HEALTHCARE 2010

HEALTH WESTERN CAPE'S PLAN FOR ENSURING EQUAL ACCESS TO QUALITY HEALTH CARE

This booklet was compiled by the Directorate:
Policy and Planning, with the assistance of the Head of Health
and the Directorate: Communication

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The information is up to date as the 31st of July 2003. It should be noted, however, that in several cases the information does not reflect a final decision but rather serves as a basis for further discussion with stakeholders.

Your comments will be welcomed. Please post them to:

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MESSAGE FROM MR PIET MEYER

PROVINCIAL MINISTER
OF HEALTH
WESTERN CAPE

A promise that I have made repeatedly over the past few months, and that I am dedicating myself to deliver on, is that the Western Cape Government is committed to the provision of quality, equitable and accessible services to all its people. In this regard the Health Department has committed itself to a vision of improved health care within the existing resource constraints.

We plan to achieve this lofty but realizable goal through the successful implementation of **Healthcare 2010**, Health Western Cape's long-term strategic plan. This initiative envisages reshaping the services to focus on primary level services, community-based care and preventative care. These services would be adequately supported by well-equipped secondary and highly specialized tertiary services. The steps have been necessitated by the HIV/AIDS epidemic, the burden of trauma and the need to provide services within the available funds amongst other reasons.

A significant area of expansion will be the delivery of specialist services within the Regional Hospitals. This will make the delivery of specialist services not only more cost-effective, but will also bring these services nearer to those

communities that require them most. We recognize that these changes cannot be brought about overnight and therefore we view the outer years of the current three-year funding MTEF (medium-term expenditure framework) period as the starting point for these changes. In order to make Healthcare 2010 a living reality, however, we have already commenced the process to achieve this far-reaching vision. In particular I have committed my-self to the upgrading and improve-ment of the Emergency Medical Services that provide an essential safety net for the people we serve.

Things are difficult in Health. They have been so for some time, and they will continue be so for some time. As Martin Luther King said more than 30 years ago, however, if we have faith, commitment and courage we can "carve a tunnel of hope through a mountain of despair". I am convinced that we are already carving our tunnel of hope.

FOREWORD BY PROFESSOR CRAIG HOUSEHAM

THE HEAD OF HEALTH

When I qualified as a medical doctor more than 20 years ago. I was idalistic and full of expectations. Now, having been a practising doctor, an academic in the health sciences, and the head of two health departments, I remain idealistic. The difference is that now my idealism is tempered by the reality that the health needs of our people outweigh the resources available to meet those needs. The challenge to all of us is to balance the needs with our resources to the best of our ability and for the greatest common good.

The Department of Health in the Western Cape experienced considerable difficulty remaining within budget during the 2001/2 and 2002/3 financial years. Fiscal stringency measures, as necessary as they may be, have been unpopular with staff, patients and other stakeholders alike. The negative publicity generated by these measures has detracted from the excellent work done in delivering health services in the province.

The Department is committed to providing equal access to quality health care for all of the people of the Western Cape. In spite of the fiscal constraints, the Department has continued to strengthen programmes aimed at combating HIV/AIDS, TB and Trauma. These three areas, together with so-called "lifestyle diseases", form the major burden of disease in the province.

During 2002 the Department produced a strategic plan for the reshaping of public health services in the Western Cape. This initiative, Healthcare 2010, maps a way forward that will substantially improve the quality of care of the health service and simultaneously bring expenditure to within budget. Based on the primary health care approach, Healthcare 2010 proposes a shift of patients to more appropriate levels of care with commensurate cost savings.

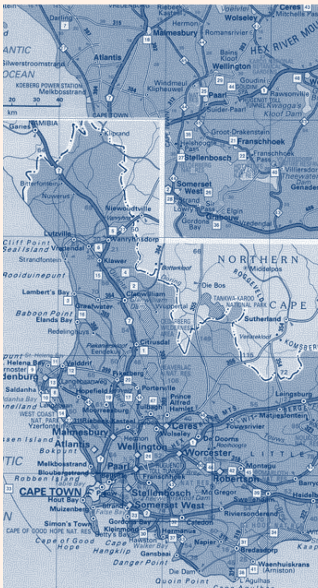
The 2003/4-year has been dedicated to detailed planning for the implementation of Healthcare 2010. Whilst the detailed planning is in progress it is important to ensure that all realignments are in the direction required by Healthcare 2010. Implementation will thus proceed without delay. The reshaping of the health services will begin in earnest in the 2004/5 financial year.

All over the province where I have been interacting with Health staff and other key stakeholders, I have come across people, facilities and projects that have energized my desire to make Healthcare 2010 work. Regrettably, in some cases they have given me a clear idea of what we don't want our Health services to be like. However, in several places they represent a model of what we do want. It is the latter that should encourage us and strengthen our belief that with Healthcare 2010 we are heading in the right direction.

The implementation of Healthcare 2010 will require discipline, dedication and resolve. Hard decisions must be taken now to yield positive results later; and these positive results will benefit the patients who come to us for good quality health care.

OVERVIEW

Healthcare 2010:
A plan to ensure
equal access to quality
health care



The challenges:

- Improve substantially the quality of the health service.
- Simultaneously bring expenditure to within budget.

The strategy:

- Reshape public health services in the Western Cape to focus on primary-level services, community-based care and preventative care:
    - o 89% of acute contacts at level 1; 8% at level 2; and 3% at level 3
    - o 99.5% of chronic contacts at level 1; and 0.5% at level 2.
- Expand delivery of specialist services within the Regional Hospitals to make them more cost-effective and bring them nearer to communities who need them most.
- Adequately support these services with well-equipped secondary, appropriately staffed and highly specialized tertiary services.

