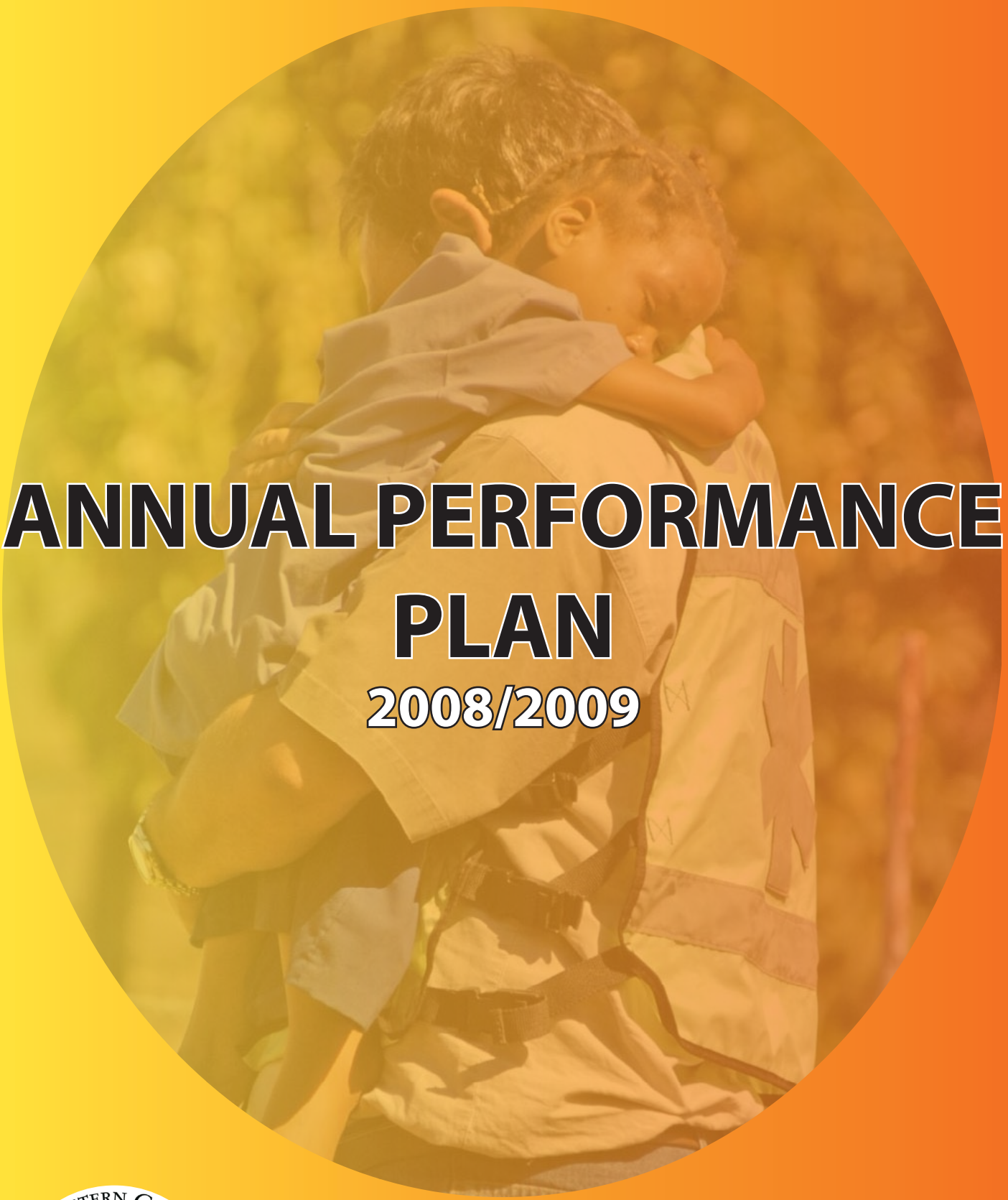

ANNUAL PERFORMANCE PLAN

2008/2009

Provincial Government of the Western Cape
Department of Health

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FOREWORD

BETTER HEALTH FOR ALL

Government has set itself the goal of achieving better health for all. As we look ahead to 2008/09, all of us must take this goal to heart and work together to strengthen our public health care system and contribute to improving the quality of life of all South Africans.

The demand for health services in our province continues to exceed the quantum of service that can be provided from available resources. The reason can be found in the increasing burden of disease coupled with the growing migration of patients from outside our borders using our facilities. To meet this challenge we must reshape our services, ensuring the optimal use of resources as outlined in the Comprehensive Service Plan (CSP).

For its part, the Annual Performance Plan (APP) for 2008/09 not only sets down service delivery targets but gives practical effect to the CSP by introducing the changes needed to improve service delivery and ensure sustainability. Taking its lead from the CSP, the APP provides us with a solid primary health care (PHC) platform that is integrated with all other levels of service thus ensuring seamless and quality health care.

The CSP as reflected in the APP also facilitates the implementation of the district health system (DHS), while the current rural regional offices are being strengthened by district offices. The Cape Town Metro district will consist of four substructure offices, which will each manage two sub-districts. These components will be responsible for directing and supporting health services in their districts.

In addition, the provision of personal primary health care (PPHC) services, previously provided by the non-metropolitan municipalities, is now a provincial responsibility making it possible to offer more streamlined service to all our patients across the Western Cape.

The first phase of the burden of disease investigation commissioned in 2006 has been completed. It confirms that the Western Cape suffers from a quadruple burden of disease, including TB, non-communicable diseases, injuries and HIV and AIDS. It also highlights mental health disorders, which place a major burden on the health facilities especially in the wake of the burgeoning abuse of substances, particularly alcohol and 'tik' in our province.

This study provides the basis for provincial interventions to reduce the disease burden. Processes have commenced with provincial departments to determine their roles in addressing factors that promote the burden of disease in the Western Cape. In the year ahead our focus must be on providing quality health services. The success achieved with this approach is evident in the progress made in halting the spread of HIV and Aids.

In line with the National HIV and AIDS and STI Strategic Plan (NSP) for South Africa, 20072011, we aim to reduce the number of new infections by 50% and expand access to treatment, care and support to 80% of people diagnosed with HIV by 2011. The APP sets a target of 45 756 patients on ART in 2008/09. This will increase to 65 000 by 2011. Our target for VCT is 324 000 and we aim to decrease Mother-To-Child-Transmission from the current 5% to under 4.5%.

The incidence of tuberculosis (TB) in the Western Cape is still among the highest in the world. However, the Department continues to make significant progress in the implementation of the WHO DOTS strategy. A TB cure rate for new smear positive cases of above 73% is envisaged for 2008/09. The Department also aims to bring the TB treatment interruption rate down to 9% from the current 11%. We will also be opening 90 new MDR and 45 XDR TB-beds at the Brooklyn Chest Hospital with a further 20 XDR-TB beds in the Southern Cape.

In treating chronic diseases the Chronic Dispensing Unit (CDU) currently dispenses pre-packed chronic medications to over 82 000 stable chronic patients each month. These are delivered to the respective facilities, which decreases waiting times for patients at the

dispensary. The number of patients receiving chronic medication will grow as more patients come into the system.

One of the key goals of both national and provincial health policy is promoting healthy lifestyles. In the year ahead there will be greater focus on health education and counselling especially within the PHC environment. There will also be increased support for our chronic lifestyle disease programme. This provides lifestyle information which enables individuals and groups to make informed choices regarding their health and well-being.

An infrastructure plan for health facilities has been developed to support the Comprehensive Service Plan, which will be implemented using all available funding for upgrading and construction. In this regard the Department faces a significant challenge to fund the necessary upgrading and construction of PHC facilities from the available budget. Yet, we cannot allow this to hold us back.

Furthermore, the Department will proceed with the construction of Khayelitsha and Mitchells Plain Hospitals. The revitalisation of George, Worcester and Paarl Hospitals continues. The construction of a new CHC in Wellington is in progress, while the construction of new ambulance stations for Ceres, Vredendal, De Doorns, Leeu Gamka, Bonnievale, and Heidelberg is planned.

The modernisation process of equipping our central hospitals with state-of-the-art medical equipment and technology will continue. The Department remains committed to the preservation of an essential core of highly specialised services in support of district and regional services where most patients are seen. With the additional funding received by way of the Adjustment Budget in 2007/08, we were able to reopen 28 beds in our Central Hospitals and a further 68 beds will be reopened during 2008/09.

The APP for 2008/09 also focuses extensively on improving the quality of care provided by our health services. A quality assurance unit monitors the quality of care by attending to matters such as complaints and compliments as well as client satisfaction surveys. In addition, the Department will implement a range of interventions that will address identified shortcomings such as the shortage of skilled staff including nurses.

The shortage of nurses in the Department hampers service delivery in some service areas. However, the implementation of the occupation specific dispensation (OSD) for nurses will improve the recruitment and retention of nurses during the 2008/09 financial year and beyond.

We will also be expanding community-based services such as home-based care. In 2008/09, the current number of carers will be increased by a 1 000 to a total of 2 300. This will translate to an increase in the number of patients seen from 13 000 to 23 000. This expansion of home-based care services will address issues of equity; the bulk of the increase will be in the Metro under-serviced areas.

Community participation and partnerships are critical success factors in meeting the challenges of improving health services in our province. The establishment of the Provincial Health Council and Health Forums means local communities are now in a better position to help shape local services, and priorities to meet local needs. The next step in this process is the establishment of District Health Councils.

The APP is our roadmap for service delivery in the period 2008/09. We all understand the purpose of the APP and what is expected from us. What remains is for us to deliver on our commitments and in so doing, improve our public health care system.

WESTERN CAPE
MINISTER OF HEALTH:

PIERRE UYS

MESSAGE FROM THE HEAD OF HEALTH WESTERN CAPE:

PROFESSOR CRAIG HOUSEHAM

This Annual Performance Plan of the Western Cape Department of Health sets out what will be delivered during 2008 and beyond. The 2007/08 financial year was characterised by much public debate regarding the adequacy of funding for health care in the Western Cape with people mobilised against the reductions in bed numbers in the Groote Schuur and Tygerberg Hospitals. There was an increasing demand for health care services as evidenced by hospital admissions and primary health care head counts. Whilst the Department received significant additional funds during the Adjusted Estimates of Provincial Expenditure the financial and service pressures on the Department remain.

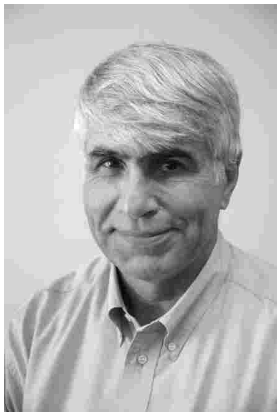
Significant steps in the Implementation of the Comprehensive Service Plan (CSP) characterise this Annual Performance Plan (APP) for 2008 and set it apart from the APP of previous years. The CSP as approved for implementation sets out the future direction of the Department and managers in all the programmes have accepted the challenge to move decisively to implement this plan. The APP outlines concretely those actions that will occur during the 2008/2009 financial year to take the Department towards the service configuration outlined in the CSP. I am convinced that the CSP, contrary to the concerns of some, will ensure that the health services provided address, to the greatest degree, the need for these services.

A key first step in the Implementation of the CSP during 2008 is the establishment of health districts and the appointment of district directors to head these offices. In the Cape Metro district the area will be divided into four administrative structures each combining two sub-districts again under the managerial responsibility of a district director. I am confident that effective management will bring greater returns in service delivery for the resources currently allocated, particularly in the Cape Metro.

The reclassification and management of hospital beds according to the level of care is another important step in the implementation of the CSP as is the further strengthening of home-based care services. This APP spells out clear steps in this regard with the designation of beds per level of care in various hospitals. The major challenge is to the central hospitals. However, the steps outlined have the potential to enhance the value for money of the health rands budgeted for this purpose.

The first report of the burden of disease study released during 2007 highlights the disease profile of the Western Cape and emphasises the significant contribution of chronic disease and injuries to this burden. The study focuses attention on the higher burden of disease in areas categorised by high levels of multiple deprivation such as Khayelitsha and Nyanga in the City of Cape Town. Clearly multi-disciplinary and interdepartmental initiatives are required to address these challenges. The APP outlines the first steps in such initiatives, for instance those focusing on alcohol and drug abuse and road traffic accidents. The roll out of mortality surveillance across all the districts in the Western Cape will improve the accuracy of data and enable a province-wide approach to the burden of disease.

In conclusion I am certain that the management and staff will deliver on the undertakings: the implementation of the many initiatives outlined in the APP will lead to the improved delivery of health care to the people of the Western Cape and beyond.



HEAD HEALTH
WESTERN CAPE:
PROFESSOR CRAIG HOUSEHAM

STRATEGIC OVERVIEW

1. OVERVIEW OF STRATEGIC PLAN

The vision, mission and values that guide the Western Cape Department of Health, support those of the National Department of Health and are:

Vision:
Equal access to quality health care.

Mission:
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.

Values:
The core values that will be reflected in the way in which the vision and mission are achieved are:

1) Integrity
2) Openness and transparency
3) Honesty
4) Respect for people
5) Commitment to high quality service.

Healthcare 2010 Comprehensive Service Plan

Healthcare 2010 sets out the strategic direction of the Western Cape Department of Health and supports the vision and mission of the National Department of Health as well as the priorities and activities for the current five-year electoral cycle. The Western Cape Health Department is a key role-player in support of the Provincial Growth and Development Strategy/iKapa Elihlumayo. The Department leads the key interventions of Healthcare 2010 and Burden of Disease and will contribute significantly to growth and development through ensuring and promoting a healthy community and workforce.

The Comprehensive Service Plan (CSP) arising from Healthcare 2010 reshapes service delivery in the Department to ensure management of patients at a level of care that is most appropriate to their need, thereby maximising the provision of health services within the available resource envelope. This will strengthen primary health care including community-based and preventive care. Regional hospitals will be strengthened to improve the accessibility to general specialist services to the communities. These services will be adequately supported with well-equipped and appropriately staffed secondary and highly specialised tertiary services.

2. SITUATION ANALYSIS

2.1. Major demographic characteristics

All inclusive censuses were conducted by STATS SA in 1996 and 2001 and until recently the 2001 data have been used to project population growth. However, the cabinet decision to move away from a 5-year to a 10 year census means that the next census is scheduled for 2011. Consequently, STATS SA conducted the Community Survey 2007 to supply information that was needed.

The outcome of the survey is particularly significant for the Western Cape since it reflects a 16.7% increase in population between 2001 and 2007, i.e. an increase from 4 524 335 to 5 278 585. The national population increased from 44 819 778 in 2001 to 48 502 063 in 2007.

At this stage the Community Survey 2007 has only analysed the distribution of population at provincial level. The final results of the survey will be published in March 2008 and will include population distribution at district and sub-district level. In order to facilitate the planning process the Department has, as an interim measure, Calculated the district population using population density as a key factor in this process.

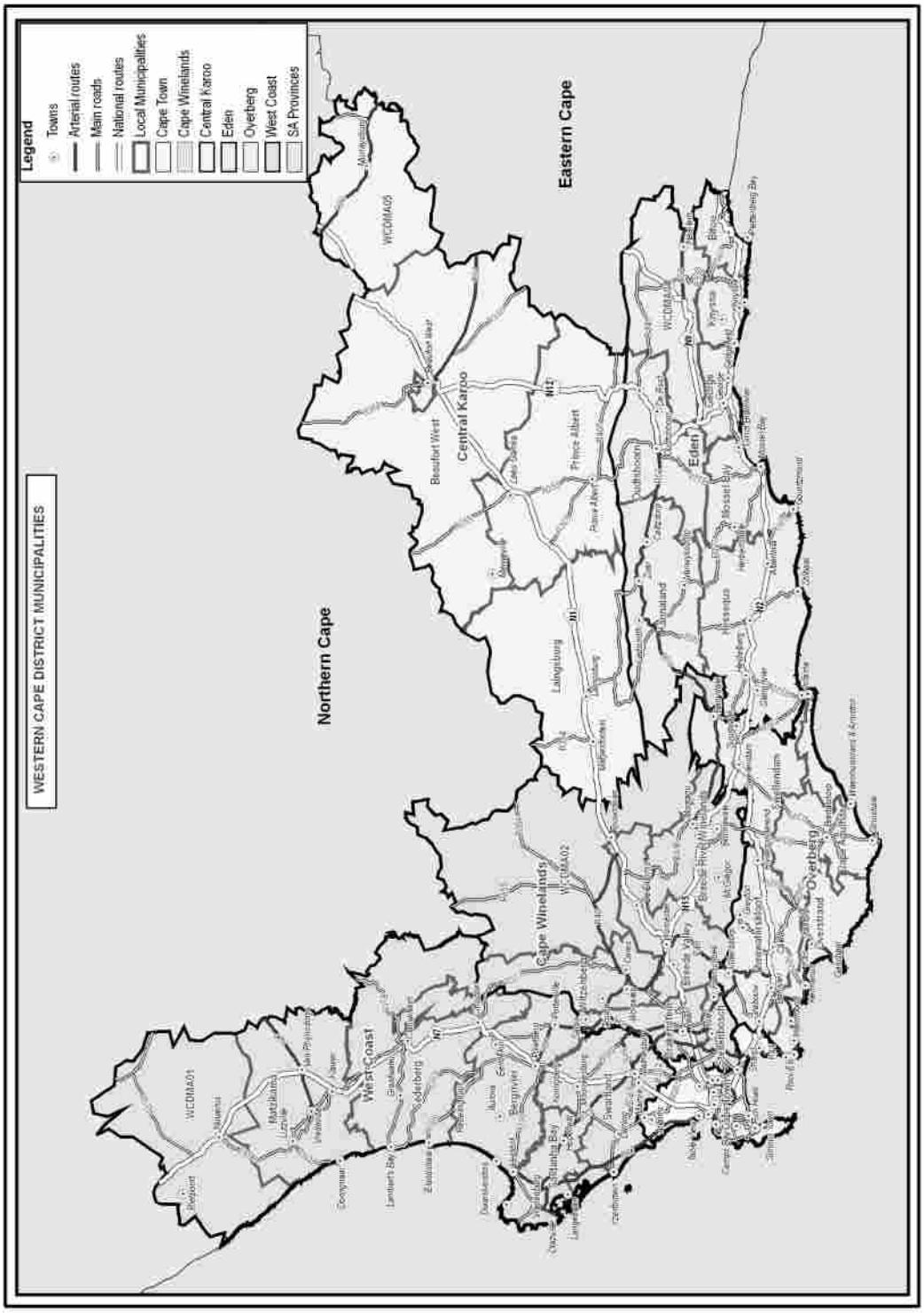
Approximately 64% of the population reside in the Cape Town Metro district, which covers ±2% of the surface area of the province, a significant factor in planning services.

The remainder of the population is distributed more sparsely, in approximately equal proportions between the other rural districts, i.e. Cape Winelands, Overberg, Eden and West Coast, with the exception of the Central Karoo which is very sparsely populated.

Table 1: Preliminary population estimates based on the 2007 Community Survey by STATS SA

TOTAL POPULATION												
	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	
	2000/01	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**Uninsured**
Cape Town	2 755 964	2 829 771	2 903 121	2 975 833	3 047 470	3 012 776	3 415 065	3 517 720	3 623 460	3 732 379	3 844 573	71.00%
West Coast	243 174	250 216	257 278	264 348	271 404	295 503	316 080	322 306	328 655	335 129	341 730	81.00%
Cape Winelands	573 993	587 509	600 894	614 113	627 110	656 455	728 962	748 160	767 864	788 087	808 843	80.00%
Overberg	171 034	176 887	182 790	188 735	194 698	213 580	228 172	232 779	237 479	242 274	247 166	83.00%
Eden	402 105	412 700	423 278	433 830	444 321	475 785	523 958	537 210	550 797	564 727	579 010	81.00%
Central Karoo	57 395	58 421	59 428	60 415	61 381	63 569	66 348	67 420	68 509	69 616	70 741	89.00%
Western Cape Province	4 203 665	4 315 504	4 426 789	4 537 274	4 646 384	4 717 668	5 278 585	5 425 595	5 576 765	5 732 213	5 892 062	74.52%
UNINSURED POPULATION												
	2000/01	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	
Cape Town	1 956 734	2 009 137	2 061 216	2 112 841	2 163 704	2 139 071	2 424 696	2 497 581	2 572 657	2 649 989	2 729 647	
West Coast	196 971	202 675	208 397	214 122	219 837	239 357	256 025	261 068	266 211	271 455	276 802	
Cape Winelands	459 194	470 007	480 715	491 290	501 688	525 164	583 169	598 528	614 291	630 470	647 074	
Overberg	141 958	146 816	151 716	156 650	161 599	177 271	189 383	193 207	197 108	201 087	205 147	
Eden	325 705	334 287	342 855	351 402	359 900	385 386	424 406	435 140	446 145	457 429	468 998	
Central Karoo	51 082	51 995	52 891	53 769	54 629	56 576	59 050	60 004	60 973	61 958	62 959	
Western Cape Province	3 131 645	3 214 917	3 297 788	3 380 075	3 461 357	3 522 826	3 936 729	4 045 528	4 157 385	4 272 388	4 390 627	

Map of the Western Cape and district municipalities



Map of the Sub-districts of the Cape Metro District

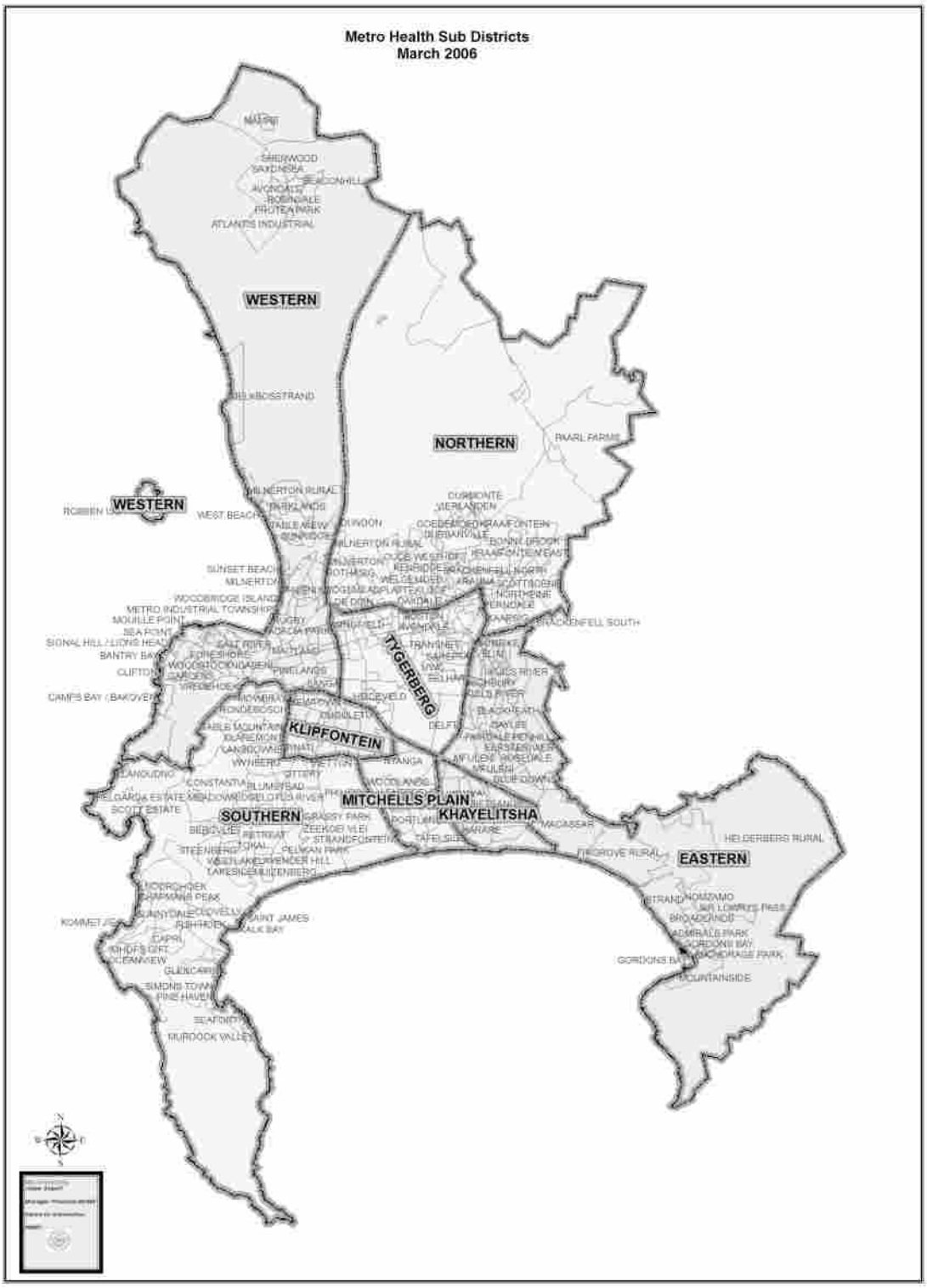


Table 2 outlines the poverty and socio-demographic data obtained from the General Household Survey of 2007.

Table 2: Poverty indicators as reported in the General Household Survey of 2007

		Western Cape	RSA Average
Percentage of households connected to the mains electricity supply	2002	88.0	76.1
	2003	88.5	77.6
	2004	92.7	80.4
	2005	92.2	80.1
	2006	93.5	80.2
Percentage of households that use paraffin or wood for cooking	2002	15.7	37.9
	2003	16.1	36.8
	2004	12.2	35.0
	2005	9.6	33.5
	2006	7.5	31.6
Percentage of households using a bucket toilet, or which have no toilet facility	2002	5.7	13.2
	2003	9.1	11.8
	2004	3.7	10.8
	2005	5.6	10.2
	2006	3.1	8.6
Percentage of households whose refuse is removed by the municipality	2002	83.4	55.0
	2003	84.8	56.8
	2004	87.7	57.1
	2005	91.3	60.1
	2006	91.9	60.6
Percentage of households with access to piped water in the dwelling or on site	2002	91.1	66.1
	2003	89.2	67.3
	2004	92.4	67.8
	2005	92.0	68.4
	2006	93.4	71.3

Source: General Household Survey, July 2007. StatsSA: P0318

The Western Cape average of access to basic amenities such as piped water and water-borne sewage is higher 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.

