to indicate the number of staff on duty or who the facility manager on duty is. A general reception area is available with no indication which queue to join or what services are available. Most of the patients seem to be familiar with the facility therefore no real confusion existed. Patient waiting time at the reception area

was the longest compared to the actual consultation time by either the doctor or the professional nurse. This could be attributed to the new patient information system being implemented at these facilities during this time therefore the opening and retrieval of folders took longer. The majority of patients accessed the services by walking to the clinic. No complaints or suggestion boxes were displayed in the waiting areas. During the time the researcher spent at these facilities no deferrals of patients took place. Before leaving the facilities patients were asked if they had in their opinion received the appropriate treatment and medication. The overwhelming majority reported they were satisfied with the service delivery and no medication stock out were mentioned. Staff on duty was all dressed according to their rank with the display of their identification cards.

On speaking to staff the researcher discovered that staff feels isolated from middle management. Staff at these facilities expressed unhappiness as they consider themselves to be victimised by patients at times due to service delivery constraints out of their control, example staff shortages. Staff felt that supervisory or management visits to facilities are infrequent and they are not given a platform to voice their concerns. No feedback is received from management if complaints are registered. Regarding the amalgamation of the City Of Cape Town and MDHS no road shows are any other consistent communication channel is available. Staff is informed about changes via unreliable sources such as colleagues in other departments. These uncertainties contribute to low staff morale and staff resignations.

4.5.3 Staff perceptions

Low staff morale influenced the response to the questionnaires. Of the thirteen staff on duty at the two facilities over the one week period only ten agreed to complete the questionnaires. Of this group six were nurses and four were admin staff members. Staff expressed unhappiness about a number of issues of which staff shortages and unsatisfactory conditions of service were the top two. Others such as poor communication channels in the organisation, lack of middle and top management visibility and patient verbal abuse of staff were also expressed.

1. How long have you been working at this facility?

Figure 10: Period of employment

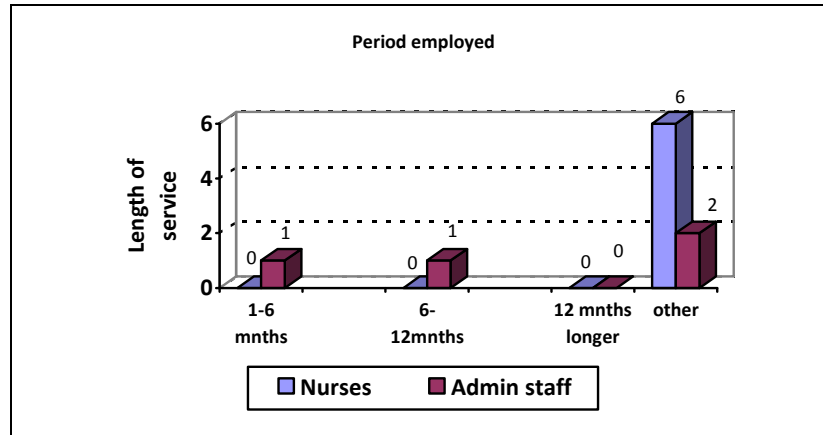
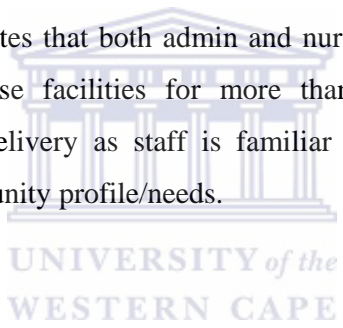


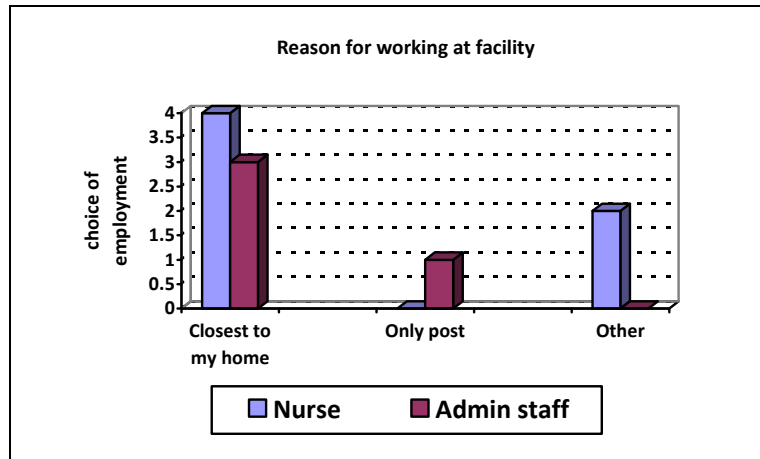
Figure 10 above indicates that both admin and nursing staff at these facilities have been employed at these facilities for more than 12 months. This contributes positively to service delivery as staff is familiar with the clinical setting of the facilities and the community profile/needs.



2. Why did you choose to work at this facility?

Figure 11 below indicates that the main reason for staff choosing to work at these facilities is because it is closer to home. Making a conscious decision to work at facility aids productivity as the decision was not enforced upon the individual.

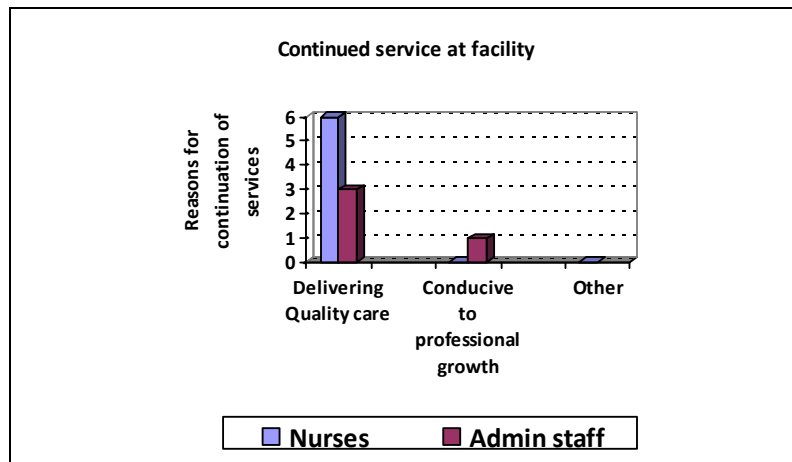
Figure 11: Reasons for working at facility



3. What do you like about this health facility?

Figure 12 below indicates the main reason for staff working these facilities are because they are able to deliver quality care. Since the majority of staff lives in the community they serve, many know their patients personally. Making a difference in these patients lives therefore improve staff conduct.