The plans:

- Service Delivery Plan. This will define and quantify the health services required by region, district and community within the required shape.
- Infrastructure Plan. This will provide buildings, equipment and maintenance in line with service requirements as set out in the Healthcare 2010 Service Delivery Plan. An integral part of this plan is to max-

imise the value of assets by fully utilising existing facilities and exploiting under-utilised capital stock to garner additional funding by various strategies.

- Human Resource Plan. This will enable facilities to be staffed appropriately and will require a revision of the existing staff establishments.
- Financial Implementation Plan. The allocated budgets will be linked to measurable, time bound objectives for the medium-term expenditure framework period and beyond to give effect to the restructuring of the Health services.

The implementation of the plan:

- Evaluate all jobs.
- Determine packages of health services per level and location.
- Match services with the necessary facilities and equipment.
- Shift services according to the identified need.
- Staff the facilities with the appropriate staff. Where necessary, upgrade skills and/or employ additional staff.
- Link funding to services to ensure sustainable quality services.

The implementation challenges:

- An incremental, step-wise process.
- Steps will not be of equal magnitude or frequency.
- The change will generate uncertainty and, in some instances, resistance
- Enthusiastic support of all levels of management is essential.
- Western Cape Department of Transport and Public Works, and medical faculties of the Universities and Technikons are key partners.
- Stakeholder participation and buy-in crucial.
- Where consensus is reached rapidly, progress will be rapid, eg the revitalisation of the rural regional hospitals.

1. INTRODUCTION

1.1 Healthcare 2010 is built on the restructuring plans that were begun in 1994. The strategic vision for Health Care 2010 flowed from the development of the Department's Strategic Position Statement (SPS).

1.2 A technical model, which took cognisance of the following key elements was used in the development of the strategic vision:

1.2.1 Population size is a key denominator and population growth has factored in the impact of HIV/AIDS.

1.2.2 The additional service burden of HIV/AIDS, including the cost of providing anti retroviral therapy for 50% of Stage 4 patients, was calculated for all levels of care.

1.2.3 Provision was made for an increase in the core package of services at Primary Health Care (PHC) level, including for mental health care.

1.2.4 The model is based on the following outputs:

- PHC visits per capita; and
- Admissions per 1 000 population for each level of care.

1.2.5 Benchmarks were set for different levels of care:

- Number of patients per clinical practitioner at PHC clinics;

- Target Bed Occupancy for acute and chronic hospitals; and
- Target average length of stay for different levels of care.

1.2.6 To render the service affordable a quantum of admissions are diverted from each level to be treated more appropriately at a lower level of care as indicated in Table 1 below:

Table 1: Admissions diverted to be treated at a more appropriate level of care

FROM LEVEL	TO LEVEL	NUMBER OF PATIENTS DIVERTED
3	2	44 366
2	1	45 328
1	PHC	55 468

1.2.7 At Level 3, equitable access is provided to patients from both the Western Cape and other provinces within the affordability levels of the National Tertiary Services Grant.

2. CABINET APPROVAL

2.1 Cabinet approved the Healthcare 2010 conceptual framework in September 2002, but requested that it be consulted with relevant stakeholders before being approved for implementation. This conceptual framework was widely consulted between September 2002 and March 2003, and an overview of the stakeholder responses was submitted to Cabinet.

2.2 In March 2003 Cabinet approved the broad framework of Healthcare 2010 and its implications for the delivery of health care within the Western Cape. A detailed implementation plan consisting of a service delivery plan, a human resources plan, an infrastructure plan and a financial plan, is currently being formulated.

3. THE NEED FOR CHANGE

3.1. Restructuring is essential because of the need to secure basic access to quality services for the whole population of the province. In addition, the changing disease profile, influenced by HIV/AIDS and TB, amongst others, and intra-provincial and inter-provincial inequities, must be addressed. Finally, the current pattern of services is unaffordable with respect to both capital stock and operational expenditure. Without restructuring, inequities and inefficiencies will continue. Quality of care will remain compromised and by 2010 the projected deficit on the Provincial Health budget will be R1,1 billion (in April 2001 rands.)

3.2 Healthcare 2010 was conceived in the face of two apparently irreconcilable objectives, namely:

- The need substantially to improve the quality of care of the health service, and simultaneously;
- The need to bring expenditure to within affordable and sustainable limits.

3.3 The **Healthcare 2010** initiative was conceptualised with the aim of achieving both objectives through the creation of a different service platform and an all-round increase in efficiency. The in-depth analysis that has followed has proved conclusively that the two objectives are attainable, albeit with difficulty, but only with additional funding for HIV/AIDS and TB. The time scale for achieving this objective is eight years – hence 2010.

3.4 The underlying principles of **Healthcare 2010**, which have been widely supported by the stakeholders consulted, are as follows:

- Quality care at all levels
- Accessibility of care
- Efficiency
- Cost effectiveness
- Primary health care approach
- Collaboration between all levels of care
- De-institutionalisation of chronic care.

3.5 **Healthcare 2010** is based on the following assumptions:

- The funding envelope for Health remains the same except for a reduction in of R230 million in the National Tertiary Services Grant.

- The reason for basing financial calculations on April 2001 Rands is that all the analysis and calculations were based on data from the 2000/01 financial year.
- The purpose of assuming that the funding envelope will remain the same is to define a base from which to make financial comparisons. Of particular importance in this regard is the assumptions that funding currently provided by Local Government for PHC services will remain in the health sector.
- This assumption presumes that changes in macro-economic factors, i.e. inflation, exchange rates, etc will be fully discounted in the appropriation of national budgets.