Table 3: Socio-demographic characteristics of the population

	% of total population	% < 15 yrs	% > 60 yrs	% Female	% Foreign born	% of population >20 years with no education	% of population 15-65 years who are unemployed
Western Cape	10,1	27,3	7,8	51,5	2,4	5,7	26,1
National	100	32%	7.32%	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 and 64 years who are unemployed.

The General Household Survey (July 2006: 34) indicates that unemployment in the Western Cape is 17,7% as compared with the national figure of 28,6%.

2.2 Epidemiological profile

The Western Cape suffers from a quadruple burden of disease which consists of pre-transitional conditions related to under development, including TB, non-communicable diseases, injuries and HIV and AIDS. Mental health disorders, which are not reflected in mortality data, place a major burden on the health facilities especially with the burgeoning abuse of substances in particular alcohol and 'tik' (methamphetamine) in the Western Cape.

Understanding the burden of disease is fundamental to the planning and decision-making processes in health departments. The challenge is not just to focus on the 'downstream' factors, such as biological factors but to ascertain whether intervening 'upstream', e.g. by addressing housing, sanitation, etc. would reduce or significantly influence the disease burden. To address this challenge the Western Cape Department of Health commissioned a study over a three-year period by a consortium of universities in the Western Cape led by the Department of Public Health and Family Medicine at the University of Cape Town. Many of the upstream interventions fall outside the scope of the Department of Health and therefore the findings are being handled within the Social Sector Cluster to facilitate inter-departmental collaboration to address the issues identified. The first report of the burden of disease study was published in June 2007 accompanied by a two-day workshop. The findings have subsequently been presented to provincial top management and various provincial departments and as a result the Department is collaborating with departments such as Social Development and Poverty Alleviation, Community Safety, and Local Government and Housing on specific projects.

In dealing with the burden of disease, it is important to note that the mortality profile in the Western Cape is somewhat different from the national profile. Although the province experiences a quadruple of the burden of disease experienced nationally, the HIV and AIDS epidemic is on a lower scale than in other provinces. Injuries and non-communicable diseases, however, are more pronounced.

There are pronounced gender differences in registered deaths with more male than female deaths whilst there are more females in the province than males. Child mortality is generally higher for males than for females, and in the age groups over 5 years the high injury burden contributes substantially to the higher numbers of male deaths.

Over the period 1997 to 2002 there was a rapid increase in the number of young adult deaths between 20 and 59 in males and 15 and 49 in females resulting from HIV and AIDS and related conditions. By 2002 the number of natural deaths among women aged 20 - 29 years exceeded the number of deaths among males. In the 60 plus age group the number of male and female deaths is similar but the female deaths occur at much older ages than the males. The nature of non-communicable diseases differs between males and females and strokes are a major cause of death in the province. Males appear to have ischaemic heart disease at younger ages by contrast to females who tend to have diabetes at younger ages. (Bourne *et al*.: 2007)

Cape Town Metro District

The burden of disease study showed that Cape Town is experiencing a changing pattern of mortality.

Among females there has been an increase in the HIV and AIDS mortality and a decrease in the non-communicable disease death rate. The mortality rate for males is much higher than for females although it declined between 2001 and 2004.

The differential pattern of mortality between the various sub-districts is marked and illustrates the patterns of inequity still existing in the City. Khayelitsha and Nyanga have a considerably higher burden of disease than other sub-districts in the Metro.

Whilst HIV and AIDS mortality increased dramatically since 2001, it appears to have stabilised in 2004 possibly demonstrating the impact of the PMTCT and ARV programmes. The data for 2001 to 2004 show that HIV mortality has become the leading cause of premature mortality in the city and that TB remains in third place. HIV and TB are closely linked and there is clear evidence that the TB epidemic is being fuelled by the HIV epidemic.

Mortality due to injuries is extremely high although there is evidence of a declining trend. However, injury mortality rates particularly homicide and road traffic fatalities are still amongst the highest in the world, particularly among men. Of particular concern is the high homicide and road traffic injury fatality rate among young males, which is linked to alcohol and other substance abuse.

Diabetes, stroke and ischaemic heart disease are among the leading causes of premature mortality and have shifted rankings with diabetes moving from 8th in 2001 to 5th place in 2004.

Child mortality appears to have remained constant over this period, but there is an unexpected increase in mortality from low birth weight.

The absence of the impact of mental health disorders is noted when only mortality data is studied (Bourne *et al*., 2007).

The following table illustrates the trends in the key provincial mortality indicators.

Table 4: Trends in key provincial mortality indicators [A1]

Indicator	SAHR 2006: 386		SADHS 2003-2004: 23	Target Health goals, objectives and indicators 2001 to 2005
	Western Cape	National	Western Cape	
Infant mortality (under 1)	31.7	59.1	43.5	45 per 1 000 live births by 2005
Child mortality (under 5)	46.3	94.7	56.5	59 per 1 000 live births by 2005
Maternal mortality per 100,000 live births	**Source**: Saving Mothers: Third report on confidential enquiries into maternal deaths in South Africa 2002-2004, 2006: 34. **Western Cape**			100 per 100 000 live births by 2005
	2000	**2002**	**2004**	
	62.4	74.7	98.8	

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

	2002[1]	2003	2004	2005	2006[2]	Source
South Africa	59	-	-	-	48	[1]South African Health Review 2005: 302 [2]South African Health Review 2006: 386
Western Cape	30	-	-	-	26	
Cape Town Metro district	**-**	**25.16**	**23.74**	**22.28**	**21.40**	City of Cape Town
Cape Town Metro Sub-districts	-					
Eastern	-	28.98	22.90	27.51	32.00	
Khayelitsha	-	42.11	36.61	34.72	31.33	
Klipfontein	-	28.65	28.79	27.41	24.65	
Mitchell's Plain	-	22.03	24.18	22.85	22.08	
Northern	-	24.55	20.80	22.88	20.62	
Southern	-	16.98	20.97	15.23	11.88	
Tygerberg	-	18.61	19.58	16.20	17.61	
Western	-	17.58	16.41	15.22	14.21	

Table 6: Leading 10 single causes of premature mortality burden (YLLs) by sex in the Western Cape 2000

	MALES		FEMALES		PERSONS	
Rank	**Cause of death**	**%**	**Cause of death**	**%**	**Cause of death**	**%**
1	Homicide/ violence	18.5	HIV and AIDS	18.8	HIV and AIDS	14.1
2	HIV and AIDS	10.8	Tuberculosis	7.7	Homicide /violence	12.9
3	Road traffic accidents	8.2	Ischeamic Heart disease	6.0	Tuberculosis	7.9
4	Tuberculosis	8.1	Stroke	5.8	Road traffic accidents	6.9
5	Ischaemic heart disease	5.7	Road traffic accident	5.0	Ischaemic heart disease	5.9
6	Stroke	3.7	Homicide/violence	4.9	Stroke	4.6
7	Trachea/bronchi/lung ca	3.1	Diabetes mellitus	3.2	Trachea/bronchi/lung ca	2.7
8	Suicide	3.0	Diarrhoeal disease	2.7	Lower respiratory infections	2.4
9	Chronic obstructive pulmonary disease	2.3	Breast cancer	2.7	Suicide	2.3
10	Lower respiratory infections	2.1	Lower respiratory infections	2.7	Diarrhoeal disease	2.3

Source: Bradshaw, D. et al. 2000: 133

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.

2.3 Major health service challenges and progress

The key challenge to the Department is the implementation of the CSP, which was formally approved for implementation by the provincial Minister of Health on 11 May 2007. The CSP found that the Department needs a minimum of an additional R500 million (2001 rands) to deliver the level of care prescribed by government policy. The initial steps to implement the CSP were taken during 2007 and will proceed further in 2008.

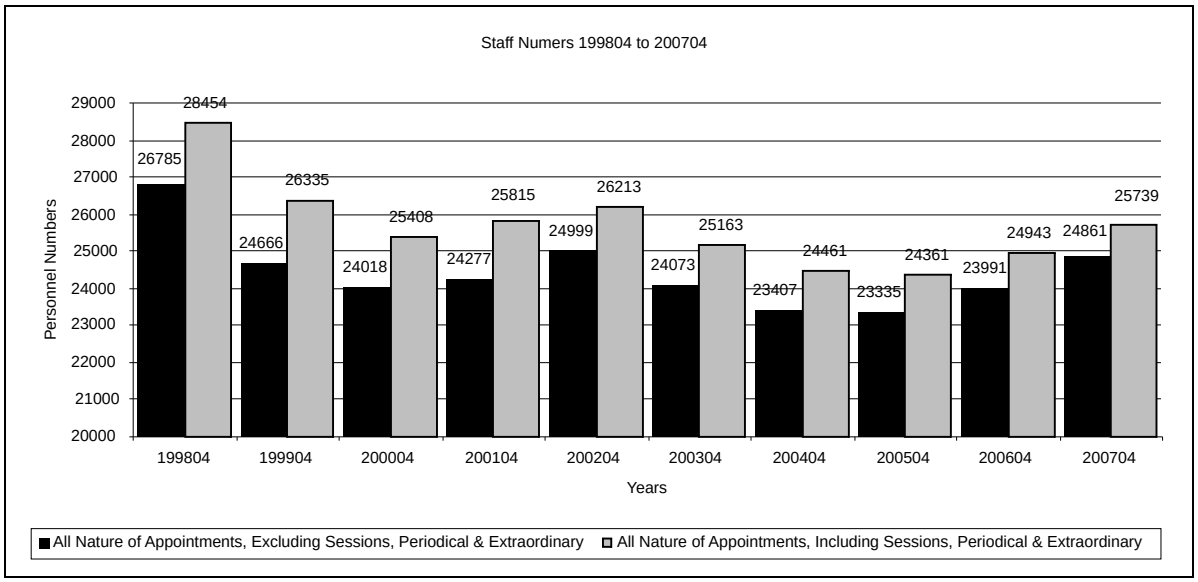
The decision to assume full responsibility for personal primary healthcare (PPHC) in the rural districts was announced by the Provincial Minister of Health on 11 March 2005 and the process has been implemented in three phases. The Department provided the funding for PPHC services in the rural districts from 1 April 2005 and this was followed by full assumption of managerial responsibility from 1 March 2006 and thereafter the transfer of all staff and assets used by local government to deliver PPHC services by July 2007. The challenge is that the physical infrastructure requires significant upgrading and that no additional funding has been allocated for the maintenance and upgrading of these facilities.

The assumption of responsibility for the PPHC services within the Cape Town Metro district remains a pending matter.

A major challenge for the health services is the quality of care. A centralised Quality Assurance Unit supports and co-ordinates the activities of the quality assurance managers at facility level and monitors the quality of care. Complaints and compliments, morbidity and mortality, client satisfaction surveys and evaluation of safety and security risks to patients and staff are regularly monitored. The challenge is to implement interventions that will address identified shortcomings.

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. Figure 1 illustrates that the number of personnel in the Department of Health has decreased by approximately 10% between 1998 and 2007. The attrition rate of nurses is of particular concern; for professional nurses it was approximately 10% and for some specialist areas of nursing it was 16% for the period from 1 April 2004 to 31 March 2007. It is hoped that the implementation of the occupational specific dispensation (OSD) for nurses during 2007 will have a positive influence on this problem.

Figure 1: Personnel numbers in Provincial Health Facilities from 1998 to 2007



2.4 Intra and inter provincial equity in the provision of services

In order to ensure equitable access for all to the full package of PPHC services the allocation of resources in the CSP is determined by the distribution of human settlements within each sub-district. The outcomes of this approach show that service delivery in sparsely populated areas is more expensive than in more densely populated areas. The table below shows the allocation of posts in full time equivalents (FTEs) per district.

Table 7 : Allocation of posts per full time equivalent per district

Health District	FTEs per 100 000 population	Density: Persons per sq km	Percentage of total population (WC)	Clinic service points	Population served per clinic
Cape Town Metro	112	1330	63.3%	102	32,734
Cape Winelands	122	32	14.2%	75	9,642
Overberg	146	20	4.7%	38	6,151
Eden	137	22	10.4%	73	7,159
Central Karoo	164	2	1.0%	18	3,861
West Coast	141	13	6.4%	70	4,638

An analysis of the human settlement profile in the Western Cape shows that 7.52% of the total population live in sparsely populated areas, which constitutes 74% of the total area of the province (Rural 2 and Deep Rural in the following table).

This means that the relatively high cost of service delivery to those settlements is offset by efficiency gains in the more densely populated areas where 77.6% of the population occupies 7.7% of the total area of the province (Metropolitan and rural high density in the following table).

Table 8: Human settlement profile in the Western Cape

Human settlement profile in the Western Cape		% of Total Western Cape Population	% of Total Western Cape Area
Metropolitan: Cape Town		63.2%	1.9%
Rural High Density: e.g. Paarl, Worcester, George		14.4%	5.8%
Rural 1:	Max travel distance to clinic between 7-12 km	14.9%	18.3%
Rural 2:	Max travel distance to clinic between 13-24 km	5.83%	26.0%
Deep Rural:	Max travel distance to clinic more than 24 km	1.69%	48.0%
		100%	100%

Rural level 1 beds were weighted according to population density to compensate for the fact that beds are geographically less accessible in rural less densely populated areas due to the greater travelling distances, poorer road infrastructure, lack of public transport, etc. Level 2 beds were weighted according to the distance of the rural regional hospital from Cape Town. To further enhance equitable services delivery in all the districts, the following additional measures were applied: Level 2 beds have been allocated to the larger rural district hospitals to provide for structured outreach and support form regional hospitals. It is generally accepted that there is a need to provide for the skills development and further training of medical officers in rural areas. Access to the specialists from the regional hospitals should have a significant impact in this regard. It also provides the opportunity to treat non-acute level 2 patients in district hospitals that would otherwise have to be referred to a regional hospital. It is anticipated that this will have a favourable impact on the quality of care and the ability of the district hospitals to deliver the full package of services and consequently improve the utilization and cost efficiency of rural district hospitals. The referral from district to regional hospitals is expected to decrease significantly.

2.5 Resource trends

The allocated budget for the Department's for 2008/09 is R 8.642 billion and compared to the revised estimate of the 2007/08 budget, R7.562 billion, which is a nominal increase of R1.080 billion or 14.28%.

The baseline allocation to the Provincial Equitable Share has been increased as a result of the adjustment of the provincial equitable share formula which has been updated with information from the 2007 Community Survey, 2007 Educational Snap Survey, 2006 General Household Survey, and the 2005 GDP-R. The impact of these updates will be phased in over the next three years and will result in increases to the equitable share of Gauteng, KwaZulu-Natal and the Western Cape.

At a provincial level it has been recognised that funding for health services must be stabilized and thus both in the adjustments estimate budget for 2007/08 and the allocation for 2008/09 additional funding has been added to the baseline funding for health services from the provincial equitable share.

Table 9 below reflects the Department's budget for the MTEF period

Table 9: Health Department budget as a percentage of Provincial budget

	Audited 2004/05	Audited 2005/06	Audited 2006/07	Main appropriation 2007/08	Adjusted appropriation 2007/08	Revised estimate 2007/08	2008/09	2009/10	2010/11
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Department of Health	5 169 199	5 718 812	6 419 515	7 095 173	7 427 305	7 561 837	8 641 973	9 470 424	10 350 772
Total Provincial budget	14 593 993	16 747 389	18 848 794	20 716 554	21 682 437	21 682 437	24 907 742	27 394 810	29 858 705
Health budget as a percentage of Provincial Total	35.42%	34.15%	34.06%	34.25%	34.25%	34.88%	34.70%	34.57%	34.67%

Source: Western Cape Provincial Government 2008 Budget

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 is reflected in Tables 10 and 11. In 2008/09 it is projected that the equitable share will account for 65.02% of the Department's funding and the conditional grants for 30.48% in contrast to the 64.65% and 29.92% respectively allocated in the revised estimate of the 2007/08 budget. The projected revenue for 2008/09 is 4.51% of the budget in comparison to the 5,18% in 2007/08.

Table 10: Funding sources of the Western Cape Health Department

	Audited 2004/05	**Audited 2005/06**	**Audited 2006/07**	**Main appropriation 2007/08**	**Adjusted appropriation 2007/08**	**Revised estimate 2007/08**	**2008/09**	**2009/10**	**2010/11**
Treasury funding	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Equitable share	3 248 276	3 627 255	4 075 807	4 555 076	4 779 737	4 888 743	5 618 625	6 321 847	6 898 499
Conditional grants	1 684 382	1 814 939	2 011 991	2 177 028	2 262 868	2 262 868	2 633 668	2 778 417	3 145 020
Financing			27 657						
Total Treasury funding	**4 932 658**	**5 442 194**	**6 115 455**	**6 732 104**	**7 042 605**	**7 151 611**	**8 252 293**	**9 100 264**	**10 043 519**
Departmental receipts	236 541	276 618	304 060	363 069	384 700	410 226	389 680	370 160	307 253
TOTAL RECEIPTS	**5 169 199**	**5 718 812**	**6 419 515**	**7 095 173**	**7 427 305**	**7 561 837**	**8 641 973**	**9 470 424**	**10 350 772**

Source: Western Cape Provincial Government 2008 Budget.

Table 11: Conditional grant allocation for 2007/08

CONDITIONAL GRANT	ALLOCATION 2008/09	% OF TOTAL HEALTH BUDGET FOR 2008/09
National tertiary services rant (NTSG)	1 486 054	17.20%
Health professions training and development (HPTDG)	356 414	4.12%
HIV and AIDS grant	241 467	2.79%
Hospital revitalisation grant (HRP)	400 388	4.63%
Forensic pathology services	55 535	0.64%
Provincial infrastructure grant (PIG)	93 810	1.09%
TOTAL CONDITIONAL GRANT ALLOCATION	**2 633 668**	**30.48%**
TOTAL HEALTH BUDGET	**8 641 973**	

Table 12: CPIX multiplier

YEAR	UPDATED CPIX MULTIPLIER
2003/04	1.11
2004/05	1.07
2005/06	1.03
2006/07	1.00
2007/08	0.97
2008/09	0.92
2009/10	0.89
2010/11	.87

The above CPIX multiplier was applied to calculate the 2006/07 real term (constant) prices in this document.

Medical inflation is significantly higher than the CPIX. Based on the index of the year 2000 = 100 the CPIX for November 2007 = 155.0 whereas the index for medical care and health services for November 2007 = 180.8. Therefore the index for medical care and health services is 25.8 index points higher than the CPIX for the same period, i.e. 200 to November 2007.

The migration into the Province and the trends in the burden of disease and service demands place an increasing burden on the limited resource envelope.

Table 13: Trends in provincial service volumes [A2]

Indicator	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)
PHC headcount in PHC facilities	13 843 759	13 068 303	12 180 933	12 366 566
L1 OPD headcount in district hospitals	692 941	712 166	695 108	822 150
Separations: District hospitals	195 150	142 054	144 373	212 948
OPD headcount in regional and central hospitals	2 048 773	1 783 783	1 771 537	1 698 949
Separations: Regional and central hospitals	300 105	310 815	324 575	251 386

Note:
Refer to the performance tables in the respective programmes for further detail regarding the shift of beds between levels and corresponding movement of outpatients.

Table 14: Public hospitals by hospital type [PHS1]

Hospital type	Number of hospitals	Number of beds	Provincial average number of beds per 1 000 uninsured
District hospitals	31	2 132	0.527
Regional hospital	6	1 371	0.339
Central hospitals	3	2 417	0.597
Sub-total acute hospitals	**40**	**5 920**	**1.46**
Tuberculosis hospitals	6	1 008	0.256
Psychiatric hospitals	4	2 015	0.512
Other special hospitals	1	156	0.040
Sub-total chronic hospitals	**11**	**3 179**	**0.81**
Total public hospitals	**51**	**9 099**	**2.27**

Table 15: 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 (District hospitals)	31	2 132	0.527
L2 Beds (Regional hospitals)	6	1 371	0.339
L3 Beds (Central hospitals)	3	2 417	0.597
All acute levels	**40**	**5 920**	**1.46**

Table 16: Division of budget between the respective financial programmes since 2002/03 and for the MTEF period

	2004/05		2005/06		2006/07		2007/08		2008/09		2009/10		2010/11	
	R'000	%	R'000	%	R'000	%	R'000	%	R'000	%	R'000	%		
1. Administration	213 316	4.13%	167 291	2.93%	162 125	2.53%	221 868	2.93%	300 788	3.48%	324 856	3.43%	347 600	3.36%
2. District Health Services	1 330 397	25.74%	1 629 951	28.50%	1 922 792	29.95%	2 743 457	36.28%	2 964 886	34.31%	3 282 884	34.66%	3 641 039	35.18%
3. Emergency Medical Services	198 170	3.83%	255 851	4.47%	277 844	4.33%	344 796	4.56%	386 026	4.47%	428 489	4.52%	475 621	4.60%
4. Provincial Hospitals	1 176 641	22.76%	1 295 905	22.66%	1 397 635	21.77%	1 302 589	17.23%	2 305 977	26.68%	2 549 937	26.93%	2 771 763	26.78%
5. Central Hospitals	1 805 918	34.94%	1 980 705	34.63%	2 123 000	33.07%	2 352 455	31.11%	1 801 295	20.84%	1 945 397	20.54%	2 081 575	20.11%
6. Health Sciences and Training	73 541	1.42%	79 009	1.38%	98 858	1.54%	138 553	1.83%	178 520	2.07%	192 802	2.04%	206 298	1.99%
7.Health Care Support Services	82 752	1.60%	93 075	1.63%	92 906	1.45%	85 511	1.13%	97 086	1.12%	131 643	1.39%	158 210	1.53%
8. Health Facilities Management	288 464	5.58%	217 025	3.79%	344 355	5.36%	372 608	4.93%	607 395	7.03%	614 416	6.49%	668 666	6.46%
TOTAL	**5 169 199**	**100.00%**	**5 718 812**	**100.00%**	**6 419 515**	**100.00%**	**7 561 837**	**100.00%**	**8 641 973**	**100.00%**	**9 470 424**	**100.00%**	**10,350,772**	**100.00%**

Source: Western Cape Provincial Government Budget 2008.

Notes:

1. The funding for Programme 8 was transferred from the Department of Public Works from 1 April 2005.
2. The funding for GF Jooste, Hottentots Holland, Karl Bremer and Nelspoort Hospitals was transferred from Programme 4 to Programme 2 during 2007/08.
3. The funding for the level 2 beds in the Central Hospitals is transferred from Programme 5 to Programme 4 from 2008/09.
4. The revised estimate of the budget was used for 2007/08.

2.6 Policy changes and trends

National Health Act, 2003 (Act No 61 of 2003)

The National Health Act has been developed 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 i.e. 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). The following regulations have been issued under this Act:

- Regulations regarding the rendering of Forensic Pathology Service (Government Gazette 30075, Notice Number: 636, Regulation: 8718)
- Regulations relating to the obtainment of information and the processes of determination and reference price list (Government Gazette: 30110, Notice Number: 681, Regulation: 8722).

3. BROAD POLICIES, PRIORITIES AND STRATEGIC GOALS

3.1 The policies, priorities and strategic goals of the Department are guided by the Millennium Development Goals and the priorities of the National Department of Health at a national level, the Provincial Growth and Development Strategy at a provincial level and Healthcare 2010 on a departmental level.

3.2 Millennium Development Goals (MDGs)

In September 2000 at the United Nations Millennium Summit South Africa was one of the 189 countries to commit to the Millennium Development Goals to reduce global poverty. 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 goals are:

1) Eradicate extreme poverty and hunger
2) Achieve universal primary education
3) Promote gender equality and empower women
4) Reduce child mortality
5) Improve maternal health
6) Combat HIV and AIDS, malaria and other diseases
7) Ensure environmental sustainability
8) Develop a global partnership for development.

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 17: 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.

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
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 be 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 the proportion of people without sustainable access to safe drinking Water by 2015.	Proportion of people with sustainable access to an improved water source.
	By 2020 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.

According to the Millennium Development Goals Country Report for South Africa, South Africa is well on course to meet all Millennium Development Goals and targets" (2005:3). Of particular interest are the following:

- **The focus of Goal 4 is to reduce the under-five mortality rate** by two-thirds between 1990 and 2015. Key factors that contribute to the attainment of this goal include good immunisation coverage, access to potable water and sanitation as well as good nutrition and maternal education. Routine data indicates that the immunisation coverage had increased nationally to 83% by the end of 2006. A comparison of the South African Demographic and Health Survey (SADHS) for 1998 and the preliminary report for 2003 suggests that the infant and under-five mortality rates have remained relatively constant since 1998 at a national level. Under-five mortality has remained stable (59 per 1 000 from the 1998 SADHS, compared with 58 for the 2003-2004 SADHS) as has infant mortality (45 vs. 43) (SADHS, 2004: 23).

- **Goal 5: Improve maternal health by reducing the reduction in the maternal mortality rate**: According to the 1998 SADHS the estimated maternal mortality rate was 150/100,000 live births which was considered unacceptably high and as a result the confidential inquiry into maternal deaths was instituted. This enquiry highlighted the major causes of maternal mortality, i.e. Non-pregnancy related infections (31,4%), complications of hypertension in pregnancy (20.7%), obstetric haemorrhage (13.9%), pregnancy related sepsis (8.6%) and pre-existing medical conditions (7.0%).

The Third Report on Confidential Enquiries into Maternal Death in South Africa 2002 - 2004 (Department of Health, June 2006) shows that 3 406 maternal deaths were reported in the country. The Western Cape had the second lowest recorded maternal deaths (6,1%) after Northern Cape (3,1%). The top five causes of maternal death in the country were non-pregnancy related infections (37,8%), complications of hypertension (19,1%), obstetric haemorrhage (13,4%), pregnancy related sepsis (8,3%) and pre-existing maternal disease (5,6%).

