PROVINCIAL DEPARTMENT OF HEALTH
WESTERN CAPE

ANNUAL PERFORMANCE PLAN

2006/2007

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MESSAGE FROM MR PIERRE UYS
WESTERN CAPE MINISTER OF HEALTH

In the year ahead, our focus as regards Healthcare 2010 will move past the planning to the implementation phase. Our goal being to bring improved delivery and equal access to quality health services to all throughout our Province.

We are already in the starting block with the new service delivery plan that defines the level of service together with the levels of staffing in each case. The implementation of this plan will ensure the delivery of health care services that is more appropriate and closer to the patients and communities who need it.

A new joint agreement with the universities is close to finalisation. It will clarify many issues including funding and conditions of service. Teaching and research are the responsibility of the universities while the Department of Health is responsible for health services. With this agreement in place, our combined focus will be on improving health care.

While we have made some improvements to our Primary Health Care (PHC) service, much remains to be done. We must further strengthen management and staffing at these facilities. This will help in reducing the unacceptable long queues. I am also serious about overcoming delays in harnessing technology to improve recordkeeping and speed up patient flow.

On 1 March 2006, the operational control of Personal Primary Health Care services in the non-metropolitan areas reverted to the Department. The transfer of assets and liabilities and staff will follow. Our challenge is to demonstrate real improvement in service delivery by creating a seamless health care service that does away with inefficiencies and duplication.

The burden of disease continues to put pressure on our health system. The incidence of HIV and Aids is on the increase and while we exceed our targets in providing anti-retroviral treatment, there is no time to admire our achievements. The huge challenge of effectively communicating prevention remains - and I look forward to more dedicated and measurable efforts in this regard.

Similarly, Tuberculosis remains a major challenge. We must work harder at getting the message across that this disease is treatable and curable and that treatment is free. We must also strengthen support for the frontline health workers who help people suffering from it - and our Home Based Carers, who play a vital role in supervising TB treatment in the community.
Trauma and violence are eroding our limited resources and placing unnecessary pressure on our health facilities and staff. Apart from providing quality health care services to all our patients, as department we have a role to play in educating our communities about the impact of violence on our ability to provide better health care to the people in the Western Cape.

I welcome the progress that we have made in the field of mental health with the appointment of the Mental Health Review Board as required by the Mental health Care Act, 2002 (Act 17 of 2002). The Board is already playing a positive role in improving the circumstances of patients and I look forward to working with them in making further improvements to the system.

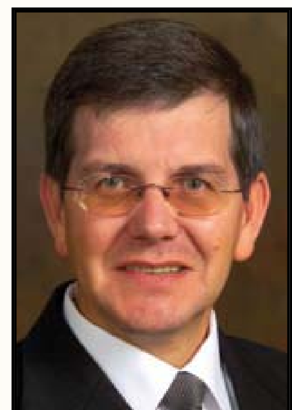
This year I will expect a strong emphasis on immunization. Having children properly immunized protects the child and the community. If a high proportion (over 90%) of children are immunized it means that a disease such as measles does not spread as easily. Immunization thus prevents both infection and spread so that epidemics do not occur.

As for possible future pandemics, I am glad to report that we have a preparedness plan for Avian Flu, should it ever reach our shores. In this matter, we took our lead from the national department, ensuring a more comprehensive approach to safeguarding the health of everyone in our country. We will continue to work closely with other departments in monitoring the situation.

It is our responsibility as a Department to create the conditions where our people are able to make healthier choices. We need to promote health and healthy living and help them choose health by demonstrating the many rewards this holds for individuals and families. Let us take this responsibility seriously and in so doing contribute to a healthy and vibrant province.

I have the greatest confidence that our management and staff will deal with the changes and the sacrifices demanded by the implementation of Healthcare 2010, positively. The rewards of a better healthcare system make it worthwhile. In the process, all of us will have to take a hard look at the way we provide healthcare and how this fits in with the needs of our people.

Ahead of us is a period of renewal asking for fresh approaches and a willingness to reconsider whenever we find something in conflict with better healthcare. Ultimately the aim is to do what we do, better, steadily raising our standards of performance. Our people deserve better – and it is our task to give them the best.



PIERRE UYS

WESTERN CAPE MINISTER OF HEALTH

FOREWORD BY PROFESSOR CRAIG HOUSEHAM

HEAD OF HEALTH

The key issue for 2006/07 is the finalisation, consultation and implementation of the Service Plan which will provide the blue print for the implementation of Healthcare 2010.

The development of the Service Plan has taken longer than anticipated and longer than I would have liked, however, the groundbreaking work that this process has entailed and the rigor of the plan have, in my view, made this time and effort well spent. The inputs from various internal stakeholders are in the process of being incorporated into the final draft document, which will then be more widely consulted externally before being finalized.

Although the Annual Performance Plan for 2006/07 is generally in line with the principles of Healthcare 2010 the detail of the implementation is not included as this will only be available following the finalisation of the Service Plan. Clearly the development of infrastructure will take longer than restructuring the service and therefore the Healthcare 2010 'shape of the service' will be accommodated within the existing infrastructure in the short-term.

In line with Healthcare 2010 additional funding has been allocated to strengthening both the management and the service delivery of Personal Primary Health Care (PPHC). Management and support structures will be aligned with the district and sub-district boundaries of the Western Cape. Together with the initiative to assume responsibility for PPHC in the non-Metro districts it is anticipated that this will eliminate inefficiencies and duplication of services. Actual service delivery will be strengthened by the appointment of family physicians at the larger Community Health Centres and the filling of vacant nursing posts, the provision of extended hours of service at CHCs and by allocating additional funding to enhance the response to HIV and AIDS and TB. An exciting initiative is the commissioning of the Faculties of Health Sciences to perform a burden of disease study which it is anticipated will provide vital information for planning and disease prevention in the medium to long-term. It is envisaged that this information will be valuable to departments across the provincial government and beyond.

Additional funding has been allocated to regional hospitals to improve the staffing, additional level 2 beds will be commissioned at Eben Donges Hospital and a day surgery ward will be commissioned at the New Somerset Hospital to fast track the turnover of patients requiring specific procedures such as cataract surgery, tonsillectomies and hernia repair.

I am pleased to report that the Western Cape has successfully implemented the Mental Health Review Board as required by the Mental Health Care Act, 2002 (Act 17 of 2002) during 2005 and whose function will continue. An amount of R2,5 million has also been allocated to facilitate the commissioning and operational costs of opiate detoxification unit at Stikland Hospital.

Funding has been allocated to the Western Cape Rehabilitation Centre to establish a specialist referral seating clinic for high-risk patients. This is a particularly exciting project as a relatively small investment of human and financial resources will have a profoundly beneficial effect on the quality of the lives of people living with disabilities.

A key issue for the Central Hospitals is the progress that has been made towards a new multilateral agreement and new bilateral agreements between the Health Department and the Institutions of Higher Education which will replace the outdated Joint Agreements that are currently in place. It is anticipated that this will be achieved during 2006/07 ending a process that has extended over more than a decade. Additional funding has been allocated for the purchase of two linear accelerators for radiation oncology. An amount of R2,5 million has been allocated for a neuropsychiatric unit at Groote Schuur Hospital while Tygerberg Hospital will benefit from funding to separate the child and adult psychiatric services.

In line with the initiative to strengthen Primary Health Care and to build capacity within communities, an amount of R20,7 million has been allocated to the Expanded Public Works Programme (EPWP) which is intended to provide an opportunity for the training of unemployed persons as community health workers, nursing assistants and pharmacist's assistants.

A fundamental problem in the Department is the shortage of skilled and experienced nurses. Particular attention is being given to the recruitment and retention of these skills and it is intended that a nursing directorate be established during 2006/07 in order to manage nursing issues across the province.

The planned transfer of the Medico-legal Mortuaries from the South African Police Services to the Department of Health in the form a new Forensic Pathology Service from 1 April 2006 will be a significant challenge. Extensive preparatory work has been done to facilitate the transition but it will require the cooperation and goodwill of all involved to ensure that there is no interruption of this essential service.

The funding for the Public Works function was transferred to the Department of Health from 1 April 2005 and a Service Level Agreement between the two departments was subsequently signed to regulate the relationship between the two departments. Despite this agreement much remains to be done to ensure effective management of this function and prompt delivery of key health infrastructure.

Health care is a challenging by important area of government service priorities. Despite constraints the Department has and will continue to deliver quality healthcare to the citizens of this province and beyond who depend on us to do so.

PROFESSOR KC HOUSEHAM

HEAD: HEALTH

Western Cape
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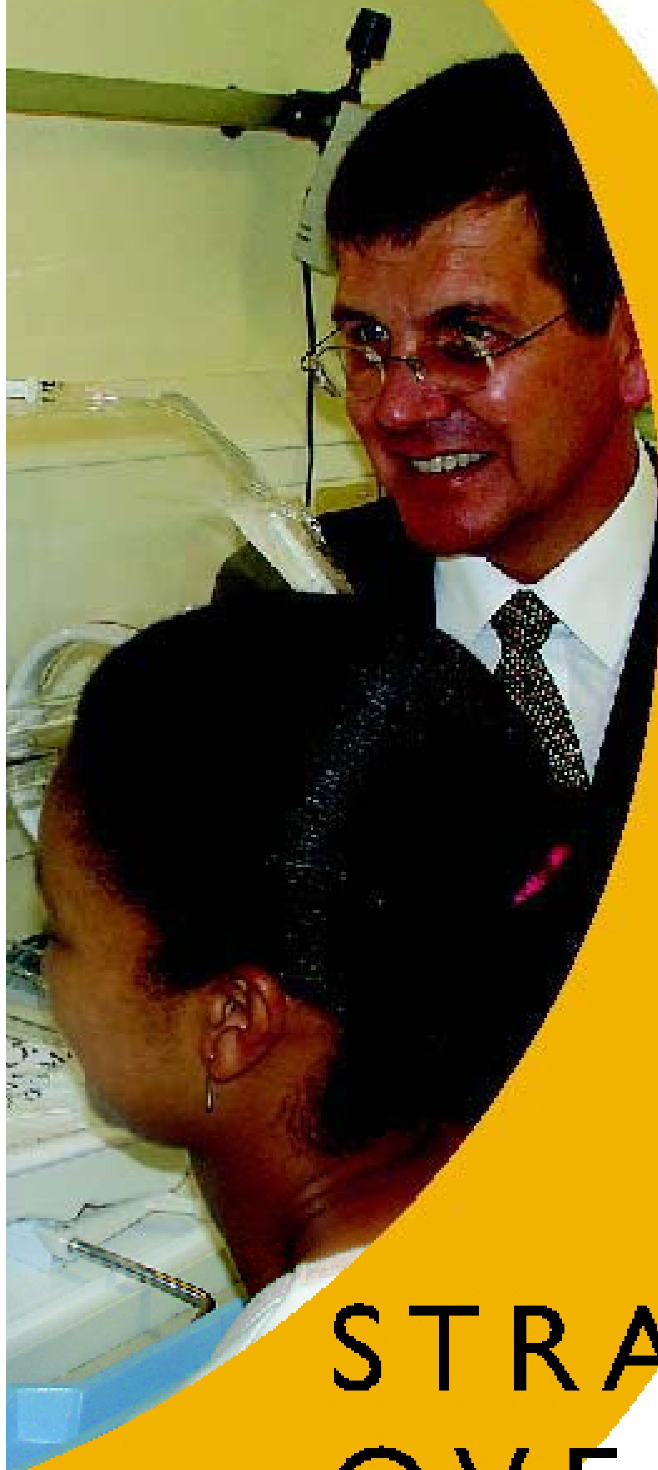
PART A



STRATEGIC OVERVIEW

STRATEGIC OVERVIEW

1. OVERVIEW OF STRATEGIC PLAN

Healthcare 2010 is the strategic plan for the Western Cape Department of Health. This strategy supports the vision and mission of the National Department of Health as well as the issues that have been identified as the priorities and activities for the current five-year electoral cycle. In addition to this the Western Cape Health Department is a key role-player in the provincial strategy: iKapa elihlumayo which means the growing Cape. The Health Department supports the Department of Social Services and Poverty Alleviation as the lead department for the strategy: Social Capital Formation with an emphasis on youth, and the Department of Transport and Public Works, with regards to the Provincial Strategic Infrastructure Plan. The Department of Health contributes significantly to the other lead strategies of iKapa elihlumayo.

Healthcare 2010:

The strategy of Healthcare 2010 is to reshape public health services to focus on primary-level services, community-based care and preventive care. It is intended that patients be treated at the level of care that is most appropriate, and therefore cost effective, for their specific health needs. Regional Hospitals will be strengthened to improve the accessibility of general specialist services to the communities that need them most. These services will be adequately supported with well-equipped and appropriately staffed secondary and highly specialised tertiary services.

2. SECTORAL SITUATION ANALYSIS

2.1 Summary of service delivery environment and challenges

2.1.1 Major demographic characteristics

The following table illustrates the estimated population growth for the Western Cape until 2010 based on Census 2001. Approximately 64% of the population resides in the Cape Town Metro Region which covers ±2% of the surface area of the province which is significant in planning services.

The remainder of the population is distributed more sparsely, in approximately equal proportions between the other three regions, i.e. Boland/Overberg, South Cape/Karoo and West Coast Winelands

Table 2 highlights the poverty and socio-demographic figures in the Western Cape in relation to the national average, based on Census 2001.

Table 2 Socio-economic conditions in the Western Cape compared to National figures

Socio Economic Factors (Census 2001)	Western Cape	South Africa
"Formal" Housing*	80.6%	63,8%
Electricity as energy source for cooking	79.0%	51.0%
Paraffin as energy source for cooking	14.0%	21.0%
Wood as energy source for cooking	2,9%	20,5%
Other sources of Energy for cooking	4,3%	6,8%
Paraffin as energy source for heating	15.0%	15.0%
Piped water in dwelling	67.0%	32.0%
Flush Toilet**	86.0%	54.0%
Refuse removal by Municipality at least once a week	88.0%	55.0%

*Census 2001denomination

**Includes Flush toilets with septic tank and chemical toilets

Comparison of the indicators in the Western Cape with the national figures illustrates that the average access to basic amenities such as piped water and water-borne sewage is higher in the Western Cape than the national average. However, there are gross inequities between different health districts across Cape Town, for example 80 % of the people in Khayelitsha live in informal housing in comparison to 10% in the Southern sub-district.
(Sanders: 2004)

Table 1 Projected Population growth in the Western Cape 2001-2010:Census 2001

Total population											
District	2 001	2 002	2 003	2 004	2 005	2 006	2 007	2 008	2 009	2 010	%Public Pop
Cape Town	2 893 248	2 938 222	2 983 897	3 030 285	3 077 397	3 125 243	3 173 835	3 223 186	3 273 307	3 324 209	68.40
W Coast	282 672	287 057	291 510	296 032	300 625	305 289	310 026	314 836	319 722	324 683	81.00
Boland	629 490	639 265	649 192	659 273	669 512	679 911	690 471	701 196	712 088	723 150	80.00
Overberg	203 517	206 672	209 875	213 129	216 433	219 789	223 196	226 657	230 172	233 741	83.00
Garden R	454 924	461 989	469 164	476 451	483 851	491 366	498 999	506 751	514 623	522 619	81.00
Central Karoo	60 485	61 425	62 379	63 349	64 333	65 333	66 348	67 379	68 427	69 490	89.00
Western Cape	**4 524 336**	**4 594 629**	**4 666 017**	**4 738 519**	**4 812 150**	**4 886 930**	**4 962 876**	**5 040 005**	**5 118 338**	**5 197 892**	**0.730**

Uninsured population										
District	2 001	2 002	2 003	2 004	2 005	2 006	2 007	2 008	2 009	2 010
Cape Town	1 978 982	2 009 744	2 040 986	2 072 715	2 104 939	2 137 666	2 170 903	2 204 659	2 238 942	2 273 759
W Coast	228 964	232 516	236 123	239 786	243 506	247 284	251 121	255 017	258 975	262 993
Boland	503 592	511 412	519 353	527 419	535 610	543 928	552 377	560 957	569 670	578 520
Overberg	168 919	171 537	174 197	176 897	179 639	182 424	185 253	188 125	191 042	194 005
Garden R	368 488	374 211	380 023	385 925	391 919	398 007	404 189	410 468	416 845	423 321
Central Karoo	53 832	54 668	55 517	56 380	57 256	58 146	59 050	59 968	60 900	61 846
Western Cape	**3 302 777**	**3 354 088**	**3 406 199**	**3 459 122**	**3 512 870**	**3 567 456**	**3 622 893**	**3 679 194**	**3 736 374**	**3 794 444**

Source: Census 2001

Table 3 Socio-demographic characteristics of the population

	% of total population	% < 15 yrs	% > 60 yrs	% Female	% Foreign born	% of population >20 with no education	% of population 15-64 who are unemployed
Western Cape	10,1	27,3	7,8	51,5	2,4	5,7	26,1
National	100	19	15,9	52,2	2,3	17,9	41,6

Source: Census 2001

The population of the Western Cape is relatively young in comparison with the national average and compares favourably with the national average for people over 20 years of age with no education and those between the ages of 15 – 64 who are unemployed.

The issue of the annual migration of approximately 46 000 people (Census 2001), into the province from neighbouring provinces continues to place an additional burden particularly on level 1 and 2 services where in terms of the equitable share of the budget allocation these patients are 'unfunded'.

2.1.2 Epidemiological profile

The following table illustrates the trends in the key provincial mortality indicators. At this stage the Actuarial Society of South Africa (ASSA) data of 2000 is used as the South African Demographic Health Survey (SADHS) data of 2003 is not yet available and it would not be useful to use the 1998 SADHS data.

Table 4 Trends in key provincial mortality indicators [A1]

Indicator	Source: ASSA 2000		Target
	Western Cape	National	
Infant mortality (under 1)	30	59	45 per 1,000 live births by 2005
Child mortality (under 5)	46	100	59 per 1,000 live births by 2005
Maternal mortality	45		100 per 100,000 live births by 2005
Life Expectancy	66,1	55	-

Although the Western Cape has some of the best health and socio-economic indicators in South Africa, there are significant disparities between different communities. Wealthy communities live in comfortable first world conditions and have good health indicators whereas the poor live in conditions that compare with some of the worst developing countries and have very poor health indicators.

Analysis of the Cape Town Equity Gauge data (2003) indicates that the Infant Mortality Rate (IMR) for the Western Cape (31/ 1 000 live births) compares favourably with the national IMR of 56/ 1 000 live births. However, there are considerable inequities between the urban Cape Town Metro district and the rural areas of the province and also between the different sub-districts within Cape Town. For example: the highest IMR for the Province is in the Khayelitsha sub-district at 44/ 1 000 live births and the lowest is in the South Peninsula sub-district at 13/ 1 000 live births.

Table 5 Infant Mortality Rate (per 1 000 live births) in 2002

Area	IMR (per 1 000 live births)
South Africa	56
Western Cape Province	31
Cape Town Metro District	25
Khayelitsha sub-district	44
South Peninsula sub-district	13

Source: Sanders: 2004

Table 6 Major causes of death in the Metropole

Rank	Cause of death in adults	%	Years of life lost (YLL)	%	Cause of death in children under 5 years of age	%
1	Homicide	10.6	Homicide	18.4	HIV/AIDS	21.6
2	Ischaemic Heart Disease	8.1	HIV/AIDS	12.2	Low birth weight & Respiratory Distress Syndrome	19
3	HIV/AIDS	7.4	TB	7.7	Diarrhoeal Disease	9.8
4	Hypertensive disease	6.4	Road Traffic Accidents	5.7	Lower respiratory infections	8.7
5	TB	5.9	Ischaemic Heart Disease	3.9	Congenital abnormalities	3.1
6	Diabetes Mellitus	5.3	Lower respiratory Infections	3.6	Septicaemia	3.1
7	Stroke	4.7	Hypertensive heart disease	3.3	Road traffic accidents	2.3
8	Lower respiratory infection	3.9	Diabetes Mellitus	2.9	Meningitis (bacterial)	1.9
9	Road traffic accidents	3.7	Low birth weight and RDS	2.6	Fires	1.7
10	Lung cancer	3.6	Stroke	2.5	Homicide	1.6
Other	COPD, renal, Septicaemia, Pulmonary disease, Ca Breast, Asthma				TB, drowning, asthma, PEM	

Source (Groenewald et al, 2003)

Note:
Years of Life Lost (YLL) is a measure of premature mortality and has been estimated using age weightings, discounting and standard life expectancies. It is a particularly useful measure of premature or preventable deaths.
Although detailed information on mortality is only available for the Cape Town Metro Region, this represents approximately two thirds of the population of the Western Cape and the relationships between socio-economic context, social capital and health are likely to be similar across the Province.

The disease and death profile in Cape Town reflects a quadruple burden of disease, i.e. infectious diseases and HIV/AIDS, non-communicable diseases and injuries (trauma and violence). An adapted version of the 1990 Global Burden of Disease list of causes of death was used for the classification (Sanders: 2004). In 2001 deaths in Cape Town were categorized as follows:

Group I: 19% infectious diseases, including 6% HIV/AIDS;
Group II: 54% non communicable diseases; and
Group III 19% injuries.

The top causes of death in Cape Town in 2001 are indicated in the above table. In males the top cause of death was homicide (16.4%), followed by IHD (7.8%), TB (6.6%) and HIV/AIDS (5.8%). In females the top causes were HIV/AIDS (9.3%), hypertensive heart disease (8.8%), IHD (8.6%) and diabetes mellitus (7.3%) (Groenewald et al, MRC study: 2004).

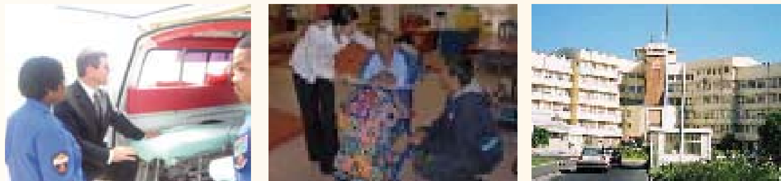
Total mortality varies across the city. Premature mortality is disproportionately higher in the Khayelitsha and Nyanga sub-districts where the years of life lost (YLLs per 100 000) in 2001 were 18 932 and 19 619 in Khayelitsha and Nyanga respectively, in comparison to 12 140 for Cape Town overall.

Homicide is the top cause of death in Cape Town at 10.6%. Twenty percent of homicides in South Africa occur in 2.1%, i.e. 23, of the country's police station precincts. Six of these 23 precincts are from Cape Town, i.e. Khayelitsha, Nyanga, Gugulethu, Kuilsriver, Kraaifontein and Mitchell's Plain.

Infectious diseases and other pre-transitional causes lead to significant mortality in infants and young children particularly in Nyanga and Khayelitsha sub-districts with age standardized mortality rates of 366/ 100 000 and 363/ 100 000 respectively, in comparison with 86/ 100 000 in Blaauwberg and 94/ 100 000 in the South Peninsula.

HIV and AIDS

Despite the provision of health education, increasing condom distribution and utilization, expansion of HIV services and almost universal awareness of HIV and AIDS, and its routes of transmission the latest ante-natal surveillance data shows that the epidemic continues to spread in the Province. The rapid growth in seroprevalence from 0.7% in pregnant women in 1990 to 27.9% in 2003 and the variations in HIV prevalence between the different health sub-districts, ranging from 1% to 27% suggest that more than individual choices and knowledge drive this epidemic. Factors that make people vulnerable in terms of exposure to HIV/AIDS and to their experience of living with HIV/AIDS are the social and economic context of their lives. This is strongly influenced by social inequalities in income and employment



status, mass resettlements and labour migrations with create high levels of mobility and high levels of sexual violence.

Non-communicable diseases are traditionally associated with increasing wealth affect the poorest communities the greatest. In Cape Town poorer communities are afflicted by high levels of chronic diseases, cardiovascular disease and diabetes mellitus in particular.

Alcohol abuse is a particular problem in the rural areas of the Western Cape. According to recent studies, the wine farm areas of the Western Cape have the highest incidence of foetal alcohol syndrome (FAS) worldwide, i.e. 40 – 46 per 1 000 children. (Sanders: 2004)

2.1.3 Major health service challenges and progress

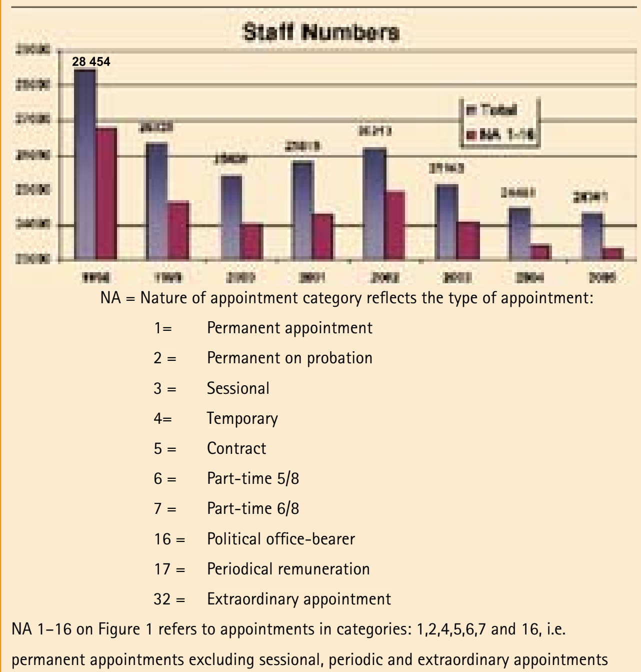
Having formulated the Department's long-term strategic framework, Healthcare 2010, the major challenge facing the Department is to develop effective implementation plans for the service platform and reshaping the staff establishments.

From 1 April 2005 the Province has been funding the Personal Primary Health Care (PPHC) services in the rural areas. Local government will continue to provide a service in the Metropole for the next three years during which time the issue of funding for these services must be resolved between provincial and national government.

A key element of service delivery in the health care environment is quality of care. A Quality Assurance Unit has been established in order to monitor quality of care. Initiatives that have been introduced are for example the regular monitoring of complaints and compliments, morbidity and mortality, client satisfaction surveys and evaluation of safety and security risks to patients and staff.

Quality of care is adversely affected by the inability to recruit and retain experienced and quality health care professionals. The current shortage of nurses, especially nurses with specialist training, who are the backbone and key determinant of health services, presents a serious challenge. Within the public health sector the attrition rate of personnel has averaged 8% since 1998 as illustrated above. However, it is of grave concern that the attrition rate of professional nurses is 12% and in some specialist areas of the nursing profession as high as 26%.

Figure 1 Personnel numbers in Provincial Health Facilities from 1998 to 2005



NA = Nature of appointment category reflects the type of appointment:

- 1= Permanent appointment
- 2 = Permanent on probation
- 3 = Sessional
- 4= Temporary
- 5 = Contract
- 6 = Part-time 5/8
- 7 = Part-time 6/8
- 16 = Political office-bearer
- 17 = Periodical remuneration
- 32 = Extraordinary appointment

NA 1–16 on Figure 1 refers to appointments in categories: 1,2,4,5,6,7 and 16, i.e. permanent appointments excluding sessional, periodic and extraordinary appointments

2.1.4 Intra and inter provincial equity in the provision of services

Table 7 below confirms that there is still inequity in the distribution of resources between the rural and urban areas in the Western Cape. The high cost of service delivery in the Central Karoo can be partly explained by the extensive geographical areas over which the service is provided.

Table 7 Expenditure per Capita for Primary Care Services (DHER 2001)

Region	Total	Province	Local Government
Boland	162	142	40
Central Karoo	222	180	42
Eden	162	128	34
Overberg	117	97	20
West Coast	152	122	30
Metropole (District Health Plan 2004)	212	176	36

2.1.5 Resource trends

The Department's total budget for 2006/07 is R6,23 billion. Compared to the 2005/06 revised estimate there is a nominal year-on-year increase in 2005/06 of 11.2%, in 2006/07 of 6.8% and in 2007/08 of 5.8%. Table 8 below reflects the Department's budget for the MTEF period

Table 8 Health Department budget as a percentage of Provincial budget

	Audited 2002/03	Audited 2003/04	Audited 2004/05	Main appropriation 2005/06	Adjusted appropriation 2005/06	Revised estimate 2005/06	2006/07	2007/08	2008/09
R'000									
Health	3,951,022	4,547,304	5,169,199	5,742,503	5,776,822	5,733,567	6,323,493	6,774,319	7,332,905
Provincial Total	11,824,628	13,100,804	14,581,101	16,374,027	16,957,497	16,911,911	18,360,059	19,838,501	21,604,851
Percentage of Health budget in relation to Provincial total	33.41%	34.71%	35.45%	35.07%	34.07%	33.90%	34.44%	34.15%	33.94%

The sources of the Department's funding are:

- The Equitable share; which is the funding allocated to each province by National Treasury based on a formula which aims to promote national equity. The Equitable share is then distributed by the Provincial Treasury between the respective provincial departments.
- Conditional grants, which are funds allocated by National Treasury for specific projects/performance levels.
- Retained revenue

Detail regarding the allocations from the respective sources are reflected in Tables 9 and 10. The equitable share accounts for 63,37% of the Department's funding and the conditional grants for 32,6%. The projected revenue for 2005/06 will account for approximately 4% of the budget.

Table 9 Funding sources of the Western Cape Health Department

	Audited 2001/02	Audited 2002/03	Audited 2003/04	Audited 2004/05	Main appropriation 2005/06	Adjusted appropriation 2005/06	Revised estimate 2005/06	2006/07	2007/08	2008/09
Treasury funding										
Equitable share	2,218,619	2,364,128	2,826,872	3,287,487	3,638,900	3,661,253	3,663,110	4,034,688	4,407,886	4,872,991
Conditional Grants	1,365,432	1,467,022	1,555,421	1,645,171	1,870,576	1,861,159	1,816,047	1,991,725	2,051,224	2,139,039
Total Treasury Funding	3,584,051	3,831,150	4,382,293	4,932,658	5,509,476	5,522,412	5,479,157	6,026,413	6,459,110	7,012,030
Departmental Receipts	117,194	119,872	165,011	236,541	233,027	254,410	254,410	297,080	315,209	320,875
TOTAL RECEIPTS	**3,701,245**	**3,951,022**	**4,547,304**	**5,169,199**	**5,742,503**	**5,776,822**	**5,733,567**	**6,323,493**	**6,774,319**	**7,332,905**

Table 10 Conditional grant allocation for 2006/07

CONDITIONAL GRANT	ALLOCATION 2006/07	% OF TOTAL HEALTH BUDGET FOR 2006/07
National Tertiary Services Grant (NTSG)	1,272,640,000	20.13%
Health Professions Training and Development Grant (HPTDG)	323,278,000	5.11%
Comprehensive HIV and AIDS	115,670,000	1.83%
Hospital Revitalisation Programme (HRP)	149,703,000	2.37%
Provincial Infrastructure Grant (PIG)	61,829,000	0.98%
Forensic Pathology Services Grant	68,605,000	1.08%
TOTAL CONDITIONAL GRANT ALLOCATION	1,991,725,000	31.50%
TOTAL HEALTH BUDGET	6,323,493,000	62.99%

Source: Western Cape Budget 2006

The allocation to the Department of Health must also be seen in the context of the high cost of medical inflation, illustrated in Table 10.

Table 11 Cost of medical inflation in comparison to CPIX

PERIOD	CPIX	MEDICAL INFLATION
APRIL 2001 – MARCH 2002	9.2%	11.5%
APRIL 2002 – MARCH 2003	7.4%	9.8%
APRIL 2003 – MARCH 2004	5.6%	10.2%
APRIL 2004 – MARCH 2005	4.1%	7.2%

Source: Western Cape Health Department: Budget Review 2004/2005: 14

The migration into the Province (± 46 000 people annually) and the trends in the burden of disease and service demands place an increasing burden on the limited resource envelope.

Table 12 Trends in provincial service volumes [A2]

Indicator	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)
PHC headcount in PHC facilities	10 346 283	11 986 838	12 064 857	12 959 900	12 238 113	12 884 522
OPD headcounts	1 594 017	1 578 701	2 055 286	1 757 842	1 698 156	2 083 039
Hospital separations						
District hospitals	98 981	128 972	122 476	141 785	123 222	195 691
Regional hospitals	137 624	155 823	147 002	169 617	166 434	180 855
Central hospitals	114 953	126 163	125 001	133 691	125 450	119 250

Table 13 Division of budget between the respective financial programmes since 2002/03 and for the MTEF period

PROGRAMME	2002/03		2003/04		2004/05		2005/06		2006/07		2007/08		2008/09	
	R'000	%	R'000	%	R'000	%	R'000	%	R'000	%	R'000	%	R'000	%
1. Administration	121,273	3.1%	215,644	4.7%	213,316	4.1%	174,782	3.0%	199,354	3.2%	219,353	3.2%	235,248	3.2%
2. District Health Services	993,592	25.1%	1,144,699	25.2%	1,330,397	25.7%	1,649,725	28.8%	1,914,072	30.3%	2,041,229	30.1%	2,279,172	31.1%
3. Emergency Medical Services	152,910	3.9%	185,695	4.1%	198,170	3.8%	253,374	4.4%	278,999	4.4%	301,473	4.5%	338,603	4.6%
4. Provincial Hospital Services	974,273	24.7%	1,053,048	23.2%	1,176,641	22.8%	1,288,031	22.5%	1,336,078	21.1%	1,427,844	21.1%	1,527,516	20.8%
5. Central Hospitals	1,476,202	37.4%	1,607,089	35.3%	1,805,918	34.9%	1,963,483	34.2%	2,086,517	33.0%	2,245,303	33.1%	2,363,400	32.2%
6. Health Sciences and Training	65,381	1.7%	71,116	1.6%	73,541	1.4%	81,533	1.4%	106,047	1.7%	142,015	2.1%	178,477	2.4%
7. Health Care Support Services	66,597	1.7%	73,837	1.6%	82,752	1.6%	92,075	1.6%	77,480	1.2%	81,885	1.2%	86,769	1.2%
8. Health Facilities Management	100,794	2.6%	196,176	4.3%	288,464	5.6%	230,564	4.0%	324,946	5.1%	315,217	4.7%	323,720	4.4%
TOTAL	3,951,022	100%	4,547,304	100%	5,169,199	100%	5,733,567	100%	6,323,493	100%	6,774,319	100%	7,332,905	100%

Note: The funding for Programme 8 was transferred from the Department of Public Works from 1 April 2005

2.1.6 Policy changes and trends

Mental Health Care Act, Act 17 of 2002

The Mental Health Care Act became operational from 15 December 2004 and has resulted in the Department developing new policies to achieve the objectives of the Act and its regulations. Of particular importance are the provisions of the Act that prescribe the procedure that must be followed in the admission of mentally ill persons and relate to the principles of unfair discrimination as contained in the Constitution. As required the Province established a Mental Health Review Board during 2005.

National Health Act, Act 61 of 2003

The National Health Act has been developed so as to comply with the obligations imposed by the Constitution and establish a structured and uniform health system within the Republic.

This Act came into effect on 2 May 2005 with the exception of some sections and chapter 6 (health establishments and relating to the certificate of need) and chapter 8 (control of use of blood, blood products, tissue and gametes in humans). However, the regulations, which must accompany the Act, have not yet been finalised by the National Department. The provincial Department are therefore developing and implementing new policies, which are in line with the regulations.

2.2 Summary of organisational environment and challenges

A key issue in the capacity of the Department to provide the required service relates to the ability to recruit and retain appropriately qualified personnel. The introduction of the scarce skills and rural allowances has, to a degree, assisted in retaining staff.

As a transitional arrangement an agency agreement was signed with the Cape Peninsula University of Technology (CPUT), which is intended to lead to a permanent transfer in the future.

In order to optimise the utilisation of personnel resources new generic staff establishments have been developed to ensure that there are the correct numbers and skill mix of personnel at the respective institutions in relation to the projected patient activities. This is linked to the development of service plans which set out how services will be distributed across the various levels of care in the health service platform.

3. BROAD POLICIES, PRIORITIES AND STRATEGIC GOALS

3.1 As indicated in the introduction the national sector specific policies, priorities and goals impacting on the Western Cape Department of Health are those of the National Department of Health. At a provincial level, the Department is guided by iKapa elihlumayo and the Health Department's strategy, Healthcare 2010.

3.2 National Department of Health

3.2.1 Free health services

In accordance with national policy the provincial Department of Health provides the following health services free of charge:

1) Family planning services;
2) Health advisory services,
3) Immunizations to combat notifiable infectious diseases, excluding vaccination for foreign travel;
4) Treatment of infectious, formidable and/or notifiable diseases, e.g. pulmonary tuberculosis, Leprosy, Meningococcal meningitis;
5) The preparation of medical reports required in cases with legal implications such as rape, assault, drunken driving, post mortems, etc.
6) Oral health services: the screening, preventive and promotive services offered at schools and also scholars classified according to a means test and referred by the school nursing services or oral health services;
7) Patients are transported free of charge in certain instances;
8) Certified psychiatric patients and state patients;
9) School children classified (as H1 patients) according to a means test;
10) Children committed in terms of section 15 and 16 of the Child Care Act, Act 74 of 1983;
11) Children under the age of six years. This applies to children classified as H0, H1, H2 in terms of a means test;
12) Immigrants residing permanently in the country, visitors and foreigners with study permits, temporary work or visitors permits as well as persons from neighbouring countries who enter South Africa illegally;
13) Pregnant women classified as H0, H1 and H2 patients;
14) Termination of pregnancies is free to hospital patients (H0, H1, and H2 patients) as well as full paying and private patients. This includes free ambulance and patient transport services.
15) Primary health care services are rendered free to permanent residents and who are classified as H0, H1 or H2 patients.

3.2.2 The Uniform Patient Fee Schedule (UPFS)

The regulations relating to the UPFS in terms of which patient fees are determined are amended annually by the provincial Minister of Health and published in the Provincial Gazette. In terms of the regulations published in the Provincial Gazette 6302 on 7 October 2005, the provincial Health Department provides free health services to the following categories of patients [subject to conditions specified in the Gazette], in addition to the free services outlined in Annexure C of Finance Instruction G50 of 2003, dated 23 December 2003, determined by the National Department of Health:

- Social pensioners
- Formally unemployed.

These patients are therefore classified as fully subsidised hospital patients (H0).

Recipients of the following types of grants are classified as social pensioners:

- Old age pension
- Child support grant
- Veteran's pension
- Care dependency grant
- Pension for the blind
- Family allowance
- Maintenance grant
- Disability grant
- Single care grant – persons with mental disorders in need of care discharged from hospitals for the mentally ill but have not been certified.

Other patients are assessed according to a means test and categorised as H1,H2 or H3 patients and are subsidised accordingly.

Table 14 Tariff categories

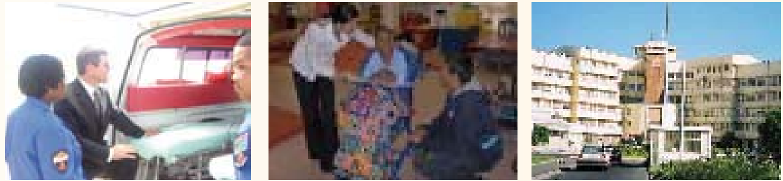
Tariff category	Individual/ single bruto income per annum	Household/ family unit bruto income per annum	Level 1, 2 and 3 Tariffs
H1	Less than R36 000	Less than R50 000	As gazetted
H2	Equal to or more than R36 000 but less than R72 000	Equal to or more than R50 000 but less than R 100 000	As gazetted
H3 (Private self-funded)	Equal to or more than R72 000	Equal to or more than R100 000	The full price of the UPFS

Meeting the commitment outlined above makes a significant contribution to providing accessible health care, addressing equity issues and the formation of Social Capital. However, this commitment also has a related impact on the limited available resources.

3.3 The Millennium Development Goals

In September 2000 the United Nations Millennium Summit brought together a large number of the world's leaders. The summit's final declaration, signed by 189 countries, committed the international community to a specific agenda for reducing global poverty. This agenda listed eight Millennium Development Goals and the targets and indicators for each goal.

The United Nations Millennium Declaration (September 2000) reads as follows:
"We will spare no effort to free our fellow men, women and children from the abject and dehumanising conditions of extreme poverty, to which more than a billion of them are currently subjected."



The following table summarises the goals, targets and indicators of the Millennium Development Goals. The health-related Millennium Development Goals against which the Department is required to report are numbers 1, 4, 5, 6, 7 and 8.

Table 15 Millennium development goals

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
1. Eradicate extreme poverty and hunger.	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children under 5 years of age.
		Proportion of the population below minimum level of dietary energy consumption.
2. Achieve universal primary education.	Ensure that by 2015, children everywhere, boys and girls alike, will able to complete a full course of primary schooling.	Net enrolment ratio in primary education.
		Literacy rate of 15 – 24 year-olds.
3. Promote gender equality and empower women.	Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.	Ratio of girls to boys in primary, secondary and tertiary education.
		Ratio of literate females to males of 15 – 24 year-olds.
4. Reduce child mortality.	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.	Under-5 mortality rate (U5MR).
		Infant mortality rate.
		Proportion of one-year old children immunised against measles.
5. Improve maternal health.	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	Maternal mortality ratio.
		Proportion of births attended by skilled health personnel.
6. Combat HIV and AIDS, malaria and other diseases.	Have halted, by 2015, and begun to reverse the spread of HIV and AIDS, malaria and other diseases	HIV prevalence among 15 – 24 year old pregnant women.
		Condom use rate of the contraceptive prevalence rate.
		Number of children orphaned by HIV and AIDS.
		Proportion of the population in malaria risk areas using effective malaria prevention and treatment measures. (Prevention to measured by the % of under 5 year olds sleeping under insecticide treated bednets and treatment to be measured by % of under 5 year olds who are appropriately treated.
		Prevalence and death rates associated with TB.
		Proportion of TB cases detected and cured under DOTS.
7. Ensure environmental sustainability.	Halve, by 2015, the proportion of people without sustainable access to safe drinking water.	Proportion of people with sustainable access to an improved water source.
	By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers.	Proportion of urban population with access to improved sanitation.
8. Develop a global partnership for development.	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.	Official development assistance
		Proportion of exports admitted free of duties and quotas.
	In co-operation with pharmaceutical companies, provide access to affordable , essential drugs in developing countries.	Proportion of population with access to affordable essential drugs on an established basis.

3.4 National Department of Health five-year priorities

The National Department of Health has developed a set of priorities for the period 2004 – 2009 which are based on the assessment of the achievements of the past 10 years and the work that is required to strengthen the National Health System in South Africa. The following priorities have been approved by the Health MINMEC.

Table 16 National Department of Health five-year priorities

PIORITY	ACTIVITY
1. Improve governance and management of the NHS	• Review and strengthen communication within and between health departments.
	• Strengthen corporate identity, public relations and marketing of health policies and programmes.
	• Strengthen governance and maintenance structures and systems.
	• Strengthen oversight over public entities and other bodies.
	• Adopt Health Industry Charter
2. Promotes healthy lifestyles.	• Initiate and maintain healthy lifestyles campaign.
	• Strengthen health promoting schools initiative.
	• Initiate and maintain diabetes movement.
	• Develop and implement strategies to reduce chronic diseases of lifestyle.
	• Implement activities and interventions to improve key family practices that impact on child health.
3. Contribute towards human dignity by improving quality of care.	• Strengthen community participation at all levels.
	• Improve clinical management of care at all levels of the health care delivery system.
	• Strengthen hospital accreditation system in each province in line with national norms and standards.
4. Improve management of communicable diseases and non-communicable illnesses.	• Scale up epidemic preparedness and response.
	• Improve immunisation coverage.
	• Improve the management of all children under the age of 5 years presenting with illnesses such as pneumonia, diarrhoea, malaria and HIV.
	• Updated malaria guidelines, integrate malaria control into comprehensive communicable disease control programme and ensure reduction of cases.
	• Implement TB programme and review recommendations.
	• Accelerate implementation of the Comprehensive Plan for HIV/AIDS.
	• Strengthen free health care for people with disabilities.
	• Strengthen programmes on women and maternal health .
	• Strengthen programmes for survivors of sexual abuse and victim empowerment.
	• Improve risk assessment of non-communicable illnesses.
	• Improve mental health services

Table 16 National Department of Health five-year priorities (continued)

PIORITY	ACTIVITY
5. Strengthen primary health care, EMS and hospital service delivery systems.	• Strengthen primary health care.
	• Implement provincial EMS plans.
	• Strengthen hospital services.
6. Strengthen support services	• Strengthen NHLS.
	• Ensure availability of blood through South African National Blood Service
	• Transfer forensic labs including mortuaries to provinces.
	• Implement health technology management system.
	• Strengthen radiation control.
	• Quality and affordability of medicines.
	• Establish an integrated disease surveillance system.
	• Integrate non natural mortality surveillance into overall mortality surveillance system.
	• Establish an integrated food control system.
7. Human resource planning, development and management.	• Implement plan to fast-track filling of posts.
	• Strengthen human resource management.
	• Implement national human resource plan.
	• Strengthen implementation of the CHW programme and expand mid level worker programme. • Strengthen programme of action to mainstream gender.
8. Planning, budgeting, monitoring and evaluation.	• Implement SHI proposals as adopted by Cabinet.
	• Strengthen health system planning and budgeting.
	• Strengthen use of health information system.
9. Prepare and implement legislation.	• Implement Mental Health Care Act
	• Implement National Health Bill
	• Implement Provincial Health Acts
	• Traditional healers, Nursing & Risk Equalisation Fund Bills implemented.
10. Strengthen international relations.	• Strengthen implementation of bi and multi-lateral agreements
	• Strengthen donor co-ordination
	• Strengthen implementation of NEPAD strategy and SADC.

3.4.1 The Western Cape Department of Health's contribution to these priorities is highlighted as follows:

1) **Improve governance and management of the National Health System**
   Governance and management of the District Health System are being strengthened through the development of District offices in the Metropole and the appointment of facility managers at the major metropolitan community health centres. Following a long process of consultation, the decision was made to assume responsibility for the provision of Personal Primary Health Care (PPHC) by the rural municipalities with effect from 1 April 2005. The transfer of services in these areas will occur during 2006. Local government will continue to provide and partially fund PHC services in the Metropole for the next three years.

2) **Promote healthy lifestyles**
   - Primary Health Care contributes towards health education and counseling.
   - Chronic lifestyle disease programme: through clubs for diabetes, hypertension, asthma and epilepsy these programmes provide lifestyle information that enables individuals and groups to make informed choices regarding their health and well-being.

3) **Contribute towards human dignity by improving quality of care**
   - Community participation is facilitated by the Facilities Boards that have been appointed in all hospitals, in line with the Health Facility Boards Act.
   - Effective public relations are facilitated by means of communication with the public and internal communication, for example face to face meetings and media coverage.
   - A provincial policy on Quality Assurance has been developed and implemented within the framework of the national policy.
   - A provincial policy for the monitoring of complaints and complimented has been implemented and is monitored quarterly.
   - External Client Satisfaction Surveys have been conducted in accordance to a planned schedule
   - Waiting time surveys and analysis of systems to reduce waiting times have been conducted at nine clinics. Plan for further roll out.
   - A policy for structured morbidity and mortality monitoring has been implemented.
   - Development of standards to monitor the quality of service delivery is in progress which will constitute a mechanism for both internal and external accreditation
   - Specific aspects of the Clinic Supervision Manual have been implemented.
   - A formal procedure for monitoring the progress of quality improvement initiatives has been implemented.
   - Staff satisfaction surveys are being rolled out.
   - Monitoring of the progress of the outputs required in terms of the Hospital Management and Quality Improvement Grant is ongoing.

4) **Improve management of communicable diseases and non-communicable illnesses**
   - HIV and AIDS: The Western Cape has implemented the national comprehensive plan for the management, treatment and care of people living with HIV and AIDS. The province has achieved significant increase in anti-retroviral treatment access and universal coverage for the PMTCT intervention, through successful partnerships and multi-sectoral efforts.
   - The incidence of tuberculosis (TB) in the Western Cape continues to be amongst the highest in the world, exacerbated by the HIV/AIDS pandemic. The Department has made significant progress in the implementation of the WHO DOTS Strategy and is working towards the overall goal of achieving an 85% cure rate.

5) **Strengthen primary health care, Emergency Medical Services and hospital delivery systems**
   - Initiatives planned to strengthen Primary Health Care are e.g. to establish facility management, to computerise PHC services and to develop an infrastructure plan for PHC.
   - Emergency Medical Services have been strengthened with additional funding as well as restructuring of the service in line with the recommendations of an expert external review.
   - Hospital services, particularly regional hospital services providing level 2 services will be strengthened.

6) **Strengthen support services**
   - The Province is managing the transfer of the forensic mortuaries, provincial plans are at the initial stages of implementation. Transfer will occur with effect from 1 April 2006.
   - Medicines and Pharmacy legislation is currently being implemented.

7) Human resource planning, development and management
   - Nurse training is being strengthened within the department.
   - Training of additional categories of health workers will be extended through the Extended Public Works Programmes with learnerships in key areas.
   - An Employment Equity Plan has been developed and implemented.

8) **Planning, budgeting, monitoring and evaluation**
   - The strategic planning of health services in the Western Cape is an activity based plan in line with the allocated funding envelope. The process is modelled using a set of inter-related variables.
   - The Department participates in the quarterly Early Warning System of the National Department of Health in which performance against select indicators is reported.
   - Programme performance is also monitored quarterly by an internal

Monitoring and Evaluation Committee where Programme Managers report on the performance of the respective programmes against the set of indicators in the Strategic Plan,

- Financial monitoring is done by means of the monthly in year monitoring.
- Health information system: The Hospital Information System (HIS) has been implemented in the Academic Hospitals and it has been rolled out to pilot sites in the regions.

9) Prepare and implement legislation

- Mental Health Act: considerable work is being done to implement this legislation.
- National Health Act 61 of 2003: is being implemented.

10) Strengthen international relations

- The Department has a number of co-operation agreements with various donor agencies, e.g. the European Union for home-based care and the Global Fund for TB/HIV.

3.5 iKapa elihlumayo

3.5.1 iKapa elihlumayo is the Xhosa term for a growing Cape. The goals of iKapa elihlumayo are:

- Higher economic growth;
- Higher levels of employment
- Lower levels of inequality; and
- A sustainable social safety net.

In order to achieve these goals the following lead strategies have been identified:

- Human resource development with an emphasis on youth,
- Social capital formation with an emphasis on youth,
- Strategic infrastructure plan,
- Spatial development framework and
- Micro-economic strategy.

Each of these strategies is championed by a lead department and supported by other related departments. The Health Department has been allocated the role of support department to the social capital formation and strategic infrastructure strategies. The lead departments are the Departments of Social Services and Poverty Relief and Transport and Public Works, respectively.

It must be emphasised, however, that the Department of Health also contributes significantly to the other lead strategies of iKapa elihlumayo as follows:

- Building human capital: Health provides training to and funds the training of many and varied health care professionals
- Effective co-ordination and communication strategy: Health supports other departments such as Education in health education within the life skills programme
- Improving financial governance: Health has a budget of ± R5.74 billion and improved financial governance within this department will contribute significantly to the level of financial governance in the province
- Improving the municipal-provincial interface: The provincial Health department currently works closely with local government in the provision of Primary Health Care
- Micro-economic strategy: Health employs approximately 24 000 staff and procures over R1 billion of goods and services annually. The Department of Health is therefore a significant role-player in the economy of the province
- Spatial development framework: Health requires health infrastructure to provide services and must be involved in determining development plans to ensure such infrastructure is provided in an integrated manner. For this appropriate utilisation of land and buildings will maximise its value to the province.

3.5.2 Strategic Infrastructure Plan

The physical infrastructure plan of Department of Health for capital and maintenance projects has the potential to contribute significantly to job creation and empowerment.

3.5.3 Social Capital Formation (SCF) in Health

Introduction and background

Social capital is described by Putnam as a community resource and defined as "...features of social organisation such as networks, norms and social trust that facilitate co-ordination and co-operation for mutual benefit." An important feature of social capital is therefore that there is a reciprocal relationship between parties, which is based on mutual respect and trust. In the health context this refers to the Department of Health as the service provider, and the communities of the Western Cape and beyond, for whom the Department is responsible for providing an effective and comprehensive health service.

The concept of *bonding* social capital is further defined as *bridging* social capital that applies to the horizontal links between individuals or groups sharing similar demographic characteristics, and *linking* social capital refers to linkages that cross different communities/ individuals. An important aspect of linking social capital is that it spans different levels of power in society.

It is important to recognise that fostering social capital is a means to an end and not an end in itself and that the department does not "do social capital" but rather, the nature of the service provided and the way in which it is provided can contribute significantly to the strengthening of social capital.

This is extremely important for the Health Department as it is believed that if social capital can be strengthened, communities can be empowered to take more responsibility for their own health and well being and thereby assist in lessening the burden of disease. In order to achieve this there must be integrated planning and functioning between the respective departments and levels of government and appropriate allocation of resources.