- The Local Government contribution towards Primary Health Care (PHC), excluding environmental health, will continue at existing levels.
- Funds allocated for conditional grants will be used according to the requirements of the Division of Revenue Act (DORA).
- Patients will be treated at the most appropriate level of care within a changed configuration of services.
- Admissions are not reduced but patients will be diverted to appropriate levels of care.
- The focus is on the provision of services to the population of the Western Cape (plus a quantum of tertiary services to other provinces).

3.6 Healthcare 2010 will strengthen PHC in the following ways:

- Increase spending at PHC level by R400 million – R60 million allocated to Home Based Care and R40 million for prevention and promotion.

- Promote the existing “Healthy City” programme within the City of Cape Town and elsewhere to reduce the burden on the health system.
- Increase PHC attendances from 11 to 13 million with PHC visits remaining over 3 per person per year against the national target of 2,9.

3.7 The efficiency gains from Healthcare 2010 are as follows:

- Overall cost per patient day equivalent (PDE) decreases form R858 to R814 (2000/2001 rands).
- Average length of acute bed stay decreases by 0,5 days.
- Funding for equipment and maintenance, as a percentage of total expenditure increases from 2.3% to 7.8% of total expenditure. This amounts to an additional allocation of R120 million in 2010.
- Bed occupancy rate will be 85%.
- The Western Cape will provide tertiary health services for approximately 2.6 million people from neighbouring provinces which is in line with the total envelope of funding in the National Tertiary Services Grant provided for tertiary services for the population of the Western Cape and beyond.
- The adjustment of beds for tertiary care will lead to the reconfiguration of the tertiary services to be provided in terms of the National Tertiary Services Grant. Accurate costing is essential to ensure that the actual cost of this service is provided for. It is envisaged that at the cost of R1 641/PDE the Conditional Grant will fully fund the 1 285 tertiary beds envisaged in Healthcare 2010.

4. IMPLEMENTATION OF HEALTHCARE 2010

4.1 Overview:

Implementation will be achieved by development and concurrent execution of four inter-related plans:

(1) **Healthcare 2010 Service Delivery Plan.** This will define and quantify the heath services required by Region, district and community within the shape as described earlier. Furthermore, it will define service packages per level of care, with clear clinical guidelines for treatment and referral.

(2) **Healthcare 2010 Infrastructure Plan.** This will provide buildings, equipment and maintenance in line with service requirements as set out in the Healthcare 2010 Service Delivery Plan. An integral part of this plan is to maximise the value of assets by fully utilising existing facilities and exploiting under-utilised capital stock to garner additional funding by various strategies.

(3) **Healthcare 2010 Human Resource Plan.** This will enable facilities to be staffed appropriately and will require a revision of the existing staff establishments.

(4) Healthcare 2010 Financial Implementation. The allocated budgets will be linked to measurable, time bound objectives for the MTEF period and beyond to give effect to the restruCturing of the Western Cape Provincial health services.

In summary, the phased implementation will be as follows:

(1) Determine packages of services per level and location.

(2) Match services with the necessary facilities and equipment.

(3) Shift services according to the identified need.

(4) Staff the facilities with the appropriate staff, where necessary upgrade skills and/ or employ additional staff.

(5) Link funding to services to ensure sustainable quality services.

4.2 Healthcare 2010 Service Delivery Plan:

4.2.1 The shape of the service platform that results from the application of the conceptual model is that 90% of Health patient contacts should occur at primary level, 8% at secondary level and 2% at tertiary level. It must be emphasised that the shape of this model was derived as an outcome of a scientific process of situational analysis and service platform modelling. It was not an initial assumption.

Table 1: Healthcare 2010: Contacts per level of care:

LEVEL	ACUTE		CHRONIC	
	2000	2010	2000	2010
PHC Contents	80.5%	81.4%	97.8%	99%
Total contacts at Level 1	8.5%	7.4%	1.1%	0.5%
Total contacts at Level 2	7.6%	8.2%	1.1%	0.5%
Total contacts at Level 3	3.4%	3%	0%	0%

4.2.2 In terms of Healthcare 2010 services there will be a requirement for 1 285 tertiary beds, 2 692 regional Level 2 specialist beds and 2 421 district beds for acute care, all with appropriate funding. Tertiary beds will be fewer than at present but will be significantly better funded for personnel, equipment and maintenance.

4.2.3 Patients with tuberculosis will be largely managed through community-based care. Provision is made for 2,7 million TB DOTS contacts. Patients with mental illness will be largely managed in the community with an additional 832 000 patient contacts.

4.2.4 The following tables serve to illustrate the implications of **a preferred possible scenario** in terms of bed and staff allocations developed in order to meet the requirements of Healthcare 2010.

4.2.5 This scenario would, for example, address the issue of inappropriate admissions to Level 2 beds in the Metropole by making provision for Level 1 beds in this region, in close proximity to the relevant communities.