The National Department of Health has developed a set of recommendations to address these issues.

- **Goal 6**: **Combat HIV and AIDS, malaria and other diseases** by having halted and begun to reverse the spread of HIV and AIDS; and having halted and begun to reverse the spread of malaria and other major diseases 2015. Dedicated expenditure on HIV and AIDS across the departments has increased significantly. In 1995 a revised National Tuberculosis Control Programme was established based on the Directly Observed Treatment Short Course (DOTS) strategy. Whilst the national target cure rate of 85% has not been met the cure rates in districts that have adopted the DOTS approach are consistently better than non-DOTS districts. The problem of TB is exacerbated by multi-drug resistance.

Table 18: The Western Cape progress on health related Millennium Development Goals 2000-2006

Millennium Development Goal	MDG objective	Indicator	2000	2001	2002	2003	2004	2005	2006	2015 Target	Source
Reduce Child Mortality.	Reduce <5 mortality by two thirds by 2015.	IMR/100 000	44 (1998)	-	-	43.5	-	-	-	15	SADH 1998 and 2003
		Child (<5y) Mortality Rate/ 100 000	56.6 (1998)	-	-	56.3	-	-	-	19	SADH 1998 and 2003
		Measles coverage under 1 year	-	82.5	84.9	78.1	91.7	90.7	93.7	>90	Departmental Annual Reports
Improve Maternal Health.	Reduce maternal mortality ratio by 75% by 2015.	Maternal Mortality Ratio/100 000 live births	62.4	54.5	74.7	85.7	98.8	-	-	15	Saving mothers, Third report on confidential enquiries into maternal deaths in South Africa 2002-2004.
Combat HIV/AIDS & other diseases.	Halve new infections by 2015.	HIV Incidence	-	-	0.7%/y	-	0.9%/y	-	-	<0.35	SADH 1998 South African National HIV prevalence, incidence behavioural and communication survey 2005 (Empirical data)
		HIV Prevalence in age group <20y	4.9	6.3	7.3	8.7	8.1	7.2	5.6	2.45	Departmental Annual Antenatal Survey reports
		Condom distribution rate from public sector health facilities (per make >15y)	-	5.9	9.1	10.3	15.6	20.1	25.7	-	Departmental Annual Reports.
		Number of maternal HIV and AIDS orphans under 15 y	1 876	3 097	4 871	7 325	10 572	14 682	19 648	-	Dorrington et al, 2003 HIV/AIDS profile in the provinces of South Africa
		New Smear Positive Cure Rate	-	72	68	72	68.3	70.2	71.2	-	Departmental Annual Reports.
Ensure environmental Sustainability.	Halve proportion of people without access to safe drinking water by 2015.	Proportion of the population with water on premise	-	-	-	92.2%	89.9%	98.5%	83.4%	-	Departmental Environmental Health Services reports
		Proportion of the population with water within 200m	-	-	-	6.3%	8.6%	-	-	-	
	Have achieved a significant improvement in the lives of at least 100 million slum dwellers by 2020.	Proportion of the population with access to improved sanitation	-	-	-	91%	92%	-	94.1%	-	Departmental Environmental Health Services reports
		Flush	-	-	-	89%	90%	-	90%		
		Chemical	-	-	-	0.9%	0.5%	-	1.7%	-	
		VIP	-	-	-	1.4%	1.7%	-	2.4%	-	

Notes:
1. Acceptable sanitation is flush, chemical and VIP toilets.
2. Information obtained from surveys and not routinely collected

3.3 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 were approved by the Health MINMEC, which was subsequently replaced by the National Health Council.

Table 19: 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. Promote 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.
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.

PIORITY	ACTIVITY
9. Prepare and implement legislation.	• Implement Mental Health Care Act. • Implement National Health Act. • 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.

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- External client satisfaction surveys are conducted in accordance with a planned schedule.
- Generic and specific services standards are in the process of being finalised.
- A provincial infection prevention and control policy has been developed and a provincial infection and control committee constituted to give strategic direction to the development of infection prevention and control strategies.
- Mortality and morbidity reviews are conducted at institutional level on a monthly basis.
- An adverse event incident reporting system with centralized data capture in order to create a provincial database of adverse clinical events, which guide the proactive arm of the risk management programmes has been finalised.
- Specific aspects of the clinic supervision manual are being implemented.
- Staff satisfaction surveys are conducted.
- Waiting time surveys are to be conducted at selected sites, representative of level 1, 2 and 3 services.

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 the level of 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.
- The Department has implemented the Chronic Dispensing Unit (CDU) which dispenses pre-packed chronic medications to over 70 000 stable chronic patients in the Metro each month. These are then delivered to the respective facilities thereby decreasing waiting times for patients at the dispensary. Similarly, the rural districts have alternative dispensing methods for chronic stable patients whose medication is pre-packed by pharmacists at the community health centres.

5) **Strengthen primary health care, Emergency Medical Services and hospital delivery systems:**

- The strengthening of personal primary health care includes the assumption of responsibility for the provision of these services in the rural districts, the establishment of facility management, the computerisation of PHC services and the development of 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, are also being strengthened.

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10) **Strengthen international relations:**

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

3.4 Annual National Health Plan for 2007/08

The National Health Act of 2003 requires the National Department of Health to develop and submit an Annual National Health Plan to the National Health Council that consolidates the annual performance plans of the national and provincial departments of health. The Annual National Health Plan (ANHP) must indicate the national priorities and the anticipated outputs.

The ANHP for 2007/08 is the second such plan that has been developed since the promulgation of the Act and is based on the five priorities adopted by the National Health Council (NHC) for the health sector for the planning cycle 2006/07 to 2008/09. These priorities are:

1) The development of service transformation plans
2) Strengthening of human resources
3) Strengthening of physical infrastructure
4) Improving quality of care
5) Strengthening strategic health programmes, with specific focus on healthy lifestyles, national TB crisis management plan, accelerated HIV prevention, and strengthening maternal child and women's health programmes with a special focus on the Expanded Programme on Immunisation (EPI) and the implementation of the recommendations of the Report on the Confidential Enquiry into Maternal Deaths.

The indicators for each of these priorities and the related progress and projected performance are reflected in Part B of this document.

3.5 National Department of Health

3.5.1 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) Transport of patients free of charge in certain instances

8) Services to involuntary (certified) mental health care users (MHCU)
9) Services to school children referred by schools and classified (as H0 and H1 patients) according to a means test
10) Services to children committed in terms of section 15 and 16 of the Child Care Act, Act 74 of 1983
11) Services to children under the age of six years who have been classified as H0, H1, H2 and H3 according to a means test
12) Services to pregnant women classified as H0, H1, H2, and H3 patients
13) Free terminations of pregnancy for H0, H1, and H2 hospital patients as well as for full paying patients, but excluding patients treated by their private doctors. The free service includes free ambulance and patient transport services
14) Free primary health care services for permanent residents who are classified as H0, H1 or H2 patients.

3.5.2 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 grantees
- Formally unemployed

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

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

- Old age pension
- Child support grant
- Veteran's pension
- Care dependency grant
- Foster care grant
- Disability grant.

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

Table 20: 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 (Self-funded)	Equal to or more than R72 000	Equal to or more than R100 000	The full price of the UPFS
Private and externally funded	Not applicable	Not applicable	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.

3.6 The Provincial Growth and Development Strategy (PGDS)

3.6.1 The Provincial Growth and Development Strategy named iKapa Elihlumayo, meaning the Growing the Cape, deepens and expands the original growth and development agenda by addressing local imperatives and realities, therefore reinforcing the shared initiative to achieve the vision of the Western Cape as a "Home for All."

The following nine first and second generation iKapa Elihlumayo strategies constitute the provincial policy and situational base of the PGDS and are described in the Provincial Growth and Development Strategy which served as a green paper for the Western Cape, (Provincial Gazette Extraordinary: 6385: 4 October 2006):

First generation strategies:	**Second generation strategies**
Micro-economic Development Strategy (MEDS)	Scarce Skills Strategy (SSS)
Strategic Infrastructure Plan (SIP)	Human Settlement Strategy (HSS)
Human Capital Development Strategy (HCDS)	Integrated Law Reform Project (ILRP)
Social Capital Formation Strategy (SCFS)	Sustainable Development Implementation
Provincial Spatial Development Strategy (PSDF)	Plan (SDIP)

Each of these strategies is championed by a lead department and supported by other related departments. The Department of Health 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.
Fundable proposals from the iKapa based strategy recommendations are identified generically as iKapa lead interventions. There is a hierarchy of such interventions:

- Path-breaking action: Integrated transport which is the core action to shift the development path of the province
- Path-shaping interventions which are the ASGISSA infrastructure and skills-led growth opportunities to remove critical constraints to the regional spatial economy, e.g. World Cup 2010 and legacy, the Cape Flats infrastructure initiative
- Path consolidating interventions which lay the foundation for a sustainable, empowering and enabling Western Cape. These include the key health interventions of Healthcare 2010, including the implementation of the Comprehensive Service Plan and the Burden of Disease Study. (Provincial Gazette Extraordinary: 6385: 4 October 2006).

3.6.2 Department of Health contributions towards the social transformation projects in the 21 priority areas

In his State of the Province Address (SOPA) 2007, the Premier highlighted focus areas for the year 2007/2008 to give effect to the Provincial Growth and Development Strategy (PGDS). The Premier identified 21 priority areas where the Provincial Government of the Western Cape (PGWC) will focus interventions (resources, collaboration with stakeholders and service delivery) to promote social regeneration. The 21 communities targeted are those most vulnerable to poverty, crime and gangsterism.

3.6.2.1 **Governance**

The Department of Health has appointed a dedicated Social Capital Manager, on contract, to coordinate social capital activities and represent the department at the provincial Social Transformation Steering Committee and service delivery planning activities covering the following areas:

1) Establishment of community intermediary structures
2) Establishment of inter-governmental teams in the 21 priority areas
3) Service delivery jamborees in 21 priority areas.

At an inter-governmental level, the Head of Health is the designated administrative champion for Paarl and Theewaterskloof and senior departmental officials attend Ministerial Imbizo consultation road-shows to promote synergy and interface between bottom-up and top-down planning activities.

3.6.2.2 **Service delivery**

During the 2007/08 financial year, the Department of Health partnered other sector departments at the service delivery jamborees and provided preventive heath services in the 21 priority areas benefiting over 3 000 clients. In addition to outreach services provided at the jamborees, the Department provides on-site healthcare services in and around the 21 priority areas as summarized in Table 21 below:

In 2008/09, the Department will:

1) Undertake appraisals of the service delivery jamborees to draw lessons, identify challenges and improve on future service provision
2) Track MEC and departmental community engagements to deepen participatory consultation in the 21 areas
3) Continue with inter-governmental activities at provincial and community levels.

Table 21: Social Transformation Projects: Twenty-one priority areas

DISTRICT	SUB-DISTRICT	PRIORITY AREA	CURRENT HEALTH FACILITIES	Types of services available at health facilities other than child and women's health and the normal hours of curative services. (VCT is offered in all fixed facilities)	Community Based Health services available	
					Home-based care	Social capital/ Prevention projects
METRO	SOUTHERN	MUIZENBERG	Victoria Hospital 90 beds	Cataract surgeries done	Compassion in Action	Physical Exercise group at Retreat CHC Chronic Disease support groups at Masipumelele by Living Hope
			False Bay Hospital: 40 beds	ARV site	Living Hope covers all these areas for HBC as well as having a palliative care centre with 20 beds. Nutrition rehabilitation programme by Living hope	
			Fish Hoek Clinic			
			Redhill Mobile Clinic			
			Simonstown Satellite Clinic			
			Muizenberg Clinic			
			Masiphumelele Clinic	ARV site		
			Ocean View CHC	Extended hours		
			Ocean View Clinic			
METRO	KLIPFONTEIN	PHILLIPI	Lansdowne Clinic		Athlone YMCA for HBC Infant feeding counselors in Hanover Park. Ithembalabantu palliative care centre 10 beds	Exercise group at Athlone Hall Chronic Disease support groups by Red Cross
			Hanover Park CHC & MOU	Extended hours & Maternity services		
			Hanover Park Clinic			
			Newfields Satellite Clinic			
			Philippi Clinic			
			Philippi CHC			
		MANENBERG/ GUGULETU	GF Jooste Hospital 180 beds	ARV site	Athlone YMCA	
			Manenberg Clinic			Sensible drinking/Substance abuse workers
			Guguletu CHC & MOU	Extended Hours & Maternity services and ARV site	St Lukes Hospice, Nokuthembeka, SACLA, SA Red Cross. Infant feeding peer counsellors by La Leche League	
			Guguletu Clinic			
		NYANGA	Masincedane Clinic		St Johns and Red Cross	Exercise group by SACLA at Nyaga clinic and Guguletu Repr Health Clinic and Chronic disease support groups by Red Cross
			Nyanga CHC	ARV site		
			Nyanga Junction RHC	Dedicated Reproductive health services		
			Nyanga Clinic			
			Uluntu RHC	Dedicated Reproductive health services		
			Browns Farm CHC [Inzame Zabantu]			
			Crossroads 1 Clinic			
			Crossroads 2 Clinic			
			Crossroads CHC	ARV site		
			Mzamomhle Clinic			
			Phumlani Clinic			
			Mandalay Satellite Clinic		Homebased care by Gods Kingdom and Arisen Women	Eye screening project and mobility workers by SANC for the Blind Chronic Disease support groups by Arisen Women, Breastfeeding club Social health workers by PPASA
			Lentegeur Clinic			
			Tafelsig CHC			
			Eastridge Clinic			
			Mitchells Plain CHC & MOU	Extended hours & Maternity services and ARV site		
			Mitchells Plain Youth Heatlh Centre	Reproductive Health services and various youth activities		
			Rocklands Clinic		Arisen Women	
			Weltevreden Valley Clinic			
			Westridge Clinic		Gods Kingdom	
			Awaiting New Mitchells Plain Hospital: 230 beds. Currently beds based at Lentegeur Hospital		St Lukes Hospice: 30 palliative/respite beds	

DISTRICT	SUB-DISTRICT	PRIORITY AREA	CURRENT HEALTH FACILITIES	Types of services available at health facilities other than child and women's health and the normal hours of curative services. (VCT is offered in all fixed facilities)	Community Based Health services available	
					Home-based care	Social capital/ Prevention projects
METRO	TYGERBERG	BISHOP LAVIS	Bishop Lavis CHC/MOU	Extended hours & Maternity services	Caring Network plus Infant feeding peer counsellors by La leche League	
			Bishop Lavis Clinic			
			Netreg Clinic			
			Valhalla Park Clinic			
		ELSIES RIVER	Adriaanse Clinic		Konoina Tehillah plus Elsies River Lifecare centre for palliative care 20 beds Infant feeding peer counsellors by La leche League	
			Elsies River CHC/MOU	Extended hours & Maternity services		Exercise group at Elsies CHC
			Elsies River Clinic			
			Leonsdale Satellite Clinic			
			Matroosfontein Satelite Clinic			
		DELFT	Delft Clinic		Ma Afrika Tikkun	Exercise group at Library
			Delft CHC	Extended hours and ARV site		
			Karl Bremer Hospital 175 beds	ARV site		
			Eerste River Hospital 30 beds	ARV site		
METRO	KHAYELITSHA	KHAYELITSHA	Khayelitsha Site B Youth Centre	Various youth services and activities	Caring network, SA Red Cross, Zanempilo, St Lukes, SACLA	Eye screening project and mobility workers by SANC for the blind, chronic disease support groups, school health workers by PPASA Community IMC and door to door campaign. Seasonal diarrhoeal campaign Pjilani Nutrition rehabilitation projects at Mayibuye,Site B, Site C and Town 2
			Khayelitsha Site B Clinic			
			Khayelitsha Site B CHC	Extended hours, ARV site		
			Khayelitsha Site B MOU	Maternity services		
			Zibonele Town 2 Clinic			
			Luvuyo Clinic			
			Matthew Goniwe CHC			
			Mayenzeke Clinic			
			Nolungile Youth Centre	Various youth services and activities	Caring network, SA red cross, Zanempilo, St Lukes, SACLA plus Bapumelele Paliative care centre with 10 beds	
			Nolungile Clinic			
			Nolungile CHC	Extended hours and ARV site		
			Michael Mapongwana CHC/MOU	Extended hours & Maternity services and ARV site		
			Zakhele Clinic			
			Kuyasa Clinic			
			Awaiting New Khayelitsha Hospital: 230 beds.	90 beds currently housed at TBH		
METRO	EASTERN	KLEINVLEI	Hilcrest Clinic			
			Kleinvlei Clinic		Eersteriver Bluedowns HIV, SA Home Bureau	
			Kleinvlei CHC	Extended hours	Infant feeding peer counsellors by La leche League	
			Blue Downs Clinic			
			Russel's Rest Clinic			
			Wesbank Clinic		Konoinia	
			Mfuleni CHC		Ma Afrika Tikkun	
			Mfuleni Clinic			
			Driftsands Satellite Clinic			
			Helderberg Hospital 90 beds			
			Eerste River Hospital 60 beds	ARV site	Eagles Rest palliative care centre with 10 beds	

DISTRICT	SUB-DISTRICT	PRIORITY AREA	CURRENT HEALTH FACILITIES	Types of services available at health facilities other than child and women's health and the normal hours of curative services. (VCT is offered in all fixed facilities)	Community Based Health services available	
					Home-based care	Social capital/ Prevention projects
CAPE WINELANDS	DRAKENSTEIN	PAARL	Paarl Hospital: 250 beds and increasing to 327 beds			
			Mbekweni Clinic		Caring Network	
			Phola Park Clinic			
			Dalvale Clinic		Drakenstein Hospice, Wellington Society for the Aged and Saron Gemeenskapdiens plus Luthando palliative care centre with 12 beds	
			Patriotplein Clinic			
			JJ du Pre Le Roux Clinic			
			Klein Nederburg Clinic			
			Klein Drakenstein Clinic			
			TC Newman CHC	Because there is no District hospital, CHC is serving district Hospital level functions		Exercise group at TC Newman Comm hall
CAPE WINELANDS	WITZENBERG SUB-DISTRICT	WITZENBERG SUB-DISTRICT	Ceres Hospital	ARV site	Witzenberg Aids Action	
			Ceres CHC	Joint IDP planning with Municipality		
			Bella Vista Clinic			
			Breërivier Clinic			
			Nduli Clinic			
			Op die Berg Clinic			
			Prince Alfred Hamlet Clinic & Mobile			
			Tulbach Clinic			
			Wolsely Clinic			
			Karoo Mobile			
			Koue Bokkeveld Mobile			
			Skurweberg Mobile			
			Warm Bokkeveld Mobile			
			Tulbach Mobile			
			Wolsely Mobile			
OVERBERG DISTRICT	THEEWATERS KLOOF	THEEWATERS KLOOF	Caledon Hospital	ARV site	Elgin Community College, Badisa Riviersonderend, Genadendal Legal Info	Theewaterskloof Health and Welfare Committee and Community IMCI project
			Caledon CHC			
			Grabouw CHC	Extended hours and ARV site		
			Grabouw CHC MOU			
			Botrivier Clinic			
			Genandendal Clinic			
			Greyton Clinic			
			Riviersonderend Clinic			
			Villiersdorp Clinic			
			Caledon Mobile 1			
			Caledon Mobile 2			
			Caledon Mobile 3			
			Grabouw Mobile 1			
			Grabouw Mobile 2			
			Grabouw Mobile 3			
			Villiersdorp Mobile 1			
			Villiersdorp Mobile 2			
			Villiersdorp Mobile 3			
EDEN	OUDTSHOORN	OUDTSHOORN	Oudtshoorn Hospital	ARV site	Coronation Memorial	Chronic Dispensing off site venues
			Bridgeton			
			Regent Street			
			Toekomsrus			
			Bongolethu			

DISTRICT	SUB-DISTRICT	PRIORITY AREA	CURRENT HEALTH FACILITIES	Types of services available at health facilities other than child and women's health and the normal hours of curative services. (VCT is offered in all fixed facilities)	Community Based Health services available	
					Home-based care	Social capital/ Prevention projects
EDEN	KANNALAND	KANNALAND	Zoar, Amalien Steyn Clinic		Huis Isak van tonder, Oasis,	Chronic Dispensing off site venues
			Calitzdorp Clinic			
			Vna Wyksdorp Mobile			
			Van Wyksdorp Satellite Clinic			
			Ladismith Mobile			
			Calitzdorp Mobile			
CENTRAL KAROO	BEUFORT WEST, LAINGSBURG & PRINCE ALBERT SUB-DISTRICT	BEUFORT WEST, LAINGSBURG & PRINCE ALBERT SUB-DISTRICT	Beaufort West Hospital	ARV site	Christ church, Prince Albert Advice, MAAG 6 sites of Nutrition rehabilitation programmes by Donald Duck centre, Bambino Creche, COMBAT, Liewe Heksie, Babbel and Krabbel and Sonstraaltjies	Chronic Dispensing off site venues
			Beaufort West CHC			
			Konstitution Street Clinic			
			Konsitution Street Mobile 1			
			Konsitution Street Mobile 2			
			Niewveldpark Clinic			
			Kwamandlenkosi Clinic			
			Laingsburg Clinic			
			Laingsburg Mobile			
			Prince Albert Clinic			
			Prince Albert & Klaarstroom Mobile			
			Merweville Clinic			
			Merweville Mobile			
			Leeuw Gamka Clinic			
			Murraysburg Mobile			
			Nelspoort Satellite Clinic			
			Swartburg Mobile			
			Matjiesfontein Clinic			
WEST COAST	MATZIKAMA SUB-DISTRICT	MATZIKAMA SUB-DISTRICT	Vredendal Hospital	ARV site	Vredendal Tehuis, KARA HIV/AIDS, Ebenhaezer Dienssentrum, Diakonale Dienste Nuwerus	Chronic disease support groups by diakonale diensteat Nuwerus and Vredendal Tehuis.
			Vredendal Noord CHC			
			Vredendal Town Clinic			
			Vredendal Mobile			
			Klawer Clinic			
			Klawer Mobile (Van Rhynsdorp)			
			Klawer Mobile (Vredendal)			
			Lutzville Clinic			
			Lutzville Mobile			
			Doringbaai Satellite Clinic			
			Ebenahaezer Satellite Clinic			
			Van Rhynsdorp Clinic			
			Van Rhynsdorp Mobile			
			Bitterfontein Clinic			
			Koekenaap Satellite Clinic			
			Nuwerus Satellite Clinic			
			Stofkraal Satellite Clinic			
			Mosvlei Satellite Clinic			
			Rietpoort Satellite Clinic			
			Kliprand Satellite Clinic			

DISTRICT	SUB-DISTRICT	PRIORITY AREA	CURRENT HEALTH FACILITIES	Types of services available at health facilities other than child and women's health and the normal hours of curative services. (VCT is offered in all fixed facilities)	Community Based Health services available	
					Home-based care	Social capital/ Prevention projects
WEST COAST	CEDERBERG SUB-DISTRICT	CEDERBERG SUB-DISTRICT	Clanwilliam Hospital 30 beds		Diakonale Dienste Lambertsbay, Ons Huis, Sederhof Clanwilliam	Psych-social Rehab group by Ons Huis, Exercise group by Ons Huis and Chronic disease support group
			Clanwilliam CHC			Chronic Disease support group by Sederhof Clanwilliam
			Clanwilliam Mobile			
			Graaffwater Mobile			
			Graaffwater Clinic			
			Wuppertal Clinic			
			Citrusdal Hospital	ARV site		
			Citrusdal Clinic			
			Citrusdal Mobile Robyn			
			Lambertsbaai Clinic			
WESTCOAST	SALDANHA	VREDENBURG	Vredenberg Clinic		Westcoast Community HIV/Aids Action, St Helena Sandvlei Hospice, Vital connection	Substance Abuse awareness, psychosocial rehab group, and Chronic disease support groups by Vital Connection
			Louwville Clinic			
			Vredenburg Hospital: 56 beds and increasing to 80 beds	ARV site		

3.7 **Healthcare 2010**

3.7.1 The Western Cape Strategic Transformation Plan, Healthcare 2010, originates from 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 restructure the Department to be financially sustainable. However, Healthcare 2010 identified that the Department is under funded by conservatively R500 million (2001 rands) if it is to deliver the level of service prescribed by government policy.

3.7.2 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
7) De-institutionalisation of chronic care.

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4. DESCRIPTION OF THE STRATEGIC PLANNING PROCESS

The planning for the current budget cycle commenced with a strategic planning workshop held in Goudini on 16-17 July 2007, which was attended by the Minister, the Head of Department, all members of the senior management service (SMS) and institutional heads and representatives from the universities. At this meeting motivations for the 2008/09 financial year for additional funding amounting to R890 million were received from line management in order to address service requirements. Motivations for funding for 2008/09 were presented to the provincial Treasury in the Medium Term Expenditure Committee (MTEC) engagements that culminated in the final budget allocations.

A parallel process during 2007 were the two-weekly meetings of the Comprehensive Service Plan Implementation Task Team chaired by the Head of Department which developed key events schedules combined into an implementation master plan to give effect to the CSP.

5. TECHNICAL NOTES

This paragraph provides a brief overview of the technical requirements of the Annual Performance Plan (APP).

The format for the APP is based on a generic format provided by National Treasury in the *Framework and templates for provincial departments for the preparation of Strategic and Performance Plans for 2005 - 2010 and Annual Performance Plans for the 2005 financial year,* which was published in August 2004. The National Department of Health used this format to develop a sector specific format for APPs*: Format for Annual Performance Plans of Provincial Health Departments.* This means that the National Department of Health customized the Treasury format for Health and also prescribed a number of performance measures against which the Department is required to report. The format also makes provision for own provincial objectives and performance indicators.

The information provided in the provincial Budget Statements, compiled by Treasury, was intended to be a subset of the information in the APP. The fact that the formats for providing programme performance information in the APP and Budget Statement were different was problematic. A further problem was the non-alignment of the formats for the Quarterly Performance Reports, Annual Report and the APP.

