Western Cape Government

Health

Healthcare 2030

The Road to Wellness

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Western Cape Government
Health

March 2014

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ABBREVIATIONS

ALS	Advanced life support
APL	Approved post list
ART	Antiretroviral treatment
ARV	Antiretroviral
ASR	Air sea rescue
BI	Business intelligence
BLS	Basic life support
BMI	Budget management instrument
CAD	Computer-aided dispatch
CBO	Community-based organisation
CBS	Community-based services
CCG	Community care giver
CCW	Community care worker
CDC	Community day centre
CEI	The Centre for e-inovation
CDU	Chronic dispensing unit
CHC	Community health centre
CHW	Community health worker
CMI	Compliance management instrument
CI	Confidence interval
CNP	Clinical nurse practitioner
COCT	City of Cape Town
COO	Chief Operating Officer
CSP	Comprehensive Service Plan
DHS	District health services / system
DoE	Department of Education
DITCOM	Departmental IT Committee
DPSA	Department of Public Service Administration
DRG	Diagnostic-related group
DSD	Department of Social Development
DTaP-IPV/Hib	Diphtheria, Tetanus, acellular Pertussis, inactivated polio vaccine and Haemophilus influenza type B combined
DTPW	Department of Transport and Public Works
ECD	Early childhood development
ECM	Enterprise content management
ECT	Emergency care technician
EEV	Emergency equipment vehicle
EFAR	Emergency first aid response
EMS	Emergency medical services
ENT	Ear Nose and Throat
FBS	Facility-based services
FBU	Functional business unit
FPL	Forensic pathology laboratory
FPS	Forensic pathology services

ABBREVIATIONS

FTE	Full-time equivalent
GIAMA	Government Immovable Asset Management Act
GBV	Gender-based violence
GSA	Geographic service area
Ha	Hectare
HCBC	Home community-based carers
HR	Human resources
HRM	Human resource management
HSRC	Human Sciences Research Council
HCT	HIV counselling and testing
ICD10	International classification of disease coding
ICS	Improved conditions of service
ICT	Information and communications technology
ICU	Intensive care unit
IDMS	Infrastructure delivery management system
IDS	Intellectually disabled services
IFR	Institute for Futures Research
IHI	Institute for healthcare improvement
IMR	Infant mortality rate
ILS	Intermediate life support
IPV	Intimate partner violence
IT	Information technology
IUSS	Infrastructure Unit Systems Support
L1	Level 1
L2	Level 2
L3	Level 3
MDG	Millennium Development Goal
MDR TB	Multi-drug-resistant TB
M&E	Monitoring and evaluation
MIMMS	Major Incident Medical Management System
MMR	Maternal mortality rate
MRC	Medical Research Council
MTEF	Medium-term expenditure framework
NCD	Non-communicable disease
NDP	National Development Plan
NEC	New engineering contract
NHI	National Health Insurance
NHS	National Health Service
NHS	National Health System
NPC	National Planning Commission
NPO	Non-profit organisation
NSDA	Negotiated Service Delivery Agreement
NSRI	National Sea Rescue Institute
OHC	Oral health centre
OHSA	Occupational Health and Safety Act

ABBREVIATIONS

OT	Occupational therapist
OSD	Occupation-specific dispensation
P1	Priority 1
P2	Priority 2
PACS	Picture archives and communication systems
PAC	Provincial AIDS Council
PCE	Person-centred experience
PDA	Personal Digital Assistant
PDE	Patient Day Equivalent
PERO	Provincial Economic Review and Outlook
PFMA	Public Finance Management Act
PHC	Primary health care
PLWID	People living with intellectual disabilities
PMTCT	Prevention of mother-to-child transmission
PN	Professional Nurse
PSA	Public Service Act
PTMS	Provincial transversal management system
RCW	Rehabilitation care worker
RIS	Radiology information systems
RTI	Road traffic injuries
SAAF	South African Airforce
SANAC	South African National Aids Council
SHERQ	Safety, Health, Environment, Risk and Quality Management
SITA	State information technology agency
TB	Tuberculosis
U-AMP	User asset management plan
UNDP	United Nations Development Programme
VPUU	Violence Prevention through Urban Upgrade
WCDoH	Western Cape Department of Health
WCDTPW	Western Cape Department of Transport and Public Works
WCG	Western Cape Government
WCIDMS	Western Cape Infrastructure Delivery Management System
WCRC	Western Cape Rehabilitation Centre
WCL	Weighted case load
WH	Women's health
WHO	World Health Organization
WMA	World Medical Association
WSAR	Wilderness Search and Rescue
XDR TB	Extensively drug-resistant TB

Minister's Message: Healthcare 2030

It gives me great pleasure to release the Healthcare 2030 vision of the Western Cape Government, which has been endorsed by the provincial cabinet. The Department of Health is to be congratulated on the in-house development of this document, which reflects a cohesive and powerful vision for the future of health care in this province. I would like to sincerely thank the many individuals and organisations that took the time to make significant inputs into this process. It is my wish that the vision of Healthcare 2030 is shared and owned by the broader communities of the Western Cape.

The publication of Healthcare 2030 is the start of a new journey in health care reform in the Western Cape. It is important that all parties in the province and beyond engage in a dialogue to deepen our understanding and build a common commitment to the vision, values and principles of Healthcare 2030 in order to improve the health and wellness of our citizens.

Healthcare 2030 signals an important shift from illness to wellness. The conventional approach of health services with the focus on curative health care is not sustainable or desirable in the face of the increasing burden of disease. The community at large must own the responsibility for health and wellness. Wellness cannot be delivered by a health service to people who remain passive recipients of the process. Thus a "whole of society" approach to improving wellness is a key pillar of Healthcare 2030 and an important strategic objective of the Western Cape Government.

I therefore call on all parties to work closely with the Western Cape Government to bring this vision to fruition. We can only do better together!

