7 HEALTH

National Health Objectives

The main theme of the National Budget 2002/03 is the reduction of poverty and vulnerability through national health objectives and programmes. This is particularly relevant for the crafting of strategies in provincial Departments of Health.

The key National Health objectives are as follows:
- Reducing morbidity and mortality;
- Improving the quality of care;
- Ensuring equity and access;
- Revitalising public hospitals;
- Improving Primary Health care and the District Health System;
- Reorganising support services;
- Improving the mobilisation, allocation and management of resources;
- Strengthening human resource development.

The National Department of Health (DOH) has further specified the following health policy priorities, which should inform programme allocations within the Provincial Health votes:
- Improvement of Mental Health Services;
- Emergency Health Services;
- Provision of essential drugs in all Primary Health Care facilities.

Western Cape Health Department Strategy

The mission of the Western Cape Department of Health is " to improve the health of all people in the Western Cape Province and beyond by ensuring the provision of a balanced health care system." In line with national objectives, the Western Cape Department of Health has the following vision:
- Progressive building up of the Primary Health Care services;
- Addressing intraprovincial inequities between regions;
- Increasing health management decentralisation;
- Upgrading regional hospitals;
- Downscaling tertiary services.

Provincial Fiscal Priorities impacting on the Western Cape Health Budget

A general principle with regard to the limitation and/or growth of future Provincial

Health budgets is that expenditure on social services (Education, Health, Welfare) should preferably be no more than 80% of total Provincial expenditure. The strategy to accommodate this fiscal "rule of thumb" is found in the Sequential Priority Framework (Western Cape Fiscal Policy, 2002-2005), namely to keep departments constant in real spending terms after adjusting for inflation, virements, function shifts, once-off expenditures, the latest improvements of conditions of service agreement and accommodating the fall in National Tertiary Services and Professional Training and Development grants.

Implications for the Western Cape Health Budget and Expenditure

Although it has to be acknowledged that financial resources in themselves do not guarantee the attainment of health objectives in the most effective way, appropriate allocations of financial resources do set a base for effective service delivery and should signify and reinforce the strategic intent of the Provincial Health Department. The above policy objectives and strategies should therefore be reflected in the allocations to the Health vote relative to other provincial votes and in the allocations between programmes, sub-programmes and standard items in the Health vote.

Conditional Grants

A closer look at the Health conditional grant allocations (excluding the Works vote), as shown in Table 1, reveals a progressively decreasing trend in real terms over the period 1998/99 to 2001/02 in the two largest conditional grants: the National Tertiary Services (NTS) grant and the Professional Training and Development grant. This trend is sustained through the MTEF and onwards, as the Western Cape portion has been scaled down over the next five years by R230 million in 2001 rand terms. A funding proposal emanating from the DOH analysis, projects a –3.71% real average annual change between 2001/02 and 2006/07, combined with a redistribution of Western Cape Specialists and Registrars to other provinces.

From 2002/03 till 2004/05, the decline in the Tertiary Services grant is counterbalanced by an increase in the provincial equitable share allocation to the academic health services programme (R74 million in 2002/03, R127 million in 2003/04 and R304 million in 2004/05). Thereafter, the continued compensation of the declining grant allocation by the equitable share is not guaranteed.

One needs to take into account that a large number of poorer people in the metropolitan area currently make use of academic health services. The health department has been - and still is - implementing a referral system in order to avoid having people treated at inappropriate levels of health care. Nonetheless, a continued decline in the academic or tertiary health sector could impact negatively on the quality of, and access to, health services. This could negatively affect poorer people in the Metro area, especially if they are not appropriately informed of the availability of Primary Health Care (PHC) facilities and services in their vicinities.

Furthermore, a proportion of clients for tertiary health services in the Western Cape come from other provinces and outside the country. For example, in his budget speech on 13 May 2002 Minister Meyer stated that 46% of the Red Cross Hospital services are delivered to patients from outside the Province and South Africa.