During 2007 the National Department of Health revised the sector specific format for the 2008/09 APP. The main changes were a reduction of the number of nationally prescribed indicators and an improved alignment between the APP format and that of the Quarterly Performance Reports and Budget Statement. It must be noted that Treasury has subsequently revised the format for reporting programme performance in the Budget Statement. The Department will conform with the current requirements of the Treasury format and will therefore not include the column requiring 'output' in the tables of provincial indicators in the APP, which was only included in the new APP format at the request of the Western Cape in order to comply with the previous Treasury format for the budget statement.

A further change has been the request by Treasury for the Department to provide quarterly targets for each of the indicators in the format illustrated below, which is derived from the National Treasury format document described above. The information regarding the quarterly targets will form a new Part C of the APP. The other parts of the APP being:

- Part A: Strategic overview.
- Part B: Budget programme plans.

Table 22: Illustration of the required format for quarterly performance targets for year one of the APP

Sub-programme:		Strategic Goal							
Strategic Objective	Measurable Objective	Performance Measure/ Indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4

This means that all the performance indicators included in Part B of the APP are repeated in Part C providing the quarterly targets for the first year of the MTEF. The Department has therefore decided to align all the performance tables in Part B with the Treasury format, thereby providing more information than what is required by the sector specific format.

The National Department of Health format does not require the Department to state the strategic goal and objective for each indicator and the tables of nationally prescribed performance indicators have not provided measurable objectives. In the process of aligning the Part B tables with the format for Part C the Department has developed and refined existing strategic goals and objectives and measurable objectives.

This process took place in consultation with the National Department of Health and the National and Provincial Treasury.

6. PAST EXPENDITURE TRENDS AND RECONCILIATION OF THE MTEF PROJECTIONS WITH PLAN

Table 23: Trends in provincial public health expenditure [A3]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total excluding capital	4 880 735 000	5 501 787 000	6 075 160 000	7 189 229 000	8 034 578 000	8 856 008 000	9 682 106 000
Total Capital	288 464 000	217 025 000	344 355 000	372 608 000	607 395 000	614 416 000	668 666 000
Grand Total	**5 169 199 000**	**5 718 812 000**	**6 419 515 000**	**7 561 837 000**	**8 641 973 000**	**9 470 424 000**	**10 350 772 000**
Total per person	1 113	1 212	1 216	1 394	1 550	1 652	1 757
Total per uninsured person	1 493	1 623	1 631	1 869	2 079	2 217	2 357
Constant 2006/07 prices							
Total excluding capital	5 414 102 398	5 693 192 211	6 075 160 000	6 944 882 093	7 419 657 229	7 915 327 905	8 384 166 265
Total Capital	319 987 386	224 575 222	344 355 000	359 943 831	560 908 451	549 153 085	579 027 633
Grand Total	**5 734 089 784**	**5 917 767 434**	**6 419 515 000**	**7 304 825 924**	**7 980 565 680**	**8 464 480 990**	**8 963 193 898**
Total per person	1 234	1 254	1 216	1 346	1 431	1 477	1 521
Total per uninsured person	1 657	1 680	1 631	1 806	1 920	1 981	2 041
% of Total spent on: -							
District health services	25.7%	28.5%	30.0%	36.3%	34.3%	34.7%	35.2%
Provincial hospital services	22.8%	22.7%	21.8%	17.2%	26.7%	26.9%	26.8%
Central hospital services	34.9%	34.6%	33.1%	31.1%	20.8%	20.5%	20.1%
Capital	5.6%	3.8%	5.4%	4.9%	7.0%	6.5%	6.5%
Health as % of total public expenditure (current prices)	35.42%	34.15%	34.06%	34.88%	34.70%	34.57%	34.67%

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 MEC

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.

To make limited provision and maintenance of accommodation needs.

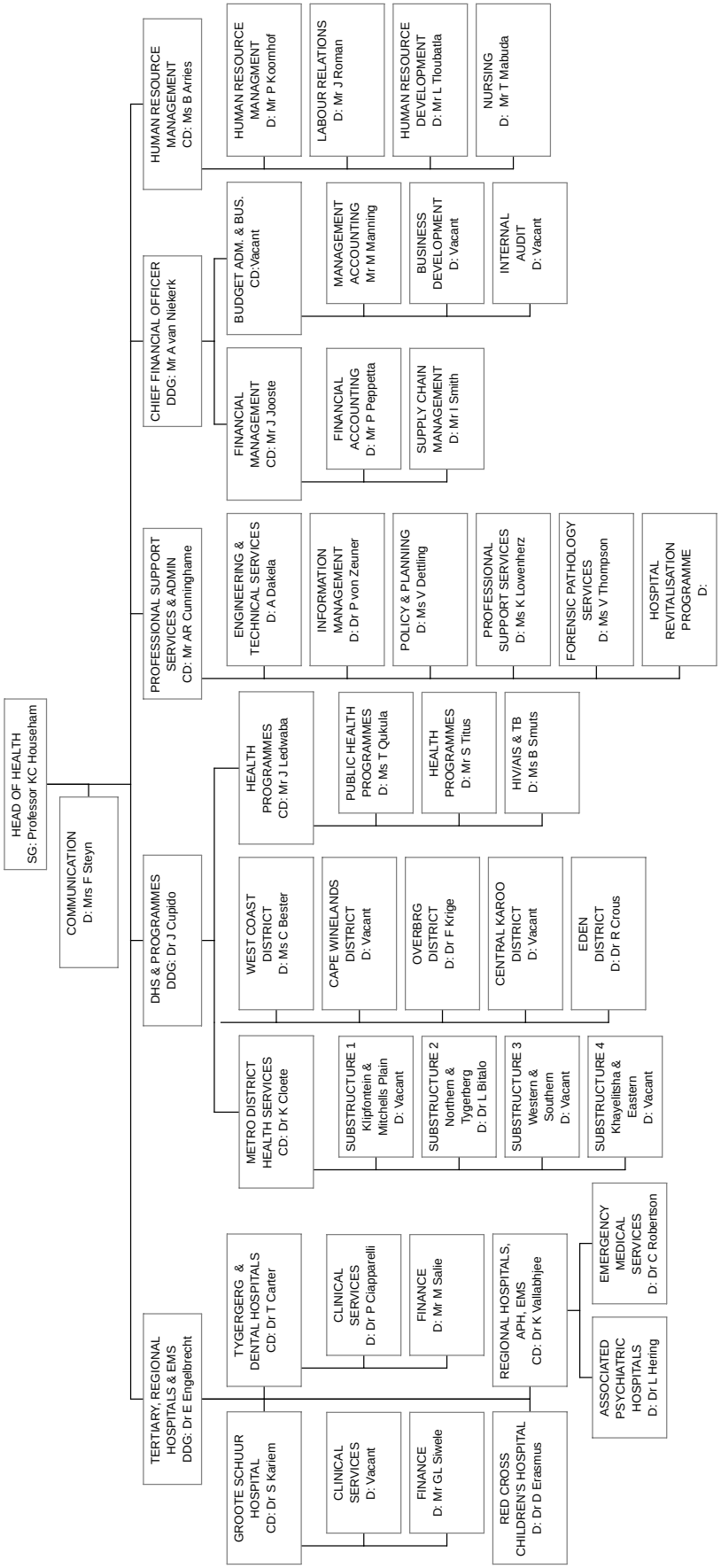
Sub-programme 1.2.1: Central management

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.

ORGANISATIONAL CHART OF SENIOR MANAGEMENT



3. ADMINISTRATION: PLANNING

3.1 SITUATION ANALYSIS

The Department of Health is managed currently by a combination of a central management component situated in the head office in Cape Town, decentralised regional offices in George, Worcester and Malmesbury and institutional management at the respective facilities.

The Provincial Minister determines provincial policy and the central head office management ensures that the Western Cape provincial health service is aligned with national, provincial and departmental policy and directives.

Human resource and financial management policies and procedures are determined and co-ordinated at the central head office. The current organisational chart of the senior management of the Department is reflected on the previous page.

High levels of migration into the Western Cape remains an issue of concern. While it is true that the province receives funding for a designated number of patients from other provinces for tertiary services, inadequate financial provision is made in terms of the provincial equitable share for the increased number of patients who require primary and secondary level care. The level of in-migration to the Western Cape from neighbouring provinces, which creates significant pressure on services, has been confirmed by the Community Survey 2007 published by Stats SA which indicates that the population of the Western Cape has increased by 16,7% since 2001. The impact of migration from neighbouring countries, which results in additional financial strain on Provincial resources, has not yet been calculated.

The demand for services exceeds the quantum of service that can be provided from the available resources. The challenge to the Department, therefore, is to reshape the services to ensure that available resources are optimally used, as outlined in the Comprehensive Service Plan (CSP) as approved by the Provincial Minister and Cabinet.

The shape of the health service requires a solid base for primary health care (PHC) that is integrated with level 2 and 3 services to provide a seamless service for patients. It is important that the reshaping of the services be viewed holistically. Any restructuring will have to be synchronised to prevent disruption of services.

An infrastructure plan for hospitals has been developed in support of the CSP, which will be implemented using all available funding for hospital upgrading and construction. A similar plan has been developed for the PHC facilities, but funding the necessary upgrading and construction of these facilities from the available budget will present a significant challenge to the Department .

The first phase of the burden of disease investigation commissioned in 2006 has been completed and the findings have been accepted by the Department and the Provincial Cabinet. This study provides the basis for provincial interventions to reduce the disease burden. The Department of Health is currently engaged in discussion with Provincial departments to determine their roles in addressing factors that promote the burden of disease in the Western Cape.

3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The Western Cape Department of Health's response to the National Department of Health's priorities is outlined in Part A: Strategic Overview.

The CSP is the Western Cape's service transformation plan and aims to improve service delivery and provide equal access to quality health care. The development of a service transformation plan is one of the National Health System priorities. The CSP is the Western Cape's service transformation plan and aims to improve service delivery and provide equal access to quality health care. The CSP provides the framework for the Department's planning for the MTEF period and beyond.

The CSP will facilitate the implementation of the District Health System and the current rural regional offices will be replaced by district offices. The Cape Town Metro district will be managed by a Chief Directorate consisting of four substructure offices, which will each manage two sub-districts. These components will be responsible for co-ordinating and integrating health services to ensure effective and efficient delivery of quality District Health Services. A key aspect of Healthcare 2010 and the CSP is the creation of a 'seamless' service in which the various levels of care in the service interact in an integrated manner. This aims to ensure the appropriate and timeous referral of patients from one level of care to another so that patients are managed at the appropriate level of care.

Key events linked to timeframes and responsible managers have been identified in key event schedules and combined in an overall CSP implementation master plan. During 2007/08 this process was driven by a task team, chaired by the Head of Department, that met bimonthly to monitor the progress made. The key events for 2008/09 have been integrated into the APP and progress will be monitored via the quarterly monitoring and evaluation meeting chaired by the Head of Department.

The Department continues to make a concerted effort to improve patient billing and revenue collection and has entered into designated service provider agreements with medical aids and other government departments. Negotiations with the Road Accident Fund (RAF) have substantially increased the revenue from this source. During the 2007/08 financial year an amount of R62 million was received from the RAF by 31 December 2007.

Communication with staff at all levels, as well as stakeholders and the media is a key objective. This is achieved by regular newsletters, staff indabas (where the head of department and top management interact with staff at various facilities across the province), and participation in Provincial and national imbizos. Communications will develop a specific strategy to inform stakeholders of the process and timeframes for the implementation of the CSP.

3.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The funding envelope is a fundamental constraint on the Department's ability to fully deliver health services in line with the need in communities. The allocated budget determines the quantum of service that can be delivered. Simply put: the budget does not match the demand. The Department has developed the Comprehensive Service Plan in order to optimally use the available funds and, very importantly, to provide a sound basis for the motivation for additional appropriate funding. Contrary to views expressed by certain critics of the plan, the CSP is not in itself aimed at reduceing the level of service provided but rather at ensuring that the services provided address, to the greatest possible degree, the need for these services.

Measures have been implemented to ensure effective control over the filling of posts and the related expenditure since this is the largest single item of expenditure in the health budget. Agreements are reached between the chief financial officer and the respective managers to determine the number of posts that may be filled in line with the available funds. This authorises managers to make appointments within the agreed framework.

Recruitment of personnel with specific skills remains a challenge. There are vacancies in the financial, human resources and business management components both at head office and institutional level. There is a high turnover rate and a limited pool of skilled individuals to apply for these posts. While additional funding has been made available to address this situation, the real solution lies in greater efforts with regard to training, mentorship and the strategies used to recruit personnel.

Recruitment of appropriate numbers of key clinical personnel, such as pharmacists and specialist nurses, remains a challenge. In order to meet the demand and improve the production of health workers a study is being undertaken to quantify the skills gap.

3.4 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.

Problems experienced with systems such as the PERSAL system, which needs to be updated and the Basic Accounting System (BAS) with slow response times continue to impact on efficiency. The Department continues to address this matter, which is a national competency with relevant departments, but to date success in this regard has been limited.

The Directorate: Supply Chain Management deals with procurement and provisioning functions including the supply of pharmaceuticals and surgical and medical sundries via the Cape Medical Depot. The Department's use of the LOGIS and Syspro systems has strengthened management capacity at the Cape Medical Depot.

The Hospital Revitalisation Programme (HRP) Unit has submitted business cases, which have been approved and funded for planning, for Khayelitsha, Mitchell's Plain and Valkenberg Hospitals. The Department together with the Department of Transport and Public Works will proceed with the construction. Construction work is in progress at George, Worcester, Paarl and Vredenburg Hospitals.

Business cases have been approved in principle, but no funding has been allocated for Tygerberg, Helderberg, Valkenberg, Victoria, Mossel Bay and Brooklyn Chest Hospitals.

It is envisaged that Somerset Hospital would be rebuilt as part of a property development proposal.

The following are among the specific quality improvement measures for 2008/2009:

- A provincial profile of complaints and compliments will be compiled and reviewed on a quarterly basis.
- External client satisfaction surveys will be conducted in accordance with a planned schedule.
- A provincial infection prevention and control policy has been developed and a provincial infection prevention and control committee constituted to give strategic direction to the development of infection prevention and control strategies.
- Generic and specific services standards will be finalised.
- Mortality and morbidity reviews are being conducted.
- Clinical audits are conducted informally at facilities whilst awaiting the finalisation of the National Clinical Audit Guidelines.
- An adverse incident reporting system with centralised data capture in order to create a provincial database of adverse clinical events which guide the proactive arm of the risk management programmers has been finalised.
- Specific aspects of the clinical supervision manual have been implemented.
- Staff satisfaction surveys will be conducted.
- Waiting time surveys will be conducted at selected sites.
- The training of pharmacists' assistants to support improved pharmaceutical care will be continued.
- The training of nursing assistants to support improved nursing care will be continued.
- A service level agreement with the NHLS has been implemented.
- The relationship between the Department of Transport and Public Works and Health will be managed through the agreed service level agreement between departments.

3.5 NATIONAL HEALTH SYSTEM (NHS) PRIORITIES: 2008/09

Table 1.1: National Health System Priority 1: Development of Service Transformation Plans

Activity	Indicators	National Targets 2007/08	Provincial progress 2007/08	National Targets 2008/09	Provincial Projection 2008/09
Application of the Integrated Health Planning Framework	Scenarios developed by all provinces	STP updated Implementation monitoring	CSP approved in principle by Provincial Cabinet on 19 July 2006, externally consulted and signed off by the Provincial Minister of Health on 11 May 2007	STP updated, Implementation monitoring	Phased implementation of the CSP
Provincial APP	Part A completed	STP updated, including EMS and modernisation of tertiary services STP completed including all 5 of the priority areas included in this framework	Part A of the A PP completed in August 2007.	STP updated, including Government Employees Medical Scheme (GEMS).	Phased implementation of the CSP
		EMS business plans updated	Complete.	EMS business plans updated	EMS restructuring plan to be implemented
		MTS (tertiary hospitals) implementation plan agreed by all provinces by December 2007	The provincial plan for spending in the current year is completed and progress monitored. The plan for the MTEF period according to the MTEF allocations is now being concluded.	Updated	MTS plan implemented according to available funds A digital medical imaging strategic plan completed for implementation
		Develop full transport systems plan for delivery of patients to hospitals and specialists to lower care levels	Complete	Service delivery plan updated.	Expand Healthnet routes
		Develop full plan for use of telemedicine links to increase specialist availability	A policy framework and implementation document for digital imaging has been drafted for comment. It is proposed that the resulting network will support the development of full scale telemedicine.	Implementation plan updated	Implementation will commence concentrating on the revitalisation of hospitals.
Provincial APP	Part B	100% of provinces with detailed implementation plans by November 2007. Part A strategies included in Part B	Deadlines for the submission of the first, second and final drafts of the APP to Treasury in August and November 2007 and February 2008, met.	Updated by November 2009	Fully updated APP
Implementation management	Effective planning and implementation monitoring	All provinces to have management KPIs linked to priorities, including use of information for management	KPIs in the APP are monitored quarterly at M&E meetings chaired by the Head of Department.		KPIs in the APP are monitored quarterly at M&E meetings chaired by the Head of Department.
	Fully implement delegations at all levels but especially at hospital level	Audit and strengthen existing delegations by September 2008	Full set of delegations in place.	Review delegations and implement recommendation	Full set of delegations in place.

3.6 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 1.2: Provincial objectives and performance indicators for Administration [ADMIN1]

Strategic Objective	Measurable Objective	Performance Measure/ Indicator	2004/05 Actual	2005/06 Actual	2006/07 Actual	2007/08 Estimate	2008/09 Target	2009/10 Target	2010/11 Target
Sub-programme 1.2:	**Management**	**Strategic Goal:**	To conduct the strategic management and overall administration of the Department of Health						
To formulate policy and provide overall management and administrative support to the Department and the respective districts and institutions within the Department.	Implementation of HIS at all contracted hospitals	Percentage of hospitals where the HIS has been implemented	15% (6/41)	25% (10/41)	35% (14/41)	50% (20/41)	60% (24/41)	70% (28/41)	80% (32/41)
	All hospitals with up-to-date asset register	Percentage of hospitals with up-to-date asset register[1]	85% (35/41)	88% (36/41)	95% (39/41)	95% (39/41)	100% (41/41)	100% (1/41)	100% (41/41)
	All other components, excluding hospitals, with an up-to-date asset register	All other components excluding hospitals with up-to-date asset register[1 & 2]	80% (12/15)	80% (12/15)	100% (15/15)	100% (15/15)	100% (15/15)	100% (15/15)	100% (15/15)
	Reduce the number of dues out at the CMD.	Number of items on dues out at the CMD	<60	<60	<50	<50	<50	<50	<50
	Quality Assurance	**Strategic goal:**	To render a support service to all institutions, regions and the department in order to ensure improved quality of care and the reduction of service risks in order to achieve the provision of a safe standard of care.						
To systematically monitor and evaluate the quality of service delivery.	Percentage of facilities that have conducted an annual client satisfaction survey (CSS) per level of care	Number of facilities which have conducted a CSS.	**33% (31/94)**	**32% (22/94)**	**30% (28/94)**	**51% (50/96)**	**75% (72/96)**	**71% (70/96)**	**82% (80/96)**
	Percentage of regional offices and facilities which submit complaints and compliments returns	Number of regional offices, facilities and EMS districts that submitted quarterly complaints and compliment returns/ Number of regional offices, EMS districts and facilities	97% (110/113)	91% (103/113)	83% (94/113)	100% (110/110)	100% (110/110)	100% (110/110)	100% (110/110)
	Timeous resolution of complaints	Complaints resolved rate	New indicator required by QPR from 2006/07		75% (2,262/ 3,014)	75% of complaints received.	75% of complaints received.	75% of complaints received.	75% of complaints received.
	Implementation of clinical audit	Clinical audit rate	New indicator required by QPR from 2006/07		34% (32/94)	32% (31/96)	38% (36/96)	41% (40/96)	46% (45/96)

Notes:
1. Indicator extracted from Table 8.7 [HFM5] as this function is managed from Programme 1 and not Programme 8.
2. The APP format prescribes: Health districts with up- to-date PHC asset register, excluding hospitals. It is not possible to provide this information therefore the indicator has been amended to: All other components excluding hospitals with up-to-date asset register.

3.7 PAST EXPENDITURE TRENDS AND RECONCILIATON OF MTEF PROJECTIONS WITH PLAN

The allocation to Programme 1 increases to 3.48% of the vote in 2008/09 in comparison to the 2.93% allocated in the revised estimate of 2007/08, which amounts to a nominal increase of R78.920 million or 35.57% from the revised estimate for 2007/08.

An amount of R45.5 million for equipment has been temporarily allocated to Programme 1 pending distribution to the respective programmes in the adjustment estimate.

An earmarked allocation of R340.229 million has been allocated to the Department for the health professional remuneration review/ occupational specific dispensation for 2008/09. These funds have been appropriately distributed across the respective financial programmes. An amount of R1.331 million has been allocated to Programme 1 for this purpose.

An earmarked allocation of R3.864 million has been made to enable the Department to develop its internal audit capacity. The internal audit function is being shifted from Treasury to the Department of Health and the funding will be used to accommodate the relocation of the internal audit staff to the Department and to augment the staff

An earmarked allocation of R14.5 million is provided in each year of the MTEF to relieve the costs associated with IT such as the purchasing of essential hardware, infrastructure and equipment.

Excluding the allocation for equipment and the earmarked allocation the funding allocated to Programme 1 in 2008/09 increases by R13.725 million or 6.19%.

Table 1.3: Trends in provincial public health expenditure for Administration [ADMIN2]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total	213 316 000	167 291 000	162 125 000	221 868 000	300 788 000	324 856 000	347 600 000
Total per person	45.91	35.46	30.71	40.89	53.94	56.67	58.99
Total per uninsured person	61.63	47.49	41.18	54.84	72.35	76.04	79.17
Constant 2006/07 prices							
Total	236 627 202	173 110 994	162 125 000	214 327 169	277 767 402	290 349 982	301 002 302
Total per person	50.93	36.69	30.71	39.50	49.81	50.65	51.09
Total per uninsured person	68.36	49.14	41.18	52.98	66.81	67.96	68.56

4. ADMINISTRATION: HUMAN RESOURCES MANAGEMENT

4.1 SITUATION ANALYSIS

4.1.1 Currently the approved staff establishment is not aligned with the service needs of the Department as outlined in the new organisational and post structure that was developed in the Comprehensive Service Plan. This will be addressed during the development of the Human Resource Plan and the implementation of the CSP.

4.1.2 This process will facilitate the relocation of posts from institutions where they are not needed to areas where they can be appropriately deployed. The personal primary health services of the rural local authorities at district level were transferred to the Department during 2006/07 and approximately 600 local government staff members at various clinics at PHC level have become public servants.

4.1.3 The shortage of nurses in the Department hampers service delivery in some service areas. It is hoped that the implementation of the occupational specific dispensation (OSD) for nurses will improve the recruitment and retention of nurses during the 2008/09 financial year and beyond.

4.1.4 The further development of OSDs for all other professional occupational groups in the Public Service has the potential to improve the recruitment and retention of these employees.

4.1.5 The implementation of the Policy and Procedure on Incapacity Leave and Ill-health (PILIR), which is a system to manage sick leave in the Public Service, has resulted in a decrease in the absenteeism rate. The average number of days of sick leave per employee during 2004 was 11 days, 10 days in 2005 and 8 days in 2006 which indicates a steady improvement in the management of sick leave.

4.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

4.2.1 The CSP staff establishment has been developed to address the service delivery needs of the Department. The generic staffing models in the CSP for hospitals are in the process of being adjusted in line with the requirements of specific facilities in consultation with facility management.

4.2.2 The Department has developed a macro Human Resource Restructuring Plan to guide the restructuring exercises of the Department. The focus of these measures is on the retention of affected staff, the upskilling of staff as well as the positive relocation of these staff. Micro restructuring plans will allow the management of the restructuring process at institutional level. A micro restructuring plan for the Metro District Health Services has been developed and is being implemented. The Department is in the process of developing a comprehensive human resource plan, which will be implemented during 2008/09.

4.2.3 An Employment Equity plan, for the period 2007 to 2012, has been developed for the Department, and was approved on 1 June 2007. This plan spells out measures to improve recruitment of appropriate candidates from the designated groups and people living with disabilities.

4.2.4 Recruitment measures to eliminate delays in the recruitment of nursing staff such as block advertisements have been implemented.

4.2.5 The implementation of the Occupation Specific Dispensation for health professionals will contribute to the retention of staff in these categories and aims to reduce the attrition rate of the Department.

4.2.6 The efficient application of the PILIR system will contribute to a reduction in absenteeism. This system will establish a new culture for the utilization of sick leave.

4.2.7 The Department has developed a nursing strategy and will implement it over the next financial year and satellite campuses will be established in the Boland and Southern Cape. The marketing and promotion of the nursing profession will be a key focus of the Directorate: Nursing.

4.3 NATIONAL HEALTH SYSTEM PRIORITIES: HUMAN RESOURCES

Table 1.4: National Health System Priority 2: Human Resources:

Activity	Indicators	National Targets 2007/08	Provincial progress 2007/08	National Targets 2008/09	Provincial projection 2008/09
Staff distribution	Proportion of establishment in each service point by level of care	20% reduction in vacancy rate in STP designated tertiary and level 2 hospitals Fully-mapped distribution of all staff and agreement on appropriate baseline level of staffing by discipline for level 1 and PHC services	The CSP has been developed with clear staffing requirements identified per level of care.	50% reduction in vacancy rate in STP designated hospitals	A new staff establishment in line with the CSP will be developed and partially implemented in 2008/09.
	HR plan	Fully-articulated HR plan for delivery of objective	Generic Macro HR Restructuring Plan drafted and consultations held with organised labour.	Updated	Draft HR plan developed.
Private sector partnerships	Private sector specialists in public facilities	Agree on SLA with GPs and specialists for sessional work in public sector facilities 10% reduction in vacancy rate through private sector SLA's	Not applicable	20% reduct ion in vacancy rate through private sector SLAs	Not applicable
		10% of PHC facilities with sessional GPs	Not applicable	20% of PHC facilities with sessional GP's	Not applicable
		15% of level 2 and level 3 public hospitals with private sector specialists	Private sector sessions are taking place in several hospitals. This is not a strategy for the Western Cape where full-time staff are preferred.	30% of level 2 and level 3 public hospitals with private sector specialists	Not applicable
Remuneration levels	Recruitment and retention	Agree on revised remuneration levels of all staff 10% reduction in turnover	The final agreement is awaited.	20% reduction in turnover	10% reduction in staff turnover.
Increase training of nurses (re-opening of nursing schools)		Training of additional students initiated	Have increased the number of students in training.		Increase the number of students in training. Opening of satellite campus in the Boland and South Cape Karoo Regions.

