HEALTHCARE 2010:
CONSULTATION PROCESS AND COMMENTS REPORT

INTRODUCTION

1. Consultation started after Cabinet requested in September 2002 that the Healthcare 2010 conceptual framework should be tested with a wide range of stakeholders.
2. The consultation process included the following highlights:

2.1 A media conference addressed by the top management team explaining the concept and inviting engagement and comment.

2.2 Over 80 engagements with the representative stakeholder groups. More than one meeting was held with many groups.

2.3 Media interviews and responses to media queries. Twenty-one articles and letters directly related to Healthcare 2010 appeared between October 2002 and February 2003.

2.4 Advertisements were placed in the English and Afrikaans media on 22 February reminding stakeholders that the closure date for comments was 28 February.

2.5 Commentary was recorded received as follows:

i. Notes of meetings held

ii. Written submissions.

3. Representatives of the senior and middle management team have considered all inputs.
4. This document summarises the major issues raised by stakeholders. They are organised under logical headings and, where necessary, the response indicates how these have been dealt with (with some clarification offered where appropriate).
5. This summary does not allow for some of the more technical commentaries. These will be addressed directly with the relevant stakeholders.
6. The Western Cape Department of Health expresses its gratitude to all those who have engaged in the consultation process. Every comment, regardless of origin, has made a valuable contribution to the planning process.

LIST OF STAKEHOLDERS THAT PROVIDED FEEDBACK TO CONSULTATION

(* denotes written feedback)

HEALTH STAFF	**EMPLOYEE REPRESENTATIVE BODIES**
Top Management & Communication Task Team	**Organized Labour**
Extended Health Management Committee	Democratic Nurses Association (Denosa) (Danver Roman)*
Inter-hospital Co-ordinating CommitteeHCC (Nils Bergman)	National Education Health and Allied Workers Union (Nehawu) (Suraya Jawoodien)*
Staff at Institutions	Public Servants Association (PSA) (Sandra Newman)*
Tygerberg Hospital	Provincial Bargaining Chamber
Groote Schuur Hospital	South African Medical Association (SAMA)
Groote Schuur Hospital Dr Saadiq Karriem*	Dr John Terblanche*
Groote Schuur Hospital Qengwa, Lulu, GSH*	Dr SNE Mazaza
Red Cross Childrens' Hospital (general group)	Dr Janeshski
Red Cross Childrens' Hospital School of Adolescent & Child Health*	Dr Denise White*
Somerset Hospital (general group)	Prof Coetsee
Somerset Hospital, Department of Social Work*	**Nursing Bodies**
Somerset Hospital Radiography Service*	Catherine Thorpe, DDN, GSH
Mowbray Maternity Hospital Dr Dave Greenfield*	Sandy Pillans
Paarl Hospital*	**Mental Health Associations**
Associated Psychiatric Hospitals (Magda Karelse)*	Mental Health Workshop Input
Karl Bremer Hospital	Lenteguer Psychiatric Hospital
Southern Cape Hospitals and Clinics	Erika Langen
West Coast/Winelands Hospitals and Clinics	**Allied Health Professionals**
Boland Overberg Hospitals & Clinics	AHP Professional Technical Committee (Jenny Hendry)*
Various primary health care facilities across the Metro	Dietetics/Nutrition
Head Office staff	Physiotherapist False Bay Hospital
Dr Tracy Eastman (Information Management)*	Radiography service: False Bay Hospital
NATIONAL HEALTH	Charn de Lange, Dietician, Metro (Conradie) Rehab Centre
Top Management	Lynn Kleinherbst, Physiotherapist, Bishop Lavis Rehabilitation Centre
UNIVERSITIES	Karin Blackbeard, Chief Pharmacist, Metropole Region
University of Cape Town	**COMMUNITY AND FAITH BASED ORGANISATIONS**
Deputy Vice-Chancellor: Research & Innovation,Professor de la Rey*	Health Systems Trust
Peninsula Maternity and Neonatal Services*	Community Health Forums at two Metro clinics
Department of Obstetrics & Gynaecology*	INCLUDID (Inclusive Living for People With Intellectual Disabilities)*
Department of Radiation Medicine/ Division of Radiation Oncology*	Cape Mental Health Society*
Otorhinolaryngology (ENT)*	Postnatal Depression Support Association*
University of Stellenbosch	Fountain House*
Professor Barney de Villiers*	Cape Consumer Advocacy Body*
Department of Anaesthesiology*	Archdiocese of Cape Town
Department of Otorhinolaryngology (James Loock)*	ANC –Western Cape Branch
University of the Western Cape	Individual members of the public
School of Public Health	**TRUSTS (DG Murray Trust)**
UNICITY HEALTH	