Table 2: Allocation of beds in 2002 and possible alternative allocations in 2010

	2002	*2010*							
HOSPITAL	*Beds*	*Level 1*	*Level 2*	*Level 3*	*TB*	*Psych*	*Step-D*	*TOTAL Beds*	*GAP*
Tertiary Care Institutions									
Groote Schuur	960		200	735				935	(25)
Red Cross	290		100	190				290	
Tygerberg	1 385		950	360				1 310	(75)
TOTAL: TERTIARY	2635	-	1250	1285	-	-	-	2535	(100)
Metropole region									
Conradie (Metropole Rehab)	448							-	(448)
Victoria	140	208	52					260	120
Somerset	234	208	52					260	26
G F Jooste	184	147	37					184	-
Hottentots Holland	121	96	24					120	(1)
Karl Bremer	243	208	52					260	17
New Hospital in Mitchell's Plain/Khayelitsha	-	108	115				270	493	493
Eerste Rivier	-	120						120	120
False Bay	70	70						70	-
Wesfleur	19	28						28	9
Mowbray Maternity	166	76	76					152	(14)
Brooklyn Chest	305				305			305	-
Booth	54						54	54	-
Maitland Cottage	85						85	85	-
Sarah Fox	60						60	60	-
St Josephs	135						100	100	(35)
Westlake	180						131	131	(49)
DP Marais	260				260			260	-
METROPOLE REGION: TOTAL	2704	1 269	408	-	565	-	700	2942	238
CAPE METROPOLE GEOGRAPHIC REGION: TOTAL	5339	1269	1658	1285	565	-	700	5477	138
BOLAND/OVERBERG: TOTAL	793	343	315	-	300	-	-	958	165
SOUTH CAPE: TOTAL	970	413	357	-	171	-	-	941	(29)
WEST COAST: TOTAL	845	396	362	-	130	-	-	888	43
ASSOCIATED PSYCHIATRIC HOSPITALS (APH)	2267		-	-	-	1332	-	1332	(935)
WESTERN CAPE: TOTAL	10214	2421	2692	1285	1166	1332	700	9596	(618)

4.3 Healthcare 2010 Infrastructure Plan:

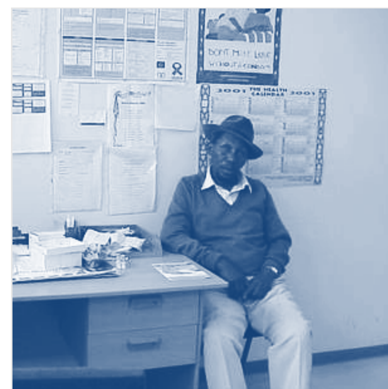
4.3.1 The ideal Service Delivery Platform defined in the Healthcare 2010 Service Delivery Plan has been compared with the existing health facilities infrastructure. The realities are:

- The original total design capacity of the infrastructure provides some 15,000 beds.
- In terms of Healthcare 2010 only 9,596 beds are required. (Refer to Table 2 above).
- Some facilities are in poor condition and are badly located.
- Some communities have no ready access to facilities.
- There is considerable scope for funding new capital infrastructure from the disposal of surplus land and unutilised facilities.

On the basis of this, various infrastructure scenarios have been considered. The object is to maximise the utilisation of current infrastructure that is accessible, in good condition, and suitable for purpose. The first specific proposals in this regard are being developed following approval of the Healthcare 2010 plan by the Provincial Cabinet. In terms of the bed allocation as discussed in paragraph 4.2.4 broad proposals are outlined below in this regard as presented for consideration by Cabinet.

4.3.2 Rural requirements:

- The rural district hospitals are generally in good condition and suitably located.
- The rural regional hospitals at George, Worcester and Paarl, however, require significant upgrading to fulfil their role as referral hospitals. This work has already started and funding for this purpose has been secured from the National Hospital Revitalisation Programme.
- The 2010 Service Delivery Plan indicates that many rural district hospitals will have fewer beds. Exceptions are Vredenburg, Robertson and Hermanus. Excess capacity, where it exists, could be made available to NGO's to be utilised as step-down facilities for care in the community.



4.3.3 Requirements in the Cape Peninsula Metropole:

- The most significant weakness in the Cape Metropole is the absence of accessible district hospitals. The Cape Metropole has only three small district hospitals – False Bay Hospital

(70 beds) and the recently purchased Eersterivier Hospital (120 beds), and Wesfleur Hospital (19 beds). To counter this weakness PHC services have been doctor- rather than nurse-driven, and referrals are often from PHC facilities directly to regional instead of district hospitals. This results in a significant cost escalation. A total of 1269 district beds are required in the Metropole. For this reason current hospitals within the Cape Metropole will largely be converted to district hospitals. Over time there will be a more appropriate distribution of these facilities across the Cape Peninsula.

- There will be one centrally located regional hospital for the Cape Metropole, with at least 8 district hospitals providing reasonable accessibility to all communities. In most of the district hospitals there will be specialist outreach from the regional hospitals and, initially, the existing tertiary hospitals, to ensure that services are taken to the people and allow for the inevitable 20% overlap of level 2 (regional) patients in level 1 (district) facilities. With a network of district hospitals in place, the doctor-driven PHC will be progressively converted to a more cost-effective and efficient nurse-driven service in line with the remainder of the province, and indeed the country.
- A new hospital will be built on the Cape Flats and will function as a district hospital, accessible to Mitchell's Plain and Khayelitsha. It will incorporate a high number of Level 2 beds to facilitate outreach from the centrally located regional hospital referred to above.
- The tertiary services hospitals, Tygerberg, Groote Schuur and Red Cross will be retained to provide the 1285 tertiary beds as determined in the strategic framework. All

three hospitals will also have level 2 beds to provide for service delivery and allow for the inevitable 20% overlap between level 2 and level 3 patients in the facilities. This will also ensure a critical mass for teaching purposes. The resulting excess bed capacity at Tygerberg Hospital will be utilised to create the Metropole regional hospital (900 beds) referred to above.