Situational analysis

The geographic focus of the Department's Social Capital Formation strategies is on the Metro as approximately 64% of the Western Cape population reside in the Cape Town Metro Region. The association between social and economic conditions and ill health is well established. Whether socio-economic status is measured in terms of income, education, employment or housing people living in poor conditions suffer the worst health. Although the Western Cape has some of the best indicators of health and socio-economic status in South Africa, there are nevertheless vast disparities between different communities. These disparities have been previously highlighted in paragraph 5.1.2.

Research has shown that there is a trend in disease profiles as communities transform their social, economic and demographic structures where there is "...a sequence of events starting with a preponderance of infectious diseases, followed by an era when chronic diseases predominate." In the informal settlements around Khayelitsha and Nyanga, where there is inadequate provision of water, lack of sanitation and poverty, caused by very low-income levels and unemployment, infectious diseases such as diarrhoea are common. As communities become more westernised in terms of diet, alcohol consumption, smoking tobacco products and being physically inactive they are more prone to chronic diseases such as heart disease, cerebro-vascular accidents, diabetes mellitus, obesity and mental ill-health.

Factors that contribute to social dislocation and breakdown in social capital in these communities are for example extensive in-migration of mainly young people trying to escape the even more dire poverty in surrounding provinces and rural areas, and the historical legacy of forced removals. It is under these conditions of rapid urbanisation, unemployment and the disruption of family units that social capital disintegrates and results in high levels of crime, homicide and trauma.

It is of concern that research has shown that if smokers had the same death rate as non-smokers, 58% of lung cancer deaths would have been avoided and approximately 8% of all adult deaths in South Africa are caused by smoking. Recent studies have also shown that the winery areas of the Western Cape have the highest prevalence of Foetal Alcohol Syndrome in the world. These facts clearly illustrate the importance of individual responsibility for their own health and therefore importance of facilitating the development of social capital in the quest to fight the burden of disease.

Healthcare 2010, the Department's long-term strategy will contribute significantly to fostering social capital. Healthcare 2010 is described in some detail in paragraph 7.6, however, the key concepts of more efficient and equitable distribution of quality health care and the leading role of primary health care are essential elements of both Healthcare 2010 and social capital formation within the context of health.

Specific lines of response

In addition to Healthcare 2010 which is the broad response of the Department to social capital formation, the Department has implemented interventions in the following areas:

1) The integrated management of childhood illnesses (IMCI) with specific emphasis on the management of diarrhoeal disease;
2) Strengthening of the immunisation campaign.
3) The management of chronic diseases to ensure the continuity of care.

Integrated management of childhood illnesses (IMCI):

Diarrhoeal disease is prevalent in informal settlements, which are characterised by a lack of potable water and sanitation amongst other indicators of social distress. The initiatives to address the problem include:

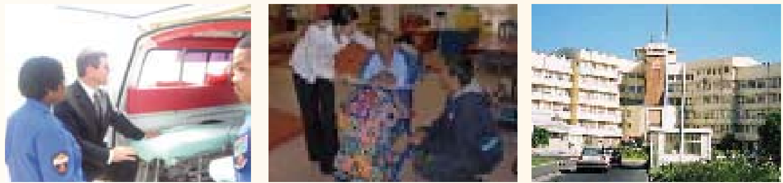
- Assisting the communities address the water and sanitation problems by engaging the relevant departments (linking social capital).
- Engaging with Education Department regarding the teaching of hygiene at schools,
- The Diarrhoeal Disease Intervention campaign from February to may each year includes support at community level for the early identification of danger signs in ill children, particularly below the age of five years for the immediate referral to a health worker, the use of sugar/salt solutions and handwashing programmes in Khayelitsha, Mitchell's Plain, Delft, Kraaifontein (Wallacedene) and Gugulethu.
- All PHC facilities will have active Oral Rehydration Treatment facilities and Khayelitsha Site B, Delft and Guguletu CHC will offer extended hours of service for all ill children on weekdays (16:30 to 20:00) and weekends (10:00 to 14:00)
- Additional paediatric bed capacity will be available at Red Cross Children's Hospital and Tygerberg, Lentegeur and Somerset Hospitals.

The Health Promoting Schools Programme includes the following initiatives:

- De-worming projects in primary schools in selected geographic areas across the Metro;
- A home visitation programme aimed at equipping care givers with basic skills on child rearing and safety; and
- A youth risk survey will be done in Mitchell's Plain.

Management of chronic diseases

Effective health education regarding a healthy lifestyle and risk factors will facilitate the prevention of many of the chronic diseases. It is also important that patients are involved in the management of their conditions and that they accept responsibility in this regard. Existing community and health structures will facilitate this process.



The Department of Health is also striving to address organisational issues that are likely to affect patient compliance and therefore the effectiveness of chronic disease management such as long waiting queues, availability of medications, alternative processes for dispensing chronic medication all of which promote trust in and credibility of the health services and government.

In addition to this the Department of Health has commissioned the faculties of health sciences of the Universities of Cape Town, Stellenbosch and the Western Cape to undertake a burden of disease study. The study will analyse the existing burden of disease and its risk factors in the Western Cape and will produce an inventory of public health sector, including NGOs, interventions which aim to reduce the burden of disease risk factors. The gap between the risk factors and the interventions will be determined and strategies to address the gap will be developed. Key outcome indicators for targeted risk factors will then be institutionalized within the Department as part of the routine monitoring and evaluation process.

3.6 Healthcare 2010

3.6.1 Healthcare 2010 is built on the restructuring plans that were commenced in 1994 and was approved by Provincial Cabinet on 26 March 2003.

The technical model is based on a set of inter-related variables such as population size, patient activities and the financial envelope. It was developed in order to substantially improve the quality of the health services and to bring the Department's expenditure within budget.

3.6.2 The underlying principles of Healthcare 2010 are:

1) Quality care at all levels
2) Accessibility of care
3) Efficiency
4) Cost effectiveness
5) Primary health care approach
6) Collaboration between all levels of care and
7) De-institutionalisation of chronic care.

3.6.3 The intention of Healthcare 2010 is therefore to maximize the return on the investment of resources by ensuring that limited resources are used to best effect by treating patients at the level of care most appropriate to their needs.

3.6.4 Implementation of Healthcare 2010

The strategic goals of the Department are:

1) Provide an integrated and quality seamless healthcare service;
2) Ensure an appropriate and affordable staff establishment;
3) Ensure that there are appropriate facilities in the right places; and
4) An appropriate funding envelope.

These realization of these goals requires the detailed development of four inter-related plans, each with a number of component projects, which form the pillars of Healthcare 2010, i.e.

- The service delivery plan;
- The personnel plan;
- The infrastructure plan; and
- The financial plan.
- The personnel plan
- The primary cost driver in Health are the personnel costs and therefore both the ability to operate within the allocated budget and most importantly the quality of the health service delivered is dependent on the personnel, a concerted effort is being invested in this matter.

The service plan

The foundation of Healthcare 2010 is the reshaping of the service to provide improved access to quality healthcare within the allocated funding envelope. This requires the reshaping of the services to ensure that the respective levels of care are appropriately resourced.

Reshaping the service entails the shift of patents to the most appropriate level of care as well as the related allocation of resources. To ensure that the reshaping is appropriately managed a service delivery plan has been developed to guide the implementation of the restructuring process.

District Health System (DHS)

The aim is to provide the full package of services to the population of the Western Cape with a target full utilization rate of 4,8 PHC visits per year per capita of uninsured population. This is not the national target which is 3,85 PHC visits per year per capita of the uninsured population. However, the full utilization includes 'walkthrough' services, e.g. dispensing of chronic medication, family planning and DOTS, which explains why this level of service exceeds the national target. Provision has been made for the treatment of HIV and AIDS patients.

The implementation of the PHC full package of services will reduce the burden on hospital outpatient facilities especially in the Cape Town Metropole district. In the Metropole level 1 beds have been allocated based on the uninsured population of each sub-district. New hospitals are planned for both the Khayelitsha and Mitchell's Plain sub-districts but in the interim the level 1 beds of these sub-districts are catered for mainly in Tygerberg Hospital. Once the hospitals have been built and commissioned the beds in Tygerberg Hospital and elsewhere will be relocated to these hospitals.

The main challenge in the Metropole in the short to medium term is to reclassify the some of the level 2 beds in the Metro hospitals as level 1 according to the Service Plan and to allocate the resources appropriately. Generic staffing models have been developed to facilitate the allocation of the appropriate numbers and skill mix of personnel.
This will be addressed by increasing the average bed occupancy rate to 85%. Level 2 beds have been allocated to the larger rural district

hospitals to facilitate the outreach from the rural regional hospitals.

Regional hospital services (mainly level 2 services)

As a referral service the regional hospital services are mostly centralized in the central hospitals in the Cape Metropole District. Mowbray Maternity Hospital (175 beds) is also classified as a specialized level 2 hospital. Outside of the Cape Metropole the required beds are in the three rural regional hospitals.

Provision for level 1 beds in the acute hospitals in the Metro results in a decrease in the number of existing level 2 beds in those hospitals. The future configuration for level 1 and 2 beds in those hospitals will be finalized during 2006.

The intention is also to strengthen the level 2 services in the rural areas to support the DHS (level 1 services) and to reduce the referrals to the Metro hospitals. These will make level 2 services more accessible to the rural population.

Central hospital services (mainly level 3 services)

The quantum of level 3 services is based on the allocation of the National Tertiary Services Grant (NTSG) and a proportion (50%) of the Health Professions Training and Development Grant (HPTDG). Indications are that the number of affordable level 3 beds will be in the region of 1 460 which is an increase from the 1 290 beds originally designated in terms of Healthcare 2010.

Brief description of the costing method

The costing of the Service Plan is based on staffing costs. The reason being that staffing is the main cost driver in all the services. Therefore Generic Staffing Models were developed for Primary Health Care services and for each type of hospital with the distinction made between levels of care. The staffing models are linked to service outputs and efficiency indicators to ensure an affordable and sustainable health service delivery platform.

Each type of post is motivated by a job description and a job evaluation. The generic staffing models have determined the optimal number of posts required per job type as determined by the workload of the specific hospital. Jobs are grouped together in functional service units and linked to an organogram of the generic hospital. This optimal establishment forms the basis for any adjustments to staffing levels based on affordability.

Outpatient services are expressed as outpatients per inpatient day as well as outpatients per admission. Patient day equivalents are the indicators for a comprehensive hospital service.

Calculation of total expenditure

The total personnel cost is used to calculate the total expenditure per hospital. An important factor impacting on total expenditure is capital expenditure. The Service Plan total expenditure per hospital therefore excludes major building projects but includes the replacement and maintenance of equipment. There is a significant capital backlog for the replacement of equipment. Therefore the target expenditure for capital has been significantly increased for all types of hospitals in the models. In developing the Service Plan generic models have been applied to the health services taking into account local and regional factors impacting on service delivery.

The infrastructure plan

The infrastructure plan for hospitals has been compiled and similar plans for Primary Health Care and the Emergency Medical Services are being compiled. Planned patient transport is a key issue to facilitate the accessibility of services to patients and is being addressed.

Finances

Key financial projects that are being addressed are revenue generation, the conclusion of service level agreements with Local Government regarding the delivery of Primary Health Care, excluding environmental health. Another important project that is being addressed is the review of the Joint Agreements with the respective universities.

4. DESCRIPTION OF THE STRATEGIC PLANNING PROCESS

4.1 The Healthcare 2010 conceptual framework was developed as a result of the Strategic Position Statement process initiated by the National Department of Health. In September 2002 the Provincial Cabinet requested that the conceptual framework be tested against a wide range of stakeholders.

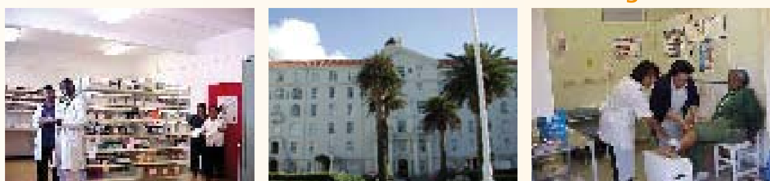
4.2 The consultation process included the following:

- Over eighty engagements with representative stakeholder groups;
- Media interviews and response to media queries, i.e. 21 articles and letters directly related to Healthcare 2010 occurred between October 2002 and February 2003;
- Advertisements were place in the English and Afrikaans media on 22 February 2004, to remind stakeholders that the closing date for comments was 28 February 2004.
- Representatives from senior and middle management considered all the inputs

4.3 A submission was made to the Provincial Cabinet who resolved that the Department of Health should proceed with the detailed planning and implementation of Healthcare 2010 on 26 March 2003.

4.4 Subsequently an information booklet titled: Healthcare 2010: Health Western Cape's plan for ensuring equal access to quality health care was published in English, Afrikaans and Xhosa.

4.5 A Service Plan has been drafted to give effect to the implementation of Healthcare 2010. This process has required groundbreaking technical work and has been extensively internally consulted. Following this process of internal consultation the plan is being further refined before being consulted with external stakeholders. This process is being vigorously pursued and will impact on the detail of the Annual Performance Plan during 2006/07.



PAST EXPENDITURE TRENDS AND RECONCILIATION OF THE MTEF PROJECTIONS WITH PLAN

Table 17 Trends in provincial public health expenditure (R million) [A3]

Expenditurew	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	3,951,022,000	4,547,303,825	5,169,201,000	5,776,822,000	---	---	---
Total per person	860	975	1,091	1,200	---	---	---
Total per uninsured person	1,178	1,335	1,494	1,644	---	---	---
Total capital	100,794,000	196,176,000	288,464,000	273,725,000	---	---	---
Constant (2004/05) prices							
Total	4,582,975,566	5,005,515,984	5,407,298,369	5,776,822,000	6,323,493,000	6,774,319,000	7,332,905,000
Total per person	997	1,073	1,141	1,200	1,294	1,365	1,455
Total per uninsured person	1,366	1,470	1,563	1,644	1,773	1,870	1,993
% of Total spent on:							
DHS	25%	25%	26%	28%	30%	30%	31%
PHS	25%	23%	23%	22%	21%	21%	21%
CHS	37%	35%	35%	34%	33%	33%	32%
Total capital	3%	4%	6%	5%	5%	5%	4%
Health as % of total public expenditure	**29.59**	**27.25**	**27.81**	**27.98**	**27.86**	**27.48**	

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PART B

BUDGET PROGRAMMES & SUB-PROGRAMMES

Programme 1: Administration

PROGRAMME 1: Administration

1. AIM

To conduct the strategic management and overall administration of the Department of Health.

2. PROGRAMME STRUCTURE

2.1 Sub-programme 1.1
Office Of The Provincial Minister

Rendering of advisory, secretarial and office support services.

2.2 Sub-programme 1.2
Management

Policy formulation, overall management and administration support of the Department and the respective regions and institutions within the Department.

Sub-programme
1.2.1 Central Management

Policy formulation by the Provincial Minister and other members of management, implementing policy and organising the Health Department, managing personnel and financial administration, determining working methods and procedures and exercising central control.

Sub-programme
1.2.2 Decentralised Management

Implementing policy and organising Health regions, managing personnel and financial administration, determining work methods and procedures and exercising regional control.

3. SITUATION ANALYSIS

The Health Service is managed by a combination of a central head office in Cape Town and currently decentralised (regional) offices in Bellville, George, Worcester and Malmesbury.
The central head office determines policy and ensures that the health service functions in harmony with both national and provincial policy and directives.

Human resource and financial management policies and procedures are determined and co-ordinated at the central head office. The central head office also provides overall policy determination, management and direction for Health Programmes.

Professional Support Services and Communication, with staff and public, are likewise co-ordinated and directed from the central head office. The organisational chart of the senior management of the Department is reflected overleaf.

ORGANISATIONAL CHART OF SENIOR MANAGEMENT

The migration into the Western Cape remains an issue of concern from the perspective that whilst the province receives funding for patients from other provinces for tertiary services, no financial provision is made in terms of the provincial equitable share for these patients who require primary and secondary level care. This places an additional financial strain on the limited provincial resources.

The demand for services exceeds the quantum for which the available resources provide. The challenge to the Department is therefore to ensure that available resources are optimally utilised as outlined in Healthcare 2010. A concerted effort has been, and will continue to be invested in revenue generation and collection in order to bolster these resources.

Extensive groundwork has been done over the past year on the implementation of Healthcare 2010. It is anticipated that the Service Plan which will outline the way in which the services should be reshaped, will be finalised and consulted with all relevant stakeholders by June 2006. This will include addressing issues such as service packages and begin to address referral guidelines. Once the Service Plan is in place it will be possible to commence restructuring the staff establishments in line with the Generic Staffing Models. It is anticipated that significant progress will be made with the latter process by the end of the 2006/07 financial year.

An infrastructure plan for hospitals has been developed in support of Healthcare 2010, which will be effected using all available funding for hospital upgrading and construction. A similar plan is being developed for the Primary Health Care facilities and the Department faces a major challenge to fund the necessary upgrading and construction of those facilities

As indicated in Part A the Faculties of Health Sciences of the universities of Cape Town, Stellenbosch and the Western Cape have been requested to assist the Department in the formulation of a strategy for the reduction of the burden of disease.

Note: In order to retain the principle of compiling the strategic plan per financial programme, table HR3 Situational analysis and projected performance for human resources (excluding health sciences and training) is reported in Programme 1 rather than Programme 6.
Human Resource Management and Labour Relations resort financially and functionally within Programme 1, and whereas Health Sciences and Training is a separate financial programme it resorts managerially and functionally under Human Resources.

Table 1.1 Public health personnel in 2004/05 [HR1]

Categories	Number employed	% of total employed	Number per 1000 people	Number per 1000 uninsured people	Vacancy rate	% of total personnel budget	Annual cost per staff member	National average	
								% of total employed	Number per 1000 uninsured people
Medical Officers	959	4.1%	0.20	0.27	29.28%	8.95%	258,823	0	0
Registrars	598	2.6%	0.12	0.17	5.53%	7.31%	338,963	0	0
Medical Specialists	377	1.6%	0.08	0.11	53.51%	6.58%	483,963	0	0
Dentists	64	0.3%	0.01	0.02	54.61%	0.67%	292,309	0	0
Professional Nurse	3880	16.6%	0.81	1.10	22.65%	20.03%	143,156	0	0
Staff Nurses	1719	7.4%	0.36	0.49	15.53%	6.32%	102,040	0	0
Nursing Assistants	3797	16.3%	0.79	1.08	13.11%	11.06%	80,752	0	0
Student Nurses	203	0.9%	0.04	0.06	55.97%	0.49%	66,349	0	0
Pharmacists	267	1.1%	0.06	0.08	29.18%	1.54%	160,278	0	0
Nutritionists & Dieticians	52	0.2%	0.01	0.01	20.00%	0.25%	135,669	0	0
Other allied health professionals & technicians	1280	5.5%	0.27	0.36	20.50%	6.57%	142,360	0	0
Managers, Administrators & all other staff	10161	43.5%	2.11	2.89	18.67%	30.22%	82,488	0	0
Total	23,357	100.00%	4.85	6.65	20.47%	100.00%	118,733	0	0

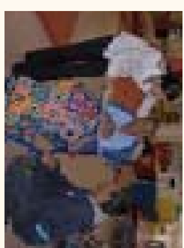


Table 1.2 Situational analysis and projected performance for human resources (excluding health sciences and training) [HR3]

Indicator	Type	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input									
1. Medical officers per 100,000 people	No	40	38	37	37	37	37	37	18.7
2. Medical officers per 100,000 people in rural districts	No	11	11	12	13	13	13	13	12.2
3. Professional nurses per 100,000 people	No	91	85	84	85	95	100	100	105
4. Professional nurses per 100,000 people in rural districts	No	59	57	55	55	60	70	80	92.5
5. Pharmacists per 100,000 people	No	5	4	5	5	8	10	15	34
6. Pharmacists per 100,000 people in rural districts	No	4	3	4	4	6	8	12	24
Process									
7. Vacancy rate for professional nurses	%	Not available	22%	19%	23%	15%	15%	15%	15
8. Attrition rate for doctors	%	31%	31%	37%	42%	30%	25%	25%	25
9. Attrition rate for professional nurses	%	10%	10%	12%	15%	12%	12%	12%	25
10. Absenteeism for professional nurses	%	3%	3%	3.24%	3.56%	3%	3%	3%	5
Output									
11. Doctors recruited against target	%								80
12. Pharmacists recruited against target	%								60
13. Professional nurses recruited against target	%								90
14. Community service doctors retained in the province	%								40
Quality									
15. Hospitals with employee satisfaction survey	%			15%	30%	45%	60%	65%	50
Efficiency									
16. Nurse clinical workload (PHC)	No		29,7	30,1	35	35	35	35	
17.Doctor clinical workload (PHC)	No		48,3	50,6	50	50	50	50	
Outcome									
18. Supernumerary staff as a percentage of establishment	%								

NOTES:
1. Excludes Local Government personnel.
2. Excludes sessions, periodical and extraordinary appointments.
3. Recruitments are Persal number and not per appointment.
4. Absenteeism is calculated: Persons*261 / days sick leave * 100
5. Doctors = medical officers, specialists, registrars and medical superintendents
6. Doctors as defined in Note 4 are used throughout the Table when reference is made to medical professionals, i.e. for Indicators 1, 2, 8 and 11
7. The unfunded posts within the Department of Health were abolished during July 2004 and the target for indicators 11, 12 and 13 will not be a true reflection of the real service need in terms various occupational classes. Furthermore the information is not obtainable from PERSAL. Once restructuring in terms of Healthcare 2010 has been finalised and proper HR planning has been done the information will be made available.
8. The job evaluation benchmark for medical officers with effect from 1/12/2003 have only been implemented during 2004. There was previously no specific job title for community service doctors to differentiate from medical officers on the PERSAL system. The information for indicator 14 will therefore only be available in the new financial year, 2005/06.
9. Although the current indicator for medical officers exceeds the national target, in the Western Cape's view there is not an over provision of personnel.
10. The indicators regarding pharmacists confirm the shortage of this category of personnel in the Province.

4. POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

4.1 National Department of Health's priorities for the next five years

In formulating the priorities for the next five years (2004 – 2009), in line with the new political term of office, the achievements of the past ten years were evaluated and the following focus areas were identified and approved by the then Health MINMEC, which has been replaced by the National Health Council. These issues are being addressed by the Western Cape as follows:

4.1.1 Improve governance and management of the National Health System

- Governance and management of the District Health System are being strengthened through the development of District offices in the Metropole and the appointment of facility managers at the major metropolitan community health centres. Following a long process of consultation, the Department is in the process of assuming responsibility for the provision for Personal Primary Health Care in rural and district municipalities.
- The City of Cape Town will continue to partially fund and provide PPHC services in the Cape Metropole probably over the next three years. Closer cooperation between the City and the Department via the participation of the Director of Health in the City on the management structures has been established.

4.1.2 Promote healthy lifestyles

- Primary Health Care contributes towards health education and counselling
- Chronic lifestyle disease programme: through clubs for diabetes, hypertension, asthma and epilepsy these programmes provide lifestyle information that enables individuals and groups to make informed choices regarding their health and well being.

4.1.3 Contribute towards human dignity by improving quality of care

- Community participation is facilitated by the Facilities Boards that have been appointed in all hospitals, in line with the Health Facility Boards Act.
- Effective public relations are facilitated by means of communication with the public and internal communication, for example face-to-face meetings and media coverage.
- A provincial policy on Quality Assurance has - implemented within the framework of the national policy.
- A provincial policy for the monitoring of complaints and compliments has been implemented and is monitored quarterly.
- External Client Satisfaction Surveys will be conducted in accordance to a planned schedule
- Waiting time surveys and analysis of systems to reduce waiting times. There is a plan for further roll out.
- A policy for structured morbidity and mortality monitoring has been implemented.
- Development of standards to monitor the quality of service delivery is in progress which will constitute a mechanism for both internal and external accreditation
- Specific aspects of the Clinic Supervision Manual have been implemented.
- A formal procedure for monitoring the progress of quality improvement initiatives has been implemented.
- Staff satisfaction surveys are being rolled out.
- Monitoring of the progress of the outputs required in terms of the Hospital Management and Quality Improvement Grant is ongoing.
- Establishment of a chronic dispensing unit to reduce waiting times which will also improve the quality of care by allowing healthcare personnel more counselling time with patients and therefore compliance.

4.1.4 Improve management of communicable diseases and non-communicable illnesses

- HIV and AIDS: The Western Cape has achieved significant increase in anti-retroviral treatment access, expansion of the prevention strategy (including increased VCT coverage, condom distribution, STI management and universal access for PMTCT and post-exposure prophylaxis) and expansion of the care and support strategy (home-based care and palliative care), through successful partnerships and multi-sectoral efforts.
- The incidence of tuberculosis (TB) in the Western Cape continues to be amongst the highest in the world, exacerbated by the HIV and AIDS pandemic. The Department has made significant progress in the implementation of the WHO DOTS Strategy and is working towards the overall goal of achieving an 85% cure rate. This is reflected in the steady improvements in the new smear positive (NSP) TB cure rates from 65% in 1997 to 72% in 2003.

4.1.5 Strengthen primary health care, EMS and hospital delivery systems

- The strengthening of Personal Primary Health Care includes the assumption of responsibility for the provision of personal primary health care (PPHC) services currently being provided by District and Local Government, the establishment of facility management, the computerisation of PHC services and the development of an infrastructure plan for PHC.
- Personal primary health care services in the Cape Town Metro district will continue to be provided by the City of Cape Town in co-operation with the Department for the next three years. [should we not be putting a date here rather – 2008?]
- Infrastructure plans for Emergency Medical Services are being developed.
- It is planned that hospital services, particularly regional hospital services providing level 2 services will be strengthened.

4.1.6 Strengthen support services

- The transfer of the Medico-Legal Mortuaries from the South African Police Services to the Provincial Department of Health has been approved as of 1 April 2006.
- Medicines and Pharmacy legislation is currently being implemented. Regional support is being provided to ensure compliance.
- A chronic dispensing unit was established in December 2006 to dispense the medications for patients with chronic conditions whose medication requirements have been stabilised. The purpose of this unit is to deflect some of the workload at clinic/CHC level to facilitate better consultation between pharmacist and patient.

4.1.7 Human resource planning, development and management

- Model staff establishments are being developed into the Generic Staffing Models. The aim of these models is to create establishments that will be linked to the finalised Service Plan and which will provide an appropriate skill mix of personnel per level of care.
- An Affirmative Action Strategy has been developed and will be implemented in consultation with the relevant stakeholders.
- A Human Resource Plan is in the process of being developed and will be consulted with the relevant stakeholders.

4.1.8 Planning, budgeting, monitoring and evaluation

- The strategic planning of health services in the Western Cape is an activity based plan in line with the allocated funding envelope. The process is modelled using a set of inter-related variables.
- The Department participates in the quarterly Early Warning System of the National Department of Health in which performance against select indicators is reported.
- Programme performance is also monitored quarterly by an internal Monitoring and Evaluation Committee where Programme Managers report on the performance of the respective programmes against the set of indicators in the Strategic Plan. The Monitoring and Evaluation Committee is chaired by the Head of Department.
- Financial monitoring is done by means of the monthly in year monitoring.
- Health information system: The Hospital Information System (HIS) has been implemented in the Academic Hospitals and has been rolled out to pilot sites in the regions and will rolled out to the rest of the hospitals in the province.

4.1.9 Prepare and implement legislation

- Mental Health Care Act: A Mental Health Review Board has been established.
- National Health Act 61 of 2003: this been implemented and the governance requirements are being implemented with the Provincial Health Council having been constituted.
- The Medicines and Related Substances Act 101 of 1965 as amended and Pharmacy Act 53 of 1974 as amended: considerable preparatory work has been done to prepare for the implementation of this legislation.

4.1.10 Strengthen international relations

- The Department has a number of co-operation agreements with various donor agencies, e.g. the European Union for home-based care, the Global Fund and TB/HIV.

4.2 Links to Healthcare 2010

The Healthcare 2010 strategy of the Western Cape supports the above initiatives of the National Department and it is a priority that Healthcare 2010 be implemented as a matter of urgency in order to improve service delivery and to address the financial constraints.

A key priority is the reshaping of the services and improving the utilisation of human resources by striving to provide the correct numbers and skills mix of personnel at the various levels of care. Another important facet of Healthcare 2010 is to ensure that quality care is accessible to the people of the Western Cape. The Infrastructure Plan, which is dependent on the Hospital Revitalisation Programme, will facilitate the process.

It is planned to restructure the current regional offices into district offices in the rural districts who will then report to a Chief Director: Rural Districts. A Chief Directorate will manage the Cape Town Metro district and will be supported by four substructure offices. These components are responsible for co-ordinating and integrating health services to ensure effective and efficient delivery of quality District Health Services.

Another major strategic objective is to ensure a "seamless" health service. This means that the various levels of the service interact in a co-operative manner so that whilst levels of service are appropriately managed; patients are not subjected to any delay when referred from one level to another.

Revenue generation is an important strategic objective. The Department is paying special attention to patient billing and revenue collection. "Private" wards or "differentiated amenities" have been established at several hospitals to attract private patients and those on medical aid. The Department has entered into preferred provider agreements with medical aids and other government departments. The objective is to make health care more cost effective so that quality of service can be improved for the benefit of all patients – both "private" and public patients.

Better communication with staff at all levels, as well as with stakeholder such as the media, is also considered a key objective. The Communications Directorate is making progress in this regard.

4.3 Funding priorities

Funding has been allocated to the following priorities during 2006/07:

- R400 000 for the appointment of data analysts to improve the availability of information.
- R5 million for the strengthening of central and regional management which includes the establishment of a directorate of nursing and other actio ns to improve administration of human resources and other support functions.

- An earmarked allocation of R53,6 million has been made for health equipment. Of this earmarked funding R11,6 million has been allocated to this programme and the balance of R42 million to Programme 5: Central Hospital Services. In addition to this an amount of R26,5 million has been allocated via the Hospital Revitalisation Programme and a further R92,8 million of the equitable share has been allocated for machinery and equipment. The total funding allocated throughout the Department for equipment for 2006/07 is therefore R172,9 million.
- R4,3 million has been allocated for the operational costs of the Central Dispensing Unit.
- R3 million is allocated to promote improved asset management while an additional R2,9 million was allocated to fund financial administrative staff over and above the R10 million allocated during the previous financial year.
- R1.5 million has been allocated for the burden of disease project.

5. CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The Department as implemented a Financial Personnel Management Instrument (FPMI) which consists of a contractual arrangement between the Chief Financial Officer (CFO) and the respective institutional managers. The purpose of this instrument is the more effective and effective control over the filling of posts.

Recruitment of specific skills remains a problem. The financial, human resources and business management components are short staffed both at head office and institutional level. Recruitment of appropriate numbers of certain clinical personnel, e.g. pharmacists, theatre nurses, etc, remains a problem.

Reshaping the service entails the shift of patients to the most appropriate level of care as well as the related reallocation of resources. To ensure that the reshaping is appropriately managed a service delivery plan has been developed to guide the implementation of the restructuring process.

The Service Plan addresses the movement of patient activities as well as the reallocation of resources over the respective levels of care over the MTEF period.

In an effort to address the shortage of staff and capacity within the Human Resource components at both central and regional levels the Department will create and fill additional posts over the MTEF period.

6. PLANNED QUALITY IMPROVEMENT MEASURES

The service and human resource restructuring process that is in progress aims to provide the optimal bed and skill mix to meet the calculated service requirements.

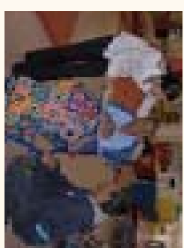
The Department intends to create a Directorate: Nursing in order to provide an enabling and co-ordinating service to nursing and therefore contributing to improving the quality of care which has been funded in the 2006/07 financial year.

In line with current prescripts and business principles the Directorate: Supply Chain Management was created to deal with procurement and provisioning functions including the Cape Medical Depot. The Department is in the process of implementing LOGIS, Delta 9 and the Basic Accounting System (BAS). These procurement, billing and accounting systems will lead to better financial control that will benefit patient care and hospital management.

The Department has commenced with the setting up of Hospital Revitalisation Programme (HRP) Project Office. An acting Provincial Project Manager has been appointed who is assisted by a professional engineer. Business cases have been submitted to the national Department of Health for Paarl, Khayelitsha, Valkenberg, Mitchell's Plain and Robertson Hospitals. The HRP Project Office is busy with the planning of the Khayelitsha, Valkenberg and Mitchell 's Plain hospitals. Construction on the Paarl hospital project is scheduled to commence in 2006. Construction work is in progress at the George, Worcester and Vredenburg hospitals. It is envisaged that further hospitals will be included in the programme during 2006.

Specific quality improvement measures for 2006/2007 include:

- The determination of waiting times at clinics by conducting waiting time surveys and based on the results the implementation of strategies to reduce waiting times.
- Rollout of the external client satisfactions survey with the following targets for tertiary hospitals – 100%, secondary hospitals – 100% district hospitals – 100% and clinics – 30%.
- The establishment of Quality Assurance committees at all facilities and regions.
- The development of standards to monitor the quality of service delivery.
- Morbidity and mortality monitoring with quarterly reporting to the Department.
- Conducting of staff satisfaction surveys.
- Formalisation of an adverse event incident reporting system and centralised data capture in order to create a provincial database of adverse clinical events which guide the pro-active arm of the risk management programme.
- Continued training of Pharmacists Assistants to support improved Pharmaceutical care.
- Continued training of Nursing Assistant to support improved nursing care.
- Implementation of a Service Level Agreement with the NHLS.
- Implementation of a Service Level Agreement with the Department of Public Works and Transport.



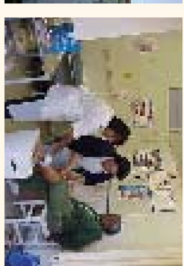
7. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 1.3 Provincial objectives and performance indicators for Administration [ADMIN1]

7.1 Chief Directorate: Professional Support Services and Administration

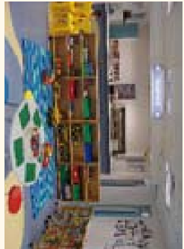
Objective	Indicator	2003/2004 (Actual) 1	2004/2005 (Actual)	2005/2006 (Target)	2006/2007 (Target)	2007/08 (Target)	2008/09 (Target)
POLICY AND PLANNING							
Development of provincial health legislation.	Promulgation of provincial health legislation and.	Not applicable	Not applicable	Drafting /discussion: • Ambulance Service Bill • R187/2002 (private hospital licensing) • Hospital Ordinance 18 of 1946	Drafting/discussion of legislation i.t.o. section 31(5) of the National Health Act (NHA) re: district councils	Drafting/discussion of: legislation i.t.o. section 41(1), 41(5), 42, 43(2) of the NHA if these sections are in operation.	
		Not applicable	Not applicable	Not applicable	Promulgation of: • Ambulance Services Act • Amendment: • R187/2002 • Hospital Ordinance	Promulgation of legislation i.t.o. section 31(5) of the NHA re: district councils.	Promulgation of legislation i.t.o. section 41(1), 41(5), 42, 43(2) of the NHA if these sections are in operation.
Rationalisation of provincial health legislation.	Promulgation of repeal/amendment to existing provincial health legislation as required.	Not applicable	Not applicable	Not applicable	Drafting and discussion for repeal of: • Ordinance 11/1955 (Ambulance personnel transfer & pensions) • Regulations: Honorary Medical Staff of provincial hospitals of 1953 • Regulations re Procurement by Provincial Hospitals of 1956 • Regulations re powers and functions of Medical Committees of 1960.	Drafting amendments/ repeal of: • Training of nurses & midwives, Ordinance of 1984 • Regulations relating to the payment of transport allowance to Hospital Boards of 1956 • Western Cape Health Facility Boards Act of 2001.	
		Not applicable	Not applicable	Not applicable		Promulgation of repeal of regulations relating to: • Honorary Medical staff; 1953 • Procurement by provincial hospitals, 1956 • Regulations re powers and functions of Medical Committees, 1960	Promulgation of repeal/ amendment of: • Training of nurses & midwives, Ordinance of 1984 • Regulations relating to the payment of transport allowance to Hospital Boards of 1956 • Western Cape Facility Boards Act of 2001

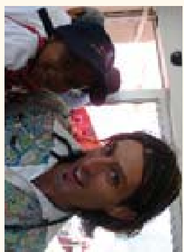
Objective	Indicator	2003/2004 (Actual) 1	2004/2005 (Actual)	2005/2006 (Target)	2006/2007 (Target)	2007/08 (Target)	2008/09 (Target)
Delivering of opinions to minimise risks and litigation.	Number of legal opinions concluded.	Not recorded.	45	60	70	75	80
Drafting and vetting of contracts for the Department to minimise or prevent risk and litigation.	Drafted and vetted contracts.	Not recorded.	10	11	15	17	20
Provision of Legal Administration support to prevent litigation and where unavoidable to ensure that the Department is appropriately defended.	Average number of litigation cases.	15	7	20	25	30	30
	Average number of litigation cases successfully defended.	6	2 All others pending	8	10	15	15
Effective health service planning to ensure that plans are developed to ensure that health services are equitable, accessible, and affordable and provide quality care.	A widely acceptable and realistic strategic plan that is based on the principles of Healthcare 2010.	Healthcare 2010 approved by Cabinet and Strategic plan in place	Strategic plan timeously submitted in accordance with the prescripts of the National Treasury and Department of Health.	Five year Strategic and Performance Plan and the Annual Performance Plan timeously submitted in accordance with prescripts.	Annual Performance Plan timously submitted in accordance with prescripts.	Annual Performance Plan timously submitted in accordance with prescripts.	Annual Performance Plan timously submitted in accordance with prescripts.
INFORMATION MANAGEMENT							
Provide health service and health status information to evaluate and monitor the effectiveness and efficiency of the services rendered by the department.	% of prescribed information collected, collated, published and disseminated.	67%	85%	90%	90%	90%	
Provide the necessary information technology, in accordance with Departmental and Provincial policy.	% of applications for information technology realised.	98%	95%	95%	95%	95%	
Manage the implementation and support of the Health Information System (HIS) in all hospitals of the department, as contracted.	% of hospitals where the HIS has been implemented.	10%	15%	30%	45%	60%	
Manage and administer the Promotion of Access to Information Act, 2000 and National Archives Act to ensure accessibility, preservation of health records respectively.	% of requests for information addressed.	Component not established.	Component established.	80%	80%	80%	

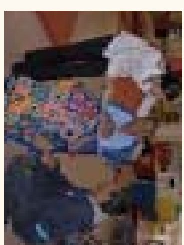


Objective	Indicator	2003/2004 (Actual) 1	2004/2005 (Actual)	2005/2006 (Target)	2006/2007 (Target)	2007/08 (Target)	2008/09 (Target)
PROFESSIONAL SUPPORT SERVICES							
Ensure that essential and quality drugs are available and dispensed as required.	% of indicator drugs immediately available and dispensed to patients.	85%	91%	90%	95%	98%	98%
	% of alignment or PGWC code list with the National EDL 1	Not known	75%	85%	90%	95%	95%
Ensure good pharmacy practice and efficient pharmaceutical care to patients.	% of pharmacists posts filled.	70%	71%	80%	90%	90%	90%
	% of pharmacist's assistants trained / in training.	30%	72%	50%	90%	100%	100%
	% of health facilities that comply with Medicines and Pharmacy Acts. 2			100%	100%	100%	100%
Establish a Chronic Dispensing Unit to dispense medications for patients with stable chronic conditions.	Number of prescriptions dispensed per year.			Component established December 2005	900 000	1 000 000	1 000 000
MEDICAL LEGAL ADVISORY SERVICES							
Containment of financial losses resulting from the defence or settlement of claims resulting from personal injury an public liability claims.	Annual settlement costs.	R600 000	R271 000	R13.5m	R14m	R14,5m	R15m
Provision of instructions to the State Attorney for purposes of defending the Department's interests in malpractice litigation.	Number of new medico-legal claims notified.	21	40	50	50	50	50
	Number of claims settled or defended.	11	15	20	25	25	25
Containment of negative publicity resulting from medico-legal queries.	Average number of medico-legal queries.	600	450	650	700	750	750
QUALITY ASSURANCE							
Ensure the effective co-ordination of quality of care improvements initiatives at facility and regional level.	% of regional offices and facilities with quality assurance committees.	10%	73%	100%	100%	100%	100%
	% of regional offices and facilities with quality improvement plans.	50%	79%	80%	90%	100%	100%
	% of regional offices that submit 6- monthly reports	0	98%	100%	100%	100%	100%

Objective	Indicator	2003/2004 (Actual) 1	2004/2005 (Actual)	2005/2006 (Target)	2006/2007 (Target)	2007/08 (Target)	2008/09 (Target)
To systematically evaluate the quality of service delivery.	% of facilities that have conducted an external client satisfaction survey, published the results and developed action plans for improvement.						
	Tertiary facilities	100%	100%	100%	100%	100%	100%
	Secondary facilities	George Eben Donges Psychiatric Hospitals x 4	50%	100%	100%	100%	100%
	District facilities	Mossel Bay Hospital	18%	40%	80%	100%	100%
	Community Health Centres	0	30%	30%	60%	90%	100%
	% of facilities that submit quarterly returns on number of client complaints & compliments received.	75%	95%	100%	100%	100%	100%
	% of facilities with have included strategies to reduce complaints as reflected in the Quality Improvement Plans 3	0	0	50%	75%	100%	100%
	Nature and extent of complaints reflect concomitant decrease in line with plans. 4	0	0	0	50%	75%	100%
	Development of a set of standards against which to measure performance.	0	Standards set for nursing, Occupational Therapy, exchange, OPD Paediatrics and Reception	Develop 5 standards for each component of service delivery.	Evaluate the 5 standards set during 2004/05	Develop 10 additional standards	Develop 15 additional standards
	% of facilities which conduct morbidity and mortality reviews in accordance with Provincial guidelines.	0%	0%	10%	45%	80%	95%
Reduce client waiting times	Establish the impact of the Chronic Dispensing Unit (CDU) on waiting times and pharmacies.	Not known	Not known	Conduct baseline surveys at pharmacies prior to the introduction of the CDU.	Repeat waiting time survey to evaluate impact.	Benchmark maintained	Benchmark maintained







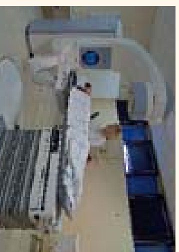
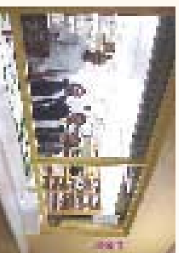
7.2 Chief Directorate: Human Resource Management

Objective	Indicator	2003/2004 (Actual) 2	2004/2005 (Actual)	2005/2006 (Target)	2006/07 (Target)	2007/08 (Target)	2008/09 (Target)
Ensure the effective management of human resource management policies and practices.	Develop and implement policies and practices and audit the application of the policies and practices.	Target Met	Target Met	Develop policies as determined by legislation and collective agreements. Execute audits.	Develop policies as determined by legislation and collective agreements. Execute audits.	Develop policies as determined by legislation and collective agreements. Execute audits.	Develop policies as determined by legislation and collective agreements. Execute audits.
The development and maintenance of an effective organisational structure for the Department.	Restructuring of departmental establishment to facilitate the achievement of Healthcare 2010.	Generic Models developed	Generic models developed. Groundwork with regard to restructuring completed	Partial implementation of the new approved organisational structure.	Implementation of the new approved organisational structure.	Emphasis on HR Planning by line managers w.r.t. their approved structures. Directorate HRM will facilitate the process.	Emphasis on HR Planning by line managers w.r.t. their approved structures. Directorate HRM will facilitate the process.
Provide an efficient personnel administration service to employees.	The execution of all personnel procedures with regard to recruitment, selection, appointments, conditions of service and the assessment of staff should be in terms of approved departmental standards.	Execute all applicable policies and practices.	Execute all applicable policies and practices.	Execute all applicable policies and practices.	Execute all applicable policies and practices.	Execute all applicable policies and practices.	Execute all applicable policies and practices.
Ensure the effective management of human resource development policies and practices.	Develop and co-ordinate the implementation of HRD policies and practices. Monitor and evaluate the implementation of HRD policies and practices.	Target met	Target met	Develop policies as determined by legislation and Departmental strategies. Monitor and evaluate the implementation of HRD policies and practices.	Develop policies as determined by legislation and Departmental strategies. Monitor and evaluate the implementation of HRD policies and practices.	Develop policies as determined by legislation and Departmental strategies. Monitor and evaluate the implementation of HRD policies and practices.	Develop policies as determined by legislation and Departmental strategies. Monitor and evaluate the implementation of HRD policies and practices
Ensure labour peace by providing and maintaining effective collective bargaining structures.	Number of incidents of labour unrest.	0	0	0	0	0	0
Provide an efficient labour relations advisory service to employees and managers	% of disputes and grievances resolved	75%	80%	80%	85%	85%	90%

Note: Information regarding Human Resource Development is reflected in Programme 6 and information regarding Engineering is reflected in Programme 7.

7.3 Finance

Objective	Indicator	2003/2004 (Actual) 2	2004/05 (Actual)	2005/2006 (Target)	2006/2007 (Target)	2007/08 (Target)	2008/2009 (Target)
FINANCIAL MANAGEMENT							
Produce financial statements.	Financial statements in accordance with National Treasury prescripts.	Financial statements produced.	Financial statements produced.	Financial statements produced.	Financial statements produced by 31 May 2006	Financial statements produced by 31 May 2007.	Financial statements produced by 31 May 2008.
To improve the level of asset management in the Department.	Credible asset registers	-	-	33%	33%	100%	100%
	Level of control and management of asset registers.	-	-	33%	33%	100%	100%
Ensure availability of essential drugs.	Number of items on dues out.	60	<60	<60	<50	<50	<50
Adequate working capital to support adequate stockholding.	Stock turnover.	R32 million	R36 million	R36 million	R40 million	R50 million	
BUSINESS DEVELOPMENT							
To increase own revenue	Number of case managers 8	10	16	16	16	16	16
	Number of designated service provider agreements	2	4	5	5	5	5
To license and inspect private health care establishments	Number of applications and adjudications outside prescribed timeframes.	20 applications approved and 12 applications declined	80 applications approved	Dependent on Health Act Regulations	Dependent on Health Act Regulations	Dependent on Health Act Regulations	Dependent on Health Act Regulations
	Number of inspections per year 9	256	430	430	430	430	430
To increase own revenue	Number of hospitals billing audits per institution per year 10	1	2	2	2	2	2

7.4 Communications

Objective	Indicator	2003/2004 (Actual)	2004/2005 (Actual)	2005/2006 (Target)	2006/2007 (Target)	2007/2008 (Target)	2008/2009 (Target)
Establish branding and visibility of the Western Cape Health Department.	Percentage of corporate items designed.	80%of items designed.	100% of items designed	Not yet determined	Not yet determined		
Maintain adequate communication with all stakeholders.	Number of publications per year.	22	22	22	22	22	22
Assist with awareness campaigns and promotions for Programmes and other Health directorates.	Number of communications plans implemented and communicated in at least 2 of the mass media.	23	64	74	74	74	74
Implement 2005/06 internal communication plan.	Number of: • staff indabas • internal newsletters • team briefings	45 Not applicable Not applicable	45 12 58	45 12 67	45 12 67	45 12 67	45 12 67
Implement the national language policy.	Development of an implementation plan for the Western Cape Health Department.	Not applicable	Finalise implementation plan.				
	Development of capacity building programmes for Health.	Not applicable	Finalise capacity building programmes				
	Establishment of a language unit for the provision of translation and interpretation services for the Western Cape Health Department.	Not applicable	Appointment of 1 language practitioner.	Appoint 2 additional language practitioners	Appoint 3 additional language practitioners		

8. PAST EXPENDITURE TRENDS AND RECONCILIATON OF MTEF PROJECTIONS WITH PLAN

The allocation to Administration increases to 3,15 per cent in of the vote in 2006/07 in comparison to the 3.05% of the Appropriation Budget allocated in 2005/06 There is a nominal increase of 14,06 per cent or R24,572 million from 2005/06 to 2006/07.

It is significant that the Department is permitted to allocate 1.5% of the personnel cost to performance incentives to personnel but in view of the financial and service pressures the Department has chosen to voluntarily reduce this, in 2004/05 it was set at 0.5% but in 2005/06 it will be increased to 1%. No additional funds have been allocated for this purpose in 2006/07.

Table 1.4 Trends in provincial public health expenditure for Administration (R' million) [ADMIN2]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	121,273,000	215,643,730	213,316,000	182,144,000	---	---	---
Total per person	26.39	46.22	45.02	37.85	---	---	---
Total per uninsured person	36.16	63.31	61.67	51.85	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	140,670,236	237,373,217	223,141,499	182,144,000	199,354,000	219,353,000	235,248,000
Total per person	30.62	50.87	47.09	37.85	40.79	44.20	46.68
Total per uninsured person	41.94	69.69	64.51	51.85	55.88	60.55	63.94
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

Programme 2: District Health Services

PROGRAMME 2: District Health Services

1. PROGRAMME DESCRIPTION

To render Primary Health Care Services and District Hospital Services including preventive, promotive and curative services. The foundation for the effective and efficient provision of these services is based on the integration of facility based services; community based and support services.

2. PROGRAMME STRUCTURE

Sub-programme 2.1 District Management

Planning, managing and monitoring the implementation of the Provincial Health service delivery strategy.

Sub-programme 2.2 Community health clinics

Rendering a nurse driven primary health care service at clinic level including visiting points, mobile- and local authority clinics.

Sub-programme 2.3 Community health centres

Rendering a primary health service with full-time medical officers in respect of mother and child, health promotion, geriatrics, occupational therapy, physiotherapy, speech therapy, communicable diseases, mental health, etc.

Sub-programme 2.4 Community based services

Rendering community based health service at non –health facilities in respect of home base care, abuse victims, mental- and chronic care, school health, etc.

Sub-programme 2.5 Other community services

Rendering environmental, port health and part-time district surgeon services

Sub-programme 2.6 HIV and AIDS

Rendering a primary health care service in respect of HIV and Aids campaigns and Special Projects.

Sub-programme 2.7 Nutrition

Rendering a nutrition service aimed at specific target groups and combines direct and indirect nutrition interventions to address malnutrition

Sub-programme 2.8 Coroner services

Rendering forensic and medico legal services in order to establish the circumstances and causes surrounding unnatural death

Sub-programme 2.9 District hospitals

Rendering of a hospital service at district level.

Sub-programme 2.10 Global Fund

Strengthen and expand the HIV and AIDS care, prevention and treatment programmes.

3. INTRODUCTION

The Department of Health's mission is to "improve the health of all people in the Western Cape and beyond, by ensuring the provision of a balanced health care system in partnership with all stakeholders, within the context of optimal socio-economic development"[1]. One of the key strategies to accomplishing this is the strengthening of primary health care (PHC) in order to respond more equitably, appropriately and effectively to basic health care needs, whilst also addressing the underlying social, economic and political causes of poor health[2].

The starting point to transforming service delivery at primary health care facilities is to strengthen the District Health System that is the vehicle to deliver PHC. Thus local management capacity and expertise must exist at ground level to significantly improve service delivery and ensure participation and local networking in the provision of PHC services at district level. This, however, needs to be underpinned by evidence-based strategic planning, effective and decentralised program implementation and management and timely production and utilization of strategic information at all levels of management.

This implies re-orientation of the service delivery model to one that incorporates the necessary public health and management expertise and has a community empowerment focus for effective community partnership and participation. This would promote the building of social capital to improve communities' ability to cope and deal with health issues and priorities through social cohesiveness and social action to improve health outcomes.

In addition, the district health services, acting as key institutions in the community, must supplement efforts toward the Provincial vision of "iKapa Elihlumayo" of tackling inequity, unemployment and poverty.

The aim is to transform the district health system as a vehicle to deliver highly efficient and effective Primary health Care that is:

- Universally accessible and covers the population on the basis of need;
- Provides comprehensive care with the emphasis on disease prevention and health promotion;
- Promotes community and individual involvement and self-reliance;
- Promotes inter-sectoral action for health; and
- Promotes appropriate technology and cost-effectiveness in relation to available resources

4. SITUATION ANALYSIS

4.1 Demographic & Socio-economic profile

According to the mid year population estimates from Statistics South Africa: 2005, the population of the Western Cape estimated to be 4.6 million comprises 9.9% of the national population. It is also estimated that 64% of people who live in the Western Cape, live within the Cape Town Metro that makes up 2% of the province's surface area[3]. About 73% of the population in the Province is uninsured and thus dependent on the Public health sector. Furthermore between the 1996 and 2001 censuses the Western Cape had a 14.3% population growth compared to the national 10.4% and in the period 2001 –2006, there were 337 300 people who in migrated from other provinces into the Western Cape, 175 000 (52%) of which were from the Eastern Cape[4].