Table 1: Actual and budgeted Expenditure on Conditional Grants (nominal values)

GRANT	Actual				Voted	MTEF estimates	
	1998/99 R'000	1999/00 R'000	2000/01 R'000	2001/02 R'000	2002/03 R'000	2003/04 R'000	2004/05 R'000
National Tertiary Services	937 737	954 499	961 949	1 011 436	1 030 510	1 049 252	1 072 703
Professional Training							
& Development	263 940	278 382	292 326	308 776	308 164	306 666	305 974
Integrated Nutrition	19 673	27 511	26 808	24 456	28 789	28 789	30 516
Hospital Rehabilitation	3 618	10 705	24 552	42 557	30 000	31 350	33 231
HIV/AIDS	-	-	1 189	2 434	8 760	14 642	21 322
Hospital Management	-	-	-	-	19 000	17 000	18 020
Total	**1 224 968**	**1 271 097**	**1 306 824**	**1 389 659**	**1 425 223**	**1 447 699**	**1 481 766**
Real %		-3,65	-3,55	0,32	-4,06	-3,99	-2,24

Source: *In-year Monitoring Database (own calculations)*

Overall Health Expenditure

Growth in the Health Budget

In nominal terms, health expenditure has increased from about R2,9 billion in 1997/98 to R3,6 billion in 2001/02, and is expected to grow to R4,1 billion in 2004/05. Table 2 below provides more detail on real growth patterns in health expenditure in relation to growth in total provincial expenditure. From 1997/98 to 2001/02, the real health allocation decreased on average at a slower annual rate (-1,30%) than the total real provincial budget (-2,29%), though with much variation in growth rates between the years. A 2,27% real decline in the health allocation for 2002/03 is noted, compared with a real increase of 4,46% in the total provincial budget.

Table 2: Expenditure 1997/98 to 2004/05 (Nominal rand values)

Expenditure	Actual					Voted	Medium-term estimate	
	1997/98 R'000	1998/99 R'000	1999/00 R'000	2000/01 R'000	2001/02 R'000	2002/03 R'000	2003/04 R'000	2004/05 R'000
Health	2 906	3 024	3 107	3 367	3 581	3 741	3 957	4 157
Total W/Cape	10 789	10 552	10 748	11 513	12 517	13 977	14 535	15 343
Real (%) Health		-2,66	-4,60	1,66	0,34	-2,27	-0,02	0,34
Real (%) Total W/Cape		-8,51	-5,42	0,49	2,57	4,46	-1,71	0,82

Source: *Intergovernmental Fiscal Review 2001, and Western Cape Budget 2002*

Personnel Spending

Personnel spending as a share of the total health expenditure

Table 3 below shows how actual personnel expenditure as a proportion of health expenditure in the Western Cape has declined in real terms between 1997/98 and 2000/01. The decline in actual personnel expenditure has mainly been the result of restructuring and downsizing efforts, implying a loss of staff.

The personnel share is increasing again for 2001/02, 2002/03 and the MTEF; mainly due to salary increases, inflation and the need for incentives in order to attract sufficient staff, as well as the provincialisation of the ambulance services and the aim to attract extra personnel in the Administration and District Health Programmes.

Table 3: Personnel spending as a share of Total Expenditure (Nom.values)

Expenditure	Actual					Voted	MTEF	
	1997/98 R'000	1998/99 R'000	1999/00 R'000	2000/01 R'000	2001/02 R'000	2002/03 R'000	2003/04 R'000	2004/05 R'000
Personnel	1 976 023	2 003 254	1 953 820	2 083 026	2 246 478	2 471 786	2 614 462	2 746 727
Other	930 366	1 020 607	1 152 885	1 283 670	1 334 539	1 269 308	1 342 625	1 410 458
Total	**2 906 389**	**3 023 861**	**3 106 705**	**3 366 696**	**3 581 017**	**3 741 094**	**3 957 087**	**4 157 185**
Personnel as % of total	67,99%	66,25%	62,89%	61,87%	62,73%	66,07%	66,07%	66,07%
Other as % of total	32,01%	33,75%	37,11%	38,13%	37,27%	33,93%	33,93%	33,93%
Real change (%)		-5,17	-9,44	0,01	1,74	2,93	-0,03	0,34

As can be seen from Table 3 above, the average decline in personnel expenditure between 1997/98 and 2001/02 was faster than the decline in total health expenditure. From 2001/02 to 2002/03, personnel expenditure increases as a proportion to budget, mainly due to provincialisation of ambulance services.

