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 L1	L2	L3	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)

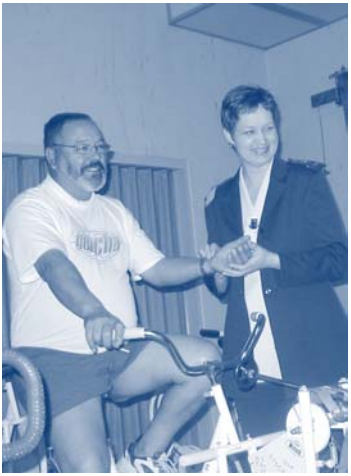
Table 4: Reconciliation of total staff establishment

	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, Infra-structure 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).