Economically the Western cape has outperformed the national economy over the period 1999-2003 averaging a real GDPR growth of 3.9% compared to the national 3.1%. Census 2001 estimates unemployment[5] in the Province to be 17.1% compared to the national average of 24.0% and citizens have relatively good access to basic services and facilities. However, despite the relative advantages of the "average" citizens in the Province, the disparity in income and access to services amongst the people of the Western Cape results in large numbers of people in the Province who suffer poverty and want.

This is clearly illustrated in the Khayelitsha sub-district of the Metropole where 80% of population lives in informal housing, 99% of the population has no Medical Aid and 55% of households live below the poverty line. This is in contrast to the Tygerberg sub-district where 4% live in informal housing, 70% have medical insurance coverage and 17% of households live below the poverty line. These disparities are reflected in the health indicators such as infant mortality rates (IMR), seen in Table 2.1 below. This shows that although the Western Cape has an IMR of 31/1000 live births that is much lower than the national IMR of 56/1000 live births, Khayelitsha has an IMR of 44/1000 live births, which closely reflects the national reality.

Table 2.1 Infant Mortality Rate (per 1000 live births in 2002[6]

Area	IMR (per 1 000 live births)
South Africa	56
Western Cape Province	31
Cape Town Metro District	25
Khayelitsha Sub-district	44
South Peninsula Sub-district	13

4.2 The Burden of Disease

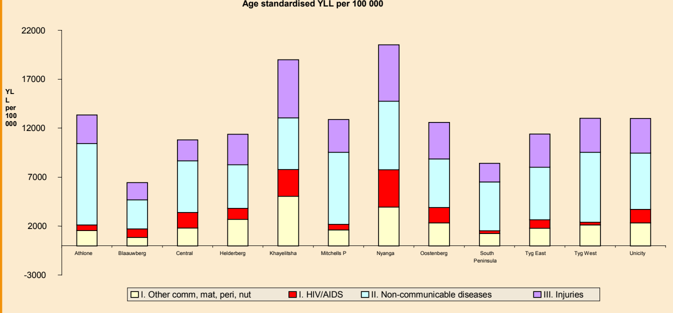
An adapted version of the 1990 Global Burden of Disease (GBD) list of causes of death divides overall mortality into three broad groups of causes of death[7], namely:

Group I Pre-transitional causes, which include communicable diseases, maternal causes, prenatal conditions and nutritional deficiencies;
Group II Non-communicable causes; and
Group III Death due to injuries.

In the Province HIV and AIDS is the leading cause of death (14.1%) followed very closely by homicide/violence (12.9%). Together with TB (7.9%), road traffic accidents (6.9%) and ischeamic heart disease (5.9%), they make up the top 5 causes of death in the Province. This highlights the quadruple burden of disease in the Province consisting of infectious diseases including HIV and AIDS/TB, non-communicable diseases and injuries.

The Cape Town Mortality report of 2001, reports that of the 23 185 deaths reported in Cape Town in 2001, the majority (54%) were due to non-communicable diseases, with injuries and pre-transitional causes accounting for 19% each. The top three causes of death in Cape Town were homicide followed by ischaemic heart disease and HIV and AIDS. Figure 1 below shows age standardised YLLs per 100,000 by cause groups and HIV and AIDS for Cape Town and sub-districts, 2001 showing the disparities between districts.

Figure 1: Age standardised YLLs per 100,000 by cause groups and HIV and AIDS for Cape Town and sub-districts, 2001 (Scott et al, 2003)

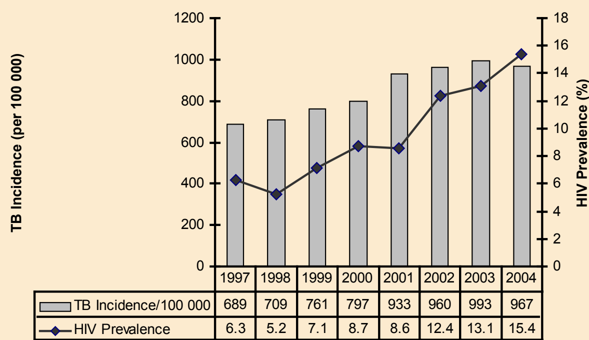


4.2.1 HIV and AIDS and TB

As shown in Figure 2 below, the annual antenatal HIV prevalence and TB incidence has steadily increased. In 2004 HIV prevalence was 15.4% and TB incidence was 967/100 000. Even though the 2004 HIV prevalence in the province is much lower than the national prevalence of 29.5%, and the increase from 2003 is not statistically significant (p<0.235)[8] the prevalence in some sub districts like Khayelitsha is estimated to be 33.0%, which is higher than the national prevalence.

The HIV epidemic has also fuelled the TB epidemic as seen in Figure 2 below. TB incidence in the Western Cape has increased from 689/100,000 in 1997 to 967/100,000 in 2004. This incidence is almost double the national TB incidence. In 2003 the national TB incidence was 550/100,000[9].

Figure 2 TB incidence and HIV Prevalence for the Western Cape Province 1997-2004



	1997	1998	1999	2000	2001	2002	2003	2004
TB Incidence/100 000	689	709	761	797	933	960	993	967
HIV Prevalence	6.3	5.2	7.1	8.7	8.6	12.4	13.1	15.4

In response to the HIV and AIDS epidemic, the province has started implementing the Comprehensive HIV and AIDS Care, Management and Treatment plan adopted by the National Cabinet in November 2003. The Department has committed itself to integrating the HIV and AIDS programme into the general health services in such a way that the additional resources lead to strengthening the general health system, rather than creating a vertical HIV and AIDS service delivery model.

As shown in Table 2.2 below, the commitment to managing the HIV and AIDS epidemic is illustrated in the increased dedicated expenditure on HIV and AIDS activities from 27,594 million in 2003/04 to 38,142 million and 94,382 million in 2003/04 and 2004/05 respectively. One hundred percent of PHC facilities offer free condoms, Voluntary Counseling and Testing (VCT), STI and PMTCT services. There were 218,089 people tested for HIV in 2004/05. VCT uptake in those 15years and older has increased from 5.9% in 2003/04 to 7.1% in 2004/05

An effective prevention of mother-to-child transmission (PMTCT) programme has also been implemented at all antenatal care facilities with the majority of women receiving dual or triple therapy combinations (depending on their CD4 counts) and many women opting for formula. Nevirapine uptake rate among babies born to women with HIV increased from 90% in 2003/04 to 97% in 2004/05.

Programmes exist to distribute condoms, 25,265,502 condoms were distributed by health facilities in 2004/05. Table 2.2 shows that the male condom distribution rate from public sector health facilities has increased by almost 40% from 2003/04 (11.2 per 100 000 males≥ 15yrs) to 2004/05 (15.6 per 100 000 males≥ 15yrs).

In terms of treatment and care, there is almost full geographic access to antiretroviral treatment and 7,670 patients are already on treatment. This is an increase of more than 200% from 2003/04 where 2 339 patients were on treatment

There is also a comprehensive network of NGO run hospice/step down care facilities (15) and all of these are linked to home-based care services (62,922 patients in 2004/05). All these NGOs providing hospice, step-down and home based care are subsidised by the Provincial Health department. The Department is gearing up local authority clinics to provide first contact ambulatory care for HIV positive patients including and up to conducting a CD4 count with a view to referral to an ARV centre.

Post Exposure Prophylaxis (PEP) for occupational exposure to HIV and sexual abuse is offered in 100% of hospitals.

There were 103,804 clients treated for sexually transmitted infections (STIs) however the STI partner treatment rate of 20.9% in 2004/05 is a significant decrease from 26.4% in 2003/04 and there has been a 45% increase in STI caseload from 2003/04 to 2004/05. This points to continuing challenges in implementing effective prevention programs.

A key challenge to the Department is dealing with the growing TB epidemic in light of the increasing rate of co-infection of TB and HIV. Currently 30% of TB patients in the Western Cape are co-infected with HIV resulting in high morbidity and mortality rates in this group. Pulmonary TB in the Western Cape has steadily increased over the past 7 years as shown in figure 2. From 1997 to 2003, TB increased by 38%, however like the HIV prevalence in 2004 there was no statistically significant increase in the number of TB cases. However, the Department is committed to managing the huge burden of the TB epidemic.

Since July 1996 the Province has been implementing the WHO Directly Observed Treatment Strategy (DOTS) which is the basis of strategic planning and implementation of TB control in the province. The DOTS Strategic framework consists of five essential elements namely:

1) Sustained political commitment to increase human and financial resources to make TB control a nation wide priority and an integral part of the national health system:
2) Access to quality-assured TB microscopy
3) Standardized short-course chemotherapy
4) Uninterrupted supply of quality-assured drugs
5) Recording and reporting system enabling an outcome assessment of each patient and assessment of overall programme performance. Local capacity to analyse and use routinely collected data should be strengthened.

In terms of the performance of the Province with regards to the TB program in line with the DOTS Strategy Framework, TB is an integral part of the health system and TB is budgeted for as one of the PHC priority diseases. Furthermore, compared to 2001/02, expenditure of TB hospitals has increased by 39% to R68 million in the revised Appropriation Budget of 2005/06.

To improve access to quality-assured TB microscopy, the Department utilises the services of the contracted National Health Laboratory Services for all TB diagnostic services. There are 7 laboratories that provide TB laboratory services in the province. Green Point laboratory is the largest accredited TB laboratory in the southern hemisphere and performs approximately 473 000 TB direct microscopic examinations and cultures per annum. Specimens are transported to the various laboratories daily to meet the target of a 48-hour turn-around time for TB microscopy. 70% of specimens in the province achieve a turn-around time of 48 hours and less.

Following the WHO-recommended treatment guidelines a new fixed four-drug combination (RHZE 150, 75, 400, 275) was phased in during 2004. All districts were trained on the new FDC's, and all districts commenced implementation during 2004. Total stock outs of streptomycin were experienced throughout the country during 2004 when the sole supplier stopped production. This problem has been resolved.

A new windows based electronic TB drug register has been fully implemented in order to improve the recording and reporting system enabling an outcome assessment of each patient and assessment of overall programme performance. Local capacity to analyse and use routinely collected data is also being strengthened.

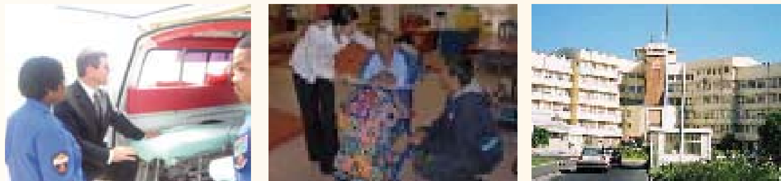
TB treatment outcomes are showing steady improvement in the Province. The New Smear Positive (NSP) Cure rate has improved from 68% in 2002/03 to 72% in 2003/04. This is significantly above the national rate of 57%. The NSP treatment interruption rate has also decreased by a further 1% from 13% in 2002/03 to 12% in 2003/04. Treatment outcomes for pre-treatment cases are much less favourable at a cure rate of 62% and an interruption rate of 19%.

It is, however, encouraging that the MDR tuberculosis rate in the Province was found to be 1% in new patients and 4% in patients with a prior history of tuberculosis treatment in a study conducted by the MRC in 2002. The provincial TB programme is currently not collecting data on MDR TB patients due to a lack of a well functioning information system for MDR TB. However, it is estimated that the province has between 422 and 770 new MDR TB cases per annum as most MDR patients are admitted for the intensive phase of treatment.

The Province continues to have a huge TB burden and the Department is committed to addressing this challenge by providing the resources required. The Department has also committed itself to provincialise the four TB hospitals that are not currently managed by the Provincial Department of Health during the next financial year to ensure the efficient functioning of these services.

Table 2.2 Situational analysis indicators for HIV and AIDS, STI's and TB control [HIV1]

Indicator	Type	Province wide value	Province wide value	Boland	Overberg	Eden	Central Karoo	West Coast	Cape Town Metro
		2003/04	2004/05	2004/05	2004/05	2004/05	2004/05	2004/05	2004/05
Input									
1. ARV treatment service points compared to plan	%	106% (16/15)	100% (33)	100% (2)	100% (4)	100% (4)	100% (1)	100% (5)	100% (20)
2. Fixed PHC facilities with ANC offering PMTCT	%	100%	100%	100% (42/42)	100% (23/23)	100% (39/39)	100% (11/11)	100% (46/46)	100% (24/24)
3. Fixed PHC facilities offering VCT	%	100% 60/260)	100% 260/260)	100% (42/42)	100% (23/23)	100% (39/39)	100% (11/11)	100% (46/46)	100% 119/119)
4. Hospitals offering PEP for occupational HIV exposure	%	100% (53/53)	100% (53/53)	100% (8/8)	100% (4/4)	100% (8/8)	100% (5/5)	100% (8/8)	100% (20/20)
5. Hospitals offering PEP for sexual abuse	%	67.9% (36/53)	77.3% (41/53)	100% (6/6)	100% (4/4)	100% (8/8)	100% (7/7)	100% (8/8)	40% (8/20)
6 HTA Intervention sites compared to plan	%	0	3	0	0	0	0	0	3
Process									
7 TB cases with a DOT supporter	%	88.3	90%	Information not available per district.					
8. Male condom distribution rate from public sector health facilities	No	10.3	15.3	5.2	3.7	4.7	9.6	4.9	21.2
Male condom distributed		16,715,351	25,265,502	187,674	288,278	763,060	192,189	510,979	22,323,322
Male population >15 years		1,618,463	1,642,114	226,538	78,583	163,962	20,094	104,828	1,048,109
9. Male condom distribution rate from primary distribution sites	No	17.3	15.3	5.2	4.3	5.8	11.3	5.0	24.1
10. Fixed facilities with any ARV drug stock out	%	No data	0	0	0	0	0	0	0
11. Hospitals drawing blood for CD4 testing	%	No data	No data	No data	No data	No data	No data	No data	No data
12. Fixed PHC facilities drawing blood for CD4 testing	%	No data	No data	No data	No data	No data	No data	No data	No data
13. Fixed facilities referring patients to ARV treatment points assessment	%	No data	No data	No data	No data	No data	No data	No data	No data
Output									
14. STI partner treatment rate	%	17.58	21	18	33	18	25	14	22
Number of STI partners treated	No.	19,541	21552	2,058	1,198	1,567	316	830	15,583
Number of STI treated – new episode	No.	111,169	103,804	11,611	3,661	8,805	1,282	6,059	72,386
15. Nevirapine dose to baby coverage rate	%	90	97	101	101	94.8	94.8	93.6	98.9
16. Clients HIV pre-test counselled rate in fixed PHC facilities	%	1.6	7.1	0.86	0.98	2.2	2.3	2.4	1.6
Number of PHC clients pre-test counselled	No.	208,380	240,500	18,621	Not available	34,936	Not available	34,799	150,632
17. Patients registered for ART compared to target	%	100		100	100	100	100	100	100
18. TB treatment interruption rate	%	12	11.5	10.7	4.6	11.2	14.2	11.8	13.6
Quality									
19. CD4 test at ARV treatment service points with turnaround time > 6 days	%	No data	No data	No data	No data	No data	No data	No data	No data
20. TB sputa specimens with turnaround time > 48 hours	%	30	26	Information not available per district.					
Efficiency									
21. Dedicated HIV/AIDS budget spent	%	70.3	100	Information not available per district.					
Outcome									
22. New smear positive PTB cases cured at first attempt	%	68%	72%	68.6%					
23. New MDR TB cases reported – annual % change	%	0	0	0	0	0	0	0	0
24. STI treated new episode among ART patients – annual % change	%	No data	No data	No data	No data	No data	No data	No data	No data
25. ART monitoring visits measured at WHO performance scale 1 or 2	%	No data	No data	No data	No data	No data	No data	No data	No data



4.2.2 Maternal, Child and Women's Health

In terms of National Policy Health Act 116 of 1990 all maternal deaths, *death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or it's management,* were made notifiable since 1 October 1997. This is applicable to both the public and private sector. A National Committee on Confidential Enquiry into Maternal Deaths (NCCEMD) was appointed to investigate all maternal deaths and make recommendations based on the confidential study to address maternal mortality and provide safe obstetric care in South Africa.

In the Western Cape the number of reported maternal deaths has increased from 34 in 1998 to 71 in 2004. The estimated MMR in the province for 2000 was 58.72/100 000 much lower than the national estimate of 150/100 000. By 2003 the MMR for the Province had increased to 70.7/100 000. This increase is attributable mainly to communicable diseases and in particular HIV and AIDS.

With regards to services that the Province provides for women's and maternal health, Table 2.3 below shows that in 2004/05 86% of hospitals and 66% of CHC's offered TOP services. This is a significant increase from 83% in hospitals in 2003/04 and a 100% increase for CHC's from 2003/04. However, antenatal coverage and cervical cancer screening have been steadily decreasing from 91.2% in 2002/03 to 87.9% in 2003/04 to 82.2% in 2004/05 for antenatal coverage from 43.6% in 2002/03 to 40.3% in 2003/04 to 38.9% in 2004/05 for cervical cancer screening. Similarly the institutional delivery rate for women under 18 years has increased significantly by 31% from 8.5% in 2003/04 to 11.1% in 2004/05.

The under five mortality rate in the Province has been measured at 46 per 100 000 with the main contributing causes being infectious diseases (diarrhoeal disease, parasitic infections, respiratory diseases) as well as non-communicable diseases (under/mal-nutrition and trauma being the main causes).

To deal with diarrhoeal disease, the province has increased the implementation of IMCI at PHC facilities by 58% from 50% in 2003/04 to 79% in 2004/05. There has also been a 50% increase in facilities certified as baby friendly in the same period. Only 2.6% children under 5 years were not gaining weight in 2004/05 a slight decrease from the previous year.

Immunisation coverage has also been very good with 91.3% of children under one fully immunised and 91.7% measles coverage for children under 1 year. Of concern however, is the 1450% increase in measles cases from 2 cases in 2003/04 to 31 cases in 2004/05.

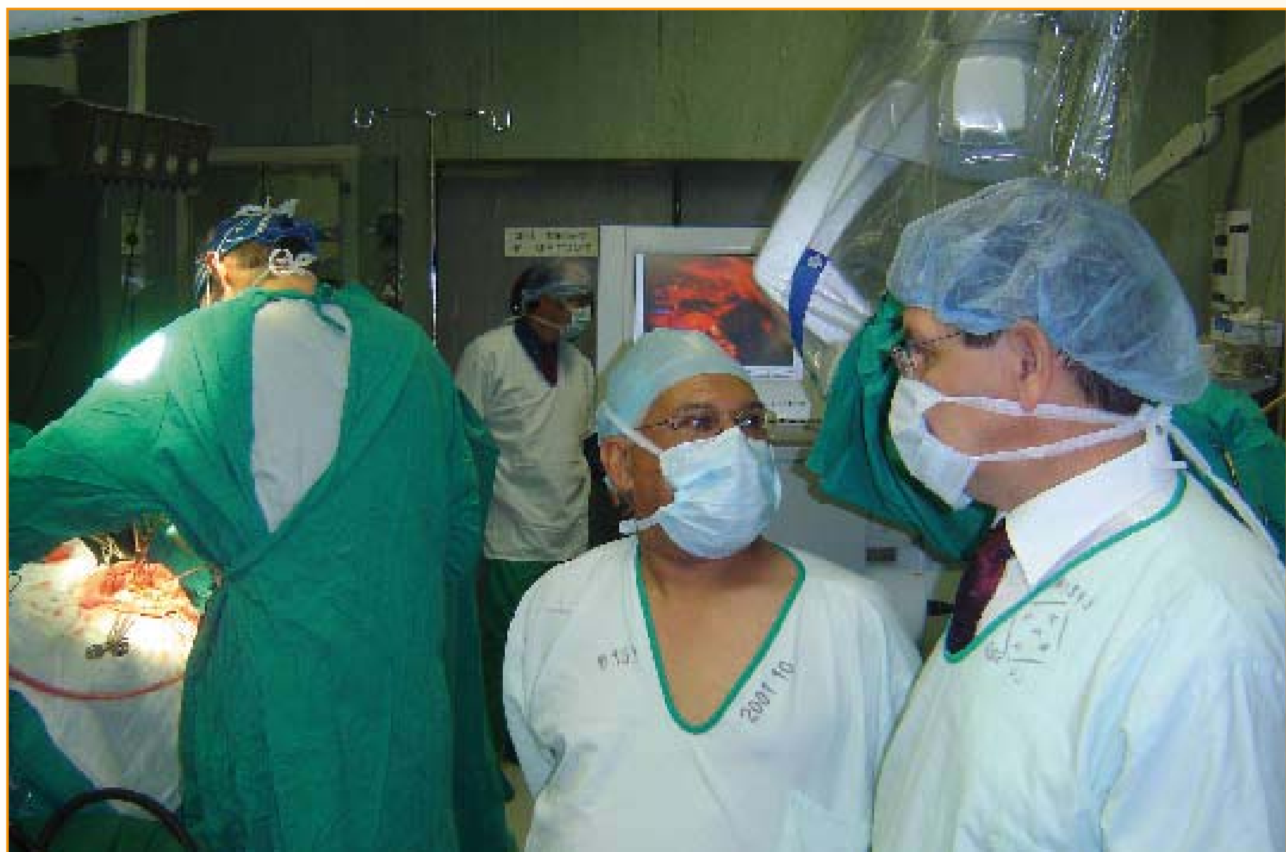


Table 2.3 Situation analysis indicators for Maternal, child and women's health and Nutrition [MCWH]

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Boland 2003/04	Overberg 2003/04	Eden 2003/04	Central Karoo 2003/04	West Coast 2003/04	City of Cape Town 2003/04
Incidence										
Population under 5 years		405,542	411,828	418,212	60,992	19,064	43,203	6,673	27,556	260,723
1. Incidence of severe malnutrition under 5 years	%	5.9	4.4	4.2	6.6	10.4	6.4	7.5	3.3	2.9
Number of severe malnutrition under 5 years	No.	2,385	1,815	1,761	400	198	277	50	92	744
2. Incidence of pneumonia under 5 years	%	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected
Number of children under 5 years with Lower Respiratory Infection	No.	66.194	62,321	66,859	7,936	2,072	5,330	2,337	3,119	46,065
Incidence of Lower Respiratory Infection under 5 years	%	16.3%	15.1%	16.0%	13.0%	10.9%	12.3%	35.0%	11.3%	17.7%
3. Incidence of diarrhoea with dehydration under 5 years	%	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected
Number of children under 5 years with diarrhoea	No.	40,400	43,735	38,476	4,403	1,183	2,273	868	1,753	27,996
Incidence of diarrhoea under 5 years	%	10.0%	10.6%	9.2%	7.2%	6.2%	5.3%	13.0%	6.4%	10.7%
Input										
4. Hospitals offering TOP services	%	N/A	N/A	88%	75%	75%	83%	100%	88%	100%
5. CHCs offering TOP services	%	N/A	N/A	33%	0%	0%	0%	0%	0%	0%
Process										
6. Fixed PHC facilities with DTP-Hib vaccine stock out	%	Not measured	Not measured	Not measured	Not measured	Not measured	Not measured	Not measured	Not measured	Not measured
7. AFP detection rate	%	1.6	1.8	1.8	Not available	Not available	Not available	Not available	Not available	Not available
8. AFP stool adequacy rate	%	64%	78%	92%	Not available	Not available	Not available	Not available	Not available	Not available
Output										
9. Schools at which phase 1 health services are being rendered	%	Not measured	Not measured	20%	Not measured	Not measured	Not measured	Not measured	Not measured	Not measured
10. (Full) Immunisation coverage under 1 year	%	Not available	Not available	90%	Not available	Not available	Not available	Not available	Not available	Not available
Measles at 9 months	%	70,784	75,256	79,500	10,115	3,391	7,200	1,055	4,471	53,268
Measles at 9 months coverage	%	81.8%	85.6%	89.1%	79.0%	83.8%	78.8%	80.1%	76.8%	94.9%
Population under 1 year	No.	86,555	87,897	89,259	12,809	4,046	9,132	1,317	5.819	56,136

4.2.3 Chronic diseases

Amongst the causes for death in Cape Town, chronic diseases including cardiovascular conditions and diabetes mellitus are amongst the highest. The highest burden of disease is in poorer communities including Athlone (843/100 000), Mitchells' Plain (832/100 000), Tygerberg West (735/100 000) and Nyanga (719/100 000).

Non-communicable diseases traditionally associated with increasing wealth and also known as Chronic Diseases of Lifestyle; in South Africa and Cape Town affect the poorest communities the greatest (Bradshaw et al. 2002). The highest burden of disease is in Athlone and Mitchell's Plain (843/100,000 and 832/100,000 respectively), followed by Tygerberg West and Nyanga (735/100,000 and 719/100,000 respectively). These data indicate that high levels of chronic conditions, particularly cardiovascular diseases and diabetes also afflict poorer communities.

According to research published by Sitas, et al, if smokers had the same death rate as non-smokers, 58% of lung cancer deaths, 37% of deaths resulting from chronic obstructive airways disease (COPD), 20% of tuberculosis deaths, and 23% of vascular deaths would have been avoided. Approximately 8% of all adult deaths in South Africa, i.e. more than 20 000 per year were caused by smoking.

With non-communicable diseases having such an impact on the health status of communities, health promotion, disease prevention, treatment and rehabilitation have to be integrated. However one of the key shortcomings with regards to the provision of chronic medicines has been the interruption in supplies. During the past year an alternative dispensing mechanism has been put in place in each of the four Regions and strenuous efforts were made to improve the functionality of the Cape Medical Depot.

4.2.4 Violence and trauma

While mortality rates are greatest in Khayelitsha and Nyanga, premature mortality due to violence and trauma (as a factor of years of life lost) is up to a factor of 1,5 times[10] higher in these sub-districts. The highest rate of injuries (e.g. homicide) is in young males aged 15 – 40 years old, with Khayelitsha and Nyanga showing the highest rates of injuries (120/100 000 and 133/100 000) and Blaauwberg and the South Peninsula the lowest rates (33/100 000 and 35/100 000). These latter two figures correlate well with generally accepted averages for middle income developing countries of 32,1 per 100 000.

Between April 2002 and March 2003 a total number of 6 502 cases of rape were reported in the Province. In addition 4 402 cases of child abuse were reported. This figure represents an increase of 62% over the figure for 2002. A number of dedicated centres for the management of clinical forensic services were initiated in 2003. These services are located in the district hospitals and 24-hour Community Health Centres. The programme has met with mixed success due to the difficulty in recruiting suitably trained personnel.

4.3 Health System

4.3.1 District Health System

Within the health districts no formalised governance and management structures, as determined by the National Health Act of 2003, have been created as yet however the previous regional management structures are managing the districts in the interim. The Department of Health is assuming responsibility for all personal primary health care in the non-metropolitan districts in keeping with the requirements of the National Health Act and the Local Government: Municipal Demarcation Act.

Management systems in many districts are rudimentary and poorly coordinated between local and provincial government and are incapable of improving service delivery to a significant degree, given the degree of fragmentation and overlap. The process of developing joint district health plans has improved this situation in some of the districts. The Department will focus on improving this situation during the next year by starting to implement the District Management Structures.

Roles of the provincial Department of Health and the municipal authorities in delivering primary health care services

Local authorities have traditionally provided the bulk of preventive and promotive services, whilst the Provincial Government provides curative services. In many instances, services are delivered within the same facility, but managed separately by different authorities. According to the District Health Expenditure Review (DHER) and a recent costing study conducted by the Provincial Treasury, Local Government contributes approximately 10% of the total PHC funding in the province.

The funding that Local Government invested in the provision of preventative PHC services was estimated to be approximately R180 million. This funding gap has been addressed by provincialising the rural districts first in 2005/06 followed by the Metro region in the next few years.

Existing provincial and local government services:

The level of service provision appears to be adequate on a provincial level with a per capita attendance at a Primary Health Care (PHC) facility of 3,8 visits per annum, including DOTS. However, there are inequalities between the various districts. The District Health Expenditure Review (DHER) conducted in 2005 indicated the areas with the lowest number of PHC attendances are Boland and Overberg, i.e. 2,4 and 2,6 respectively, and the area with the highest utilisation rate is the Central Karoo with an attendance rate of 4,0. The utilisation rate for the Central Karoo must be viewed in the context that this district has the lowest population density in the province and mobile units service a large proportion of the population.

4.3.2 Primary Health Care facilities

As shown in Table 2.6 on page 49, the Western Cape primary health care service comprises 220 fixed and 126 mobile clinics, 63 community health centres and 27 district hospitals. Currently the clinics in the non-metro districts are being provincialised. The provincial Department of Health (DOH) is responsible for the majority of community health centres. These facilities serve a population of 4.5 million spread over 129 370 km^2.

Table 2.4 District health service facilities by health district [DHS1]

Health district1	Facility type	No.	Population (Uninsured)	Population per PHC facility5	Per capita utilisation6
WEST COAST	Non fixed clinics3	37	243,506	5,294	3.23
	Fixed Clinics4	44			
	CHCs	2			
	Sub-total clinics + CHCs	46			
	District hospitals	7			
BOLAND	Non fixed clinics3	21	535,610	12,753	2.60
	Fixed Clinics4	36			
	CHCs	6			
	Sub-total clinics + CHCs	42			
	District hospitals	4			
OVERBERG	Non fixed clinics3	13	179,639	7,810	2.84
	Fixed Clinics4	21			
	CHCs	2			
	Sub-total clinics + CHCs	23			
	District hospitals	4			
EDEN	Non fixed clinics3	30	391,919	10,049	3.55
	Fixed Clinics4	30			
	CHCs	9			
	Sub-total clinics + CHCs	39			
	District hospitals	6			
CENTRAL KAROO (Rural development node)	Non fixed clinics3	6	57,256	5,205	4.68
	Fixed Clinics4	10			
	CHCs	1			
	Sub-total clinics + CHCs	11			
	District hospitals	4			
METROPOLE	Non fixed clinics3	24	2,104,939	17,689	4.18
Province	Fixed Clinics4	71	3,512,870	12,546	3.74
	CHCs	48			
	Sub-total clinics + CHCs	119			
	District hospitals	3			
	Non fixed clinics3	131			
	Fixed Clinics4	212			
	CHCs	68			
	Sub-totalclinics + CHCs	280			
	District hospitals	28			

Almost two-thirds of the population of the province resides in the Cape Peninsula within the demarcated boundaries of the City of Cape Town. Seventy-one fixed clinics and 48 community health centres are found in the Metropole. The rest are spread through large and small towns in the rural areas. Although small in number, people living in small villages and farms are reached by mobile clinics and have to make their way to the nearest towns for treatment of serious illnesses or for more sophisticated health interventions.

Seventy three per cent of the population depends on the public health sector for their health care. The rest of the population has medical insurance and generally utilises private health care, which is well developed. As shown in Table 2.5 currently there are 12,184 PHC client visits with DHS expenditure per uninsured person of R 341 including Local Government spending.

Table 2.5 Situational analysis indicators for District Health System Indicators [DHS 3]

Indicator		Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05	National target 2005/06
Input						
1	Uninsured population served per fixed public DHS facility	No	11,184	12,354	12,184	
2	Provincial DHS expenditure per uninsured person	R	212	241	289	N/A
3	Local government DHS expenditure per uninsured person	R	44	54	54	N/A
4	DHS expenditure (provincial plus local government) per uninsured person	R	256	295	341	227
5	Professional nurses in fixed DHS facilities per 100,000 uninsured person	No	Not available	40.34	41	107
6	Sub-districts offering full package of DHS services	%	Not available	65	80	60
7	EHS expenditure (provincial plus local govt) per uninsured person	R	Not available	Not available	Not available	9
Process						
8	Health districts with appointed manager	%	0	0	66.6	
9	Health districts with plan as per DHP guidelines	%			100	92
10	Fixed PHC facilities with functioning community participation structure	%	Not available	29	40	69
11	Facility data timeliness rate for all PHC facilities	%	Not available	Not available	Not available	80
Output						
12	PHC total headcount	No	13,101,550	12,997,879	12,884,522	N/A
13	Utilisation rate - PHC (uninsured population)	No	4	3.9	3.8	
14	Utilisation rate - PHC under 5 years	No	1.8	1.9	2.1	3.8
Quality						
15	Supervision rate	%	Not available	Not available	Not available	78
16	Fixed PHC facilities supported by a doctor at least once a week	%	Not available	Not available	Not available	31
Efficiency						
17	Provincial PHC expenditure per headcount at provincial PHC facilities	R	55	63	79	99
18	Expenditure (provincial plus LG) per headcount at public PHC facilities	R	66	78	98	99
Outcome						
19	Health districts with a single provider of PHC services	%	0	0	0	50

At the level of the district health services, there is a severe shortage of health professionals particularly doctors, nurses and pharmacists. There is great difficulty in recruiting and retaining health professionals and many facilities suffer chronic staff shortages.

Table 2.6 Personnel in district health services by health district [DHS2]

Health district	Personnel category	Posts filled	Posts approved	Vacancy rate %	Total Personnel (incl. LG)	Number in post per 1000 uninsured people
West Coast	PHC facilities					
	Medical officers	1	1	0%	3	0.01
	Professional nurses	6	6	0%	78	0.33
	Pharmacists	1	1	0%	N/A	N/A
	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	1	1	0%	1	0.004
	Professional nurses	79	93	15%	79	0.33
	Pharmacists	8	8	0%	8	0.03
Boland	PHC facilities					
	Medical officers	8	11	27%	20	0.04
	Professional nurses	60	75	20%	189	0.36
	Pharmacists	9	11	18%	7	0.01
	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	16	24	33%	16	0.03
	Professional nurses	95	122	22%	95	0.18
	Pharmacists	12	15	20%	12	0.02
Overberg	PHC facilities					
	Medical officers	6	10	40%	4	0.02
	Professional nurses	13	17	24%	70	0.39
	Pharmacists	N/A	N/A	N/A	N/A	N/A
	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	11	17	35%	11	0.06
	Professional nurses	53	70	24%	53	0.30
	Pharmacists	5	5	0%	5	0.03
Eden	PHC facilities					
	Medical officers	14	14	0%	12	0.03
	Professional nurses	22	47	53%	133	0.34
	Pharmacists	2	4	50%	N/A	N/A
	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	27	30	10%	27	0.07
	Professional nurses	139	163	15%	139	0.36
	Pharmacists	11	13	15%	11	0.03
Central Karoo	PHC facilities					
	Medical officers	3	3	0%	5	0.09
	Professional nurses	6	6	0%	31	0.55
	Pharmacists	1	2	50%	1	0.02
	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	3	2	0%	3	0.05
	Professional nurses	17	26	35%	17	0.30
	Pharmacists	3	3	0%	3	0.05

Health district	Personnel category	Posts filled	Posts approved	Vacancy rate %	Total Personnel (incl. LG)	Number in post per 1000 uninsured people
Metropole	PHC facilities					
	Medical officers	133	175	24%	96	0.12
	Professional nurses	479	578	17%	838	0.40
	Pharmacists	47	61	23%	45	0.02
	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	21	24	13%	21	0.01
	Professional nurses	82	90	9%	82	0.04
	Pharmacists	7	7	0%	7	0.003
Province	PHC facilities					
	Medical officers	165	214	23%	165	0.05
	Professional nurses	586	729	20%	586	0.17
	Pharmacists*	N/A	N/A	N/A	N/A	N/A
	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	79	98	19%	79	0.02
	Professional nurses	465	564	18%	465	0.13
	Pharmacists	46	51	10%	46	0.01

In the past insufficient attention has been paid to the organisation and development of primary health care services and a lack of management capacity has arisen at the PHC level, together with a lack of computerisation of these facilities and the neglect of physical infrastructure. To improve this situation, decentralised district health system is being strengthened. Currently 66.6% of health districts have an appointed manager and 100% health districts have a district plan while 40% of districts have a functioning community participation structure.

Currently the network of PHC facilities is inadequate to provide a decentralised system that is effective and efficient. Implementation of an information, communication technology system is being implemented with computerization of the community health centres with a view to networking all community health centres and ultimately have access to a PHC information management system that includes patient administration and access to hospital, laboratory and pharmacy information. The necessary information technology infrastructure is also being created in the major community health centres in order to allow managers access to the Provincial intranet and other applications. This will expedite the procurement process, human resource management process as well as improve the ability to collect service related data in facilities. Currently 15 CHC's have been networked and have access to the Provincial intranet

4.3.3 Community Based Services (CBS)

Rapid expansion and improvement of community-based services has been undertaken through the implementation of a new integrated model for home-based and step-down care (including hospice) and an improved management of NGO partners. This service has been funded mainly from the European Union for home-based care, and from the Global Fund for step-down care. The implementation of this structured Community based programme has offered exciting opportunities to the Division, with regard to improving quality of services, providing an additional interface with communities and consumers and supporting social capital imperatives of "iKapa Elihlumayo".

CBS are currently rendered in all sub-districts across the Province. However the services are still fragmented according to vertical health programmes and the respective service providers (mostly function specific NPO's e.g.). A consequence of this service fragmentation is fragmented line management, a lack of integrated planning and management of CBS.

The management and planning of CBS has been further complicated by a flow of diverse sources of funding. Most of the funding for CBS is "seed money" sourced from donor funding and Conditional Grants – all with different criteria and conditions attached.

4.3.4 District hospitals

Historically a very strong network of hospitals has existed in the Western Cape, but the location and staffing of these hospitals has proven to be inappropriate for the creation of a District Health System. During the past decade concerted efforts have been made to strengthen Regional Hospital services in the rural regions. These efforts have generally been successful despite challenges in recruiting and retaining staff. There still exists some overlap in function between some of the bigger District Hospitals and the Regional Hospital, particularly in towns where a single hospital cannot fulfil the functions of both Regional and District Hospital, e.g. George. In two studies done in Province (source Belinda Jacobs and Nils Bergman) it was found that a significant proportion of services provided at Regional (level 2) hospitals could be classified as Level 1 services and about 50% of services at tertiary hospitals were actually level 2 services.

There are currently 1 546 level 1 beds in the Province and the restructuring of Health services according to the HealthCare 2010 policy imperatives will see an increase of 33% to 2 056 beds in 2005/06 and another 15% increase to 2367 in 2007/08. As shown in Table 2.6 below, expenditure on hospital staff as a percentage of total hospital expenditure has however decreased slightly from 75.9% in 2002/03 to 71.7% in 2004/05. On the other hand expenditure on drugs and total hospital expenditure have increased slightly.
Operationally, 100% of all district hospitals have an operational hospital board and CEO in place and 90% of hospitals submit hospital data on time. In 2004/05 there per 213 PDE's/ 1000 uninsured population, a 7% increase from the previous two years. The caesarean section rate has also increased by about 65% in the last two years from 6.5% in 2002/03 to 10.7% in 2004/05.

It is encouraging that 100% of district hospitals have a clinical Monitoring and Evaluation (M&E) meeting, have a designated official responsible for coordinating quality management and have conducted and published a patient satisfaction survey in the last 12 months. It is also encouraging that bed utilisation is steadily increasing and is currently 76%. There is less than 1% case fatality for surgery separations. However only 31% of facilities are in condition 4 or 5, a 158% decrease from 2002/03. This suggests that the infrastructure of district hospitals requires urgent action in order to maintain and improve the quality of care provided y the district hospitals.

4.3.5 Forensic pathology services (Sub-programme 2.8)

The transfer of the "Medico-Legal Mortuaries" from the South African Police Service (SAPS) to the Provincial Departments of Health has been approved for 1 April 2006. The Department of Health, Provincial Government Western Cape will establish a new Forensic Pathology Service (FPS) in the Province that will render a service via two M6 Academic Forensic Pathology Laboratories in the Metro, three Regional Referral FPS Laboratories and smaller FPS Laboratories and Holding Centres in the West Coast / Winelands, Boland / Overberg, and Southern Cape / Karoo Regions.

The Western Cape FPS will be managed through a central unit that will be responsible for the management and coordination of the service. The FPS is being developed as a new service but it has a history of having been divided between SAPS and Health, being very under-resourced and having been rendered without a clear service framework or plan. The Cabinet decision to move the responsibility for the mortuary component out of SAPS to the Department of Health means that the entire service will be under a single function, but managed by the nine provinces.

Table 2.7 Situational analysis indicators for District Hospitals sub-programme [DHS4]

Indicator		Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05	National target 2004/05
Input						
1	Expenditure on hospital staff as % of district hospital expenditure	%	75.9	73.0	71.7	
2	Expenditure on drugs for hospital use as % of district hospital expenditure	%	5.9	6.3	6.5	11
3	Expenditure by district hospitals per uninsured person	R	101	108	114	
Process						
4	District hospitals with operational hospital board	%	90	100	100	76
5	District hospitals with appointed (not acting) CEO in post	%	86.0	86.0	100.0	69
6	Facility data timeliness rate for district hospitals	%	90.0	90.0	90.0	34
Output						
7	Caesarean section rate for district hospitals	%	6.5	8.2	10.7	12.5
Quality						
8	District hospitals with patient satisfactory survey using DoH template	%	36	50	100	10
9	District hospitals with clinical audit (M & M) meetings every month	%	50	85	100	36

Indicator		Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05	National target 2004/05
Efficiency						
10	Average length of stay in district hospitals	Days	2.6	2.6	2.5	4.2
11	Bed utilisation rate (based on usable beds) in district hospitals	%	65	66	76	68
12	Expenditure per patient day equivalent in district hospitals	R	517	550	543	814 in 2003/04 prices
Outcome						
13	Case facility rate in district hospitals for surgery separations	%	0.62	0.62	0.63	3.9

5. POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

5.1 Policy Context

Three broad policy developments inform the provision of primary health care and district hospital services. These are the National Health Act, 2003 (no.61 of 2003), the Healthcare 2010 strategy, adopted in 2002, and the provincial objective of social capital formation as described in iKapa Elihlumayo. The National Health Act will establish the district health system and with it new boundaries, governance structures, planning and reporting formats.

One of the key strategies of HealthCare 2010 is to "reshape public health services to focus on primary-level services, community based care and preventative care". This change in strategy will see the expansion of community based services, increased funding and improved management and efficiency of clinics and community health centers and increased numbers of district hospital beds. The foundation for implementing this strategy will be an integrated approach of community-based services, facility based services and support services

Programme 2 is a key role-player in the Department's Social Capital Formation initiatives as a result of the Primary Health Care (PHC) focus on which Healthcare 2010 is based. The Western Cape Department of Health has committed itself to "improving the health of all people in the Western Cape, by ensuring the provision of a balanced health care system, in partnership with all stakeholders, within the context of optimal socio-economic development". The people that the department serves, live and work within a broader social and economic context, which can either support or break-down their overall health and well-being. Furthermore, a social capital based approach to health, which emphasises all the key elements of the primary healthcare approach and leverages civil society resources, if well conceptualised and implemented, may also lower the financial pressure on the Department.

To meet the healthcare needs of the people in the Western Cape, the Department's activities and programmes must be integrally linked to their needs, to their ability to access services and to their willingness to be involved and participate in managing their own health and the overall health of their community. This is central to the ideology of social capital, that is, building a community rich in social cohesiveness, together working towards (social action) improving health outcomes and in so doing, improving the community climate for success. Increased social cohesion provides the Department with an opportunity to strengthen and further grow the networks with the communities it has, and establish a platform for real dialogue with local communities

Within the context outlined above, a strategy for building social capital through the development of a divisional plan towards the long-term realization of the "iKapa Elihlumayo" vision has been developed. Linked to this notion is the focus on equity and the provision of and access to resources. Focusing on equitable delivery mechanisms should point clearly to a more broad-based, integrated health promotion and comprehensive health care approach.

The policy options for which funding has been allocated for 2006/07 are the following:

1) An amount of R10 million has been allocated for the appointment of additional staff for the Metro District Health Services. This policy option aims to strengthen the Primary Health Care (PHC) delivery system by employing six senior family physicians for six 24-hour Community Health Centres (CHC) and filling approximately 106 nursing posts at both the Community Health Centres and the district hospitals.
2) Funding is required to establish extended hours of service for one CHC per sub-district. The Department has adopted the strategy to implement a nurse-driven service providing the comprehensive PHC package at CHCs for an extended period, i.e until 21:30. It is anticipated that this will improve access to services and also relieve the burden of non-emergency visits to emergency services. An amount of R4 million is allocated to this process.

3) An amount of R12,5 million was allocated to improve the Tuberculosis (TB) services, particularly in the clinics and the mobile clinics. The HIV and Aids epidemic is a significant factor in the increase of TB within the province. It is estimated that TB is responsible for a third of all deaths in HIV infected people, therefore strengthening this service will result in more effective management of the dual epidemic of HIV and TB.

4) An amount of R10 million has been allocated for the strengthening of district management and PHC by establishing district management structures and support staff establishments in the four Metro districts and in each of the rural districts. This will facilitate the effective functioning of the District Health System in line with demarcated district boundaries and will contribute towards the establishment of the governance structures (District Health Councils, sub-district health structures and Health Facility Boards) as well as the provision of appropriate management support particularly relating to finance, human resource management and the monitoring and evaluation of performance. The timing of the implementation of this policy option is, however, dependent on the approval of the Service Plan.

5.1.1 Social Capital Formation

Health care 2010 recognises the limitations of the medical model of health care in influencing the physical, social and economic environment in improving health holistically. It is for this reason that it advocates for collaboration and partnerships with all relevant stakeholders in building healthy communities and realising the true definition of health according to the World Health Organisation (health is the physical, social and mental well-being and not merely the absence of disease and infirmity).

The strategic priorities for the National Health System (2004-2009) have included the promotion of healthy lifestyles as one of its indicators and targets. Intervention strategies are focused at nutrition, substance abuse, tobacco use, health promoting schools, and household

The Western Cape strategy of Ikapa Elihlumayo and Social Capital formation focuses on building healthy communities through intensive collaboration between the public sector and the civil society. This strategy aims at the development of the community through social and economic empowerment with special emphasis on women and youth.

As a support department in the Social Capital Formation strategy, the foundation of the Department of Health's strategy is the promotion of an efficient and effective Primary Health Care service which will provide equal access to quality healthcare and is also the foundation of Healthcare 2010.

Social Capital in integrated into all 8 Divisional priorities as shown in Table 2.8 below.

Table 2.8 Social Capital Linkages to the 8 Divisional Priorities

Priority	Social Capital linkages
District Health System	Governance structures (District Health Councils; sub-district health structures; health facility boards)
Community based services	Employment of community based workers (via NPOs); sub-district co-ordinating structures
District Hospitals	Health Facility Boards (HFB)
Chronic disease management	Therapeutic groups; community based workers (adherence supporters/ health promoters)
TB	Community DOTS supporters
HIV and AIDS	Multi-sectoral Action teams (MSATs); community based ARV adherence support; HIV prevention, VCT and PMTCT lay counsellors
Women's Health	Support to abused women; outreach to women's organisations
Child Health	Community and household IMCI

The Division has identified three focal social capital formation issues, two relating to child health and one relating to the management of chronic diseases to be addressed with a focus on the Metropole:

1) The Integrated Management of Childhood Illnesses (IMCI) with a specific emphasis on the management of diarrhoeal disease;
2) The strengthening of the immunisation programme;
3) The management of chronic diseases to ensure continuity of care.

This will be further developed and extended during 2006/07.

Key Strategies:

1) Internal capacity building:
2) Expansion of Community IMCI interventions:
3) Expansion of community based chronic disease management interventions:
4) Expansion of Health Promoting Schools (HPS) interventions in support of the intervention priorities.

5.1.2 Divisional priorities

In keeping with the National Health Act, Millennium Development Goals, iKapa Elihlumayo, Healthcare 2010 and the burden of disease, the following eight Divisional Priorities have been identified.

The first group of priorities relates to the key health care delivery system components that are critical in the transformation of the service delivery platform. The implementation of the district health system is seen as the key to unlocking efficient and effective service delivery at the interface with the patients. These are:

1) Strengthening the District Health System
2) Community-based services[11]
3) District Hospitals
4) Chronic disease management[12]

By creating the appropriate infrastructure, eliminating duplication and inefficiency and creating the environment for staff to perform coherently it is anticipated that many of the problems can be corrected. Three additional vital support initiatives have been identified which are, the strengthening of community-based services, improvement of the district hospital platform and improved management of chronic diseases.

The second group of priorities relates to priority health programmes deemed critical to improve the overall health of the people of the Western Cape. These programme priorities were selected with the view of serving as the key entry points into improving the overall health status of the communities of the Western Cape, within the context of overall burden of disease in the province.

These are:

1) TB
2) HIV and AIDS
3) Women's health
4) Child health

5.2 Key strategies: System Priorities

5.2.1 Implementation of the District Health System

A review of management structures, staff establishments, infrastructure and financial requirements of the district health system including district hospitals have been conducted in all provincial districts as part of the process of developing a service plan for Healthcare 2010. In line with this, district management capacity will be strengthened together with bringing in of the necessary public health and management expertise at Divisional level to oversee the provision of evidenced based, effective and efficient services in the districts.

The district health system is the vehicle that will be used to move from disaggregated services to comprehensive integrated systems in line with the three policy imperatives already discussed. In this regard four critical areas relating to strengthening the District Health System have been identified.

Key Strategies

1) Establishment of district management structures
2) Decentralisation of management (appointment of facility managers, the development of district management teams)
3) Computerization of facilities (ICT roll-out at CHC's)
4) Provincialisation of PPHC services

5.2.2 Community-based Services

The creation of a different service platform for the community within a re-shaped primary health care context implies that a comprehensive de-institutionalised package of care is designed for those members of the community requiring health within the home environment, support group, a day care facility, schools, old age home, step- down facility and hospice. Community health workers and mid-level workers from within the communities can and must be mobilised, empowered and trained appropriately to provide a wider package of service that includes prevention of diseases, promotion of health, advocacy, development, support, basic care and basic rehabilitation. Thus the following key strategies have been identified for the effective implementation and institutionalisation of the community based services

Key Strategies

1) Provision of services by mid level workers (MLW's) who have been trained by Accredited Training Providers in accordance with accredited curricula as per SAQA approved Unit Standards. Non Profit Organisations will employ these MLW to provide the following services:
   - Services for de-hospitalised clients in sub acute centres, respite centres, chronic/life long care centres, home based care and community mental health centres
   - Community based adherence support for chronic diseases, TB and HIV/AIDS
   - Disease prevention and health promotion services that will focus on community education in the reduction of the impact of risk factors causing the biggest burden of disease such as unsafe sex, inter-personal violence, smoking, alcohol, healthy diet, exercise.
2) Provision of services that are delivered by health personnel to non-health institutions such as Schools, Crèches, Prisons

5.2.3 District Hospitals

District Hospitals play an important part in the provision of an effective and efficient health service. Currently a significant proportion of services provided at level 2 hospitals could be classified as Level 1 services thus affecting efficient use of resources. Thus the main aim is to increase the capacity of district hospitals to provide effective and efficient in-patient, outpatient, trauma and emergency and outreach and support services that are fully integrated into the District Health System, which includes PHC facilities. The key strategies to realise this aims is as follows:

Key Strategies

1) Increase the availability and access of level one hospital beds;
2) Increase theatre cases; and
3) Optimise the in-patient bed capacity.

5.2.4 Chronic Disease Management

Chronic diseases including heart disease, diabetes, hypertension, epilepsy, arthritis, asthma, psychiatric illness and AIDS account for a substantial proportion of clients who regularly seek health care at public health facilities. These are also the patients who, due to a lack of control of their illness, are admitted to hospital beds.

Improvements in the management of chronic diseases at the primary care level will be undertaken, these will include the setting up of primary and secondary prevention, health education and rehabilitation services. The following are the key strategies for Chronic Disease Management.

Key Strategies

1) Developing a package of care for simple chronic disease management at all clinics, which includes the dispensing of, repeat medicine scripts at the clinic level.
2) Introducing family medicine as a specialty in the community health centres to provide clinical governance to PHC particularly for chronic disease Management.
3) Alternative chronic medicine supply through a chronic dispensing unit.
4) Increase community based interventions for persons with chronic diseases through the social capital program

5.2.5 Combat TB epidemic

Building upon the long-term Millennium Development Goals established by the United Nations Development Programme, the National Department of Health has identified TB control as one of the key national priorities for 2004 – 2009 (medium-term goals). In 2006/07 the TB programme will receive an additional R12.5 million to manage this burden of disease. Similarly Healthcare 2010 will be increasing TB beds to 1 287. TB DOTS contacts in community-based care will also be increased to 2,7 million by 2009.

Key Strategies

1) Provincialisation of all four non-provincial TB hospitals to establish an appropriate TB in-patient care platform, in line with the overall departmental 2010 hospital bed plan.
2) Integration of a community based service delivery system that includes an increase in community DOTS to 40% of all treated TB cases
3) Strengthen the capacity of the health facilities to produce a NSP cure rate of 74%

5.2.6 Combat HIV pandemic

The Comprehensive Plan for the Prevention, Treatment and Care for HIV and AIDS forms the foundation for the integrated response developed by this department. To meet the optimistic targets set by the Millennium Development Goals, the National Strategic Priorities have focussed on accelerating the implementation of the Comprehensive Plan. HealthCare 2010 has been built on the changing burden of disease profile as a result of HIV and AIDS, and it assumes additional resources will be added to the existing envelope to deal with the impacts of the additional service burden.