Issues	Response
Reasons for restructuring, conceptual framework and underlying principles: ➢ Widespread support for: o More equitable spread of services o Strengthening primary and secondary care o The vision of a "seamless referral service" o Extending specialist care from academic/ tertiary hospitals for regional and district hospitals.	➢ This support is welcomed and appreciated.
➢ Approach appears to be driven by budget constraints for desire to improve health status	➢ Healthcare 2010 is informed primarily by a desire to improve the health status of the province within the likely budget constraints that will apply. However, the Superintendent-General is on record as saying that the service would have been transformed along these lines even if there had been no budget constraint.
➢ The real problem is inadequate funding. Why accept budget limitations? Provincial health officials should fight for more money.	➢ Management teams in each of the provincial service departments compete for funds in each budget cycle. The Department of Health always competes vigorously for funds in this process. Final budget allocations are a political responsibility.
➢ Implementation will be expensive. Where will the money come from?	➢ Healthcare 2010 will be implemented incrementally over 8 years. Operating budgets will be allocated to cover transformational expenses. On the whole, the savings generated from increased efficiencies will fund transformational expenses.
➢ Why does the financial plan not allow for internally generated revenue?	➢ Revenue generation plans are being drawn up to accommodate the projected R90 million/year shortfall anticipated by 2010.
➢ Primary Health Care and Home Based Care is thought by some to be more expensive than hospital-based care.	➢ Healthcare 2010 is not based necessarily on the offering of cheaper services. It is intended to offer better quality services for all. For many South Africans, Home Based Care is the most

Issues	Response
	appropriate form of healthcare intervention. It is not comparable with the UK National Health Service home based nursing care.
➢ What about prevention/promotion strategies?	➢ Healthcare 2010 allows for expenditure of R40 million/year on disease prevention and health promotion.
➢ Is there any flexibility built into the implementation plan?	➢ Healthcare 2010 is a conceptual framework. Implementation will be incremental overt the next eight years. It will remain firm on principle but will take into account changing circumstances.
The model and its assumptions: ➢ Is it: o "Scientific"? o Capable of being manipulated?	o Yes, in the sense that it is based on empirical evidence. o It can and will be adapted to take into account a range of assumptions and changing circumstances
➢ Was the proposed 90+8+2 "shape" of the service in 2010 imposed on the model (i.e. ideologically-driven) or the outcome of proper and rigorous analysis?	➢ The proposed shape emerged from detailed analyses of population needs over many months. It is indicative only of the likely number of client contacts at each level of the service. It does not purport to represent bed numbers, budget allocations or any dimension of the service. It was not imposed or ideologically driven.
➢ Does the 90+8+2 "shape" apply equally to all disciplines and situations?	➢ No, it is an "average" which merely signals the broad intent of Healthcare 2010. There will be major difference between acute and chronic care.
➢ The assumptions used must be explained more carefully. o How was inflation dealt with? o Population growth?	➢ Accepted, but this can be provided in more detail to interested parties. It can be stated that the relevant variables such as inflation and population growth were dealt with.
Communication and consultation: ➢ The academic fraternity is keen to participate in the technical manipulation of the model, including different assumptions and scenarios.	➢ Specialists and special interest groups will be consulted in detail before any changes are made. Where appropriate, the model can be used to

Issues	Response
	assist in further decision making.
Timetable: ➢ How will we get from the current reality to the Healthcare 2010 Vision? What steps are to be taken each year?	➢ The Department is not talking about a "big bang" approach. Once the overall concept is finally approved, the incremental step changes will be planned in some detail. It is likely that the changes made over time will be driven by the physical location of new or upgraded facilities at each level of service, accompanied by the training of appropriate service providers.
Organisational issues: ➢ There is a degree of cynicism about numerous change procedures introduced in the past but not fully implemented ("Transformation fatigue").	➢ Healthcare 2010 is founded on these earlier initiatives. In that sense, it is merely a continuation of previous efforts. The Department believes that the current initiative must succeed since the present structure is simply not sustainable. High levels of consultation should contribute to the success of this initiative. For this reason it has not been deemed appropriate to re-open issues that have been extensively considered previously.
➢ It is important first to build the lower levels of service before downsizing the tertiary level of service.	➢ The Department's approach will be to initiate multi-faceted change processes at all three levels of the service at the same time. The rate of change at each level will, of course, be influenced by transformation in the other levels.
➢ Does senior management have the full support of middle management and staff?	➢ Management has consulted widely with health staff. There is a high degree of acceptance, albeit tinged with a degree of anxiety and excitement about the possible implications.
➢ How many jobs will be lost?	➢ It is unlikely that there will be any direct job losses. Although Healthcare 2010 calls for better-trained personnel, it is anticipated that normal attrition, retraining and redeployment will accommodate the changes.
➢ Is staff prepared to relocate?	➢ It is too early to be specific, but we certainly hope to attract the right staff to