Theuns Botha

Provincial Minister of Health

Western Cape Government

March 2014

Foreword

Reflection on the achievements of and lessons learned from the 2010 Comprehensive Service Plan acknowledged that the Department, while making many positive organisational changes, had not focused adequately on many "people issues", related both to patients as well as to the staff. For this reason since 2010, the patient experience and a person-centered approach to health care have become a focus of the Department. Following extensive consultation the vision of Healthcare 2030 emerged as "access to person-centered quality care". The process of achieving a shared understanding of the vision, values and principles of Healthcare 2030 amongst staff and strategic partners will continue over the forthcoming period.

The Department has recognised that person-centered quality care can only become a reality if staff is dedicated to serve, committed to the vision, feel engaged and passionate about their work and feel happy and proud to work in the Department.

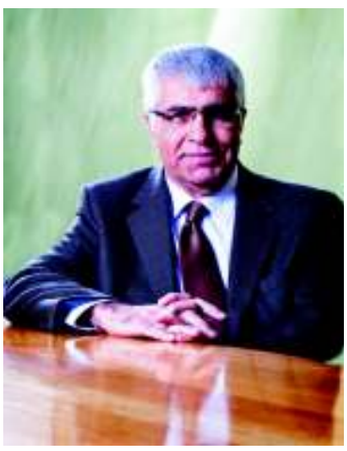
While the department is a large organisation with currently over 30 000 employees, quality care is delivered at the clinical interface between health workers and patients. Thus the Department will shift focus and effort to the support of the staff and management working at the service-rendering coalface.

Visible and responsive management and leadership at all levels of the organisation will be critical to the successful implementation of what is outlined in the Healthcare 2030 document. Championing the vision and principles of Healthcare 2030 amongst the staff as well as with our strategic partners will be key to success.

While the Department performs well within a South African context, Healthcare 2030 creates an exciting opportunity to sustain the good practices that have been built over the years as well as to be innovative and take the organisation to another level over the next two decades. Planning for the long term necessitates that the strategic intent is demonstrated through the vision, values and principles, but also to be flexible to adapt to changes in the internal and external environment.

The measure of successful implementation of Healthcare 2030 will lie in the achievement of time-bound targets. The Department will use flexible planning tools, based on the principles of Healthcare 2030 to determine the specific service needs for institutions and geographic areas. The priorities will need to be based on the affordability limits of the Department. Five-year and annual plans will translate Healthcare 2030 into implementable bites with defined indicators and targets to measure progress.

The achievement of the noble and indeed far-sighted vision of Healthcare 2030 requires collective commitment from our staff, partners and stakeholders as well as the cohesive functioning of all parts of the organisation. Unity of purpose to deliver a comprehensive quality health service and achieve optimal health and wellness outcomes amongst the best in the world will be key to success. The impact of the social determinants of disease on health outcomes is well documented and to address this requires a broader whole of society approach to improving health and wellness. The Department will need to play an important catalytic role to focus the attention of the broader community on these issues.



As I prepare to leave the department after more than a decade at its helm, I am reassured that the road map is now clear to take the department forward well into the 21st century. I have no doubt that the leadership and staff of the Western Cape Department of Health has what is needed to make this organisation one of the best of its kind in the world!

Professor Craig Household

Head of Department: Health

Western Cape Government

March 2014

EXECUTIVE SUMMARY

Introduction

Given the changing environment, uncertainties and assumptions, long term planning for the future necessitates a regular revisiting of the strategic thinking and basic parameters. The Western Cape Government: Health has finalised the Health Care 2030 framework, after considering the substantial verbal and written comments received on earlier drafts. It has been endorsed in principle by the provincial cabinet. The process of developing the 2030 strategy has already begun to energise, excite and engage our staff and strategic partners.

The document sets out the vision, values and principles guiding the Department to 2030. The document also presents a strategic framework for the Department together with a set of planning parameters and tools that will be incrementally applied. The 2030 strategy represents the third wave of health reform in the Western Cape since the Health Plan of 1995 and the Healthcare 2010. This document is divided into 10 sections and each section is discussed briefly below.

Background Context

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

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

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

The two main focus areas that provide a compelling context for change are firstly, continuous improvement in the patient experience and the provision of quality health services on a sustainable basis to meet the escalating burden of disease and achieve wellness and secondly, the fact that we cannot achieve this without caring and better engagement of our staff.

Approach to Wellness :

Wellness is defined as not merely the absence of disease but the ability to maximise personal potential in all spheres of life. The World Health Organization (WHO) framework is used to think about an approach to Wellness. The five pillars of this framework include socio-economic context, differential exposure to risk factors, differential vulnerability, differential health care outcomes and differential consequences.

The Government of the Western Cape is committed to increasing the wellness of the people of the Province through a whole of society approach. The Department will strengthen its advocacy role through wide engagement with other departments and stakeholders outside of government.

The Department wants to conceptually move away from an all consuming curative paradigm of treating illness and disease to one of prevention, promotion and wellness. This is in keeping with the World Health Organization's definition of Health being not merely the absence of disease but a complete state of physical, mental and social wellbeing. It's about fulfilling one's full potential in life.

The priority focus areas for intervention include:

1. Reducing Infectious diseases such as HIV/TB
2. Improving healthy lifestyles
3. Preventing injuries and violence
4. Improving maternal and child health
5. Strengthening women's health
6. Improving Mental Health

From Health Service Delivery to Person-Centred Care

The crux of a re-imagined future in 2030 is the focus on person-centredness. This focus is woven throughout the document from the vision, values and principles to the service platform reconfiguration and quality.

The four conceptual pillars of person-centred care are: a person-centred approach, integrated provision of care, continuity of care, and a life course approach.