Key Strategies

The Department of Health forms part of the Social Cluster within the Provincial Government. Together with a number of sister departments, it is responsible for the social capital formation strategy, which is one of the lead strategies of Ikapa Elihlumayo and a strategy that underpins the following strategies:

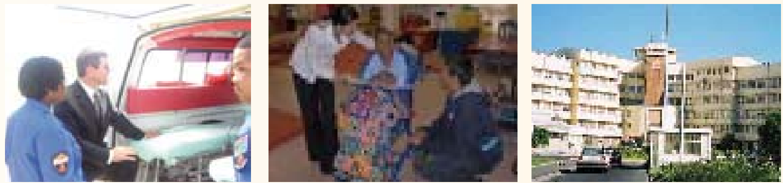
1) For Prevention, the strategy would be to expand the VCT programme to attain a coverage target of greater than 7% of the adult population over the age of 15 years; the provision of condoms, the management of STIs and the provision of PMTCT
2) With its partners the Western Cape Education Department and the Department of Social Services and Poverty Alleviation, major investments in the rollout of peer education (therefore linking closely to the focus on youth) and social mobilisation campaigns.
3) Increasing access to HIV and AIDS Care including ARV provision
4) Provide an integrated community-based care & support program

5.2.7 Women's health

Women's health remains a priority area, but much work is still required to provide women with adequate preventive and curative interventions. More attention will be given in the areas such as the management of rape victims and screening for cervical cancer.

Women's health has been identified in a number of policy documents as a key area for intervention in improving overall health status of communities.

- The Millennium Development Goals seeks to reduce the maternal mortality rate (MMR) by three quarters in the year 2015 translating to reducing MMR to 17 deaths/100 000 by 2015. It also seeks to halve the spread of HIV and AIDS in pregnant women in age 15-24 years.
- Similarly the strategic priorities of the National Health System (2004-2009) aim to strengthen programmes focusing on women and maternal health.



Key strategies

1) Increasing cervical cancer screening coverage is seen as a key element to reducing both morbidity and mortality in women.
2) Increasing coverage of antenatal care in pregnant women, particularly in women less than 20 weeks pregnant
3) Increased access to services for rape survivors and victims of sexual abuse.

5.2.8 Child Health

Greater emphasis is placed on child and youth health. In particular diarrhoeal diseases and the expanded programme on immunization will be tackled more vigorously as key strategies in the Social Capital Formation initiative.

The Millennium Development Goals seek to reduce the under five years mortality rates by two-thirds in 2015 and reduce Infant Mortality Rate to 13 deaths/1000 live births by 2015. The Millennium Development Goals also seek to halve the proportion of people who suffer from hunger.

The Strategic Priorities of the National Health System (2004-2009), aim at eliminating Poliomyelitis by December 2005 and ensuring that no baby dies from measles. The immunisation average of 80% in every district is targeted as well as full implementation of the IMCI strategy within all PHC facilities.

Key Strategies

1) 90% target of full immunization coverage of children below one year.
2) Reduce the incidence of underweight for age below 5 years
3) Increase % of nurses seeing children who have been trained in IMCI
4) Increase the number of sub-districts implementing household and community IMCI

5.3 Forensic pathology services

To provide a Forensic Pathology Service in the Province in accordance with the provisions of the following Acts: Inquest Act, National Health Act, Human Tissue Act, Births & Death Registration Act, Prisons Act, and the Medical, Health Professions Act.

In terms of section 27(2) of the National Health Act, 2003, the provincial Departments of Health (Heads of Department) will be responsible for implementation of the entire Forensic Pathology Service, excluding Forensic Laboratories (which is a national responsibility), in compliance with national policies and law.

The Forensic Pathology Service (FPS) aims to render a standardised, objective, impartial and scientifically accurate service, following national protocols and procedures, for the medico-legal investigation of death that serves the judicial process in the Provincial Government of the Western Cape. The priority is to retain the necessary medical expertise to ensure a uniform, high standard of medico-legal autopsy in cases of unnatural death or unattended/ non-ascertained natural deaths.

A strategic objective is to provide training of medical and non-professional staff that is sufficient to ensure that forensic pathology services in the province, and beyond, are adequately resourced. The Division's main function is service delivery to the community in rendering a service in providing medico-legal evidence from the performance of post-mortem examinations in terms of the above mentioned Acts. The components further provide training and consultation on clinical forensic cases for the Province. The academic divisions are also responsible for undergraduate and postgraduate training as well as research in the pursuit of service excellence.

Currently, 10 000 medico-legal post-mortems (PM) are performed annually in the Western Cape in order to establish the cause of death in cases as defined in The Inquest Act. Of these 5 600 Medico-Legal post-mortems are performed in the Metropole region, and 4 400 in the rural regions.

Post-mortem statistics have decreased slightly over the past 5 years due to a decrease in the number of cases of natural causes of death being referred to the mortuaries. There is still concern that a substantial number of medico-legal cases are under-reported. The Provincial Department of Health may become aware of unsatisfactory medico-legal post-mortems or complete failure to perform such post-mortems, via complaints voiced by the SA Police Services, the Independent Complaints Directorate, or the Department of Justice. However, few such cases are reported, and those that are, most likely under-represent the scope of the problem, with significant and negative implications for the criminal justice system in South Africa. As a result of this the Provincial Department of Health has identified the need to improve the Forensic Pathology Support in the rural regions, thus the proposed organisational structure for the Forensic Pathology Service, in terms of which the Medico-legal service will be transferred from SAPS to Health will make provision for specialist forensic pathologist support in the regions.

6. ANALYSIS OF CONSTRAINTS AND MEASURES TO OVERCOME THEM

Table 2.9 Constraints and measures to overcome them for system priorities

SYSTEM PRIORITIES	CONSTRAINTS	MEASURES TO OVERCOME THEM
STRENGTHEN THE DISTRICT HEALTH SYSTEM	• National Health Act regulations being promulgated.	• Creation of District Health Councils
	• Failure to reach consensus with partners re DHS governance.	• Ministerial decision to assume responsibility for PPHC..
COMMUNITY BASED SERVICES	• Availability of physical infrastructure.	• Infrastructure planning in progress.
	• Programme for decanting mental health patients to be developed in conjunction with Programme 4 managers.	• Coherent strategy for decanting of mental health patients developed in conjunction with Programme 4 managers
	• Continued availability of donor funding for HBC.	• Training and capacitation of NPO's rendering HBC services
	• Complexity of procurement procedures.	• Training of home-based carers and technical assistants.
	• Availability of professional staff.	• Efforts being made to focus on recruitment of certain professional categories.
DISTRICT HOSPITALS	• Availability of Hospital Revitalisation Project funding.	• Development of feasible Business Plans; and • Secure HRP funding.
CHRONIC MEDICATION SUPPLY	• Recruitment and retention of pharmacy personnel. • Regulations relating to dispensing medications.	• Chronic dispensing unit (CDU) established.

Table 2.10 Constraints and measures to overcome them for programme priorities

PROGRAMME PRIORITIES	CONSTRAINTS	MEASURES PLANNED TO OVERCOME THEM
TB new sputum positive (NSP) CURE RATE	• Inadequate funding for Programme.	• Availability of funding for expansion of TB services.
ANTI-RETROVIRAL TREATMENT	• Inadequate physical facilities. • Insufficient Health personnel.	• Recruitment and training of medical and nursing personnel. • Viability of PHC platform. • Physical infrastructure requirements addressed.
WOMENS' HEALTH	• Inadequate and poorly trained personnel • Poor quality of laboratory assessments.	• Availability of additional funding for recruitment of personnel. • Quality of laboratory work being performed by NHLS.
CHILD HEALTH	• Availability of funds for training and replacement of personnel.	• Funding for IMCI and PHC training.

Forensic pathology services

The high workload and related stress of performing approximately 10 000 medico-legal autopsies per annum results in a high turnover of medical specialists. This will be addressed by providing additional specialist posts of suitable grading as provided in the proposed human resource plan for the FPS.

A present constraint is lack of employment opportunities for the specialists who are trained, in spite of a need for these specialists in rural areas. This is addressed in the proposed organisational structures for the Forensic Pathology Service (transfer of Medico-legal Service from SAPS to Health) with the creation of additional specialised capacity.
It is anticipated that a high percentage of staff in the new Forensic Pathology Service will be new to the Department of Health and the Forensic Pathology Service and orientation of these staff as well as comprehensive basic training will be required in order to ensure continued service delivery to the community.

The delay in the implementation of the Cabinet decision taken on 29th April 1998 to transfer the medico-legal mortuaries from SAPS to health has impacted on the service due to uncertainty from the Police with regard the exact date of transfer and this impacted on appropriate levels of staffing and resourcing as well as staffing and maintenance of facilities. This will now be addressed with implementation of the transfer as per the strategic and implementation plan as accepted by Budget and Health Council for implementation.

7. PLANNED QUALITY IMPROVEMENT MEASURES

The proposed transfer of medico-legal mortuaries from SAPS to Health will provide a model for establishing and building a comprehensive Forensic Pathology Service in the Western Cape.

The Forensic Pathology Services in the province are designed to contribute positively to:

1) Ensure the development of a just South African society
2) Assist in the fight against crime
3) Assist in the prevention of crime
4) Assist in the prevention of unnatural death
5) Endeavour to protect the rights of all persons
6) Establish the independence of medical and related scientists
7) Ensure that the service is rendered within a uniform system
8) Ensure participation of society in the service
9) Ensure that the service is equitable
10) Ensure that the service is efficient and cost effective
11) Ensure the promotion of relevant education, training and research
12) Rectify the deprived state of the service
13) Provide for the specific needs of those persons rendering the service and
14) Establish adequate data collection and processing.

It is proposed that the expenditure on the Forensic Pathology Service will grow from R41,345 million recurrent in 2006/7 to R45,594 million in 2007/8.
Each region will have a Co-ordinator that is responsible for ensuring that there is always sufficient staff in the region to form a roster for 24 hour duty at services.

Table 2.11 Forensic Pathology Services: Indicative allocations for 2006/07 – 2008/09

Financial year	Total recurrent costs R('000)			Total capital costs R('000)		TOTAL 2006/07 R('000)
	Within Health Budget	Ex SAPS	New Recurrent	Fixed Capital (Buildings)	Moveable Capital (Equipment /vehicles)	
2006/07	12,771	16,209	12,365	22,500	4,503	68,347
2007/08	N/A	N/A	45,594	26,697	6,861	79,152
2008/09	N/A	N/A	47,417	8,220	0	55,637

The Western Cape will make use of existing facilities, extensions and improvements to Provincial mortuaries and in certain cases private mortuary facilities. Each of the three Rural regions will have a larger FPS Laboratory (M3) that will act as referral centre (based at Paarl, Worcester and George respectively) each of which will have a fulltime Specialist responsible for the autopsies.

In the more remote and smaller mortuaries the services of Medical Officers, either in the hospitals or in private practice, will be utilised to conduct autopsies on site. The fall-back position will be the transporting of corpses from holding centres to larger FPS centres for autopsies.
The Western Cape also has two academic complexes, those of University of Cape Town (UCT) and University of Stellenbosch (US). The UCT association is with the Salt River FPS Laboratory, which will be managed by a manager supported by an assistant responsible for the administration. The professional and technical support will be through the services of a Chief Specialist, a number of other specialists and medical officers. A similar arrangement is anticipated for the Tygerberg FPS Laboratory based in Bellville. Each of these two tertiary linked FPS Laboratories will also have a full time Medical Technologist to assist with a number of the laboratory investigations that can be done in support of the autopsy.

The FPS funding as detailed above will be provided via the 'Division of Revenue Act' as a conditional grant and budget and expenditure will most appropriately be reflected in Programme 2 Sub-programme 2.8, Programme7, as well as Programme 8.

MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.12 Provincial objectives and performance indicators for the DHS and PHC [DHS5]

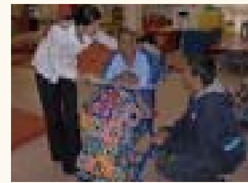
Measurable objective	Performance measure	Year-1 2004/05 (Actual)	Base year 2005/06 (Target)	Year 1 2006/07 (Target)	Year 2 2007/08 (Target)	Year 3 2008/09 (Target)
Sub-programme 2.1: District Management						
Establishment of district management structures	Number of health district management structures created.	0	3	6	6	6
	% Health facilities with community based accountability/governance structures	40%	60%	70%	75%	100%
Decentralisation of management to district & sub district level	% of districts with appointed managers.	66.60%	83%	100%	100%	100%
	% District Health Plans developed.	100%	100%	100%	100%	100%
Computerization of CHC's	Number of CHC's computerised and with access to the Provincial intranet	15	25	35	All CHC's	All CHC's
Provincialisation of PPHC services	Number Local Government posts that have become vacant and filled by Province	0	300	450	930	930
Sub-programme 2.2: Community health clinics						
Provision of Primary Health Care (PHC) services to uninsured citizens of the Western Cape.	Number of clinic visits per annum	7,635,203	No Target Set	8m	9m	10m
	Utilisation rate – PHC for total population (Headcount/ visits per person per year)	3.8	3.87	3.87	3.87	3.87
Provision of Immunisation coverage as per World Health Organisation (WHO) standard.	% of 1 yr olds immunised.	91.30%	92%	92%	92%	92%
	Number sub-districts with immunisation coverage of >90%	8	12	16	20	24
Implement cervical screening programme in Clinics and Community Health Center's (CHC's).	% of patients in target group reached.	3.9%[13]	5.5%	6.5%	7.5%	8.5%
Effective management of suspected TB cases.	% of smear positive TB cases cured	72%	73%	74%	75%	75%
	PTB smear conversion rate at 3 months for new cases	76.7%	77%	77.5%	78.0%	78.5%
Sub-programme 2.3: Community health centres						
Provision of CHC services	Number of CHC visits per annum[1]	4,483,318	4,954,226	6 million	8 million	8 million
Improve facility management	Number of facility managers appointed	15	15	35	All large CHC's	All large CHC's
Institute clinical Governance at CHC's	Number of CHC's appointed with senior family medicine physicians	9	9	15	35	All large CHC's
Strengthen Trauma & emergency services	Number of Emergency physicians employed for clinical governance of T&E services at CHC's	5	9	15	20	25
Improve chronic disease management	Number of patients with prescriptions issued for chronic medication through an alternative supply system	0	540,530	646,384	757,192	873,137

Measurable objective	Performance measure	Year-1 2004/05 (Actual)	Base year 2005/06 (Target)	Year 1 2006/07 (Target)	Year 2 2007/08 (Target)	Year 3 2008/09 (Target)
Sub-programme 2.4 & 2.5 Community based services & other community services						
Increase the number of category 3 clients receiving care	Number of category 3 clients registered and alive	2910	4 717	6000	7000	8000
	Total number of NPO appointed home carers.	125	700	900	1 000	1000
Sub-programme 2.6: HIV and AIDS						
Rollout of Anti-retroviral (ARV) therapy.	Number of patients receiving ARV treatment.	7,670	13681	15000	17 000	19 000
Voluntary counselling and testing.	% VCT uptake in those 15years and older.	7.10%	7.5%	7.8%	8.0%	8.0%
Sub-programme 2.7: Nutrition						
Monitoring of growth in vulnerable children.	% of babies provided with a Road-to-Health Chart.	90%	100%	100%	100%	100%
	% children under 5 years not gaining weight[14]	2.60%	2.1%	1.6%	1.1%	0.6%
Micro-nutrient supplementation to vulnerable children.	% of malnourished children provided with vitamin A supplementation.	Not available	80%	80%	80%	80%
Sub-programme 2.8: Forensic pathology services						
Provision of an effective and efficient forensic pathology service in accordance with the statutory requirements.	Number of post mortem examinations performed and documented.	5 016 Metro only	5 600 Metro only	10 000	10 000	10 000
	Number of post mortem examinations performed by Specialist Forensic Pathologists.	5 016 Metro only	5 600 Metro only	6 500	7 500	8 500
	Number of post mortem examinations performed with a conclusive finding.	Not recorded	Not recorded	9 500	9 500	9 500
	Number of corpses positively identified by next of kin, or by scientific means.	Not recorded	Not recorded	9 000		
	Turnaround time from receipt to dispatch of the corpses	Not recorded	Not recorded	7 days	7 days	7 days
	Waiting period for Forensic Pathology Services documentation.	Not recorded	Not recorded	20 working days	20 working days	20 working days
	Average cost per examination.	R1 284 (Only Health	R1 390 (Only Health	R4 100	R4 500	R4 500
Sub-programme 2.9: District Hospitals						
Increase the availability and access of level one hospital beds	Number of level one beds	1546	2056	2367	2367	2367
	Bed utilisation rate (based on usable beds) in district hospitals	76%	76%	76%	76%	76%
Increase theatre cases	Number of operation under 30 minutes	4,286	4,715	5,210	5,770	6,404
Sub-programme 2.10: Global Fund HIV and AIDS Programme						
Roll-out of Anti-retroviral (ARV) therapy.	Number of patients receiving ARV treatment from Global Fund Funding	1 300	2 695	4 376	4 376	4 376
Expansion of peer education	Number of peer educators trained	1 000	1 470	4 070	4 070	4 070
Expansion of palliative in-patient service	Number of in-patient days for palliative care	18 000	28 000	48 000	48 000	48 000
Provision of community-based response	Number of community-based projects funded	28	59	108	108	108

[13]Women aged 30 –59y receive one cervical smear every ten years thus in a year we should screen 10% of women aged 30 –59years. Since we largely cater for the uninsured population (73% of total population), we target to screen 8% of women aged 30–59years in a year by 2008/09.
[14]This indicator denotes the % of children who are less that 5 years old classified to be growth faltering (i.e. Number of children < 5 years who has either dropped weight or failed to gain weight in accordance with the reference or birth curve in 2 or more months) out of all children under 5years old who were weighted.

Table 2.13 Provincial objectives and performance indicators for District Hospitals [DHS5]

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
INPUT									
Provide sufficient funds for non-personnel expenditure district hospital.	Expenditure on staff as % of total expenditure	0.67	75.90	73.00	71.70	70.0%	69.0%	69.0%	69.0%
	Expenditure on drugs as % of total expenditure	11.0%	5.90	6.30	6.50	7.0%	8.0%	8.0%	8.0%
	Expenditure on maintenance as % total expenditure	4.40%	1%	1%	0.6%	3.0%	3.0%	3.0%	3.0%
Provide district hospitals infrastructure in line with Healthcare 2010	Useable beds per 1000 people	0.46	0.38	0.37	0.37	0.39	0.38	0.37	0.37
	Useable beds per 1000 uninsured population	0.63	0.52	0.51	0.51	0.53	0.52	0.51	0.50
Provide sufficient funding to ensure an efficient and efficient district hospitals service for the population of the Western Cape.	Hospital expenditure per capita (total population)		73.99	78.73	83.15	86.89	90.95	94.85	99.93
	Hospital expenditure per capita (uninsured population)		101	108	114	119	125	130	137
Provide services that adequately address the needs of inpatients, outpatients and trauma.	Outpatients per inpatient day ratio	1.00	1.73	1.76	1.46	1.18	1.12	0.97	1.17
	Trauma as % of total outpatient headcounts		28.8%	31.2%	35.3%	35.0%	35.0%	35.0%	35.0%
	Total number of inpatient days	737,775	415,547	419,193	486,236	528,119	541,660	575,514	575,514
	Total number of outpatient headcounts (incl trauma)	737,775	717,860	738,283	709,895	624,146	604,888	558,478	598,062
PROCESS									
Facilitate representative management.	Percentage of hospitals with operational hospital board	100%	90.00	100.00	100.00	100.00	100.00	100.00	100.00
Facilitate decentralised management and accountability.	Percentage of hospitals with appointed CEO in place (or Medical Superintendent)	100%	86.00	86.00	100.00	100.00	100.00	100.00	100.00
	Percentage of hospitals with business plan agreed with the Provincial Department of Health	100%				100.00	100.00	100.00	100.00
OUTPUT									
Ensure accessible district hospital services to the population of the Western Cape.	Separations per 1000 people	49.2	36.0	36.0	41.0	43.04	42.63	42.95	42.29
	Separations per 1000 uninsured population	67.4	50.0	50.0	57.0	59.0	58.4	58.8	57.9
	Patient day equivalents per 1000 people		143	143	153	153	152	153	159
	Patient day equivalents per 1000 uninsured population		199	199	213	210	208	210	217
QUALITY									
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in the last 12 months.	100	36	50	100	100	100	100	100
	Percentage of hospitals with designated official responsible for coordinating quality management.	100	Not available	Not available	100	100	100	100	100
	Percentage of hospitals with clinical audit (M&M) meetings at least once per month.	100	50	85	100	100	100	100	100
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources	Average length of stay	2.87	2.60	2.60	2.50	2.55	2.60	2.70	2.70
	Bed utilisation rate based on useable beds	0.85	0.65	0.66	0.76	0.78	0.80	0.85	0.85
	Expenditure per patient day equivalent	753	517	550	543	569	604	618	630
OUTCOME									
Ensure desired clinical outcomes	Case fatality rate for surgery separations		0.62	0.62	0.63	0.63	0.63	0.63	0.63



7.1 National Monitoring and Evaluation indicators

Table 2.14 Performance indicators for District Health Services [DHS6]

	Indicator	Type	2004/05	2005/06	2006/07	2007/08	2008/09	National target 2008/09
Input								
1	Uninsured population served per fixed public PHC facility	No	12,184	12,347	12,479	12,671	12,821	<10,000
2	Provincial PHC expenditure per uninsured person	R	289	253	277	295	286	
3	Local government PHC expenditure per uninsured person	R	54	53	52	58	51	N/A
4	PHC expenditure (provincial plus local government) per uninsured person	R	341	286	329	337	346	274
5	Professional nurses in fixed PHC facilities per 100,000 uninsured person	No	41	45	52	57	58	130
6	Sub-districts offering full package of PHC services	%	80%	85%	90%	100%	100%	100
7	EHS expenditure (provincial plus local govt) per uninsured person	R	0	10	12	15	15	13
Process								
8	Health districts with appointed manager	%	67	66	80	85	100	100
9	Health districts with plan as per DHP guidelines	%	0	100	100	100	100	100
10	Fixed PHC facilities with functioning community participation structure	%	40	60%	70%	75%	100%	100
11	Facility data timeliness rate for all PHC facilities	%	Not available	100%	100%	100%	100%	100
Output								
12	PHC total headcount	No	12,884,522	14,436,450	15,638,176	15,881,120	16,039,931	N/A
13	Utilisation rate - PHC	No	4	3	3.2	3.87	3.87	3.87
14	Utilisation rate - PHC under 5 years	No	6.4	5.4	5.5	5.5	5.5	5.0
Quality								
15	Supervision rate	%	0	60	70	85	100	100
16	Fixed PHC facilities supported by a doctor at least once a week	%	Not available		90	100	100	100
Efficiency								
17	Provincial PHC expenditure per headcount at provincial PHC facilities	R	79	84	87	87	92	78
18	Expenditure (provincial plus LG) per headcount at public PHC facilities	R	98	95	103	102	107	78
Outcome								
19	Health districts with a single provider of PHC services	%	0	0	100	100	100	100

Table 2.15 Performance indicators for HIV and AIDS, STI and TB control [HIV3]

	Indicator	Type	2004/05	2005/06	2006/07	2007/08	2008/09	National target 2008/09
Input								
1	ARV treatment service points compared to plan	%	100	100	100	100	100	100
2	Fixed PHC facilities offering PMTCT	%	100	100	100	100	100	100
3	Fixed PHC facilities offering VCT	%	100	100	100	100	100	100
4	Hospitals offering PEP for occupational HIV exposure	%	100	100	100	100	100	100
5	Hospitals offering PEP for sexual abuse	%	73.6	75	80	85	100	100
6	HTA Intervention sites compared to plan	%	100	100	100	100	100	100
Process								
7	TB cases with a DOT supporter	%	90	95	98	98	100	100
8	Male condom distribution rate from public sector health facilities	No	15.6	16	18	20	25	11
9	Male condom distribution rate from primary distribution sites	No	18	22	25	30	35	32
10	Fixed facilities with any ARV drug stock out	%	Not measured	Not measured	Not measured	Not measured	Not measured	0
11	Hospitals drawing blood for CD4 testing	%	100	100	100	100	100	100
12	Fixed PHC facilities drawing blood for CD4 testing	%	25	50	75	100	100	20
13	Fixed facilities referring patients to ARV treatment points assessment	%	25	50	100	100	100	10
Output								
14	STI partner treatment rate	%	20	25	30	35	35	40
15	Nevirapine dose to baby coverage rate	%	90	90	90	90	90	70
16	Clients HIV pre-test counselled rate in fixed PHC facilities	%	1.6	2	2.5	3	3.5	100
17	Patients registered for ART compared to target	%	100	100	100	100	100	100
18	TB treatment interruption rate	%	11.5	11	10	9	8	4
Quality								
19	CD4 test at ARV treatment service points with turnaround time >6 days	%	20	15	10	5	3	0
20	TB sputa specimens with turnaround time> 48 hours	%	26	22	18	15	10	0
Efficiency								
21	Dedicated HIV and AIDS budget spent	%	105	100	100	100	100	100
Outcome								
22	New smear positive PTB cases cured at first attempt	%	68.6	70	72	74	75	85
23	New MDR TB cases reported - annual % change	%	0	-2	-4	-6	-8	-30
24	STI treated new episode among ART patients - annual % change	%	To be set	To be set	To be set	To be set	To be set	
25	ART monitoring visits measured at WHO performance scale 1 or 2	%	To be set	To be set	To be set	To be set	To be set	

Table 2.16 Performance indicators for MCWH and Nutrition [MCWH3]

Indicator		Type	2004/05	2005/06	2006/07	2007/08	2008/09	National target 2008/09
Incidence								
1	Incidence of severe malnutrition under 5 years	%	Awaiting SADHS	Awaiting SADHS	Awaiting SADHS	Awaiting SADHS	Awaiting SADHS	
2	Incidence of pneumonia under 5 years	%	Not planned	Not planned	Not planned	Not planned	Not planned	
3	Incidence of diarrhoea with dehydration under 5 years	%	No target set	No target set	No target set	No target set	No target set	
Input								
4	Hospitals offering TOP services	%	86	88	90	90	100	100
5	CHCs offering TOP services	%	66	48	52	60	80	80
Process								
6	Fixed PHC facilities with DTP-Hib vaccine stock out	%	Not available	Not available	Not available	Not available	0	
7	AFP detection rate	%	1.81	1.5	1.5	1.5	1	1
8	AFP stool adequacy rate	%	96%	90%	90%	90%	90%	80
Output								
9	Schools at which phase 1 health services are being rendered	%	20	40	60	80	100	
10	(Full) Immunisation coverage under 1 year	%	91.3	95	95	95	95	90
11	Antenatal coverage	%	91.2	95	95	95	95	80%
12	Vitamin A coverage under 1 year	%	Not available	85	85	85	85	80%
13	Measles coverage under 1 year	%	91.7	90	90	90	95	90
14	Cervical cancer screening coverage	%	38.9	60	65	68	70	15
Quality								
15	Facilities certified as baby friendly	%	12	20	25	30	35	30
16	Fixed PHC facilities certified as youth friendly	%	2	4	8	16	35	30
17	Fixed PHC facilities implementing IMCI	%	79	85	95	100	100	
Outcome								
18	Institutional delivery rate for women under 18 years	%	11.1	11	11	11	15	13
19	Not gaining weight under 5 years	%	No targets set	No targets set	No targets set	No targets set	No targets set	

Table 2.17 Performance indicators for district hospitals sub-programme [DHS7]

Indicator		Type	2004/05	2005/06	2006/07	2007/08	2008/09	National target 2008/09
Input								
1	Expenditure on hospital staff as % of district hospital expenditure	%	71.7	70	69	69	69	62
2	Expenditure on drugs for hospital use as % of district hospital expenditure	%	6.5	7	8	8	8	11
3	Expenditure by district hospitals per uninsured person	R	114	119	125	130	137	
Process								
4	District hospitals with hospital board	%	100	100	100	100	100	100
5	District hospitals with appointed (not acting) CEO in post	%	100	100	100	100	100	100
6	Facility data timeliness rate for district hospitals	%	90	100	100	100	100	100
Output								
7	Caesarean section rate for district hospitals	%	10.7	11	11	11	11	11
Quality								
8	District hospitals with patient satisfaction survey using DoH template	%	100	100	100	100	100	100
9	District hospitals with clinical audit (M and M) meetings every month	%	100	100	100	100	100	100
Efficiency								
10	Average length of stay in district hospitals	Days	2.5	2.6	2.6	2.7	2.7	3.2
11	Bed utilisation rate (based on usable beds) in district hospitals	%	76	0.78	0.8	0.85	0.85	72
12	Expenditure per patient day equivalent in district hospitals	R	618	543	568	604	618	814 in 2007/08
Outcome								
13	Case fatality rate in district hospitals for surgery separations	%	0.63	0.63	0.63	0.63	0.63	3.5

Table 2.18 Performance indicators for disease prevention and control [PREV3]

	Indicator	Type	2004/05	2005/06	2006/07	2007/08	2008/09	National target 2008/09
Input								
1	Trauma centres for victims of violence	No	At least 1/district	At least 1/district	At least 1/district	At least 1/district	At least 1/district	1 per district
Process								
2	CHCs with fast queues for elder persons	%	Not planned	Not planned	Not planned	Not planned	30	20
Output								
3	Health districts with health care waste management plan implemented	%	100	100	100	100	100	All districts
4	Hospitals providing occupational health programmes	%	35	100	100	100	100	100
5	Schools implementing Health Promoting Schools Programme (HPSP)	%	7	Not yet planned	100	100	100	
6	Integrated epidemic preparedness and response plans implemented	Y/N	Y	Y	Y	Y	Y	Yes
7	Integrated communicable disease control plans	Y/N	Y	Y	Y	Y	Y	Yes
Quality								
8	Schools complying with quality index requirements for HPSP	%	No standard tool	No target set	No target set	No target set	No target set	
9	Outbreak response time	Days	3	1	1	1	1	1
Outcome								
10	Dental extraction to restoration rate	No	Not available	15	12	11	8	0.4
11	Malaria fatality rate	No	2.3					0.25
12	Cholera fatality rate	No	0					0.5
13	Cataract surgery rate	No	757	2 069	2 522	No target set	No target set	1,000
14	Trauma centres for victims of violence	No	41	41	41	50	50	1 per district

9. TRANSFERS TO MUNICIPALITIES AND NON-GOVERNMENT ORGANISATIONS

The table below reflects the transfer payments to municipalities and non-governmental organisations.

Table 2.19 Transfers to municipalities and non-government organisations (R '000) [DHS8]

Transfers to local government by transfer/grant type/category and municipality

Municipalities R'000	Outcome						Medium-term estimate			
	Audited 2002/03	Audited 2003/04	Audited 2004/05	Main Appropriation 2005/06	Adjusted Appropriation 2005/06	Revised estimate 2005/06	2006/07	2007/08	2008/09	% change from Revised estimate 2005/06
Category A	114 072	132 304	131 074	106 655	108 930	108 930	127 075	122 928	129 944	16.66
City of Cape Town	114 072	132 304	131 074	106 655	108 930	108 930	127 075	122 928	129 944	16.66
Category B	28 540	33 449	40 241	75 393	52 932	52 932				(100.00)
Beaufort West	1 088	1 131	1 073	879	714	714				(100.00)
Bergrivier	348	33	3	25						
Bitou	1 631	1 329	2 313	4 363	4 335	4 335				(100.00)
Breede River/ Winelands	801	808	805	1 963	1 133	1 133				(100.00)
Breede Valley	1 620	1 659	1 745	6 016	4 426	4 426				(100.00)
Cape Agulhas	63	67								
Cederberg	409	483	588	556	556	556				(100.00)
Drakenstein	2 777	3 313	6 648	4 955	4 955	4 955				(100.00)
George	4 650	6 411	5 949	11 874	11 418	11 418				(100.00)
Kannaland	17	24	1							
Knysna	1 349	1 860	2 004	4 313	4 263	4 263				(100.00)
Laingsburg	19	32	7							
Hessequa	1 999	1 881	1 871	1 013	1 013	1 013				(100.00)
Matzikama	470	738	828	686	686	686				(100.00)
Mossel Bay	2 281	2 231	2 482	5 091	5 001	5 001				(100.00)
Oudtshoorn	695	603	1 139	1 823	1 570	1 570				(100.00)
Prince Albert	244	342	248	244	244	244				(100.00)
Saldanha Bay	1 364	1 936	2 284	3 303	3 388	3 388				(100.00)
Stellenbosch	1 937	2 546	2 727	3 797	3 747	3 747				(100.00)
Swartland	1 458	1 935	3 990	2 064	1 788	1 788				(100.00)
Swellendam										
Theewaterskloof	1 719	2 487	1 855	2 682	2 152	2 152				(100.00)
Witzenberg	641	592	625	757	452	452				(100.00)
Unallocated				17 068						
Category C	32 143	36 603	49 372	62 072	48 836	48 836	9 394	9 297	9 010	(80.76)
Cape Winelands	8 448	8 619	16 570	15 752	15 984	15 984	2 074	2 053	1 989	(87.02)
Central Karoo	3 207	3 651	3 356	3 861	3 868	3 868	1 164	1 152	1 116	(69.91)
Eden	7 909	8 468	9 044	11 018	10 593	10 593	2 538	2 512	2 434	(76.04)
Overberg	6 237	7 084	8 640	7 417	7 912	7 912	1 565	1 549	1 501	(80.22)
West Coast	6 342	8 781	11 762	11 092	10 479	10 479	2 053	2 031	1 970	(80.41)
Unallocated				**12 932**						
Total transfers to local government	174 755	202 356	220 687	244 120	210 698	210 698	136 469	132 225	138 954	(35.23)

Note: Excludes regional services council levy.
No transfer payments are made to the rural municipalities for Personal Primary Health Care in the MTEF period as the Province is assuming responsibility for the provision of this service.

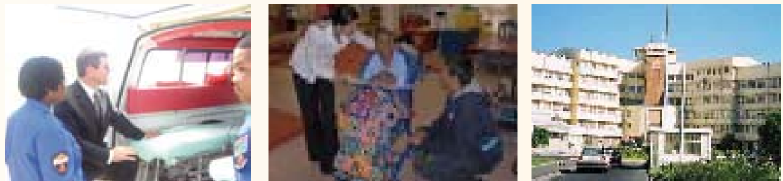


Table 2.20 Transfers to municipalities and non-governmental organisations (R'000) for Personal Primary Health Care Services

Municipalities R'000	Outcome						Medium term estimate			
	Audited 2002/03	Audited 2003/04	Audited 2004/05	Main appropriation 2005/06	Adjusted appropriation 2005/06	Revised estimate 2005/06	2006/07	2007/08	2008/09	% Change from Revised estimate 2005/06
Personal Primary health care services	174 755	202 356	209 752	229 066	195 356	195 356	113 608	116 271	123 211	(42)
Category A	114 072	132 304	125 041	99 065	99 065	99 065	113 608	116 271	123 211	14.68
City of Cape Town	114 072	132 304	125 041	99 065	99 065	99 065	113 608	116 271	123 211	14.68
Category B	28 540	33 449	38 253	73 959	52 781	52 781				(100.00)
Beaufort West	1 088	1 131	923	714	714	714				(100.00)
Bergrivier	348	33	3	25						
Bitou	1 631	1 329	2 303	4 335	4 335	4 335				(100.00)
Breede River/Winelands	801	808	805	1 963	1 133	1 133				(100.00)
Breede Valley	1 620	1 659	1 745	6 016	4 426	4 426				(100.00)
Cape Agulhas	63	67								
Cederberg	409	483	557	556	556	556				(100.00)
Drakenstein	2 777	3 313	6 431	4 955	4 955	4 955				(100.00)
George	4 650	6 411	5 537	11 418	11 418	11 418				(100.00)
Kannaland	17	24	1							
Knysna	1 349	1 860	1 950	4 263	4 263	4 263				(100.00)
Laingsburg	19	32	7							
Hessequa	1 999	1 881	1 871	1 013	1 013	1 013				(100.00)
Matzikama	470	738	808	686	686	686				(100.00)
Mossel Bay	2 281	2 231	2 403	5 001	5 001	5 001				(100.00)
Oudtshoorn	695	603	972	1 570	1 570	1 570				(100.00)
Overstrand	960	1 008	1 056	1 921	1 091	1 091				(100.00)
Prince Albert	244	342	248	244	244	244				(100.00)
Saldanha Bay	1 364	1 936	1 915	3 303	3 303	3 303				(100.00)
Stellenbosch	1 937	2 546	2 453	3 726	3 726	3 726				(100.00)
Swartland	1 458	1 935	3 785	1 743	1 743	1 743				(100.00)
Swellendam										
Theewaterskloof	1 719	2 487	1 855	2 682	2 152	2 152				(100.00)
Witzenberg	641	592	625	757	452	452				(100.00)
Unallocated				17 068						
Category C	32 143	36 603	46 458	56 042	43 510	43 510				(100.00)
Cape Winelands	8 448	8 619	16 438	14 898	14 898	14 898				(100.00)
Central Karoo	3 207	3 651	3 099	2 927	2 927	2 927				(100.00)
Eden	7 909	8 468	8 433	9 277	9 277	9 277				(100.00)
Overberg	6 237	7 084	8 549	6 740	7 140	7 140				(100.00)
West Coast	6 342	8 781	9 939	9 268	9 268	9 268				(100.00)
Unallocated				12 932						

Note: Excludes regional services council levy.

Table 2.21: Transfers to local government by transfers /grant type, category and municipality: Integrated Nutrition

Municipalities R'000	Outcome			Main appropriation 2005/06	Adjusted appropriation 2005/06	Revised estimate 2005/06	Medium-term estimate			
	Audited 2002/03	Audited 2003/04	Audited 2004/05				2006/07	2007/08	2008/09	% Change from Revised estimate 2005/06
Integrated Nutrition			4 983	4 800	3 000	3 000	3 000	3 177	3 361	
Category A			2 882	3 000	3 000	3 000	3 000	3 177	3 361	
City of Cape Town			2 882	3 000	3 000	3 000	3 000	3 177	3 361	
Category B			1 081	1 042						
Beaufort West			150	165						
Bergrivier										
Bitou			10	28						
Breede River/ Winelands										
Breede Valley										
Cape Agulhas										
Cederberg			31							
Drakenstein			75							
George			412	456						
Kannaland										
Knysna			54	50						
Laingsburg										
Hessequa										
Matzikama			20							
Mossel Bay			79	90						
Oudtshoorn			167	253						
Overstrand										
Prince Albert										
Saldanha Bay			42							
Stellenbosch			18							
Swartland			23							
Swellendam										
Theewaterskloof										
Witzenberg										
Unallocated										
Category C			1 020	758						
Cape Winelands			62							
Central Karoo			141	178						
Eden			398	580						
Overberg										
West Coast			419							
Unallocated										
Note: Excludes regional services council levy. Due to structural changes comparitive figures cannot be submitted.										

Table 2.22 Transfers to local government by transfers/grant type, category and municipality from the Global Fund

Municipalities R'000	Outcome			Main appropriation 2005/06	Adjusted appropriation 2005/06	Revised estimate 2005/06	Medium-term estimate			
	Audited 2002/03	Audited 2003/04	Audited 2004/05				2006/07	2007/08	2008/09	% Change from Revised estimate 2005/06
Global fund			2 905	7 937	8 639	8 639	12 910	12 777	12 382	49.44
Category A			2 117	3 773	3 773	3 773	3 516	3 480	3 372	(6.81)
City of Cape Town			2 117	3 773	3 773	3 773	3 516	3 480	3 372	(6.81)
Category B										
Beaufort West										
Bergrivier										
Bitou										
Breede River/ Winelands										
Breede Valley										
Cape Agulhas										
Cederberg										
Drakenstein										
George										
Kannaland										
Knysna										
Laingsburg										
Hessequa										
Matzikama										
Mossel Bay										
Oudtshoorn										
Overstrand										
Prince Albert										
Saldanha Bay										
Stellenbosch										
Swartland										
Swellendam										
Theewaterskloof										
Witzenberg										
Unallocated										
Category C			788	4 164	4 866	4 866	9 394	9 297	9 010	93.05
Cape Winelands			70	854	1 086	1 086	2 074	2 053	1 989	90.98
Central Karoo			116	440	625	625	1 164	1 152	1 116	86.24
Eden			213	1 161	1 316	1 316	2 538	2 512	2 434	92.86
Overberg			91	677	772	772	1 565	1 549	1 501	102.72
West Coast			298	1 032	1 067	1 067	2 053	2 031	1 970	92.41
Unallocated										
Note: Excludes regional services council levy. Due to structural changes comparative figures cannot be submitted.										

Table 2.23 Transfers to local government by transfers/grant type, category and municipality for HIV and AIDS

Municipalities R'000	Outcome			Main appropriation 2005/06	Adjusted appropriation 2005/06	Revised estimate 2005/06	Medium-term estimate			
	Audited 2002/03	Audited 2003/04	Audited 2004/05				2006/07	2007/08	2008/09	% Change from Revised estimate 2005/06
HIV and Aids			3 047	2 317	3 703	3 703	6 951			87.71
Category A			1 034	817	3 092	3 092	6 951			124.81
City of Cape Town			1 034	817	3 092	3 092	6 951			124.81
Category B			907	392	151	151				(100.00)
Beaufort West										
Bergrivier										
Bitou										
Breede River/ Winelands										
Breede Valley										
Cape Agulhas										
Cederberg										
Drakenstein			142							
George										
Kannaland										
Knysna										
Laingsburg										
Hessequa										
Matzikama										
Mossel Bay										
Oudtshoorn										
Overstrand										
Prince Albert										
Saldanha Bay			327		85	85				(100.00)
Stellenbosch			256	71	21	21				(100.00)
Swartland			182	321	45	45				(100.00)
Swellendam Theewaterskloof Witzenberg										
Unallocated										
Category C			1 106	1 108	460	460				(100.00)
Cape Winelands										
Central Karoo				316	316	316				(100.00)
Eden										
Overberg										
West Coast			1 106	792	144	144				(100.00)
Unallocated										

Note: Excludes regional services council levy. Due to structural changes comparitive figures cannot be submitted.

10. PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

In 2006/07 Programme 2 is allocated 30,72 per cent of the total vote in comparison to the 28,77 per cent of the vote that was allocated in the revised estimate of the Appropriation Budget in 2005/06. This translates to an increase of approximately R264,347 million or a 16,02 per cent increase in nominal terms.

This increase is due to the reallocation of the funding for the district management from Programme 1: Administration to Programme 2: District Health Services and the reallocation for Forensic Pathology Services from Programme 7: Health Care Support Services to Programme 2 and also the increased allocation of donor funding from the Global Fund, which is still subject to approval.

Table 2.24 Trends in provincial public health expenditure for District Health Services (Programme 2) (R million) [DHS9]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	993,592,000	1,144,699,180	1,330,397,000	1,640,479,000	---	---	---
Total per person	216	245	281	341	---	---	---
Total per uninsured person	296	336	385	467	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	1,152,513,921	1,260,045,571	1,391,676,108	1,640,479,000	1,914,072,000	2,041,229,000	2,279,172,000
Total per person	251	270	294	341	392	411	452
Total per uninsured person	344	370	402	467	537	563	619

Note: Current price projections are not required for the MTEF period as these figures will be the same as the constant price projections for the same years.

Table 2.25 Trends in provincial public health expenditure for District Hospital Services (Sub-programme 2.9) (R'million) [DHS9]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	293,089	333,717	376,649	419,173	---	---	---
Total per person	64	72	79	87	---	---	---
Total per uninsured person	87	98	109	119	---	---	---
Total capital	24,470	47,625	70,030	57,132	---	---	---
Constant (2005/06) prices							
Total	339,968	367,344	393,998	419,173	445,463	473,281	502,416
Total per person	74	79	83	87	91	95	100
Total per uninsured person	101	108	114	119	125	131	137
Total capital	28,384	52,424	73,256	57,132	56,241	56,936	100,699

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

Table 2.26 Trends in provincial public health expenditure for HIV and AIDS conditional grant (R' million) [HIV4]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	19,678,000	38,146,000	94,394,000	116,023,000	---	---	---
Total per person	4.28	8.18	19.92	24.11	---	---	---
Total per uninsured person	5.87	11.20	27.29	33.03	---	---	---
Constant (2004/05) prices							
Total	22,825,434	41,989,808	98,741,860	116,023,000	150,954,000	158,502,000	166,912,000
Total per person	4.97	9.00	20.84	24.11	30.89	31.94	33.12
Total per uninsured person	6.81	12.33	28.55	33.03	42.31	43.75	45.37

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

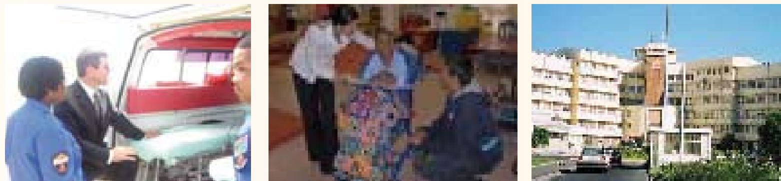


Table 2.27 Trends in provincial public health expenditure for INP Conditional Grant (R'million) [MCWH4]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	15,378,000	12,908,000	15,442,000	14,811,000	---	---	---
Total per person	3.35	2.77	3.26	3.08	---	---	---
Total per uninsured person	4.58	3.79	4.46	4.22	---	---	---
Constant (2004/05) prices							
Total	17,837,663	14,208,683	16,153,270	14,811,000	15,744,000	16,674,000	17,639,000
Total per person	3.88	3.05	3.41	3.08	3.22	3.36	3.50
Total per uninsured person	5.32	4.17	4.67	4.22	4.41	4.60	4.79

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

(Footnotes)

[1] Budget Statement Number 2, page 371

[2] Concept document – see WC service delivery Review 2004)

[3] Metropole District Health Services Annual report, 2003-2004

[4] Mid year population estimates: South Africa 2005, Statistics South Africa, 2005.

[5] The official definition of the unemployed is that they are those people within the economically active population who (a) did not work during the 7 days prior to the interview, (b) want to work and are available to work within a week of the interview, and (c) have taken active steps to look for work or to start some form of self-employment in the 4 weeks prior to the interview.

[6] Data for rural districts not available.

[7] Cape Town Mortality, 2001. Cause of death for each sub district, P. Groenewald et al, 2003

[8] National HIV and Syphilis antenatal seroprevalence survey in South Africa 2004. Department of Health 20/07/2005

[9] Data for 2004 not yet available

[10] Data courtesy of Social Capital Formation in Health Concept Document (2004)

[11] Home-based care is a priority programme that will drive community-based services

[12] the broader management of chronic diseases will be a priority programme within Health programmes

[13] Women aged 30 –59y receive one cervical smear every ten years thus in a year we should screen 10% of women aged 30 –59years. Since we largely cater for the uninsured population (73% of total population), we target to screen 8% of women aged 30-59years in a year by 2008/09.

[14] This indicator denotes the % of children who are less that 5 years old classified to be growth faltering (i.e. Number of children < 5 years who has either dropped weight or failed to gain weight in accordance with the reference or birth curve in 2 or more months) out of all children under 5years old who were weighted.

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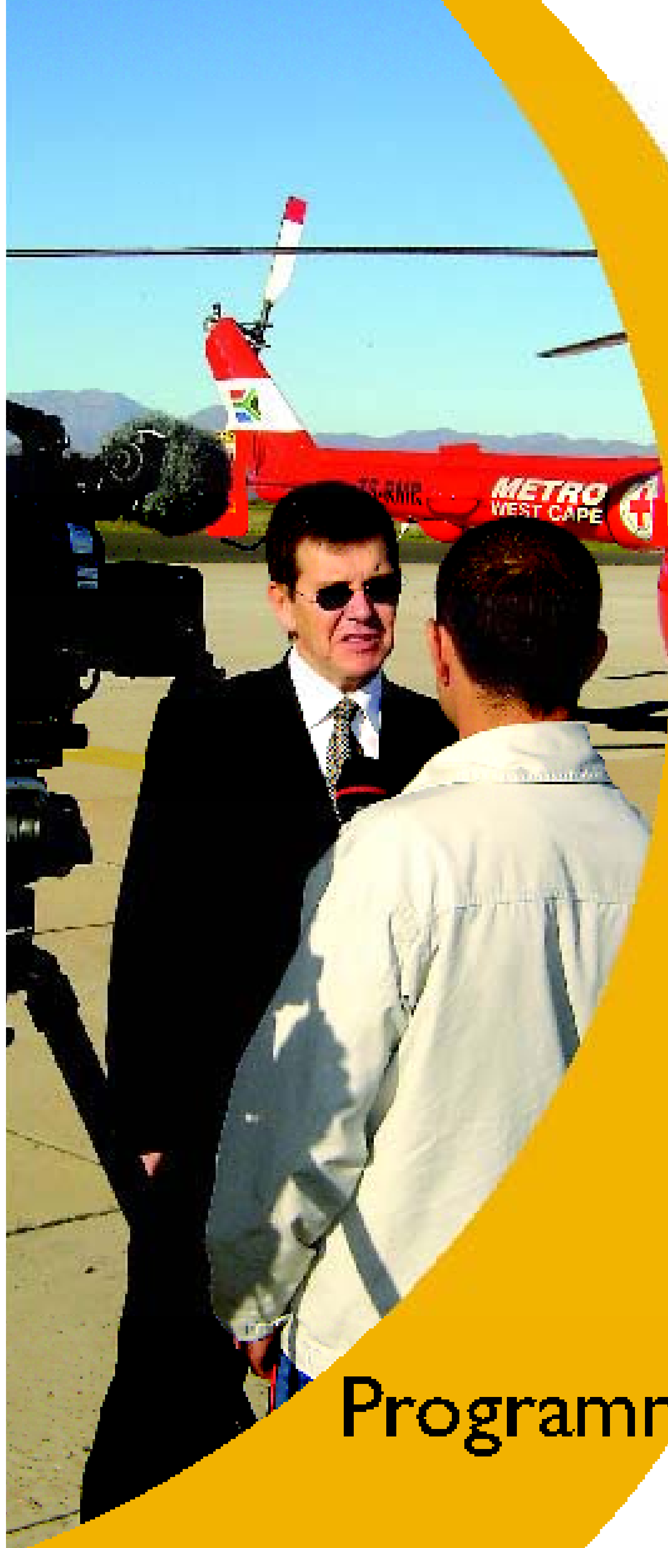


Programme 3: Emergency Medical Services

PROGRAMME 3: Emergency Medical Services

1. AIM

The rendering of pre-hospital Emergency Medical Services including inter-hospital transfers, Medical Rescue and Planned Patient Transport.

2. PROGRAMME STRUCTURE

Sub-programme 3.1 Emergency Medical Services (EMS)

Rendering Emergency Medical Services including ambulance services, special operations, communications and air ambulance services.

Sub-programme 3.2 Planned patient transport

Rendering planned patient transport including local outpatient transport (within the boundaries of a given town or local area) and inter-city / town outpatient transport (into referral centers).

3. SUB PROGRAMME 3.1 EMERGENCY MEDICAL SERVICES

3.1 SITUATIONAL ANALYSIS

Emergency Medical Services are provided throughout the Western Cape Province and managed by District, Sector and Station.

3.1.1 Functions of EMS

The Emergency Medical Services provides the following functions within the Province of the Western Cape

- Emergency Communications Call Taking and Dispatch
- Basic, Intermediate and Advanced Life Support Ambulance based Emergency Care throughout the Province
- Rescue from entrapments in motor vehicles including heavy vehicle rescue
- Industrial rescue from entrapments in industrial and agricultural machinery
- Rotor Wing (Helicopter) Rescue and Transport in support of Wilderness (mountain) Rescues and In-shore air sea rescue
- Fixed Wing (Aeroplane) transfers from rural towns into referral centres
- Wilderness Search and Rescue of patients in wilderness areas, Mountains, River Gorges etc.
- Urban Search and Rescue of patients entrapped by building collapse
- Swift water rescue including rescue diving and support to the National Sea Rescue Institute
- Special events standbys and medical management at major events
- Disaster mass casualty incident management and
- Emergency radio communication.

3.1.2 Existing services and performance

More than a million patients present to hospital emergency departments annually in the Western Cape and of these approximately 40% arrive by ambulance. The headcount consists of approximately 40% trauma patients and the remaining 60% consists of medical emergency patients (including medical, surgical, paediatrics and obstetrics). The burden of violent injury and road traffic accidents is similar to the National profile.

The average response times in the rural or out of town areas in the Western Cape do not meet the National norm of 40 minutes within the 90% target. During 2003, 60% of the responses were within target, in 2004 this increased to 66,4% and in 2005 this improved to 75%.