Table 1.5: Public health personnel in 2006/07 [Hr1]

Categories	Number employed	% of total employed	Number per 1000 people	Number per 1000 uninsured people	Vacancy Rate[1]	% of total personnel budget	Annual cost per staff member
Medical Officers	1677	6.72	0.35	0.48	13.20	16.64	323 843
Medical Specialists	431	1.73	0.09	0.12	23.58	7.12	539 347
Dentists	67	0.27	0.01	0.02	20.24	0.65	318 584
Professional Nurse s	4 259	17.07	0.90	1.23	27.81	19.69	150 904
Enrolled Nurses	1 886	7.56	0.40	0.55	18.85	6.14	106 316
Enrolled Nursing Auxiliaries	3 866	15.49	0.81	1.12	17.53	9.94	83 939
Student Nurses	9	0.04	0.00	0.00	98.04	0.05	165 938
Pharmacists	299	1.20	0.06	0.09	33.11	1.64	178 882
Physiotherapists	112	0.45	0.02	0.03	22.76	0.49	142 492
Occupational Therapists	99	0.40	0.02	0.03	22.05	0.42	137 264
Clinical Psychologists	66	0.26	0.01	0.02	20.48	0.35	173 446
Radiographers	393	1.58	0.08	0.11	11.09	1.95	161 976
Emergency medical staff	1 125	4.51	0.24	0.33	10.36	4.59	133 227
Dieticians	63	0.25	0.01	0.02	24.10	0.29	148 343
Other allied health professionals & technicians	771	3.09	0.16	0.22	25.44	3.66	154 750
Managers, Administrators & all other staff	9 828	39.39	2.07	2.84	24.44	26.37	87 573
Grand Total	**24 951**	**100.00**	**5.25**	**7.21**	**23.40**	**100.00**	**130 794**

Notes:

1. These vacancy rates are expressed as a percentage vacancy determined by the existing approved staff establishment. This is materially different from the envisaged staff establishment that will be derived from the Comprehensive Service Plan.
2. Professional nurses on salary levels 9 - 12 are included as managers.

Table 1.6: Situational analysis and projected performance for human resources (excluding health sciences and training) [Hr3]

Sub-programme 1.2.1	Administration	Strategic goal:	The recruitment and retention of an appropriate workforce for the Department of Health.								
Strategic objective	**Measurable objective**	**Performance Measure/Indicator**	**Type**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**National Target 2007/08**
To have an effective and efficient and skilled workforce.	**Provide sufficient staff with appropriate skills per occupational group.**	1. Medical officers per 100 000 people	No	37	37	37	37	37	37	37	18.7
		2. Medical officers per 100 000 people in rural districts	No	13	13	13	13	13	13	13	12.2
		3. Professional nurses per 100 000 people	No	85	95	100	100	100	100	100	105
		4. Professional nurses per 100 000 people in rural districts	No	55	60	70	80	80	80	80	92.5
		5. Pharmacists per 100 000 people	No	5	8	10	15	15	15	15	34
		6. Pharmacists per 100 000 people in rural districts	No	4	6	8	12	12	12	12	24
		Process									
		7. Vacancy rate for professional nurses	%	23%	15%	15%	13%	13%	13%	13%	15
		8. Attrition rate for doctors	%	42%	30%	25%	20%	20%	20%	20%	25
		9. Attrition rate for professional nurses	%	15%	12%	12%	10%	10%	10%	10%	25
		10. Absenteeism for professional nurses	%	3.56%	3%	3%	2.7%	2.7%	2.7%	2.7%	5
		11. Hospitals with employee satisfaction survey	%	30%	45%	60%	65%	65%	65%	65%	50
		Efficiency									
		12. Nurse clinical workload (PHC)	No	35	35	35	35	35	35	35	
		13. Doctor clinical workload (PHC)	No	50	50	50	50	50	50	50	
		Outcome									
		14. Supernumerary staff as a percentage of establishment	%	0	0	0	0	0	0	0	

NOTES:

1. Excludes local government personnel.
2. Excludes sessions periodical and extraordinary appointments.
3. Absenteeism is calculated: Persons*261 / days sick leave * 100
4. Doctors = medical officers, specialists, registrars and medical superintendents.
5. 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.
6. The unfunded posts within the Department of Health were abolished or frozen since July 2004 and the information for indicators 11, 12 and 13 would not be a true reflection of the real service need in terms various occupational classes. Furthermore the information is not obtainable from PERSAL.
7. 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 is only be available from the 2006/07 financial year.
8. 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.
9. The indicators regarding pharmacists confirm the shortage of this category of personnel in the Province.
10. Attrition rate for doctors (Indicator 8) and professional nurses (Indicator 9) excludes with effect from 2007/08 terminations on contract. If the latter is included it inflates the attrition figure which does not reflect the true situation.

PROGRAMME 2: DISTRICT HEALTH SERVICES

1. PROGRAMME DESCRIPTION

District health Services provide primary health care (PHC) services and district hospital services including preventive, promotive, curative and rehabilitation services. 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 and administration of services, managing personnel and financial administration and co-ordinating and the management of the Day Hospital Organisation and Community Health Services rendered by Local Authorities and Non-Governmental Organisations within the Metro and determining working methods and procedures and exercising district control.

Sub-programme 2.2 Community health clinics

Rendering a nurse-driven primary health service at clinic level including 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, psychiatry, speech therapy, communicable diseases, mental health, etc.

Sub-programme 2.4 Community-based services

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

Sub-programme 2.5 Other community services

Rendering environmental and port health services, etc.

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 which 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 a hospital service at district level.

Sub-programme 2.10 Global Fund

Strengthening and expanding the HIV and AIDS care, prevention and treatment programmes.

3. DISTRICT HEALTH SERVICES

3.1 SITUATION ANALYSIS

3.1.1 Demographic profile

The Western Cape is estimated to have a population of 5 278 585 according to the Community Survey 2007 and comprises approximately 10% of the population of South Africa. Females make up 49.8% of the population and males 50.2%. Ten per cent of this population are younger than five, 37% are younger than 20, and 57% are between 20 and 64.

The province has six districts namely, Cape Town Metro District, Cape Winelands, Westcoast, Overberg, Eden and Central Karoo. The majority of the population (64%) live in the Metro, which constitutes only 2% of the province's surface area. Table 2.1 below shows the population distribution in the province. About 73% of the population of the province are uninsured and thus dependent on the Public Health Sector.

Table 2.1: Population distribution for the Western Cape

District	% of population
Cape Town Metro	64%
Cape Winelands	14%
Westcoast	6%
Overberg	5%
Eden	10%
Central Karoo	1%
Provincial Total	100%

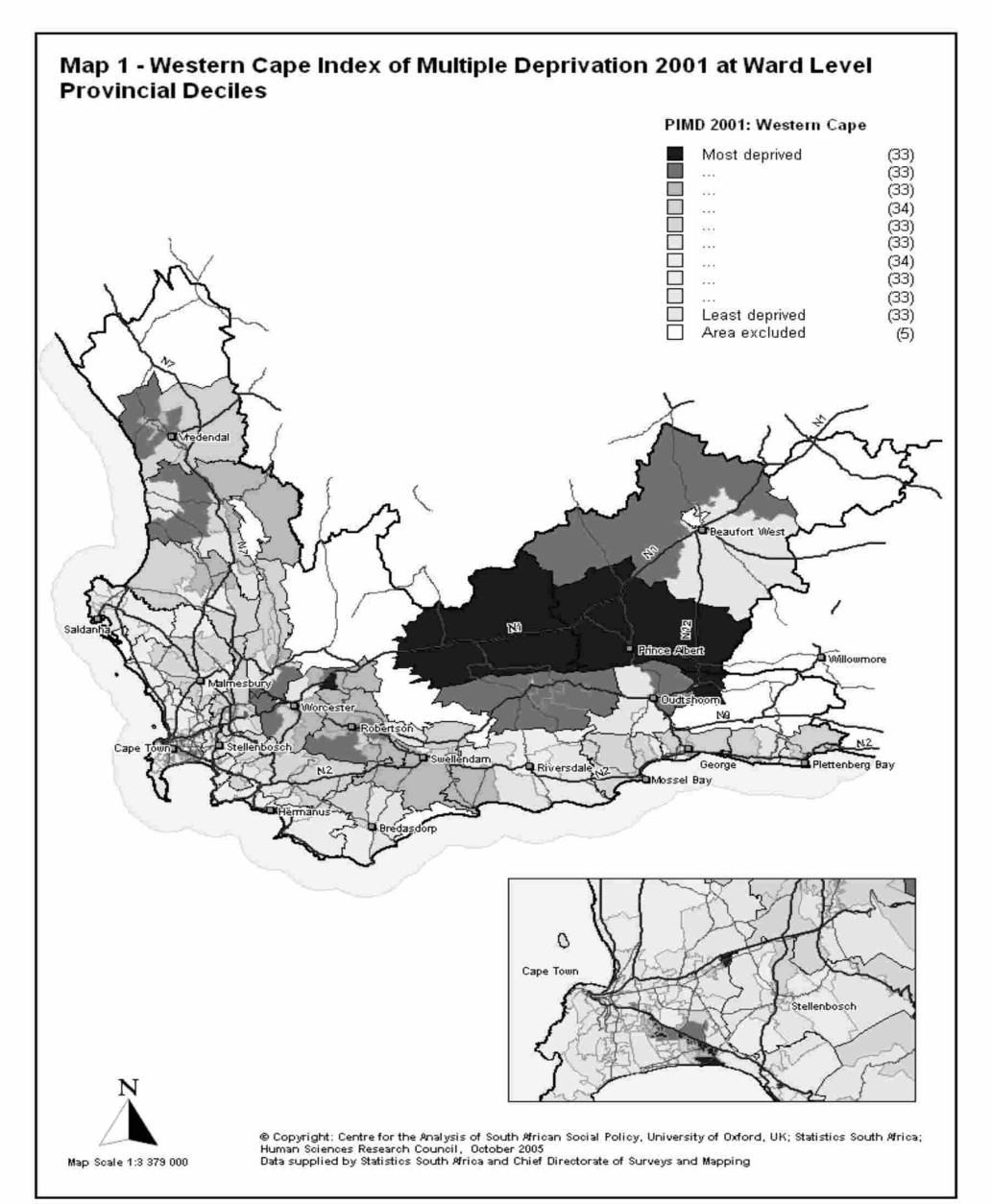
Source: Directorate: Information Management, Western Cape Department of Health

In 2001, STATS SA, the University of Oxford and the Human Science Research Council (HSRC) developed provincial indices for multiple deprivations where wards were rated according to five domains of deprivation namely: Income and material deprivation, employment deprivation, health deprivation, education deprivation, and living environment deprivation.

Figure 2.1 below shows that the most deprived wards in the Western Cape are within the City of Cape Town municipality particularly the townships on the Cape Flats alongside the N2 as well as the wards in the Little Karoo. It must, however, be noted that even though the Karoo has the largest geographical area of multiple deprivation it has a relatively small population compared to the City of Cape Town. As shown in Table 2.1 above Central Karoo comprises 1% of the population versus 64% of the Metro. Therefore the Metro not only has the largest population in the province, it also has the highest concentration of multiple deprivation.

The provincial indices of multiple deprivation report further reports that about half of the 50 most deprived wards in the Western Cape are in the most deprived on four or more domains named above.

Figure 2.1: Map illustrating the Western Cape index of multiple deprivation



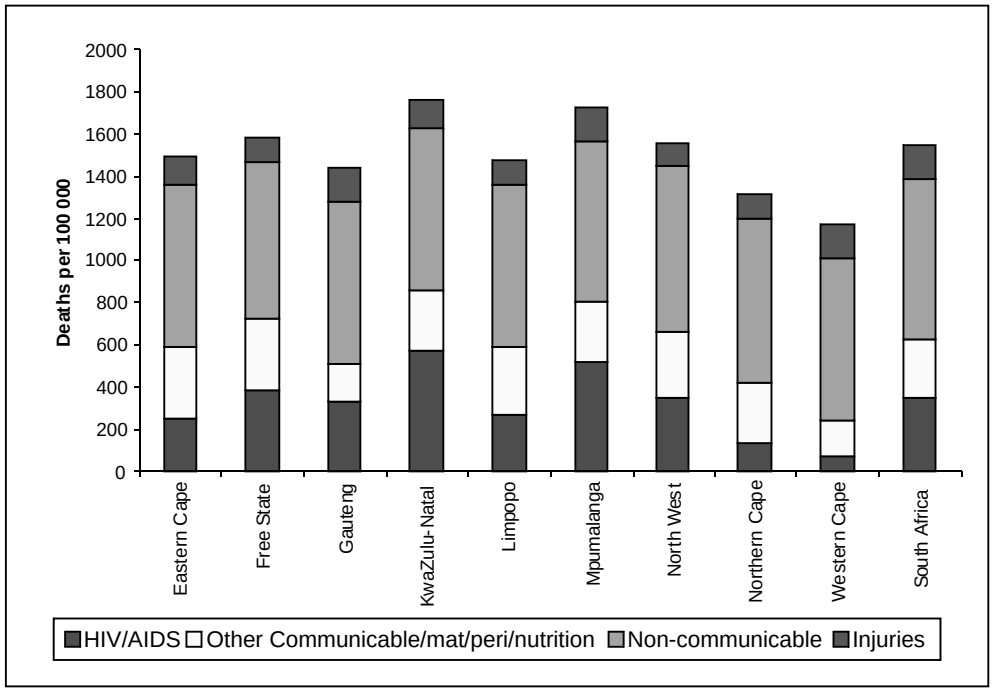
SOURCE: Provincial Indices of Multiple of Deprivation[1]

[1]Noble, M., Babita, M., Barnes, H., Dibben, C., Magasela, W., Noble, S., Ntshongwana, P., Phillips, H., Rama, S., Roberts, B., Wright, G. and Zungu, S. (2006) *The Provincial Indices of Multiple Deprivation for South Africa 2001*, University of Oxford, UK.

3.1.2 Epidemiological profile

Figure 2.2 below, shows that the Western Cape has the lowest burden of disease in the country, particularly with regard to HIV and AIDS and other communicable diseases/maternal causes of death/perinatal cause of death/nutritional causes of death. As a result of its demographic transition, the Western Cape suffers disproportionately more from chronic diseases particularly ischaemic heart disease and strokes. Injuries from intentional and unintentional injuries including road traffic injuries are also a significant component of the burden of disease.

Figure 2.2: Distribution of Burden of disease by Province

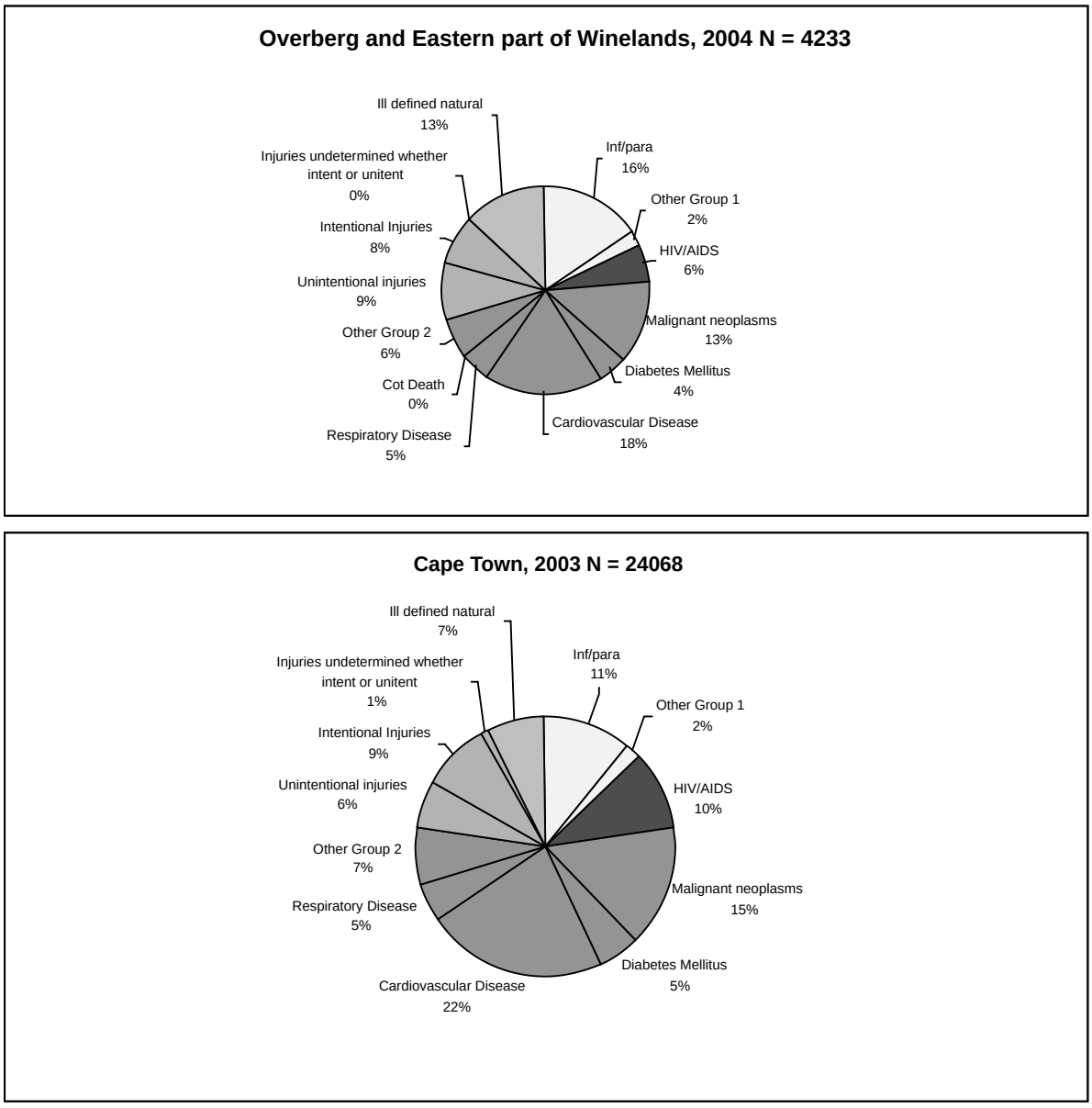


Source: Bradshaw, D., Nannan, N., Laubscher, R.,Groenewald, P., Joubert, J.,Nojilana, B.et al..2004.

Within the province, mortality surveillance has been institutionalised in the Boland Overberg and the City of Cape Town. The data show that just as the burden of disease is disproportionately distributed in the country, it is also disproportionately distributed between the districts and even more so between the sub-districts in the districts.

Considering deaths for Overberg and the Eastern part of Cape Winelands (shown as Boland Overberg in Figure 2.3) and the City of Cape Town shown in Figure 2.3 below, the Overberg and the Eastern part of Cape Winelands have more pronounced communicable diseases (18% compared to 13%) a large proportion of which is due TB the leading cause of death in the Overberg and the Eastern part of Cape Winelands; lower burden of HIV (6% compared to 10%) and similar proportion of injuries. The use of firearms is very limited in the Overberg and the Eastern part of Cape Winelands and homicide rates amongst females are almost double those experienced in Cape Town.

Figure 2.3: Burden of Disease for Overberg and the Eastern part of Cape Winelands and City Cape Town

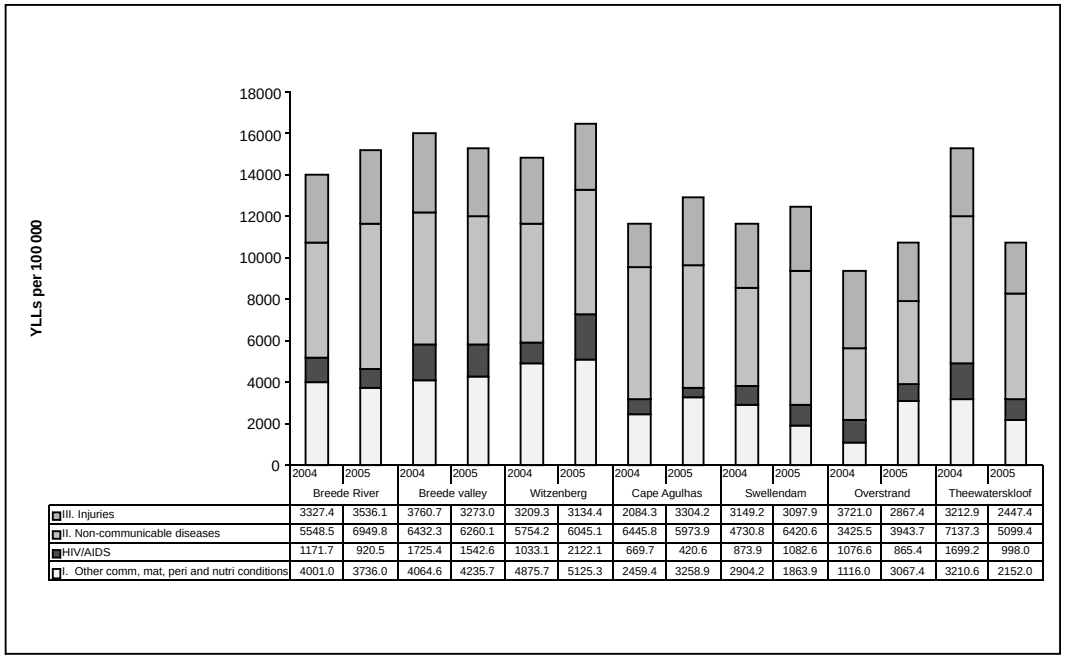


SOURCE: PGWC BOD Project using data from City of Cape Town and Boland/Overberg mortality data, 2007

Within the districts there is a disproportionate distribution of the burden of disease. Often the areas of high multiple deprivation suffer the most from the burden of disease. In the City of Cape Town Khayelitsha and Nyanga have by far the highest burden in the Metro. Similarly they have been shown not only to suffer from diseases of transition such as HIV and AIDS and other communicable disease especially TB and injuries, but they also suffer significantly from non-communicable diseases particularly ischaemic heart disease, diseases of lifestyle. This burden is described as the quadruple burden of disease.

Similarly. as shown in Figure 2.4 below, Overberg and the Eastern part of Cape Winelands also shows a disproportionate distribution of the burden of disease among the sub-districts. Witzenberg, Breede Valley and Breede River have the highest burden of the quadruple burden described above for Cape Town. Witzenberg between 2004 and 2005 shows very significant increase in mortality due to HIV and AIDS and TB.

Figure 2.4: YLLs per 100 000 by cause group and HIV/AIDS for Boland Overberg Region and by sub-districts, 2004 and 2005



	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
	Breede River		Breede valley		Witzenberg		Cape Agulhas		Swellendam		Overstrand		Theewaterskloof	
III. Injuries	3327.4	3536.1	3760.7	3273.0	3209.3	3134.4	2084.3	3304.2	3149.2	3097.9	3721.0	2867.4	3212.9	2447.4
II. Non-communicable diseases	5548.5	6949.8	6432.3	6260.1	5754.2	6045.1	6445.8	5973.9	4730.8	6420.6	3425.5	3943.7	7137.3	5099.4
HIV/AIDS	1171.7	920.5	1725.4	1542.6	1033.1	2122.1	669.7	420.6	873.9	1082.6	1076.6	865.4	1699.2	998.0
I. Other comm, mat, peri and nutri conditions	4001.0	3736.0	4064.6	4235.7	4875.7	5125.3	2459.4	3258.9	2904.2	1863.9	1116.0	3067.4	3210.6	2152.0

SOURCE: Groenewald et al, 2007[3]

There are differences in the burden of disease between the sexes. In Cape Town the top three leading causes of premature death in women are HIV and AIDS, TB and diabetes. In men they are homicide, HIV and AIDS and TB. In the Boland the top three causes of premature death in women are HIV and AIDS TB, and lower respiratory tract infections, while for men, they are TB, homicide and HIV and AIDS

3.1.3 Services within the District Health system

3.1.3.1 Management and governance

In line with the National Health Act (No 61 of 2003) and the Healthcare 2010 strategy, the implementation of the District Health System is a key vehicle for delivering PHC and district hospital services. One of the key successes in the implementation of the DHS within 2007/08 was the finalisation of the assumption of responsibility for PPHC in the rural districts. The Department took over 150 more staff from the municipalities than the expected 450. The integration of municipal staff into the PGWC has facilitated more effective management of the DHS and accelerated the setting up of interim sub district management structures. All districts have managers fully responsible for the management of all services provided in the DHS. Management requires support systems such as information systems in order to monitor service performance and to use the information for decision-making. The Department has exceeded its target of facilities with access to the provincial intranet.

Groenewald P, Bradshaw D, Van Niekerk M, Jefferies D, & van der Merwe W (2007) *Western Cape Province Mortality. Report on cause of death and premature mortality in the Boland-Overberg Region 2004-2005.* Western Cape Department Of Health Burden of Disease Project.
Ibid.

3.1.3.2 **Primary Health Care Services**

The six districts in the Western Cape have 138 non-fixed clinics, 233 fixed clinics and 57 Community Day/Health Centres.

All sub-districts offer a full package of PHC services. In 2006/07 the province spent R273 per uninsured person on PPHC; this is an increase of 14% from 2005/06. This large increase could be attributed to the assumption of responsibility for PPHC services in the rural areas. There has also been an additional 13% (R142 million) of the total funding spent on PPHC services provided by the Metro

In 2006/07 there were 40.3 professional nurses per 100 000 uninsured in the province. This was a decrease from 2005/06 due to the challenges of staff recruitment and retention. However, the Department projects that the rate of 40.3 will be maintained for 2007/08.