Vision, Values and Principles

Vision

The 2030 vision for the Western Cape Department of Health is: Access to person-centred, quality care. There are multiple perspectives to this vision. These perspectives include those of patients, staff, the community, the Department, spheres of government and strategic partners. To bring the vision for 2030 to life at a physical, intellectual and emotional level, we have attempted to describe in detail what the achievement of the vision will feel like for a range of role players, from patients to other stakeholders.

Values

The values of the Department are caring, competence, accountability, integrity, responsiveness and respect. The challenge of the Department is how to make these values a living reality for each staff member across the Department as we move towards our vision for 2030. The leadership will lead this process by example. Values are important in building a cohesive organisation and must be embedded in the organisational culture of the Department.

Principles

The principles underlying our vision and values are as follows:

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

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

The evolution of a shared meaning and rich, common understanding of these principles will happen through a series of dialogues with staff and partners over time. The principles will inform the strategies to give effect to Healthcare 2030.

Leadership and Governance

Leadership

An essential requirement to communicate and build commitment to the vision of Healthcare 2030 is a dynamic and distributed leadership across the management, clinical and administrative ranks of the Department. Leadership is about inspiring change, providing strategic direction, building cohesion and motivating people. Steps to strengthen leadership and facilitate transformational action will be taken. Reciprocal accountability which is a shift from top down to mutual accountability is an important culture change that will help to cement a cohesive commitment to common objectives.

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

A competitive values framework for organisational effectiveness identifies the tensions between the need to collaborate and the emphasis on competing for results, as well as the need to be creative and the requirements to control and comply. The key is to acquire the appropriate balance between these competing tensions for a specific situation.

Governance

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

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

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

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

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

Service Platform

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

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

The four tenets of the planning methodology are using the dependent population as a base, the smallest geographic entity for which there is good data, household income as a proxy for inequity and creation of norms and planning tools for application within specific service settings.

Primary Health Care Services

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

- Home and community-based care (HCBC),
- Primary care services (PCS) at health facilities , and
- Intermediate care.

Collectively these settings will provide a comprehensive array of preventive, promotive, curative, rehabilitative and palliative interventions.

Home and Community based care (HCBC)

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

The core primary care team in HCBC comprises community care workers (CCWs) and a professional nurse. The service model is population-based and organised per electoral ward in the metro and per sub-district in rural areas. These teams will be entrusted with the responsibility of the health of a defined population. It does not depend on individual- or community-initiated access, thus maximising opportunities for preventive care and health promotion.

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

Counselling is an essential part of a health care provider's work, from encouraging adherence to supporting behaviour change, and has an important role in increasing the preventive and promotive aspects of the clinical encounter. The Department will further explore how, where and by whom counselling can be provided, what training and other resources will be required and how it could be implemented in a phased manner.

Primary care services

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

The Clinical Nurse Practitioner, supported by a medical officer will provide the core of this front line service. There will be additional capacity to target amongst others, clinical support services, maternity care, eye care, Ear, Nose and Throat (ENT) services, oral health, nutrition, rehabilitation and chronic diseases. The specific circumstances within a geographic area – such as the burden of disease, access, economies of scale and efficiencies – will need to be considered to determine the provision of limited after-hour emergency services and labour ward facilities for the delivery of babies.

Intermediate care

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

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

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

Acute hospital services

A well-functioning PHC service, as well as an efficient patient transport system are critical to the efficient functioning of acute hospitals. The international trends in the utilisation of hospitals and strategic parameters to guide the technical planning of acute hospitals are identified.

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

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

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

The central hospitals will be sub-specialist led, but will also provide a general specialist service to the population in their immediate vicinity. The National Department of Health is developing a tertiary services plan for the country, which will also inform the technical planning for central hospitals services. There will also be an enhanced capability to render specific rehabilitative care activities, psychiatric care and specific oral health service activities in the regional and central hospital.

Specialised hospitals

Mental health and psychiatric hospitals

There is strong evidence that mental illness is on the increase. This is further aggravated by societal stressors such as socio-economic deprivation, violence, poor family structures, as well as co-morbidly with chronic diseases, substance abuse and HIV. There are large proportions of unmet need. Importantly, there is emerging evidence that a significant proportion of patients can recover from their mental illness.

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

The Department believes that the majority of people living with intellectual disabilities require supported living arrangements and not medical institutionalisation. The medical treatment should be provided on a needs basis by the Department of Health. The supported living arrangements should be the responsibility of the Department of Social Development (DoSD). An integrated approach by the whole of government should ensure that the needs of this vulnerable community are addressed.

Rehabilitation services and the Western Cape Rehabilitation Centre

In line with the departmental approach to improving the person centred experience and to providing integrated health care, rehabilitation services will be accessible at all levels of care. Acute services will be provided in health facilities such as district hospitals and PHC facilities, whereas non-acute services will be provided from a community-based platform. The major investment towards 2030 is to mainstream and strengthen these services within the general health service platform. A community rehabilitation care worker has been piloted with very positive results for broader application.

The Western Cape Rehabilitation Centre will continue to provide high-intensity-, specialised comprehensive, and multi-disciplinary inpatient and outpatient rehabilitation services. An integral aspect of the rehabilitation service will include the provision of the required mobility- and other assistive devices, orthotics and/or prosthetics, to facilitate full re-integration of persons with disabilities back into the community.

Tuberculosis services and TB hospitals

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

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

Oral health and oral health centres

Oral conditions are important public health concerns because of their high prevalence, their severity, their impact on the quality of life and the public demand for services.

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

Specialised services

Emergency medical services (EMS)

Access to emergency care is a constitutional right in South Africa and is prioritised within the 2030 vision for

person-centred quality care. Emergency medical services has set ambitious targets for 2030, which may have to be adjusted within the available resources.

The EMS has five important components including communications, ambulance service, medical rescue, aeromedical and non-emergency patient transport. The province is geographically divided into six districts, each with an emergency contact centre, which also doubles as a disaster risk management centre in the rural districts. The communication centre will receive a modernised software application to enhance its operations. This will also enable better management reporting in real time and improved communication with the emergency centres in hospitals. A bed bureau will also be developed to monitor the availability of acute beds in all the major hospitals.

