



## INTRODUCTION

Historically, the Western Cape has been one of the better funded provinces in the country and generally still enjoys a better state of health than most of the poorer provinces. This is reflected in the infant mortality rate, which is regarded as being a good indicator of the general state of health of a population: in 2002, the infant mortality rate for the Western Cape was estimated to be 30 per 1000 live births, almost half of the national rate of 59 per 1000 live births. While mortality rates in general have been steadily increasing across all age groups and provinces, the infant mortality rate in the Western Cape has remained steady, and even slightly decreased since 1990 (Dorrington et. al., 2002).

Health care in South Africa is still struggling to recover from the inequalities of the apartheid system, which created a strong bias towards doctor-orientated secondary and tertiary care, with no real primary health care system. Also, resources and access to services were heavily weighted to favour the white population (Johnson, 2001). Furthermore, the system inherited by the Government in 1994 was highly fragmented and bureaucratic. A national policy shift towards a district-based health care system, aimed at standardising and co-ordinating local level control of health care, is slowly redressing these imbalances (Department of Health, 2001). Building on numerous health planning initiatives since 1994, the Western Cape Department of Health has formulated a conceptual framework for change – Healthcare 2010 (Health Western Cape, 2002). Patients will enter the health service and be treated at the most appropriate level of care with adequate provision for referral up and down within the service.

The Primary Health Care approach favoured by the Department aims at organising services and skills in such a way that for the Western Cape population:

- 90% of health contacts would be at the level of Primary Health Care (PHC) and District Hospitals;
- 8% of health contacts would be at the level of Regional Hospitals;
- 2% of health contacts would be at the level of Central or Academic Teaching Hospitals.

The Western Cape faces a number of significant challenges in managing the health of its population. Some of the most significant health issues in the Western Cape include the incidence of communicable diseases (including Tuberculosis (TB), HIV/AIDS and sexually transmitted diseases (STDs)), the high incidence of trauma and injury (mainly resulting from road accidents and inter-personal violence, and related to the high incidence of alcohol abuse), poor diets leading to increasing incidence of non-communicable diseases, environmental health issues and ensuring equitable access to facilities and services for all.

**The priority issues reported on here are:**

- Prevalence of HIV and TB, and
- Access to quality health services.

## DRIVERS AND PRESSURES

Some of the driving forces and pressures that influence health in the Western Cape include:

**Social conditions and poverty** – Poor people suffer from greater ill health due to multiple factors such as inadequate housing, water supply and sanitation, poor nutrition and other factors such as loss of dignity and self esteem. Poor people often have greater difficulty accessing health care facilities due to geographical positioning, and are more likely to receive sub-standard care once they do access the health system than more affluent members of the population (Johnson, 2001). While the Western Cape is generally one of the most affluent provinces in the country, there are stark inequalities with large pockets of extreme poverty.

**Economic constraints and budget allocations** – Fiscal federalism<sup>27</sup>, introduced in 1997, has slowed progress in the reallocation of resources (Johnson 2001). Government expenditure on health care in South Africa at approximately

US\$100/person/year greatly exceeds the World Bank recommended level for a middle income country<sup>28</sup> (Johnson, 2001). However, more equitable distribution of funds between provinces has reduced budgets for provinces such as the Western Cape that received better funding historically. Additionally, the Western Cape has a relatively heavy loading of tertiary institutions that make substantial demands on the remaining budget, so although funding is still good in comparison with other provinces, it has decreased substantially within the province.

**Environmental conditions** – Factors such as the quality of air and water, toxic exposure, etc, all affect the health of a population. The Medical Research Council estimates that more than one third of the burden of disease in Africa is caused by exposure to wood, coal and paraffin smoke from indoor cooking fires, which is associated with acute lower respiratory infections such as pneumonia. Children under 5 years old are most vulnerable to this exposure, and pneumonia is ranked among the top five killers of young South African children (MRC, 2004). Studies in many parts of the Province have found almost universal childhood infestation with worms reflecting poor sanitation and hygiene (Fincham, 2001).