The major drop in real terms took place in 1999/2000.

Capital Spending

Health Capital Spending overall (including amounts reflected under the Transport and Public Works Vote)

Health capital spending grew on average in real terms between 1997/98 and 2001/02. This was partly due to a capital injection in 2000/01 and continued capital growth in 2001/02. The capital injection was mainly the result of a provincial medical equipment conditional grant of R33,771 million commissioned in that period.

In 2002/03, a decline in capital expenditure is projected, which is continued over the MTEF. This decline is much steeper than the decline in other health expenditure. Real average change between 1997/98 and 2001/02 is 39,78%, whereas the change from 2001/02 to 2002/03 and 2001/02 to 2004/05, is (-45,74%) and (-15,12%) respectively.

Capital expenditure in the Health Department of the Western Cape as a share of the total budget (3%) is below the national average of 8,9%. This may be partly due to the fact that facilities in the Western Cape are generally sufficient and facilities are in a better condition than in other parts of the country. Notwithstanding, there is an infrastructure backlog of R543 million for the Department of Health, compared with a total provincial backlog of R1,185 billion, as stated in the Building Audit Programme (BAP), 1999.

The major proportion of capital expenditure in the Health Vote is absorbed by expenditure on equipment as on average, about sixty per cent of total equipment expenditure is in respect of medical and surgical equipment. Expenditure on equipment is an important indicator of the quality of medical care. Other major components of equipment expenditure are domestic equipment, computers, gas cylinders and office equipment.

The health capital expenditure devoted to buildings and structures is reflected in the Transport and Public Works Vote. Between 1997/98 and 2001/02, the share of capital spent on buildings and structures ranged between 28% and 78% (R44,942 million in 1997/98 and R110,505 million in 2001/02). This share is set to grow above 80% in 2004/05, despite real declines in buildings and structures allocations.

Hospital Information System (HIS)

(Expenditure reflected under Vote 1: Premier, Director-General and Corporate Services)

An effective and efficient health information system is vital for planning and managing health service delivery. Whilst some progress has been made in the past years, it has been slow. During 1999 tenders were invited to install a new Health Information System in the three academic hospitals. The minimum cost of the project, spread over six years, amounts to R234 million. The first phase of the implementation took place during June 2000 and has the following objectives:

- Expansion of HIS to all clinics and hospitals and the adoption of a common fee schedule for hospitals
- Strengthening the registration of deaths and births
- Adoption of a common procedural code and a common data dictionary in both public and private health sectors
- Expansion of the district-based health information system
- Migration of systems to improve the pharmacy management information system.

Medicine, other medical supplies and non-medical stocks

Sufficient medicine and medical supplies are of paramount importance when the aim is to provide quality health care. The growth rate in the standard item, Stores and Livestock, was taken as a proxy for medical supplies and medicine. Table 4 below shows how spending on stores has increased by 12,15% on average in real terms between 1997/98 and 2001/02, but between 2001/02 and 2002/03 a real decline in expenditure is evident.

Over the MTEF, a real increase of 0,30 % in Stores and Livestock expenditure is projected. Taking into account that the prices of medical requisites as at 1 April 2002 increased by 12% and pharmaceutical prices increased by approximately 15%, this may not be sufficient to cater for exchange rate fluctuations and the increased number of patients expected.

Table 4: Spending on Stores and Livestock 1997/98 to 2004/05

	Actual					Voted	Medium-term estimate	
	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Expenditure	380 450	430 039	503 764	568 685	601 823	584 068	617 804	649 017
Real % change		5,73	8,77	5,90	-0,16	-9,21	-0,02	0,34

Deferred/Subsequent payments

According to the 2001/02 Financial Statements for the Western Cape Department of Health, a substantial portion of claims from local authorities and Non-Governmental Organisations (NGOs) was not paid in 2001/02 as a result of documentation not being supplied in full. This amounted to approximately R51 million for the 2001/02 financial year. At present, the Department is addressing this problem by informing the relevant entities about the standards of claims and invoices.