The usage rate of PHC services has remained constant since 2005/06. The actual PHC headcounts, however, appear to have decreased over the last three years. The largest decrease has been in the Metro district with the largest decrease (8%) being in the City of Cape Town and 3% in the Metro District Health Services. The City of Cape Town has had a serious drive to establish an electronic patient recording system, which has systematically improved data management at a facility level. This improvement has resulted in a reduction of double counting and better quantification of facility statistics. Community-based services have also contributed to a decrease in the PHC headcount. Over 17 000 clients were seen in their homes in 2006/07. The quality of the data remains one of the key challenges which is being addressed with the roll out of Information Officers at a sub district level and strengthening of data management processes and procedures. In 2007/08 the Department projects that the headcount will increase by approximately 5% to about 12.8 million.

In 2008/9 the quality of services at district hospitals and primary level will be significantly strengthened by the employment of additional family physicians. The registration of family medicine as a speciality by the Health Professions Council heralds an exciting new era in the training of family physicians. In 2008 the first intake of 20 family medicine registrars will take place. Family physicians will increasingly perform a critical role in improving access to quality health care at health facilities.

Access to emergency care is a constitutional right and it is imperative that trauma and emergency services are strengthened at all levels of care in the public health system. All Community Health Centres with 24-hour emergency centres have implemented the uniform South African Triage System (SATS) to improve access to high quality emergency care.

3.1.3.3 District Hospital Services

The Western Cape has 35 district hospitals including the Khayelitsha and Mitchell's Plain district hospital hubs based at Tygerberg and Lentegeur hospitals, respectively. Most sub-districts have at least one district hospital. In the case of Khayelitsha and Mitchell's Plain planning is in progress to build district hospitals. The re-classification of three Metro regional hospitals into district hospitals has increased the level 1 beds in the Province from 1 541 to 2 113 beds which is progress towards the Comprehensive Service Plan (CSP) target of 2 460.

As far as management and governance for district hospitals is concerned, all the district hospitals have a community participation structure in the form of facility boards. Most (90%) of the district hospitals have full-time chief executive officers (CEOs). Two hospitals in the Overberg have part-time CEOs and the hub of Mitchell's Plain District hospital has an acting CEO. Hospital expenditure per uninsured has increased significantly (52%) from R87.01/uninsured in 2005/06 to R133/uninsured in 2006/07 and this is projected to increase even further in 2007/08 in line with the transformation of the hospital platform.

The case fatality rate for district hospitals increased to 0,79% in 2006/07 but this remains lower than the national target of 1,3% for district hospitals. To address this, the Department has employed family physicians/chief medical officers responsible for clinical governance at district hospitals.

Mental health services at district hospitals

Recent analysis of the Stress and Health Survey (SASH), South Africa's first psychiatric disorder prevalence household survey, found that the annual prevalence of common psychiatric illnesses in the Western Cape is 22.4%. Furthermore, of those people found to have a diagnosable mental disorder in South Africa, only 5.6% accessed a mental health professional, and only 19% consulted any health professional (SASH 2007). Ongoing surveillance of mental illness is difficult to ascertain because of the lack of routinely collected morbidity data; in this instance, homicide, road-traffic accident and suicide rates only provide an indication of the extent of mental illness in the Province (suicides alone are a very poor proxy measure).

At a global level, five of the ten leading causes of disability are psychiatric conditions (WH0, 2004). In South Africa, neuro-psychiatric disorders account for the second highest proportion of the local burden of disease after HIV and AIDS (Bradshaw, 2003).

This calculation excludes the burden of risk-taking behaviour associated with mental disorders. For example, mental illness results in higher risks of injuries, cardio-vascular disorders and HIV thereby contributing significantly to the Burden of Disease in South Africa (Herman & Jané-Llopis, 2005).

Mental health services have historically been provided at psychiatric hospitals, but the promulgation of the Mental Health Care Act (2002) in December 2004, has resulted in the increased integration of mental health at all levels of care. District and regional hospitals have now been mandated to provide mental health services in terms of its scope of practice. Currently acute mental health services are provided at district hospitals without the appropriate infrastructure.

3.1.3.4 **Community-based services**

There are five types of care facilities for community-based services i.e. sub-acute care, palliative care, chronic care, community mental health care and integrated home-based care facilities:

1) **Sub-acute care facilities** provide care for patients who are fairly ill, but do not necessarily need to be in an acute hospital bed. The average length of stay at these centres is six weeks. There are currently two funded organisations running sub-acute care facilities in the province, i.e. Booth Memorial Hospital with 84 adult beds and Sarah Fox Convalescent Home with 60 paediatric beds.
2) **Respite care facilities** provide care to terminally ill or chronically ill patients for a relief period. The average length of stay is two weeks; there are currently 18 funded palliative care facilities in the province. There are 10 facilities in Metro with a total of 129 adult and 38 paediatric beds, two in the Southern Cape/Karoo with a total of 36 adult beds, three in the Boland/Overberg with a total of 36 adult beds, and three in the Westcoast/Winelands with a total of 30 adult beds. In total there are 269 beds for palliative care.
3) **Chronic or lifelong care facilities** provide care for long-term care patients who need to stay for longer than six months e.g. those with head injuries. There are currently two funded organisations running chronic/ lifelong care in the province, i.e. Lifecare with 280 adult beds and St Joseph Children's Home with 114 active paediatric beds out of a total of 125.
4) **Community mental health facilities** provide services to assist mental health clients to live more independently in the community. These facilities provide services to de-hospitalised mental health clients in order to prevent hospitalisation or placement in a more restrictive environment. The average length of stay varies from medium- to long- term. There are currently 1 481 clients in funded community mental health services; 395 in Type 1 Group Homes and 243 in Type 3 group homes needing 24-hour care, and 843 in day care programmes**.**
5) **Integrated Community Home-based Care Services** are provided to clients in their homes/communities. Integrated home-based care has three service delivery streams: home-based care, community adherence support and prevention. There are currently 79 NPOs funded for home-based care**,** which received an allocation of R16.9million from the European Union and R12million from the Expanded Public Works Programme (EPWP).

Since the non-governmental sector provides community-based services, the Department has developed positive partnerships with non-profit organisations (NPO). It has facilitated the strengthening of their infrastructure and management processes and systems through training and capacity development through community based service summits where sharing of best practice is facilitated. The Department has developed a NPO database, better guidelines for NPO funding and monitoring and evaluation to ensure maintenance of high service quality.

The EPWP is a national programme designed to provide productive employment opportunities for a significant number of the unemployed. It offers opportunities not only to earn an income but for the unemployed to gain skills which will increase their employability. The Department, as one of the Social Sector departments, has identified projects, which include one for community-based ancillary health workers, i.e. community-based care workers, IMCI workers, TB DOTS workers, ARV counsellors and VCT counsellors. These workers are being upskilled through the programme to become ancillary health workers in the first phase, leading on to the possibility of becoming community health workers. The training is co-ordinated by Programme 6, Health Sciences and Training, but the operational issues are dealt with by community-based services.

Through the Expanded Public Works Programme, the Department started training 1 063 carers on NQF Level 1 in 2006/07 about 1 009 of these will complete the training at the end of 2007. An additional 420 learners enrolled for NQF 1 and 490 at the beginning of 2007. Of the 1 009 learners who complete NQF, 1 490 will advance to NQF 2. This programme will provide an adequate number of quality service providers who can provide community-based services. As part of building human capital, this programme also offers carers, who would otherwise not have had the opportunity to do so, to develop a career path into nursing. The Department, however, faces the challenge of not having an adequate number of accredited training providers. There are currently only four accredited service providers that can provide the required training thus restricting the number of carers that can be trained at any one time.

Community-based services coordinators have been employed on the provincial staff establishment at district and sub-district level to coordinate services within the District Health System.

Community-based services are recognised in the CSP as key to relieving the pressure on the facility-based services within the acute hospital and Primary Health Care platforms. However, the Department has to meet the challenge of improving the measurement of service needs so that this platform can fulfil its mandate. In this regard Cape Mental Health was commissioned to estimate the expected client numbers per sub-district and to look at the human resource needs for community mental health services. The costing for this service platform has also been undertaken and will be used to plan and fund the services more appropriately. A service plan for sub-acute services has also been developed and costed.

3.1.3.5 **Chronic Disease Management (CDM) System:**

Chronic diseases present a major burden on all the people of the Western Cape. Approximately 10% of people die prematurely from cardiovascular diseases in the province. The management of chronic diseases places a significant burden on the health system. The main reason is that these patients require regular visits to health facilities for monitoring and treatment. Thus the Department is committed to meeting the critical challenge of implementing a system to manage chronic diseases appropriately so it can offer improved services to CDM clients.

The Department has undertaken a rapid assessment of the current management of chronic diseases. Health worker practice, client support systems, organisational systems and health promotion were investigated. This assessment has been used to develop a coherent strategy to manage chronic diseases. The management of the following chronic diseases has been prioritised: chronic lung disease especially asthma, diabetes, hypertension, cardiovascular diseases, epilepsy, mental health. The Chronic Disease Management Strategy should be available for distribution by early in 2008.

This strategy could build on initiatives that have already been implemented. One of the initiatives instituted is the Chronic Dispensing Unit (CDU), which is an alternative way of providing pre-packaged medicines for patients with chronic diseases. This is aimed at decreasing waiting times for monthly medication collection.

Family physicians have been employed within the district health system to oversee clinical governance and ensure good quality care to clients and in particular those with chronic diseases.

The primary health care information system (PHCIS) is being used in pilot sites to improve the management of appointment systems. In the medium- to long-term this system will also be used to support clinical governance initiatives through the individual electronic clinical record management module. This should improve the ability to undertake initiatives such as clinical audits.

On the community-based services platform, chronic diseases support groups have been initiated and will be expanded in 2008/09. This initiative is aimed at standardising the different models used by support groups that are providing services for the different chronic diseases, including HIV and AIDS and TB.

Table 2.2 District health service facilities by health district [DHS1]

Health district	Facility type	No.	Population (Uninsured) 2006/07	Population per fixed PHC facility	Per capita utilisation[1]
WEST COAST	Non-fixed clinics[2]	37	256 025	9 482	3.28
	Fixed clinics	27			
	CHCs	0			
	Sub-total clinics + CHCs	**64**			
	District hospitals	**7**			
CAPE WINELANDS	Non-fixed clinics[2]	30	583 169	10 414	4.39
	Fixed clinics	52			
	CHCs	4			
	Sub-total clinics + CHCs	**86**			
	District hospitals	**4**			
OVERBERG	Non-fixed clinics[2]	14	189 383	7 284	2.92
	Fixed clinics	25			
	CHCs	1			
	Sub-total clinics + CHCs	**40**			
	District hospitals	**4**			
EDEN	Non-fixed clinics[2]	25	424 406	8 162	3.39
	Fixed clinics	47			
	CHCs	5			
	Sub-total clinics + CHCs	**77**			
	District hospitals	**6**			
CENTRAL KAROO (Rural development node)	Non-fixed clinics[2]	8	59 050	4 921	4.20
	Fixed clinics	11			
	CHCs	1			
	Sub-total clinics + CHCs	**20**			
	District hospitals	**4**			
METROPOLE	Non-fixed clinics[2]	24	2 424 696	20 724	3.05
	Fixed clinics	71			
	CHCs	46			
	Sub-total clinics + CHCs	**141**			
	District hospitals	**6**			
PROVINCE	Non-fixed clinics[2]	138	3 936 729	13 575	3.31
	Fixed clinics	233			
	CHCs	57			
	Sub-total clinics + CHCs	**428**			
	District hospitals	**31**			

Notes:

1. Per capital utilisation = PHC headcount + district hospital separations and district hospital OPD
2. Non-fixed clinics = satellites + mobiles

Table 2.3: Personnel in district health services by health district [DHS2]

Health district	Personnel category	Posts filled	Posts approved	Vacancy rate (%)	Total Personnel (incl. LG)	Number of post per 1000 uninsured people	Uninsured Population 2006/07
West Coast	**PHC facilities**						256 025
	Medical officers	2	7	71.4%	2	0.008	
	Professional nurses	107	137	21.9%	107	0.418	
	Pharmacists	2	7	71.4%	2	0.008	
	Community health workers	Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment	
	District hospitals						
	Medical officers	56	68	17.6%	56	0.219	
	Professional nurses	111	131	15.3%	111	0.434	
	Pharmacists	17	23	26.1%	17	0.066	
Cape Winelands	**PHC facilities**						583 169
	Medical officers	18	21	14.3%	18	0.031	
	Professional nurses	321	383	16.2%	321	0.550	
	Pharmacists	15	18	16.7%	15	0.026	
	Community health workers	Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment	
	District hospitals						
	Medical officers	19	23	17.4%	19	0.033	
	Professional nurses	150	170	11.8%	150	0.257	
	Pharmacists	6	8	25.0%	6	0.010	
Overberg	**PHC facilities**						189 383
	Medical officers	7	7	0.0%	7	0.037	
	Professional nurses	83	83	0.0%	83	0.438	
	Pharmacists	7	7	0.0%	7	0.037	
	Community health workers	Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment	
	District hospitals						
	Medical officers	13	13	0.0%	13	0.069	
	Professional nurses	63	64	1.6%	63	0.333	
	Pharmacists	3	4	25.0%	3	0.016	
Eden	**PHC facilities**						424 406
	Medical officers	17	19	10.5%	17	0.040	
	Professional nurses	156	298	47.7%	156	0.368	
	Pharmacists	11	13	15.4%	11	0.026	
	Community health workers	Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment	
	District hospitals						
	Medical officers	25	26	3.8%	25	0.059	
	Professional nurses	134	286	53.1%	134	0.316	
	Pharmacists	8	9	11.1%	8	0.019	
Central Karoo	**PHC facilities**						59 050
	Medical officers	4	7	42.9%	4	0.068	
	Professional nurses	29	71	59.2%	29	0.491	
	Pharmacists	2	3	33.3%	2	0.034	
	Community health workers	Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment	
	District hospitals						
	Medical officers	4	4	0.0%	4	0.068	
	Professional nurses	36	78	53.8%	36	0.610	
	Pharmacists	2	3	33.3%	2	0.034	
Metropole	**PHC facilities**						2 424 696
	Medical officers	160	218	26.6%	176	0.073	
	Professional nurses	605	790	23.4%	906	0.374	
	Pharmacists	86	109	21.1%	94	0.039	
	Community health workers	Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment	
	District hospitals						
	Medical officers	137	155	11.6%	137	0.057	
	Professional nurses	250	445	43.8%	250	0.103	
	Pharmacists	16	21	23.8%	16	0.007	
Province	**PHC facilities**						3 936 729
	Medical officers	208	279	25.4%	224	0.057	
	Professional nurses	1301	1762	26.2%	1602	0.407	
	Pharmacists	123	157	21.7%	131	0.033	
	Community health workers	Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment	
	District hospitals						
	Medical officers	254	289	12.1%	254	0.065	
	Professional nurses	744	1174	36.6%	744	0.189	
	Pharmacists	52	68	23.5%	52	0.013	

Table 2.4: Situation analysis indicators for district health services [DHS3]

Sub-programmes 2.1 - 2.3 Strategic goal: In line with Comprehensive Service Plan targets transform the District Health System (DHS) in order to ensure the delivery of the full package of good quality DHS services in all the districts of the Western Cape													
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Province wide value 2004/05**	**Province wide value 2005/06**	**Province wide value 2006/07**	**Metro District 2006/07**	**Cape Winelands District 2006/07**	**Overberg District 2006/07**	**Eden District 2006/07**	**Central Karoo District 2006/07**	**West Coast District 2006/07**	**National target 2003/04**
Allocate sufficient resources for the provision of the full package of PHC services.	Allocate sufficient funds per uninsured person to sustain an average utilisation rate of 3.87 per annum.	1	Provincial PHC expenditure per uninsured person	R235	R272	R259	R276	R148	R252	R281	R376	R500	
		2	Total PHC headcount per annum	13 843 759	13 068 303	12 180 933	7 072 785	2 418 150	485 787	1 271 629	232 033	700 548	
		3	PHC utilisation rate (per uninsured person)	4.00	3.71	3.09	2.92	4.15	2.57	3.00	3.93	2.74	
		4	PHC utilisation rate per capita (total population)	2.98	2.77	2.31	2.07	3.32	2.13	2.43	3.5	2.22	2.3
		5	PHC utilisation rate – under 5 years (uninsured person)	5.5	5.2	4.8	4.6	4.7	5.5	6	6.8	5.5	3.8
		6	Percentage of sub-districts offering the full package of PHC services	65%	80%	100%	100%	100%	100%	100%	100%	100%	60%
	Ensure the efficient and quality delivery of the full package of PHC services.	7	Percentage fixed PHC facilities supported by a doctor at least once a week	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	31%
		8	Supervision rate	58.81%	73.34%	71.76%	74.85%	58.63%	59.31%	59.32%	60.67%	23.27%	78%
		9	Expenditure per PHC headcount - Province	R59	R73	R84	R75	R42	R62	R60	R61	R108	R99

The above Strategic goal covers Sub Programmes 2.1, 2.2 and 2.3

Table 2. 5: Situation analysis indicators for district hospitals sub-programme [DHS4]

Strategic goal: To render the full package of district hospital services in all the districts of the Western Cape

Strategic Objectives	Measurable objectives		Measure / Indicator	Province wide value 2004/05	Province wide value 2005/06	Province wide value 2006/07	Metro District 2006/07	Cape Winelands District 2006/07	Overberg District 2006/07	Eden District 2006/07	Central Karoo District 2006/07	West Coast District 2006/07	National target 2003/04
Provide sufficient capacity to render quality in-patient and out-patient services in district hospitals.	Provide sufficient theatre capacity and resources at district hospitals to perform caesarean sections at a rate of between 10 and15%.	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	8.2%	10.7%	14.3%	8.4%	18.2%	19.4%	16.6%	17.8%	15.4%	12.5%
	Provide sufficient resources for the rendering of out patient services at a target rate of one out patient per in-patient day by 2010.	2	Patient Day Equivalents (number of PDEs)	725 693	643 244	661 655	158 390	51 983	78 102	188 420	47 289	137 471	
		3	OPD Total headcount (number of OPD headcount + Trauma/emergency/casualty)	692 941	712 166	695 108	289 028	126 010	46 574	126 010	5 049	102 437	
	Implement quality assurance measures to minimise patient risk in district hospitals.	4	Patient satisfaction survey using DoH template (percentage of district hospitals)	100%	46%	35.7%	100%	75%	0	50%	50%	19%	10%
		5	Mortality and Morbidity meetings every month (percentage of district hospitals)	100%	45%	21.40%	100%	33%	25%	50%	0	0	36%
		6	Clinical audit meetings every month (percentage of district hospitals)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	
		7	Complaints resolved within 25 days (percentage = total complaints resolved in district hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	
		8	Case fatality rate in district hospitals for surgery separations (total surgery fatalities/total operations*100)	0.62%	0.70%	0.79%	0.60%	1.10%	0.60%	0.20%	0.20%	0.40%	3.9%
Ensure the effective and efficient rendering of sustainable district hospital services.	Manage bed utilisation to achieve an average length of stay of approximately 3 days and a bed occupancy rate of 85% in district hospitals.	9	Average length of stay	2.5	2.8	2.8	2.8	2.7	3.3	2.9	3.2	2.4	4.2
		10	Bed use rate (based on usable beds)	76.00%	71.00%	71.70%	50.80%	85.80%	64.40%	85.20%	**73.00%**	67.30%	68%
		11	Separations – Total	195 150	142 054	144 373	21 784	16 279	20 063	39 071	10 946	36 231	
	Ensure the cost effective management of district hospitals at a target expenditure of approximately R900 per PDE by 2010.	12	Expenditure per patient day equivalent[1]	R576	R674	R690	R573	R770	R527	R586	R546	R806	814 in 2003/04 prices

Note:

1. 2006/07 prices

3.2. POLICIES, PRIORITIES AND STRATEGIC GOALS

3.2.1 Programme 2 functions within a national, provincial and divisional strategic framework as illustrated in Table 2.6 below.

Table 2.6: Policy and strategic framework

National	The Constitution National Health Act Public Finance Management Act Medium Term Strategic Framework National Spatial Development Framework Accelerated Shared Growth Initiative of South Africa Strategic Priorities for the National Health System (2004 – 09)
Provincial	IKapa elihlumayo (PGDS) Healthcare 2010 Comprehensive Service Plan
Divisional	**EIGHT DIVISIONAL PRIORITIES:** **Implementation of the DHS:** 1) Strengthening the district health system 2) Community-based services 3) District hospitals 4) Chronic disease management **Priority Health Programmes** 5) TB 6) HIV and AIDS 7) Women's health 8) Child health

The Department functions within the broader national and provincial policy context that is outlined in Table 2.6 above. Of particular importance are the National Health Act (No 61 of 2003) and the Strategic Priorities for the National Health System (20042009) which detail what the mandate of the Department is with regard to service provision and strategic programme priorities and the Provincial Growth and Development Strategy (PGDS) of the Provincial Government which recognises the upstream risk factors (or the so called social determinants of the Burden of Disease) as a key developmental issue for the Provincial Government as a whole and not only for the Department of Health though the Department is recognised as a key driver in addressing the issue. The PGDS further mandates the Department to implement its Healthcare 2010 strategy in order to contribute to the objective of "promoting liveable communities that foster and nurture the well-being of all residents".

The implementation of Healthcare 2010 requires the development of four interrelated plans. These are the Comprehensive Service Plan (CSP), approved for implementation in May 2007, the Human Resource Plan, the Infrastructure and Technology Plan and the Finance Plan.

The CSP has been completed and details the service model for district health services (DHS), acute hospitals (Level 1, 2 and 3), specialised hospitals (TB, rehabilitation and psychiatric services), emergency medical services (EMS) and forensic pathology services

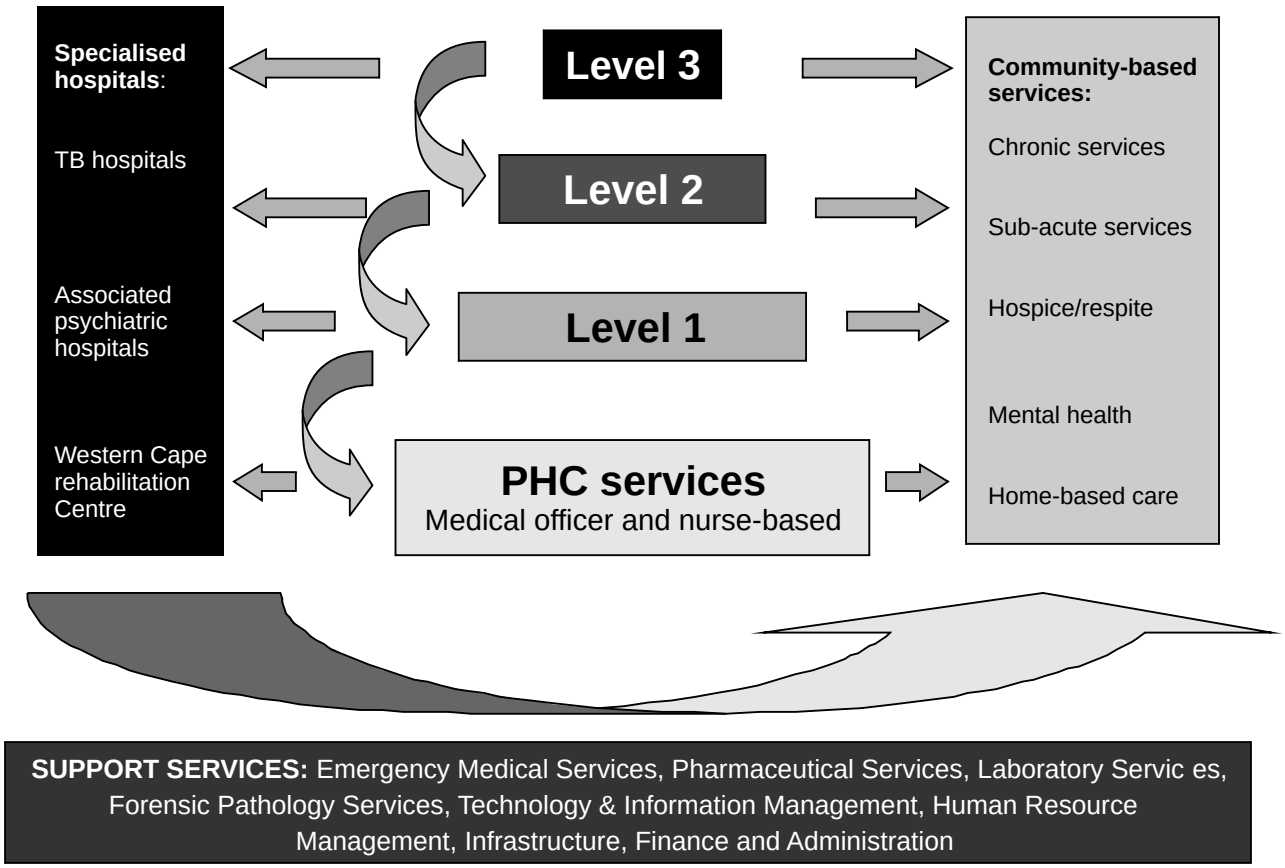
The development of these services is based on the following key principles:

1) Quality of care at all levels
2) Accessibility of care
3) Efficiency
4) Cost effectiveness
5) PHC approach
6) Collaboration between all levels of care
7) Reduction of chronic institutional care.

The cost modelling done in 2001 when the Healthcare 2010 strategy was developed states that the Department could expect to overspend by R1,1 billion (in 2001 Rands) by 2010 if the status quo of service delivery were maintained. However, if the fundamental Healthcare 2010 strategy of providing the appropriate care to the appropriate patient managed at the right level of care, with the right skills at the right cost (with 90% of first contacts managed within the District Health System, 8% within level 2 and 2% within level 3 services) were implemented, there would be a R500 million saving. Even so, the Department would still be R500 million short by 2010.