- The psychiatric hospitals will be rationalised to provide 1300+ beds with the retention of Valkenberg, Lentegeur, Stikland and Alexandra Hospitals.
- The TB hospitals will be rationalised to provide 1100 beds with the retention of Brooklyn Chest Hospital. It must be noted that the Healthcare 2010 conceptual framework was adjusted with respect to tuberculosis and as a result the required number of beds has been adjusted upwards.

4.4 Healthcare 2010 Human Resource Plan:

4.4.1 The Human Resource Plan will be developed in conjunction with organized labour.

4.4.2 One of the biggest challenges facing the Department is the need to ensure that its workforce meets the challenges of service delivery within a changing environment with a sizeable burden of disease.

4.4.3 A major challenge will be to recruit, train, retrain and to retain staff. In particular, strategies to attract clinical staff to rural/underserved areas will require both incentives and aggressive recruitment and retention strategies. The National Department of Health is currently working on a recruitment and retention strategy which will support the Provincial processes.

4.4.4 The personnel plan developed to support the Service Plan will determine:

- The demand for and the availability of employees with the skills that are necessary to achieve the goals and objectives of Healthcare 2010;
- The gap between the demand and supply; and
- Realistic and acceptable strategies to close the gap.

4.4.5 In line with the Service Plan, strong shifts in health service delivery will occur. These shifts will require the following broad staffing shifts:

(1) **Primary Health Care:**

The total staff establishment will increase by approximately 1 300 personnel.

(2) **Hospitals:**

Based on the Staffing Norms applicable to different levels of hospitals, it is envisaged that a total number of 5301 staff will be required to relocate or be re-skilled within the Health Service.

Table 3: Possible hospital staffing allocation to meet the service delivery requirements illustrated in Table 2

	2010							Dec-02	
HOSPITAL	*L 1*	*L 2*	*L 3*	*TB*	*Psych*	*Step-D*	*Total*	*Staff Staff*	*Additional (Surplus)*
Tertiary Care Institutions									
Groote Schuur	-	486	2940				3426	3853	(427)
Red Cross	-	243	600				843	1036	(193)
Tygerberg -	2309	1600	3				909	4184	(276)
TERTIARY:TOTAL	-	3038	5140	-	-	-	8178	9073	(896)
METROPOLE REGION: TOTAL	2343	991	-	253	-	-	3885	3578	307
CAPE METROPOLE GEO-GRAPHIC REGION: TOTAL	2343	4029	5140	253	-	297	12062	12651	(589)

	2010							Dec-02	
HOSPITAL L 1	L 2	L 3	TB	Psych	Step-D	Total	Staff	Staff	Additional (Surplus)
BOLAND/ OVERBERG: TOTAL	623	765	-	249	-	-	1673	1197	440
SOUTH CAPE: TOTAL	652	868	-	59	-	-	1579	1389	190
WEST COAST: TOTAL	594	880	-	-	-	-	1474	1139	335
ASSOCIATED PSYCHIATRIC HOSPITALS (APH): TOTAL	-	-	-	-	1598	-	1599	2046	(447)
WESTERN CAPE: TOTAL	4213	6542	5140	561	1598	297	18351	18422	(71)

Table 4: Reconciliation of total staff establishment

	December 2002	2010
Hospital Services	18 422	18 351
Primary Health Care	2 546	3 909
Other	3 297	3 300
Total	24 265	25 560

4.4.6 Changes to staffing levels will occur only after the staffing norms have been applied to each individual hospital.

4.4.7 The Primary Health Care approach, which is based on a nurse-driven service, requires that the Department engage in partnerships with the training institutions to ensure that appropriate, relevant and sustainable training opportunities are available.

4.4.8 The challenge in ensuring a constant pool of nurses lies in progressive solutions. This should not only address the continuous loss of nurses but also areas of required clinical expertise. A carefully considered comprehensive and aggressive strategy, supported by adequate resources will be required to develop and sustain a viable pool of nurses.

4.4.9 In support of the national strategy to extend the training of mid-level workers across various disciplines, the Department will embark on training of mid-level workers with priority given to the training of persons fo home-based care.

4.4.10 In addition the Department will expand its existing programmes of learnerships. The present learnerships for Pharmacist Assistants, which has demonstrated positive impact on the service, and that for Enrolled Auxiliary Nurses, will be expanded further. Other learnerships will also be explored to ease the burden of the health professionals.

4.4.11 It is accepted that while resources are constantly constrained the situation calls for

creative, innovative strategies to ensure that staff in hard-to-reach areas, or in workplaces that cannot easily spare their release are accommodated through use of innovative training interventions. Examples of such interventions include satellite technology, self teachings, distance learning, and modular-based learning programmes.

4.5 Healthcare 2010 Financial Implementation Plan

4.5.1 Current status of the budget and alignment to the Medium Tem Expenditure Framework

(1) Services currently being rendered have been funded in the 2003/2004 budget allocation. This allocation can therefore be described as a "holding budget" pending Cabinet's decision regarding the implementation of Healthcare 2010.

(2) The roll-out of the detailed Service Delivery plan, Infrastructure plan, and Human Resource plan will determine

to what extent the "holding budget" will be adjusted during the current financial year. Healthcare 2010 will be implemented over the next eight years, necessitating a stepwise adjustment of the MTEF over this period. The budget allocations within the MTEF will be determined according to the scale and pace of implementation of Healthcare 2010.

(3) The MTEF links key measurable objectives (KMO's) to time and cost over the next 3 years with 2010 figures as targets to indicate the required total shift. These KMO's will be incorporated in individual managers, performance agreements to ensure the targets are achieved.