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

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

Forensic pathology services

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

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

Quality of Care

The essence of Healthcare 2030 is "access to person-centred quality care". This vision needs to be rekindled with renewed vigour. The Department needs to deepen the daily conversation around quality and to make meaning of what terms like quality care and superior patient experience actually mean, what will it require to make it happen, how do we give effect to it in practice and make it a part of our being in our daily work.

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

The vision for quality of care within the 2030 strategy will focus on person-centred experience, technical quality and caring for the carer. Caring for and engaging staff is central to achieving optimal PCE and is a theme that is picked up in several parts of the 2030 strategy.

Support Services

The process of developing a new vision and strategic framework for 2030 has created an opportunity for critical reflection and review of Support Services. There will be a cohesive alignment and common commitment of both line function services and support services to the shared vision, set of values and principles of Healthcare 2030. The organisational culture of working together and continuous improvement will be embedded in the Department.

The leadership at all levels will systematically create and nurture the space to allow for new and more effective ways of doing business within the department. The launch of Healthcare 2030 provides renewed energy and opportunity for innovation. Building strong and trustful relationships, the free flow of information and ideas, effective communication across boundaries and divisions and working in cross functional and diverse teams, will enhance the culture of learning and innovation.

The Department has a decentralised management model within which the roles, responsibilities, powers and functions and the levels of accountability are well defined. There will be three tiers of management viz. at the service entity, district or regional and provincial levels. Over the next few years, the focus is going to be on developing the clinical and administrative leadership and management capacity at institutional level that is directly responsible for service delivery and quality of care.

Support Services are defined as those that are not direct patient facing. The client of support services is therefore primarily the line function manager and its key purpose is to enable service delivery. Support services include financial management, human resources management, appropriate infrastructure, medical technology, availability of consumables , information management and ICT, communication as well as health programmes and clinical support services (e.g. pharmacy services, radiography, laboratories and bloods). The substance and form of these support services are centrally informed by the service delivery imperatives.

Clinical support services

Certain of the support services are more closely aligned to direct patient care and have been clustered as clinical support services. This includes, amongst others, laboratory services, provision of blood products, pharmacy services, imaging and radiography, and nursing. These services are critical to the efficient and effective delivery of patient care. The health professionals that perform these functions within the service rendering facilities are an integral part of the team at the local level.

The Clinical Support Services will revise their priorities and policies, in collaboration with the line function service, to align with the vision and principles of Healthcare 2030.

Human resources

Notwithstanding the envisaged changes in the system and opportunities that advances in technology will create, the people factor will be central to the successful achievement of the strategic objectives of Healthcare 2030. The biggest challenges to achieving the objective of a person-centred service are: re-energising the staff and building renewed commitment to the principles, vision and values of 2030 and creating an organisation where staff have a deep sense of belonging.

Leading and managing the people within the Department is a distributed responsibility at all levels of the organisation, and not the sole preserve of human resource management. The day-to-day listening to staff and effectively communicating, providing meaningful support, uplifting morale, managing performance for results and leading by example is the function of the line manager.

The 2030 Strategic Human Resources (HR) approach will focus on :

- developing capability in HR analytics and research to provide the workforce intelligence that informs workforce planning, development and monitoring and evaluation (M&E);
- an integrated HR policy and planning framework ;
- Executing the HR priorities which include :
    - People management (bringing back the “human” in HRM),
    - Employee Wellness,
    - Scarce Skills,
    - implications for Task Shifting/ Sharing,
    - Leadership and management development.

Implementation support will include efficient and creative addressing of HR operational management challenges, performance management and productivity, capacity building and provision of systems, tools and support.

From a M&E perspective, the Department will have effective systems and a set of metrics in place to assess progress against the objectives of Healthcare 2030.

Financial management

There will always be an inevitable tension between effectively balancing the demand for health services against limited resources. The allocation of budgets, financial management and the procurement of supplies are a major support function that is central to the effective and efficient functioning of the Department and the achievement of the objectives of Healthcare 2030.

Gathering good financial intelligence to inform the planning and resourcing of services is key. Financial policy priorities include appropriate decentralisation with devolved accountability, building financial accountability into performance management and declaring war on red tape. Integrated planning and priority setting will inform budget allocations. A standard medical and surgical consumables and equipment list will simplify procurement and improve efficiencies.

Implementation support to the services will include automation, improved procurement and stock management, better communication and relationships across all levels of the service, staff recruitment and development.

The Department will closely monitor expenditure against its budget allocation, measuring efficiency and cost effectiveness and monitor compliance with financial prescripts to ensure that it receives an unqualified audit.

Infrastructure and technology

The modernisation, management, and maintenance of health infrastructure and technology continue to remain one of the cornerstones for enabling the health service in 2030. The process for the delivery and maintenance of health infrastructure and technology also needs to be economical, efficient, effective, and take cognisance of the continuous development of medical technology.

The approach to policy and planning of Infrastructure will continue to be governed by the 5L's : Long life (sustainability), Loose fit (flexibility and adaptability), Low impact (reduction of the carbon footprint), Luminous healing space (enlightened healing environment), Lean design and construction (collaborative and integrated).

The following priority areas have been identified: PHC facilities, Emergency Centres at Hospitals, District hospital replacements, the New Tygerberg Hospital, a focus on maintenance of facility infrastructure.

Monitoring and Evaluation will focus on maintenance and capital projects, physical condition of the health infrastructure and technology and learning lessons from post-occupancy evaluations of newly commissioned facilities.