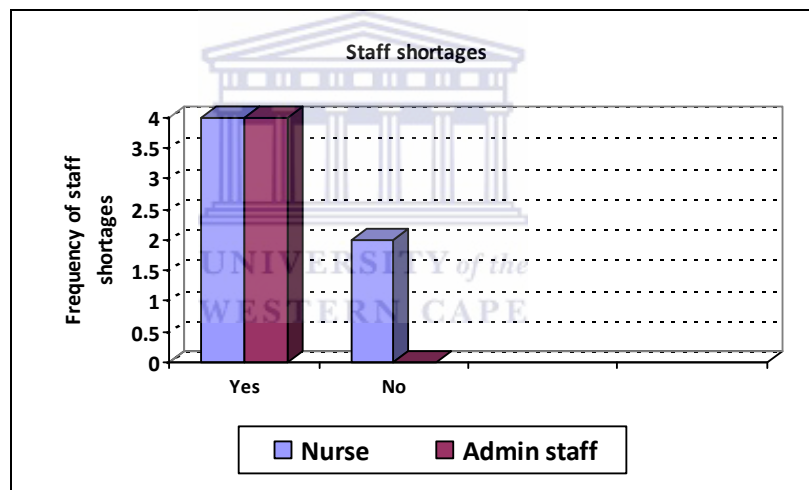
Figure 12: Reasons for staff continuing to work at facility



4. Have you ever being unable to render health care to clients at this facility due to staff shortages?

Figure 13 below indicates that both admin staff and Nurses were unable to deliver a service to patients due to staff shortages. This indicates that staff shortages impacts negatively on service delivery as patients need to be deferred.

Figure 13: Staff shortages



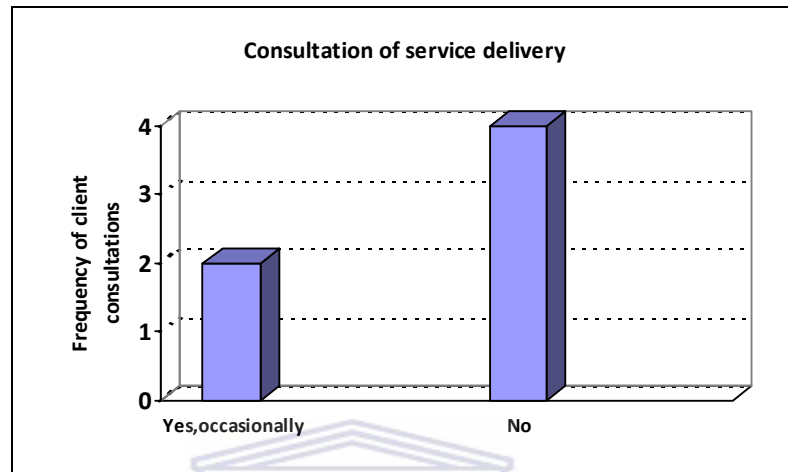
Questions 5-12 are applicable to nurses only

5. Have you ever consulted clients at this facility when you were unable to dispense the required medication due to stock shortages?

Chapter 4: Quality of Decentralised Primary Health Care

Figure 14 below indicate that 66.6% of staff do not consult patients on service delivery issues.

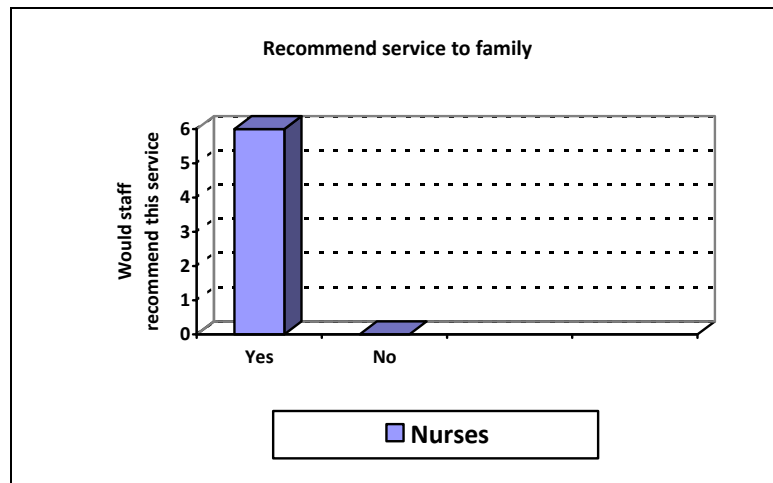
Figure 14: Consultation of service delivery



6. Would you recommend the quality of care and services been rendered at this facility to your family and friends?

Figure 15 below indicate that 100% of Nurses would recommend the health care at these facilities to their family. This relates to the results of figure 12, when staff indicated they continue to work at these facilities as they are able to render quality care.

Figure 15: Personal recommendation of services



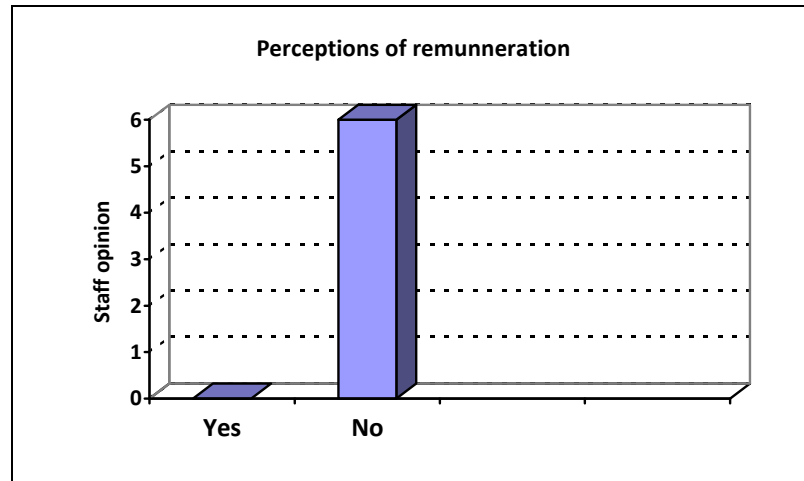
7. How well informed are you about the amalgamation of the City of Cape Town and Metro District Health Services?

