Collaboration to provide Public Health expertise to a provincial health department: The Western Cape story

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Healthcare 2010 strategy

Public health practice should provide the intelligence for better delivery of health services and achievement of conditions conducive to health for the population – in short, strengthening the health system.

The Western Cape Government: Health (further referred to as 'the department') has historically had an institutional relationship with the School of Public Health and Family Medicine at the University of Cape Town (UCT) and the Division of Community Health at the University of Stellenbosch (US) through a joint employment agreement with the respective medical schools. This agreement applies to all medical disciplines linked to academic institutions and is governed by a bilateral agreement most recently revised and finalized in 2012. These joint members of staff perform various functions on the department and university platforms, including training of undergraduate and post graduate students, research and service provision. When these three functions are aligned towards a common objective they are mutually beneficial to both parties.

The School of Public Health (SOPH) at the University of the Western Cape (UWC) has not had a joint agreement with the department historically as it does not have a medical school. However, recognising the unique contributions that can be made by Public Health professionals who are not medical doctors, the department has also established multiple contractual arrangements with the UWC SOPH to provide Public Health expert services.

Historically, the provision of Public Health expertise to the department has been uncoordinated and did not maximize the limited resources available. The experience of Public Health registrars placed in the department for in-service training varied widely, and their projects lacked coordination and alignment to a common organisational objective. Similarly, the work of the Public Health specialists was valuable but also not aligned to departmental objectives. Furthermore, registrars were

sometimes given menial tasks inconsistent with their training objectives or they filled in for vacant posts. There was also very little collaboration between the department and the academic institutions to ensure the alignment of services, research and teaching.

The aim of the Healthcare 2010 strategy in the Western Cape was to substantially improve the quality of the health service to impact on population health outcomes. This strategy recognized, amongst others, the need for increased Public Health capacity within the department that would instill evidence-based practice with a distinctive health systems perspective that balances the roles of community, primary, secondary and tertiary levels of care.

The Healthcare 2010 strategy proposed the establishment of a Public Health Unit within the Division: District Health Services (DHS) and Programmes. The aim of this unit was to plan, lead, organize and coordinate the provision of Public Health expertise to the entire department in line with key strategic objectives and priorities.

Setting up a collaboration to provide Public Health Expertise

The department began engagement with academic institutions in 2003 to explore the available Public Health competencies. Key public Health competencies identified were in measurement sciences, social sciences, management sciences and communication sciences. Measurement sciences of epidemiology and biostatistics are required for planning, monitoring and evaluation; the social sciences are required for advocacy; the management sciences are required for information functions, human resources, finances; and the communication sciences are required for programme implementation; advocacy which promotes community and individual involvement, self-reliance and inter-sectoral action for health.

With this understanding a Technical Task Team (TTT) of representatives from UCT, US, UWC and the department was established. The aim of the TTT was to develop a Public Health vision and strategy for the department and plan its implementation. At the end of 2006, the TTT produced a strategy that informed the establishment of the current Health Impact Assessment (HIA) directorate in the department. The TTT report also proposed possible university–service synergies in the absence of an institutional structure for Public Health.

The ‘embryonic’ Public Health unit took shape within the DHS & Programmes Division soon after the TTT was established. This was made possible because the department had employed a full time Public Health Specialist in the Office of the Deputy Director General: DHS & Programmes and Public Health registrars were placed in this office. What we learnt in this time helped lay the ground for the functioning of the HIA directorate. All the Public Health joint positions were officially transferred to the Division in 2009 from the tertiary hospitals.

The strategy developed by the TTT was submitted to the Organisational Development Unit to develop a staff establishment and final structure, (Figure 1).

Figure 1: Health Impact Assessment Directorate Organogram

The organogram contained 4 sub directorates: Epidemiology & Surveillance, Health Research, Programme Impact Evaluation and Quality Assurance (QA). The first three were new units and QA was a pre-existing unit moved from another component in the department and augmented with Public Health specialist and registrar capacity. Since then an additional sub-unit called Increasing Wellness, responsible for intersectoral collaboration to reduce the Burden of Disease, was added to the HIA directorate.

Each unit has full-time departmental posts at the level of Deputy Directors (DD), Assistant Directors (ASD) and administrative support staff together with joint posts of Public Health specialists, a specialist scientist and Public Health registrars. The Public Health specialists and registrars were matched and placed in the new units, the Director was employed in July 2011 and most of the directorate's posts were filled by the beginning of 2012/2013 financial year. Supernumery posts funded through the universities also function within the Directorate.

The Public Health specialists and specialist scientist provide technical support to the different functions within the directorate. The registrars take on a mix of technical work and specific line functions for Public Health responsibilities, supported by the specialists and provincial staff in the directorate and other cognate directorates.

The location of HIA within the department was also reviewed. It was relocated within the Chief Directorate: Strategy and Health Support with Information Management and Strategic Planning. This facilitated/enabled close collaboration amongst these sections and the provision of Public Health support to the entire department.

