Health care achievement and challenges in the Western Cape

The health sector in the country and in the province has probably delivered most to the expectations of the mass of our citizens: (*i*) the introduction of free primary health care (PHC) services has made health much more accessible to those living in poverty around the country; (*ii*) a substantial number of new primary health care centres has been built in the country, 37 of them in the Western Cape; (*iii*) we have seen substantial funding increases to the poorest provinces with the worst health indicators; (*iv*) the significant increase in the remuneration of doctors in the public sector, with student interns receiving virtually 100% increases from July 1996; (*v*) significant national health policy reform as contained in the Report on Restructuring the National Health System for Universal Primary Health Care.

In the light of such significant achievement, it is a pity that health care delivery has become as controversial as it has. Part of the reason is to be found in the response of major interests in the health domain, such as sections of the pharmaceutical industry, but it would be dishonest to ignore the impact of mistakes such as the *Sarafina 2* affair.

Such substantial change over a short period of time has been difficult to manage. Budget cuts to this province, and to the tertiary academic hospitals in particular, have received wide press coverage and have often led to uncertainty and confusion.

Some of the issues that our young Ministry and Health Department have had to address are often underestimated and our achievements have not been sufficiently recognised.

1. We have successfully divided what was the Health Department of the old Cape Province into three new health departments for the three new provinces, i.e. the Western Cape, Eastern Cape and Northern Cape. That in itself was a substantial task requiring the complete division of personnel establishments and capital and other assets.

2. We have integrated the old regional office of what used to be called the Department of National Health and Population Development into the Provincial Administration.

3. The old racially divided authorities of the House of Representatives, House of Delegates, House of Assembly (which operated separate facilities based on race, e.g. hospitals with two entrances, which had to be structurally re-engineered) have been successfully integrated into the new non-racial health service. This process began towards the end of the apartheid years and has now been completed.

4. We formed a strategic management team, which brought together some of the brains in the province to produce the Provincial Health Plan with its 26 task team reports, which have been widely acclaimed.

5. We have embarked on a process of making health services more available to those who did not have access to them before.

6. We have pursued the upgrading and increase of beds at secondary level and emergency health facilities. The recent opening and upgrading of hospitals such as Jooste Hospital on the Cape Flats and George Hospital for the southern Cape region demonstrate this commitment to making secondary level services more accessible.

7. We have championed a PHC philosophy, based on equity in accordance with 'Health For All'.

8. We have declared tuberculosis a provincial emergency and unveiled a comprehensive plan to address it.

9. We have established a decentralised regional system and are in the process of establishing a district-based health system.

10. Our 32 000 health workers treat over 3 million outpatients and half a million inpatients per year.

Undoubtedly the most difficult issue we have faced has been that of restructuring at a time of diminishing financial resources. The reduction in provincial allocation has been the result of two very important factors:

1. The quest for equity in interprovincial resource allocation. There is no doubt that massive inequities existed in funding per capita between the nine new provinces, with funding levels varying by as much as 300%. With the establishment of a new democratic government it was inevitable that these gross inequities would be addressed. Virtually every resource allocation formula developed by the National Department of Health, the Financial and Fiscal Commission or the Centre for Health Policy proposed progressive and substantial moves towards interprovincial equity. The negative effects of these initiatives have obviously been felt most strongly in provinces such as ours. While our province receives a smaller slice of the funding pie, the division of capital assets of the old Cape Province left the Western Cape with virtually all the most expensive and specialised services. The Cape Metropole alone has over 15 specialised hospitals.

2. The second reason for the financial pressures that we face has been the national government's new macro-economic plan, also known as the growth employment and redistribution (GEAR) strategy. The National Finance Ministry has argued that to achieve economic growth, South Africa must cut its fiscal deficit (currently 5.1% of the GDP) to 3.5% of the GDP. It argues that we have a national public debt of R315 billion, that the government is borrowing a further R38 billion yearly, and that debt servicing levels at around 20% of total government spending are too high. The National Finance Ministry has argued that the entire country has to live within its means and that we cannot afford to continue to live (and particularly fund recurrent expenses) from billions of borrowed funds. It is the effects of these macro-economic changes that may lead to financial reductions of around R200 million in the 1997/98 financial year. Our Department has publicly acknowledged on many occasions the effects that these kinds of reductions will have on critical health services. We have argued that the introduction of a strict deficit reduction programme at this time will substantially weaken the effects of the Reconstruction and Development Programme. We have met with the Financial and Fiscal Commission, with Minister Manuel and with the national Budget Council, have made numerous written submissions, press statements and the like, and have ourselves been publicly criticised for the position we have taken.

Our province therefore faces the combined financial pressures of a decreasing share of a pie that is itself decreasing. These financial pressures are the single most important challenge that our Department faces and it is important that we understand and address them.

Ultimately, however, there are several approaches we could adopt; we can either: (*i*) bemoan our fate, put our heads in the sand, take little action and overspend our limited budgets by hundreds of millions of rand; (*ii*) cut indiscriminately, thus crippling entire services in respect of effectiveness and efficiency; or (*iii*) attempt to prune our health service using rational and logical principles such as effectiveness, cost-effectiveness, efficiency, equity and rational referral networks to optimise the provision of appropriate and affordable services at each level of care.

The decisions involved in down-sizing are complex and difficult, and have significant health care and political dimensions. However, it is important to realise that a down-sizing exercise should not mean the collapse of health services. The public sector budget for health services in South Africa is R17 billion annually. The budget of this province alone is R2.3 billion. A down-sizing of R200 million is a huge decrease and calls for wise and skilful management.

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