(4) Through the progressive shift to more cost-effective levels of service, savings of more than R500 million will be released for further shifts and improved quality.

4.5.2 Migration of patients: Level 1 and Level 2 services

The National Tertiary Services Grant provides funding for the rendering of highly specialised services to patients from other provinces essentially at the three existing Tertiary Care Institutions. However, this province is experiencing a considerable influx of patients into primary and secondary levels of service as well. The Western Cape Province accepts this responsibility as a

provider of Health Services in South Africa but the funding of Level 1 and Level 2 services will have to be addressed both at national and provincial level and bilaterally with the provinces concerned.

4.5.3 Revenue generation and retention

The Department has taken steps to enable institutions to generate additional revenue by means of the following:

(1) The implementation of systems to facilitate the application of the Uniform Patient Fee Schedule (tariffs for services) at all non-academic hospitals. This is applied to all externally funded patients, e.g. patients funded by medical schemes, the Road Accident Fund, the Commission for injury on duty and other government departments such as Correctional Services and Defence.

(2) The implementation of the Hospital Information System (HIS), with specific reference to the Billing Module at Tertiary Hospitals, and the Delta 9 system for other hospitals.

(3) Agents have been appointed to process all Road Accident Fund claims and to facilitate debt collection.

(4) Preferred provider agreements have been signed with medical schemes, granting their members access to Provincial services, especially through the private bed network with enhanced hotel facilities.

(5) A revenue generation policy will enable the department to raise its revenue targets to address the budgetary strategies envisaged in Healthcare 2010.

4.5.4 The financial perspective on infrastructure

(1) Ideally, new facilities would be built, equipped, and commissioned before dismantling the existing delivery system. However, this is neither practical nor affordable. The reality is that services will have to be adjusted incrementally according to the availability of the requisite resources.

(2) The active support of Public Works is essential to provide the changes to the physical infrastructure in the very short timeframe of eight years.

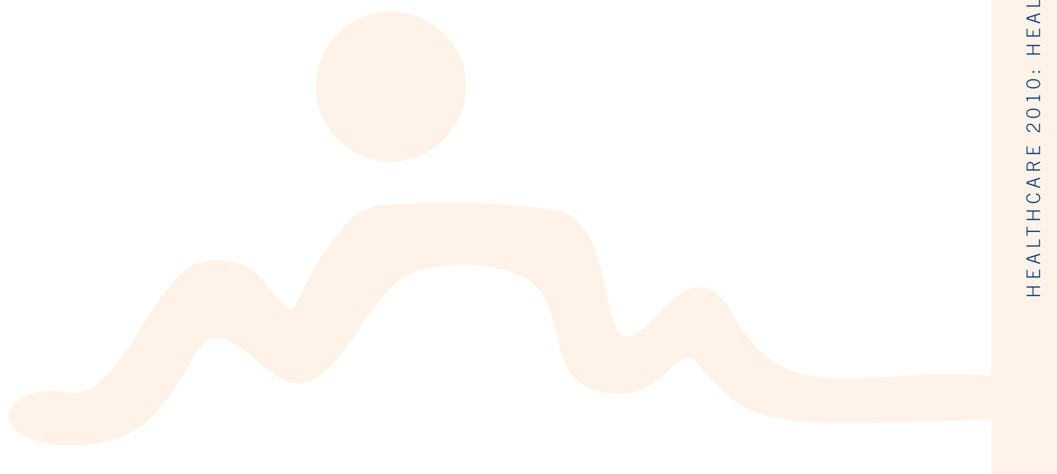
(3) Creating the required physical infrastructure to support Healthcare 2010 will be possible provided present funding streams are maintained. The following funding sources have been identified:

- The Hospital Revitalisation Programme (HRP). This is a national conditional grant.
- The Provincial Infrastructure Grant (PIG)
- Asset swops (i.e. the sale of surplus property to generate funding for capital works)
- Public Private Partnerships (PPP)

Table 5: Illustration of the funding requirements, sources and available funding

Funding	Health Capital R000	HRP R000	PIG R000	Asset swop R000	PPP R000	TOTAL R000
Requirement for Healthcare 2010	80,000	640,000	320,000	165,000	195,000	**1,400,000**
Projected total budget for infrastructure	160,000	640,000	320,000	165,000+	195,000	**1,480,000**

(4) The above table indicates that a total of R1,4 billion will be spent on Health capital infrastructure over the next eight years. There will be additional Capital Works expenditure in the private sector as a result of asset swops and Public Private Partnerships. This will support economic growth in the Province and will contribute to the strategy of iKapa Elihlumayo.



4.5.5 Equipment backlogs

(1) During 2001 it was established that the Department needs to replace critical equipment to the value of R333 million.

(2) Current allocations that have been made to address these backlogs are:

R40 million in 2003/04;

R42 million in 2004/05; and

R44 million in 2005/06.

(3) Additional revenue amounting to a minimum of R11,742 million per year for the MTEF period, will be generated and has also been allocated for the purchase of Capital equipment.

4.6 Management structure

The management structure of the department has been restructured in line with the priorities as outlined in Healthcare 2010 with effect from 1 June 2003. Management will be strengthened to ensure a particular focus on the challenges of change management faced firstly at PHC and district level, secondly at regional and finally at tertiary level. Financial management will be strengthened through the creation of a Financial Branch under a Chief Financial Officer (CFO – experienced chartered accountant at level 15) as well as the creation of a Supply Chain Management directorate. (See Annexure 1 for the new macro structure).