Response times in the Metropolitan area of Cape Town, deviate significantly from the National norm of 15 minutes, where the average has remained at 90 minutes and may on occasion extend up to six hours, in particular for inter hospital transfers. The Metropolitan Service is achieving Priority 1 (immediately life threatening) responses within 15 minutes in only 12% of responses.

During 2004, 79,8% of urban response times in non-metropolitan areas were within 15 minutes and during 2005, 77.9% achieved this target.

During December 2004 an independent external review of the Western Cape Emergency Medical Services was performed by a consultant (Barry John) from the West Midlands Emergency Ambulance Service in the United Kingdom in order to quantify and qualify the gap between current performance and national requirements. While the report did not quantify the staffing and fleet needs, this was done through modelling and described below. The Barry Johns report acknowledged that efficiency gains will result in limited improvements to the response times of ambulances and that a significant investment in additional resources will be required to bring the response times within acceptable levels. Recommendations of the review report have been accepted and implementation thereof has commenced. During 2005, significant strides have been made in appointing additional uniformed staff (108 in total, of which 75 are in the metro), additional vehicles (27 in Cape Town and 9 in rural areas), calls have been prioritised into P1, P2, P3 and attention has been focussed on improving the response times for priority one calls, workshops and training initiatives have begun to motivate and improve the management capacity within EMS.
During 2005/06 an additional amount of R50,98 million was allocated to fund additional personnel, vehicles and equipment in order to improve response times and service delivery, with an emphasis on the Metropolitan Area.

The response times above reflect, amongst other factors, the deficiencies in personnel and vehicles in the Metropolitan area. A mathematical formulation using emergency rates and ambulance turnaround times reveals that the required personnel in the Western Cape is close to 1 800. The distribution of the staff for 2005 is illustrated in Table 3.1.

Table 3.1 Distribution of the operational staff during 2005

DISTRICT	NUMBER OF PERSONNEL
Central Karoo	43
Eden	149
West Coast	112
Winelands	146
Overberg	87
Total rural areas:	537
Metro	412
TOTAL PERSONNEL	**949**

The number of ambulances in the rural areas 97 is adequate but the Metropolitan area has a fleet of 76 ambulances where 90 are required.

Rescue is not staffed as a separate function in the rural areas and rescue duties are performed over and above ambulance duties which may result in delays in rescue response. The Western Cape has 30 rescue vehicles with 40 Jaws of Life in 35 towns (some in trailers).

The Red Cross Air Mercy Service flies approximately 342 000km and rescues and transports 933 patients (517 fixed wing, 39 rescues and 416 helicopter transfers) at an equivalent road km cost of R26.43 per km.

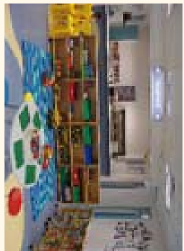
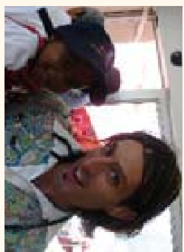
During 2004 the Western Cape EMS attended several major incidents involving mass casualties, which excludes road traffic accidents.

3.1.3 The transfer of the City of Cape Town operational personnel to the Province has still not been completed. The City of Cape Town staff remain under operational control of the province until a solution to their placement can be found.

Table 3.2 Situational analysis indicators for EMS and Patient Transport [EMS1] 2005/6

Indicator	Type	Province wide value	Province wide value	Province - wide value	Metro	West Coast	Overberg	Cape Winelands	Eden	Central Karoo	National target
		2003/04	2004/05	2005/06							2006/07
Input											
1. Ambulances per 1000 people	No	0.045	0.041	0.73	0.12	0.34	0.42	0.22	0.27	0.86	0.2
2. Hospitals with patient transporters	%	0	5	5	0.02	0.17	0.12	0.04	0.06	0.23	
Process											
3. Kilometres travelled per ambulance (per annum)	Kms	61 449	57 258	50 793	41 544	69 418	67 007	65 712	50 193	59 145	
4. Locally based staff with training in BLS	%	20	33	41	36	46	31	53	43	48	48
5. Locally based staff with training in ILS	%	71	60	38	40	30	49	25	35	27	46
6. Locally based staff with training in ALS	%	9	7	7	7	5	6	2	8	5	8
Quality											
7. Response times within national urban target (15 mins)	%	NA	NA	30	15	80	91	58	66	79	50
8. Response times within national rural target (40 mins)	%	NA	NA	73	NA	75	80	71	75	49	80
9. Call outs serviced by a single person crew	%	0	0	0	0	0	0	0	0	0	1.8
Efficiency											
10. Ambulance journeys used for hospital transfers	%	30	14	20	19	7	8	2	5	6	
11. Green code patients transported by ambulance	%	49	37	29	25	39	51	27	36	88	43
12. Cost per patient transported by ambulance	R	593	502	557.11	408.23	682.81	624.81	585.29	471.15	625.71	450.00
13. Ambulances with less than 500,000 kms on the clock	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Output											
14. Patients transported (by PTS) per 1,000 separations	No		34	22	20	31	38	17	23	98	

*Only a global budget figure is available therefore the cost per emergency patient transported would not be accurate.
** Single person ambulance crews were abolished a few years ago in the Western Cape.
Note: Some of the national targets are currently being reviewed and are therefore omitted from the table above.

3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Vision

Quality Emergency Care - Fast

Mission

The Mission of the Emergency Medical Services is a health focused EMS system, delivered by skilled, efficient and motivated personnel with well equipped resources, that is rapidly accessed and responds timeously to place the right patient in appropriate care within the shortest possible time, resulting in the best possible outcome. (National Committee EMS).

3.2.1 Strategic priorities

The main goal of EMS is to improve response times and provide quality care to emergencies. This is centrally linked to the number and skills of the staff, adequately equipped vehicles and the functionality of the communication system.

Communications: to establish electronic computer aided communications systems including automatic vehicle location to support the call taking and dispatch needs of the service and ensure efficient response within all districts.
The provision of a modern computerised communication system to manage Emergency Medical Services (EMS) resources is the top priority, central to the efficient deployment of resources in achieving appropriate response times. The electronic communications systems are essential to rapid response, efficient deployment and co-ordination with other emergency services. All of these matters contribute to improved patient care.

In a joint initiative with the Departments of Local Government, Housing and Community Safety, EMS sought to establish Disaster Management and Emergency Medical Services Communication Centres in Bredasdorp, Worcester, Cape Town, Beaufort West, George and Mooreesburg in 2005/6. The Bredasdorp and Beaufort West Centres became operational in June 2005 and August 2005 respectively. The Cape Town Centre came online in December 2005. It is anticipated that the George Centre will be brought online in March 2006 and the Worcester and Moorreesburg Centre online in the new financial year.

Personnel: to establish a personnel establishment appropriate to the effective delivery of emergency care within response times consistent with National Norms, to develop a management with the capacity to efficiently manage the service, to develop an education and career structure for communications personnel, to develop the appropriate skills mix of clinical personnel and to intensify continuing medical education.

Emergency Medical Services continue be a priority of the National and Provincial Department of Health and approximately R11 million additional funding has been allocated as earmarked funding in the budget allocations for 2006/07.

- R2m has been allocated for new ambulances. Approximately 6 ambulances will be procured and be mainly deployed in the metro region.
- R400 000 will be spent on equipping ambulances.
- An amount R3 million is budgeted in 2006/07 to recruit and place additional personnel in the Metropolitan Area and critical rural towns, this excludes the implementation of job evaluation benchmarking.

In addition an amount of R5,3 million has been allocated to compensate for additional operational costs associated with increased Government Motor Transport tariffs.

The Red Cross Air Mercy service has been expanded in the 2005/06 year to service additional rural areas and this will be maintained during 2006/07.

Negotiations have begun with the Cape Peninsula University of Technology to provide a systematic management training programme for EMS managers. There will also be in-house initiatives to improve the capacity in the areas of labour relations, general management and other areas.

A plan to improve quality of care has been developed in 2005/06. The implementation will continue in 2006/07. This includes training of uniformed staff, clinical audits of specific incidents, employee assistance for stressed staff and improved physical facilities, e.g. ambulance stations. A plan to systematically address infrastructure needs within EMS has been developed and will be systematically addressed in a phased manner beginning in 2006/07. The call centres are being strengthened by having standard operating procedures, increased Xhosa speaking persons taking calls and training of the call taking staff in their patient manner as well as their ability to prioritise calls.

3.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

3.3.1 Finance

Significant strides have been made in improved funding of EMS in the last two years and this commitment continues over the current MTEF period. These funds will enable EMS to move significantly closer to the targets and service levels outlined in the National EMS Framework. The additional funding provided will improve response times in the Metropolitan area.

3.3.2 Human Resources

There is a significant Human Resource gap in EMS services. International models determine that 11 personnel are required to crew an ambulance twenty-four hours a day (11 Liverpool Formula) and this formula is used to calculate rural requirements where availability of an ambulance, irrespective of emergency rates, is the determining factor. The rural regions will require 1184 staff according to the modelling. There are currently 547 personnel.

Emergency rate based calculations using stochastic modelling indicate that at least 624 personnel are required in the Metropolitan Area of Cape Town having discounted a 15 minute gain in mission time through improved communications and management intervention. There are currently 412 personnel in the Metro, i.e. there is a shortfall of 212 personnel against the modelled requirement. Clearly affordability will have to be taken into account in formulating the Western Cape models.

Many of the services in the Western Cape consist of four personnel in small towns who are expected to provide a twenty-four hour service and this is not sustainable within current Labour Legislation.

Improvement of EMS services over the next three years will therefore require significant improvement in management and operational efficiencies as well as augmented finance. The additional finance provided for personnel in 2006 will provide key posts in small rural towns and marginally augment the Metropolitan Staff complement.

3.3.3 Support and Information Systems

The institution of Computer Aided Dispatch and Automatic Vehicle Location Systems (Vehicle Tracking) will substantially improve the management of the mobile EMS resources and improve efficiencies both in financial management and service delivery. Provincial Treasury has committed funding to this function for two years to initiate essential systems.

The 15 minute improvement in mission time is expected to result from the institution of these systems.

4. SUB PROGRAMME 3.2: PLANNED PATIENT TRANSPORT

4.1 SITUATIONAL ANALYSIS

Function of Planned Patient Transport
Rendering Planned Patient Transport including Local Out-Patient Transport (within the boundaries of a given town or local area) and Inter-City/Town Out Patient Transport (into referral centres). Planned patient transport is rendered currently by the Emergency Medical Services from within an existing budget and infrastructure.
As of April 2005 Outpatient Transport Services were separated from Emergency Ambulance Services. Outpatient transport is a particular problem of the rural areas where poor rural communities do not have access to local health facilities because of the lack of public transport infrastructure and long distance transfers are required to get patients in to referral centers for treatment.

Limited public transport and no rural OPD transport system exists except for that provided by EMS. Patient access to health institutions is severely limited by poor patient transport infrastructure. Planned Patient Transport Services in the Western Cape transfers approximately 46 495 outpatients annually.

4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

As from April 2005 the functions of the Emergency Ambulances Services and Planned Patient Transport (PPT) were separated. The PPT (HealthNET, i.e. Health Non Emergency Transport) will undergo significant changes over three years. The ICT components of PPT will be improved and integrated with hospital booking and referral systems.

It is also essential that the level of service to be provided is accepted by all stakeholders and made known to the general public, for example what transfer times that can be expected in rural and urban areas.

The Department has made a decision to centralise the management of planned patient transport within EMS. This will mean that individual hospitals would terminate their transport contracts where they exist and the function with funds will move to EMS. This will result in a better co-ordinated and more efficient service.

Planned initiatives to improve patient transport in the Province include:

- Separation from Emergency Services;
- Creation of a Transport Hub at Tygerberg Hospital;
- Focussed management of the function;
- Introduction of electronic booking systems; and
- Procurement of multi-load (wheelchairs, stretchers, seats) patient transporters.

It must be noted that a significant reduction in demands for the service could result from appropriate discretional patient referral and referral back from academic complexes to regional and district hospitals. An analysis of referrals to the central hospitals in planned for 2006.

The following policy options that would significantly contribute to the development of the service have been identified. An incremental increase in funding will result in a gradual improvement in performance targets.

- R3,7m has been allocated to procure 10 patient transport vehicles and R1,8m will be used to employ 35 additional drivers. This will free up ambulances to focus on emergency cases only.
- Treasury funding for computer aided dispatch and automatic vehicle location systems.

- Development of an effective patient booking system.
- The Tygerberg Hospital Hub will be created and become operational from January 2006.

4.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

4.3.1 Finance

The 2006 financial year will be the second year that the budget for PPT is separated from the Emergency Services. Significant strides have been made in improved funding of EMS in the last two years and the commitment continues over the MTEF period. A portion of these funds will go towards improving PPT. Funding has been provided for 10 Patient Transporters and 30 additional drivers for 2006.

4.3.2 Human resources

The personnel deployed in the function of PPT were separated from Emergency Ambulance personnel from 1st April 2005. An evaluation of PPT driver jobs will need to be conducted during 2006/07 as part of a broader organizational development exercise.
A contract manager has been appointed to manage the function of PPT and develop systems necessary to the function. The organizational structure for PPT is currently under review to create an appropriate platform from which to deliver PPT.

Thirty additional drivers will be appointed in 2006 and personnel will be appointed to manage the transport hub at Tygerberg Hospital.

4.3.3 Support systems

A PPT Hub will be created at Tygerberg Hospital to focus and structure the movement of PPT vehicles within and outside the Metropolitan Area. PPT vehicle design will be revisited to look at multipurpose PPT Vehicles to accommodate the range of wheelchair, sitting or stretcher patients likely to use the service. Procurement of these new vehicles is planned for 2006.

4.3.4 Information systems

The TRANSMETRO computer software which records the movement of patients relative to vehicles will be upgraded to a WINDOWS based system in 2005/6. A web based hospital booking system for outpatients will be designed and developed in 2005/6 to facilitate the parallel booking of outpatient visits and PPT.

Table 3.3 Performance indicators for the EMS and planned patient transport [EMS3]

Indicator	Type	2004/5	2005/06 Target	2006/07 Target	2007/08 Target	2008/9 Target	National target 2007/08
Input							
1. Ambulances per 1000 uninsured population 1 000??	No	0.054	0.05	0.053	0.056	0.056	
2. Hospitals with patient transporters	%	5					
Process							
3. Kilometres travelled per ambulance (per annum)	Kms	57 258	50 000	50 000	50 000	50 000	
4. Proportion of non-supervisory, uniformed staff with BLS qualification	%	33	41	48	44	44	30
5. Proportion of non-supervisory, uniformed staff with ILS qualification	%	60	51	46	48	48	50
6. Proportion of non-supervisory, uniformed staff with ALS qualification	%	9	7	8	8	8	20
Quality							
7. Proportion of Priority 1 Urban Calls within 15 minutes	%	N/A	29.6	50	75	75	90
8. Proportion of Priority 1 Rural Calls within 40 minutes	%	N/A	75	80	85	85	90
9. Proportion of Priority 1,2 and 3 Calls with response time of greater than 60 minutes	%	N/A	12	10	8	5	10
10. Call outs by a single person crew.	%	0	0	0	0	0	0
Efficiency							
11. Ambulance journeys used for hospital transfers.	%	0	0	0	0	0	0

Indicator	Type	2004/5	2005/06 Target	2006/07 Target	2007/08 Target	2008/9 Target	National target 2007/08
12. Green code patients transported by ambulance.	%	37	30	30	30	30	
13. Cost per emergency patient transported by ambulance.	R	502	450	400	350	350	
14. Ambulances with less than 500 000 kms on the clock	%	100	100	100	100	100	
Output							
15 Number of patients transported by PPT or Outpatient Transport Busses per 10 000 uninsured population.	No	136	125	134	149	149	
16. Number of emergency patients transported by ambulance per 10000 uninsured population.	No						

5. PAST EXPENDITURE TRENDS AND RECONCILIATON OF MTEF PROJECTIONS WITH PLAN

In 2006/7 Emergency Medical Services is allocated 4.4% of the vote as was the case in the revised allocation of the Appropriation Budget of 2005/6. This amounts to a nominal increase of 10,11 per cent or R25,625 million.

Table 3.4 Trends in provincial public health expenditure for EMS and patient transport (R million) [EMS4]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	152,910,000	185,694,687	198,171,000	255,109,000	---	---	---
Total per person	33	40	42	53	---	---	---
Total per uninsured person	46	55	57	73	---	---	---
Total capital	2,455,000	4,779,000	7,027,000	510,000			
Constant (2004/05) prices							
Total	177,367,474	204,406,339	207,298,908	255,109,000	278,999,000	301,473,000	338,603,000
Total per person	39	44	44	53	57	61	67
Total per uninsured person	53	60	60	73	78	83	92
Total capital	**2,847,670**	**5,260,559**	**7,350,669**	**510,000**	**14,820,000**	**16,250,000**	**2,415,000**

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

Programme 4: Provincial Hospital Services

PROGRAMME 4: Provincial Hospital Services

1. AIM

Delivery of hospital services, which are accessible, appropriate, effective and provide general specialist services, including a specialized rehabilitation service, as well as a platform for training health professionals and research.

2. PROGRAMME STRUCTURE

Sub-programme 4.1 General (Regional) hospitals

Rendering of hospital services at a general specialist level and a platform for training of health workers and research.

Sub-programme 4.2 Tuberculosis hospitals

To convert present Tuberculosis hospitals into strategically placed centers of excellence in which a small percentage of patients may undergo hospitalization under conditions, which allow for isolation during the intensive phase of the treatment, as well as the application of the standardized multi-drug resistant (MDR) protocols.

Sub-programme 4.3 Psychiatric hospitals

Rendering a specialist psychiatric hospital service for people with mental illness and intellectual disability and providing a platform for the training of health workers and research.

Sub-programme 4.4 Chronic medical hospitals

These hospitals provide medium to long-term care to patients who require rehabilitation and/or a minimum degree of active medical care but cannot be sent home. These patients are often unable to access ambulatory care at our services or their socio-economic or family circumstances do not allow for them to be cared for at home.

The aim is to reorganize this sub-programme and place the institutions in the programmes where they operate. To this effect Maitland Cottage Hospital will move to Programme 5 and all the other institutions bar the Western Cape Rehabilitation Centre will move to Programme 2.

Sub-programme 4.5 Dental training hospitals

Rendering an affordable and comprehensive oral health service, supporting the primary health care approach and training.

The hospital sub-programs are quite different in terms of the services they render and the narrative is therefore captured within each of the sub programmes.

3. SUB-PROGRAMME 4.1 General (Regional) hospitals

3.1 SITUATION ANALYSIS

Emergency services have been under severe strain with high volumes of attendances and a high acuity of illness amongst patients at presentation. An extensive audit was done during 2003 on all medical emergency visits at GF Jooste Hospital in the Metro Region, which illustrates this problem. This study showed that 65% of all attendees to the Emergency Department are ill enough to warrant admission, but due to limited bed numbers, only 45 to 50% can be admitted to this hospital. Twenty five percent of all medical admissions from the Emergency Unit are severely ill, with an in-patient mortality risk of 25% at presentation (V Birch, 2003).

The level of acuity of trauma cases has remained high, resulting in an escalation in the cost of acute care of trauma cases as well as specialized rehabilitation services. There has been increased pressure on the need for access to ICU services and ventilation of patients. The increased need for emergency trauma surgery has also caused the waiting time for elective surgery to increase.

The HIV and AIDS pandemic is a chief contributor to the load on the services both in terms of patient numbers and acuity of illness. The impact is being felt at acute hospitals, TB and chronic medical hospitals. Of all medical admissions who die at GF Jooste Hospital, 32% are HIV positive and a further 10% (not tested) die of AIDS related diseases e.g. Kaposi's sarcoma (Birch 2003). Tuberculosis rates remain high and co-infection of TB and HIV has resulted in uncommon forms of presentation and late diagnosis of the disease. Thirty one percent of patients who die at GF Jooste Hospital are TB positive.

The provision of anti retroviral drugs to an increasing number of patients will reduce the concomitant sequelae of other AIDS related diseases. These hospitals are over full, with occupancy rates often exceeding 85%. The opening of 150 level 1 beds in the Metro during 2005 has alleviated the situation to some extent.

Table 4.1 Public hospitals by hospital type [PHS1:]

Hospital type	Number of hospitals	Number of beds 2006/07	Provincial average number of beds per 1 000 uninsured
District	28	1,855	0.52
Regional	9	2,150	0.60
Central	3	2,551	0.72
Sub-total acute hospitals	40	6,556	1.84
Tuberculosis	6	1,073	0.30
Psychiatric	4	2,205	0.62
Other Special	7	729	0.20
Sub-total chronic hospitals	17	4,007	1.12
Total public hospitals	57	10 563	2.96

Table 4.2 Public hospitals by level of care [PHS2]

Level of care	Number of Hospitals providing level of care*	Number of Beds	Provincial average number of beds per 1 000 uninsured
L1 Beds	28	2,110	0.59
L2 Beds	9	2,896	0.81
L3 Beds	3	1,550	0.43
All acute levels	40	6,556	1.84

Table 4.3 Situation analysis indicators for general (regional) hospitals [PHS3]

Indicator		Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05
Input					
1	Expenditure on hospital staff as % of regional hospital expenditure	%	72.8	67.7	67.3
2	Expenditure on drugs for hospital use as % of regional hospital expenditure	%	4.3	4.4	4.5
3	Expenditure by regional hospitals per uninsured person	R	165.2	197.4	219.5
Process					
4	Regional hospitals with operational hospital board	%	90	90	100
5	Regional hospitals with appointed (not acting) CEO in post	%	82	86	100
6	Facility data timeliness rate for regional hospitals Percentage of regional hospitals with data submitted to National DoH within 60 days after the end of the month, for each month in the period.	%	Not available	Not available	Not available
Output					
7	Caesarean section rate for regional hospitals	%	29.1	29.4	27.5
Quality					
8	Regional hospitals with completed annual patient satisfaction survey using DoH template in the last 12 months	%	0	36	80
9	Regional hospitals with clinical audit (M and M) meetings every month	%	40	85	100

Indicator		Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05
Input					
Efficiency					
10	Average length of stay in regional hospitals	Days	3.7	3.5	3.6
11	Bed utilisation rate (based on usable beds) in regional hospitals	%	91	88	90
12	Expenditure per patient day equivalent in regional hospitals	R	793	791	791
Outcome					
13	Case fatality rate in regional hospitals for surgery separations	%	1.9	1.7	1.7

Note:
The above table does not reflect referral routes or access of district population to regional hospitals as the drainage areas of regional hospitals do not correspond with district boundaries.

3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

In line with Healthcare 2010, Level 1 and 2 services in the Metro and rural regions will be strengthened to improve access to hospital care and avoid inappropriate referrals to tertiary level.

- Given the shortage of nurses, the department will spend R2m on nurse training and mentorship within sub programmes 4.1: General hospitals, 4.3: Psychiatric/mental hospitals, and 4.4: Chronic medical hospitals.
- The recruitment and retention of specialists in the rural regional hospitals is a priority. The upgrading of the posts to principle specialists to head the different disciplines will begin during 2006/07. An amount of R1,5m has been allocated to the rural regional hospitals to commence this process and will increase to R3 million thereafter.
- 20 Additional Level 2 beds will be commissioned at Eben Donges in keeping with the expanded infrastructure through the Hospital Revitalisation Programme (HRP). This will cost approximately R3m per year. An amount of R3 million is allocated in 2006/07 to facilitate the commissioning of an additional 100 level 2 beds at Eben Donges Hospital over the next three years.
- R1,2 m will spent on commissioning a day surgery ward of 10 beds at New Somerset Hospital to fast track the basic procedures such as cataracts, tonsillectomies and hernias. The culture of efficiency and rapid turnover of patients will be instituted from the outset.
- R2,33m will be used to fill critical posts at Regional Hospitals. Most hospitals have been steadily losing staff especially professional nurses.
- The pressure on availability of beds in the Metro for new admissions has increased. In addition to the creation of additional bed capacity described above, greater efficiency in the management of beds will be developed. A central co-ordination and equitable distribution of patient load after hours is being developed within Programme 3: Emergency Medical Services to facilitate the admission of new patients and preempt the diversion of ambulances which has come to be a regular occurrence within the Metro.
- The upgrading of George and Worcester Hospitals in terms of the Revitalisation Programme will continue. Construction at Paarl Hospital will commence during 2006.
- Implementation of extended ENT services began two years ago. The services will be strengthened by training of medical officers to sustain the ENT service at regional and district hospitals to reduce waiting lists for basic ENT services such as tonsillectomies.
- A closer working relationship and co-management of trauma and emergency services between the regional and district hospitals and the CHCs within the DHS will be forged.
- Level 2 beds are being separated from level three services within the central hospitals. The sum total of the level 2 beds within the central hospitals is greater than all the regional hospitals within the Metro. Identification of all level 2 beds will allow better co-ordination and management of the level 2 service platform within the Metro.
- The appointment of clinical co-ordinators to co-ordinate services across all levels of care will have a positive impact on the streamlining and referral of patients between institutions.

3.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

3.3.1 Human Resource constraints

Re-shaping of the Service in line with Healthcare 2010

The proposed Service Plan will require changes in bed numbers and service delivery within facilities, shifting of staff members between facilities, upgrading of current hospitals and building (and staffing) of new hospitals.

Difficulty in attracting and retaining staff especially nurses and medical officers

The lack of key staff has become the limitation to the provision of services within the current platform and to any further expansion. The range of strategies adopted by the Department will to some extent improve the ability to recruit and retain staff, especially professional nurses and doctors.

3.3.2 Goods and Services

Increase in the transport costs of patient and non-patient transport is being investigated within the department with the aim of improved service delivery but also better management and increased efficiencies.

Currently hospitals still depend significantly on agency staff and this will be addressed during 2006/07, by the filling of posts, especially for nursing.

3.4 PLANNED QUALITY IMPROVEMENT MEASURES

- Provision of adequately trained clinical personnel
- Strengthen Facility Boards at each facility to provide communities with a greater share of ownership in overall strategic direction of facilities and to increase accountability of institutional management to communities. Most facility boards will have to be re-constituted through the appointment of new members after their first term of three years have been completed in 2006.
- General improvements in Hospital infrastructure are to be achieved through the Revitalization Programme
- Continuous development and training of health care workers
- Improving quality of patient care by:
- Assessment of Client Satisfaction
- Assessment of the implementation of the Patient's Rights Charter
- Refinement of the Patient Complaints and Complements procedure
- Improving technical quality by:
- Morbidity and Mortality Monitoring and reporting
- Development of clinical protocols for the improvement of care

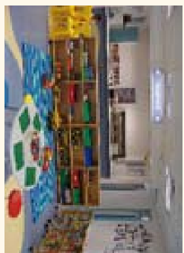
Care for the Carers by:

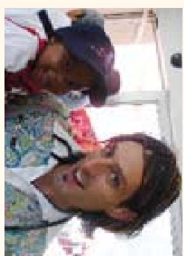
- Monitoring of Safety and Security Risks
- Assessment of staff satisfaction
- EAP to support staff working in a stressful environment
- Improvement of the physical working environment
- Clinical audits
- Protocol driven clinical service
- Improved equipping of hospitals through dedicated funds from provincial treasury.

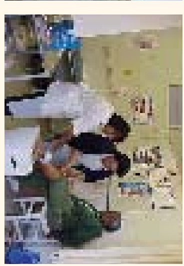
3.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.4 Provincial objectives and performance indicators for general (regional) hospitals [PHS4]

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
INPUT									
Provide sufficient funds for non-personnel expenditure in regional hospitals.	Expenditure on staff as % of total expenditure	64.40%	72.8	68	67	66	65	65	65
	Expenditure on drugs as % of total expenditure		4.3	4.4	4.5	5.0	6.0	6.0	6.0
	Expenditure on maintenance as % total expenditure	6.40%			6	6	7	7	7
Provide regional hospitals infrastructure in line with Healthcare 2010	Useable beds per 1000 people	0.48	0.39	0.40	0.43	0.44	0.44	0.44	0.44
	Useable beds per 1000 uninsured population	0.66	0.53	0.55	0.59	0.60	0.60	0.61	0.60
Provide sufficient funding to ensure an efficient regional hospital service for the population.	Hospital expenditure per capita (total population)		155	157	166	163	172	180	190
	Hospital expenditure per capita (uninsured population)		212	215	227	224	235	246	261
Provide services that adequately address the needs of inpatients, outpatients and trauma cases.	Outpatients per inpatient day ratio	1.02	1.55	1.61	1.44	1.30	1.25	1.12	1.20
	Trauma as % of total outpatient headcounts		27.2%	30.1%	30.3%				
	Total number of inpatient days		589,729	600,659	669,107	659,190	674,885	682,550	682,550
	Total number of outpatient headcounts (incl trauma)		912,237	967,406	963,697	856,411	844,413	765,624	819,210
PROCESS									
Facilitate representative management	Percentage of hospitals with operational hospital board	100	90	90	100	100	100	100	100
Facilitate decentralised management and accountability.	Percentage of hospitals with appointed CEO in place (or Medical Superintendent)	100	82	86	100	100	100	100	100
	Percentage of hospitals with business plan agreed with the Provincial Health Department	100							







OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
INPUT									
OUTPUT									
Ensure accessible regional hospital services to the population of the Western Cape.	Separations per 1000 people	37.6	35	38	38	38	38	37	37
	Separations per 1000 uninsured population	51.5	48	51	52	52	53	51	50
	Patient day equivalents per 1000 people		195	198	210	196	196	189	190
	Patient day equivalents per 1000 uninsured population		267	272	287	269	268	259	260
QUALITY									
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in the last 12 months.		0	36	80	100	100	100	100
	Percentage of hospitals with designated official responsible for co-ordinating quality management		Not available	Not available	100	100	100	100	100
	Percentage of hospitals with clinical audit (M&M) meetings at least once per month.		40	85	100	100	100	100	100
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources	Average length of stay	4.00	3.7	3.5	3.6	3.6	3.6	3.7	3.7
	Bed utilisation rate based on useable beds	85%	91	88	90	86	86	85	85
	Expenditure per patient day equivalent		793	791	791	822	863	932	979
OUTCOME									
Ensure desired clinical outcomes	Case fatality rate for surgery separations		1.9	1.7	1.7	1.4	1.4	1.4	2

Table 4.5 Performance indicators for general (regional) hospitals [PHS5]

	Indicator	Type	2004/05	2005/06	2006/07	2007/08	2008/09	National target 2008/09
Input								
1	Expenditure on hospital staff as % of regional hospital expenditure	%	67	66	65	65	65	66
2	Expenditure on drugs for hospital use as % of regional hospital expenditure	%	4.50	5.00	6.00	6.00	6.00	12
3	Expenditure by regional hospitals per uninsured person	R	227	224	235	246	261	
Process								
4	Regional hospitals with operational hospital board	%	100	100	100	100	100	100
5	Regional hospitals with appointed (not acting) CEO in post	%	100	100	100	100	100	100
6	Facility data timeliness rate for regional hospitals	%						100
Output								
7	Caesarean section rate for regional hospitals	%	27.5	25	25	25	25	18
Quality								
8	Regional hospitals with patient satisfaction survey using DoH template	%	80	100	100	100	100	100
9	Regional hospitals with clinical audit (M and M) meetings every month	%	100	100	100	100	100	100
Efficiency								
10	Average length of stay in regional hospitals	Days	3.6	3.6	3.6	3.7	3.7	4.1
11	Bed utilisation rate (based on usable beds) in regional hospitals	%	90	86	86	85	85	75
12	Expenditure per patient day equivalent in regional hospitals	R	791	822	863	932	979	1,128
Outcome								
13	Case fatality rate in regional hospitals for surgery separations	%	1.9	1.7	1.7	1.4	1.4	2.0

3.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 4.6 Trends in provincial public health expenditure for general (regional) hospitals (R million) [PHS6]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	**613,307,000**	**665,389,477**	**750,742,000**	**785,678,000**	**---**	**---**	**---**
Total per person	133	143	158	163	---	---	---
Total per uninsured person	183	195	217	224	---	---	---
Total capital	60,572,000	117,892,000	173,353,000	155,526,000	---	---	---
Constant (2004/05) prices							
Total	711,403,529	732,437,900	785,321,753	785,678,000	838,501,000	891,508,000	958,890,000
Total per person	155	157	166	163	172	180	190
Total per uninsured person	212	215	227	224	236	246	261
Total capital	**70,260,301**	**129,771,467**	**181,337,772**	**155,526,000**	**163,418,000**	**120,356,000**	**105,570,000**

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

4. SUB – PROGRAMME: 4.2 TUBERCULOSIS HOSPITALS

4.1 SITUATIONAL ANALYSIS

Pulmonary TB in the Western Cape dramatically increased over the past 7 years. From 1997 until 2003, TB increased by 38%. In 2004, 44 502 TB cases were reported in the Western Cape Province. This reflects a growing population, migration, improved case detection and an increased burden of disease. 30% of TB patients in the Western Cape are co-infected with HIV resulting in high morbidity and mortality rates in this group and an increase in the average length of stay (ALOS) of patients.

An amount of R2,23 million was allocated in 2005/06 to facilitate the provincialisation of the SANTA and Local Government TB hospitals.

4.1.1 DP Marais Hospital

DP Marais Hospital is a state-aided specialised hospital situated in the suburb of Retreat in Cape Town, and is currently managed by Santa Western Cape TB. The hospital currently has 260 available beds and bed occupancy rates have remained stable over the past few years at approximately 85%.

DP Marais only caters for adult ambulatory TB patients, [over 18 years of age], requiring daily-observed therapy who are unable to receive treatment in an out-patient/community setting.

Management of the hospital will be taken over by the Department during 2006.

4.1.2 Brooklyn Chest Hospital (BCH)

Brooklyn Chest Hospital caters for complicated TB cases requiring admission and specialised care. Brooklyn Chest is also the designated multi-drug resistant (MDR) specialist centre and is responsible for the management of all MDR patients in the Metropole Region and West Coast/Winelands.

The number of extra-pulmonary TB cases has increased by 66% in the Metropole over the last 3 years (from 12% to 16% of all TB cases). This could be a reflection of the impact of the HIV epidemic.
Due to the high TB and HIV co-infection rates of patients admitted to Brooklyn Chest Hospital, the severity of the disease in patients is significantly higher than in the past and this has resulted in increased length of stay and increased fatalities. This creates bottlenecks within the referral system of patients from secondary and district hospitals to Brooklyn Chest Hospital, with TB patients “blocking beds” in the secondary and district hospitals whilst waiting for vacant beds at Brooklyn Chest Hospital.

Two wards [90 beds] at BCH have been converted to isolation facilities for MDR patients. These wards are equipped with germicidal ultraviolet lights and plans are in place to provide separate barriers/fences

for these wards. The opening of these isolation wards has not been sufficient to deal with the demand for beds for MDR patients especially males and the possibility of using a third ward for MDR patients is being considered. The hospital also increasingly has to manage patients with chronic or terminal MDR TB and the option of building a step-down/ palliative care facility for these patients is being considered.
An increasing number of dually infected patients also qualify for ARV treatment and there is a need to provide either ARV out-reach services to the hospital or accredit the hospital as an ARV site.

4.1.3 Brewelskloof Hospital

Brewelskloof Hospital has 206 beds in use for TB patients with 34 beds utilised by the BCG Research Unit of the School for Child and Adolescent Health, UCT. The Hospital is also the designated multi-drug resistant (MDR) specialist centre and is responsible for the management of all MDR patients in the Boland Overberg Region.

Brewelskloof provides TB outreach services to 21 clinics in the Boland / Overberg region – Medical Officers carry out monthly visits and the hospital also provides TB drugs to all other hospitals and clinics in the Region. The other regional services include supply of psychiatric drugs, medicine and sundries to old age homes and the repair of wheelchairs. The current pharmacy is very small and inadequate and plans are under way to move the pharmacy to larger premises and refurbish a new pharmacy that will meet the required needs.

Tuberculosis and HIV co-infected patients average at 16%. Currently approximately 19% of TB patients are MDR, with no isolation wards or germicidal ultraviolet lights available to protect staff. Germicidal ultraviolet lights were installed during 2005/6. Bed occupancy rates average at 82% and have been affected by staff shortages, both medical and nursing.

The hospital has entered into a partnership with Eben Donges Hospital in Worcester to provide antiretroviral services to patients who qualify for treatment.

The hospital has experienced difficulty with planned patient transport, resulting in patients not attending respiratory clinics or failing to be admitted as arranged.
Brewelskloof Hospital accommodates a school (average 10 pupils) which has moved from the hospital to an old staff house on the premises where it is functioning well.

4.1.4 Harry Comay

SANTA Centre (TB Hospital) in George has reduced the number of beds from 125 to 90, with a concomitant expansion of Tuberculosis services at Oudtshoorn Hospital during the past year. This has affected mainly the paediatric wards which have been relocated because of inadequate funding and inadequate clinical management. Priority is given to patients from deep rural areas requiring streptomycin injections. The hospital was provincialised as from 01 June 2005. The current hospital infrastructure is generally of poor quality and inadequate for the type of services that needs to be delivered. Consideration must be given to replace the hospital with improved facilities in the medium term. The hospital also manages TB MDR cases for the Southern Cape Region and currently makes provision for 18 patients.

4.1.5 Sonstraal Hospital

in Paarl will be provincialised by 1 April 2006. It currently has 90 beds and patients are referred to the hospital from PHC clinics and hospitals in the area. Acutely ill patients are first stabilised at Paarl Hospital. Multi-drug resistant patients are referred to Brooklyn Chest Hospital in Cape Town.
6.6.6 The Infectious Diseases Hospital in Malmesbury will be provincialised from 1 April 2006. It has 52 beds and a personnel component of 19. The hospital facility is in a poor state and not adequately staffed at present.

4.1.7 Multi-Drug Resistant TB

The emergence of multi-drug resistance (MDR) is potentially the most serious aspect of the TB epidemic and refers to TB, which is resistant to the first line TB drugs. Multi-Drug Resistant TB is difficult and expensive to treat, with cure rates of 50% at best. Since 1990 MDR TB in the Metro has largely been managed through a specialist clinic at Brooklyn Chest Hospital.

The DOTS Plus survey conducted by the Medical Research Council, confirmed that the Western Cape has the lowest MDR rates in the country. The reported rates were 1% for new cases, and 4% for re-treatment cases. These rates were the same as those reported in a survey conducted in 1995. It is important that the Department take steps on an ongoing basis to keep the rates for MDR TB low.

Table 4.7 Situation analysis indicators for TB hospitals [PHS3]

Indicator		Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05
Input					
1	Expenditure on hospital staff as % of TB hospital expenditure	%	80.4	79.0	70.0
2	Expenditure on drugs for hospital use as % of TB hospital expenditure	%	9.9	9.8	10.0
3	Expenditure by TB hospitals per uninsured person	R	15.5	16.3	17.1
Process					
4	TB hospitals with operational hospital board	%	0	0	0
5	TB hospitals with appointed (not acting) CEO in post	%	100	100	100
6	Facility data timeliness rate for TB hospitals Percentage of TB hospitals with data submitted to the National DoH within 60 days after the end of the month, for each month in the period.	%	Not available	Not available	Not available
Quality					
7	TB hospitals with completed annual patient satisfaction survey in the last 12 months using DoH template	%	0	0	0
8	TB hospitals with clinical audit (M and M) meetings every month	%	0	0	0
Efficiency					
9	Average length of stay in TB hospitals	Days	66.7	71.9	72.4
10	Bed utilisation rate (based on usable beds) in TB hospitals	%	83	88	77
11	Expenditure per patient day equivalent in TB hospitals	R	169.52	170	206.27

4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The dual TB and HIV epidemic will result in more "complicated TB cases" that will require more expert clinical skills. This will be amplified with the roll-out of ARV programmes. The increased "complicated TB cases" will require hospitalisation and can be expected to have an increased length of stay.

The health facilities infrastructure plan for the province provides for the upgrading of Brooklyn Chest Hospital and the possible move of D.P. Marais from the current Princess Alice Orthopaedic Hospital site to the BCH site.

According to the Healthcare 2010 Service Plan, the number of beds at Brewelskloof should be increased to 250, however the current shortage of nursing staff does not allow for an increase in the current number of beds at present.

The DOTS Plus strategy requires hospitalisation for MDR and complicated TB cases under proper standards (isolation protection in intensive phase, 4 months). The Brooklyn Chest Hospital will become a centre of excellence for MDR and complicated TB. The D.P. Marais facility will accommodate the more ambulant TB cases, but will benefit from the proximity to the centre of excellence on the same premises. Two isolation wards for MDR patients were opened at BCH during 2004.

The MDR DOTS Plus strategy which requires admission for 4 months, as well the increase in the number and acuity of absolute cases will increase the pressure on hospital beds. This may result in acutely ill TB patients blocking acute general hospital beds while they await a bed within TB hospitals. The Department is currently developing a Healthcare 2010 TB Hospital Plan to address these challenges.

The provincialisation of Harry Comay, Paarl Tuberculosis (TB) Hospital (Sonstraal), Malmesbury TB Hospital (Infectious Diseases) and DP Marais Hospital requires the Department to upgrade the services and facilities of these hospitals and increase their capacity to care for more acutely ill patients. An amount of R1,4m has been committed in Programme 2: District Health Services to equalise the salaries of staff from DP Marais and Harry Comay. The capacity of all the TB hospitals to collect and manage information must be addressed. Increased measures to protect staff and patients from contracting TB and MDR TB must be put in place.

4.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The impact of the HIV epidemic on the management of TB clients, especially in the light of the imminent large-scale introduction of ARV programmes, will have to be managed effectively. The likely emergence of complex clinical presentations will be an added challenge that the centre of excellence will have to cope with. The general skills and competencies of clinicians to deal with patients with complex clinical presentations at all levels of care will need to be upgraded.
The acuity of patients being managed in TB hospitals has increased. This has required more intensive hospitalisation, an increase in the drug budget and an increase in staffing levels.

The infrastructure within certain TB hospitals is ole and requires renovation, maintenance and upgrading. An additional amount of R4,3 million has been allocated to enhance the TB response: R930 000 to DP Marais Hospital, R2,8 million to Brooklyn Chest Hospital and R600 000 to Harry Comay Hospital.

There is a lack of skilled clinicians at BCH to establish and drive the centre of excellence.

4.4 PLANNED QUALITY IMPROVEMENT MEASURES

The major challenge will be the protection of health workers against occupational exposure of TB, especially MDR TB. The Metro policy on this issue was finalised and implemented during the 2004/2005 financial year. Brooklyn Chest Hospital and D.P. Marais are high-risk settings, that need significant protective measures to safe guard their staff.

Client satisfaction surveys will be implemented and norms around patient care and discharge plans (especially for MDR clients) are in the process of being finalised.

The general approach to improving quality of care mentioned under Sub program 4.1: General Hospitals, will also apply to TB Hospitals.

Improving the clinical skills at PHC level to diagnose TB in a HIV positive patient, who is sputum negative, needs to be addressed. These missed opportunities result in patients being diagnosed at a later and more acute stage of the disease with a poorer prognosis.

As indicated in Programme 2, an additional amount of R12,5 million is allocated to combat TB during 2006/07.

4.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.8 Performance indicators for TB hospitals [PHS4]

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
INPUT									
Provide sufficient funds for non-personnel expenditure in TB hospitals	Expenditure on staff as % of total expenditure	90.00%	80.4	79.0	68.8	70	75	75	75
	Expenditure on drugs as % of total expenditure	12.0%	9.9	9.8	9.9	10.0	10.0	10.0	10.0
	Expenditure on maintenance as % total expenditure	2.00%	0.90	1.00	1.00	2	2	2	2
Provide TB hospitals infrastructure in line with Healthcare 2010	Useable beds per 1000 people	0.23	0.22	0.21	0.21	0.21	0.20	0.20	0.20
	Useable beds per 1000 uninsured population	0.31	0.30	0.29	0.29	0.28	0.28	0.28	0.27
Provide sufficient funding to ensure a efficient TB hospital service for the population.	Hospital expenditure per capita (total population)		12.9	12.8	13.7	13.3	15	15.6	16.3
	Hospital expenditure per capita (uninsured population)		17.7	17.5	18.8	18.3	20.6	21.4	22.4
Provide services that adequately address the needs of inpatients. Outpatients and trauma cases.	Outpatients per inpatient day ratio	0.02	0.01	0.01	0.01	0.02	0.02	0.02	0.07
	Trauma as % of total outpatient headcounts								
	Total number of inpatient days		300,910	319,622	281,034	281,050	292,730	297,475	310,250
	Total number of outpatient headcounts (including trauma)		4,456	4,472	4,091	4,304	4,979	6,846	22,765
PROCESS									
Facilitate representative management.	Percentage of hospitals with operational hospital board	100	20	30	50	100	100	100	100
Facilitate decentralised management and accountability	Percentage of hospitals with appointed CEO in place (or Medical Superintendent)	100	100	100	100	100	100	100	100
	Percentage of hospitals with business plan agreed with provincial health department.	100	40	50	100	100	100	100	100

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
INPUT									
OUTPUT									
Ensure accessible TB hospital services to the population of the Western Cape.	Separations per 1000 people	1	1.0	1.0	0.8	0.8	0.8	0.8	0.8
	Separations per 1000 uninsured population	1.4	1.3	1.3	1.1	1.1	1.1	1.1	1.1
	Patient day equivalents per 1000 people		66	69	60	59	60	60	63
	Patient day equivalents per 1000 uninsured population		90	94	82	80	83	83	86
QUALITY									
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in the last 12 months.	100	20	20	30	50	100	100	100
	Percentage of hospitals with designated official responsible for coordinating quality management.	100	0	0	0	100	100	100	100
	Percentage of hospitals with clinical audit (M&M) meetings at least once a month.	100	40	50	100	100	100	100	100
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources.	Average length of stay	80.00	66.7	71.9	72.4	72.0	74.0	74.0	74.0
	Bed utilisation rate based on useable beds	90%	0.83	0.88	0.77	0.77	0.80	0.82	0.85
	Expenditure per patient day equivalent		196	186	230	227	232	241	243

Table 4.9 Performance indicators for TB hospitals [PHS5]

	Indicator	Type	2004/05	2005/06	2006/07	2007/08	2008/09	National target 2008/09
Input								
1	Expenditure on hospital staff as % of TB hospital expenditure	%	68.8	70	75	75	75	66
2	Expenditure on drugs for hospital use as % of TB hospital expenditure	%	9.9	10	10	10	10	12
3	Expenditure by TB hospitals per uninsured person	R	18.76	18.29	20.60	21.44	22.37	
Process								
4	TB hospitals with operational hospital board	%	50	100	100	100	100	100
5	TB hospitals with appointed (not acting) CEO in post	%	100	100	100	100	100	100
6	Facility data timeliness rate for TB hospitals	%	90	90	90	100	100	100
Quality								
7	TB hospitals with patient satisfaction survey using DoH template	%	30	50	100	100	100	100
8	TB hospitals with clinical audit (M and M) meetings every month	%	100	100	100	100	100	100
Efficiency								
9	Average length of stay in TB hospitals	Days	72	72	74	74	74	
10	Bed utilisation rate (based on usable beds) in TB hospitals	%	0.77	0.77	0.80	0.82	0.85	75
11	Expenditure per patient day equivalent in TB hospitals	R	230	227	232	241	243	

4.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 4.10 Trends in provincial public health expenditure for TB hospitals(wR million) [PHS6]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	51,154,000	54,268,611	62,049,000	64,238,000	---	---	---
Total per person	11	12	13	13	---	---	---
Total per uninsured person	15	16	18	18	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	59,335,922	59,737,025	64,907,025	64,238,000	73,490,000	77,666,000	82,301,000
Total per person	13	13	14	13	15	16	16
Total per uninsured person	18	18	19	18	21	21	22
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant rice projections for the same years

5. SUB-PROGRAMME 4.3 PSYCHIATRIC HOSPITALS

5.1 SITUATIONAL ANALYSIS

Psychiatric services function within a changed world view and approach to the care of mentally ill and intellectually disabled people, in which institutional long term care is viewed as the last resort and not the best option for the patient.

Table 4.11 Situation analysis indicators for psychiatric hospitals [PHS3]

Indicator		Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05
Input					
1	Expenditure on hospital staff as % of Psychiatric hospital expenditure	%	82.0	81.5	79.5
2	Expenditure on drugs for hospital use as % of Psychiatric hospital expenditure	%	2.0	1.9	2.2
3	Expenditure by Psychiatric hospitals per uninsured person	R	74	72	79
Process					
4	Psychiatric hospitals with operational hospital board	%	90	90	100
5	Psychiatric hospitals with appointed (not acting) CEO in post	%	82.0	86.0	100.0
6	Facility data timeliness rate for Psychiatric hospitals	%	80	90	90
Quality					
7	Psychiatric hospitals with patient satisfaction survey using DoH template	%	0	100	100
8	Psychiatric hospitals with clinical audit (M and M) meetings every month	%	40	50	100
Efficiency					
9	Average length of stay in Psychiatric hospitals	Days	115.7	114.7	118
10	Bed utilisation rate (based on usable beds) in Psychiatric hospitals	%	0.83	0.82	0.83
11	Expenditure per patient day equivalent in Psychiatric hospitals	R	380	378	411

5.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

5.2.1 Policy

The number of specialist psychiatric hospitals will remain unchanged in Healthcare 2010 and is linked to the provision of psychiatric beds at Regional and District hospitals and the development of community based services.

Regulations promulgated in terms of the Mental Health Care Act 17 of 2002 have resulted in the need to adjust many of the mental health policies to ensure compliance with obligations imposed by the Act. The Mental Health Review Board is playing an integral role in ensuring compliance with the provisions of the Mental Health Care Act 17 of 2002, particularly relating to the protection of the rights of mental health care users in the broader service context.
The licensing capacity and inspectorate aspects of the Act are still to be established, particularly in respect to community- based services such as day centres and group homes.

In terms of the Act the Provincial Minister of Health has designated mental health facilities and units, which are for the exclusive purpose of providing mental health care, rehabilitation and treatment programmes. However, mental health care users can present at any health care facility for treatment and can expect to receive treatment at all levels of care in the least restrictive manner, and only if required be referred to a designated facility.

R1 million has been allocated for the increased costs of security contracts at mental health facilities. All new contracts have been awarded except for Lentegeur pending PPP finalisation.

An amount of R672 000 has been allocated for transfer to a group home, run by a non-profit organisation caring for people discharged from Alexandra and Lentegeur Hospitals. This situation will be reviewed for 2006/07 in conjunction with Department of Social Services

5.2.2 Service Priorities and Broad Strategic Objectives.

5.2.2.1 Bed plan

The number of beds in the specialist hospitals are now 2 127. It is now not possible to reduce the numbers any further as there has not been an increase in district and regional hospital beds.

- Whilst chronic bed closures are expected in the specialist hospitals the number of district and regional acute beds for the province is expected to increase from the current 12 in the Southern Cape to a total of 300 for the province, 50 in each of the rural regions and 150 in the Metro as part of the Healthcare 2010 strategy. Since 2010 modelling was done in 2001 the APH have closed 22% of the expected beds for closure yet only 4% of the expected District and Regional beds have been commissioned, this is resulting in growing service pressures.
- Similarly a range of alternative community based support services, including alternative residential options is expected to develop making it possible for people and their families in the ff. groups to obtain the necessary safe, alternative care:
- Care for the aged with mental illness and intellectual disability in old age homes.
- Care for adolescents particularly those who no longer attend school.
- Placement for people with severe mental illness in supervised group homes.
- Placement for people with intellectual disability in-group homes with varying levels of supervision.
- Supervised community residences for state patients in the forensic service who do not have stable families to which they can be discharged under supervision.
- Frail care for the multiply disabled.
- It will be essential for Health and Social Services to implement formal agreements regarding the primary responsibility for providing financial assistance to the above groups of people to purchase these services.
- An assessment tool has been developed to assess the functionality of these patients, in order to determine the Department responsible for their care. The mild and moderately disabled patients would be the responsibility of Social Services and the profound and severely disabled would be the responsibility of the Health Department.

5.2.2.2 Service priorities for 2006/2007

1) Child and Adolescent Services
   - The focus remains on the continued consolidation, broadening and strengthening of adolescent services across the service platform.
   - In the Red Cross and Groote Schuur service there is scope for further consolidation and the APH plays a facilitation role as the principal specialist for the Child and Adolescent service platform for the Province is located within the APH.
   - At Lentegeur Hospital, the subacute unit for adolescents with psychotic illness requires increased staffing to run at full capacity. Currently, only 12 beds of the planned 18 beds, are operational due to the lack of adequately skilled staff. While this unit does provide some relief to the Tygerberg acute service, the waiting list for admission to these services remains at 12 to 15 people at any given time.
   - There is an urgent need to separate the adolescent and adult acute psychiatric services at Tygerberg Hospital. Plans are being developed to address this problem on an urgent basis and funding has been allocated to address this during 2006/07
   - The development of general specialist services for Children and Adolescents at Regional Hospital level remains a priority. Liaison services in South Peninsula and Metro North have been started at False Bay and Karl Bremer Hospitals respectively under the supervision of the community psychiatric team.
   - The two areas that need further development are services for adolescents with substance abuse and mental illness and

juvenile offenders with mental illness dual diagnoses. This will require collaboration between the relevant Departments including Social Services, Education and Correctional / Justice Departments.