This Integrated Delivery Management System provides tools, systems, and processes for improved management of infrastructure programmes and project

Information communication technology (ICT)

One of the most exciting developments is the realisation of the centrality of Information Communication and Technology (ICT) as an enabler and the opportunities it presents in achieving the vision and objectives of 2030. ICT will be mainstreamed within the generic processes of planning, budgeting, risk management, implementation, monitoring and evaluation in the department. This has served to systematically elevate the importance and focus of ICT in the minds of managers.

Business Intelligence (BI) with good-quality information is an important prerequisite for the planning, implementation and M&E of the 2030 plan. The strength of BI lies in its ability to integrate information from various systems and provide meaningful reports for better management. Integrated information at a clinical level will advance the cause of person-centredness and continuity of care, improve clinical management and automated coding will facilitate effective data mining.

Data Harmonization refers to the agreement, synchronization, and coordination of eHealth initiatives in the department to be able to inter-operate more effectively to achieve the goals of Healthcare 2030. The project focuses on Financial Business Intelligence and Clinical Business intelligence

ICT Policy and Planning will prioritise ICT Governance including risk management, producing annual implementation and project plans to give effect to the objectives in the ICT strategic plan, developing a system for technology refresh, creating organisational arrangements to encourage and respond to IT innovation and using the potential of mobile technology to advance health care delivery.

Implementation support will focus on data harmonisation at a patient level that will enable better and

integrated patient management, use of integrated information for research and health services management, the electronic Continuity of Care Record (eCCR) which is intended to foster and improve continuity of care across institutions and health professionals, and the availability of skilled technical capability. A range of ICT opportunities are identified at various levels i.e citizen, home and community based platform, health facility, management, support services.

The ICT M&E process will monitor progress on the roll-out of ICT projects.

Monitoring and Evaluation (M&E)

The Department will apply the Triple AIM framework, which identifies key dimensions for "optimising health system performance". These dimensions include population health outcomes, health services (acceptability, appropriateness, access, quality, equity, effectiveness, and person-centeredness) and cost efficiency in service delivery. A set of potential indicators to measure each of these dimensions is proposed. The National Development Plan indicators will also be incorporated into the M&E framework.

The culture of monitoring and evaluation and continuous improvement which is important for health system strengthening, will be developed through improving the quality of information, deepening capacity, ensuring leadership and accountability and the widespread sharing of good practices. The purpose of M&E is to improve decision - making and support the process of whole system change and must allow for real-time learning and feedback i.e. move beyond the mere monitoring of variances from targets to meaningful dialogue to better understand and address the underlying challenges of the system and service.

Health research is critical to understanding the well-being of the population, the burden of disease, its associated risk factors and populations at highest risk as well as the performance of the health system with regards to access, quality, efficiency and impact.

Conclusion

Healthcare 2030 is a substantial piece of work built on the preliminary thinking, vision, principles and values circulated in earlier drafts, the extensive and valuable input received from staff and external stakeholders and the further evolution of conceptual thinking and technical work to date.

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

The process of consultation and engagement and coalescing of the multiple perspectives of people within and outside of the Department into a cohesive document is always a challenge. The Department believes that this final version is a fair reflection of the collective thinking and its strategic intent to date.

The provincial cabinet has endorsed Healthcare 2030 in principle. The work will now shift to converting this broad strategic direction to more specific details by applying the models and approaches to specific services and geographic areas. This will include, amongst others, identifying the priorities for incremental implementation through five year and annual plans within the affordability limits of allocated budgets.

Healthcare 2030 as a strategic compass will have to be regularly revisited to be able to titrate its intention and assumptions with the changing realities of the next two decades.

History will judge us by the degree to which we have been able to put in place the various plans and processes we have outlined in this document and its actual implementation to improve the health status of our citizens.

The provincial cabinet has endorsed Healthcare 2030 in principle. The work will now shift to converting this broad strategic direction to more specific details by applying the models and approaches to specific services and geographic areas. This will include, amongst others, identifying the priorities for incremental implementation through five year and annual plans within the limits of allocated budgets.

SECTION A:

THE CONTEXT OF HEALTHCARE 2030

SECTION A: THE CONTEXT OF HEALTHCARE 2030

SUMMARY POINTS

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

Introduction and Background

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

- Changes, including opportunities and threats in the external environment;
- Distilling key lessons from the Comprehensive Service Plan (CSP) of 2010;
- Fresh thinking about a re-imagined future; and
- Significant comments that have been submitted on both drafts

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

The Department's preliminary thinking was shared in a draft document circulated for public comment in 2012 and again in December of 2013. Facilitated dialogue sessions were convened with a range of external stakeholders and staff through specially convened sessions by the geographic service area management structures. Many submissions were received on both occasions and colleagues raised interesting, relevant and creative ideas during the dialogue sessions. All comments were considered and the written comments were individually responded to.

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

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

The 2030 planning process is as important as the end product. It has already served to energise, excite and engage our staff and strategic partners. Work has already begun to embed the principles, vision and values of 2030 within the language of the Department and plant the seeds within the hearts and minds of our staff.

A CHANGING ENVIRONMENT

SUMMARY POINTS

1. Changes in the environment include demography, socio-economic determinants of health, politics, burden of disease and its associated risk factors, climate change, advances in technology and limited resources.
2. 2030 takes into account the changing political environment, which includes the MDGs, the National Development Plan, priority national health outcomes, the NHI, and provincial strategic objectives.
3. The Department will build on the strong foundation, direction and many other achievements of the Comprehensive Service Plan (CSP) and learn from the lessons in its planning and implementation towards 2030.
4. A baseline assessment against national core standards identifies several areas for improvement in the quality of care. Surveys have identified significant numbers of staff that do not feel engaged in the organisation.
5. The two main focus areas that provide a compelling context for change are the continuous improvement in the patient experience and the provision of quality of health services on a sustainable basis to meet the escalating burden of disease and achieve wellness and the fact that we cannot achieve this without caring and better engagement of our staff.