5. PERSONNEL IMPLICATIONS

It is anticipated that approximately 5 000 staff will be relocated and/or re-skilled over the eight-year period as a result of the restructuring process. However, due to the fact that there is an annual attrition rate of approximately 1 000, it is not envisaged that there will be significant numbers of staff exposed to the risk of being declared in excess. This matter will be dealt with in terms of the Bargaining Council framework and relevant legislation.

6.FINANCIAL IMPLICATIONS

6.1 It is estimated that the Department will require R4,2 bn to render the existing service in 2010. This is compared to an predicted financial envelope of R3,1 bn, with a resulting deficit of R1,1 bn.

6.2 The total expenditure estimated for the services envisaged in Healthcare 2010 is R3,789 bn. Increased efficiencies as outlined above will effect savings of the order of R502m.

6.3 The estimated cost of HIV/AIDS to the entire health service of the Western Cape is estimated at R541m. It is envisaged that following national initiatives between Health and Finance, in

which the Western Cape has played a prominent role, that this will be funded **in addition** to the existing funding envelope outlined above.

6.4 On the assumption that HIV/Aids will be funded separately, the implementation of Healthcare 2010 results in a relatively small deficit of R133m. The Department is developing a strategic revenue plan with short, medium and long-term targets, as indicated earlier and is confident that sufficient additional revenue will be generated to address the deficit by 2010. (Refer to paragraph 4.5.3).

6.5 By allocating an additional R214 million to non-personnel expenditure, the ratio of non-personnel expenditure to total expenditure will increase from 27.6% to 36%.

6.6 In summary, the projected financial implications of Healthcare 2010 are as follows (in 2001 Rands):

- Reduction of expenditure by restructuring = R502 million.
- Total expenditure = R3,789 billion.
- Deficit = R674 million.
- Additional funding required for AIDS = R541 million.
- Shortfall = R133 million: which will be negated by revenue generation as described earlier.

7. IMPLEMENTATION

OF HEALTHCARE 2010 PROCESS

7.1 In order to effect the implementation of Healthcare 2010 the following 24 projects have been identified and allocated to members of the Department's Top Management Team to co-ordinate.

7.2 Healthcare 2010 projects

PROJECT	MEMBER OF TOP MANAGEMENT RESPONSIBLE FOR CO-ORDINATION
1. Communication/co-ordination	Professor Househam
2. Finalisation of service packages	Dr E Engelbrecht
3. Replacement of equipment	
4. Formulation of standard treatment guidelines	
5. Formulation of referral guidelines	
6. Upgrading of patient transport and Emergency Medical Services	
7. Regional Hospitals	
8. Consolidation of Level 3 care	
9. Health promotion/disease prevention	Dr F Abdullah
10. Primary Health Care services – clinics	
11. Community Health Centres (CHC's)	
12. District Hospitals	
13. Chronic care (TB and Mental Health)	

PROJECT	MEMBER OF TOP MANAGEMENT RESPONSIBLE FOR CO-ORDINATION
14. Home-based care 15. Finalisation of the infrastructure platform 16. Revision of staff establishments 17. Finalisation of the Human Resources Plan 18. Revenue generation plan 19. Infrastructure revitalisation/restructuring 20. Revision of the Provincial pharmaceutical coding list 21. Service level agreements 22. Joint agreements 23. Budget links output/expenditure 24. Delivery of chronic medication (Metro)	Mr A Cunninghame

7.3 In addition to the co-ordinating role played by the members of Top Management, Project Managers will be identified to drive and manage the projects.

8. THE WAY FORWARD

8.1 The implementation of Healthcare 2010 is an incremental, step-wise process. The steps will not be of equal magnitude or frequency. The speed of implementation will be governed largely by the need for major stakeholder participation and buy-in. In some instances, where consensus is reached rapidly, progress will be rapid. The revitalisation of the rural regional hospitals is an example. In other areas the planning process may be more laborious.

8.2 The implementation of Healthcare 2010 is dependent on the enthusiastic support of all levels of management. A concerted effort will be made to ensure that they are kept informed and participate in the planning processes.

8.3 The Health Science Faculties of the Universities and Technikons have been identified as important partners in the provision of health care. They are required to play a major role in the restructuring of the tertiary health institutions.

8.4 The Provincial Department of Transport and Public Works is another key partner in respect of the provision of physical infrastructure. Their support is vital.

8.5 It is natural that the magnitude of Healthcare 2010 will generate uncertainty and in some instances resistance. The Department is resolute in its endeavour to provide "equal access to quality care" through Healthcare 2010. Nevertheless, the process will be managed in a sensitive and responsible manner. The benefits are already evident in small measure. As the impact of accessibility and service improvement grows there will be cause for patients and personnel alike to applaud the progress.

ANNEXURE

CONSULTATION PROCESS AND COMMENTS REPORT (AS AT 26 MARCH 2003)

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.