2) Acute Adult services
   - Definition of the regional hospital service package with distinction between those services, which will be rendered in general hospitals as opposed to specialist hospitals, remains important for service planning.
   - Acute services in the three psychiatric hospitals continue to experience bed occupancy rates of 90 to 105%. This pressure on these services continues to grow and will only be alleviated with the opening of regional and district beds for 72 –hour assessments and for the transfer of more stable patients. Current infrastructure and staffing are key rate limiting factors. The vacancy rate for professional nurse posts remains a challenge ranging from a 22% vacancy rate at Stikland Hospital to a 62% vacancy rate at Valkenberg Hospital. The nursing agencies are also not able to supply sufficient professional nurses to make up the shortfall. The loss of critical mass of skilled nurses continues to negatively impact on any attempts to improve service delivery quality or to expand acute service availability.

3) Forensic Psychiatric Services
   - The waiting list for places in the male observation services remains static as the overall number of observation beds cannot be increased until a new unit is built.

Payment for these services remains erratic in the absence of a formal service level agreement between the Departments of Justice and Health resulting in funds for acute, general services being diverted to fund these resource intensive services. This is being currently addressed

5.2.2.3 Infrastructure

The physical infrastructure of psychiatric hospitals is one of the key elements to providing a safe and therapeutic service and has been a major challenge facing this service and continues to be a priority.

The reduction of the size of the estate and the necessary replacement and essential upgrading of facilities has been slow. This is becoming a greater priority with increasing security risks brought about by large estates.

Alexandra Hospital

There is still great potential for further consolidation, with the development of occupational therapy, physiotherapy, pharmacy and outpatient services in suitably upgraded facilities close to in patient facilities and consideration being given to drawing support services closer to the core in-patient, hospital facilities. Electrified perimeter fences are essential for safety and security. The upgrading of the Pharmacy to comply with legislation was at tender document phase at the end of 2005.

Lentegeur Hospital

The consolidation that has been part of the relocation of the Western Cape Rehabilitation Centre to this site is complete and this is the hospital within the APH group that has the best overall infrastructure development.

Stikland Hospital

This service has been largely consolidated onto the Southern Site The tender for the relocation of the hospital administration building has been awarded and the project is due for completion during 2006.

The hospital is funding and overseeing the upgrade of a vacant ward in conjunction with the works department for the commissioning of an opiate detoxification unit for the management of complicated detoxification. This ward is adjacent to the existing alcohol rehabilitation unit and it is envisaged that once staffed and commissioned this unit would become a centre for providing a 24 hour help line to general health care emergency services which will continue to provide most first line detoxification services on both an outpatient and inpatient basis throughout the Province. R1,6m has been set aside to commission this facility.

Valkenberg Hospital

The consolidation of the Valkenberg services onto the Observatory Estate (Valkenberg West) remains the target.

A business case was completed in September 2005 to motivate for Valkenberg Hospital to become a National Hospital Revitalisation Project and it is hoped that this will be accepted for 2006/2007.

In the interim after another setback the completion of the new acute admission wards and admission suite was handed over to a new building contractor and the completion date at the end of 2005/2006 financial year appears to be a reality. Ward 4 was totally renovated to replace ward 16 in the male admission service and was commissioned in October 2005.

Significant upgrades have been undertaken to ward 20 as an interim measure prior to the replacement of the acute forensic service facilities. This has not alleviated the pressure for additional observation service capacity but has significantly improved living and working conditions within this facility.

The contract for an electrified perimeter fence and electronic access control is expected to be awarded in time for work to commence at the beginning of 2006.

5.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.3.1 Finance and financial management

Financial administrative capacity at hospital level remains a challenge and funding to the value of R12.96 million, allocated primarily in Programme 1 will address this shortcoming in the 2006/07 financial year. All such posts allocated to the APH have been filled. The acquisition of financial skills is part of the identified priorities for skills development with supply chain management being a particular focus area.

5.3.2 Human resources

The single greatest challenge is the shortage in professional nurses especially those with psychiatric skills or advanced psychiatry training. Numerous strategies are employed to address this. However, without being able to pay for scarce skills or apply other methods of improving remuneration, it is difficult for psychiatry to compete with more popular areas in addition to the overall difficulties experienced countrywide. People with psychiatric skills are particularly sought after in the international market. The ongoing negative media campaigns which continue to stigmatise both the patients and staff working in mental health services further impact on the ability to recruit this scarce resource into the mental health service field. Even nursing agencies are unable to meet the short-term needs of our hospitals.

A strategy that is expected to address some of the retention and skills development challenges is the launch of the Associated Psychiatric Hospitals Training Academy to be located at Stikland Hospital . R640 000 has been set aside for the nurse training project within APH.

Phase 1. September – December 2005

- An APH nurse training department established located at Stikland Hospital supported by the clinical training components at all four APH service sites. Psychiatry diploma training in partnership with a suitable HEI will be based here. Discussions have been initiated with the University of the Western Cape as a partner.
- Capacity established for clinical accompaniment and mentorship support at each clinical site.
- A core group of professional nurses identified at each hospital who will be prepared to enter a skills programme to become mentors in all key clinical areas. These mentors will support diploma trainees, newly qualified professionals and trainees who enter into SETA accredited short courses in Mental Health Care

Phase 2. January 2006 to June 2006

- Develop curriculum for the basic diploma course in conjunction with HEI for those registered nurses who have followed a bridging programme to become professional nurses. Obtain the accreditation of the South African Nursing Council (SANC) for the curriculum.
- In parallel develop short courses for all levels of nursing caregivers in mental health care and obtain SETA accreditation i.e. for ENA, EN and for PN to provide continuous professional development and train existing staff to become competent mental health care practitioners, which is a requirement of the Mental Health Care Act.
- Provide train the trainer in –service programme for mentors.
- Launch short course training modules from July 2006.

Phase 3 January 2007

- First intake of trainees for 1-year diploma in basic psychiatry.

Mental health services, by their very nature, are provided within a stressful environment. Staff are supported by an outsourced Employee Assistance Programme. The utilisation statistics, which far exceed the market benchmark, bear testimony to the value that this service brings in supporting staff within a difficult environment.

5.3.3 Support systems

The single greatest challenge and risk to the service lies within the arena of managing decaying physical infrastructure on large estates with poor perimeter security. This further impacts on the daily stressful work experience of staff, which has negative implications for the retention of staff.

5.3.4 Information

Until 2003/2004 all psychiatric information systems were manual. In 2003 and beginning of 2004 DELTA 9 was introduced at Alexandra, Lentegeur and Stikland and almost simultaneously LOGIS was introduced at all four hospitals. The HIS roll out to Valkenberg Hospital as the psychiatric hospital pilot site was successfully completed in June 2005.

5.4 QUALITY IMPROVEMENT MEASURES

5.4.1 Management of Organisation

There is a deputy director at Regional level who has the quality of care co-ordination portfolio as part of her brief and the hospitals have all identified senior staff members to be their quality of care representatives, this group has chosen to meet on a monthly basis and steady incremental progress is being made in terms of quality of care initiatives. This post became vacant in October 2005 and has been advertised again, it should be filled by March 2006.

5.4.2 Patient Care

The third client satisfaction survey was conducted at all four of the hospitals during November 2005.

Complaints and compliments are monitored in accordance with departmental policy. Submissions have been made on time and at

Hospital and Regional level trends monitored and each complaint used to improve services and identify risks.

Morbidity and mortality committees are in place at all hospitals and quarterly reporting in accordance with provincial Policy has been established, more importantly these reviews are used at hospital level to improve service delivery by identifying areas for improvement within a multidisciplinary team context. Meetings are held regularly at all hospitals.

Similarly the monitoring of adverse incidents and potential adverse incidents occurs in the hospitals to varying degrees. A standardized report is being developed on baseline indicators. This is an incremental process and attention is now being paid to ensuring that indicators are adequately defined.

The mental health service Drug and Therapeutic forum meets quarterly and represents the psychiatric services across the Provincial platform. This forum is consulted regularly and the chairman represents psychiatric services at the Provincial Coding Committee. Treatment protocols for the treatment of mental health problems at regional and district hospital level were published and are reviewed annually. All the APH hospitals have now established pharmaceutical control committees and together with this forum all aspects of drug and therapeutic management are monitored and evaluated. This group has successfully motivated for the inclusion of second generation antipsychotics as well as newer antidepressants onto provincial Code as well as providing the clinical guidelines for their use.

5.4.3 Human Resource Management

The Associated Psychiatric Hospitals (APH) became the first region to contract an outsourced Employee Assistance Programme (EAP) from July 2002. The EAP provider conducted a staff climate survey at the end of 2003 and recommendations made in this survey are being addressed at each hospital.

5.4.4 2006/2007

Services

1) Creation of a provincial 6-10 bed opiate detoxification unit at Stikland for complicated detoxification management.(out of the 2010 beds for district and region)
2) Forensic 20 bed step down facility at Lentegeur Hospital for State patients in rehabilitation preparing for community supervised placement.
3) Budget for the Province for use of newer generation psychiatric medications to improve outcomes in support of independent living.
4) Lentegeur improve infrastructure to increase capacity to manage adolescent patients on in-patient basis, provide equipment for electro convulsive therapy to be administered at Lentegeur and to reorganise adult admission services to improve quality of care.

Human Resource Management/Development

To set up an HRD section for the creation of sustainable training of nurses and other mental health care practitioners.

SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.12 Provincial objectives and performance indicators for psychiatric hospitals [PHS4]

OBJECTIVE	INDICATOR	2010 TARGET	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
INPUT									
Provide sufficient funds for non-personnel expenditure in Psychiatric hospitals.	Expenditure on staff as % of total expenditure	80.00%	82	82	80	80	80	80	80
	Expenditure on drugs as % of total expenditure		2.0	1.9	2.2	2.5	4.0	4.0	4.0
	Expenditure on maintenance as % total expenditure	2.00%	0.00	0.00	1.00	1.00	2.00	2.00	2.00
Provide Psychiatric hospitals infrastructure in line with Healthcare 2010.	Useable beds per 1000 people	0.26	0.49	0.48	0.45	0.44	0.44	0.43	0.42
	Useable beds per 1000 uninsured population	0.35	0.67	0.66	0.62	0.61	0.60	0.59	0.58
Provide sufficient funding to ensure an efficient Psychiatric hospital service for the population.	Hospital expenditure per capita (total population)		57	55	57	59	62	66	69
	Hospital expenditure per capita (uninsured population)		78	75	77	81	86	91	95
Provide services that adequately address the needs of inpatients and, outpatients services.	Outpatients per inpatient day ratio	0.02	0.03	0.04	0.03	0.04	0.04	0.04	0.13
	Total number of inpatient days		679,491	668,741	645,245	684,156	699,705	699,705	699,705
	Total number of outpatient headcounts		22,300	29,752	22,121	29,817	29,212	27,613	88,961
PROCESS									
Facilitate representative management	Percentage of hospitals with operational hospital board.	100	90	90	100	100	100	100	100
Facilitate decentralised management and accountability.	Percentage of hospitals with appointed CEO in place (or Medical Superintendent)	100	82	86	100	100	100	100	100
	Percentage of hospitals with business plan agreed with Provincial Health Department.	100	100	100	100	100	100	100	100
OUTPUT									
Ensure accessible Psychiatric hospital services to the population of the Western Cape.	Separations per 1000 people	0.8	1.3	1.3	1.2	1.2	1.2	1.3	1.3
	Separations per 1000 uninsured population	1.1	1.8	1.7	1.6	1.7	1.7	1.8	1.8
	Patient day equivalents per 1000 people		150	145	138	144	145	143	145
	Patient day equivalents per 1000 uninsured population		205	199	189	198	199	196	198

OBJECTIVE	INDICATOR	2010 TARGET	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in the last 12 months.	100	0	100	100	100	100	100	100
	Percentage of hospitals with designated official responsible for coordinating quality management.	100	0	100	100	100	100	100	100
	Percentage of hospitals with clinical audit (M&M) meetings at least once a month.	100	40	50	100	100	100	100	100
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources.	Average length of stay	106.00	115.7	114.7	118.0	118.0	118.0	110.0	106.0
	Bed utilisation rate based on useable beds	90%	0.83	0.82	0.83	0.88	0.90	0.90	0.90
	Expenditure per patient day equivalent		380	378	411	411	427	453	471

Table 4.13 Performance indicators for psychiatric hospitals [PHS5]

	Indicator	Type	2004/05	2005/06	2006/07	2007/08	2008/09	National target 2008/09
Input								
1	Expenditure on hospital staff as % of Psychiatric hospital expenditure	%	80	80	80	80	80	
2	Expenditure on drugs for hospital use as % of Psychiatric hospital expenditure	%	2.2	2.5	4	4	4	
3	Expenditure by Psychiatric hospitals per uninsured person	R	77	81	86	91	95	
Process								
4	Psychiatric hospitals with operational hospital board	%	100	100	100	100	100	
5	Psychiatric hospitals with appointed (not acting) CEO in post	%	100	100	100	100	100	
6	Facility data timeliness rate for Psychiatric hospitals	%	100	100	100	100	100	
Quality								
7	Psychiatric hospitals with patient satisfaction survey using DoH template	%	100	100	100	100	100	
8	Psychiatric hospitals with clinical audit (M and M) meetings every month	%	100	100	100	100	100	
Efficiency								
9	Average length of stay in Psychiatric hospitals	Days	118	118	118	110	106	
10	Bed utilisation rate (based on usable beds) in Psychiatric hospitals	%	0.83	0.88	0.90	0.90	0.90	
11	Expenditure per patient day equivalent in Psychiatric hospitals	R	411	411	427	453	471	

5.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 4.14 Trends in provincial public health expenditure for psychiatric hospitals (R million) [PHS6]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	225,209,000	232,790,236	256,210,000	285,273,000	---	---	---
Total per person	49.02	49.89	54.07	59.28	---	---	---
Total per uninsured person	67.14	68.34	74.07	81.21	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	261,230,473	256,247,503	268,011,229	285,273,000	305,115,000	328,852,000	348,665,000
Total per person	56.86	54.92	56.56	59.28	62.43	66.26	67.18
Total per uninsured person	77.88	75.23	77.48	81.21	85.53	90.77	94.77
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

6. SUB-PROGRAMME 4.4: CHRONIC MEDICAL HOSPITALS

6.1 SITUATIONAL ANALYSIS

The following hospitals were previously classified as chronic medical hospitals: Maitland Cottage Hospital, Booth Memorial Hospital, Western Cape Rehabilitation Centre, Sarah Fox Hospital, St Joseph's Home, Malmesbury Infectious Diseases Hospital and Nelspoort Hospital. In 2006/07, Maitland Cottage Hospital which is closely linked to Red Cross Children's Hospital will be shifted to Programme 5, while the Booth Memorial Hospital, Sarah Fox Hospital and St Joseph's Home will be shifted to Programme 2.

Table 4.15 Situation analysis indicators for chronic medical hospitals [PHS3]

	Indicator	Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05
Input					
1	Expenditure on hospital staff as % of Chronic medical hospital expenditure	%	82.8	81.5	70.9
2	Expenditure on drugs for hospital use as % of Chronic medical hospital expenditure	%	0.0	0.0	1.1
3	Expenditure by Chronic medical hospitals per uninsured person	R	14.6	17.2	16.7
Process					
4	Chronic medical hospitals with operational hospital board	%	90	90	100
5	Chronic medical hospitals with appointed (not acting) CEO in post	%	82	86	100
6	Facility data timeliness rate for Chronic medical hospitals	%	60	70	70

Indicator		Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05
Quality					
7	Chronic medical hospitals with patient satisfaction survey using DoH template	%	0	0	36
8	Chronic medical hospitals with clinical audit (M and M) meetings every month	%	40	50	85
Efficiency					
9	Average length of stay in Chronic medical hospitals	Days	70.5	63.7	57.6
10	Bed utilisation rate (based on usable beds) in Chronic medical hospitals	%	0.87	0.90	0.85
11	Expenditure per patient day equivalent in Chronic medical hospitals	R	220	249	246

6.2 POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

The activities of the Rehabilitation Centre were previously downscaled in order to facilitate the move from Conradie Hospital to the Lentegeur site. An amount of R4 million was allocated to provide for the upscaling of patient services at the new WCRC during 2005/06 and this process will continue during 2006/07. The plan to employ a facility manager and outsource non-core activities at the new facility is in progress.

The WCRC will co-manage with Program Development a specialist referral seating clinic for high risk patients. This will include motorized wheelchairs and pressure care cushions for these patients. There will be outreach, mobile seating clinic to build capacity within the regions to decrease referrals from the rural regions, transport costs and delays in repairs of wheelchairs. The increased provision of assistive devices requires additional capacity for repairs. This initiative will commence with funding allocated in the 2006/07 year.

6.3 CONSTRAINTS

The availability of staff to commission additional services at WCRC. Ongoing attempts are being made to recruit staff. The additional transport costs for staff previously working at Conradie and Karl Bremmer has been a deterrent. Attempts to have the most affected staff transferred to facilities closer to their homes were made.

6.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.16 Performance indicators for Chronic hospitals [PHS4]

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
INPUT									
Provide sufficient funds for non-personnel expenditure.	Expenditure on staff as % of total expenditure	75.00%	83	82	71	74	80	80	80
Provide Chronic hospitals infrastructure in line with Healthcare 2010.	Useable beds per 1000 people	0.13	0.15	0.15	0.16	0.19	0.18	0.18	0.18
	Useable beds per 1000 uninsured population	0.18	0.21	0.21	0.22	0.25	0.25	0.25	0.24
Provide sufficient funding to ensure an efficient Chronic hospital service for the population of the Western Cape.	Hospital expenditure per capita (total population)		10.6	12.6	12.2	20.6	12.5	13.8	14.4
	Hospital expenditure per capita (uninsured population)		14.6	17.2	16.7	28.2	17.1	18.9	19.7
Provide services that adequately address the needs of inpatients, outpatients and trauma cases.	Outpatients per inpatient day ratio	0.02	0.01	0.01	0.01	0.02	0.08	0.14	0.23
	Trauma as % of total outpatient headcounts								
	Total number of inpatient days		221,344	234,195	233,858	277,674	277,674	277,674	277,674
	Total number of outpatient headcounts (including trauma)		2,120	1,909	3,273	4,376	22,895	38,550	63,692
PROCESS									
Facilitate representative management.	Percentage of hospitals with operational								
	hospital board	100	90	90	100	100	100	100	100
Facilitate decentralised management and accountability.	Percentage of hospitals with appointed CEO in place (or Medical Superintendent)	100	82	86	100	100	100	100	100
	Percentage of hospitals with business plan agreed with Provincial Health Department.	100	100	100	100	100	100	100	100
OUTPUT									
Ensure accessible Chronic hospital services to the population of the Western Cape.	Separations per 1000 people	1.3	0.7	0.8	0.9	1.0	1.0	1.0	1.0
	Separations per 1000 uninsured population	1.7	0.9	1.1	1.2	1.4	1.4	1.4	1.4
	Patient day equivalents per 1000 people		48	50	50	58	58	59	59
	Patient day equivalents per 1000 uninsured population		66	69	68	79	80	80	81
QUALITY									
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in the last 12 months.	100	0	0	36	100	100	100	100
	Percentage of hospitals with designated official responsible for coordinating quality management.	100	0	0	0	50	100	100	100
	Percentage of hospitals with clinical audit (M&M) meetings at least once per month.	100	40	50	85	100	100	100	100
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources.	Average length of stay	35.00	70.5	63.7	57.6	55.0	55.0	55.0	55.0
	Bed utilisation rate based on useable beds	90%	0.87	0.90	0.85	0.85	0.85	0.85	0.85
	Expenditure per patient day equivalent		220	249	246	347	361	375	390

Table 4.17 Performance indicators for chronic medical hospitals [PHS5]

Indicator		Type	2004/05	2005/06	2006/07	2007/08	2008/09	National target 2008/09
Input								
1	Expenditure on hospital staff as % of Chronic medical hospital expenditure	%	82	71	74	80	80	
3	Expenditure by Chronic medical hospitals per uninsured person	R	16.71	28.20	17.10	18.90	19.70	
Process								
4	Chronic medical hospitals with operational hospital board	%	100	100	100	100	100	
5	Chronic medical hospitals with appointed (not acting) CEO in post	%	100	100	100	100	100	
6	Facility data timeliness rate for Chronic medical hospitals	%	70	100	100	100	100	
Quality								
7	Chronic medical hospitals with patient satisfaction survey using DoH template	%	36	100	100	100	100	
8	Chronic medical hospitals with clinical audit (M and M) meetings every month	%	85	100	100	100	100	
Efficiency								
9	Average length of stay in Chronic medical hospitals	Days	58	55	55	55	55	
10	Bed utilisation rate (based on usable beds) in Chronic medical hospitals	%	0.85	0.85	0.85	0.85	0.85	
11	Expenditure per patient day equivalent in Chronic medical hospitals	R	246	347	361	375	390	

6.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 4.18: Trends in provincial public health expenditure for chronic hospitals (R million) [PHS6]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	42,078,000	53,228,009	55,265,000	99,095,000	---	---	---
Total per person	9	11	12	21	---	---	---
Total per uninsured person	13	16	16	28	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	48,808,244	58,591,566	57,810,548	99,095,000	60,986,000	68,509,000	72,661,000
Total per person	11	13	12	21	12	14	14
Total per uninsured person	15	17	17	28	17	19	20
Total capital							

Note: Current prices projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.
The increase in 2005/06 is due to the transfer of the funds from Sub-programme 4.1 for the Western Cape Rehabilitation Centre

7. SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

7.1 SITUATIONAL ANALYSIS

The merging of the dental schools of the Universities of Stellenbosch and the Western Cape into the Tygerberg Oral Health Centre with effect from 01 April 2004, created a single platform for the training of oral health practitioners and facilitated integrated tertiary and health services.

7.1.1 Policy and political environment

Policies that must be taken in consideration for the purposes of planning:
1) Healthcare 2010
2) District Health System
3) Strategic Oral Health Planning 2003
4) Batho Pele service delivery principles
5) Higher Education Act regarding merger

7.1.2 Population characteristics and equity

The ratio of public sector dentist per population is very low, considering that the vast majority of population depends on the public sector. The present situation in the Western Cape is 1 dentist per 20 000 people which is only half the required number as per the norm of 1:10 000

Projected increase in public oral health services demand is based on four factors:
1) According to census 2001, the Western Cape is experiencing a high growth rate especially in the urban areas (2,4%).
2) Increased socio-economic depression in the communities that need our services the most.
3) The new medical aids innovation of allocating oral health financing to the saving account will increase the public sector workload as non-primary dental procedures are generally high expense items and therefore not out of pocket items.
4) Migration flow into the province

7.1.3 Service facilities, utilization and gaps

Private referrals to OHC are either because medical aids are depleted or ad hoc individual referral because of the expert skill available.

As a service facility the Combined Oral Health Centres (COHC's) has become the de facto referral center for **"difficult to treat" patients**. The COHC package of care consists of primary, secondary, tertiary and quaternary services. The COHC's are not funded to deliver primary health care package.

The Tygerberg OHC and the **satellite clinic of the COHC situated at the Mitchell's Plain Day** Hospital are the only specialized children's clinics offering comprehensive oral health service for children and children with special needs. It is also the screening site for children that require treatment under general anaesthetic.

The **outreach programme of the COHC at Guguletu** is serviced by staff and students from the COHC on a rotational basis and takes comprehensive oral health care to the lower level of service. This outreach programme sees in excess of 30 000 patients per year. One mobile clinic does outreach to under-serviced areas.

Patients from all over the province, as well as neighbouring provinces and countries, attend for treatment at the COHC, many of them referred from the public oral health service clinics.

Incapacity of OHC to cope with demand is reflected in the **long waiting times**. The level of service utilisation high and is being reflected in our high number of visits to the OHC.

7.1.4 Resources

- It is unlikely that there will be short-term growth in resources for OHC.
- Dental inflation is substantially greater than medical inflation.
- There are gaps in current and projected personnel
- The infrastructure from which service are delivered are owned by the universities. Both buildings at Tygerberg hospital and Mitchell's Plain are old and functionally not optimal in terms of space or high maintenance cost.

7.1.5 Health needs

Health needs as assessed by National survey on oral health disease highlighted the following with the highest prevalence rate and incidence. The target population is children.
1) Caries: 60-80% of children < 6 years has tooth decay.
2) HIV/AIDS: the epidemic fuelled by migration and no ARV drugs.
3) Dentures: 50% of adults are edentulous
4) Trauma impact on maxillo-facial surgery

The pattern of health problems is for the large part preventable by **educational programme** and **water fluoridation** or treatable by primary care facilities.

7.1.6 Cost efficiency

Average cost is R300/visits (including theatre cases). Average revenue generated per visit is R8. Cost per personnel is high due to the fact that there is less support staff, supervision of students is labour intensive and all provincial dental specialists are consolidated at the COHC. It is of note that a significant part of the services are rendered by students especially registrars (average patient load is 100 patient for an orthodontics registrar.) In general the **cost** of preventive measures, infection control and sterilization, has **increased** in the face of the HIV/AIDS epidemic and the specific treatment cost has significantly increased due to laboratory cost and drug therapy for opportunistic infection.

7.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

By the progressive realization of Healthcare 2010 principles it is intended to deliver the highest quality patient care within affordable and available resources.

1) Healthcare 2010
2) Higher Education Act, which has led to the rationalisation of services.

7.2.1 Improve accessibility to oral health services

- To develop a package of care for each level of care, with due consideration to national norms and standards.
- To deliver service at the appropriate level while considering the educational requirements of oral health students.
- Develop a continuity of service via referral protocols in collaboration with rural and Metro regions to formalise the provincial reconfiguration based on a District Oral Health System. The COHC as the nucleus of a referral system for the Oral Health Clinics in the Metropole region.
- To pilot maxillo-facial surgery department as an integrated service and training platform in the province, while adhering to the principle that funds will follow activity.
- Consolidate existing outreach in Mitchell's Plain and Guguletu. Continue with existing mobile service to under-serviced areas.

7.2.2 Improve efficiency

- Establishment of cost centres .
- Involve clinicians in management decisions though regular meetings.
- Identify efficiency and beneficial gains in the merger and incorporation process.

1) Procurement
2) Administration
3) Equipment
4) Human resources.
5) Management / organisational structure

- Use process-mapping techniques to improve priority areas where bottlenecks occur.
- Reducing theatre utility demand by creating conscious sedation clinics for minor oral surgery and children. Maximize theatre efficiency by employing session anaesthetist.
- Maintain high throughput and low attrition of students. Students trained to implement the primary health care approach. Incorporate more clinical exposure in the latter years of undergraduate training.
- Fill administration posts to improve revenue collection.

7.2.3 Improve cost-effectiveness

- Together with provincial business unit do feasibility study regarding preferred provider status with medical aids.
- To expand training of dentists and extended duties of oral hygienists in the Metropole clinics so that services other than just primary health care are taken away from the OHC and the specialized children's clinic.

7.2.4 Primary care approach

- Focus on the expansion of preventive and promotive strategies, that over a period of time there is a positive outcome for oral health services as a whole and for services at the OHC in particular.

1) Fluoridation of water
2) Educational programmes to improve dental hygiene and dental awareness

- Using appropriate technology for treatment.
- To formalize participation and collaboration with community, other health service providers, health sciences faculties, other tertiary institutions as well as other university faculties.
- Use needs base or epidemiological approach to identified areas of priority.

7.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

7.3.1 An assessment of water fluoridation levels in the province conducted in 2000/1, revealed that the water quality in the urban areas of the Province was adequate in most instances. However, it was noted that the level of water fluoridation on many of the farms in the Province was inadequate. A lack of resources has, however, precluded an in-depth investigation to quantify the extent of the problem and resource constraints have similarly curtailed attempts to rectify the problem. The persistent drought in the province has also complicated matters. The finalization of the process of reorganization of environmental health services will create an opportunity to address this problem once resources are made available. It has been proposed that a project management team be created to drive the process in the Province.

7.3.2 Develop an integrated provincial service platform to meet demand based on the principles of equity and affordability. Turnkey requirement is to develop referral sites at George and Paarl with a minimum of six dental chairs per site. Rationale is to deliver services that are accessible and affordable for non-Metro areas. Allocation of activity based budget to these centres.

7.3.3 Reduce the theatre demand by using conscious sedation for children and minor oral surgery procedures. This is a more cost-effective manner in delivering the same services. Initially the sedation clinics would only be at COHC but roll-out to other facilities when training dentists in this regard has been completed. Presently there is only one conscious sedation unit at COHC. It is envisaged that three more units be established.

7.3.4 An increase of dentures for the population between 18 to 35 years would serve them well in regards to suitability for employment and their quality of life. It would be advantageous to increase the production of dentures by 15% and reduce the cost per denture though collaboration with Technicons and private entities.

7.4 PLANNED QUALITY IMPROVEMENT MEASURES

To incrementally implement the Provincial Quality of Care policy. The three components to be addressed are:

7.4.1 Patient Satisfaction

- The development of a client based survey to assess the satisfaction with services rendered at the OHC.
- Complaints mechanism in place (PALS).
- The establishment of the Hospital Board in line with the Facilities Boards Bill thereby making the OHC accessible to the community and facilitate community participation in decision-making.
- Reduction of waiting lists with the transfer of skills and services to the lower level of care, general improved efficiency and PPI (dentures and orthodontics).

7.4.2 Care for the Carer

- Staff support unit established (EAP)
- Employee satisfaction survey

7.4.3 Clinical Quality

- To develop management tools by clinicians to measure quality assurance of services per department. To use monitoring indices to measure impact of the services on quality of life indicators.
- Develop evidence-based treatment protocols that are accepted by all stakeholders.
- Multi disciplinary quality assurance team to evaluate adverse events and services as a peer review mechanism.
- To measure prevalence and incidence rates to assist in quality of care for HIV/AIDS and special categories of ill patients.

7.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.19 Measurable objectives and performance indicators: Academic Dental Services [PHS4]

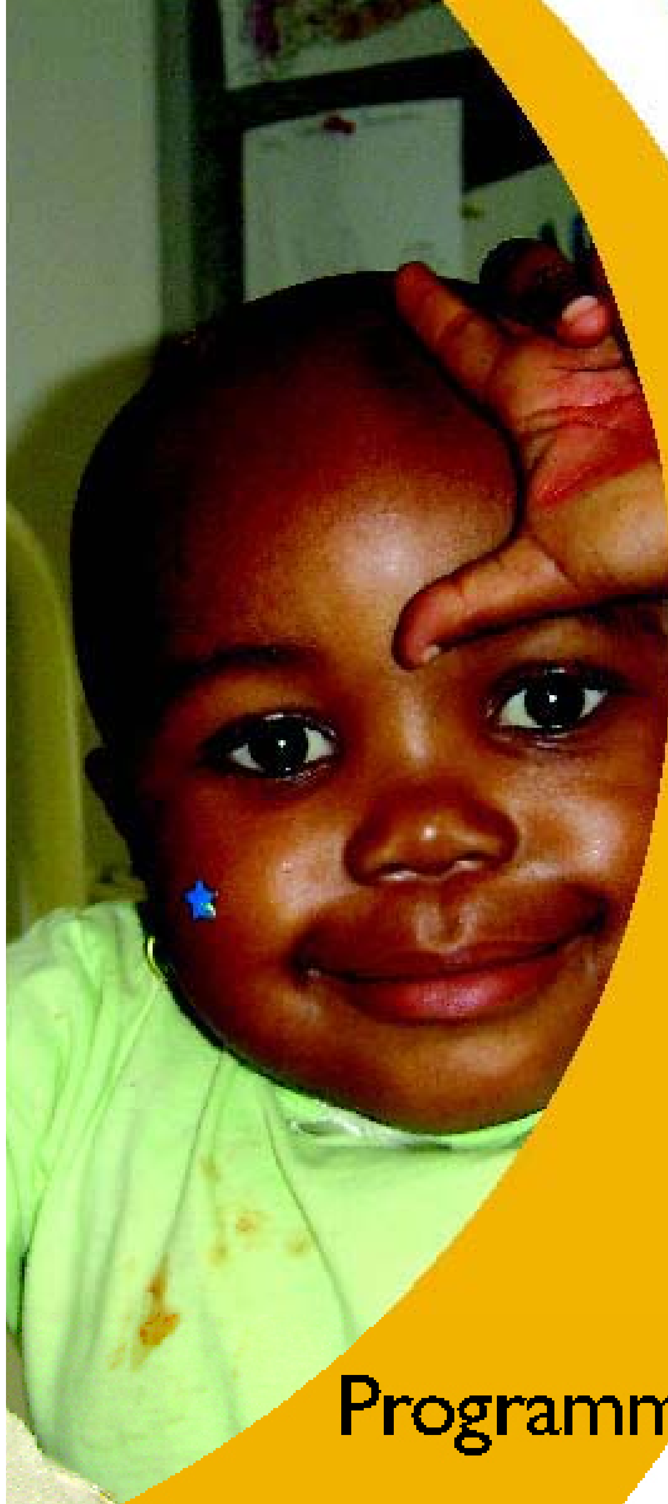
Objective	Performance measure/ indicator	HC 2010 Target	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)
Optimise Student training as agreed to by Committee of Dental Deans	Graduating students	80	64	129 *	97 *	84	100	100	100
Evaluate service rendering	The number of patient visits	120 000	150 000	160 000	160 000	170000	150 000	151 000	151 000
Reduce waiting lists for dentures	Number of patients on waiting lists for dentures	500	1000	1000	900	700	700	650	650
Increase patient revenue	Percentage of accrued accounts received	75%	60%	70%	75%	60%	75%	75%	75%
Improved efficiency	Theatre stats.	1500	1293	1300	1400	1700	1500	1500	1500

7.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 4.20 Trends in provincial public health expenditure for academic dental services (R million) [PHS6]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	42,525,000	47,371,448	52,375,000	53,747,000	---	---	---
Total per person	9	10	11	11	---	---	---
Total per uninsured person	13	14	15	15	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	49,326,740	52,144,865	54,787,433	53,747,000	57,986,000	61,309,000	64,999,000
Total per person	11	11	12	11	12	12	13
Total per uninsured person	15	15	16	15	16	17	18
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.



Programme 5: Central Hospital Services

PROGRAMME 5: Central Hospital Services

1. AIM

To provide tertiary health services, and to create a platform for the training of health workers.

2. PROGRAMME STRUCTURE

Sub-programme 5.1 Central hospital services

Rendering of highly specialized medical health and quaternary services on a national basis and a platform for the training of health workers and research.

3. IKAPA ELIHLUMAYO, SOCIAL, HUMAN AND INTELLECTUAL CAPITAL

Apart from service delivery, Central Hospitals contribute significantly to the strategic priorities of the Provincial Government of the Western Cape.

- These institutions provide care to patients from neighbouring provinces and although quantifying the number of patients from other provinces is not easy the 21% increase in Xhosa speaking patients is evidence of the change in the community served by the Central Hospitals.
- The Western Cape Health Services provide a platform for 3,5 million health science student hours during 2005, of which 2,4 million were in the Central Hospitals. This is a significant contribution towards human and intellectual capital and provides doctors, nurses and pharmacists amongst others for the country.
- The services platform provides the necessary access for research by Institutes of Higher Education (HEI). Apart from generating revenue for the Province, it also contributes to the intellectual development, human capital and continuous improvement of our services at all levels of care.
- The clinicians involved in service delivery actively enhance the capacity at referring institutions through a system of outreach and support, in-service training of health workers and advocacy. This contributes to prevention programmes and strengthening Primary Health Care Services and social capital.
- The Child Injury Prevention Programme is housed and run from the Red Cross Children's Hospital, producing educational material in conjunction with the Department of Education. Internationally it has the largest database regarding child injuries in the world.
- Both Tygerberg and Red Cross Children's Hospitals have poison centres advising families and general practitioners across the country.
- Red Cross Children's Hospital took a leading role during 2005 in establishing a diarrhoeal disease prevention and early treatment programme, as well as developing educational material for the general public.

4. SITUATIONAL ANALYSIS

Tygerberg, Groote Schuur and Red Cross Children's Hospital are the three Central Hospitals receiving funds from this Programme. These hospitals provide tertiary, secondary and quaternary services for both adults and children. The tertiary and quaternary components of the hospitals provide services for the whole of the Western Cape province including other provinces particularly the Eastern Cape.

Table 5.1 Situation analysis indicators for central hospitals [CHS2]

	Indicator	Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05
Input					.
1	Expenditure on hospital staff as % of hospital expenditure	%	70.40	65.00	65.00
2	Expenditure on drugs for hospital use as % of hospital expenditure	%	6.8	6.9	5.7
Process					
3	Operational hospital board	Y/N	100	100	100
4	Appointed (not acting) CEO in post	Y/N	100	100	80
5	Individual hospital data timeliness rate*	%	Not available	100	100
Output					
6	Caesarean section rate	%	34.67	28.57	35

	Indicator	Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05
Quality					
7	Patient satisfaction survey using DoH template	Y/N	25	100	100
8	Clinical audit (M and M) meetings at least once a month	Y/N	75	100	100
Efficiency					
9	Average length of stay	Days	6.16	6.21	6.04
10	Bed utilisation rate (based on usable beds)	%	78	80	82
11	Expenditure per patient day equivalent	R	1,575	1,594	1,692
Outcome					
12	Case fatality rate for surgery separations	%	3.72	3.67	3.00

*The NTSG review data on clinical activities as agreed to in the Service Level Agreement for the NTSG funding is used as the proxy for this indicator.

Table 5.2 below shows the current bed situation. Note that the level 1 beds situated within Tygerberg Hospital forms the nucleus of the future Khayelitsha hospital. During 2006/2007 each of the Central Hospitals will continue to redefine levels of care within the hospital so as to ensure appropriate level of care for the needs of patients. Each of the hospitals experiences heavy pressures on beds, where they function at bed occupancy rates for various wards at more than 85%. The national target is 80%. The bed occupancy rate provides an index of efficiency, and is limited to the type of beds. Beds for pregnant women and children cannot be exchanged with beds for general adult patients for which there is a consistent and increased demand due to the increase of burden of disease of chronic and lifestyle illnesses amongst adults.

Step-down and level 1 capacity is required to assist the hospitals increase efficiency and improve the availability of beds for acute care. Where level 1 capacity cannot be established outside of the hospitals in the short term, it would be necessary to establish these in-house. The establishment of level 1 beds in TBH has provided major relief of pressures in the system.

Table 5.2 Numbers of beds in central hospitals by level of care [2005]

Central /tertiary hospital (or complex)	Level 3 and 4 beds	Level 2 beds	Level 1 and step-down beds	Total beds
Groote Schuur hospital	820	90		910
Red Cross Children's hospital	250	38		288
Tygerberg hospital	1124	150	90	1 274
Total	**2 194**	**278**	**90**	**2 562**

4.1 Significant issues

4.1.1 The reduced nursing capacity, both in terms of numbers and of experience, remains the key challenge in this service. Professional and specialised nurses are highly mobile in a global environment of high demand for nurses. The attrition rate for professional nurses is 25%. Several strategies have been embarked upon within the Department to address this significant challenge.

- More bursaries have been allocated for formal training (see section on programme 6) and the capacity for sub-professional training in a few hospitals (Tygerberg and Groote Schuur Hospitals and the Western Cape Rehabilitation Centre) has been increased, also allowing for bridging towards a professional qualification.
- During 2005 167 sub-professional categories were bridged.
- A postgraduate training programme for midwifery, in conjunction with the University of the Western Cape, has been established at Mowbray Maternity Hospital

4.1.2 The hospital system experiences service bottlenecks, in certain critical service areas such as operating theatres and intensive care units. The lack of theatre and intensive care nurses results in increased waiting times and waiting lists. A survey has shown that the current deficit of nursing staff, compared to the minimum requirement is 40%. There is a dependency on agency staff for nurses who often do have the required experience.

Several strategies have been embarked upon:

1) The Cape Peninsula University of Technology has been approached to assist with the training of theatre technicians, a midlevel category or worker to support theatre nurses.
2) Non-nursing tasks have been identified and appropriate staff appointed.
3) Improving the nursing environment with functioning basic equipment and hospital beds would still require significant funding.
4) Theatre managers have been appointed at Tygerberg and Groote Schuur Hospitals at executive level in order to improve efficiencies and the throughput of theatres.
5) Nursing mentors are being appointed in theatres and intensive care units to provide support for sub-professional, professional and student categories of nurses.

4.1.3 Quality Assurance

Ensuring quality of care is a key priority but achieving this in 2 550 beds and other service areas requires dedicated attention. Key strategies being implemented in 2005 are:

1) Establishing full time quality assurance capacity in the Central Hospitals;
2) Establishing a focused structure to deal with infection prevention and control;
3) Continued and regular assessments of the levels of satisfaction of staff and clients;
4) Response to the information received from complaints and compliments;
5) The implementation of regular morbidity and mortality reviews in all disciplines.

4.1.4 Management of acute admissions

There are an insufficient number of acute beds in the Metropole. During 2005, 150 level 1 beds were created in hospitals where space was available and includes the 90 beds in Tygerberg Hospital. However, the hospitals are regularly filled beyond capacity and an Acute Admissions Policy has been developed to ensure an even distribution of emergency patients awaiting admission. This was coupled with the implementation of a uniform triage system whereby the urgency of the conditions of patients is assessed on an objective and scientific basis which has improved the situation.

4.1.5 Improving the functioning of the Health System

The need for co-ordinating clinicians was identified in 2003 as a result of the fragmentation of the health system in the Western Cape. This system implemented during 2005, streamlined service delivery, enhanced clinical governance and facilitated both the treatment of patients at the level of care appropriate to their needs and the clinical outcomes. The positive effect has already been felt in Paediatrics and Child Health, and Obstetrics where Co-ordinating Clinicians have been appointed.

4.2 Financial issues

The main sources of funding of the Central Hospitals are as follows:

- The National Tertiary Services Grant (NTSG)
- The Health Professions Training and Development Grant (HPTDG)
- Equitable Share

In line with a decision to prioritise Primary Health Care services, the funding for the Central Hospitals has remained relatively constant over the past few years. Nevertheless these hospitals have faced an increased patient load, an upward adjustment to the wage bill, and increased burden of disease due mainly to chronic illnesses, patients living with and compromised by HIV, and increased acute illnesses, including trauma and emergency services. The increased need for obstetric and neonatal services, orthopaedic services, breast cancer surgery, and mental illnesses have been significant. Increased revenue generation has allowed some additional funding to be returned to these institutions to address urgent needs.

Modernisation of Tertiary Services

A national process is underway to modernize tertiary services. To this effect an earmarked amount of R13,2 was provided for in the 2006/07 financial year. This will contribute towards the cost of one Linear Accelerator, two of which are required and will be funded from equitable share funding allocated for equipment during this financial year.

An amount of R2,5 million has been allocated to fund a neuropsychiatric service at Groote Schuur Hospital and an amount of R1 million has been allocated to fund the separation of child from adult psychiatric services at Tygerberg Hospital. An additional 30 interns will be employed at Tygerberg Hospital following a request from the National Department of Health for which an additional R5,4 million has been provided.

Table 5.3 The sources of funding for the Central Hospitals during 2005/06

Source of funding	R'000	Percentage of Programme 5 budget	Percentage of conditional grant
National Tertiary Services Grant (NTSG)	1,272,640	60.99%	100.0%
Health Professions Training and Development Grant (HPTDG)	199,677	9.57%	61.8%
Subtotal conditional grants	1,472,317		
Equitable share	614,200	29.44%	
Total allocation	**2,086,517**	**100.00%**	

Source: Budget 2006

After detailed representation to both the National Treasury and the National Department of Health the trend has been reversed. Allocations have been augmented by R93,3 million in 2005/06, R84 million in 2006/07 and R76 million in 2007/08.

The Health Professions Training and Development Grant (HPTDG) funds the service costs related to teaching and training across all services in the province, and for all health sciences study courses. The University of Stellenbosch is largely involved in Tygerberg Hospital, the Western and Northern part of the metro, health facilities in the West Coast, Winelands, Boland and Overberg Districts. University of Cape Town is largely involved with Groote Schuur and Red Cross Children's Hospitals, part of the metro, and the Southern Cape and Karoo districts. The University of the Western Cape and the Cape Peninsula University of Technology also access the service platform for the training of health sciences students.

Institutes of Higher Education in future will have equal access to defined health facilities, a fundamental principle contained in the pro-forma bilateral new agreements between the Provincial Health Services and the various Institutes of Higher Education. The HPTDG funds allocated to the Western Cape have not increased in accordance with inflation or increased student requirements. In fact the allocation for 2005/06 decreased by R3,9 million in comparison to 2004/05, i.e. a nominal decrease of 1%. The funding in 2006/07 remains constant, which translates into a 5% decrease in real terms. This trend is symptomatic of the policy gap at a national level in terms of the funding of health sciences training in the country.

The relationship between Institutes of Higher Education and the Department of Health is governed by outdated Joint Agreements. A concerted effort, led by the Premier, the Provincial Minister of Health and the Vice Chancellors during 2005, is paving the way for new multilateral and bilateral Agreements that would pave the way towards new Agreements to replace current agreements. It is expected that a multi-lateral agreement between government and the Institutions of Higher Education will be signed during 2006/07 paving the way toward revised bilateral Joint Agreements.

The central hospitals will significantly change their configuration in the years to come. Many of the service units are below the critical mass of sustainability, diminishing the capacity to provide the full package of care, and to effectively train students. This is further exacerbated by the backlogs in equipment and health technology. The poor condition and extent of the physical infrastructure, at Tygerberg Hospital, which is the subject of an investigation by the CSIR, contributes significantly to making the current level of activities unsustainable. For this reason Tygerberg Hospital will be registered as a Hospital Revitalisation Project during 2006/07.

4.3 Burden of disease

The Western Cape experiences a triple burden of disease: trauma, chronic diseases of lifestyle, as well as infectious diseases, especially the HIV/Aids epidemic and the particularly morbid link to TB. A research study done in collaboration with the Health Economics Unit of the University of Cape Town on the impact of HIV on the expenditure of Tygerberg hospital revealed that the expenditure is approximately R50 million per year (based on 2003/4 costs).

Chronic disease is a particular challenge and various strategies are being developed, in collaboration with District Health Services, to manage and contain this increasing demand.
The rapid increase in the demand for obstetric care at the central and regional hospitals in the metropolitan area, is of particular concern. A strategy and enhanced capacity is required to deal with this demand, which, in the case of complicated deliveries requires an emergency service.

4.4 Consumables

Funding restrictions for costly consumables in particular are an obstacle at times to the provision of services, where staff is available. On average, institutions spend 31% during 2005/06 of their total budget on consumables instead of the targeted norm of 24%, once again highlighting the unsustainable nature of the current configuration of the services.

4.5 Estate and Equipment

Maintenance of buildings and equipment at the central hospitals requires urgent attention. Tygerberg Hospital for example has a maintenance backlog that was estimated at R200 million in 1999, which escalated to R800 million in 2004/05. The CSIR has subsequently been appointed to survey and report on the condition of Tygerberg Hospital and a business case will be submitted to the National Department of Health to motivate for funds to rebuild or replace Tygerberg Hospital.
As reported in Programme 1: Administration an amount of R53,6 million has been allocated for health equipment. Of this, an amount of R11,6 million has been allocated to be managed by Programme 1: Administration and the balance of R42 million has been allocated to Programme 5: Central Hospital Services.

4.6 The service platform

The central hospitals provide services grouped into 9 different disciplines, which are subdivided into 32 divisions (sub-disciplines), and further subdivided into 50 units. Each of these services experience waiting lists for care.

A gap analysis of the position of the central hospitals in relation to Healthcare 2010 targets revealed the following:

1) Over the years Central Hospitals have reduced level 3 beds.
2) The skills mix and resultant wage bill could not be transformed at the same speed, requiring an urgent review of the organizational design of the central hospitals. The lack of specialized nurses,

especially in theatre technique and intensive care, as well as some key scarce technical support staff such as medical physicists, clinical technologists, radiographers and pharmacists has had a limiting effect on the delivery in Central hospital services.

3) The number of outpatients currently seen is higher than the Healthcare 2010 target. The outpatient numbers include casualty and day treatment of patients. Strategies are now being designed to address this situation. The management of patients on an outpatient basis and with day surgery are key strategies. The overall funding envelope nevertheless remains the determining factor. Ophthalmology, ENT, Allergology and Dermatology have high numbers of outpatient services that could be devolved to more appropriate levels, depending on the availability of services at these levels.

The retention of the highly specialized services for both the province and the country lies in strengthening the capacity of regional (level 2) services, especially in the Metro, and in turn the appropriate level 1 acute services capacity. Tygerberg Hospital will play an instrumental role in the required domino effect in the envisaged reshaping of the services in the Metropolitan region.

The Health Information Systems have been rolled out to the Central Hospitals. The systems require adequate capacity to manage and obtain maximum benefits from this investment. The capacity is currently not in place and the recruitment of suitably qualified staff is a significant challenge. A Cost Centre Accounting system, deemed critical in terms of decentralized management, was implemented as a pilot at Groote Schuur Hospital in 2004/5, and will roll out to Tygerberg and Red Cross Hospitals at the beginning of 2005/6. The process of decentralizing the management of cost centers in the Central Hospitals is well advanced
.

There is a need to develop decentralized decision-making in the institutions, and to have budgets and service information at that level. Whilst the structural developments of a cost center management system have progressed, there is a lack of support towards decentralized decision-making. It is planned to establish the necessary financial and information support so as to establish "mini-hospitals" or responsibility centers within the larger hospital organizations.

The central hospitals face a significant challenge in meeting the employment equity targets. This is particularly true for the medical professional categories, and more so in Tygerberg Hospital, where language has been a historical challenge. Focused, joint strategies with the respective universities will be required to address this situation.

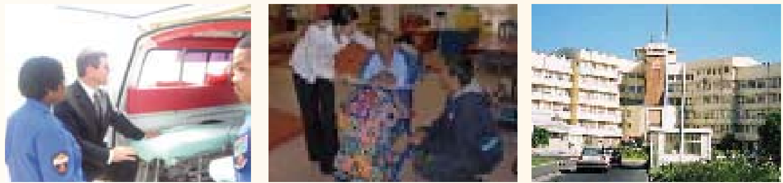


Table 5.4 Analysis of the Central Hospitals staffing profile: 2003/04 and 2004/05

HOSPITAL	2002/2003	% of Total	2003/2004	% of Total	2004/2005	% of Total
Central Hospitals						
01-Management	39	0.4%	42	0.5%	44	0.5%
02-Medical	1,029	11.6%	1,026	11.8%	1,043	12.3%
03-Nursing	3,665	41.4%	3,596	41.5%	3,517	41.3%
04-Allied Health Sciences	551	6.2%	503	5.8%	485	5.7%
05-Scientist / technical	160	1.8%	159	1.8%	158	1.9%
06-Admin	1,026	11.6%	1,010	11.7%	1,016	11.9%
07-Maintenance	150	1.7%	149	1.7%	144	1.7%
08-Ancillary	2,241	25.3%	2,178	25.1%	2,101	24.7%
09-Dental	-	0.0%	-	0%	-	0%
10-EMS	-	0.0%	-	0%	-	0%
Total	**8,861**	**100%**	**8,663**	**100%**	**8,508**	**100%**
Groote Schuur Hospital						
01-Management	18	0.5%	18	0.5%	19	0.5%
02-Medical	476	12.8%	464	12.8%	472	13.3%
03-Nursing	1,389	37.3%	1,379	38.0%	1,373	38.7%
04-Allied Health Sciences	240	6.4%	208	5.7%	199	5.6%
05-Scientist / technical	75	2.0%	72	2.0%	68	1.9%
06-Admin	440	11.8%	429	11.8%	434	12.2%
07-Maintenance	86	2.3%	85	2.3%	79	2.2%
08-Ancillary	1,003	26.9%	972	26.8%	904	25.5%
09-Dental	-	0%	-	0%	-	0%
10-EMS	-	0%	-	0%	-	0%
Total	**3,727**	**100%**	**3,627**	**100%**	**3,548**	**100%**
Tygerberg Hospital						
01-Management	16	0.4%	17	0.4%	16	0.4%
02-Medical	434	10.7%	438	11%	440	11.3%
03-Nursing	1,732	42.6%	1,687	42%	1,609	41.5%
04-Allied Health Sciences	242	6.0%	221	6%	212	5.5%
05-Scientist / technical	70	1.7%	70	2%	73	1.9%
06-Admin	471	11.6%	468	12%	463	11.9%
07-Maintenance	51	1.3%	51	1%	52	1.3%
08-Ancillary	1,046	25.8%	1,018	26%	1,015	26.2%
09-Dental	-	0%	-	0%	-	0%
10-EMS	-	0%	-	0%	-	0%
Total	**4,062**	**100%**	**3,970**	**100%**	**3,880**	**100%**
Red Cross Children's Hospital						
01-Management	5	0.5%	7	0.7%	9	0.8%
02-Medical	119	11.1%	124	11.6%	129	12.0%
03-Nursing	544	50.7%	530	49.7%	533	49.5%
04-Allied Health Sciences	69	6.4%	74	6.9%	74	6.9%
05-Scientist / technical	15	1.4%	17	1.6%	17	1.6%
06-Admin	115	10.7%	113	10.6%	119	11.0%
07-Maintenance	13	1.2%	13	1.2%	13	1.2%
08-Ancillary	192	17.9%	188	17.6%	182	16.9%
09-Dental	-	0%	-	0%	-	0%
10-EMS	-	0%	-	0%	-	0%
Total	**1,072**	**100%**	**1,066**	**100%**	**1,075**	**100%**

5. POLICIES, STRATEGIES AND BROAD STRATEGIC OBJECTIVES

The package of care and quantified outputs has been defined per hospital, discipline and sub-discipline. Each hospital submits an annual business plan with a detailed personnel and equipment plan, as well as clear targets of performance. The key focus areas for 2006/2007 are outlined below.