**Access to health services** – As outlined above, serious inequalities exist in terms of access to health services, both between different population groups and between rural and urban populations.

**The apartheid legacy** – whilst there are numerous policies in place to address many of the difficulties faced in the health system, an underlying challenge is to develop governmental and managerial capacity for implementing policy initiatives, particularly in disadvantaged areas. Progress is being made in terms of strengthening capacity and delegating decision-making authority to lower levels. However, responding to the need to redress imbalances through affirmative



action, as well as the widespread changes to senior health management personnel at national and provincial level, means that this process will take time (Johnson, 2001; Connelly, 2002).

**Personal health practices** – Factors such as obesity, smoking, drug and alcohol abuse are personal issues that have ramifications for the overall health of a population. Alcohol abuse, a historical legacy of the 'dop system' on many farms in the Western Cape, is rampant in the province, which is believed to have one of the highest incidences of foetal alcohol syndrome (FAS) in the world. FAS is estimated to occur on an average of 3 live births per 1000 (Schultz, 2002), but in the Western Cape, this figure is as high as 14 live births per 1000 (Ministry of Health, 2001).

27. Government funds can no longer be 'ringfenced' for specific purposes, but are put into a central pot for allocation.

28. Lower to middle income countries are often referred to as developing countries. Middle income economies have a gross national income per capita of more than \$765 but less than \$9 386 (Little Green Data Book, World Bank).

## ISSUE: PREVALENCE OF HIV AND TB

### STATE

#### Prevalence of HIV infection

Annual antenatal HIV surveys are internationally recognised tools for monitoring HIV trends and provide the basis for

HIV estimation in the general population, which have been conducted in South Africa annually since 1990 (Department of Health, 2003). In 2003, the Western Cape still showed the lowest prevalence rate<sup>29</sup> of HIV infections of all the provinces (Table 10.1). Despite the apparently low rates in comparison to national prevalence rates, what should be cause for alarm is the percentage rate of increase in infection: from 1998 to 1999, the increase of prevalence of HIV infections recorded

at antenatal clinics in the Western Cape increased from 5.2% to 7.1%, a percentage increase of 36.5% (Stannard, 2001). This continues to increase steadily (Figure 10.1). Also, the Western Cape prevalence rates – 13.1% in 2003 – are still very high in comparison to global HIV prevalence rates.

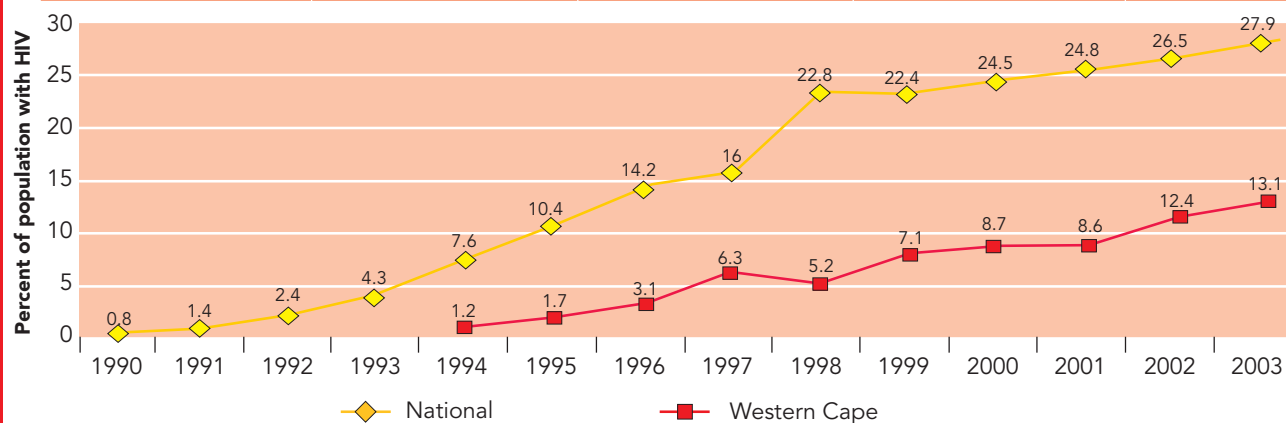
The prevalence of HIV is not evenly distributed across the province. HIV recorded in antenatal clinics is over 25% in Khayelitsha (a comparable rate to most other parts of the country), whilst in neighbouring Mitchells Plain it is around 6% (Dept. of Health, Western Cape). It is therefore essential that the HIV epidemic in high-prevalence areas such as Khayelitsha is targeted for control, whilst prevention activities in other districts are strengthened to ensure that the overall rate for the province stabilises and then reduces.