About the amalgamation of health services between the City of Cape Town and the Western Cape Department of Health 66.6% of Nurses are not well informed. This amalgamation would directly effect their job description and the services they deliver and it is also the main reason why nurses are leaving the services. This result is shocking because of the implications it would have for this category of staff.

8. Do you feel you are adequately remunerated by your employer for you services?

Figure 16 below indicates that 100% of the nurses interviewed/ completed questionnaire suggested that they were not adequately remunerated.

Figure 16: Perceptions of remuneration



9 How do you feel about the PDR system that is used for monitoring and evaluating your facility?

Figure 17: Opinion of PRD System

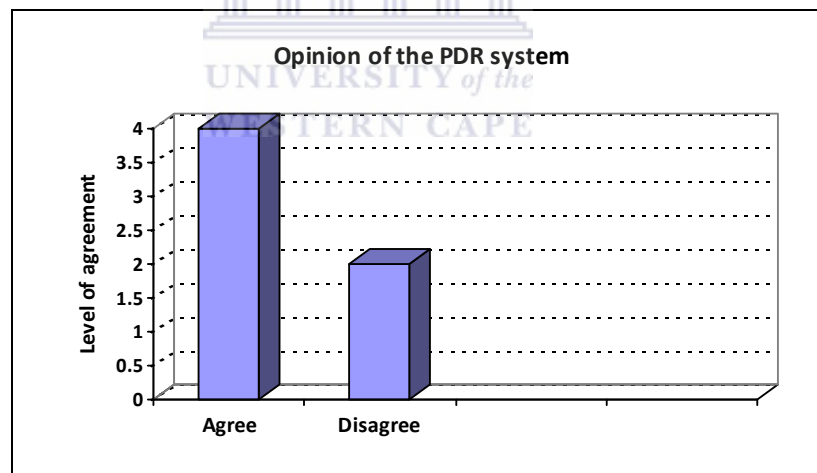


Figure 17 above indicates that 66% of the nurses agree with the PDR system as an adequate monitoring tool. Others felt that a less rigid monitoring tool is required, as the PDR system does not report on reasons for poor performance, example infrastructure constraints. Services are not rendered at times because the facility infrastructure cannot accommodate for it, example antenatal care at clinic level.

10. How often do you receive feedback on the performance of you facility from management?

Figure 18: Facility performance feedback

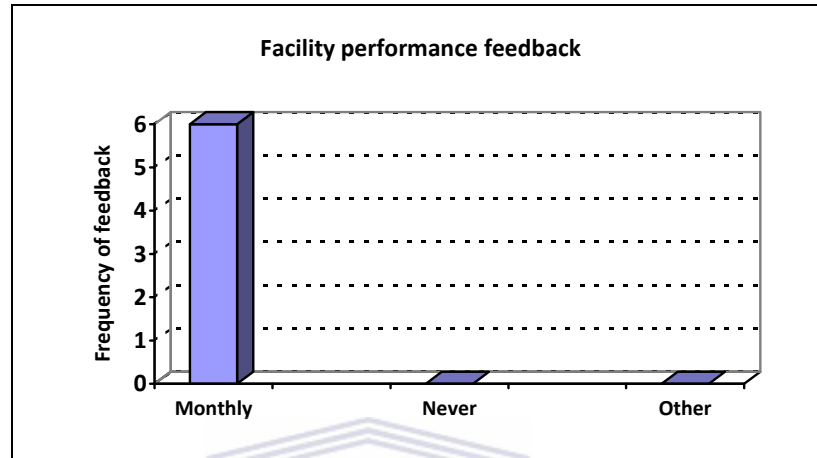
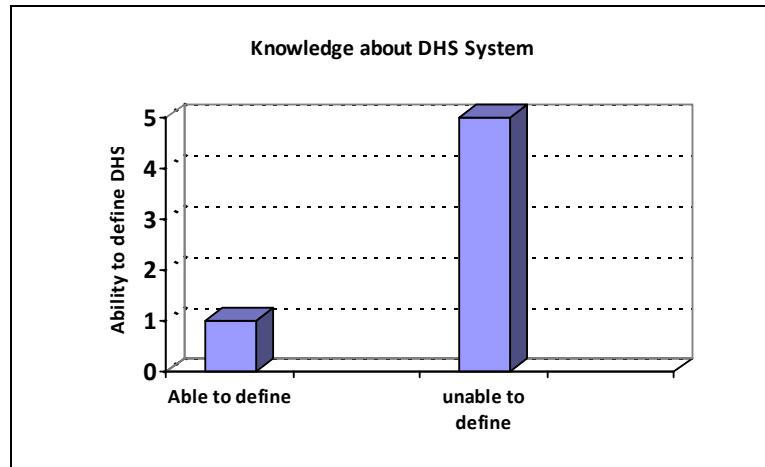


Figure 18 above indicates that 100% of the nurses receive feed back on their facilities performance. The PDR system is used to give facility feedback.

11. What do you know about the DHS?

Figure 19 below indicates that 83% of the nurses were not able to define the district health system as a concept

Figure 19: Knowledge about DHS System



12. Define PHC?

Figure 20: Knowledge of PHC

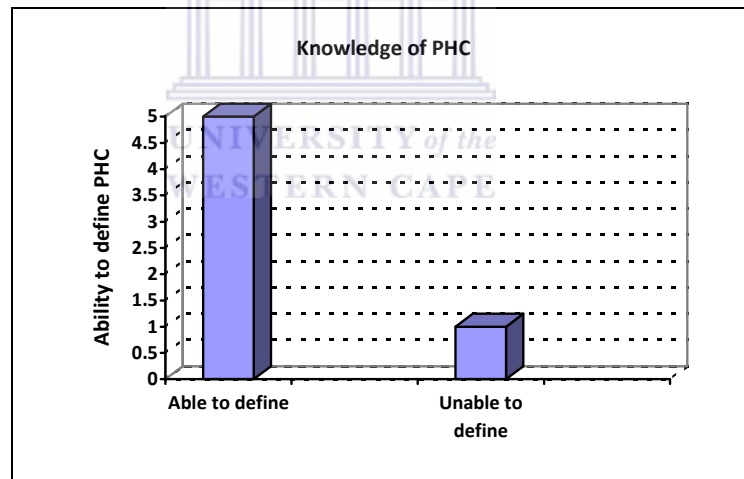


Figure 20 above indicates that 83% were able what is meant by the concept PHC

The nurses were not able to define the concept of DHS and many referred to it not as a management structure but as services rendered within a district. This concept was confused with that of PHC services.