Healthcare 2010 provides the framework for tertiary services delivered in the Province. The detail of this plan must be defined in terms of the range, quantum and location of the various services across the central hospitals platform. The focus over the MTEF period will be on integrating the detailed and refined tertiary services plan with the other levels of the health care system in support of the implementation of Healthcare 2010. The revision of the staffing structure will evolve from the service plan. Effective communication with stakeholders and the development of an implementation strategy is essential.

Key strategic priorities for the MTEF period are listed below. Each institution determines priorities within this framework.

1) Nursing:
   - Enhance nurse training and outputs;
   - Enhance the working environment of nurses;
   - Establish mentorship in key areas.
2) Quality assurance:
   - Establish dedicated QA capacity at institutions;
   - Establish a provincial structure for Infection Prevention and Control in collaboration with the QA Unit;
   - Develop uniform operational policies regarding infection prevention and control;
   - "Tough on toilets" campaign;
   - Arrange at least one fun event with staff per institution;
   - Staff and patient satisfaction surveys.
3) Improve institutional performance:
   - Establish a balanced scorecard for each institution;
   - Monitor key indicators and outcomes for resource management and clinical service delivery;
   - Enhance junior and middle management capacity;
   - Establish day surgery;
   - Enhance theatre management;
   - Implement a uniform Emergency Services triage system;
   - Focused management on levels of care in the institutions.
4) Improve system performance and assess the impact:
   - Establish central clinical operations co-ordination;
   - Establish Co-ordinating Clinicians in each of the major disciplines;
   - Establish central intelligence for acute admissions management;
   - Establish a uniform operational policy for the co-ordination of acute admissions;
   - Monitor services and outcomes
5) Implement Healthcare 2010:
   - Establish change management capacity;
   - Project manage key priorities / policy options.

5.1 Organisational development

The management structure has been designed to devolve operational management to the level of cost centres. The Responsibility Centres being implemented will consist of a Clinical Manager, Nurse Manager, Clinical Departmental Head and administrative support.

The Responsibility Centres for clinical areas will eventually function as "mini-hospitals" within a large hospital with its own budget, personnel establishment and appropriate delegations. The resources and output targets will be progressively aligned towards the Healthcare 2010. Information management capacity and dedicated administrative support will be required.

The institutions aim to modernise management and establish bed management, theatre management and quality management capacity. Both Tygerberg and Groote Schuur Hospitals will establish focused management for the various levels of care in the institutions.

Once the service packages for each institution have been finalized, the organizational design will be refined and finalized towards an appropriate skills mix.

5.2 Individual Central Hospitals

International experience indicates that sub-specialist surgical disciplines perform better if regionalized or consolidated. This principle is guiding the reshaping of the service.

5.2.1 Red Cross Children's Hospital (RCCH)

Red Cross Children's Hospital is a national asset and has been established as a separate entity with its own support structure. Aspects of financial, human resource management and information management capacity are still lacking.

- Identified sub-specialist paediatric services across Red Cross and Tygerberg Hospitals will be consolidated into single discipline departments. Implementation has already commenced in the Cardiology and Cardiothoracic services, Nephrology and Renal Transplant services and Neurology and Child Development services.

Estate Management

The community support for Red Cross War Memorial Children's Hospital has been phenomenal and the fundraising arm of the hospital, The Children's Hospital Trust has raised over R90 million since 1995 for redevelopment projects, such as:

- A new specialist outpatients and emergency services wing – R43 million
- A new integrated paediatric intensive care unit – R3.8 million
- Specialized medical equipment – R15 million
- A new trauma and diagnostic radiology unit R16 million
- A new oncology unit – R16 million
- During 2006/07 a project to upgrade theatres and wards with substantial provincial funding support will continue.

5.2.2 Tygerberg Hospital_

- During 2003, continued through 2005 Tygerberg Hospital commenced with consolidating regional services into separate wards as the first step towards strengthening capacity for regional metro hospital services. This process will continue during the MTEF period towards completely separating levels 2 and 3.
- An infrastructure assessment is currently in progress to ascertain the best option to deal with the unnecessarily large estate and develop modern and functional facilities that are appropriate to the vision of the Department.
- The principles of Healthcare 2010 include improving the quality and access to appropriate health services by strengthening level 2 services and restructuring level 3 services.
- **Revenue generation** has been identified as a key strategic objective for the Department in addressing the budgetary constraints.
- Tygerberg hospital is experiencing an increasing load on trauma and emergency services. Therefore the creation of additional management and infrastructure capacity has been prioritized, specifically for theatre management. Trauma headcounts have consistently increased. The nature of trauma requires very expensive interventions and orthopedic trauma places a significant burden on medical surgical consumables. The projections of orthopedic implants on current trends indicate an increase in this expenditure in excess of R1,5 million
- Tygerberg Hospital re-engineered its services to accommodate 90 level 1 beds as the nucleus of Khayelitsha hospital.

5.2.3 Groote Schuur Hospital

The key strategies of GSH are as follows:

- Re-engineering the institutional framework – this will include restructuring management, the interface between the hospital and higher education institutions, clinical departmental and divisional structures, and the separation of tertiary and secondary services within the institution. The consolidation of the Intensive Care Units, Wards and Trauma and Emergency Units will be completed.
- Improve theatre efficiencies.
- Strengthen de-centralised management through five clinical centers, supported by Cost Centre Accounting.
- Strengthen revenue flows by expanding on the bed capacity and aggressive following up of road accident fund and other hospital fees. Specific revenue generating opportunities in haematology, cardiac care and radio-oncology will be pursued.
- Consolidate secondary services and ensure appropriate outpatient attendances.
- Provide a supporting environment to nurses by different categories of staff taking on non-nursing tasks. The "turning team" pilot during 2005/06 has proven the impact such initiatives have.

5.2.4 Other strategies

- The Department has established a dedicated team to address prioritization and central procurement to systematically address the equipment backlogs.
- A high-level intervention in terms of the joint agreements with Universities is underway in order to replace the current agreements.

6. SPECIFIC PROJECTS FOR 2006/2007

The following key priorities will be managed through a dedicated project management approach, funding of which will be earmarked in the programme:

1) Continue to enhance the nursing capacity and related strategies.
2) Service delivery issues
   - Finalisation of the Service Plan followed by the phased implementation of the plan;
   - Addressing issues such as infection control and quality assurance;
   - Sustain the strengthening of maternity and neonatal services;
   - Monitor waiting lists and address bottlenecks with a focus on disease conditions affecting Quality Adjusted Life Years, such as breast cancer surgery, arthroplasty, especially in the young, cataract surgery; and
   - Strengthen outreach and support to referring institutions
3) Maintenance and equipment:
   - Purchase of two linear accelerators to improve the radio-oncology service; and
   - Increased funding for maintenance for buildings and equipment will make a significant contribution to providing the infrastructure required to provide a quality service
4) Establish an enabling environment
   - Implement the multilateral structures provided for in the new Agreements with Universities (Institutes of Higher Education);
   - Widen the Co-ordinating Clinician system to other general specialty groupings; and
   - Facilitate monitoring and evaluation in a common performance framework.

7. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 5.5 Provincial objectives and performance indicators for Central Hospitals 2004/05 Real Terms [CHS3]

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
INPUT									
Provide sufficient funds for non-personnel expenditure in Central hospitals.	Expenditure on staff as % of total expenditure	64.00%	70	65	65	64	64	64	63
	Expenditure on drugs as % of total expenditure		6.8	6.9	5.7	6.0	8.0	9.0	11.0
	Expenditure on maintenance as % total expenditure	6.80%	1.90	0.90	1.00	7.00	8.16	6.80	6.80
Provide Central hospitals infrastructure in line with Healthcare 2010.	Useable beds per 1000 people	0.25	0.55	0.53	0.51	0.53	0.52	0.51	0.51
	Useable beds per 1000 uninsured population	0.57	0.75	0.73	0.70	0.73	0.72	0.70	0.69
Provide sufficient funding to ensure an efficient Central hospital service for the population of the Western Cape.	Hospital expenditure per capita (total population)		373	379	399	408	427	452	469
	Hospital expenditure per capita (uninsured population)		511	519	546	559	585	620	642
Provide services that adequately address inpatients, outpatients and trauma cases.	Outpatients per inpatient day ratio	1.00	1.47	1.54	1.56	1.25	1.21	1.25	1.29
	Total number of inpatient days		709,972	715,642	714,938	772,825	791,448	791,448	791,448
	Total number of outpatient headcounts (incl trauma)		1,040,526	1,098,867	1,114,363	963,940	959,762	987,510	1,019,226
PROCESS									
Facilitate representative management.	Percentage of hospitals with operational hospital board.	100	100	100	100	100	100	100	100
Facilitate decentralised management and accountability.	Percentage of hospitals with appointed CEO in place	100	100	100	80	80	100	100	100
	Percentage of hospitals with business plan agreed with the Provincial Health Department.	100	100	100	100	100	100	100	100
OUTPUT									
Ensure accessible Central hospital services to the population of the Western Cape.	Separations per 1000 people	12.7	25.3	24.9	25.2	26.8	27.0	26.6	26.2
	Separations per 1000 uninsured population	17.4	34.7	34.1	34.5	36.7	37.0	36.4	35.9
	Patient day equivalents per 1000 people		237	238	236	227	227	226	224
	Patient day equivalents per 1000 uninsured population		324	326	323	311	312	309	307
QUALITY									
Ensure quality patient care.	Percentage of hospitals that have conducted and published a patient satisfaction survey in the last 12 months.	100	25	100	100	100	100	100	100
	Percentage of hospitals with designated official responsible for coordinating quality management.	100	20	30	100	100	100	100	100
	Percentage of hospitals with clinical audit (M&M) meetings at least once a month.	100	75	100	100	100	100	100	100
EFFICIENCY									
Ensure efficient and cost effective utilsation of resources.	Average length of stay	6.00	6.2	6.2	6.0	6.0	6.0	6.0	6.0
	Bed utilisation rate based on useable beds	85%	0.78	0.80	0.82	0.83	0.85	0.85	0.85
	Expenditure per patient day equivalent		1,575	1,594	1,692	1,769	1,851	1,943	2,060
OUTCOME									
Ensure desired clinical outcomes	Case fatality rate for surgery separations		3.72	3.67	3.00	3.00	3.00	3.00	

Table 5.6 Performance indicators for central hospitals [CSH4]

Indicator		Type	2004/05	2005/06	2006/07	2007/08	2008/09	National target 2008/09
Input								
1	Expenditure on hospital staff as % of hospital expenditure	%	65	64	63	63	63	
2	Expenditure on drugs for hospital use as % of hospital expenditure	%	5.7	6	8	9	11	
Process								
3	Operational hospital board	%	100	100	100	100	100	100
4	Appointed (not acting) CEO in place	%	80	80	100	100	100	100
5	Individual hospital data timeliness rate*	%	100	100	100	100	100	100
Output								
6	Caesarean section rate	%	35	35	35	35	35	
Quality								
7	Patient satisfaction survey using DoH template	%	66	100	100	100	100	100
8	Clinical audit (M and M) meetings at least once a month	%	75	100	100	100	100	100
Efficiency								
9	Average length of stay	Days	6.04	6.0	6.0	6.0	6.0	6
10	Bed utilisation rate (based on usable beds)	%	0.82	0.83	0.85	0.85	0.85	85
11	Expenditure per patient day equivalent	R	1692	1769	1851	1943	2060	
Outcome								
12	Case fatality rate for surgery separations	%	3.00	2.80	3.00	3.00	3.00	3.0

* The timeous returns of the NTSG review data as per the DORA and Service Level Agreement is being used as a proxy.

8. PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

The Central Hospitals are allocated 33 percent of Vote 6 during 2006/07 in comparison to the 34,25 per cent of the revised estimate of the Appropriation Budget that was allocated during 2005/06. This amounts to a nominal increase of 6,27 per cent or R123,034 million.

Table 5.7 Trends in provincial public health expenditure for central hospitals (R million) [CHS5]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	1,476,202,000	1,607,088,871	1,805,918,000	1,963,483,000	---	---	---
Total per person	321	344	381	408	---	---	---
Total per uninsured person	440	472	522	559	---	---	---
Total capital	5,094,000	9,914,000	14,578,000	36,698,000	---	---	---
Constant (2004/05) prices							
Total	1,712,315,876	1,769,028,273	1,889,099,970	1,963,483,000	2,086,517,000	2,245,303,000	2,363,400,000
Total per person	373	379	399	408	427	452	469
Total per uninsured person	511	519	546	559	585	620	642
Total capital	**5,908,769**	**10,912,991**	**15,249,474**	**36,698,000**	**34,185,000**	**60,078,000**	**65,916,000**

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

Programme 6: Health Sciences and Training

PROGRAMME 6: Health Sciences and Training

1. AIM

Rendering of training and development opportunities for actual and potential employees of the Department of Health.

2. PROGRAMME STRUCTURE

Sub Programme 6.1 Nurse Training College (WCCN)

Training of nurses primarily at undergraduate level with limited post-basic training for nurses. Target group includes serving and potential employees.

Sub Programme 6.2 Emergency Medical Services (EMS) Training College

Training of rescue and ambulance personnel. Target group includes serving and potential employees.

Sub Programme 6.3 Bursaries

Provision of bursaries for health science training programmes at undergraduate and postgraduate levels. Target group includes serving and potential employees.

Sub Programme 6.4 Primary Health Care (PHC) Training

Provision of PHC related training for personnel, provided by the regions.

Sub Programme 6.5 Training (Other)

Provision of skills development interventions for all occupational categories of personnel in the Department. Target group includes serving and potential employees.

3. SITUATION ANALYSIS

3.1 Appraisal of existing services and performance during the past year

Legislative mandate

The provision of human resource development (HRD) services is mandated by several key legislation and policy prescriptions such as example: Skills Development Act, Skills Development Levies Act, HRD Strategy for South Africa, National Skills Development Strategy 2005 – 2010, White Paper on Transformation of the Health System, Employment Equity Act. etc.

Assessing training needs

The analysis of training needs and scarce skills is informed by the annual Workplace Skills Plan. In addition, the HWSETA produces the Sector Skills Plan which addresses HRD priorities for the health sector.

This is supported by information from Persal reports including attrition trends, vacancy trends per occupational category per institution and regions, labour market trends and forces, supply and demand issues.

Planning

Planning for Human Resource Development addresses the educational needs of future employees based on the skills shortages in occupational groups within the Department. In addition, it addresses the developmental needs of serving personnel through assessing skills gaps against competencies required. The main vehicle for gleaning the required information is the Individual Performance Development Plan for each employee. Areas to be included are student interns, learnerships, functional training, life skills development, and development of a critical mass of health professionals as one of several HR strategies to sustain the health service staffing, recruitment and retention levels.

Training strategy

The achievement of the goals of Healthcare 2010 is reliant upon the provision of constant supply of health science professionals and support staff at sustainable levels to ensure effective service delivery. Training interventions need to be informed by health service needs and priorities and must be designed in such a way as to ensure that learners i.e. serving employees and prospective employees are empowered to assume the responsibilities and challenges of realities in the workplace The training strategy for the Department is addressed through the annual Departmental Workplace Skills Plan (WSP). The plan is developed through a consultative process with inputs from the regional and institutional Workplace Skills Plans and reflects the prioritisation of skills needs throughout the Department.

Prospective health professionals and in particular prospective nursing professionals as well other professional categories in scarce supply are recruited each year through the allocation of bursaries by the Department, for South African citizens and permanent residents. The allocation of bursaries to support health science education, training and development is aligned to the planning within the Medium Term Expenditure Framework (MTEF) cycles, and in support of the Health Care 2010 plan of the Department.

iKapa Elihlumayo
The budget is aligned to iKapa Elihlumayo in the provision of training opportunities for the unemployed and more particularly for youth to have an opportunity to gain skills in the health service sector. This is achieved through the implementation of 18.2 Learnerships (for unemployed persons) for the training of Enrolled Nurse Assistants and Pharmacist Assistants: (Basic) at training sites in the Department. This strategy addresses identified gaps and is utilised as a ladder-approach recruitment mechanism for nurses and pharmacists. In addition, bursaries are offered to school leavers to pursue careers within the Department.

Social Capital
Formal relationships and networks have been established with key social partners to inform the delivery of a responsive HRD agenda, and these include internal and external clients and partners. Formal relationships have been established with all the Higher Education Institutions in the Province.

A partnership has been entered into to promote a regional platform for undergraduate training of nurses with the Cape Higher Education Consortium (CHEC) comprised of the University of Cape Town, University of Stellenbosch, University of the Western Cape and Cape Peninsula University of Technology.

At the Departmental Training Committee meeting, internal partners and organized labour address matters related to skills development and broader HRD issues that impact on the delivery of health services through provision of education, training, and development interventions.

The Department has also established a partnership with HWSETA, to support the sustainability of its learnership programmes and other key skills development priorities.

The training strategy provided interventions for employees in the following key areas:

- Health science training to ensure a critical mass of health professionals;
- Functional / generic training to ensure competency on the job;
- Technical skills training to support specialist / dedicated areas of skills;
- Management training to support effective management of all public resources and policy implementation;
- Computer-based training to increase and enhance efficacy and efficiency levels;
- Learnerships in a number of prescribed areas;
- Adult Basic Education and Training and Adult Further Education and Training; and
- In-service training to ensure continuous professional development.

All education, training and development interventions through formal education programmes, accredited training courses and short course programmes based on need are aligned to budget, service delivery and programme objectives.

Interventions are monitored on a quarterly and annual basis through formal processes such as the Quarterly Monitoring Reports, the Quarterly Training Reports and Annual Training Reports.

Quantitative information is reflected in Table HR 2

Expanded Public Works Programme
Expanded Public Works Programme is a national programme designed to provide productive employment opportunities for a significant number of the unemployed, not only to earn an income but to skill them to increase their employability.

To ensure a culture of service delivery with work creation as well as building mutually beneficial networks and relationships, the Department as part of the Social Sector Departments, has identified projects which includes Community Based Ancillary Health Workers, i.e. community home-based care workers, integrated management of childhood illness community worker and TB DOTS community workers, Anti Retroviral Counselors (ARV) and Voluntary Counseling Testing (VCT) Counselors. These workers will be up skilled through the programme to become ancillary health workers in the first phase leading to a community health worker. In addition key learnerships will be extended in areas such as nursing and pharmacy assistants.

In line with the social and human capital strategies of the Western Cape Province, the Social Sector departments must create the long-term work opportunities in under-resourced communities and opportunities that trained personnel can then exit into, thereby bridging the gap between first and second economies.

Table 6.1 Outputs: Number of learners trained through Expanded Public Works Programme

	Financial year				
	2004/05	**2005/06**	**2006/07 Target**	**2007/08 Target**	**2008/09 Target**
Community Home based care	Not applicable	Not applicable	1 430	2 720	3 165
ARV / VCT Counselors	Not applicable	Not applicable	220	270	700
Total	**Not applicable**	**Not applicable**	**1 630**	**2 990**	**3 865**

Notes:
1 First year programme is based on part qualification of General Education and Training : Ancillary Health Care : 20 unit standards
2 Training programme based on unit standards drawn from four levels of Community-Based Worker Qualifications

3.2 Key challenges over the strategic plan period

- Alignment of HRD strategies with Health Care 2010 plan (Service Plan), key legislation and policies
- Increase the critical mass of all categories of nurses at basic level and post basic level
- Dedicated training budget for implementation of education, training and development priorities
- Effective recruitment / placement of graduating bursars
- Strengthen Human Resource Development Information system
- Quality assurance of education training and development interventions
- Strengthening the capacity of decentralised Human Resource Development units
- Release of all serving personnel, in particular at management levels, to participate on training programmes
- Availability of adequate resources for delivery of Expanded Public Works Programme

3.3 Policy and Priority perspectives

The policy on iKapa Elihlumayo and the Health Care 2010 plan frames and supports the mandate to meet the HRD needs of the Department through appropriate education, training and development interventions for health workers to enable them to render health services.
The priority is to ensure a multi-year rolling-out plan that supports the development and provision of a critical mass of health workers from the Department to enable it to render its core business of health service delivery.

The Department remains a committed partner in ensuring that sustainable levels of competent health practitioners are educated to meet the regional health service needs, and to this end the Department has been a key supporter in contributing towards the advancement of nursing education at various levels.

The establishment of learnerships in partnership with the Health and Welfare Sector Education Training Authority (HWSETA) will be further strengthened to alleviate unemployment and poverty by providing skills development and employment access opportunities.
The following table highlights the number of nurses that are expected to qualify over the MTEF period.

Table 6.2 Outputs: Number of expected nursing graduates

4th year students	Academic year				
	2004	2005	2006	2007	2008
	Financial year				
	2004/05	2005/06	2006/07 Target	2007/08 Target	2008/09 Target
R 425 Diploma (Bursary students)	02	02	1463	834	202
R 425 Diploma (Salaried students)1	121	147	5	4	0
B Cur (Bursary students)	3	90	146	359	305
B Cur (Salaried students)1	84	21	2	0	0
Total number of qualified nurses	**208**	**258**	**299**	**446**	**507**

Notes:
1 Salaried students will be phased out by the 2006 and 2007 academic year respectively
2 Bursary system introduced at WCCN during the 2003 academic year. Due to 4-year lead-time of training, the first intake of R 425 Diploma (Bursary students) will graduate for the earliest at the end of the 2006 academic year.
3 20 Salaried Students will complete their studies in quarter 3 of 2006/07: 16 Bursary and 4 salary students will complete in 2007/08: Lead-time of training is 4 years.
4 No intake at WCCN for the 2004 academic year. This will reduce the number of potential R 425 Diploma (Bursary students) graduates for the 2007/08 financial year.

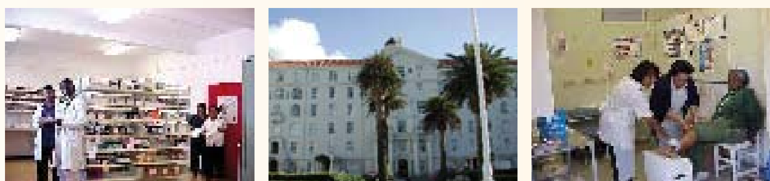


Table 6.3 Outputs: Number of expected General Nurses: Enrolled Nurses (EN) to Registered Nurses (RN)

4th year students	Academic year				
	2004	2005	2006	2007	2008
	Financial year				
	2004/05	2005/06	2006/07 Target	2007/08 Target	2008/09 Target
Part-time Bursaries: EN to RN	25	19	20	50	100
Learnerships (18.1): EN to RN1	0	0	222	502	802
Part-time self study: EN to RN	19	63	25	3	3
Total number of general nurses	**44**	**82**	**67**	**100**	**180**
Total: Graduates: RN Total qualified nurses (Table 6.2) + number of general nurses	252	340	366	546	687

Notes:
1 Learnerships for this category commenced in the 2005/2006 Financial Year (FY)
2 Students will complete their studies in quarter 4 of the respective FY: Lead-time of training is 2 years
3 Information currently not available

Key learnerships have already been implemented in nursing for unemployed persons and as pharmacist assistants for existing employees (SASO category). These and other learnerships will be further explored for possible expansion, funding being provided within the Extended Public Works Programme for the Social Sector.

Human resource development at a Departmental level can promote transformation through education, training and development interventions for all personnel as well as potential employees to the health sector.
As part of a coherent human resource development strategy, the gap between existing skills deficits and the desired competency levels of workers and practitioners for all occupational categories must address historical backlogs and the urgent needs of health service delivery towards narrowing and eventually eliminating skills and proper placements in workplace.

Programmes such as ABET (Adult Basic Education and Training), learnerships and management development programmes all contribute towards bridging the skills gap, while providing higher portability of skills and wider opportunities for career paths and employability.

The achievement of Health Care 2010 is reliant upon the provision of constant supply of health science professionals and support staff at sustainable levels to ensure effective service delivery. Training interventions need to be informed by health service needs and priorities and must be designed in such a way as to ensure that learners are empowered to assume the responsibilities and challenges of realities in the workplace.

4. POLICIES, STRATEGIC PRIORITIES AND OBJECTIVES

4.1 POLICIES

A summary list of some of the key mandating legislation and policies that govern the execution of Programme 6 is provided. It is accepted that relevant accompanying prevailing Regulations and Amendments apply.

Acts of Parliament of South Africa

- Constitution of the Republic of South Africa, 1998 (Act No. 108 of 1996)
- Skills Development Act, 1998 (Act No. 97 of 1998)
- Skills Development Levies Act, 1999 (No. 97 of 1998)
- South African Qualifications Act, 1995
- National Education Policy Act (Act No. 27 of 1996)
- Further Education and Training Act (Act No. 98 of 1998)
- Higher Education and Training Act (Act No. 101 of 1997)
- Adult Basic Education and Training Act (Act No. 52 of 2000)
- Public Finance Management Act, 1999 (Act No. 1 of 1999)
- Labour Relations Act, 1995 (Act No. 66 of 1995)
- Public Administrative Justice Act
- Employment Equity Act, 1998 (Act No. 55 of 1998)
- Public Service Act, 1994 (Act No. 103 of 1994)
- Basic Conditions of Employment Act, (Act No. 75 of 1997)
- Occupational Health and Safety Act, 1993 (Act No. 63 of 1993)
- Health Act, 1977 (Act No. 63 of 1977)
- Nursing Act, 1978 (Act No. 50 of 1978)

Western Cape Province

- Training of Nurses and Midwives Ordinance, 1994 (Ordinance No. 4 of 1984)
- Constitution of the Western Cape, 1997 (Act No. 1 of 1998)
- Western Cape Provincial Languages Act, 1998

White Papers

- White Paper on Reconstruction and Development, 1994
- White Paper on Transformation of the Public Service, 1995
- White Paper on Human Resource Management, 1997
- White Paper on Transformation of the Health System of South Africa, 1997

Policies and Plans

- Human Resource Development Strategy for South Africa, 2001
- Human Resource Development Strategy of the Public Service, 2002
- National Skills Development Strategy II
- Integrated Human Resource Planning, 2002
- Western Cape Provincial Health Plan, 1995
- Health Care 2010, 2002 (WC)
- ikapa Elihlumayo, 2003 (WC)
- Departmental Policy for Full Time Higher Education Bursaries (WC)
- Bursary Contract for Full Time Bursar Students

Collective Agreements

- Public Service Co-ordinating Bargaining Council (PSCBC) Collective Agreements
- Provincial Service Bargaining Council Agreements

4.2 STRATEGIC PRIORITIES

The key strategic priorities to be addressed within the Health Care 2010 plan context includes the following:

4.2.1 Addressing the shortfall in the number of professionals being trained in order to meet future service requirements by:

1) Increasing the critical mass of nurses based on health service needs and priorities;
2) Increasing the critical mass of health science professionals and support staff in scarce skills, based on health service needs and priorities (pharmacists, radiographers, medical / clinical technologists, medical physicists, industrial technicians);
3) Supporting the broadening of clinical teaching / learning platform to widen access to health science students in support of recruitment and retention;
4) Securing the dedicated training budget to attain the targets for delivery in terms of Health Care 2010; and
5) Increasing the critical mass of pharmacist assistants, enrolled nurse assistants and enrolled nurses through the learnership programme.

4.2.2 Ensuring the relevance and quality of training programmes by:

1) Alignment of HRD strategies with policy directives of the skills development legislation, National Skills Development Strategy, the HRD transformation agenda, and the Departmental Health Care 2010 plan for service delivery.
2) A review of decentralised Primary Health Care training to assess alignment of departmental training to Health Care 2010 priorities.
3) Strengthening partnerships with Higher Education Institutions.

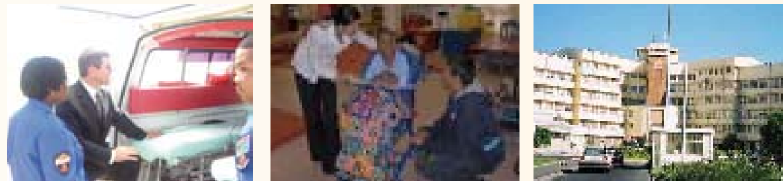
4.2.3 Addressing the training skills and competencies gap, both in-service and pre-service are:

1) Training programmes for clinical nurse practitioners;
2) Reorientation programmes for primary health care;
3) Training programmes for mid-level workers through short courses, learnerships, mentoring;
4) Enhancing capacity of health science professionals through encouraging appropriate CPD training;
5) Programmes such as integrated management of childhood illnesses and home based care are programmes coordinated under the Chief Directorate: Programmes;
6) ABET programmes for staff all contribute towards bridging the skills gap, while providing higher portability of skills and wider opportunities for career paths and employability; and
7) The establishment of learnerships in partnership with the Health and Welfare Sector Education Training Authority (HWSETA) some of which will be intended to alleviate unemployment and poverty by providing skills development and employment access opportunities.

4.2.4 The training strategy will include interventions in the following key areas:

1) Functional / generic training to ensure competency on the job;
2) Technical skills training to support specialist / dedicated areas of skills;
3) Management training to support effective management of all public resources and policy implementation;
4) Computer-based training to increase and enhance efficacy and efficiency levels;
5) Learnerships to alleviate unemployment and increase employability; and
6) In-service training to ensure continuous professional development

4.2.5 The Western Cape College of Nursing is being transferred to the Cape Peninsula University of Technology (CPUT).



5. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.1 Budget Constraints

Limitations to the training budget may mean that not all the training objectives and targets will be met. The financial management and control of training budgets in alignment with the provisions and prescripts of the Public Finance Management Act and Treasury Regulations will ensure the effective, efficient, economic and appropriate utilisation of resources.

Measures to overcome constraint

HRD strategies aligned to the service needs.

A bursary scheme to support the development of a critical mass of health professionals.

5.2 HRD Information System

Inadequate fragmented systems

Measure to overcome constraints

Ensure development of an effective and efficient decentralised information system as a planning and monitoring instrument.

6. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 6.4 Provincial objectives and performance indicators for human resource development [HR2]

Programme 6.1 Nurse Training College

Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)
6.1.1 Nurse Training: R425 Nursing Diploma Programme and B Cur Nursing Science Programme	Input: **4-year R425 Diploma / Degree Programme:** Number of student nurse s **on the staff establishment (i.e. Employee Students) of the Western Cape College of Nursing (WCCN) trained per year**							
	1st Year	159	177 [1 & 2]	0 [2 & 4]	202 [2 & 3]	235 [2 & 3]	265 [2 & 3]	340 [2 & 3]
	2nd Year	273	174	177	0 [3 & 4]	166 [3]	224 [3]	258 [3]
	3rd Year	212	208	174	177	80 [3 & 4]	154 [3]	214 [3]
	4th Year	184	196	208	174	166	99 [3 & 4]	143
	Sub-Total: Basic Nurse Training	828	755	559	553	647	742	955
	Output: **Progression of successfully trained nurses based on year 1 to year 4 per financial year**							
	Target: **85% graduates per programme**	755	645	475	450	475	520	769
6.1.2 Post basic nurse Training	Input: Number of Professional nurses admitted to the post-basic nurse-training programme. (Employees)							
	1. Critical Care: General	10	13	12	15	16	18	22
	2. Critical care: Trauma	14	9	11	12	15	18	22
	3. Operating Theatre	2	0	3	3	4	4	6
	Sub-Total: Post Basic Nurse Training	26	22	26	30	35	40	50
	Output: Progression of successfully trained Professional nurses							
	Target: **99% graduates per programme**	25	21	25	29	34	39	49
	GRAND TOTAL: Nurse Training	854	777	585	583	682	782	1005

Notes
1 Bursary system introduced at WCCN.
2 This projection is reflected under sub-programme 6.1 and sub-
3 This includes failures of the previous academic years, which is based on a 15% attrition (failure) rate per year of study.
4 No intake at WCCN for the 2004 academic year. This will reduce the bursary numbers for the subsequent 3 financial years.
Sub Programme 6.2: EMS Training College

Programme 6.3

Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)
6.2 EMS Training Monitor and evaluate the EMS training programmes	Number of intake of students for training per year.							
	1. National Diploma EMC (3-Yr Course)	60	60	60	60	60	60	60
	2. Paramedic (1-Yr Course)	15	14	16 3	16 3	16 3	16 3	12 3
	3. AEA (5- Months Course)	75	75	24 2	24 2	24 2	24 2	24 2
	4. BAA (5- Week Course)	294	200	12 1	12 1	12 1	12 1	12 1
	5. BMR (5- Week Course)	99	16	24 2	24 2	24 2	24 2	24 2
	6. Flight Medical (2- Weeks Course)	17	15	14	14	14	14	12
	7. CPD Training (1 to 2 Days Course)	60	100	150	150	150	150	200
	8. IMR (Being phased out)	16	12	0 4	0 4	0 4	0 4	0 4
	9. Level 3 (Being phased out)	362	100	0 5	0 5	0 5	0 5	0 5
	GRAND TOTAL: Number of new intake	998	592	300	300	300	300	344
	Number of graduates per programme							
	1. National Diploma EMC (3-Yr Course)	50	50	50	50	50	50	50
	2. Paramedic (1-Yr Course)	12	12	14	14	14	14	10
	3. AEA (5- Months Course)	65	65	20	20	20	20	20
	4. BAA (5- Week Course)	250	170	10	10	10	10	10
	5. BMR (5- Week Course)	85	14	20	20	20	20	20
	6. Flight Medical (2- Weeks Course)	14	123	12	12	12	12	10
	7. CPD Training (1 to 2 Days Course)	50	85	150	150	150	150	200
	8. IMR (Being phased out)	13	10	0	0	0	0	0
	9. Level 3 (Being phased out)	305	85	0	0	0	0	0
	GRAND TOTAL: Number of learners to complete programmes per year.	844	614	276	276	276	276	320

Notes
1 Number of candidates reduced due to less need in service for this qualification.
2 Training capacity limited due to availability of only one instructor.
3. The number of candidates has been increased, as there is a greater need for paramedics specifically in the rural areas.
4 Course redesigned for compliance with HPCSA accreditation standards.
5 Entrance level course for BAA (1) course. No longer required as limited capacity on BAA.

Sub Programme 6.3 Bursaries

Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)
6.3.1 Nursing Bursaries	Input: 1. Number of new bursary students admitted to nurse training (basic and post-basic nursing) 1							
Identify nurse training needs based on service delivery priorities for all categories of nursing: • Bridging Nurse Training • Basic Nurse Training • Post basic / post registration Nurse Training	1.1. Bridging Nurse Training – Mid Level (ENA To EN and EN To RN)							
	ENA to EN	10	27	150	40	40	40	50
	EN to RN	75	35	100	40	150	200	250
	Sub-Total: Bridging Nurse Training	85	62	250	80	190	240	300
	1.2. Basic Nurse Training							
	R425 Nursing Diploma	0 1	169 2	0 2	202 2	200 2	250 2	300 2
	B Cur Nursing Science	119	188	407	300	300	350	400
	Sub –Total: Basic Nurse Training	119	357	407	502	500	600	700
	1.3. Post basic Nurse Training							
	(Clinical specialty/ non clinical for RN)	73	118	120	42	210	230	250
	TOTAL:Number of new students admitted to nurse training	277	537	777	624	900	1070	1250
	Throughput 2. Maintenance of existing nursing bursaries							
	1.1. Bridging Nurse Training Mid Level (ENA To EN and EN To RN)							
	2.1.1 EN to RN	0	35	26	50	120	120	150
	2.2. Basic Nurse Training							
	R425 Nursing Diploma	0	0	169	161	356	618	637
	B Cur Nursing Science	0	119	297	667	830	1126	1020
	Sub –Total: Basic Nurse Training	0	119	466	828	1186	1744	1657
	2.3. Post basic Nurse Training	0	50	61	40	242	100	150
	TOTAL: Maintenance of existing nursing bursaries	0	204	553	918	1548	1964	1957
	GRAND TOTAL: Nursing Bursaries	**277**	**741**	**1330**	**1542**	**2448**	**3034**	**3207**

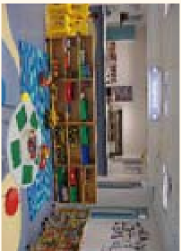
Notes
1 Employee students at WCCN. Bursary introduced at WCCN during 2003/04.
2 This projection is reflected under sub-programme 6.1 and sub-programme 6.3.

Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)
6.3.2 Bursaries for Health Science, excluding nursing Identify training needs based on service delivery priorities for all categories of health science students.	1. New bursaries for:							
	1.1. Full-time studies.							
	1.1.1 Health Science	110	115	117	96	98 103	108	132
	1.1.2 Support Services	3	0	0	0	0	0	0
	Sub –Total:	113	115	117	96	103	108	132
	1.2 Part-time studies	89	71	31	262	280	400	500
	TOTAL: Number of new students admitted to health science training	202	186	148	358	383	508	632
	2. Maintenance of existing bursaries							
	2.1. Full-time studies.							
	2.1.1 Health Science	91	133	182	199	192	203	231
	2.1.2 Support Services		2	0	0	0	0	0
	Sub –Total:	91	135	182	199	192	203	231
	2.2 Part-time studies	119	95	77	59	70	222	300
	TOTAL: Maintenance of existing health science bursaries	210	230	259	258	262	425	531
	GRAND TOTAL: Bursaries for Health Science, excl. Nursing	412	416	360	616	645	933	1163

Sub Programme 6.4: Primary Health Care Training

Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)
6.4.1. Primary Health Care Training 1 Provision of PHC related training interventions for personnel, provided by the regions	Number of training interventions provided to PHC personnel	2013	5467 2	3180	3500	4000	4500	4500

Notes
1 This budget is decentralised to and accounted for by the regions. This is not in a separate envelope It is recommended that Primary Health Care-related Training is costed and funded by the regions and a separate funding envelope is identified within the regional budgets
2 Figures for generic non-service delivery included in total



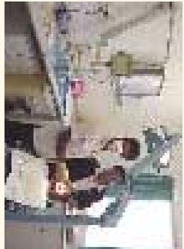
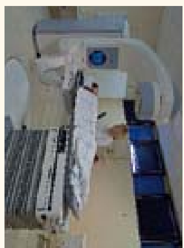
Sub Programme 6.5 Training (Other)

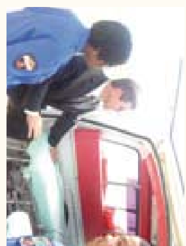
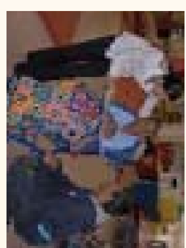
Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)
6.5.1 Levy payment to HWSETA 1		R 1 440	R 1 654	R 1 873	R 1 966	R 2 065	R 2 170	R 2 280

Notes
1 Administrative levy payable to HWSETA in terms of skills development legislation.

Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)
6.5.2 Workplace Skills Plan 1 Coordinate the implementation of the Departmental Workplace Skills Plan through the provision of training and development of personnel within the Department	Number of training interventions provided to personnel	8338	15286	14441	17400	16300	16600	16600
6.5.3 Management and Leadership Development Skills 2 Ensure appropriate development of human resources to support health service delivery through the development of management and leadership development skills	Number of management and leadership development training opportunities	838	663	1846	1450	1400	1400	1400
6.5.4 ABET 3 Ensure appropriate development of human resources to support health delivery through the provision of ABET training	Number of ABET learners registered for courses.	160	545	1189	1200	1200	1200	1200

Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)
6.5.5 Learnerships 4	**Number of learnerships: employees: 1.1 Nursing**							
Ensure appropriate development of human resources to support health delivery through the provision of learnerships for personnel	1.1.1 EN to RN	N/A	0	20	150	150	150	150
	1.1.2 ENA to EN			116	130	130	130	130
	1.1.3 Post Basic: Critical Care			19	30	30	30	30
	1.1.4 Post Basic: Operating Theatre			11	30	30	30	30
	1.1.5 ENA			28	40	40	40	40
	Sub-Total: Nursing			194	380	380	380	380
	1.2 Pharmacist Assistant:	N/A	0					
	1.2.1 Basic			121	80	60	40	20
	1.2.2 Post basic			65	70	60	60	60
	Sub-Total: Pharmacist Assistant			186	150	120	100	80
	TOTAL: Learnerships: Employees: 18.1		**0**	**380**	**530**	**500**	**480**	**460**
Contribute to the goals of iKapa Elihlumayo through provision of learnerships for unemployed people	Number of learnerships: Unemployed: 2.1 Nursing	N/A						
	2.1.1 ENA to EN			2	20	20	20	20
	2.1.2 ENA		19	75	100	100	100	100
	Sub-Total: Nursing		19	77	120	120	120	120
	2.2 Pharmacist Assistant	N/A	0					
	2.2.1 Basic			27	25	25	25	25
	2.2.2 Post basic			0	5	5	5	5
	Sub-Total: Pharmacist Assistant			27	30	30	30	30
	TOTAL: Learnerships: Unemployed: 18.2		**0**	**104**	**150**	**150**	**150**	**150**
	GRAND TOTAL: LEARNERSHIPS	**N/A**	**19**	**484**	**680**	**650**	**630**	**610**

Objective	Indicator	2002/03 (actual)	2003/04 (actual)	2004/05 (actual) (estimate)	2005/06	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)
6.5.6 Internships 5 Partner Higher Education Institutions to contribute to the growth and development of the province through the provision of internships	Number of interns placed	N/A	21	57	60	70	80	80
7.7.7 Expanded Public Works Programme 6	Number of Community Based Health workers placed:							
Provide productive employment opportunities for a significant number of the unemployed	1.1 Ancillary Health Care Level 1 Qualification	N/A	N/A	N/A	N/A		7	7
	1.1.1 Community based Home-based Care: Integrated management of Childhood Illnesses community workers					63		
	1.1.2 Community based Home-based Care: TB dots community workers					813		
	Sub-Total: Pharmacist Assistant					876		
	1.2 Ancillary Health Care Level 1 Part Qualification							
	1.2.1 Community based Home-based Care: ARV community worker	N/A	N/A	N/A	N/A	120	7	7
	1.2.2 Community based Home-based Care: VCT / HRV Counselors	N/A	N/A	N/A	N/A	150	7	7
	Sub-Total: Community Based Health workers					270		
	GRAND TOTAL: COMMUNITY BASED HEALTH WORKERS					1146		

Notes
1 Data collected via Quarterly Training Reports.
2 Target group is Senior Officials, Deputy Directors, and Assistant Directors. In addition personnel, in other categories who have financial / management responsibilities
3 Figures reflect ABET and AFET interventions from ABET level 1 to NQF level 4.
4 Learnerships: Enrolled Nurse Assistants, Enrolled Nurses, Post Basic Nursing. Pharmacist Assistants: Funded by HWSETA
5 Internships: workplace-learning opportunities for students (excludes Health Professional interns)
6 Funding available from 2006 / 2007 Financial Year.
7 New programme introduced as from 2006 / 2007 Financial Year. Financial and key performance areas to be planned for the subsequent Financial Years.
end-note: HRD perspectives

Training is in alignment with iKapa Elihlumayo, HealthCare 2010 and the Social Cluster set up by the Provincial Cabinet in March 2003.

HealthCare 2010

- Train, retrain and retain staff in health facilities, with increased emphasis on primary health care clinics, district level services and staff at community level.

iKapa Elihlumayo

- Broadening base of skills amongst personnel toward an economically viable and valued workforce in increasing and sustaining growth and development

Social Cluster

- Social cluster with Social Services & Poverty Alleviation, Education, Cultural Affairs and Sport, Community safety and Housing.
- Establish strategic partnerships (Delivery of ABET with WCED the service provider: Establish Memorandum of Understanding)
- Broaden base of skills; personnel remain employable thereby maintaining a sustainable social net

Table 6.5 Situational analysis and projected performance for health sciences and training [HR4]

Indicator	Type	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	National target for 2007/08
Input									
1. Intake of medical students	No	201 US only	419 US + UCT	418 US + UCT	413 US + UCT	200 UCT	200 UCT	200 UCT	
2. Intake of nurse students	No	73	81	98	0				
3. Students with bursaries from the province	No	66	222	274	229	62			
Process									
4. Attrition rates in first year of medical school	%	23	17	23	20	0			10
5. Attrition rates in first year of nursing school	%	19	10	10	15	15	15	15	10
Output									
6. Basic medical students graduating	No	129 US only	344 US + UCT	293 US + UCT	302 US + UCT	147 UCT			
7. Basic nurse students graduating	No	198	213	253	263	216	298	445	
8. Medical registrars graduating	No	32 US only	58 US + UCT	50 US + UCT	41 US + UCT	12 UCT			
9. Advanced nurse students graduating	No	133	214	299	341	154	150	150	
Efficiency									
10. Average training cost per basic nursing graduate	R	40,576	32,709	34,663	37,674	39,214	26,000	26,000	
11. Development component of HPT & D grant spent	%								100

Notes:

1. Information received from University of Cape Town reflects from years 2002/2003 to 2007 / 2008
   Information received from University of Stellenbosch reflects from 2001 / 2002 to 2004 / 2005
   Information from University of the Western Cape has not been received.

Indicator 10:

For the 2001/02 financial year nurse students were in salaried posts. The bursary system for nurse training was introduced during the 2002/03 financial year.
From the 2006/07 financial year the variance in the average training cost is due to the phasing out of salaries students and the funding of bursary students only.

7. PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Health Sciences and Training is allocated 1,68 per cent of the vote in 2006/07 in comparison to the 1,42 per cent of the vote that was allocated in 2005/06. This is a nominal increase of 30,07 per cent or R24,514 million.

Table 6.6 Trends in provincial public health expenditure for Health Sciences and Training (R million) [HR5]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	65,381,000	71,116,500	73,542,000	83,648,000	---	---	---
Total per person	14.23	15.24	15.52	17.38	---	---	---
Total per uninsured person	19.49	20.88	21.26	23.81	---	---	---
Constant (2004/05) prices							
Total	75,838,486	78,282,602	76,929,401	83,648,000	106,046,000	142,015,000	178,477,070
Total per person	**16.51**	**16.78**	**16.23**	**17.38**	**21.70**	**28.62**	**35.41**
Total per uninsured person	22.61	22.98	22.24	23.81	29.73	39.20	48.51

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Programme 7: Health Care Support Services

PROGRAMME 7: Health Care Support Services

1. AIM

To render support services required by the Department to realise its aims

2. PROGRAMME STRUCTURE

Programme 7.1
Laundry Services:

Rendering a laundry service to hospitals, care and rehabilitation centres and certain local authorities.

Programme 7.2
Engineering Services

Rendering a maintenance service to equipment and engineering installations, and minor maintenance to buildings.

Programme 7.3
Forensic Services

Rendering specialised forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death.

Programme 7.4

Orthotic and Prosthetic Services
Rendering specialised orthotic and prosthetic services.

Programme 7.5
Medicine Trading Account

Managing the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities.

3. SUB-PROGRAMME 7.1 LAUNDRY SERVICES

3.1 SITUATION ANALYSIS

Laundry services are provided by large central laundries at Tygerberg, Lentegeur and George Hospitals. Several rural hospitals have small in-house laundries. A large portion of the service has been successfully outsourced resulting in significantly reduced costs and improved availability of linen. The outsourcing has resulted in a substantial reduction in overtime worked at in-house laundries. The previous problem of sustainability in the private sector has been resolved by the award of 5-year contracts in place of the 2-year contracts that were previously awarded.

Maintaining an in-house laundry capability is of strategic importance as a number of private sector laundries have failed over recent years. Fortunately the in-house laundries have been able to meet the service requirements at the affected hospitals and institutions.

No major equipment has been replaced for more than 10 years, which is of concern. It is envisaged that approximately R20 million will be required to replace ageing equipment and to conform to the South African National Standard (SANS) over the next 5 years. A tunnel washer costing R8 million will be purchased during 2006/07 to begin to address this need.

3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

In order to provide a cost effective service with minimum risk, a combination of in-house and outsourced laundry services has been instituted. The priority has been to increase the efficiency of in-house services. Large volumes of work are imperative for the strategic laundries to make them cost-competitive with the private sector. Recent productivity gains have led to a shift of work from the private sector to the in-house laundries. This was necessary to ensure that personnel resources were fully utilised.
In the future the emphasis will be placed on further outsourcing as this will lead to both cost savings and service improvements.

3.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The relatively high salaries of in-house laundry personnel compared with the private sector are a significant constraint to making these laundries cost competitive. A gradual reduction in staff coupled with morale building and training has significantly improved productivity. The problem facing the laundry service is aging equipment that must be replaced at high cost.

The lack of capacity in the private sector in the Western Cape has had a negative effect on laundry service costs. Period contracts have been extended from 2 years to 5 years to make contracts financially viable for private contractors. A plan to build capacity has been developed and will incorporate a procurement process that provides time for emerging contractors to set up laundry operations.

3.4 PLANNED QUALITY IMPROVEMENT MEASURES

A plan to replace ageing equipment over the next 5 years and maintain one strategic laundry in the Cape Metropole has been developed.

3.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.1

Table 7.1 Provincial objectives and performance indicators for Laundry services

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Provide a laundry service to all provincial hospitals	A combination of strategic in-house and out-sourced services	Clean and disinfected linen	Number of pieces laundered **Target:** 22 million pieces per annum	Production records	Number of pieces laundered	Number of pieces laundered	1 (year)	DD: Laundry Services	Yes
Provide cost effective in-house laundry service	Personnel productivity, production cost control and increased volumes	Average cost per item processed competitive with out-sourced service	Average cost per item **Target:** R1-50 per item	Production records and financial statements	Average cost per item	Total cost of in-house laundries	Total number of items laundered in-house	DD: Laundry Services and Institutions	Yes
Provide cost effective out-sourced laundry service	Competitive tendering process	Lowest average cost per item processed	Average cost per item **Target:** R1-10 per item	Production records and financial statements	Average cost per item	Total cost of out-sourced laundry service	Total number of items laundered by out-sourced laundry service	DD: Laundry Services and contractors	Yes

Objective	Indicator1	2002/03 (actual)2	2003/04 (estimate)2	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)
Provide a laundry service to all provincial hospitals	Total number of pieces laundered:	21m	21m	18m	20m	20m	21m	21m
	Number of pieces laundered: in-house laundries	14.4m	17m	14m	14m	14m	14m	14m
	Number of pieces laundered: outsourced services	7.6m	5m	4m	6m	6m	7m	7m
Provide cost effective in-house laundry service	Average cost per item	R1.50	R1.68	R1.81	R1.74	R1.74	R1.74	R1.74
Provide cost effective out-sourced laundry service	Average cost per item	R1.10	R1.15	R1.30	R1.48	R1.60	R1.73	R1.73

Note: In-house laundry costs exclude cost of capital for buildings and equipment
Outsourced costs include cost of capital, profit and VAT (all of which are not included in the in-house cost).

4. SUB-PROGRAMME 7.2 ENGINEERING SERVICES

4.1 SITUATIONAL ANALYSIS

The policy is that each hospital has its own engineering workshop to provide routine day-to-day maintenance for which a minimal staff complement is provided. However, at some institutions there are no staff, or staff with limited capabilities. Two general engineering workshops (at Zwaanswyk and Bellville) and one clinical engineering workshop (at Vrijzee) provide support to the hospitals. The Bellville, Vrijzee and Zwaanswyk workshops employ engineers, technicians and artisans that are able to assist hospitals with larger and more complex maintenance and repair work. These three workshops are part of the Directorate: Engineering and Technical Support.

4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The hospital workshop personnel and the Directorate: Engineering and Technical Support do all hospital maintenance and repairs of hospital equipment.

Maintenance of buildings is a joint venture with the Department of Transport and Public Works. The latter undertake all major construction, repair and maintenance work at hospitals. The Directorate: Engineering and Technical Support is responsible for prioritising and defining the work to be done by Public Works.