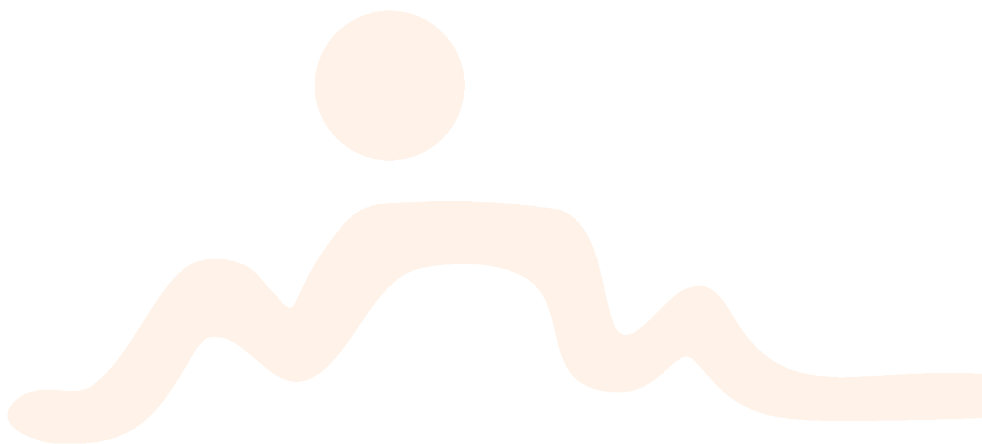
2.5 Commentary was recorded received as follows:

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	Various primary health care facilities across the Metro
Extended Health Management Committee	Head Office staff
Inter-hospital Co-ordinating Committee (Nils Bergman)	Dr Tracy Eastman (Information Management)*
Staff at Institutions	NATIONAL HEALTH (Conradie)
Tygerberg Hospital	Top Management
Groote Schuur Hospital (SAMA)	UNIVERSITIES
Groote Schuur Hospital Dr Saadiq Karriem*	**University of Cape Town**
Groote Schuur Hospital Qengwa, Lulu, GSH*	Deputy Vice-Chancellor: Research & Innovation, Professor de la Rey*
Red Cross Childrens' Hospital (general group)	Peninsula Maternity and Neonatal Services*
Red Cross Childrens' Hospital School of Adolescent & Child Health*	Department of Obstetrics & Gynaecology*
Somerset Hospital (general group)	Department of Radiation Medicine/ Division of
Somerset Hospital, Department of Social Work*	Radiation Oncology*
Somerset Hospital Radiography Service*	Otorhinolaryngology (ENT)*
Mowbray Maternity Hospital Dr Dave Greenfield*	**University of Stellenbosch**
Paarl Hospital*	Professor Barney de Villiers*
Associated Psychiatric Hospitals (Magda Karelse)	Department of Anaesthesiology*
Karl Bremer Hospital	Department of Otorhinolaryngology (James Loock)*
Southern Cape Hospitals and Clinics	**University of the Western Cape**
West Coast/Winelands Hospitals and Clinics	School of Public Health
Boland Overberg Hospitals & Clinics	UNICITY HEALTH

LIST OF STAKEHOLDERS THAT PROVIDED FEEDBACK TO CONSULTATION (* denotes written feedback)	
STAFF	
Organized Labour	Dietetics/Nutrition
Democratic Nurses Association (Denosa) (Danver Roman)*	Physiotherapist False Bay Hospital
	Radiography service: False Bay Hospital
National Education Health and Allied Workers (Nehawu) (Suraya Jawoodien)*	Charn de Lange, Dietician, Metro Union Rehab Centre
Public Servants Association (PSA) (Sandra Newman)*	Lynn Kleinherbst, Physiotherapist, Bishop Lavis Rehabilitation Centre
Provincial Bargaining Chamber	Karin Blackbeard, Chief Pharmacist, Metropole Region
South African Medical Association	**COMMUNITY AND FAITH BASED ORGANISATIONS**
Dr John Terblanche*	Health Systems Trust
Dr SNE Mazaza	Community Health Forums at two Metro clinics
Dr Janeshsk	INCLUDID (Inclusive Living for People With Intellectual Disabilities)*
Dr Denise White*	Cape Mental Health Society*
Prof Coetsee	Postnatal Depression Support Association*
Nursing Bodies	Fountain House*
Catherine Thorpe, DDN, GSH	Cape Consumer Advocacy Body*
Sandy Pillans	Archdiocese of Cape Town
Mental Health Associations	ANC –Western Cape Branch
*Mental Health Workshop Input	Individual members of the public
Lenteguer Psychiatric Hospital	**TRUSTS (DG Murray Trust)**
Erika Langen	
Allied Health Professionals	
AHP Professional Technical Committee (Jenny Hendry)*	

ISSUES	RESPONSE
Reasons for restructuring, conceptual framework and underlying principles: • Widespread support for: • More equitable spread of services • Strengthening primary and secondary care • The vision of a "seamless referral service" • 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.

ISSUES	RESPONSE
• 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 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: • "Scientific"? • Capable of being manipulated?	• Yes, in the sense that it is based on empirical evidence. • 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.

ISSUES	RESPONSE
• 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. • How was inflation dealt with? • 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 assist in further deci sion 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

ISSUES	RESPONSE
	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 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.

ISSUES	RESPONSE
Concerns were expressed that the following specific health challenges have not been dealt with adequately:	
• TB: 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: Impact on staff level considered?	• Yes, allowances have been made within strategies to be accom modated within the additional R540 million funding to be allocated fro HIV/AIDS.
• Trauma: 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: De-institutionaliza tion 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.

ISSUES	RESPONSE
Human resources:	
Concerns have been expressed that unless means are found to "retain and retrain" doctors 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)?	• Agreed. Such strategies will form part of the Human Resource Plan. Strategies are being developed at National level for the retention of scarce skills to address this challenge. • Agreed.
Physical resources: • 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, al though 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.)

ISSUES	RESPONSE
• 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 serv ice.	• Agreed.
Trans-border services: • Will treatment be available for patients from other provinces? • Will the service cope the Levels 1, 2 and 3 inflows from the Eastern Cape?	• Yes. Level 3 is funded by the Conditional Grant. Levels 1 & 2 are not. With regard to the latter, the matter will be taken up with both the Eastern and the North-ern Cape.