4.6 Summary

In summary the main finds of the chapter are: In section two the 2010 Health Care is Plan is discussed. The fact that this plan is service driven and not budget or infrastructure driven but the same time Provincial Minister Piet Meyer admits that resources are limited in health therefore certain services cannot be offered at every facility. Limited resources are also the reason for the decentralisation process not being completed, regardless of the deadline set. However significant milestones in the process have been reached – joint ISDMT, PDR meetings are now held. A joint health information data base is used for monitoring and evaluating service deliver and the achievement of targets.

Section three defines the concept of quality and discusses health standards. Section four lists and discusses four barriers to providing quality health care. Questions concerning these barriers are posed in the consumer and staff questionnaires in this section. Graphs are used to illustrate the findings of the questionnaires. Section five has tables illustrating the results of the 2005 and 2007 waiting and service time surveys which were conducted by the School of Public Health. In sum the chapter presented the findings of the fieldwork conducted by the researcher and concludes with suggestions by patients on how to prove service delivery, while also illustrating the level of staff understanding of the DHS and PHC.

CHAPTER 5: ANALYSIS OF FINDINGS CHALLENGES AND CONSTRAINTS OF PROVIDING A COMPREHENSIVE DECENTRALISED PRIMARY HEALTH CARE SERVICE

5.1 Introduction

The purpose of this chapter is to report on the analysis of the fieldwork, challenges and constraints of the decentralisation process in the Cape Metro District of the Western Cape. Toms (2006) makes reference to the following elements of the DHS: decentralisation, overcoming fragmentation, comprehensive package, intersectoral collaboration, equity and local accountability. These concepts have been discussed throughout the document but in this chapter the success in implementing these elements of the DHS will be examined.

Section one introduces the purpose of the chapter. Section two discusses four reports by the Health System Trust on the quality of Primary Health Care (PHC) services in South Africa. These reports focus the availability of services, drugs and staff workload. In the last section recommendations for the way forward in terms of the success, challenges and constraints of providing a comprehensive decentralised Primary Health Care Service in the Cape Metro District is discussed.

The Achievement of our goals

The Comprehensive Service Plan speaks about the PHC workload and utilization calculator which will be used to determine the staffing levels of facilities. This calculator will use the following variables:

- The direct patient care factor which is the percentage of time spent in direct contact with patients.
- Minutes per consultation per staff category of staff.
- Number of contacts of a patient with health workers at different service points during one visit to a facility. (Comprehensive Service Plan;2006;2-3)

Chapter 5: Challenges and constraints

This utilisation calculator has however not been implemented. No formula exists for the calculation of direct patient care. Staff has not been informed via policy what the standard consultation time per patient is. Nurse patient ratio has not been standardised and even though these are all good quality improvement initiatives' management consultation with staff is lacking in this process and therefore implementation pending.

The City Of Cape Town has implemented the PREMIS system in July 2007. This is a patient identification and monitoring system in that each patient is given a unique identification (folder) number but that this number is linked the MDHS system which prevents duplication should this patient be referred to a CHC ,level one or two hospital This System also allows for a RMR sheet to be attached to the folder on each visit and this monitors the service the patient has received and which health worker has rendered the service (measuring workload). The School of Public Health has also conducted a number of patient waiting and service times surveys in the Klipfontein to measure patient numbers and staff workload. The last survey was conducted in August 2007.

Analysis of the waiting time surveys of 2005 and 2007 at Manenberg (see annexure C) and Masincedane clinics (see annexure B) indicate that more staff has been appointed at these two health facilities but an increase in patients is not evident while deferrals are also taking place at these facilities. These surveys also indicate that most people walk to the nearest health facility as this is what they can afford. Therefore the 3-4 km radius for a health facility in every community as stated in the comprehensive service plan is necessary.

The patient perceptions questionnaire indicates that generally patients are happy with service delivery at their health facilities. It also indicates that patients even though they report to be happy with service delivery they are not consulted on service delivery issues (see annexure H). Patients are not familiar with their local health committees and ward councillors which is surprising as both these communities have active health committees. Suggestions from patients were the appointment of more staff and the fast lane system implementation to reduce patient waiting time. Patient

Chapter 5: Challenges and constraints

did not report that affected by drug stock, but this issue was a problem this year. (see annexure G)

The staff perception questionnaires indicated that staff works in the areas they live giving them good insight into the needs of the community they serve. The staff generally also works at facilities for periods longer than 12 months while they report to be unhappy about their remuneration packages. About the amalgamation process they report not be well informed and most could not define the DHS.

On the 4th July 2008 Dr. Keith Cloete Chief director Metro District Health Services confirmed that provincialisation of primary health care services in the Cape Metro district will only take place after the 2009 presidential elections. Political influence on the process decentralisation cannot be ignored and this will mean that 15 years after democracy in South Africa and the renewed commitment to the process of full implementation, it is still pending, once again depending on the results of this elections. What does this mean for the staff employed within the public health sector that has awaiting this provincialisation for more than five years now, but more importantly what does this mean for service delivery and the ordinary man making use of the public health sector facilities. In this regard the objectives of the decentralisation process have not been met as the deadline for provincialisation of PHC services has again been extended. This means these services will continue to run parallel as different service providers are offering this service.