The most urgent priority is to address the backlog of maintenance and rehabilitation of hospital infrastructure. This is to be achieved by focussed use of maintenance and Provincial Infrastructure Grant funding and the upgrading of Hospitals in terms of the Hospital Revitalisation Programme. The disposal of the most dilapidated infrastructure that is surplus to the needs of the service will further reduced the maintenance backlog without additional expenditure

4.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Inadequate funding for maintenance has been a problem for many years. Healthcare 2010 commits the Department to the realistic funding of maintenance. A priority will be the filling of all vacant engineering posts to improve the day-to-day maintenance so that the deterioration, particularly of new building and equipment, is halted.

4.4 PLANNED QUALITY IMPROVEMENT MEASURES

The Hospital Revitalisation Programme and the increased availability of funds for new equipment will reduce the maintenance backlog by replacing obsolete buildings, infrastructure and equipment.

Table 7.2 Physical condition of hospital network

Hospitals by type	Average 1996 NHFA condition grading1	*Estimated grading 2005	Outline of major rehabilitation projects since last audit
DISTRICT HOSPITALS			
Beaufort West	4	3	The construction of a new pharmacy and administration wing.
Caledon	4	3	Routine maintenance only.
Ceres	5	4	Routine maintenance only.
Citrusdal	4	4	Internal and external renovations and painting.
Eerste River	N/A	3	
False Bay	4	3	Internal and external renovations.
Hermanus	4	3	Routine maintenance only.
Knysna	4	3	Internal and external renovations and painting.
Ladismith	4	4	Routine maintenance only.
LAPA Munnik	4	4	Routine maintenance only.
Montagu	2/3	3	Internal and external renovations and painting.
Mossel Bay	4	2	Partial internal and external renovations and painting.
Otto du Plessis	3/4	4	Routine maintenance only.

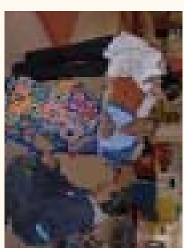
Hospitals by type	Average 1996 NHFA condition grading1	*Estimated grading 2005	Outline of major rehabilitation projects since last audit
DISTRICT HOSPITALS			
Oudtshoorn	4	4	Routine maintenance only.
Riversdale	4	3	External renovations and painting.
Robertson	4	3	Routine maintenance only.
Stellenbosch	4	3	Roof replaced.
Swartland	4	3	Roof replaced and kitchen upgraded.
Swellendam	4	3	Routine maintenance only.
Vredenburg	3	2	Comprehensive revitalisation in progress.
Vredendal	4	4	Casualty upgraded.
Wesfleur	2	2	Extensive internal and external repairs and renovations
PROVINCIALLY AIDED DISTRICT HOSPITALS			
Clanwilliam			Ward upgraded for “private” patients.
Laignsburg			One wing converted for use as a clinic.
Murraysburg			OPD added.
Prnce Albert			OPD added.
Radie Kotze			Ward upgraded for “private” patients.
Uniondale			Routine maintenance only.
GENERAL HOSPITALS			
Eben Donges	4	3	Comprehensive revitalisation in progress.
GF Jooste	4	3	Casualty upgraded OPD and staff amenities block added
George	4	5	Comprehensive revitalisation in progress.
Hottentots Holland	3	1	Maternity wing upgraded.
Karl Bremer	4	4	Central steam installation converted to point of use electrical heating. Wards and reception upgraded for “private” and hospital patients.
Paarl	3	2	Casualty upgraded. Central steam installation converted to point of use electrical heating. Revitalisation to commence in 2006.
Somerset	4	2	Central steam installation converted to point of use electrical heating.
Victoria	2	1	Substantial external renovation of buildings. Central steam installation converted to point of use electrical heating.
CENTRAL HOSPITALS			
Groote Schuur	5	3	Major renovations and improvements to maternity block and OPD.
Red Cross	4	3	New specialist OPD added. Prefab buildings replaced with permanent structures. Day theatre extensively upgraded. External renovation of main hospital building. Renovation of nurses home. Central steam installation converted to point of use electrical heating. New Trauma Unit added. New oncology ward built.
Tygerberg	3	2	Pharmacy upgraded. Several wards renovated.

Hospitals by type	Average 1996 NHFA condition grading1	*Estimated grading 2005	Outline of major rehabilitation projects since last audit
TUBERCULOSIS HOSPITALS			
Brewelskloof	4	4	Extensive internal and external repairs and renovations
Brooklyn Chest	4	3	Ongoing internal and external renovation of wards. Installation of UV lights in progress.
PROVINCIALLY AIDED TB HOSPITALS			
DP Marais SANTA	4	4	Ablutions upgraded.
Harry Comay SANTA	1	1	Minor renovations and painting.
PSYCHIATRIC HOSPITALS			
Alexandra	3	3	Administration and teaching/clinic blocks upgraded. Standby generator replaced.
Lentegeur	4	4	Renovation of ward blocks in progress.
Nelspoort	3	3	Central steam installation converted to point of use electrical heating.
Stikland	4	2	Several ward blocks renovated.
Valkenberg	3	2	Hospital being scaled down from 1039 to 320 beds. New admissions ward under construction.
CHRONIC MEDICAL AND OTHER SPECIALISED HOSPITALS			
KBH Rehabilitation			None – has been relocated to Lentegeur
Mowbray Maternity	3	3	Portion of nurses home converted to active birthing unit and ward for "private" patients. Comprehensive renovations and upgrading in progress.
PROVINCIALLY AIDED CHRONIC MEDICAL AND OTHER SPECIALISED			
Booth Memorial			One wing renovated. Standby generator installed.
Die Wieg			Internal and external renovations and painting.
Maitland Cottage Home			Routine maintenance only.
Sarah Fox			
St Josephs Home			Routine maintenance only.
Conradie - Lifecare			Wards upgraded for use by Lifecare

* the estimated 2005 grading is based on routine inspections by the Engineering personnel and the requirements of Healthcare 2010.

NHFA grading

Category	Description
5	As new; appropriate (purpose designed) for proposed use; requires almost no attention; annual maintenance allowance should be 1% of budget; zero backlog maintenance
4	Good condition; generally suitable for use; needs normal maintenance, or minor repairs or alterations to remain in use; annual maintenance allowance should be 3% of budget; zero backlog maintenance
3	Poor condition; requires major repairs and/or is unsuitable for its proposed use, but rehabilitation or alterations will not exceed 65% of replacement cost; annual maintenance allowance should be 8% of budget; average cost of refurbishment 50% of replacement cost
2	Replace; requires major repairs or is unsuitable for its current function, such that renovation costs would exceed 70% of replacement cost; annual maintenance allowance should be at least 8% of budget, but may not be worthwhile unless no replacement will be available
1	Condemn; should be demolished and replaced; effectively no useful value



4.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.2

Table 7.3 Provincial objectives and performance indicators for Engineering services

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Effective maintenance of buildings and engineering installations	A combination of in-house and out-sourced maintenance in co-operation with Works	Health facilities that are maintained safe, presentable and fit for purpose	Maintenance backlog as % of replacement value Target: <4%	Routine inspections and cost estimates	Maintenance backlog as % of replacement value	Estimated maintenance backlog	Total replacement cost of buildings and engineering installations	Hospital Engineering Services and Works	Yes
Efficient engineering installations	Monitoring of plant efficiency and modification or renewal as necessary	Minimised cost of utilities and operation	Cost of utilities per bed Target: R3600 p.a.	Inspections, measurements and bench-marking	Cost of utilities per bed	Cost of utilities	Number of beds	Institutions and Information Management	Not immediately & Yes
Cost effective maintenance of medical equipment	A combination of in-house and out-sourced maintenance	Extended economic life of equipment and increased safety	Number of requisitions completed- in-house/ outsourced	Routine inspections and records kept by Technicians	Number of tasks completed- in-house/ outsourced.	Number of tasks completed- in-house/outsourced	Number of tasks received	Clinical Engineering Departments	Yes

Objective	Indicator	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)
Effective maintenance of buildings and engineering installations	Maintenance backlog as % of replacement value	9%	8%	8%	7%	7%	6%
Efficient engineering installations	Cost of utilities per bed	R3 600	R5 560	R4 200	R4 000	R4 000	R4 000
Safe working environment (Buildings, machinery and equipment)	Number of reportable incidents	300	291	300	300	300	300
Cost effective maintenance of medical equipment	Number of jobs completed – in-house/outsourced	11 200	10 507	12 800	13 800	13 800	13 800

5. SUB-PROGRAMME 7.3 FORENSIC SERVICES

The funding for this function has been transferred to Sub-programme 2.8.

6. SUB-PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

6.1 SITUATION ANALYSIS

The Orthotic and Prosthetic (O&P) Service is rendered from a provincial centre situated on the Conradie Hospital site. Orthotist/Prosthetists attend orthopaedic clinics throughout the province. The service in the Southern Cape/Karoo has been successfully outsourced.

6.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The policy is to render an effective, efficient and sustainable service through a combination of in-house and outsourced services. The immediate priority is to recruit, train and retain personnel to sustain the in-house service. The broader strategic objective is to ensure continuity of service delivery through an optimum mix of in-house and outsourced services.

6.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

A major constraint is the inability to attract and retain suitably skilled and experienced personnel. This can be attributed to a shortage of qualified Orthotist/Prosthetists and surgical boot-makers, coupled with uncompetitive salaries. The shortage is being addressed by in-house training programmes. The uncompetitive salaries are part of a larger problem of uncompetitive salaries of registered health support personnel. The outsourcing of Orthotic and Prosthetic services linked to the Provincial Rehabilitation Centre is planned to commence in 2006/7. This will reduce the current backlog and improve the quality of care.

6.4 PLANNED QUALITY IMPROVEMENT MEASURES

Quality improvement focuses on two areas:

- The reduction of waiting times which is being addressed by recruiting additional personnel and outsourcing selected services.
- Working with other professionals in the rehabilitation field to improve the quality of appliances.

5.5 5.6 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

Table 7.4 Provincial objectives and indicators for orthotics and prosthetics

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Render an Orthotic and Prosthetic service for the Province	A combination of in-house and out-sourced services	Orthotic and Prosthetic devices	Number of patients registered and number of devices manufactured Targets: 4500 patient registrations. 3500 completed devices	Patient data-base	Number of devices manufactured	Number of devices manufactured	1 (year)	O&P patient data base	Yes
Provide quality devices	Training and liaison with Physiotherapists and Occupational Therapists	Devices that meet patient needs first time	% of devices requiring remanufacture Target: <5%	Production records	% of devices requiring remanufacture	Number of devices requiring remanufacture	Total devices manufactured	O&P production data base	Yes
Provide a responsive service	Increase productivity and outsourcing where cost effective	More devices for same cost. Reduced waiting time	Number of patients waiting over 6months Target: <600	Patient data-base	Number of patients waiting over 6 months	Number of patients waiting over 6 months	1 (year)	O&P patient data base	Yes

Objective	Indicator	2002/03 (actual)2	2003/04 (actual)	2004/05 (actual)	2005/06 (target)	2006/07 (target)	2007/08 (target)	2008/09 (target)
Render an Orthotic and Prosthetic service for the Province	Number of devices manufactured	4 500	5 884	4109	5 000	5 000	5 000	5 000
Provide quality Orthotic and Prosthetic devices	% of devices requiring remanufacture	5%	3%	3%	3%	2%	2%	2%
Provide a responsive Orthotic and Prosthetic service	Number of patients on waiting list waiting over 6 months	600	600	705	800	600	400	200

7. SUB-PROGRAMME 7.5 MEDICINE TRADING ACCOUNT

7.1 SITUATION ANALYSIS

The Cape Medical Depot (CMD), operating on a trading account, is responsible for the purchasing, warehousing and distribution of pharmaceuticals and medical sundries. Orders are supplied in bulk to larger hospitals or as smaller one-off items to smaller institutions. The academic hospitals generally buy directly from manufacturers and tend to use the CMD as a top-up service, which adversely affects other institutions.

The CMD is also responsible for pharmaceutical quality control. This is achieved by means of a Quality Control Laboratory (QCL) situated at the Cape Technikon. The Pre-pack Unit is responsible for preparing patient ready packs.

7.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

In order to render an effective service, the CMD needs sufficient working capital to maintain adequate stock levels in the face of poor supplier performance, erratic deliveries and erratic demands. The Capital Account was therefore augmented by R4,103 million during the 2004/05 financial year. However, this amount is still insufficient as an additional R13 million is required.

The immediate priority is to obtain Cabinet approval for the abolition of the interest levied on working capital employed which impedes efficient performance. This will enable the CMD to adequately fund the Capital Account to meet demands.

7.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Inadequate working capital is an on-going problem. Motivations have been made annually to augment the working capital in line with the inflationary price increase percentage for pharmaceuticals, taking into account the annual turnover of the CMD. As indicated in paragraph 7.2 the Capital Account was augmented by R4, 103 million during 2004/05 and it is anticipated that the R13 million shortfall will be addressed in due course.

7.4 PLANNED QUALITY IMPROVEMENT MEASURES

The upgrading of the CMD to comply with the Pharmacy Act is a priority and although essential is not funded in the 2005/6 year.

7.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.5

Table 7.5 Provincial objectives and performance indicators for the MEDPAS trading account

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Ensure availability of essential drugs	Monitor stock levels in terms of demand and supplier performance	Dues out below 60	Dues out below 60 items Target: <60	Dues out reports	No of items on dues	No of items with Nil balance	1	Medsas	Yes
Efficient utilisation of working capital	Monitor low turnover items and put on DDV's	Stock turnover 8 or more times per year	Stock turnover Target: >8	Medsas report	Stock turnover	Stock issued	Working capital	Medsas	Yes
Adequate working capital to support adequate stockholding	Increase working capital in line with projected inflator	Adequate working capital	Sufficient working capital to keep stock turnover below 12	Increased Working capital	Working capital	Working capital	1	Medsas	Yes
Sufficient stock available at end-user level	Number of demands to be satisfies within 48 Hours	Service level above 85%	Service level Target: >85%	Medsas reports	Service level	No of demands satisfied	Total no of demands	Medsas	Yes

Objective	Indicator	2002/03 (actual)2	2003/04 (actual)	2004/05 (actual)	2005/06 (target)	2006/07 (target)	2007/08 (target)	2008/09 (target)
Ensure availability of essential drugs	No of items on dues	61	60	<60	60	60	60	60
Efficient utilisation of working capital	Stock turnover	8.7	9	9	9	9	9	9
Adequate working capital to support adequate stockholding	Working capital	32 million	46 million	50 million	53 million	59 million	59 million	59 million
Sufficient stock available at end-user level	Service level	81,5%	> 85%	> 85%	> 85%	> 95%	> 95%	> 95%

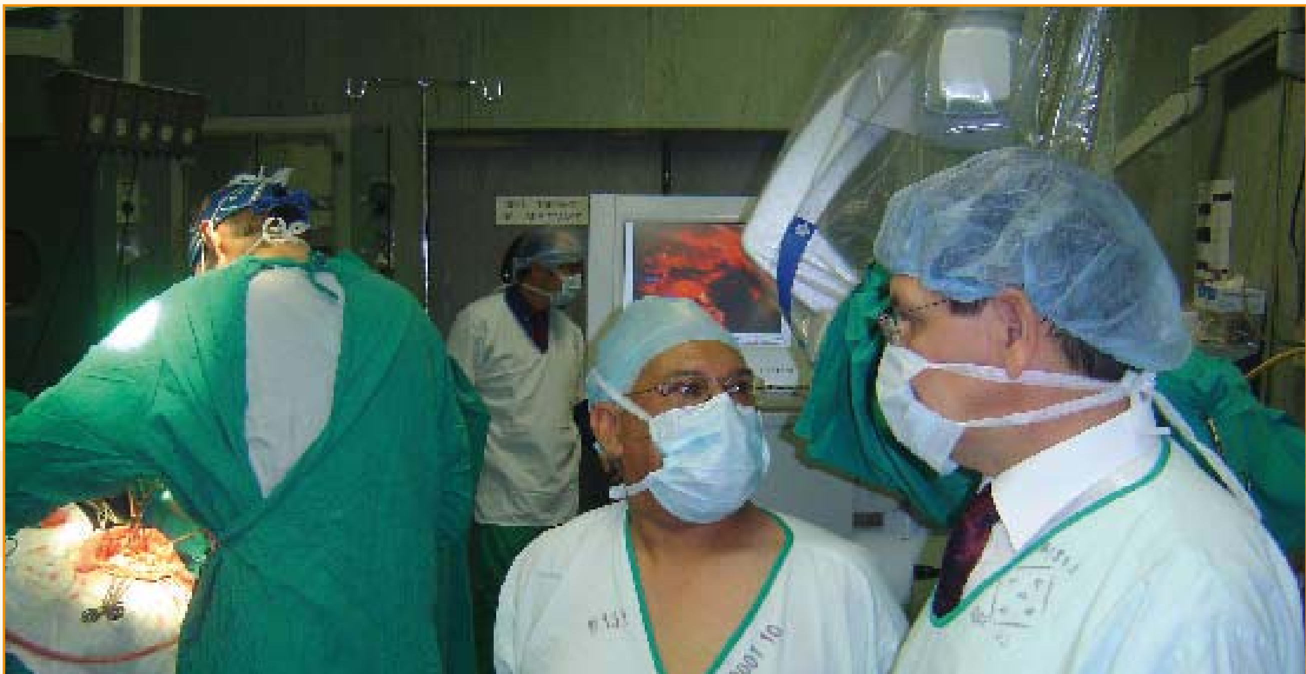
8. PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Health Care Support Services is allocated 1,23 per cent of the vote in 2006/07 in comparison to the 1,61 per cent of the revised estimate of the Appropriation Budget that was allocated in 2005/06. This is a decrease of R14,595 million or 15,85 per cent in nominal terms. This is due to the reallocation of the funding for Forensic Pathology Services from Subprogramme 7.3 to Subprogramme 2.8.

Table 7.6 Trends in Health Care Support Services expenditure (R million)

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	66,597,000	73,837,075	82,752,000	90,203,000	---	---	---
Total per person	14	16	17	19	---	---	---
Total per uninsured person	20	22	24	26	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	77,248,981	81,277,318	86,563,621	90,203,000	77,480,000	81,885,000	86,769,000
Total per person	17	17	18	19	16	16	17
Total per uninsured person	23	24	25	26	22	23	24
Total capital							

Note:
Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.



Programme 8: Health Facilities Management

PROGRAMME 8: Health Facilities Management

1. AIM

To provide for new health facilities, upgrading and maintenance of existing facilities, including the Hospital Revitalisation Programme and the Provincial Infrastructure Grant.

2. PROGRAMME STRUCTURE

Sub-programme 8.1
Community health facilities

Sub-programme 8.2
Emergency medical rescue

Sub-programme 8.3
District hospital services

Sub-programme 8.4
Provincial hospital services

Sub-programme 8.5
Central hospital services

Sub-programme 8.6
Other facilities

Programme 8 includes: the management of capital assets, i.e. health facilities and equipment (medical equipment and furniture) in all programmes.

ACCURACY OF INFORMATION
Where possible, audited or verified information has been used to calculate the values in the tables in this section. However, in many instances the calculations are based on estimates based on experience or trends.

3. SITUATION ANALYSIS

3.1 Emergency Medical Services (EMS)

The EMS is a highly visible and essential service rendered by the Department. Unfortunately, the accommodation occupied by this service is far from optimal.

The ambulance service was transferred from local government to the Provincial Government. A large number of the ambulance stations are still on municipal property. The remainder are located at provincial health facilities. Only a few ambulance stations are purpose built. The majority are accommodated inappropriately in buildings originally designed for other purposes and that have been neglected over the years. The cost upgrading and providing new ambulance stations is provisionally estimated at R51,3 million.

The policy is to relocate all ambulance stations to purpose built accommodation at appropriate hospital premises. It is planned to achieve this in the next 5 years utilizing Provincial Infrastructure Grant (PIG) funding.

3.2 District Health: Primary Health Care

The Department of Health and the Local Authorities are busy with the amalgamation of the PPHC facilities. The rural Local Authority clinics and the CHCs will be transferred to the Department of Health during 2006. Most of these facilities will require additional infrastructure and changes to match a comprehensive service package. A situational assessment and an initial estimate of costing to correct the Primary Health Facilities has been done. The initial estimate of funding needed amounts to R 102,6 million including all rural facilities and all the AIDS treatment sites. However, the extensive maintenance backlog is not included in this estimate as it must still be assessed and costed.

The facilities in the Metro Region will continue to be provided by the Metropole for the next three years during which time the funding issues will be resolved.

3.3 Hospital Network : District, Regional Tertiary, Mental Health and Special Hospitals

Healthcare 2010 underpins the district level health care model as the entry point to health care services and aims to provide equal access to quality health. The hospital service platform in the Metro Region requires a shift of the platform to meet the needs of the population currently living in Khayelitsha and Mitchell's Plain

The most densely populated area in the Western Cape, is the Cape Flats, which is also the area were there are no district hospitals. An urgent requirement is for district hospitals to be provided for the uninsured population on the Cape Flats, particularly in the Khayelitsha and Mitchell's Plain area. Two new district hospitals will be built in these areas using hospital revitalisation funding. Victoria and Hottentots Holland Hospitals are both in a poor state of repair and both will be relocated to sites nearer to the uninsured communities.

The services within the Central Hospitals and the Mental Health hospitals will be rationalised to correct the bed configuration required for 2010.

The rural hospital network similarly requires the upgrade and revitalisation of the regional hospitals. To this effect George and Worcester Hospitals are both being revitalised and Paarl Hospital is due to start shortly.

3.4 Hospital maintenance backlog

There is a significant backlog of maintenance work. In 1999 a survey done by Public Works estimated the backlog to be R500 million.

Using the national cost norms for the construction and equipping of hospitals the replacement cost of hospitals as envisaged in Healthcare 2010 is as follows:

- Cost of replacing hospitals R5,984 million
- Cost of replacing hospital equipment R2,195 million

Based on the above replacement costs and the national targets the maintenance budgets for 2006/7 should be as follows:

- Cost of replacing hospitals R180 million
- Cost of replacing hospital equipment R170 million

The actual budget is approximately half of these targets.

The existing hospital infrastructure is not affordable. The original design capacity of the existing infrastructure is over 15,000 beds and the requirement for Healthcare 2010 is approximately 9,600 beds. Much of the theoretical excess of over 5,000 beds is located in dilapidated buildings or in institutions that are poorly located in terms of the population they serve and thus do not meet the accessibility and equity criteria for Healthcare 2010. A number of hospitals are on excessively large sites where the cost of securing and maintaining the sites is unaffordable.

Rural hospital infrastructure

The rural hospital infrastructure is in relatively good condition. Much of the unsatisfactory infrastructure will be upgraded in the near future:

- The revitalisation of George, Worcester and Vredenburg Hospitals is in progress.
- The revitalisation of Paarl hospital is scheduled to commence in 2006.
- The major downscaling of Nelspoort Hospital and the renovation of the small remaining portion is in progress.

Metropole hospital infrastructure

In contrast to the rural hospital infrastructure, the Metropole hospitals are in poor condition and many are no longer fit for purpose in respect of condition, design and locality. During 2004 Conradie Hospital was closed with the transfer of services to Groote Schuur Hospital, Eerste River Hospital, the Vanguard CHC and the newly constructed Western Cape Rehabilitation Centre. The Healthcare 2010 Infrastructure Plan proposes the upgrading and/or replacement of many Metropole hospitals. Major renovation and upgrading is in progress at Mowbray Maternity Hospital. New hospitals are planned for Khayelitsha, Mitchells Plain, Victoria (replacement) and Hottentots Holland (replacement).

Equipment

There is an urgent need for the replacement of much of the hospital equipment. In the 2003/4 year a programme to replace defective and obsolete equipment was commenced. Expenditure on equipment has almost doubled since 2002/03 as is reflected in Table 8.1. The programme has been assisted by donor funding (Red Cross Hospital) and equipment supplied in terms of the Hospital Revitalisation Programme at the hospitals mentioned above. The need for new and replacement equipment is such that this programme will be on-going for some years.

4. POLICIES, PRIORITIES AND STRATEGIC GOALS

The funding for construction projects will be allocated as follows:

- Health Capital (equitable share) mainly for PHC facilities
- Provincial Infrastructure Grant (PIG) which is a conditional grant mainly for hospital schemes
- Hospital Revitalisation Projects (HRP) funding for hospital revitalisation as prescribed

Health Care 2010 aims to reshape the service platform towards primary level services, community based care and prevention of disease. It is intended that patients be treated at the level of care that is most appropriate, cost effective and efficient.

Regional Hospitals will be strengthened to improve level 2 services and will expand the accessibility of general specialist services to the communities that need them most and to support the level 2 services with well-equipped, appropriately staffed and specialized tertiary services.

The implementation of Healthcare 2010 includes an Infrastructure plan that would provide the buildings, equipment and maintenance in line with the service requirements as set out in Healthcare 2010.

All health care facilities are being accessed for universal access. The need of people with special needs is currently being addressed with a specific facility audit, which will in future be incorporated in the infrastructure planning of all facilities.

The Department of Health is working in close liaison with the Municipal Authorities to try and keep pace with the population shifts and external influences that could impact on infrastructure provision.

The Healthcare 2010 plan is a systematic approach to correct the shape of the service platform to provide equal access to quality care. The success of the re-engineering process hinges on the ability to provide the required infrastructure within the time schedules as suggested by the plan, which was widely consulted. The infrastructure needs for the ambulance stations, primary care, the hospital network and the mortuary and forensic services are being addressed.

Funding for the mortuary services that were previously rendered by SAPS will be transferred to the Department. From the next financial year the Department of Health will be responsible for the maintenance and upkeep of the services.

The national Department of Health has indicated that the allocation for the Hospital Revitalisation Programme (HRP) will increase significantly in the coming years. Provinces have been invited to submit additional hospitals for revitalisation. The Department has prioritised the development of infrastructure in line with Healthcare 2010 and this is reflected in the Hospital Revitalisation Projects at George, Worcester and Vredenburg. The Paarl Hospital will commence during 2006.

Tygerberg Hospital is in urgent need of upgrading and renovation. The CSIR has been appointed to survey and report on the condition and suitability of the hospital in terms of its future role in Healthcare 2010.

Health has a few hospitals that are on excessively large and valuable pieces of land. There are also hospitals that are planned to relocate and are on valuable land. It is proposed that this surplus land could be disposed of to generate capital funding for the infrastructure needs of primary healthcare. The land in question is presently utilised and can therefore only be made available for disposal once the institutions are rationalised and/or replaced.

5. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Four major problem areas have been identified and are as follows:

Inadequate capacity within the Department to produce business cases for capital projects has resulted in delays. The most notable was the Paarl Revitalisation Project that was delayed for 8 months as a result. During 2006 the Department is committed to increasing the capacity within the Directorate: Policy and Planning to address this situation.

The second major problem is the lack of health facility design capacity. This comment is applicable to both Health and Transport and Public Works. During 2006 the Department will create a design office to ensure that the needs of Health are submitted to Public Works in a much more detailed and acceptable format.

The third major problem area is the lack of capacity in respect of the Hospital Revitalisation Programme. This programme provides very substantial funding for the revitalisation of hospitals. In order to access this funding the projects have to be properly managed. A component is required to produce the business cases, project implementation plans and reporting as required in the Division of Revenue Act (DORA). This has resulted in the withholding of funding for non-compliance. In 2006 the Department is committed to creating and operationalising the necessary structures.

The fourth problem relates to the management of this programme, and in particular that which relates to financial administration and accountability. The present arrangement makes the Accounting Officer of Health accountable for all expenditure and the programme performance, while having no jurisdiction over the actions that lead to such expenditure. A service level agreement has been signed between the Departments of Health, and Transport and Public Works.

Table 8.1 Historic and planned capital expenditure by type [HFM1]

R 000's	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 MTEF (estimate)	2006/7 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Major capital (Health)	8 282	17 350	43 741	18 000	19 000	18 000	18 000
Major capital (HRP)	36 954	81 939	124 115	103 445	149 703	10 897	124 244
Major capital (PIG)	25 483	36 324	54 411	55 229	61 829	80 262	85 880
Major capital (Other)					21 217	24 789	6 216
Major capital (Donor RCCH)	5 575	9 147	11 400	16 000	0	0	0
Maintenance & minor capital	30 210	71 677	65 102	48 538	73 197	84 269	89 380
Equipment	61 277	92 679	123 948	114 436	116 000	120 000	124 000
Equipment (Donor RCCH)	2 882	9 734	3 737	0	0	0	
Equip maintenance	48 025	50 426	55 871	58 665	61 598	64 678	67 912
Total capital	218 688	369 276	482 325	414 313	502 544	499 895	515 632

Notes on table HFM 1
1. "Maintenance & minor capital" is the "maintenance" expenditure by Public Works.
2. "Equipment maintenance" excludes the personnel costs of Hospital and Clinical Engineering workshop personnel.

Table 8.2 Summary of sources of funding for capital expenditure [HFM2]

R 000's	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/7 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Equitable share	147 794	232 132	288 662	239 639	269 795	286 947	299,292
Revitalisation grant1	36 954	81 939	127 427	172 038	149 703	107 897	124 244
Infrastructure grant	25 483	36 324	51 878	55 229	61 829	80 262	85 880
Donor funding (RCCH)	5 575	9 147	11 400	16 000	0	0	0
Other	0	0	0	0	21 217	24 789	6 216
Total capital	53 779	215 806	359 542	478 588	414 313	502 544	499 895

Notes on table HFM 2
1. Hospital rehabilitation and reconstruction grant (HR&R) expenditure prior to 2003/4 is recorded under revitalisation grant

Table 8.3 Historic and planned major project completions by type [HFM3]

	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/7 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
New hospitals	0	1	1	0	0	0	0
New clinics / CHC's	0	0	0	0	2	4	2
Upgraded hospitals	0	0	1	2	4	2	2
Upgraded clinics / CHC's	0	0	0	2	0	1	1

Table 8.4 Total projected long-term capital demand for health facilities management (R'000) [HFM4]

Programme	Province wide total R1 000's	Planning horizon (years)	Province total annualised[4] R1 000's	Annualised District		
Programme 1				**Information not available by District**		
MECs office and Administration[1]	-	-	-	-	-	-
Programme 2	**0**		**0**			
Clinics and CHC's	324000	18	18 000			
Mortuaries	75 300	3	25 100			
District hospitals	1 285 000	10	128 500			
Programme 3	**0**		**0**			
EMS infrastructure[1]	40 000	5	8 000	-	-	-
Programme 4	**0**		**0**			
Regional Hospitals	660 000	8	78 000			
Psychiatric hospitals[1]	759 000	8	37 833	-	-	-
TB hospitals[1]	130 000	8	16 250	-	-	-
Other specialised hospitals[1]	30 000	3	10 000	-	-	-
Programme 5	**0**		**0**			
Provincial tertiary and national tertiary hospitals[1]	1 400000	14	100 000	-	-	-
Other programmes[1,3]	0		0			
Compliance with Pharmacy Act.	96 000	6	16 000	-	-	-
Total all programmes	**4 799 300**		**494 725**			

Note on table 8.4 [HFM 4]
1. The above figures are for building work only and specifically exclude equipment and furniture
2. The planning horizon is based on expected available cash flows. The horizon could shorten substantially if additional funding is available from conditional grants, donors or the sale of surplus property.
3. The above estimates are based on the 2004 Hospital Infrastructure Plan and will be revised during 2006.
4. The budget for clinic's and CHC's is largely based on existing provincial services. The projection could vary substantially as the full implication of the provincialisation of personal primary health care is determined.

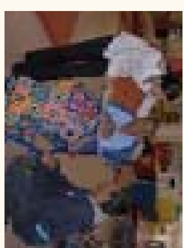


Table 8.5 Situation analysis indicators for health facilities management [HFM5]

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05	National target 2003/4
Input						
1. Equitable share capital programme as % of total health expenditure	%	0.31	0.22	0.40		1.5
2. Hospitals funded on revitalisation programme	%	3	3	5		17
3. Expenditure on facility (building) maintenance as % of total health expenditure	%	0.51	0.78	1.64		2.5
4. Expenditure on equipment maintenance as % of total health expenditure	%	1.28	1.25	1.15		2
Process						
5. Hospitals with up to date asset register	%					100
6. Health districts with up to date PHC asset register (excl hospitals)	No					All
Quality						
7. Fixed PHC facilities with access to piped water	%	100	100	100		100
8. Fixed PHC facilities with access to mains electricity	%	100	100	100		100
9. Fixed PHC facilities with access to fixed line telephone	%	100	100	100		100
10. Average backlog of service platform in fixed PHC facilities	R	270 000 000	270 000 000	270 000 000		30
11. Average backlog of service platform in district hospitals	R	23 361 284	23 361 284	23 601 284		30
12. Average backlog of service platform in regional hospitals	R	124 723 006	120 437291	120 437 291		30
13. Average backlog of service platform in specialised hospitals	R	54 626 937	54 626936	54 293 641		30
14. Average backlog of service platform in tertiary and central hospitals	R	359 849 408	357 921 375	356 254 708		30
15. Average backlog of service platform in provincially aided hospitals	R	13 066 667	13 066 667	13 066 667		30
Efficiency						
16. Projects completed on time	%	10	10	10		
17. Project budget over run	%	0	5	5		
Outcome						
18. Level 1 beds per 1000 uninsured population	No	0,45	0,45	0,45		100
19. Level 2 beds per 1000 uninsured population	No	0,45	0,45	0,56		65
20. Population within 5km of fixed PHC facility	%	93	93	93		85

Notes on table HFM 5
1. Average backlog of service platform is for building work only and specifically excludes equipment and furniture.

6. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 8.6 Performance indicators for health facilities management [HFM7]

Indicator	Type	2003/04	2004/05	2005/06 Projection	2006/07 Projection	2007/08 Projection	2008/09 Projection	National target 2007/08
Input								
1. Equitable share capital programme as % of total health expenditure	%	0.40	0.92	0.36	0.36	0.33	0.31	2.5
2. Hospitals funded on revitalisation programme	%	5	5	8	12	14	16	25
3. Expenditure on facility maintenance as % of total health expenditure	%	1.64	1.37	0.98	1.4	1.53	1.55	4
4. Expenditure on equipment maintenance as % of total health expenditure	%	1.15	1.18	1.18	1.18	1.18	1.18	4
Process								
5. Hospitals with up to date asset register	%							100
6. Health districts with up to date PHC asset register (excl hospitals)	No							All
Quality								
7. Fixed PHC facilities with access to piped water	%	100	100	100	100	100		100
8. Fixed PHC facilities with access to mains electricity	%	100	100	100	100	100		100
9. Fixed PHC facilities with access to fixed line telephone	%	100	100	100	100	100		100
10. Average backlog of service platform in fixed PHC facilities	R	270 000 000	270 000 000	270 000 000	265 000 000	260 000 000	255 000 000	15
11. Average backlog of service platform in district hospitals	R	23 601 284	22 341 281	1 285 000 000	1 285 000 000	1 285 000 000	1 285 000 000	15
12. Average backlog of service platform in regional hospitals	R	120 437 291	116 151 577	660 000 000	600 000 000	550 000 000	450 000 000	15
13. Average backlog of service platform in specialised hospitals	R	54 293 641	43 071 419	42 738 086	39 071 405	34 626 939	30 000 000	15
14. Average backlog of service platform in tertiary and central hospitals	R	356 254 708	352 921 375	1 400 000 000	1 400 000 000	1 400 000 000	1 400 000 000	15
15. Average backlog of service platform in provincially aided hospitals	R	13 066 667	13 066 667	13 066 667	13 066 667	13 066 667	13 066 667	15

Efficiency								
16. Projects completed on time	%	10	10	25	50	50	50	
17. Project budget over run	%	5	5	5	5	5	5	
18. Level 1 beds per 1000 uninsured population	No	0,45	0,45	0,45	0,75	0,75	0,75	90
19. Level 2 beds per 1000 uninsured population	No	0,56	0,55	0,55	0,61	0,60	0,60	60
20. Population within 5km of fixed PHC facility	%	93	93	94	94	95	95	95

Notes on Table H8.6
1. Average backlog of service platform is for building work only and specifically excludes equipment and furniture
2. All hospitals have asset registers but cannot be considered comprehensive at this stage. This is work in progress.
3. The large increase in the backlog for hospitals in 2005/06 and beyond is because the revised cost of complete revitalisation has been used to calculate the backlog.

7. PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Programme 8 is allocated 5,14 per cent of the vote in comparison to the 4,02 per cent of the vote that was allocated in the revised estimateAppropriation Budget of 2005/06. This translates into an increased allocation of R94,382 million or 40,94 per cent in nominal terms.

Table 8.7 Trends in provincial public health expenditure for health facilities management (R' million) [HFM8]

Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/7 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices	218,688	369,276	482,325	414,313	502,544	499,895	515,632
Total	218,688	369,276	482,325	414,313	502,544	482,325	414,313
Total per person	47.82	80.04	103.56	88.19	106.14	104.77	107.24
Total per uninsured person	66.41	111.17	143.84	122.48	147.38	140.33	119.60
Constant (2004/05) prices							
Total	241,708	388,712	482,325	401,229	465,514	426,477	366,340
Total per person	52.85	84.25	103.56	85.40	98.32	89.38	76.19
Total per uninsured person	**73.41**	**117.02**	**143.84**	**118.61**	**136.52**	**124.09**	**105.75**

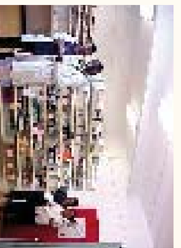
Table 8.8 Trends in provincial public health expenditure on health facilities management funded from Programme 8 (R' million) [HFM8]

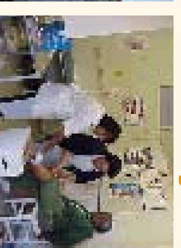
Expenditure	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (estimate)	2006/07 (MTEF projection)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices							
Total	100,794,000	196,176,000	288,464,000	273,725,000	324,946,000	315,217,000	323,720,000
Total per person	22	42	61	57	69	66	67
Total per uninsured person	30	58	83	78	95	92	93
Constant (2004/05) prices							
Total	116,915,684	215,943,808	301,750,873	273,725,000	324,946,000	315,217,000	323,720,000
Total per person	25	46	64	57	66	64	64
Total per uninsured person	**35**	**63**	**87**	**78**	**91**	**87**	**88**

Table 8.9 Provisional priorities for hospital revitalisation

Priority	HOSPITAL	2010 Classification	2004 BEDS	2010 beds	Building ESTIMATE R'million	Start	End
1	George	Provincial	202	265	80	2003	2006
2	Eben Donges	Provincial	213	315	196	2003	2008
3	Vredenburg	District	56	80	56	2003	2008
4	Paarl	Provincial	250	326	240	2006	2010
5	Khayelitsha	District	0	230	230	2006	2009
6	Mitchells Plain	District	0	230	230	2007	2010
7	Valkenberg	Psychiatric	385	315	490	2007	2011
8	Tygerberg	Central	1273	1081	1100	2008	2013
9	Victoria	District	159	230	230	2007	2010
10	Hottentots Holland	District	121	230	230	2007	2010
11	Mossel Bay	District	80	90	100	2008	2010

Notes on the above provisional priorities:
1. Estimates include equipment – with the exception of Tygerberg





Schedule 1 Capital Projects Funding

	Name of the Project	Type of infrastructure	Brief,need/ proposed outcome	Current project stage	Project duration months	Start target date	Completion target date	Total requirement R'000	2005/06 R'000	2006/07 R'000	2007/08 R'000	2008/09 R'000
1	4 Dorp Street Office accommodation	Other facilities		Construction	12	Apr 05	Mar 06	2000	2000	0	0	0
2	Atlantis hospital - Replace ambulance station	Ambulance Station		Construction	36	Apr 05	Mar 08	1720	50	820	850	0
3	Beaufort West renovations alterations and additions	Hospital	Yes	Retention/ Final account	37	Jan 03	Jan 06	280	280	0	0	0
4	Browns farm	Clinic	Yes	Construction	48	Apr 04	Mar 08	6000	2262	2500	1000	0
5	Cape Medical Depot - air-conditioning	Other facilities		Inception	3	Apr 06	Jun 06	1000	0	1000	0	0
6	Delft - Upgrade clinic	Clinic	Yes	Inception	24	Apr 08	Mar 10	4650	0	0	0	200
7	Eerste river hospital - Stores	Hospital	Yes	Retention/ Final account	24	Apr 04	Mar 06	2500	2143	50	0	0
8	Elsies river clinic	Clinic	Yes	Retention/ Final account	24	Apr 04	Mar 06	3700	2572	50	0	0
9	GF Jooste hospital - Upgrading & renovation	Hospital		Retention/ Final account	35	Aug 03	Jun 06	9000	2410	10	0	0
10	Hermanus ambulance station	Clinic		Construction	24	Apr 05	Mar 07	4500	159	1700	1350	500
11	Knysna - Replacement clinic	Clinic		Inception	24	Apr 08	Mar 10	5000	0	0	0	50
12	Ladismith hospital	Hospital	Yes	Retention/ Final account	36	Apr 03	Mar 06	1050	1222	50	0	0
13	Maitland - Upgrade clinic	Clinic	no	Inception	24	Apr 08	Mar 10	3500	0	0	0	50
14	Malmesbury - Wesbank - New clinic	Clinic	no	Inception	24	Apr 07	Mar 09	5500	0	0	0	50

The Capital Funds as indicated above will be used to upgrade and provide the Primary health services required

	Name of the Project	Type of infrastructure	Brief,need/ proposed outcome	Current project stage	Project duration months	Start target date	Completion target date	Total requirement R'000	2005/06 R'000	2006/07 R'000	2007/08 R'000	2008/09 R'000
15	Montagu community health centre	Clinic	Yes	Construction	72	Apr 03	Mar 09	7000	100	2000	3900	1000
16	Plettenberg Bay - Kwanaokuthula - Replacement clinic	Clinic	no	Inception	36	Apr 07	Mar 10	7000	0	0	200	5000
17	Robbie Nurock - Replacement clinic	Clinic	no	Inception	36	Apr 07	Mar 10	7000	0	0	250	5000
18	Simondium community health centre	Clinic	Yes	Construction	60	Apr 03	Mar 08	5400	145	2200	3050	0
19	Somerset hospital relocation of pharmacy	Hospital	Yes	Retention/ Final account	30	Aug 03	Jan 06	161	161	0	0	0
20	Stanford community health centre	Clinic		Construction	48	Apr 04	Mar 08	5400	200	2200	3000	0
21	Swellendam community health centre	Clinic	Yes	Construction	60	Apr 03	Mar 08	7500	2028	4200	1200	0
22	Table View - De Noon - New clinic	Clinic		Inception	36	Apr 07	Mar 10	5500	0	0	200	3450
23	Tygerberg - Fire Doors	Hospital		Tender	9	Oct 05	Jun 06	800	800	0	0	0
24	Tygerberg - U2 Joe Slovo victims	Hospital		Retention/ Final account	12	Apr 05	Mar 06	988	980	0	0	0
25	Wellington community health centre	Clinic	Yes	Construction	60	Apr 04	Mar 09	8000	104	2200	3000	2700
26	Western Cape Nursing College electrical contractor	Other facilities		Retention/ Final account	59	Aug 01	Jun 06		4304	20	0	0
								105,149.00	21,920.00	19,000.00	18,000.00	18,000.00

Schedule 2 Provincial Infrastructure Grant

Facility	Type of infrastructure	Brief need/ proposed outcome	Current project stage	Project duration months	Start target date	Completion target date	Total requirement R'000	2005/06 R'000	2006/07 R'000	2007/08 R'000	2008/09 R'000
Alexandra hospital - Rationalisation	Hospital	No	Inception	36	Apr 06	Mar 09	13000	0	800	4000	11770
Atlantis Hospital - Replacement of roof	Hospital		Construction	15	Apr 05	Jun 06	2615	2615	200	0	0
Beaufort West - New ambulance station	Ambulance Station	No	Inception	24	Apr 06	Mar 08	5000	0	1000	4000	0
Bonnievale - New ambulance station	Ambulance Station	No	Inception	24	Apr 07	Mar 09	1500	0	0	800	749
Bredasdorp hospital - Ambulance station	Ambulance Station	No	Inception	10	Jun 05	Mar 06	750	10	690	50	0
Brooklyn Chest hospital	Hospital	No	Inception	36	Apr 06	Mar 09	17000	0	1000	6000	10700
Caledon hospital	Hospital	Yes	Planning	48	Apr 05	Mar 09	7500	200	3300	2500	535
Caledon hospital - Ambulance station	Ambulance Station	Yes	Planning	26	May 05	Jun 07	850	0	800	50	0
Ceres hospital - Ambulance station	Ambulance Station		Inception	36	Apr 05	Mar 08	4500	10	490	4000	0
Citrusdal Hospital - Ambulance Station	Ambulance Station		Inception	36	Apr 05	Mar 08	850	30	0	0	0
De Doorns hospital - Ambulance station	Ambulance Station	No	Inception	10	May 06	Feb 07	100	0	100	0	0
Eerste River Hospital	Hospital	No	Inception	60	Apr 04	Mar 09	7200	0	200	3000	4280
G F Jooste - AIDS centre	Clinic	No	Inception	12	Apr 07	Mar 08	4500	0	0	800	3959
Groote Schuur Hospital - Interim measures	Hospital		Inception	24	Apr 07	Mar 09	25000	0	1500	12500	14333
Groote Schuur Hospital - OMB - M Floor upgrading	Hospital		Inception	12	Apr 05	Apr 06	816	816	0	0	0

Facility	Type of infrastructure	Brief need/ proposed outcome	Current project stage	Project duration months	Start target date	Completion target date	Total requirement R'000	2005/06 R'000	2006/07 R'000	2007/08 R'000	2008/09 R'000
Groote Schuur Office Accommodation	Hospital	No	Planning	9	Oct 05	Jun 06	1200	0	1000	0	0
Heidelberg - New ambulance station	Ambulance Station	No	Inception	24	Apr 07	Mar 09	1800	0	0	1000	856
Hermanus ambulance station	Ambulance Station	Yes	Planning	36	Apr 05	Mar 08	5000	0	4600	200	0
Hermanus Hospital - PPP	Hospital		Planning	36	Apr 05	Mar 08	0	0	2982	2982	3190
Lamberts Bay hospital - Ambulance station	Ambulance Station	No	Inception	12	Apr 06	Mar 07	320	0	320	0	0
Lentegeur hospital - Ambulance station	Ambulance Station	Yes	Planning	36	Apr 05	Mar 08	3500	200	1800	1500	0
Lentegeur hospital - Civil Works	Hospital		Retention/ Final account	30	Oct 03	Mar 06	734	734	0	0	0
Lentegeur hospital - Phase 1	Hospital		Retention/ Final account	41	Nov 02	Mar 06	854	854	0	0	0
Lentegeur hospital - Phase 2	Hospital		Retention/ Final account	38	Feb 03	Mar 06	157	157	0	0	0
Lentegeur hospital - Phase 3	Hospital		Retention/ Final account	33	Jul 03	Mar 06	205	205	0	0	0
Lift Maintenance	All Facilities		Maintenance	12	Apr 05	Mar 06	7000	7000	0	0	0
Mossel bay hospital	Hospital	No	Inception	48	Apr 05	Mar 09	30000	0	1000	12000	16050
Mowbray maternity hospital	Hospital	Yes	Construction	30	Apr 04	Sep 06	48200	19262	16200	500	0
Oudtshoorn hospital - Ambulance station	Ambulance Station	Yes	Inception	24	Apr 06	Mar 08	1200	0	1000	200	0
Oudtshoorn hospital - Medical depot	Hospital	Yes	Planning	24	Apr 05	Mar 07	1700	200	1500	0	0
Red Cross Hospital - Ward Upgrades	Hospital	No	Planning	24	Apr 07	Mar 09	10000	7000	0	4430	4815

Facility	Type of infrastructure	Brief need/ proposed outcome	Current project stage	Project duration months	Start target date	Completion target date	Total requirement R'000	2005/06 R'000	2006/07 R'000	2007/08 R'000	2008/09 R'000
Red Cross Hospital - new fence to vacant land	Hospital	No	Planning	12	Apr 05	Apr 06	300	300	0	0	0
Riversdale hospital	Hospital	Yes	Planning	36	Apr 05	Mar 08	13500	500	7000	5000	0
Riversdale hospital - Ambulance station	Ambulance Station	Yes	Inception	9	Apr 05	Dec 05	1200	0	900	300	0
Stellenbosch hospital - Ambulance station	Ambulance Station	No	Inception	10	Mar 06	Dec 06	750	0	600	150	0
Stikland hospital	Hospital	Yes	Construction	25	Apr 04	Apr 06	4000	2779	500	0	0
Swellendam hospital - Improve ambulance station	Ambulance Station		Inception	12	Apr 07	Mar 08	2100	0	0	1800	310
Tygerberg - Fire Doors	Hospital		Tender	9	Oct 05	Jun 06	3897	0	2897	0	0
Tygerberg Hospital - CSIR Study	Hospital		Planning	12	Apr 05	Mar 06	1527	1527	0	0	0
Tygerberg Hospital - (DMC) Disaster Management Centre	Hospital		Planning	12	Apr 05	Mar 06	1600	1600	0	0	0
Tygerberg Hospital - Interim measures	Hospital		Planning	24	Apr 07	Mar 09	30000	0	1500	12500	14333
Tygerberg Hospital - Linear accelerator	Hospital		Planning	12	Apr 05	Mar 06	1600	1600	0	0	0
Valkenberg forensic wards	Hospital		Inception	60	Apr 04	Mar 09	57500	293	2000	0	0
Valkenberg Hospital - New Electrified Perimeter Fence	Hospital		Tender	18	Oct 05	Mar 07	3000	500	2500	0	0
Valkenberg hospital: Admissions	Hospital	Yes	Construction	63	Apr 01	Jun 06	16410	6787	500	0	0
Vredendal Hospital	Hospital	Yes	Planning	24	Apr 05	Mar 07	3000	50	2950	0	0
							343,435	55,229	61,829	80,262	85,880

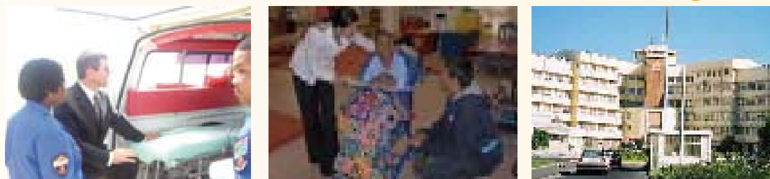
The Provincial infrastructure Grant will be used to upgrade hospitals, ambulance stations to the required standard of repair.

Schedule 3 Hospital Revitalisation

Name of the project/Programme	Type of infrastructure	Brief need/ proposed outcome	Current project stage	Project duration (months)	Start target date	Completion target date	Total requirement R'000	2005/06 R'000	2006/07 R'000	2007/08 R'000	2008/09 R'000
George hospital	Hospital	Yes	Construction	39	Apr 00	Jul 06	79 500	40,000	7,737	0	0
Khayelitsha hospital	Hospital	No	Planning	36	Apr 05	Mar 10	230 000	2,000	8,000	8,000	57,295
Paarl hospital	Hospital	Yes	Tender	48	Oct 00	Mar 08	240 000	15,000	30,104	56,319	45,593
Vredenburg hospital	Hospital	Yes	Construction	41	Apr 00	Mar 07	55 550	40,000	14,198	5,167	
Worcester hospital	Hospital	Yes	Construction	40	Apr 00	Aug 08	195 700	51,038	71,000	18,814	779
Mitchell's Plain hospital	Hospital	No	Inception	36	Apr 06	Mar 10	230 000	0	0	0	0
Victoria hospital	Hospital		Inception	47	Apr 06	Mar 10	230 000	0	0	0	0
Hottentots Holland hospital	Hospital		Inception	47	Apr 07	Mar 11	230 000	0	0	0	0
Valkenberg Hospital	Hospital		Inception	40	Apr 06	Apr 10	490 000	0	0	0	0
Hospital management and quality improvement grant (HMQIG)									18,664	19,597	20,577
Total							**1,715,247**	**148,038**	**149,703**	**107,897**	**124,244**

Note: Funding for years beyond 2008/09 is not indicated

The hospital revitalization funding is used for new hospitals, large upgrades for which National treasury authorize the funding based on an approved business case that motivates the need and the priority of the proposed project in terms of the strategic fit.



Schedule 4 Recurrent Maintenance

Name of the project/ Programme	Type of infrastructure	Brief need/ proposed outcome	2005/06 R'000	2006/07 R'000	2007/08 R'000	2008/09 R'000
Vote 6 : Health	Community Health facilities		5,370	8,015	9,130	9,678
	District Hospitals		8,723	13,019	14,830	15,720
	Provincial Hospitals		15,810	23,596	26,879	28,491
	Central Hospitals		15,000	22,387	25,502	27,032
	Other Facilities		3,635	6,180	7,928	8,459
Total			**48,538**	**73 197**	**84 269**	**89 380**

Schedule 5 Upgrade of the forensic and pathology service

Budget year	2005/06 R'000	2006/07 R'000	2007/08 R'000	2008/09 R'000
Total		21 217	24 789	6 216