Hospitals: Performance and Effficiency

Admissions

Before 1997/98 a sharp decline was observed in admissions to academic hospitals (Health Status Review: 1997/98). This decline was not accompanied by increased admissions to regional and district hospitals. Between 1997/98 and 1999/00 the decline in admissions to academic hospitals continued, but it was combined with an increase in patients making use of district and regional hospitals. The later trend can be seen in Table 5 below. The increase in the number of admissions to district hospitals only took off in 2000/01. The decrease in the number of overall hospital admissions is in line with the departmental strategy to refer patients to the relevant lower levels of care.

Table 5: Hospital Admissions

Hospital level of care	Admissions in 1997/98	Admissions in 2001/02	1998 vs 2002	Annual average % change
Academic	125 113	89 124	-35 989	-8,13
Regional	125 334	132 060	6 726	1,32
District	96 867	120 993	24 126	5,72
Total	**347 314**	**342 177**	**-5 137**	**-0,37**

Source: *Western Cape Health Status Report 2001/02, 1997/98*

Beds

The number of academic beds declined from 3 023 to 1 751 between 1997/98 and 2001/02, implying a decrease of 1 272 beds or an annual average percentage decline of 12,76% over four years. In the same period the number of beds in regional hospitals declined from 2 045 to 1 905 (-1,76%) and in district hospitals from 1 636 to 1 488 (-2,34%), due to the closure of four hospitals (Princess Alice, William Slater, Lady Michaelis, St. Monica`s) and the reduction in the number of beds per hospital.

Table 6: Hospital Beds

Hospital level of care	Actual average beds in 1997/98	Actual average beds in 2001/02	Difference 1998 vs 2002	Annual average % change
Academic	3 023	1 751	-1 272	-12,76
Regional	2 045	1 905	-140	-1,76
District	1 636	1 488	-148	-2,34
Total	**6 704**	**5 144**	**-1 560**	**-6,41**

Source: *Western Cape Health Status Report 2001/02, 1997/98*

Efficiency indicators by level of care

Bed occupancy rates improved at all levels except the district level from 1997/98 to 2001/02 (see Table 7 below). The major improvement in occupancy rates in academic hospitals is obviously related to the sharp decline in the number of actual beds, which was larger than the decrease in the number of admissions. District Hospitals could become more efficient in terms of bed occupancy, whereas it may be difficult to further improve on occupational efficiency in the academic hospitals.

Table 7: Bed Occupancy Rates

Hospital level of care	Bed occupancy in 1997/98	Bed occupancy in 2001/02	Difference 1998 vs 2002	Annual average % change
	%	%	%	%
Academic	71	85	14	4,60
Regional	85	89	4	1,16
District	70	67	-3	-1,09

Source: *Western Cape Health Status Report 2001/02, 1997/98*

Primary Health Care

Access to Primay Health Care (PHC) Facilities

Access to PHC in the Western Cape increased between 1998/99 and 1999/00, as the number of visits per person per year increased (9 858 million in 1998/99 and 10 346 million in 19999/00). At 3,5 visits per capita, PHC utilisation in the Western Cape was above the national target of 2,9. In terms of interregional equity, head counts for primary health care have been increasing in all four regions of the Western Cape between 1998 and 2000.

The frequency of mobile clinics to stopping points, which may indicate the extent of access to primary health care in rural and non-urban areas, was relatively low. In 2000 the interval between two visits was on average 5,4 weeks, less frequent

than the national average of 3,8 weeks, and much less frequent than in Gauteng[1]

Much has been done to improve the availability of physical infrastructure, to train personnel in both clinical and management skills and to provide essential pharmaceutical supplies and equipment. A critical challenge is the definition and provision of a comprehensive package of PHC service. This package should tackle the leading causes of mortality and morbidity in the country using cost-effective strategies. The platform for delivery of such a package is clinics and the community health centres.