5.3 Health System Trust Reports: Analysis of findings

Four documents on the progress of Primary Health Care Services in South Africa will be discussed. The first document – Measuring the move towards equity: From the site of service delivery. This document was published by the Health Systems Trust in November 1997. The aim of the document was to evaluate the quality of service provision rendered at primary level in South Africa and to describe major differences between provinces. Some of the indicators used were;

- Workload – number of patients per nurse per month
- Support – visit by doctor in the last month

Chapter 5: Challenges and constraints

- Equipment – availability of working scales for weighing babies
- Drugs availability – a selection of drugs from the essential drug list

This survey was carried out in 1997 by the Health Systems Trust in all the health regions of South Africa. One district was randomly selected from the region and data was collected from three clinics in the district.

Table 9: Availability of Health Care

INDICATORS	WESTERN CAPE PROVINCE (N)	EASTERN CAPE PROVINCE (N)
Average number of patients seen per nurse per month	471	548
Percentage of clinics visited by a doctor in the last month	70 – 80	0 - 10
Percentage of avail immunisation services	20-40	40-60
Percentage of avail family planning services	80-100	80-100
Percentage of clinics visited: availability of selected essential drugs :antibiotics	92	89

Source: Health System Trust, Measuring the Move towards Equity. From the site of Service Delivery (1997).

The second document – Measuring Quality of Care in South African Clinics and Hospitals was published by the Health Systems Trust in November 1998. The aim of the document was to obtain baseline data on the quality of public sector clinic services in South Africa. A Specific objective was to describe the quality of care provided by clinics within provinces. A stratified random sampling method was used, where each province formed a stratum and a 10% sample of clinics was drawn from each province.

Chapter 5: Challenges and constraints

Table 10: Measuring Health Care standards

INDICATORS	WESTERN CAPE PROVINCE (N)	EASTERN CAPE PROVINCE (N)
Number and percentage of clinics with at least one full-time PHC Nurse.	27	0
Number and percentage of clinics with at least one full-time Professional Nurse	27	64
Percentage of clinics with community health committees	72	77
Percentage of clinics with patient complaint procedures	77.4	50
Percentage of clinics with all TB drugs available (essential drug list drugs)	91	44
Percentage of clinics providing daily immunisation services	44	76
Percentage of clinics providing daily family planning services	72	94

Source: Health Systems Trust. Measuring Quality of Care in South African Clinics and Hospitals (1998). Health Systems Trust.2000.The National Primary Health Care Facilities Survey 2000.Durban.The Press Gang. Health Systems Trust.2004. The National Primary Health Care Facilities Survey, Durban, The Press Gang.

The next survey in 2000 was a follow-up on the 1997 and 1998 surveys as part of ongoing monitoring and evaluation of Primary Health Care services. A random sample of 445 clinics (10% per province) was drawn.

Chapter 5: Challenges and constraints

Table 11: Monitoring the availability of Health Services

INDICATOR	WESTERN CAPE (N)	EASTERN CAPE (N)
Availability of EPI (Percentage of facilities offering Immunisations daily)	40	89
Availability of Family Planning services (Percentage of facilities offering family planning services daily)	70	96.7
Average number of patients attended to per nurse per month	592	520
Availability of TB Drugs (Percentage with the indicated drugs in stock)	56.7	39.7

Source: Health Systems Trust The National Primary Health Care Facilities Survey (2000).

The purpose of this survey was to measure progress with regard to availability, accessibility and quality of the provision of Primary Health Care Service and make recommendations for improvement. This survey used the District Health Information System database to draw their sample from. A 10% sub-sample of Primary Health Care facilities was selected in each province. The sampled clinics were randomly selected using proportional stratified sampling at the district level to ensure that all districts were adequately represented.

Comparing the 1997, 1998, 2000 and 2003 from the respective surveys the following can be said: Average number of patients seen in the Western Cape in 1997 compared to the data from the 2000 survey shows an increase in workload of nurses in this province but the opposite for the Eastern Cape Province. Percentage of Immunisation services daily available for the Western Cape Province since 1997 to 2003 has shown a moderate improvement. For the Eastern Cape Province the most improvement in availability of this service is from 1997 to 1998, moderate improvement is noticeable since then Percentage Family Planning services available daily for the Western Cape Province has remained the same for 1998, 2000 and 2003.

Chapter 5: Challenges and constraints

Table 12: Measuring progress of Health services

INDICATOR	WESTERN CAPE (N)	EASTERN CAPE (N)
Percentage Immunisations Service provision	40-50	80-90
Availability of Family Planning services (Percentage of facilities offering family planning services daily)	75-85	90-100
Availability of Professional Nurses per population	159 per 599,101	316 per 738,875
Availability of Doctors per population	21per 599,101	18 per 738,875
Availability of full time health personnel equivalents across all categories	2.8 per 100 000	6.1per 100 000
Percentage of facilities with Anti-TB drugs in stock	70-80	81-91

Source Health Systems Trust The National Primary Health Care Facilities Survey (2004)

The Eastern Cape Province appears to have this service more readily available than the Western Cape and has maintained a percentage availability of between 90-100%. Percentage anti-TB drugs available has for the Western Cape Province decreased significantly from 1998 to 2000. There has been improvement in the availability from 2000 to 2003 but this is not satisfactory as these are Essential Drugs to the delivery of Primary Health Care Services and availability should be 100%. For the Eastern Cape Province there has been a steady improvement from 44% in 1998 to between 81-91% in 2003.

It is difficult to accurately comment on the quality of service delivery for the Cape Metro District given the above data for the whole Western Cape which include the provision of services for both the provincial government and the City of Cape Town. Although this gives in sight into overall service delivery for the province problem areas cannot be highlighted on this basis for any one of the service providers. This however can be used jointly by the two organisations to plan since they are both using the District Health Information system to set joint target indicators. This is also a good overall view of the progress these provinces are making in services delivery.

Chapter 5: Challenges and constraints

The Western Cape Province data was compared to that of Eastern Cape Province on the basis of migration from the Eastern Cape to the Western Cape been a particular problem in the Klipfontein sub-district and the writer wanted to establish if this is related to the availability of services in this province. A migration study conducted in 2001 by local academics for the Provincial Government of the Western Cape indicated a nett of 48 000 people migrate into the Western Cape every year mostly from the Eastern Cape and Northern Cape. (Metro District Health Services Strategic Plan 2004-2007, 2004:74). Patients also report that the access to PHC services in the Eastern Cape is limited therefore they travel to this province as it is known for delivering quality PHC services which are accessible and available.