**Table 10.1:** Estimated HIV prevalence among antenatal clinic attendees, by Province (Department of Health, 2003)

Province	2000	2001	2002	2003
KwaZulu-Natal	36.2%	33.5%	36.5%	37.5%
Gauteng	29.4%	29.8%	31.6%	29.6%
Free State	27.9%	30.1%	28.8%	30.1%
Mpumalanga	29.7%	29.2%	28.6%	32.6%
North West	22.9%	25.2%	26.2%	29.9%
Eastern Cape	20.2%	21.7%	23.6%	27.1%
Limpopo	13.2%	14.5%	15.6%	17.5%
Northern Cape	11.2%	15.9%	15.1%	16.7%
Western Cape	8.7%	8.6%	12.4%	13.1%
National	24.5%	24.8%	26.5%	27.9%

#### TB incidence in the Western Cape

TB is serious problem in the Western Cape, which has one of the highest incidence rates for TB globally. TB is linked to more than 99% of communicable diseases in the Cape Metropolitan Area. As a result, this ubiquitous disease has been declared a 'Health Emergency' in the province (van Schalkwyk et. al., 2003). Statistics for TB incidence in the Western Cape as compared to national statistics are shown in Table 10.2.



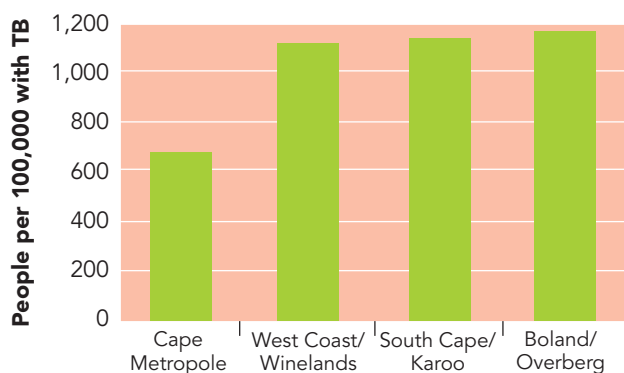
**Figure 10.1:** HIV Prevalence: 1990 – 2003, National versus Western Cape (Source: Department of Health Western Cape, 2004).

29. Prevalence rate is the percentage of a group who are infected at a particular point in time.



**Table 10.2:** Number of Incidence of TB for 2001/2002. (Source: NTCP, Department of Health, quoted in Bamford et. al., 2004).

	Total TB cases	Incidence all TB per 100 000
<b>Western Cape 2002</b>	39 650	493.7
<b>South Africa 2002</b>	224 420	423.5
<b>South Africa 2001</b>	188 695	493.7



**Figure 10.2:** TB rates/100 000 population for the four administrative districts of the Western Cape (Source: after van Schalkwyk et. al., 2003)

Note: Administrative municipalities in this figure are as they were in 2001 – they have since changed.