Referral Systems

PHC providers generally had a very positive perception of the referral system in 2000. 100% of the satellite health workers, 90% of workers in the fixed facilities and 84,6% in the mobile clinics perceived the system as efficient[2]. For all types of facilities this was above the national average (70,9%, 90% and 79,3% respectively). With regard to the perception of the referral system in mobile clinics, a benchmark could be Gauteng and the Northern Cape, both scoring 100%.

Number of patients consulted per nurse/doctor

As can be seen in Table 8 below, the average number of patients consulted per nurse per month in fixed PHC facilities in the Western Cape increased between 1997 and 2000. This would be due to the number of PHC visits growing at a faster rate than the number of nurses in PHC (which also increased in this period).

Table 8: Number of patients consulted per nurse per month – comparison

Province	Mobile 2000	Satellite 2000	Fixed 2000	Fixed 1997
Western Cape	471	217	592	352
KwaZulu Natal	459	598	656	1 033
Gauteng	412	911	400	189
South Africa	553	381	474	488

The average number of PHC facilities that was visited by a doctor to consult patients in the Western Cape decreased between 1997 and 2000, as shown in Table 9 below.

[1] Health Systems Trust, South African Health Review 2000: 26-27).
[2] Health Systems Trust, South African Health Review 2000:32

Table 9: Percentage PHC Facilities visited by a doctor to consult

Province	Satellite 2000	Fixed 2000	Fixed 1997
Western Cape	77,0%	66,7%	N/A
KwaZulu Natal	86,0%	65,0%	25,0%
Gauteng	59,0%	75,0%	33,3%
South Africa	62,6%	54,0%	17,5%

There was much variation between the provinces and types of facility with regard to average numbers of patients consulted per doctor or nurse per month. Although these ratios could be seen as indicators of health care efficiency, higher ratios may be a result of trade-offs in terms of quality.

Efficiency in Primary Health Care

The real cost of PHC per headcount increased marginally between 2000/01 and 2001/02, from R37,95 to R38,04. This could be due to the medical inflation rate exceeding the CPI-X, coupled with primary health care providers treating more complicated diseases in order to reduce referrals to higher levels of care.

Emergency Medical Services (EMS)

One of the aims of the EMS programme in 2002/03 is to improve response time through the provincialisation of all emergency services. According to the South African Health Review 2001, the emergency vehicle response time for fixed PHC facilities in the Western Cape deteriorated marginally between 1997 and 2000: from 77% with a response time of one hour or less to 76,7%.

Between 2000/01 and 2001/02 a 1,45% decrease in the number of vehicles, from 345 to 340, was reported with a 7,76% increase in the number of people transported. The fact that sixty vehicles were replaced in 2001/02 and the purchase of an additional 100 ambulances has been budgeted for in 2002/03 may increase response time.

The EMS Volunteer Association has been very successful in attracting volunteer personnel. This could boost the EMS's ability to cater for the number of calls. In order to assess whether the target of 100% of rural ambulances staffed by two persons will be achieved in 2002/03, a breakdown of ambulance personnel per vehicle in each region classified as "rural" or "urban" is needed. A proper communication system would upgrade the quality of service delivery and response time as well.

Priority Diseases and Target Groups

Tuberculosis (TB)[3]

The incidence of new TB cases increased between 1998 (292) and 1999 (317) per 100 000 population, and the number of TB cases reported per 100 000 population in the Western Cape between 1998 (677) and 1999 (750) is substantially higher than in South Africa (469 and 528) but the rate of growth per 100 000 in the Western Cape is slower than the national average, both between 1997 and 1998 (81,5%), and between 1998 and 1999 (10,8%). The number of new cases still increased considerably over the years.

The cure rate for new smear positive cases stagnated around 69% between 1997 and 1998 and improved to 71,7% in 2001/02. Although this is above the national average of 60% it is still quite far below the national 85% cure rate objective for new TB cases (smear positive). The provincial target for 2002/03 has been set at 74%. A sincere effort is necessary to halt the spread and improve the quality of treatment of this disease, as it may be exacerbated by the increase in HIV prevalence.