External Environment

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

Demography: The Census 2011 data was released in November 2012. According to the State of the Cities report, the City of Cape Town had the highest growth rate at 20.91% between 2001 and 2007. Migration and urbanisation are important factors in this regard. The Western Cape population is estimated to be 5,8 million currently. Some of the important trends are: life expectancy slowly increasing; population growth continuing until 2030; population ageing, a changing racial mix; and the continuation of urbanisation and migration.

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

The incidence of non-communicable diseases which consist mainly of cardiovascular diseases, cancers, respiratory diseases, diabetes and mental illness and its associated risk factors such as smoking and obesity is on the increase in the Western Cape. Large proportions of these patients are undiagnosed, untreated or poorly controlled on treatment. This is one of the most significant risks in the forthcoming decades and requires not only a comprehensive approach by the Department of Health but a full frontal assault by the whole of society similar to that undertaken to control HIV and AIDS.

Socio-economic conditions: It is well documented that socio-economic factors are important upstream determinants of health. The National Development Plan identifies poverty, inequality and unemployment as the key triad of socio-economic challenges facing South Africa. Notwithstanding the higher level of development and living standards in the Western Cape, these challenges are as relevant to the Western Cape as they are to the rest of the country. According to the Provincial Economic Review and Outlook (PERO), in quarter two of 2012, the Western Cape had an unemployment rate of between 24,9 percent and 33,5 percent depending which definition was used. The Gini coefficient, which is a measure of inequality, was 0,63 for the province in 2008 with one representing complete inequality and zero representing complete equality. Also in 2008, 22.3% of the population lived below the poverty line of R6 302 per annum. Associated socio-economic challenges are a lack of basic services such as clean water and sanitation, electricity and housing. These challenges are compounded by the pace and scale of migration and urbanisation in relation to the ability of government to provide these services. The situation is aggravated by the low levels of numeracy and literacy and other skills within significant sections of the population. This situation exists notwithstanding the significant gains made by government in the delivery of basic services to date.

Health outcomes: Despite the fact that the WC provincial health outcomes are good, they still lag behind what is required by the MDG targets. Notwithstanding the 2015 deadline for the MDG goals, achieving these targets has now become one of the key drivers of the strategy for 2030 and the revised targets will continue to drive our vision in a post-2015 development agenda. Outcomes for significant challenges not included in the current MDGs such as chronic diseases, mental health and trauma will also be addressed.

Public expectations and accountability: There is a growing awareness and demand for the right to good-quality health care. Public expectations are high and there is an increased demand for public accountability and responsiveness of government. This is evidenced by the increasing frequency of social protest action by communities.

Sustaining and improving good practice: While the Department currently performs well on many fronts including improving health outcomes and consistently achieving an unqualified audit over the last ten years, there is a need to embed and institutionalise good practice to sustain and improve its performance. The culture of organisational learning and continuous improvement and capacity to change will be strengthened to raise the performance bar even higher.

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

Climate Change: Climate change is predicted in some quarters to be the biggest global health threat of the 21st century. Climate change, water scarcity and extreme weather events are all identified in the top ten risks in the Global Risks 2014 Report of the World Economic Forum. The increased emission of greenhouse gases and the consequent climate change effects are significant and growing realities that must be addressed. South Africa contributes about 39 percent of the greenhouse gases (GHG) on the African continent. From assessments of other countries, health services are an important contributor to greenhouse emissions.

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

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

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

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

The Department has created a climate change committee (CCC), convened by a senior manager, to systematically start to address both the mitigation and adaptation aspects. Work is currently in its infancy. Disaster preparedness in the Department is being systematically supported by the emergency medical services. The CCC will also be the liaison point for engaging with other sectors and spheres of government in this regard. Khayelitsha and Lentegeur hospitals have been identified as flagship projects as part of the Premier's 110% Green campaign. Local initiatives by institutions in the Department are being encouraged and the expertise, technical knowledge and research within the Higher Education Institutions (HEIs) are being harnessed by the Department.

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

Legislative and Policy Environment

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

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

International	**Millennium Development Goals** In September 2000 South Africa was one of the 189 countries to commit to the Millennium Development Goals to reduce global poverty at the United Nations Millennium Summit. A table that summarises the goals, targets and indicators of the MDGs is contained in Annexure B. The specific health-related MDGs are goals four, five and six, which relate to child mortality, maternal mortality and HIV/TB/Malaria respectively. The MDGs are being currently reviewed by the UN. **UN Convention on the Rights of People with Disabilities** This was signed in 2007 and is a wide ranging international treaty of human rights to protect the rights and dignity of persons with disabilities. The principles include respect and individual autonomy, non – discrimination, full and effective participation and inclusion in society, equality of opportunity and accessibility. Article 25 makes specific provision for persons with disabilities to attain the highest standards of health without discrimination.
Constitutional	**The Constitution of the Republic of South Africa, Act No. 108 of 1996** The rendering of health services is a national and provincial legislative competence in terms of Schedule 4, Part A of the Constitution of the Republic of South Africa, 1996. The Constitution places the following obligations upon the Department: » Section 27(1)(a) obliges the Department to provide access to health services, including reproductive health care; » Section 27(3) provides that no-one may be refused emergency medical treatment; and » Section 28(c) prescribes that every child has the right to basic health care.
National	**Negotiated Service Delivery Agreement (NSDA)** The National Government continues to follow an outcomes-based approach and has identified 12 targeted outcomes against which the respective national ministers have signed performance agreements with the President. The health outcome is: improve healthcare and life expectancy among all South Africans. The key outputs of the NSDA between the National Minister of Health and the President are: 1. Increasing life expectancy; 2. Decreasing maternal and child mortality; 3. Combating HIV and AIDS and decreasing the burden of disease from TB; 4. Strengthening health system effectiveness, with a particular focus on: » Revitalisation of primary health care; » Health care financing and management; » Human resources for health; » Quality of health and the accreditation of health establishments; » Health infrastructure; and » Information, communication and technology and health information systems.