Successes and challenges

Some of the successes of this initiative have been:

a) The presence of HIA has allowed for better coordination of the Public Health resources and aligning these to departmental objectives in a systematic and coherent way. Though this has taken a few years to achieve, the result is strengthened capacity in the services for Public Health action.
b) The conversations about what Public Health can do resulted in a major collaborative project, "The Western Cape Burden of Disease Reduction Project" that included the department and not just UCT and US but also UWC, MRC, HSRC and the City of Cape Town. This project revitalised the notion of social determinants and intersectoral action. It gave the entire government, including those outside the department, a common language and understanding in that regard. This project provided the catalyst to the Western Cape Government development of a "whole of society" approach to wellness, exemplified in its formally adopted Strategic Objectives.

c) The department has now established a sub-unit focused on coordinating intersectoral action along six priority areas identified by the Western Cape Burden of Disease Reduction Project.
d) The department, in collaboration with the City of Cape Town and the Medical Research Council, has been able to establish a provincial-wide mortality surveillance system that can provide mortality estimates by sub-district. The production of league tables for ranking causes of death have become important planning tools in the districts in particular.
e) The department has been able to establish a highly functional Provincial Health Research Committee that comprisises members from all academic institutions in the Western Cape; UCT, US, UWC, Cape Town University of Technology (CPUT), HSRC, MRC; civil society, SANGOCO (Western Cape); individual members of the public and the department.
f) Public health capacity within HIA has enabled Monitoring and Evaluation (M&E) within the department to be vastly strengthened. Previously annual M&E meetings focused on whether or not targets were met, now annual M&E meetings translate data from multiple sources, assesses the impact of interventions on health outcomes, identifies areas requiring attention and identifies the evidence for possible future interventions. The recommendations from this have been used in provincial planning processes.
g) The HIA's Public Health role in the department has also helped the 'seeding' of Public Health competencies and Public Health trained staff in other parts of the department with Public Health specialists and Public Health graduates taking up key programmatic and service positions in the department.
h) The department has formed an indicator work group that determines which indicators are most relevant to measure department performance and population health outcomes. Public Health expertise, working in conjunction with Information Management, has been central to providing guidance to this complex area.
   Benefits to the academic sector include improved access to health facilities and information on health and health care for research purposes; increased awareness of departmental priorities; research and teaching collaborations between institutions, including some senior managers holding honorary lecturer positions.

Some of the challenges are:

1. The need for Public Health expertise far exceeds the current capacity. In fact, the more visible the success, the higher the demand placed on the Public Health resources.
2. While one of the benefits of a joint agreement is the possibility of aligning the teaching and research agenda to the service agenda, there are also dual and sometimes divergent priorities between the partners, which create competing needs. Historically, Public Health specialists developed areas of academic expertise not necessarily aligned with health service priorities. Changing this was a process requiring gradual reorienting of focus, as well as the physical re-location of the specialists within the department to create a sense of belonging to the department. Moreover, Public Health specialists and registrars were increasingly embedded within various departmental processes to develop an

organic understanding of the issues to enable a meaningful channelling of their expertise. The above has required the Public Health specialists to move beyond their historical areas of interest to service priority areas. A credit to the colleagues has been their willingness to learn and engage in "new domains" such as quality of care. This process, as well as the gradual marrying of different institutional cultures, takes time to evolve and needs ongoing nurturing and incisive leadership to achieve optimal synergy.

3. The creation of HIA has surfaced the need to clarify roles and responsibilities between health programs, HIA and other sections within the department. The department is currently working through these issues.
4. Whereas health systems thinking has begun to take root in the services, it is a constant struggle to avoid reverting to a focus on the short-term, health-service oriented agenda at the expense of broader health systems issues.
5. Intersectoral collaboration continues to be a challenge.
6. The academic sectors only have 35% of the time of the specialists thus limiting especially their availability for teaching.

In conclusion, starting a dialogue results in better understanding of what is possible for collaboration. This results in a spin-off of collaborative projects and strong team efforts. Establishing HIA has taken a very long time, nearly 10 years from conceptualisation to full implementation. It has, however, resulted in a stronger registrar programme, better use of evidence for planning and management in the department and improved coordination of intersectoral action for improved health. The availability of permanent staff allows for sustainability and continuity, the specialists are better able to provide technical support to build the capacity of the system and registrars can rotate through a wide range of projects to fulfil their training requirements. A critical success factors has been building a critical mass of Public Health trained managers in the services to infuse Public Health principles into the way the entire system functions. The litmus test of the development of Public Health in the department is the demand for more Public Health specialists and registrars by the line function service managers. The medium- to long-term vision is for every district to have a Public Health specialist to assist with planning, implementation support, M&E, operational research and impact assessment. Nothwithstanding the resource constraints, it is encouraging to note that Public Health expertise is being prioritised against so many other competing needs.