In this regard, it is laudable to note that the availability of TB care in fixed PHC facilities in the Western Cape increased from 84,4% in 1998 to 86,7% in 2000, just above the national average of 84,1%. The availability of TB sputum testing in fixed clinics improved from 97% to 100% in the same period, and the 2000 figures for satellite (85,7%) and mobiles (100%) were above their national averages as well. The Department also appointed TB coordinators in 12 districts and established 20 Multiple Drug Resistance (MDR) beds at Brooklyn Chest hospital and 10 MDR beds at Brewelskloof hospital in order to improve the delivery of tuberculosis hospital services.

Western Cape PHC figures regarding the implementation of the DOTS system (Directly Observed Treatment System) for treatment of both fixed (86,7%) and mobile facilities (69,2%) were above the 2000 national figures (79,2% and 60,9%) respectively. In 2001/02, the community DOTS in the Western Cape was expanded to include farms.

Aids and STDs

Although HIV prevalence in the Western Cape is low compared with the national average, the percentage among women attending public health antenatal clinics has increased from 6,3% in 1997 to 8,7% in 2000, with the highest proportion in the 20 to 39 age group. This points to the importance of awareness and health education services for this age group and the youth in particular.

The availability of HIV testing in the Western Cape improved from 97% to 100% in fixed PHC facilities between 1998 and 2000, whilst the availability of HIV testing in satellite clinics (85,7%) and mobile clinics (92,3%) was above the

[3] South African Health Review 2000

national average in 2000 (62,5% and 45,7% respectively). In 2001 six sites were fully operational to prevent Mother-to-Child Transmission (MTCT). The 28% increase in the distribution of condoms, from 6,5 million in 2001/01 to 8,3 million in 2001/02, is encouraging.

The number of new Sexually Transmitted Infections (STIs) per 100 000 reported in the public health sector declined by about 11% between 1998/99 (1 574) and 1999/00 (1 401). Syphilis prevalence has increased from 3,8% in 1998 to 5,1% in 2000, which is just above the national average of 4,9% in 2000.

The availability of daily STD services in fixed PHC facilities in the Province increased from 78,1% to 90% between 1998 and 2000, a move towards the national average of 94,9%. This has been supported by the fact that 90% of providers in the public health sector were trained on the syndromatic approach in 2001/02. The target of 100% of all professional nurses in the PHC public sector and an additional 100 general practitioners for 2002/03 would help build on this.

Reproductive and Women's Health

The maternal mortality rate in the Province in 2000 was 50/100 000, compared with 150/100 000 for South Africa. Although pregnancy-related deaths of women decreased as a proportion of total maternal deaths between 1998 and 1999 from 50% to 43%, this proportion still remains very high. Furthermore, there has been a decline in availability of antenatal care on a daily basis in fixed PHC facilities between 1998 and 2000, from 21,9% to 10%, way below the national average of 59,3% in 2000.

Mortality and Morbidity

It is generally accepted that immunising children is one of the most cost-effective health interventions. This is particularly true in our country where preventable diseases contribute significantly to childhood mortality and morbidity. The value of immunisation is not often mentioned in the media. The results of non-immunisation should be brought to people`s attention far more often. Ongoing advocacy and promotional effort is needed to counteract this tendency. A key focus at present is the eradication of polio and the elimination of endogenous measles transmission through active ongoing surveillance and periodic mass campaigns. Coverage is measured as vaccine doses given per child under one year of age. In Table 10 below an indication of vaccines given in the various regions within the Western Cape is provided.

Table 10: BCG Vaccine Coverage (%)1997-2000

Region	1997	1998	1999	2000
Metropole	77	76	66	45
West Coast	105	99	89	63
Boland	92	89	64	68
South Cape	64	100	96	99

The very low coverage of BCG vaccine in 2000 was due to a countrywide shortage of the vaccine as a result of local manufacturing problems. The coverage of over 100% is due to the number of children immunised being higher than the calculated census figure. Although mass campaigns have probably protected the Province from outbreaks of measles and lowered the incidence dramatically, a reported 73% routine coverage in the Province is cause for serious concern.