The Department therefore has to meet the critical challenge of transforming the health service. In many cases, services are under pressure because inappropriate services are being provided. For example, patients are inappropriately treated in acute beds instead of sub-acute beds which are more cost effective. Figure 2.5 below illustrates the conceptual framework. Service transformation is based where patients are managed at the appropriate levels, including diversion to lower levels of care or specialised services or community-based services. Support services play an important role in the realisation of these ideals e.g. Emergency medical services need to transport patients directly to the appropriate level of care depending on clinical protocols instead of taking them to the nearest service point.

Figure 2.5: Conceptual framework for service transformation



In addition to articulating the service formulation within the DHS, the CSP describes the structure and functions of the district and sub-district management structures and facility management. These district, sub-district and facility management structures will strengthen district-based planning, monitoring and evaluation and improve functional integration within the Integrated Development Planning Framework where inter-sectoral planning, monitoring and evaluation is a critical means of realising the set of developmental goals and objectives and addressing the key upstream drivers of the burden of disease such as inadequate housing, poverty, unavailability of basic services such as sanitation, water etc.

In that regard, by the end of 2007/08 the Department appointed district managers at director level for Central Karoo, located in Beaufort West, and Cape Winelands, based in Worcester. Eden has a manager based in George, West Coast a manager based in Malmesbury and Overberg a manager based in Caledon. This will mean that every district in the province will have a dedicated district manager.

Sixty five per cent of the population in the province resides in the Metro. As a result, the Metro district has a chief director who employs an additional four directors to manage two sub-districts each in the form of sub-structure offices. These offices will be based in the following places:

1) Southern and Western sub-districts based in Retreat
2) Northern and Tygerberg sub-districts based in Bellville
3) Mitchell's Plain and Klipfontein sub-districts based in Mitchell's Plain
4) Khayelitsha and Eastern sub-districts based in Khayelitsha

3.2.1.1 **Community-based Services**

The implementation of this change in strategy will be based on an integrated approach to community-based services, which will include three broad NPO service delivery streams: de-hospitalised care, community adherence and prevention and promotion.

The Western Cape strategy of iKapa Elihlumayo and social capital formation focuses on building healthy communities through intensive collaboration between the public sector and civil society. Social capital is social cohesiveness, working towards (social action) improving health outcomes and in so doing improving the community climate for success. The support groups, the community-based workers, i.e. adherence supporters/ health promoters and the community-based workers employed via NPOs, and sub-district community participation structures such as health committees form social capital links to the Department.

Other policies applicable to community-based services:

- Mental Health Care Act 17 of 2002
- Implementation of national programmes for the control and management of chronic diseases, e.g. diabetes and hypertension
- Development and implementation of home based care
- National free health services for disabled persons.

3.2.1.2 **De-hospitalisation Services**

Eight of the eighteen facilities providing palliative care were initially funded by the Global Fund. As part of its exit strategy the Department has been taking over two facilities each year. For 2008/09 four rural palliative care facilities will still be funded by the Global Fund to the amount of R5.6m and the Department will fund the other fourteen facilities to the amount of R16m. The funding norm for palliative care for 2008/09 will be R250/bed/day, an increase from R235 per bed per day.

The Department will consolidate de-hospitalised services in current facilities and will also explore the use of some district hospital beds, which are currently under-used, for “de-hospitalisation” purposes in order to increase access to services particularly in areas with “high service pressures” or areas with limited access.

With the emergence of MDR/XDR, TB in-patient care has come under immense pressure. There is therefore a plan to decant TB in-patients who are inappropriately admitted to TB hospitals to the de-hospitalised platform. This will alleviate bed pressures for the admission of multi-drug resistant (MDR) and XDR patients.

3.2.1.3 **Community Mental Health**

A priority for 2008/09 is to ensure that mental health users who are inappropriately placed at acute psychiatric hospitals are transferred to more appropriate facilities. Two hundred users have been identified for transfer out of the psychiatric hospitals to de-hospitalised services to make space for acute patients.

In response to the above need for appropriate placement of clients and to alleviate the bed pressure at the psychiatric hospitals, the division is commissioning 89 sub-acute care beds; 49 at Stikland Hospital and 40 at William Slater. These will to be run by a consortium of NPOs, one with accommodation experience and one with psychosocial rehabilitation experience. This new model is different from group homes where patients stay for life. The length of stay at these facilities will be 6 - 12 months with a view of re-integrating the patients back into their families or into group homes. The estimated cost is R2 million per annum.

Training of home-based care NPOs in mental health is planned to start in early 2008. This will offer an integrated approach to home-based care and provide all users discharged from the various levels of care with access to home-based care services.

Support groups for mental health users will be initiated in line with the principles of the departmental strategy for chronic disease management. Community mental health services will thus be provided in Group Homes, Licensed Homes and Day Care Centres.

Wards 1 and 26 at Stikland will be used to consolidate the 24-hour care of licensed homes for people with profound and severe intellectual disability. The ex-Golden Girls Home and the ex-Durbanville Home children are already at Ward 1. Other clients from smaller organisations where the quality of care cannot be fully guaranteed will be brought to these wards. The aim is that this service will be run by an experienced NPO. The current running costs of wards 1 and 26 are similar to those already proposed, which is R3 375 per bed per month.

There will be a process to standardise and consolidate Department of Health and Department of Social Development and Poverty Alleviation funding of existing NPOs that serve intellectually-disabled clients.

3.2.1.4 **Home-based Care**

As part of implementing a comprehensive service package, NPOs will be required to provide the full package, which includes home nursing, community-integrated management of childhood illnesses, adherence management and disease prevention. In 2008/09, the current number of carers will be increased by 1 000 from 1 300 to 2 300. This will mean that there will be full equity in service provision and increased coverage of services for the province. This will translate into an increase from 13 000 to 23 000 in the number of clients seen. This expansion of home-based care services will address equity and the bulk of the increase will be in the Metro under-serviced areas.

An integrated community-based adherence model for all chronic diseases will be developed and implemented.

The EPWP programme will increase its funding to NPOs providing community-based services from R12 million in 2007/08 to R24 million in 2008/09. By contrast European Union funding will decrease from R16.9 million in 2007/08 to R14 million in 2008/09. The Department will, however, increase funding to community-based services as a whole from R120.955 million in 2007/08 to R132.227 million in 2008/09. This translates into a net increase of over R20 million.

3.2.2 Strategic Goals and Objectives

In order to fulfil the vision of Healthcare 2010, District Health Services have the following strategic goal and objectives:

3.2.2.1 Strategic Goals:

1) Transform the District Health System (DHS) In line with CSP targets in order to ensure the delivery of the full package of good quality DHS services in all the districts of the Western Cape.
2) Ensure easy access to district hospitals in all the districts of the Western Cape.
3) Implement a comprehensive community-based service package in all sub-districts of the Western Cape.
4) Improve chronic disease management.

3.2.2.2 Strategic objectives for District Health Services

The focus of the Department in 2008/09 will be the progressive and phased implementation of critical service reform activities as proposed in the CSP. The implementation of the CSP deliverables will be project managed by a detailed Key Events Schedule (KES).

The activities listed below will be the events listed in the KES.

1) Establish decentralised management capacity in all six districts.
2) Ensure the provision of accessible, good quality District Health Services.
3) Ensure the provision of good quality PHC services which are also efficient and accessible.

3.2.2.3 Strategic objectives for District Hospitals

The key CSP principle for the transformation of the acute hospital services is to treat the right patient right, with the right service providers at the right cost. Thus the greatest challenge in implementing this is the transformation of inappropriate level 3 beds to level 2 beds and inappropriate level 2 beds into level 1 beds. The Department has identified the beds to be transformed as the designated beds, and those that have been transformed in line with the CSP definition as the functional beds. In order to achieve the necessary transformation, the Department has the following strategic objectives for District Hospital Services:

1) Provide sufficient bed capacity to ensure accessibility of district hospital services.
2) Provide sufficient capacity to render quality in-patient and out-patient services in district hospitals.
3) Ensure the effective and efficient rendering of sustainable district hospital services.

In 2008/09 the increase in level 1 beds will largely be as a result of inappropriate level 2 beds being transformed in G.F Jooste, Helderberg, Karl Bremer, Victoria and New Somerset Hospitals and additional beds being provided in the hub of Khayelitsha and Mitchell's Plain District Hospitals.

There are particular service pressures in the Metro which require alleviation as a matter of urgency and if addressed will impact positively on the level 1 platform in particular. These are:

1) **Emergency (point of entry) care will be established** in Khayelitsha (Site B CHC) and Mitchells Plain (Lentegeur Hospital) sub-districts to relieve pressure on GF Jooste Hospital; and the construction of emergency units are planned for Eerste River and Karl Bremer Hospitals.
2) **Obstetrics and Neonatology:** There will be increased level 1 capacity at Mowbray Maternity Hospital. Furthermore, additional level 1 obstetric beds will be commissioned at the Khayelitsha District Hospital hub at Tygerberg Hospital to address acute service pressures in both the Metro West and East. All midwife obstetric units (MOUs) will be consolidated into the Metro DHS and there will also be an increased MOU capacity. Neonatal services will be expanded at the Mitchell's Plain District Hospital hub at Lentegeur Hospital and at the Karl Bremer Hospital Kangaroo Mother Care unit.
3) **Mental Health:** With the introduction of the Mental Health Care Act (2002) promulgated in December 2004, districts hospitals have had to meet the challenge of having acute mental health services fully implemented in an infrastructure which is not conducive to treating people who are behaviourally agitated, or disturbed. The plan is to create low secure areas and/or safe observation rooms to cater for users who require safe and secure environment because of their mental illness or medical condition. Mental health nurses will also be employed at identified priority hospitals.
4) **Surgery and anaesthetics:** An increase in level 1 surgical outputs to maximise theatre capacity will be accompanied by level 2 anaesthetic and surgical team outreach and support. There will be training in anaesthetics and surgery with set career paths for medical officers. Day surgery will also be investigated to relieve pressure on theatre time.

3.2.2.4 Strategic objectives for community-based services

1) Provide home-based care for prioritised clients in need of care.
2) Provide in-patient palliative care to prioritised clients in need of care.
3) Provide sub-acute care to prioritised clients in need of care.
4) Provide chronic care to prioritised clients in need of long term care.
5) Implement care and support programmes for people living with HIV and AIDS.

3.2.2.5 Strategic objectives for Chronic Disease Management Systems

1) Implement a coherent strategy for chronic disease management.
2) Effect the removal of appropriately identified patients to access appropriate services closest to their place of residence.

3.4 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.7: Analysis of constraints and measures to overcome them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
PHC	• Attrition of nurses • Conditions of work for health workers	• Occupational specific dispensation for health professionals
	• Poorly maintained infrastructure particularly infrastructure that will be taken over from municipalities	• The Department is participating in a national process to undertake an audit of current PHC infrastructure and submit a bid to the National Treasury
	• The size of the Metro district exceeds the capacity of the current management structure	• Four management structures will be created in the Metro
	• Information Management	• The PHC Information System has been developed and is currently being rolled out in the Province
DISTRICT HOSPITALS	• Recruitment of trained staff. • Conditions of work for health workers	• Occupational specific dispensation for health professionals
	• Level 2 services currently provided on a level 1 platform in the rural areas and driving the costs at level 1 hospitals	• Assessment of the cost drivers on level 1 platform currently being undertaken with a view to informing the implementation of the CSP and ensuring that Level 1 hospitals are funded appropriately • Implementing the departmental Outreach and Support policy particularly with regard to appropriate funding of activities per level of care
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 mental health patients developed in conjunction with Programme 4 managers
	• Continued availability of donor funding for HBC	• Implementation of the CSP and its related resources • EPWP funding for NPOs as training platform for the carers
CHRONIC DISEASES MANAGEMENT	• Regulations relating to dispensing medications • Continued availability of funding for eye care	• Development of guidelines for the management of Chronic Diseases • Dedicated funding

Table 2.8: National Health System Priority 3: Quality of Care

Activity	Indicators	National Targets 2007/08	Provincial progress 2007/08	National Targets 2008/09	Provincial projection 2008/09
Hospital improvement plans	Clinical audits	Clinical audits routinely monitored in all level 2 hospitals, 35% of district hospitals	Clinical protocols applied. Morbidity and Mortality processes are in place. The Department has structured reporting systems and reports for facilities are at the Provincial Head Office.	Clinical audits routinely monitored in all level 1 hospitals	Clinical audits routinely monitored in 40% of district hospitals
	Complaints mechanisms	Complaints mechanisms routinely managed in all level 2 hospitals, 35% of districts (level 1 hospitals and PHC facilities)	Complaints and compliments procedures are in place. Complaints are reported and appropriately managed. Reporting is done to the Provincial Head Office in a structured manner.	Complaints mechanisms routinely managed in all districts (level 1 hospitals and PHC facilities)	Complaints mechanisms routinely managed in 100% of districts (level 1 hospitals and PHC facilities)
	Infection control	Infection control management effected in all level 2 and level 1 hospitals and CHCs, 35% of all clinics	Provincial Infection Prevention and Control Committee is established.	Infection control management effected in all clinics	Infection control management effected in all level 2 and level 1 hospitals and CHCs, and all clinics
	Telemedicine	Develop implementation plans for skills decentralisation using telemedicine, flying doctors services and private sector practitioners. Hub and spoke systems developed in accordance with STP	A policy framework and implementation document for digital imaging has been drafted for comment. It is proposed that the resulting network will support telemedicine.	Hub and spoke systems developed in accordance with STP	Implementation will commence concentrating on the Revitalisation hospitals.
Supervision	Supervision rate for PHC	Supervision plan included in all provincial strategic plans (Part B). 50% supervision rate overall, 67% in rural facilities	42.4%	100% supervision rate	100%

3.5. MEASUREABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.9: Provincial objectives and performance indicators for District Health Services [DHS5]

Strategic Objectives	Measurable objectives		Measure / Indicator	Province wide value 2004/05 (actual)	Province wide value 2005/06 (actual)	Province wide value 2006/07 (actual)	Province wide value 2007/08 (estimate)	Province wide value 2008/09 (target)	Province wide value 2009/10 (target)	Province wide value 2010/11 (target)
In line with Comprehensive Service Plan targets transform the District Health System (DHS) in order to ensure the delivery of the full package of good quality DHS services in all the districts of the Western Cape										
To establish decentralised management capacity in all six districts.	Establish a fully functional DHS management office in each of the districts by 2010.	1	The number of DHS offices created in the province[1]	0	0	3	5	6	6	6
	Establish fully functional sub structure management structures in the metro by 2010.	2	The number of DHS sub-structure offices created in the metro	0	0	0	4	4	4	4
To ensure the provision of accessible, good quality District Health Services.	Increase access to emergency care.	3	Number of CHCs with a designated emergency unit implementing the South African Triage System at all times of service delivery	0	0	0	9	15	20	25
		4	Percentage of District Hospitals implementing the South African Triage System at all times of service delivery	0	0	0	0	100%	100%	100%
		5	Percentage of towns with populations of more than 5000 that have access to an emergency service 24hours a day .	N/A	N/A	N/A	N/A	50%	75%	100%
	Improve the access to primary health care clinic services by extending the service hours CHCs in the Cape Town metro district	6	The number of CHC's in the Metro offering nurse-based extended hours to 21h30 weekdays and 8h00 to 12h00 on weekends	0	0	0	9	11	20	25
	Ensure clinical governance and quality of district health services in all six districts by 2010.	7	The number of family medicine registrars employed in district Hospitals	0	0	0	20	40	50	60
		8	The number of district hospitals with appointed family physicians	0	0	0	8	20	25	30
		9	The number of CHCs and district hospitals with a functioning Maintenance of Competencies Programme (MOCOMP)	N/A	N/A	11	20	30	35	40
Improve information management systems.	Computerise and network all community health centres (CHCs) to ensure the maintenace of effective information management systems by 2010.	10	The number of networked PHC facilities with access to the Primary Health Care Information System (PHCIS) and the provincial intranet	0	0	23	33	54	73	90
Strategic goal:	**Ensure accessibility to district hospitals in all the districts of the Western Cape**									
To provide sufficient bed capacity to ensure accessibility of district hospital services.	Provide a total of 2311 beds in district hospitals by 2010.	11	Number of level one beds	1 546	1 546	1 570	2 132	2 300	2 311	2 311
		12	Number of patient days in district hospitals	494 713	406 505	411 569	757 534	755 550	759 164	759 164
		13	The ratio of total out patient headcount to in-patient days[2]	0.89	1.10	1.06	1.09	1.00	1.00	1.00

Strategic Objectives	Measurable objectives		Measure / Indicator	Province wide value 2004/05 (actual)	Province wide value 2005/06 (actual)	Province wide value 2006/07 (actual)	Province wide value 2007/08 (estimate)	Province wide value 2008/09 (target)	Province wide value 2009/10 (target)	Province wide value 2010/11 (target)
To provide outreach and support to PHC platform.	Provide administrative support and clinical outreach and support to the PHC platform from all district hospitals.	14	Percentage of district hospitals providing administrative support and clinical outreach and support to the PHC platform	N/A N/A	N/A N/A	N/A N/A	51% 16	90% 28	95% 29	100% 31
Strategic goal: **Implement a comprehensive community-based service package in all sub-districts of the Western Cape.**										
To provide home-based care for prioritised clients in need of care	Implement exit strategy for European Union (EU) partnership funding.	15	Number of PGWC funded posts in districts & sub-districts previously funded by EU	N/A	0	0	4 Regional & 29 Sub district Coord & 4 clerks	4 Regional & 29 Sub district Coord & 4 clerks	4 Regional & 29 Sub district Coord & 4 clerks	4 Regional & 29 Sub district Coord & 4 clerks
	Increase the number of NPO appointed home-carers.	16	Number of NPOs funded by PGWC	24	55	85	90	110	120	120
	Increase the number of clients receiving home-based care service.	17	Total number of NPO appointed home carers.	125	933	1 100	1 300	2 300	2 500	2 700
	Increase number of home-based care (HBC) clients seen.	18	Total number of clients seen	N/A	10 222	11 000	13 000	23 000	25 000	27 000
	Improve referral of clients from hospitals to HBC programme.	19	Number of hospital referrals	N/A	N/A	N/A	7 200	8 200	9 200	9 400
	Improve referral of clients from PHC to the integrated HBC programme.	20	Number of PHC referrals (Homebased care, TB DOTS, mental health, chronic disease and ARV adherence clients)	N/A	N/A	N/A	N/A	14 800	15 800	17 600
To provide in-patient palliative care to prioritised clients in need of care	Sustain the funding of palliative care beds.	21	Number of palliative beds	N/A	269	254	269	269	269	269
	Ensure bed utilization to full capacity.	22	Number of in-patient days	N/A	76 584	74 168	83 457	83 457	83 457	83 457
		23	Bed occupancy rate	N/A	78%	80%	85%	85%	85%	85%
To provide sub-acute care to prioritised clients in need of care	Increase the number of sub-acute care beds.	24	Number of usable beds (adult)	N/A	84	84	84	84	144	174
		25	Number of usable beds (paediatrics)		60	60	60	60	60	60
		26	Number of in-patient days (adult)		16 226 Global funding only	16 227 Global funding only	24 480	34 884	44 064	53 244
		27	Number of in-patient days (paediatric)		18 360	18 361	18 360	18 360	18 360	18 360
	Ensure bed utilisation to full capacity.	28	Bed occupancy rate		78%	80%	85%	85%	85%	85%

Strategic Objectives	Measurable objectives		Measure / Indicator	Province wide value 2004/05 (actual)	Province wide value 2005/06 (actual)	Province wide value 2006/07 (actual)	Province wide value 2007/08 (estimate)	Province wide value 2008/09 (target)	Province wide value 2009/10 (target)	Province wide value 2010/11 (target)
To provide chronic care to prioritised clients in need of long term care	Increase the number of mental health clients in community mental health programmes	29	Number of clients in community mental health programmes			-	1 481	1 681	1 700	17 500
	Provide in-patient chronic care to all patients in need of long term care.	30	Number of usable beds (adult)		280	280	280	280	280	280
		31	Number of usable beds (paediatric)		114	114	114	114	125	125
To implement care & support programmes for people living with HIV/AIDS	Transfer funding to district municipalities in order to fund CBOs that implement HIV related projects.	32	Number of MSAT projects funded via Global Fund			160	274	343	412	
Strategic goal: Improve Chronic Disease Management										
To effect the shift of appropriately identified patients to access appropriate services closest to their place of residence	Increase number of CDM clients receiving medication at a reduced time.	33	Number of patients with prescriptions issued for chronic medication through an alternative supply system	New indicator	688 222	700 000	720 000	730 000	740 000	750 000
		34	Number of patients receiving medication through non-health sites (accredited NPOs)	N/A	N/A	N/A	N/A	8 000	16 000	32 000
		35	Number of patients receiving medication through home delivery (via courier, adherence supporters)	N/A	N/A	N/A	N/A	4 000	8 000	16 000
		36	Number of CDM clients shifted from level 3,2, & 1 to appropriate level	N/A	N/A	N/A	10 000	20 000	30 000	40 000
To implement a coherent strategy for chronic disease management (CDM).	Implement a clinical governance system for chronic diseases	37	Number CHC's undertaking annual clinical audits for the management of cardiovascular risk factor management	N/A	N/A	N/A	38	40	50	60

Notes:
1. DHS Management structures will be implemented in an incremental manner in such a way that functionality of the structures increases over the years with the view of full functionality by 2011.
2. The transfer of GF Jooste, Helderberg, Karl Bremer Hospital has resulted in an increase in-inpatient days.

Table 2.10: Performance indicators for District Health Services [DHS6]

Sub-programmes 2.1 - 2.3:	Strategic goal:	In line with Comprehensive Service Plan targets transform the District Health System (DHS) in order to ensure the delivery of the full package of good quality DHS services in all the districts of the Western Cape								
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Province wide value 2004/05 (actual)**	**Province wide value 2005/06 (actual)**	**Province wide value 2006/07 (actual)**	**Province wide value 2007/08 (estimate)**	**Province wide value 2008/09 (target)**	**Province wide value 2009/10 (target)**	**Province wide value 2010/11 (target)**	**National target 2007/08**
To allocate sufficient resources for the rendering of the full package of PHC services.	Allocate sufficient funds per uninsured person to sustain an average utilisation rate of 3.87 per annum by 2010.	1 Provincial PHC expenditure per uninsured person[1,]	R235	R272	R259	R292	R319	R335	R347	
		2 Total PHC headcount per annum	13 843 759	13 068 303	12 180 933	12 820 136	13 384 235	14 043 921	14 730 155	
		3 PHC utilisation rate (per uninsured person).	4.00	3.71	3.09	3.17	3.22	3.29	3.35	3.5
		4 PHC utilisation rate (per capita).	2.98	2.77	2.31	2.36	2.4	2.45	2.5	
		5 PHC utilisation rate – under 5 years.	5.50	5.20	4.80	5	5	5	5	5
		6 Percentage of sub-districts offering the full package of PHC services.	65%	80%	100%	100%	100%	100%	100%	100%
	Ensure the efficient and quality delivery of the full package of PHC services.	7 Percentage fixed PHC facilities supported by a doctor at least once a week	Not available	Not available	Not available	81%	100%	100%	100%	
		8 Supervision rate	58.81%	73.34%	71.76%	60%	100%	100%	100%	
		9 Expenditure per PHC headcount - Province[1]	R59	R73	R84	R92	R99	R102	R103	

Notes:
1. 2006/07 prices.
2. The above Strategic goal covers Sub Programmes 2.1, 2.2 and 2.3
3. Fixed PHC facilities means fixed clinics plus Community Health Centres.
4. Public means provincial plus local government facilities.