The main drivers of the epidemic remain environmental conditions and malnutrition, lack of access to treatment, and treatment not being completed. More recently the HIV epidemic has also become an important factor, with both diseases predominantly affecting young people. It is estimated that 55% of patients with smear or culture positive TB in South Africa are HIV positive (Bamford et. al., 2004), and that more than 70% of HIV-infected patients die from TB (van Schalkwyk et. al., 2003). The TB epidemic in the Western Cape has increased by almost 20% during the last decade, directly in relation to HIV/AIDS infection rates<sup>30</sup>.

The Department of Health has expanded the National TB Control Programme (NTCP) to include Voluntary Counselling and Testing (VCT) and provision of TB prophylaxis to HIV positive patients, which is a major step towards integrating TB and HIV/AIDS care. This will require ongoing effort at all levels.

Adequate TB control is critically dependent on a number of district level support systems, including transport, drug supply management and supervision, as well as training of staff and increasing capacity. Lack of management capacity, poor management systems and inadequately trained and motivated staff at a district level are cited as the primary causes of failure of the NTCP. The link between poor programme performance or insufficient coverage of a good programme is indicated by levels of drug resistance, and here the Western Cape appears to be performing reasonably well compared with other provinces, as levels of multiple-drug-resistant TB cases remained stable between 1999-2002 (Bamford et. al., 2004).

However, the severity of this trend is not equally distributed across the province. This is reflected in the chart below (Figure 10.2), which indicates a significantly lower rate of infection for the population of the Cape Metropolitan Area. This is despite urban living conditions and adverse climatic factors in this area, both of which would be expected to exacerbate TB infection rates. The primary reason for this is that the population of the Cape Metropolitan Area has better access to health services than the outlying districts (van Schalkwyk et. al., 2003).

## IMPACTS

- Estimates of the macro-economic impact of HIV/AIDS vary dramatically, but there is no doubt that it will ultimately have a significant effect on the economy of the country. Although the effects have not yet been detected in terms of standard economic yardsticks such as Gross Domestic Product (GDP), this is because SA has a labour surplus, so workers lost to AIDS are quickly replaced with minimal loss of productivity. However, the supply of human capital is not infinite, and the World Bank suggests that the accumulated loss of GDP per capita will be large. This suggests that South Africa could face progressive economic decline over several generations unless it combats the AIDS epidemic more urgently (IRIN Plusnews, 2005). Further, it should be noted that many of those struck down by HIV are involved in informal economic activities and that, although type of economic activity is not captured by official economic measures such as GDP, loss of this sort of income generation will have a devastating effect at a household level.
- Additional welfare payments for sickness and disability place an additional economic burden on the state.
- It is estimated that there were over 885 000 orphans<sup>31</sup> in South Africa in July 2002, of which 38% were orphaned by AIDS. Again, the Western Cape has considerably better statistics than other provinces, being the only province where less than half of all orphans (only 7 133 of 49 442) are as a result of AIDS. (In KwaZulu Natal, it is estimated that AIDS accounted for 81% of new orphans in 2002.) Clearly, however, this places an enormous strain on social services in the province (Dorrington et. al., 2002).
- The cost of caring for the sick by the rest of the family is also a major burden for many households, a burden which increasingly affects the elderly, who are becoming the main breadwinners in multigenerational households and spend most of their income on household necessities and education for their grandchildren. (AfroAIDSinfo, 2004). There is also increasing evidence that the cost of funerals and burials is crippling.
- Health facilities are already overstretched and the increasing incidence of disease places an additional strain on this resource.

30. It should be noted that this increase may also reflect improved detection and reporting between 1996 - 2001.  
31. Defined as being a person under the age of 18 whose mother has died.

## ISSUE: ACCESS TO QUALITY HEALTH SERVICES

### STATE

The provincial health department has been radically scaled down in recent years. Historically, the province has spent more per capita on health care than other provinces (largely due to its very large tertiary health care<sup>32</sup> system, which provides services to patients from other provinces and which trains some 40% of the doctors in the country. In order to achieve better equity per province, the Western Cape was expected to reduce spending.