5.4 Successes, challenges and constraints and lessons learnt.

The DHS has been implemented but just how well is the system functioning? Clear sub-district boundaries are in place as well as sub-structures boundaries but PHC services are still fragmented. Not to the same extent as before but the progress made over the last 14 years has not met the needs of the public nor have the time frames set for this process been met. Concerns over poor service delivery has been voiced repeatedly of late, staff shortages, low staff morale, infrastructure and financial constraints still hinder the process of service delivery and the role of politics in the decentralising process is evident in the delays encountered.

The South African legislature has successfully passed the National Health Act of 2003 as a blue print for public sector health service delivery. Also other legislative documents such as the White Paper for the transformation of health services and the Municipal Systems, Structures and Finance Acts guide the decentralisation process yet the successful implementation of a decentralised Primary Health Care System has not happened. Significant progress has been made in the last year with the Metro District Health Services appointing the Directors for the sub-structures. This is however not enough for the ordinary man as very little difference is noticeable at grass root level since the remaining sub-structure staff have not been appointed therefore management at this level is incomplete.

Chapter 5: Challenges and constraints

Initially an eight year time frame was set for the full scale decentralisation process to be complete in the Cape Metro District it has been more than ten years and Dr. Keith Cloete (2008) has indicated that this will now take place in the 2010/11 financial year due to a number of political influences. This will mean that in total the process will take twice as long to be completed.

From the evidence presented in this document it is clear that the management of Primary Health Care Services should be assigned to one sphere of government and the situation within the Cape Metro District at present is not conducive to delivering the full package of primary health care services at every health facility until this has been resolved. Difference in management structures and staff conditions of service will continue to hinder the successful rendering of these services and the decentralisation process.

Within the South African context provincial governments are required to implement laws passed by parliament as well as legislation passed by provincial legislatures on specified matters. Local or municipality level governments are autonomous; they have legislative, governmental and administrative functions but are subject to the laws passed by parliament and the provincial legislatures. This level of government controls its own budget- 'the power of the purse', allowing it to specify the activities to be undertaken and the allocating money accordingly (Cloete 1996:91-108).

Currently the COCT makes a significant contribution from its own revenue to PHC services and since the provincial department cannot afford to take over this funding the status quo remains. Outside of the Cape Metro District Primary Health Care Services have been provincialised, complicating matters as all health districts within a province are to function the same.

Other obstacles are poor organisational communication from management on the progress to date and the future which would a lay most concerns staff has but uncertainty is causing experienced staff particularly nurses to leave the service and since Primary Health Care is a Nurse driven service, the effect is most felt by the patient, in the form of deferrals or prolonged patient waiting times.

Chapter 5: Challenges and constraints

The Essential Drug Lists first introduced in 1996 is a list of essential Primary Health Care drugs without which primary health care services cannot function adequately. The availability of drugs at PHC level has been a problem throughout 2008 (see annexure G). Drug stock outs has been a problem for both the City of Cape Town facilities and the Metro District Health Service facilities and at times the drug stock outs were a national problem example TB drugs: streptomycin, Rifinah 300mg.

Another challenge is providing health to all are infrastructure constraints Every service should be offered every day but for the same reasons stated above in addition to most health facility buildings being too small to render all services every day, some services example antenatal care are provided on specific days only.

The decentralised district management structures are an indication of the progress towards the District Health System. The extended hour services at selected Community Health Centres improve access and availability of services should patients require basic primary health care services after four 'o'clock which is often the case, examples rehydration therapy for acute gastro-enteritis or nebulisation for asthmatic attacks.

The appointment of Family Physician allow for the majority of medical conditions which are out of scope of practice of Professional nurses to be treated at primary health care level as they will treat these patients (avoiding referral to a level one hospital for management by a doctor) improving the effectiveness and efficiency of services at this level which enhances the quality of this service. Since the target for the appointment of Family Physicians has not been met and in this case no Family Physicians have been appointed for the Klipfontein sub-district. Therefore equity of services has not been met as this service is available in every other sub-district but Klipfontein.

5.5 Summary

A definite decision to adhere to the National Health Act 61 of 2003 should be taken and PHC should be assigned to one sphere of government to avoid more

Chapter 5: Challenges and constraints

disillusionment of the decentralisation process. Sufficient planning and consultation has been done, full scale implementation is now necessary

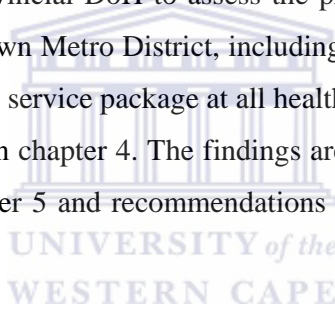
Section one of this chapter discusses the elements of the DHS. Section two the demographics of the Klipfontein sub-district and the Comprehensive Service Plan. In Section three four reports by the Health System Trust highlighting some indicators they used to assess the status of Primary Health Care services in South Africa from 1997 to 2003 are discussed. Section four of this chapter discussed some of the successes, challenges and constraints of the decentralisation process relating to the key indicators of PHC.



CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Restating the objectives

In terms of the main and general objective set for the mini-thesis which is to assess the quality of decentralised primary health services in the Cape Metro District of the Western Cape. The objectives were generally achieved. The DHS is defined and the PHC approach in terms of the legislative framework governing the process was discussed in chapter 2. The progress and the implementation process of the DHS in the Cape Metro District was discussed in chapter 3. A consumer perception survey of service delivery in terms of the 2010 Health Care model (ie 3A3E model) is discussed. Using the plan do and review monitoring and evaluation tools of the City of Cape Town and Provincial DoH to assess the progress of primary health service delivery in the Cape Town Metro District, including the proxy indicators for offering the comprehensive PHC service package at all health care facilities in the Cape Metro District was discussed in chapter 4. The findings are analysed in terms of constraints and challenges in chapter 5 and recommendations for the way forward are made in chapter 6.