Table 11: Measles Vaccine Coverage (%) 1997-2000

Region	1997	1998	1999	2000
Metropole	37	59	60	66
West Coast	74	85	89	76
Boland	95	93	92	83
South Cape	71	93	88	93

Challenges facing the Department

Public sector health services in the Western Cape are faced with significant challenges with respect to an increasing burden of disease and a constrained resource base. In the face of these challenges what is required is:

- Restructuring of the pattern of health services delivery to ensure an efficient, effective and sustainable health service within an affordable framework;

- A balanced, integrated health care system based on a strong primary health care service with adequate emphasis on health education and promotion programmes. The aim is to:

  - Provide quality, equitable and accessible health services to all the people in the Western Cape;
  - Ensure basic services to especially the poor;
  - Fight HIV/Aids, TB and other diseases in a comprehensive manner;

- An optimal shape of health services for the Western Cape where patients enter the health system at the lowest appropriate level of care with adequate

provision for referral up and down the system:
- 90% of health first contacts will be at primary level (Primary Health Care and district hospitals)
- 8% of health contacts at secondary level (mainly regional hospitals)
- 2% of health contacts at tertiary level (mainly tertiary hospitals);

- Strengthening of the capacity at primary and secondary levels of care to prevent inappropriate referrals to more expensive, highly specialised tertiary services;

- Consolidation of tertiary service to prevent fragmentation and duplication of expensive services and to ensure the optimum utilisation of scarce resources within the context of a core package of highly specialised services;

- Strengthening of the role of the Western Cape as provider of tertiary services to patients from other provinces;

- Efficient and cost-effective non-clinical support systems;

- The rehabilitation of the infrastructure to ensure the adequate provision and effective utilisation of buildings and equipment;

- Efficient management systems and an enabling policy and legal framework to enhance the practice of decentralised management and cost centre management at operational level.

If these steps are taken, it is envisaged that the public sector will be in a position to ensure the continued access to quality health services by the population, often poor and disadvantaged who are dependent on these services.

Conclusion

Public health funding has increased since 1998 but is projected to grow negatively over the MTEF in real terms. Among other things, the high salary bill necessitated rapid restructuring in the hospital sector. The result has been a reduction in health workers and hospital beds since 1997/98.

Despite evidence of improved quality of primary health care services, many problems and inequities remain. Early budget estimates show that the overall allocation to primary care (district hospital services) is set to decline in real terms over the next three years.

Further investigation and monitoring is needed to ensure that funds are aligned to policy priorities.

The HIV/Aids epidemic means that real growth in health budgets may not be adequate to deal with the increase in demand for services and the impact of the disease on resources in the health sector.

Reconfiguration of public health services is needed, taking into account that the Central Hospital and Training grants for the Western Cape have been cut by the National Government to the tune of R230 million over five years (2002/03 – 2006/07) in 2001 rand terms. To enhance hospital efficiency and quality, issues in the sector include finalising the Integrated National Planning Framework, revenue retention, governance reform, management decentralisation in hospitals and an appropriate staff mix, human resource development and training strategies.

Strategies to deal with the declining health budget, which are in line with national policies with regard to reorganising support services and shifting the focus from higher to lower levels of health care are, *inter alia*:

- Increased efficiency in the hospital services (through improved referral systems, day surgery and strenghthening of capacity at secondary and primary levels of care);
- Consolidated tertiary and highly specialised services, development of an essential core package of tertiary services and ensuring optimum use of scarce resources;
- Greater efficiency and cost effectiveness with regard to non-clinical support services.

Given the Department's exposure to patient growth and inflationary pressures combined with exchange rate fluctuations, stark choices need to be made if the health budget is to remain constant in real terms and to absorb the aforementioned pressures. Alternatively the services need to run down.

The replacement of outdated equipment needs to be stepped up to facilitate cost effectiveness within the health system.

With regard to the National Tertiary Service Grant further work needs to be done by the National and Provincial Health Departments to reach agreement on the particular services to be rendered and costs related to such services.