Issues	Response
	the right location at the right time.
➢ How can the Provincial Department plan for a Metro Health Services that it does not control?	➢ While financial responsibility for the Metro Health Service will lie with the Metro local government, we are confident that colleagues will co-operate fully with the provincial Department to ensure a seamless and integrated quality service. Future discussions related to the provincial and local government spheres will assist this process.
Concerns were expressed that the following specific health challenges have not been dealt with adequately:	
➢ TB: o Challenge to the assumption that the number of TB beds can be cut and Home Based Care will be effective.	➢ Stakeholder proposals to increase the number of beds allocated for acute and chronic TB sufferers have been accepted and Healthcare 2010 adapted accordingly.
➢ HIV AIDS o Impact on staff level considered?	➢ Yes, allowances have been made within strategies to be accommodated within the additional R540 million funding to be allocated fro HIV/AIDS.
➢ Trauma: o Said to be one of the fastest growing and costly health impacts.	➢ Agreed. This will need review within the assumptions regarding the provision of health services within Healthcare 2010 and in the light of future trends.
➢ Mental health: o De-institutionalization of patients welcome but only with community-based support services in place.	➢ Agreed.
➢ Diseases of lifestyle / poverty	➢ These are being addressed on an on-going basis as part of health promotion.
➢ Social services	➢ The concern is noted, and the Department will engage the Social Services Cluster on this issue.
Human resources:	
Concerns have been expressed that unless means are found to “retain and retrain” doctors	➢ Agreed. Such strategies will form part of the Human Resource Plan.

Issues	Response
and nurses, and attract new candidate nurses, the Province cannot deliver the desired level of service. Similar concerns have been extended to other professionals (such as physiotherapists, nutritionists, radiographers)?	Strategies are being developed at National level for the retention of scarce skills to address this challenge. ➢ Agreed.
Physical resources: ➢ Concerns that: ➢ The ability to reduce the number of chronic beds throughout the Province has been overestimated.	➢ Noted. The figures have been adjusted with respect to the TB beds.
➢ "Step down" needs for children are likely to increase, especially for those with AIDS.	➢ Agreed. This will be addressed by increased resources at PHC level.
➢ Will some hospitals be closed?	➢ No hospitals will be closed, although hospitals may be relocated and 'repositioned' in terms of services delivered.
➢ The receiving environment for Home Based care is already under stress.	➢ The Department already provides home-based care through existing NGO's. Existing programmes will be extended, supported by EU funding (R17 million).
➢ How can we ensure the appropriate training for Home Based Carers?	
➢ Level 3 services are already under strain (inadequate equipment, staffing and operating budgets). Further restraints will lead to collapse of service?	➢ Healthcare 2010 specifically addresses this with increased funding per Level 3 bed, plus funding has been allocated to address the existing equipment backlog. (>R120 million over the next three years from 2003.)
➢ Demand for Level 3 services will increase as service delivery becomes more effective at Levels 1 and 2.	➢ This view is understood but not accepted. In fact, the contrary is to be expected. In the Western Cape currently all patients have access. Better services will mean earlier more effective treatment and thus be more cost effective.
Operational issues: ➢ Can the patient-transport system cope with the proposed referral system?	➢ Not in the current state; but this will require immediate action.
➢ Clinical guidelines/protocols will be needed to deliver a seamless service.	➢ Agreed.
Trans border services: ➢ Will treatment be available for patients from	➢ Yes. Level 3 is funded by the

Issues	Response
other provinces? ➢ Will the service cope the Levels 1, 2 and 3 inflows from the Eastern Cape?	Conditional Grant. Levels 1 & 2 are not. With regard to the latter, the matter will be taken up with both the Eastern and the Northern Cape.