National	**National Development Plan (NDP)** The NDP charts a new path for South Africa and seeks to eliminate poverty and reduce inequality by 2030. In terms of the plan, by 2030 the health system should provide quality health care to all, free at point of service, or paid for by publicly provided or privately funded insurance. The NDP identifies the following areas in the public health system for reform: » Improved management, especially at institutional level; » More and better trained health professionals; » Greater discretion over clinical and administrative matters at facility level, combined with effective accountability; and » Better patient information systems supporting more decentralised and HBC models. **The section on health also identifies the following key targets and actions** » By 2030, life expectancy should reach at least 70 for both men and women; » The under-20 age group should largely be an HIV-free generation; » The infant mortality rate should decline from 43 to 20 per 1 000 live births and the under-five mortality rate should be less than 30 per 1 000 from the 104 it is today; » Maternal mortality should decline from 500 to 100 per 100 000 live births; » All HIV-positive people should be on treatment and preventive measures such as condoms, and microbiocides should be widely available, especially to young people; » Non-communicable diseases should reduce by 28% and deaths from drug abuse, road accidents and violence by 50%; and » Everyone should have access to an equal standard of basic health care regardless of their income.
National Department of Health	**National Health Act No. 61 of 2003** This Act provides the framework for a structured uniform health system taking into account the obligations imposed by the Constitution and other laws within the national, provincial and local governments spheres with regard to health services.
	Ten Point Plan This is a key policy document which serves as a roadmap to consolidate Government's response to health system challenges. It includes: 1. Provision of strategic leadership and creation of a social compact for better health outcomes. 2. Implementation of a National Health Insurance (NHI) Plan. 3. Improving quality of health services. 4. Overhauling the health care system and improving its management. 5. Improving HR planning, development and management. 6. Revitalisation of physical infrastructure. 7. Accelerated implementation of the HIV and AIDS and sexually transmitted infections National Strategic Plan 2007-11 and increased focus on TB and other communicable diseases. 8. Mass mobilisation for better health for the population. 9. Review of the drug policy. 10. Strengthening of research and development.

National Department of Health	**Human Resource Strategy for the Health Sector 2012/13 – 2016/17** This strategy deals with the supply of health professionals and equity of access; education, training and research; and the working environment of the health workforce. Eight priorities were identified which form the framework for the HRH strategy: » Leadership, governance and accountability; » Health workforce information and health workforce planning; » Re-engineering of the workforce to meet service needs; » Upscaling and revitalising education, training and research; » Creating infrastructure for workforce and service development - academic health complexes and nursing colleges; » Strengthening and professionalising the management of human resources and prioritising health workforce needs; » Ensuring professional, quality care through oversight, regulation and continuing professional development; » Improving access to health professionals and health care in rural and remote areas.
	Green Paper on National Health Insurance (NHI) NHI will be introduced to South Africa over a 14 year period. The strategic intent is to build social solidarity and provide universal coverage of health care. The NHI reforms will focus on: » Strengthening of district health structures, not only in terms of the re-engineered PHC approach but establishing the District Health Authorities that would need to contract with the NHI Fund and with accredited private providers; » Comprehensive quality improvement, assurance and compliance by all providers; » Increasing human resources in the health system (including increasing the capacity of training facilities for various health professionals); » Piloting the system in 10 selected health districts (initially funded by an NHI conditional grant); » Completion of an assessment of existing health infrastructure; » Implementing hospital management reforms in relation to governance reforms, financial management, autonomy and accountability; » Developing the necessary purchasing and procurement processes; » Developing processes for population registration; » Refinement of the "financial resource envelope" and the "revenue mobilisation strategy and pooling systems" (including alignment with the Road Accident Fund, Compensation for Occupational Diseases and Injuries, Compensation Commission for Occupational Diseases and the Occupational Diseases in Mines and Works Act); » Refinement of the "provider payment mechanisms"; » Development of an integrated health information system; and » Review of existing legislation and creation of an enabling legislative framework (including legislation to establish the NHI Fund, initially at a national level and later at sub-national levels). *Footnote : The Western Cape Government supports elements of the NHI policy and has concerns with others that will be addressed at a political level. (Also see section on provincial policy).*

National Department of Health	**Primary Health Care Re-engineering** This is a major policy development, which aligns with the 10 Point Plan objective of overhauling the health care system and improving its management. PHC re-engineering is key to the success of the NSDA implementation process and seeks to shift the PHC system from a largely passive, curative, vertically and individually oriented system to one with a more proactive, integrated and population-based approach. The core principles of PHC re-engineering are: » to attain a population-orientation to health care, focused on meeting priority health needs of geographically coherent populations in a comprehensive manner, including prevention, promotion and good quality, essential care; » to focus on health outcomes aimed at reducing mortality and morbidity from the major causes of ill-health; » to develop integrated, efficient and well-supported PHC teams, guided by and accountable to communities; » to establish a well-functioning DHS; and » to pay closer attention to those factors outside of the health sector that impact on health, namely the social determinants of health. » Three PHC streams are envisaged: » multi-disciplinary teams of clinically competent professionals in which nurses play a critical role; » community municipal ward-based multi-disciplinary health teams with nurses again playing a critical role; and » effective implementation of national school-based PHC system led by nurses.
	Office of Health Standards Compliance (OHSC) This office has come into effect through the passing of the National Health Amendment Act and will be headed by a qualified Executive Director and supported by competent personnel including Health Officers. The OHSC will oversee the development and compliance with the national core standards, and ensure that complaints received from health care users or the public (patients and families) are properly and independently investigated. The OHSC is also expected to pave the way for the implementation of the National Health Insurance as the provision of quality care will be one of the core requirements for the NHI.
Provincial	**The Provincial Strategic Plan** The Provincial Strategic Plan has 12 strategic objectives that have been identified to facilitate the achievement of the vision of creating an 'open opportunity society for all'. These objectives are closely aligned with national outcomes, particularly in relation to concurrent functions such as health. The health-specific strategic objective for which the Department takes the lead is increasing wellness. One of the mechanisms to give effect to the achievement of the strategic objectives is the Provincial Transversal Management System (PTMS), which provides political support for effective inter-sectoral collaboration within the provincial government.