During the period 1998 – 2001, 8 000 staff were lost and 3 500 beds, particularly at academic, psychiatric and chronic care hospitals, were closed (PAWC, 2003). A key element of the Provincial Healthcare Plan (PHP) has been to downsize the academic tertiary hospitals and to build up primary and secondary care (PHC), administered at local/district level. The province has significantly expanded the PHC infrastructure, with the construction of 55 new clinics and has implemented a free PHC policy. This has resulted in an increase of PHC visits of over 1.2 million a year (PAWC, 2003).



In terms of HealthCare 2010, the Department sets out its aims as follows (Health Western Cape, 2002):

- Increased emphasis on quality Primary Health Care at the Province's 242 clinics, 130 mobile clinics and 64 community health centres.
- Increased emphasis on appropriate high quality health care in the Province's 58 District, Regional and Academic Teaching Hospitals.
- Increased emphasis on improving skills levels in all facilities and hospitals.
- Significant cost saving through improved efficiencies of scale, elimination of duplication and focus on core business.
- Equal access by all three universities to an improved tertiary health service platform.
- Equitable access for patients from other provinces within the affordability limits of the National Tertiary Services Grant.
- Reallocation of beds, equipment and staff from aging and inadequate facilities to better located, new or upgraded facilities.
- Innovative measures to generate additional revenue, including asset swaps and Public Private Partnerships.



### Location of health care facilities in the Western Cape, in relation to population density

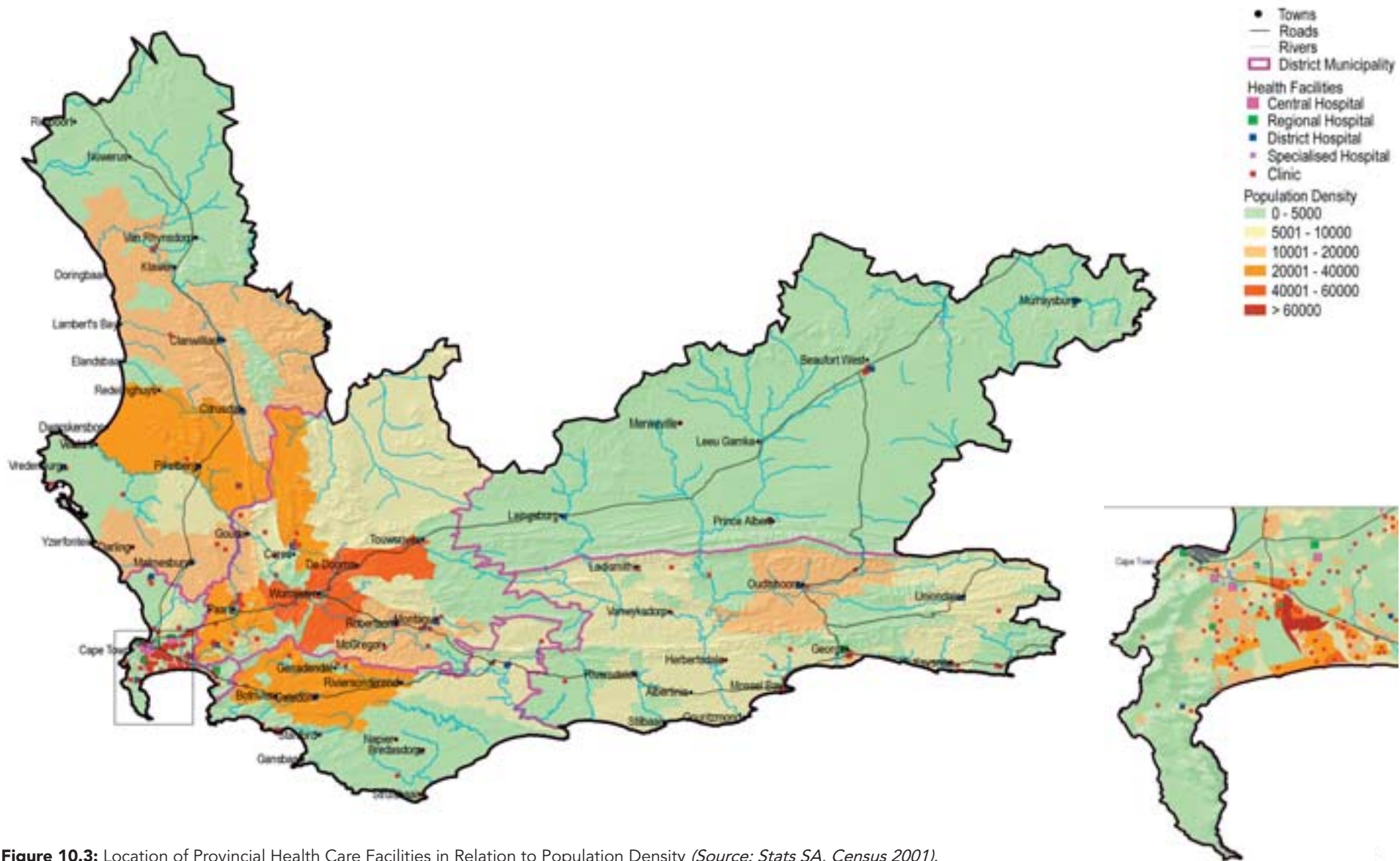
Although there is substantial health care infrastructure in the Western Cape, it is not always appropriately located relative to the population (Figure 3). For example, there are no hospitals in Khayelitsha or Mitchell's Plain, two areas with high levels of poverty and of health need, which together have a population of more than a million (although a District Hospital is reportedly planned for the area). Expenditure on health services and personnel is still skewed away from the poor areas of the Cape Metropolitan Area and this urgently needs to be addressed (Cape Town Equity Gauge, 2003).