6.2. Findings

In conclusion the thesis focused on introducing the international and local definitions of Primary Health Care and the District Health System. A significant mile stone was the first international conference on PHC in 1978 by the WHO and relates to the origin of the concept of PHC. The importance of National Health Act (2003) is the extent to which the principles as legislated by the Act conformed to PHC. This is consistent with the Constitution of 1996 and outlines the sphere of government responsible for the management of Primary Health Care Services. The bi-ministerial task team recommendations, the institutional and service level agreements between the City of Cape Town and the Provincial Government of the Western Cape were discussed as these agreements is what governs Primary Health Care Service in the

Chapter 6: Conclusions and recommendations

Cape Metro District currently, while the debates on the provincialisation of Primary Health Services continue. This in turn is translated into the broad targets set in the 2010 Health Care Plan and its implementation strategy.

The thesis reflects on the reasons for full provincialisation of PHC services in South Africa. The geographics of the Cape Metro District is discussed as the area of this research study. The critical role played by the Metro District Health Services Organisation in the decentralisation process. The collaboration and service level agreement between the City of Cape Town and the Western Cape Provincial health department is strong. However there remain significant challenges to managing PHC some of these barriers include communication and staff shortages.

The millennium development goals (MDG) are seen as the priorities of the national department of Health, the 2010 Health Care targets and finally the strategic objectives of the District Health Services. The 2010 Health Care is Plan is service driven and not budget or infrastructure driven but at the same time Provincial Minister Piet Meyer admits that resources are limited in health therefore certain services cannot be offered at every facility. Limited resources are also the reason for the decentralisation process not being completed, regardless of the deadline set. However significant milestones in the process have been reached – joint ISDMT, PDR meetings are now held. A joint health information data base is used for monitoring and evaluating service deliver and the achievement of targets.

The concept of quality, health standards and the four barriers to providing quality health care is discussed. In sum the thesis presented the findings of the fieldwork conducted by the researcher and concludes with suggestions by patients on how to prove service delivery, while also illustrating the level of staff understanding of the DHS and PHC.

6.3. Recommendations

A definite decision to adhere to the National Health Act 61 of 2003 should be taken and PHC should be assigned to one sphere of government to avoid more disillusionment of the decentralisation process. Sufficient planning and consultation

Chapter 6: Conclusions and recommendations

has been done, full scale implementation is now necessary. The benefits of implementing legislation will be: improved governance and management of the national health system, strengthened PHC services that is provided by a single health system offering the comprehensive PHC package at the first point of entry of the client with the district as its administrative unit. For PHC services to be offered and managed by two organisations often in the same building causes confusion to the client.

The consolidation of the provision of PHC services will ensure improvement in the quality of service delivery, example fragmented services delivery where parts of the PHC package is offered by MDHS, such as maternal health while child health is offered by the City of Cape Town defies the principles of PHC, which are accessibility, appropriateness and availability. Clients do not distinguish between the two service providers and are only interested in having their needs met. For one client to be referred while attending the same facility for a service does not make sense to individual clients in need of care.

Fragmented service delivery also hinders community participation across the health sector as well as the planning and monitoring of services as the two organisations although having joint PDR and ISDMT meetings have different management structures and monitoring tools for the programme. One of the strategic objectives of the District Health Services Programme Western Cape is to institutionalise monitoring and evaluation of PHC services. However even though the above has been legislated and documented political influences remain a stumbling block to full scale implementation. The researcher recommends that these influences be addressed and a commitment to improved PHC service delivery be fulfilled.

6.3 Conclusion

In conclusion the main findings indicate that not enough resources have been allocated to the decentralising process causing much delay in its implementation, shortages of health professionals, infrastructure constraints and poor adherence to

Chapter 6: Conclusions and recommendations

legislation also contribute to the delay in implementation. This is why to date the four health districts of the Cape Town Metro District is not fully functional and the quality of the service they provide do not fully adhere to the 2010 Health Care Plan Model.

Within this sub-district the link between CHC and clinic has not yet been established. Clinics and CHC operate independently while neither offers the full package of PHC services. Family physician posts at CHC level are vacant and the workload calculator as described below is not applied. All health facilities in this sub-district are also not located within a 3-4km radius as per the Comprehensive Service Plan recommendations and certain parts of the community only has access to mobile facilities.



References and annexus

REFERENCES

- Baron, P 2000, Whose the boss – local government health services Health Systems Trust [online]. <http://new.hst.org.za/news/index.php/20000415>
- Baumgartner, T. A, Strong, C. H and Hensley, L.D 2002 Conducting and Reading Research in Health and Human Performance Third Edition United States of America McGraw-Hill Companies
- Bi – ministerial Task Team 2000 Report of the Bi – ministerial task team on the implementation of a municipality based District Health System in the Western Cape Logo Print Cape Town
- Cloete, J.J.N 1996 Accountable Government and Administration for the Republic of South Africa First Edition Western Cape Van Schaik Publishers
- Cloete, K 2008. The District Health System. Interviewed by N.Peton Cape Town South Africa
- Constitution of the Republic of South Africa. No 108 of 1996. Pretoria. Government Printers.
- Department of Health South Africa 1996 Restructuring the National Health System for Universal Primary Health Care. Department of Health
- Department of Health Western Cape. 2006. Health Planner 2007. Cape Town. Cape Health Promotion Office
- Department of Health. 2003. Healthcare 2010: A Plan to ensure equal access to quality health care. Health Western Cape.
- Department of Health Western Cape 2006 Comprehensive Service Plan for the Implementation of Healthcare 2010. Health Western Cape
- Hall, Haynes. & McCoy 2002, The long Road to the District Health System Legislation and Structures for the District Health System in South Africa: An Appraisal as at August 2002 Health Systems Trust Durban