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

Provincial	**Provincial Strategic Objective: Increasing wellness** Upstream factors contributing to the burden of disease are frequently the result of socio-economic deprivation, such as unemployment, poverty, poor housing and sanitation. The wellness of the people of the Western Cape is undermined by the growing burden of disease. The strategic objective of increasing wellness contains a two-pronged approach to address this. Firstly, the Department has a responsibility to manage the burden of disease through disease prevention, health promotion, and early detection of disease, treatment and rehabilitation – i.e. the provision of comprehensive health services. Secondly, the Department is working with stakeholders, such as other departments, academia and non-profit organisations through the mechanism of the PTMS, to address the upstream factors that contribute to the burden of disease. Aligned with the quadruple burden of disease and the MDGs, the Department has identified the following focus areas within the PTMS: » Violence and road traffic accident injuries prevention; » Healthy lifestyles; » Women's health; » Maternal and child health; » Infectious diseases (HIV and TB); and » Mental health.
	Universal Health Care for All The WCG developed the Universal Health care for All policy as a response to the Green paper on the NHI. The NHI will be implemented in phases over a 14 year period. The vision of Healthcare 2030, which centres around access to quality care is completely aligned with the underlying strategic intent of the NHI. The WCG supports several parts of the NHI proposal especially in the early phases of the process. These include the strengthening of the District Health Services and PHC re-engineering, leadership and management development, the focus on quality improvement and compliance with the national core standards, and the strengthening of information and other management systems and processes. However, the WCG also has major concerns with the NHI proposals that will be taken up with National Health at a political level. These include: 1. NHI may be unconstitutional as it erodes provincial authority. 2. The true cost and affordability of the NHI is unclear. 3. The country lacks the human resources to implement NHI. 4. Centralisation of healthcare funding will be bureaucratic and inefficient. 5. NHI does not address accountability for service delivery. 6. The private sector is not responsible for the poor quality outcomes in the public sector. Universal Health Care for All proposes high quality care that is accountable, affordable, efficient and effective based on the Western Cape experience: 1. The National Department of Health must create an enabling environment through the setting of norms and standards. 2. Provincial Departments of Health must be strengthened for better health service delivery.

	3. The autonomy of health providers and facilities must be supported. 4. Health care standards need to be monitored by independent bodies. 5. Patients must be protected financially. 6. The private sector should be regulated through national guidelines. 7. Public-private cooperation should be promoted. 8. Human resources must be capacitated to meet growing needs.
	The Western Cape Health Facility Boards Act, 7 of 2001 This Act provides for the establishment, functions, powers and procedures of health facility boards. This legislation will be amended to more appropriately accommodate clinic committees at a PHC level. **The Western Cape District Health Councils Act, 5 of 2010**. This Act provides for matters relating to District Health Councils to give effect to section 31 of the National Health Act, 2003. This Act allows for the structured engagement between Local Government and other local representatives with the Department around district health services.

Internal Environment

Comprehensive Service Plan 2010 – Lessons learned and achievements

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

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

Achievements

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

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

a. **District Health Services**

- » Implementation of the district health system, including the unbundling of the Metro PHC service into more manageable sub-structures;
- » Strengthening the district health service by the appointment and training of family medicine specialists and expansion of the CNP cadre; and
- » Improvement in access to health care by expansion of the community-and home-based services.

b. **Acute hospitals**

- » General specialist services in rural regional and central hospitals have been strengthened.
- » The appointment of General Specialist heads and Family Medicine specialists strengthened clinical governance in the health system.
- » The package of care for acute hospitals was defined.

c. **Mental hospitals**

- » Chronic psychiatric and intellectually disabled patients have been dehospitalised;
- » Several mental health care policies have been developed and a Mental Health Review Board that provides oversight is well established; and
- » The Mental Health Care Act required the mainstreaming of the management of mentally ill patients. While there were and continue to be significant challenges in implementing the Act, significant progress has been made, especially at district and regional hospitals.

d. **Infrastructure**

- » Major progress in the revitalisation of the physical infrastructure of the rural regional hospitals, some district hospitals, several ambulance stations and forensic mortuaries;
- » Upgrading and building of a number of PHC facilities;
- » Constructing a state of the art Western Cape Rehabilitation Centre (WCRC) to replace an out-dated rehabilitation service facility at Conradie and Karl Bremer hospitals; and
- » Building and commissioning the new Khayelitsha and Mitchells Plain Hospitals.

e. **Emergency medical services (EMS)**

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

f. **Provincialisation**

- » A range of services was transferred to the provincial Department of Health. These included the provincially aided hospitals; PHC services provided by local government in rural districts; TB hospital services provided by SANTA and local government; forensic pathology services from SAPs; and EMS provided by local government.
- » The Department is in discussion with the City of Cape Town and a formal political process to investigate options for a single authority within the Cape Metro district is currently underway.

Lessons Learned from the CSP 2010

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

These include the following:

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

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

Quality of care

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

The staff satisfaction surveys identify a sizable proportion of staff that do not feel valued or listened to in the organisation. A survey of metro doctors identified staff burnout in a stressful working environment as a major challenge. The Barret's surveys conducted over the previous two years had identified the limiting values to be, amongst others, cost consciousness, bureaucracy, hierarchy, and confusing messages.

The above observations and findings form a significant basis for the renewed thinking within Healthcare 2030.

SECTION B:

OUR APPROACH TO WELLNESS