Transport access to healthcare infrastructure, both for immediate and follow-up care, is also critical. The majority of health service users are not car-owners, and it is important that public transport access, during all hours, is maximised in the location of hospitals.

### IMPACTS

Poor access to good quality health services results in the following consequences:

- Costs of transportation for accessing health facilities places additional strain on poor households.
- Long waiting periods experienced by patients to see doctors, with some patients having to be turned away, increases the burden of illness. Lack of sufficiently equipped and staffed facilities result in poor treatment, with the proper expertise, medicines and equipment not always being available.
- Insufficient facilities result in doctors and other medical staff being over worked, tired and unable to devote enough time to patients.
- Poor facilities and a lack of access to facilities impacts can extend the duration of illness and impacts on people's ability to function properly both economically and socially.



**Figure 10.3:** Location of Provincial Health Care Facilities in Relation to Population Density (Source: Stats SA, Census 2001).

## Summary and Status of Indicators Used in this Chapter

Health Indicators	How we are doing?	Comments
Prevalence of HIV infection	☹️	The Western Cape has a lower HIV/AIDS prevalence than the rest of SA but it is still high compared to international standards.
TB incidents in the Western Cape	☹️ ☹️	The Western Cape has a far higher TB prevalence compared to the rest of SA and compares very poorly to international standards.
Location of health care facilities in the Western Cape in relation to population density	☹️	The Western Cape has better health care infrastructure than most other provinces but these are not always appropriately located, relative to the population.