References and annexus

- Health System Trust.1997.Measuring the Move towards Equity.From the site of Service Delivery.Results from the Nine Provinces.Durban.Kwik Kopy Printing.
- Health Systems Trust.1998.Measuring Quality of Care in South African Clinics and Hospitals.Durban.The Press Gang.
- Health Systems Trust.2000.The National Primary Health Care Facilities Survey 2000.Durban.The Press Gang.
- Health Systems Trust.2004.The National Primary Health Care Facilities Survey.Durban.The Press Gang.
- Homedes,N and Ugalde, A 2004 Why Neoliberal Reforms failed in Latin America Health Policy vol.71 no1 pp83-96
- Katz. J. M and Green E Managing 1997 Quality A guide to System – Wide Performance Management in Health Care Second Edition U.S.A Mosby Year Book Inc
- Kovacs, A. R 1987 The Research Process:Essentials of Skill Development United States of America F.A.Davis Company
- Local Governemnt:Municipal Finanace Management Act.N0 56 Of 2003.Cape Town. Creda Communications.
- Local Government:Municipal Systems Act.No 32 of 2000.Cape Town. Creda Communications.
- Metro District Health Services. Metropole District Health Services Strategic Plan 2004-2007.2004.Cape Town. Department of Health Western Cape.
- Metropole District Health Services 2007 Annual Performance Plan 2007/8 Mitchells Plain & Klipfontein Substructure.Western Cape Department of Health
- Muller. M, Bezuidenhout. M & Josste, K 2006 Healthcare Service Management Cape Town Juta and Co Ltd

References and annexus

National Department of Health 2007 Health District Development & Performance Assessment Tools

National Health Bill. Government Gazette No.23696 of 8 August 2002.Pretoria.Government Printers.

No.61 of 2003.National Health Act.2003.Government Gazette No.26595.Cape Town. Creda Commications

School of Public Health. 2007.Waiting Time and Service Time survey. Available on Compact Disc

School of Public Health.2005.Waiting Time and Service Time Survey. Available on Compact Disc

Shah, A. 2005 Public Sector Governance and Accountability Series.Public Service Delivery.Washington DC.The World Bank

Shortell S.M and Kaluzny A.D 1988 Healthcare Management. AText in Organization Theory and Behaviour.Second Edition. New York.Delmar Publishers Inc

Silverman, J.M 1992 World Bank Technical Paper No 188: Africa Technical Department series Public Sector Decentralisation:Economic Policy and Sector Investment Programs Washington U.S.A

Tarimo, E.1991 Towards a Healthy district. World Health Organisation England

The Western Cape Province 2008 Geography and Climate The Western Cape Province [Online] Available [http:// www.capegateway.gov.za](http://www.capegateway.gov.za)

Toms, I 2007 The District Health System.Interviewed by N.Peton Cape Town South Africa

Toms, I.2006.Local Government View of Progress to DHS – A case of the powerful deciding not to consult. Cape Town

References and annexus

USAID 2001. The District Health System Competition: What we have done and learnt in the last two years [Online] Available <http://The Department of Health files\district.htm>

Walt, G 1996 Health Policy. An Introduction to Process and Power. People, governments and international agencies – who drives policy and how is it made Johannesburg Witwatersrand University Press

White Paper for the Transformation of the Health System in South Africa. Government Gazette No17910 of 16 April 1997. Pretoria. Government Printers.

White Paper on Transforming Public Service Delivery. Government Gazette No 18340 of 1 October 1997. Pretoria. Government Printers.

Winkler, D.R 1994 235 World Bank Discussion Papers Fiscal Decentralisation in Latin America. The Design and Administration of Intergovernmental Transfers Washington U.S.A

Zwarenstein, M and Barron P. 1992. Managing Primary Health Care In South Africa At The District Level: The MRC/IUPHC Workshop Cape Town Health Systems Division for Epidemiological Research in Southern Africa

References and annexus

Annexture I: Service Delivery Questionnaire

Age:

Race:

Sex:

Employment status:

Educational level:

1. How long have you been attending this Health Facility (clinic)?

1-6 months	6-12 months	12 months and longer	other
------------	-------------	----------------------	-------

2. Why do you attend this Health Facility?

It is closest to my home
It is the only medical care I can afford
Other, please give reasons

3. What do you like about this Health Facility?

I receive quality care and service
The staff are professional and friendly
Other

References and annexus

4. Have you ever been refused health care at this facility?

Yes and the reason for refusal were explained to me.
Yes, but no reason was given to me.
No

5. Have you ever been told that this facility is out of stock of medication?

Yes all the time
Yes, occasionally
Yes, once before
No

6. Would you recommend the service received at this facility to your friends and family?

Yes Please give reasons
No Please give reasons

7. Have you ever been consulted about service delivery at this Health Facility?

References and annexus

Yes, please explain
No, please explain

8. Are you familiar with the Local Health Committee are?

Yes, Give reasons
No, Give reasons

The logo of the University of the Western Cape, featuring a classical building with columns and a pediment, with the text "UNIVERSITY of the WESTERN CAPE" below it.

9. Do you know who your ward councillor is?

Yes,
No,

10. Please give suggestions (at least three) on how service delivery at this Health Facility can be improved?

References and annexus

Annexture J: Service Delivery Questionnaire

Age:

Race:

Sex:

Staff category:

Qualifications:

1. How long have you been working at this Health Facility (clinic)?

1-6 months	6-12 months	12 months and longer	other
-------------------	--------------------	-----------------------------	--------------

2. Why did you choose to work at this Health Facility?

It is closest to my home
It is the only post I could find
Other, please give reasons

3. What do you like about this Health Facility?

I can render quality care and service to the community
The working environment is conducive to professional growth
Other

References and annexus

4. Have you ever being unable to render health care to clients at this facility due to staff shortages?

Yes and the reason was explained to the client/s.
Yes, but no reason/s were given to the client/s.
No

5. Have you ever consulted clients at this facility that you were unable to dispense the required medication to, due to stock shortages?

Yes all the time
Yes, occasionally
Yes, once before
No



6. Would you recommend the quality of care and services been rendered at this facility to your friends and family?

Yes, Please give reasons...
No, Please give reasons

7. How well informed are you about the amalgamation of the City of Cape Town and Metro District Health Services (MDHS)?

References and annexus

I am well informed and fully understand the process.
I have briefly been informed about the process and do not fully understand it.
Other.

8. Do you feel you are adequately remunerated by your employer for your services.

Yes Please give reasons
No Please give reasons
Please provide suggestions for the remuneration package/s you feel would be more suitable.



9. How do you feel about the PDR System that is used for monitoring and evaluating your Health Facility?

I agree with it as a monitoring tool Please give reasons
I disagree with target indicators as a measurement of performance Please give reasons
Other

10. How often do you receive feedback on the performance of your Health Facility from Management?

References and annexus

Monthly
Never
Other

11. What do you know about the District Health System?

12. Define Primary Health Care?