## RESPONSES

The table below summarises some of the legislation and other initiatives that have been implemented in response to the health issues discussed above:

<b>National</b>	<ul style="list-style-type: none"> <li>• National Constitution of South Africa</li> <li>• National Department of Health Five Year Strategic Plan (1999 – 2004)</li> <li>• Signatory to World Health Organisation's Healthy Environments for Children Alliance</li> <li>• Signatory to the Amsterdam Declaration to Stop TB (March 2000), which commits the county to accelerated action against TB through a number of avenues (<a href="http://www.stoptb.org/conference/decla.access/htm">http://www.stoptb.org/conference/decla.access/htm</a>)</li> <li>• Formation of National Progressive Health Care Network</li> <li>• Review of legislation to               <ul style="list-style-type: none"> <li>– make drugs more affordable and promote the use of generics</li> <li>– regulate the medical schemes industry to limit discrimination against 'high risk' groups such as the aged and sick</li> <li>– legalise abortion</li> <li>– limit smoking in public places and increase public awareness through advertising controls</li> </ul> </li> <li>• Programme of placement of Cuban doctors in rural health facilities</li> <li>• Compulsory year of community service for newly graduating doctors and pharmacists</li> <li>• National TB Control Programme</li> <li>• Incentive schemes for Health Departments, such as the National DHS competition</li> </ul>
<b>Provincial</b>	<ul style="list-style-type: none"> <li>• Western Cape Provincial Health Plan: Healthcare 2010</li> <li>• 20 million condoms distributed during 2002 (Dorrington et. al., 2002)</li> <li>• 70 public facilities offering Voluntary Counselling and Testing</li> </ul>

## LINKS

Health is an important factor determining the quality of the lives of the Western Cape population. This chapter has the strongest links to:

### **Economics and poverty, (unemployment and growth)**

– Health, and in particular HIV/AIDS, increases the number of orphans and contributes to poverty generally and has an impact on the economy of the Western Cape. Additionally poverty reduces households' ability to cope with illness and access good quality treatment.

### **Education**

– Education has a fundamental role to play in improving the health of the population of the Western Cape. HIV/AIDS education is one of the focus areas for the Western Cape Education Department.

### **Air Quality and Climate**

– pollution and the poor air quality influence people's susceptibility to diseases such as asthma





and pneumonia. Additionally, it is predicted that climate change is likely to change and increase the spread of malaria risk areas globally.

**Waste and Sanitation** – poor access to sanitation and potable water increase people’s vulnerability to diseases such as diarrhoea and cholera. Badly managed waste services and practices can increase the risks of poor health and the spread of disease.

## CONCLUSION

The health status of the Western Cape still appears to be relatively good in comparison to the rest of the country, but not in terms of global comparisons, and there are several areas of concern.

Many new clinics have been constructed as the province has shifted emphasis from tertiary institutions to Primary Health Care (PHC). Although there is substantial health care infrastructure in the Western Cape, it is not always appropriately located. Transport access to health care infrastructure, both for immediate and follow-up care, is also critical. The majority of health service users are not car-owners, and it is important that public transport access, during all hours, is maximised in the vicinity of hospitals.

HIV prevalence may be the lowest in the country (although still increasing in all age groups except the 40+ group), but is still very high and the rate of new infections is increasing faster than anywhere else in the country. Surveys also indicate that the HIV epidemic is spreading and maturing at different rates at a local level, indicating that the epidemic has not stabilised in the province and that a significant opportunity to halt the epidemic through intensive preventative strategies and education exists (Department of Health Western Cape, 2004).

The need for collaboration and integration between the HIV and TB services as well as the key role of HIV prevention in controlling the TB epidemic is becoming increasingly clear (Bamford et. al., 2004). The Department of Health has expanded the National TB Control Programme (NTCP) to include Voluntary Counselling and Testing (VCT) and provision of TB prophylaxis to HIV positive patients, which is a major step towards integrating TB and HIV/AIDS care. This will require ongoing effort at all levels. Additionally, the link between poor programme performance or insufficient coverage of a good programme is indicated by levels of drug resistance, and here the Western Cape appears to be performing reasonably well compared with other provinces, as levels of multiple-drug-resistant TB cases remained stable between 1999-2002 (Bamford et. al., 2004).

All of these disease related issues can only be addressed and the general health status of the population improved if equitable and effective access to appropriate health service facilities is achieved.