Table 2.11: Performance indicators for District Hospitals [DHS7]

Strategic goal: To render the full package of district hospital services in all the districts of the Western Cape											
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Province wide value 2004/05 (actual)**	**Province wide value 2005/06 (actual)**	**Province wide value 2006/07 (actual)**	**Province wide value 2007/08 (estimated)**	**Province wide value 2008/09 (target)**	**Province wide value 2009/10 (target)**	**Province wide value 2010/11 (target)**	**National target 2007/08**
To provide sufficient capacity to render quality in-patient and out-patient services in district hospitals	Provide sufficient theatre capacity and resources at district hospitals to perform caesarean sections at a rate of 10-15%	1	Caesarean section rate for district hospitals (caesarean sections/total deliveries)	8.2%	10.7%	14.3%	12%	13%	14%	15%	11%
	Provide sufficient resources to provide out-patient services at a target rate of one out-patient per in-patient day.	2	Total patient day equivalents (PDEs) in district hospitals	725 693	643 244	661 655	1 019 460	1 007 400	1 012 218	1 012 218	
		3	Total OPD headcount (OPD+trauma) in district hospitals	692 941	712 166	695 108	822 150	755 550	759 164	759 164	
	Implement quality assurance measures to minimise patient risk.	4	Percentage of district hospitals with patient satisfaction survey using DoH template	100%	46%	32%	70%	100%	100%	100%	100%
		5	Percentage of district hospitals with Mortality and Morbidity meetings every month	100%	45%	21%	60%	70%	80%	100%	100%
		6	Percentage of district hospitals with Clinical audit meetings at least once a month	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	60%	70%	80%	100%	100%
		7	Percentage complaints resolved within 25 days (=total complaints resolved in all hospitals within 25 days/ total complaints received)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	N/A	90%	100%	100%	
		8	Case fatality rate in district hospitals for surgery separations (total surgery fatalities/total operations)	0.62%	0.70%	0.79%	1.00%	1%	1%	1%	3.5%
To ensure the effective and efficient rendering of sustainable district hospital services	Manage bed utilisation to achieve a n average length of stay of approximately 3 days and a bed occupancy rate of 85% in district hospitals.	9	Average length of stay in district hospitals	2.50	2.80	2.80	3.56	3.3	3	3	3.2
		10	Bed utilisation rate (based on usable beds) in district hospitals	76%	71%	72%	97%	90%	90%	90%	72%
		11	Total separations in district hospitals	195 150	142 054	144 373	212 948	228 955	253 055	253 055	
	Ensure the cost effective management of district hospitals at a target expenditure of approximately R970 per PDE by 2010.	12	Expenditure per patient day equivalent[1]	R576	R674	R690	R810	R905	R971	R1 035	814

3.6 SERVICE LEVEL AGREEMENTS AND TRANSFERS TO MUNICIPALITIES AND NON-GOVERNMENT ORGANISATIONS

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

3.6.1 Table 2.12 Transfers to municipalities (R'000) [DHS8]
Transfers to local government by transfers/grant type, category and municipality

Municipalities R'000	Outcome						Medium-tern estimate			
	Audited	Audited	Audited	Main appropriation	Adjusted appropriation	Revised estimate				% change from revised estimate
	2004/05	2005/06	2006/07	2007/08	2007/08	2007/08	2008/09	2009/10	2010/11	2007/08
Total departmental transfers/ grants										
Category A	131 074	104 662	129 915	139 133	143 633	143 633	155 838	173 605	197 211	8.50
City of Cape Town	131 074	104 662	129 915	139 133	143 633	143 633	155 838	173 605	197 211	8.50
Category B	40 241	58 284								
Beaufort West	1 073	1 463								
Bergrivier	3									
Bitou	2 313	3 510								
Breede River/Winelands	805	850								
Breede Valley	1 745	3 997								
Cape Agulhas										
Cederberg	588	707								
Drakenstein	6 648	7 699								
George	5 949	11 981								
Kannaland	1									
Knysna	2 004	3 738								
Laingsburg	7									
Hessequa	1 871	1 040								
Matzikama	828	749								
Mossel Bay	2 482	3 766								
Oudtshoorn	1 139	1 362								
Overstrand	1 056	1 230								
Prince Albert	248	335								
Saldanha Bay	2 284	4 000								
Stellenbosch	2 727	6 570								
Swartland	3 990	2 829								
Swellendam										
Theewaterskloof	1 855	2 112								
Witzenberg	625	346								
Unallocated										
Category C	49 372	54 481	9 318	7 683	8 646	8 646	7 673	1 894		(11.25)
Cape Winelands	16 570	17 140	1 311							
Central Karoo	3 356	4 910	1 369	1 676	1 676	1 676	1 306	323		(22.08)
Eden	9 044	13 641	2 540	2 464	2 854	2 854	2 612	645		(8.48)
Overberg	8 640	7 921	1 684	1 592	2 165	2 165	1 687	416		(22.08)
West Coast	11 762	10 869	2 414	1 951	1 951	1 951	2 068	510		6.00
Unallocated										
Total transfers to local government	220 687	217 427	139 233	146 816	152 279	152 279	163 511	175 499	197 211	7.38

Note: Excludes regional services council levy.

Table 2.13: Transfers to municipalities and non-government organisations (R'000) for Personal Primary Health Care Services [DHS8]

Municipalities R'000	Outcome						Medium-tern estimate			
	Audited	Audited	Audited	Main appropriation	Adjusted appropriation	Revised estimate				% change from revised estimate
	2004/05	2005/06	2006/07	2007/08	2007/08	2007/08	2008/09	2009/10	2010/11	2007/08
Personal primary health care services	209 752	206 214	112 758	119 288	119 288	119 288	128 232	144 324	158 756	7.50
Category A	125 041	97 589	112 638	119 288	119 288	119 288	128 232	144 324	158 756	7.50
City of Cape Town	125 041	97 589	112 638	119 288	119 288	119 288	128 232	144 324	158 756	7.50
Category B	38 253	57 863								
Beaufort West	923	1 463								
Bergrivier	3									
Bitou	2 303	3 510								
Breede River/Winelands	805	850								
Breede Valley	1 745	3 997								
Cape Agulhas										
Cederberg	557	707								
Drakenstein	6 431	7 699								
George	5 537	11 981								
Kannaland	1									
Knysna	1 950	3 738								
Laingsburg	7									
Hessequa	1 871	1 040								
Matzikama	808	749								
Mossel Bay	2 403	3 766								
Oudtshoorn	972	1 362								
Overstrand	1 056	1 230								
Prince Albert	248	335								
Saldanha Bay	1 915	3 839								
Stellenbosch	2 453	6 355								
Swartland	3 785	2 784								
Swellendam										
Theewaterskloof	1 855	2 112								
Witzenberg	625	346								
Unallocated										
Category C	46 458	50 762	120							
Cape Winelands	16 438	16 545								
Central Karoo	3 099	4 465								
Eden	8 433	12 538								
Overberg	8 549	7 165	120							
West Coast	9 939	10 049								
Unallocated										

Note: Excludes regional services council levy.

Table 2.14: Transfers to municipalities and non-government organisations (R'000) for Integrated Nutrition [DHS8]

Municipalities R'000	Outcome						Medium-tern estimate			
	Audited	Audited	Audited	Main appropriation	Adjusted appropriation	Revised estimate				% change from revised estimate
	2004/05	2005/06	2006/07	2007/08	2007/08	2007/08	2008/09	2009/10	2010/11	2007/08
Integrated Nutrition	4 983	2 997	2 973	3 150	3 150	3 150	3 308	3 473	3 647	5
Category A	2 882	2 997	2 973	3 150	3 150	3 150	3 308	3 473	3 647	5.02
City of Cape Town	2 882	2 997	2 973	3 150	3 150	3 150	3 308	3 473	3 647	5.02
Category B	1 081									
Beaufort West	150									
Bergrivier										
Bitou	10									
Breede River/Winelands										
Breede Valley										
Cape Agulhas										
Cederberg	31									
Drakenstein	75									
George	412									
Kannaland										
Knysna	54									
Laingsburg										
Hessequa										
Matzikama	20									
Mossel Bay	79									
Oudtshoorn	167									
Overstrand										
Prince Albert										
Saldanha Bay	42									
Stellenbosch	18									
Swartland	23									
Swellendam										
Theewaterskloof										
Witzenberg										
Unallocated										
Category C	1 020									
Cape Winelands	62									
Central Karoo	141									
Eden	398									
Overberg										
West Coast	419									
Unallocated										

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

Table 2.15: Transfers to municipalities and non-government organisations (R'000) for the Global Fund [DHS8]

Municipalities R'000	Outcome						Medium-tern estimate			
	Audited	Audited	Audited	Main appropriation	Adjusted appropriation	Revised estimate				% change from revised estimate
	2004/05	2005/06	2006/07	2007/08	2007/08	2007/08	2008/09	2009/10	2010/11	2007/08
Global Fund	2 905	7 296	12 645	11 042	12 005	12 005	11 705	2 894		(2.50)
Category A	2 117	3 773	3 447	3 803	3 803	3 803	4 032	1 000		6.02
City of Cape Town	2 117	3 773	3 447	3 803	3 803	3 803	4 032	1 000		6.02
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	3 523	9 198	7 239	8 202	8 202	7 673	1 894		(6.45)
Cape Winelands	70	595	1 311							
Central Karoo	116	363	1 369	1 232	1 232	1 232	1 306	323		6.01
Eden	213	1 103	2 540	2 464	2 854	2 854	2 612	645		(8.48)
Overberg	91	756	1 564	1 592	2 165	2 165	1 687	416		(22.08)
West Coast	298	706	2 414	1 951	1 951	1 951	2 068	510		6.00
Unallocated										

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

Table 2.16: Transfers to municipalities and non-government organisations (R'000) for the HIV and AIDS [DHS8]

Municipalities R'000	Outcome						Medium-tern estimate			
	Audited	Audited	Audited	Main appropriation	Adjusted appropriation	Revised estimate				% change from revised estimate
	2004/05	2005/06	2006/07	2007/08	2007/08	2007/08	2008/09	2009/10	2010/11	2007/08
HIV and AIDS	3 047	920	10 857	13 336	17 836	17 836	20 266	24 808	34 808	13.62
Category A	1 034	303	10 857	12 892	17 392	17 392	20 266	24 808	34 808	16.52
City of Cape Town	1 034	303	10 857	12 892	17 392	17 392	20 266	24 808	34 808	16.52
Category B	907	421								
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	161								
Stellenbosch	256	215								
Swartland	182	45								
Swellendam										
Theewaterskloof										
Witzenberg										
Unallocated										
Category C	1 106	196		444	444	444				(100.00)
Cape Winelands										
Central Karoo		82		444	444	444				(100.00)
Eden										
Overberg										
West Coast	1 106	114								
Unallocated										

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

3.6.2 Service level agreements and transfers to municipalities and non-government organisations

Table 2.17: Transfers to municipalities and non-governmental organisations (R'000) [DHS8]

Entities R'000	Outcome						Medium-term estimate			
	Audited	Audited	Audited	Main appropriation	Adjusted appropriation	Revised estimate				% Change from Revised estimate
	2004/05	2005/06	2006/07	2007/08	2007/08	2007/08	2008/09	2009/10	2010/11	2007/08
Universities										
Metro										
Stellenbosch	25 996	22 437								
Western Cape	11 005	9 835								
Cape Town	18 392	18 996								
Cape Peninsula University of Technology	1 586	3 161	1 275	1 477	1 477	1 477	1 567	1 692	1 810	6.09
Cape Medical Depot Trading Account	4 103	7 316	4 044	2 667	1 411	1 411	1 573	1 699	1 818	11.48
SETA	1 873	1 947	2 045	2 168	2 168	2 168	2 801	3 025	3 237	29.20
Provincial Aided Hospitals										
St Joseph	5 357	5 483	5 757	6 045	6 045	6 045	6 591	7 418	8 160	9.03
Sarah Fox	3 780	3 842	4 034	4 236	4 236	4 236	4 618	5 198	5 718	9.02
Maitland Cottage	4 098	4 376	4 595	4 825	4 825	4 825	5 919	6 393	6 841	22.67
Booth Memorial	6 798	7 138	7 796	8 185	8 185	8 185	8 924	10 044	11 048	9.03
Clanwilliam	6 464	6 793	7 029	7 574	3 788	3 788				(100.00)
Radie Kotze	3 532	3 850	4 043	4 324	4 482	4 482	4 612	5 191	5 710	2.90
Murraysburg	2 057	2 177	2 360	2 478	2 478	2 478	2 620	2 949	3 244	5.73
Prince Albert	3 280	3 380	3 500	3 675						
Uniondale	2 384	2 595	2 850	2 993	3 013	3 013	3 185	3 584	3 942	5.71
Laingsburg	2 805	2 905								
SA Red Cross Air Mercy	8 696	11 835	16 053	17 249	17 249	17 249	21 000	23 310	25 874	21.75
Conradie Care Centre	24 818	25 744	27 008	28 390	28 390	28 390	30 952	34 836	38 320	9.02
Tuberculosis (Contract Hospitals)										
DP Marais	7 896	8 291	5 330							
Harry Comay	4 519									
Non Government Organisations										
HIV/Aids	31 686	31 103	34 245	47 012	47 452	47 452	**53 337**	59 220	79 620	12.40
Nutrition	1 966	1 622	1 374	1 564	1 564	1 564	1 636	1 731	1 818	4.60
NGO (APH)	224			741	1 051	1 051	1 115	1 249	1 381	6.09
Health Committees	2 055	2 629	4 894	7 044	5 994	5 994	8 336	9 383	10 322	39.07
HCW: NGO's	713	451	486	510						
Mental Health	7 202	9 851	10 159	9 079	12 891	12 891	17 903	20 150	22 165	38.88
Santa Guidance	23	17	81	132	132	132				(100.00)
Global Fund	10 180	16 730	18 451	19 723	21 714	21 714	18 397	8 713	1 326	(15.28)
Expanded Public Works Programme					12 000	12 000	19 732	21 311	22 803	64.43
Social Capital		1 331	4 480	2 677	2 677	2 677	3 511	3 951	4 345	31.15
Total departmental transfers to development corporations	203 488	215 835	171 889	184 768	193 222	193 222	218 329	231 047	259 502	12.99

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Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total excluding capital	817 957 000	1 022 808 000	1 149 888 000	1 397 142 000	1 550 057 000	1 729 124 000	1 902 047 000
Total Capital	18 485 000	13 126 000	31 249 000	31 728 000	34 213 000	73 578 000	95 400 000
Grand Total	**836 442 000**	**1 035 934 000**	**1 181 137 000**	**1 428 870 000**	**1 584 270 000**	**1 802 702 000**	**1 997 447 000**
Total per person	180.02	219.59	223.76	263.36	284.08	314.49	339.01
Total per uninsured person	241.65	294.06	300.03	353.20	381.07	421.94	454.93
Constant 2006/07 prices							
Total excluding capital	907 343 454	1 058 391 126	1 149 888 000	1 349 656 056	1 431 425 402	1 545 457 440	1 647 067 104
Total Capital	20 505 043	13 582 649	31 249 000	30 649 631	31 594 532	65 762 587	82 611 104
Grand Total	**927 848 498**	**1 071 973 775**	**1 181 137 000**	**1 380 305 687**	**1 463 019 934**	**1 611 220 027**	**1 729 678 208**
Total per person	199.69	227.23	223.76	254.41	262.34	281.08	293.56
Total per uninsured person	268.06	304.29	300.03	341.19	351.91	377.12	393.95

There is a nominal increase of R132.309 million or R15.48 per cent to Sub-programme 2.9: District hospitals in 2008/09 in comparison to the revised estimate of the 2007/08 budget.

Included in the funding allocated to Sub-programme 2.9 in 2008/09 is an earmarked allocation of R59.118 million for the health professionals' remuneration review.

Table 2.19: Trends in provincial public health expenditure for District Hospitals [DHS9]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total excluding capital	376 649 000	419 084 000	456 673 000	854 878 000	987 187 000	1 099 832 000	1 209 820 000
Total Capital	70 030 000	27 639 000	58 649 000	52 515 000	220 119 000	220 455 000	335 056 000
Grand Total	**446 679 000**	**446 723 000**	**515 322 000**	**907 393 000**	**1 207 306 000**	**1 320 287 000**	**1 544 876 000**
Total per person	96.13	94.69	97.63	167.24	216.49	230.33	262.20
Total per uninsured person	129.05	126.81	130.90	224.30	290.40	309.03	351.86
Constant 2006/07 prices							
Total excluding capital	417 809 255	433 663 783	456 673 000	825 822 479	911 633 338	983 008 475	1 047 636 953
Total Capital	77 682 888	28 600 551	58 649 000	50 730 125	203 272 347	197 038 396	290 139 894
Grand Total	**495 492 143**	**462 264 334**	**515 322 000**	**876 552 603**	**1 114 905 685**	**1 180 046 871**	**1 337 776 848**
Total per person	106.64	97.99	97.63	161.56	199.92	205.86	227.05
Total per uninsured person	143.15	131.22	130.90	216.67	268.17	276.20	304.69

4. HIV AND AIDS, STI AND TB CONTROL

4.1 SITUATION ANALYSIS

4.1.1 Overview

The annual antenatal HIV prevalence in 2006 was 15,1%. Even although the 2006 HIV prevalence in the province remains lower than the national prevalence, in some districts such as Khayelitsha the prevalence is estimated to be 32.7%, which is higher than the average national HIV prevalence rate (29.1%).

The HIV epidemic has fuelled the TB epidemic. The incidence of TB in the Western Cape has increased from 689/100 000 in 1997 to 1 038/100 000 in 2006. This incidence is almost double the national TB incidence of 550/100 000 in 2003.

The Department has implemented the Comprehensive HIV and AIDS Care, Management and Treatment Plan adopted by the National Cabinet in November 2003 and is committed 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. The Department will take steps to address the issues arising from the National Strategic Plan (NSP) for HIV and AIDS for 2007 - 2011.

4.1.2 HIV Prevention programmes

HIV prevalence amongst antenatal clinic attenders in the Western Cape has shown that certain areas within the province such as Khayelisha, Guguletu/Nyanga and Knysna/ Plettenberg Bay continue to show high levels of HIV infection. This could pose a serious challenge in terms of the delivery of health services, social services, as well as for other sectors, in various ways. Therefore, it is of critical importance that the prevention strategy is successfully implemented in conjunction with treatment and care interventions in order to avert the long-term impact of the epidemic in this province.

4.1.2.1 Community mobilisation:

There are 33 multi-sectoral action teams throughout the province bringing together relevant role-players [government departments, local government and non-governmental organisations and civil society organisations] at sub-district level to initiate local responses to the epidemic. Three hundred and forty-three projects are funded through community-based organisations. Targeted work is undertaken in high transmission areas, e.g. sex workers and truckers, women and youth. Research was undertaken in 2006 with men aged 18 - 62 in high HIV prevalence sub-districts and specific interventions with this age group will be implemented during 2007.

4.1.2.2 Life skills and peer education:

There is a peer education programme in 131 secondary schools in the high burden areas of the Metro, Paarl, Wellington, George and Plettenberg Bay. There are also LoveLife programmes at selected secondary schools. There are at present 16 455 Lovelife leaders at 139 schools.

4.1.2.3 **Voluntary Counselling and Testing (VCT)**:

VCT is offered at 473 health facilities, which include PHC facilities and hospitals. There are 23 NGOs who employ 499 lay counsellors, who provide the bulk of the pre and post-test counselling services. The annualised VCT coverage in those 15 years and older was 9.4% for 2006/07, translating into 245 271 people between 15 years and 49 years old. In 2007/08 the Department will test a projected 12%, approximately 318 000 people between 15 years and 49 years old.

4.1.2.4 **Prevention of mother-to-child transmission (PMTCT):**

There were 99 224 new antenatal bookings during 2006/07. Of these 94 108 (94.8%) were counselled; 88 626 accepted testing resulting in an 89.3% acceptance rate. The Department intends to test about 88 000 women attending antenatal care in the PMTCT programme in 2007/08. Of those tested thus far, 12 360 were found to be HIV positive. The 14.0% HIV prevalence during this period compares well with the Antenatal Surveillance survey data.

A two-drug regimen for PMTCT has been implemented throughout the province. The transmission rate has decreased to 5.4% for 2006/07 from 6.1% in 2005/06.

4.1.2.5 **Sexually transmitted infections (STIs):**

The STI programme remains a challenge for the department. The STI partner treatment rate was 19.7% for 2006/07 (Target was 22%). For the public sector services, the provincial NSP will employ measures to mobilise male partners to come forward for treatment thus permitting incremental expansion of this programme.

4.1.2.6 **Condoms:**

The province has an extensive condom distribution network that includes public sector and non-traditional non-public sector sites. From 1 April 2006 to 31 March 2007 there were 58 972 742 male condoms distributed, which translates into 34.9 condoms per adult male over the age of 15 years per year. In 2007/08 the Department projects that it will distribute 45 million male condoms. In 2006/07 there were 254 426 female condoms distributed from 35 sites. The Department intends to distribute almost 400 000 female condoms in 2007/8.

4.1.2.7 **Post Exposure Prophylaxis (PEP):**

PEP for occupational exposure to HIV is offered in all hospitals. The Department has a PEP programme for victims of sexual assault at designated sites where PEP is available. The HIV and AIDS, STI and Tuberculosis (HAST) Directorate is making concerted efforts to integrate its services with Women's Health and other key related programmes thus ensuring that PEP is provided within the context of a seamless Clinical Forensic Services across the healthcare delivery service platform.

4.1.3 Treatment programme:

4.1.3.1 Care of HIV infected persons

All CHCs and clinics provide first contact ambulatory care for HIV positive patients including conducting CD4 counts with a view to referral to an ART centre. Treatment for opportunistic infections and nutritional support is available at primary health care facilities.

4.1.3.2 Anti retroviral treatment (ART)

At the end of March 2007, there were 26 111 patients on treatment at 50 treatment sites, which exceeded the original target of 22 489 and even the revised target of 25 697 patients. The number of sites providing ART in the Western Cape increased to 56 by September 2007. The monthly enrolment of new patients is steadily increasing. From the start of 2007 an average of 1 005 patients has been started on treatment each month. At the end of September 2007 a total of 31 320 patients were on treatment and remaining in care in the Province. Data indicate that after four years on ART, 76% of adults remain in care. In the 2007/08 financial year it is estimated that the number of patients accessing ART over the year represents 54% of those projected to be progressing to stage IV HIV disease and requiring treatment in the same time period.

Over 60% of patients receive ART at primary care sites in the province overall, and in the metropolitan area 75% of all patients receive care at primary care sites. A process of decanting stable patients from the tertiary and secondary level sites to primary care nurse- based, doctor-supported sites is underway.

4.1.3.3 Diflucan partnership

A donor partnership programme was started in 2001 for the treatment of oesphogeal candidiasis and cryptococcal meningitis. In 2006/07, there were 143,073 Diflucan tablets used to treat 6,170 patients [4,414 oesophogeal candidiasis and 1,756 cryptococcal meningitis]. In the same period, 1,127 bottles of Diflucan syrup were used to treat 43 patients (39 for oesophageal candidiasis and 4 for cryptococcal meningitis).

4.1.4 Tuberculosis

4.1.4.1 Introduction

Tuberculosis (TB) remains a great concern. Despite highly effective drugs, disease and deaths due to tuberculosis is increasing in the Western Cape, fuelled by the widespread HIV epidemic. Although the Western Cape has some of the best health and socio economic indicators in South Africa, significant socio-economic disparities remain between different communities and tuberculosis therefore persists as a public health problem of serious magnitude. To help overcome these challenges there is an urgent need to allocate additional resources to implement effective interventions.

4.1.4.2 **Overview of the epidemic**

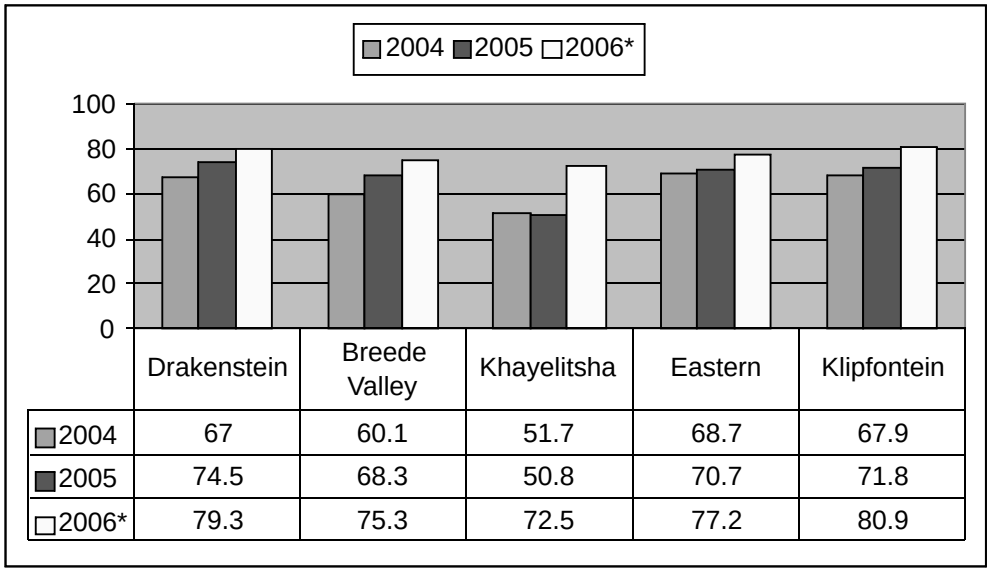
The Western Cape Province has consistently reported total of more than 40 000 TB cases per annum since 2001 with the total number of cases for 2006 at 48 983. The incidence of TB in the Western Cape is 1 038 cases/100 000 population for all TB cases and 553 cases/100 000 for new smear positive cases. The Western Cape Province has the highest incidence of TB in South Africa.

Of the Western Cape caseload 72.2% were newly diagnosed TB cases and 27.8% of the cases had previously been treated for TB. Pulmonary TB made up 88.1 % of the caseload and extra-pulmonary TB cases made up 11,9%. Of all the pulmonary TB cases 64.4% were smear positive infectious cases. Children under the age of seven years made up 14.1%.

4.1.4.3 **Progress in 2006/07 financial year**

In response to the growing TB epidemic a strategy to accelerate and enhance the response to TB was developed. Additional funding has been allocated over the past two years for TB control at primary health care level. Five high TB and HIV burden sub-districts with sub-optimal TB control programmes were declared TB crisis sub-districts and received additional funding to strengthen TB control in these districts. These were Khayelitsha, Cape Town Eastern, Klipfontein, Breede Valley and Drakenstein. In the 2007/08 financial year the focus was on 22 high burden TB/HIV health facilities to ensure that these facilities have the resources they require to improve TB control. All crisis sub-districts have improved their performance as illustrated below.

Figure 2.6: Progress in TB crisis sub-districts NSP TB cure rate 2004 2006



	Drakenstein	Breede Valley	Khayelitsha	Eastern	Klipfontein
2004	67	60.1	51.7	68.7	67.9
2005	74.5	68.3	50.8	70.7	71.8
2006*	79.3	75.3	72.5	77.2	80.9

Note: * 2006 data is only for the first three quarters as all the data for the 2006 outcomes is not yet available.

A TB cure rate of 71.9% for new smear positive cases and a treatment success rate of 79.3 % was achieved 2006/07. This is a 1% improvement over the previous year. Greater effort is required to reach the global target of 85%. Unfortunately 11% of patients still interrupt their treatment and many new TB infections are missed. The Programme strives to ensure an integration between the TB and the HIV and AIDS programmes by implementing interventions such as promoting HIV voluntary counselling and testing for all TB patients and the provision of cotrimoxazole prophylactic treatment.

4.1.4.4 **MDR and XDR-TB**

The emergence of multi-drug resistant (MDR) and extreme drug resistance (XDR) is potentially the most serious aspect of the TB epidemic in the province, given the large burden of disease, the late presentation of cases, high interruption rates and high proportion of previously treated patients. This underlines the importance of sustaining and strengthening the general TB DOTS strategy implementation to prevent MDR/XDR-TB tuberculosis generation. The full extent of XDR-TB is not known at this stage. The Western Cape started testing for XDR-TB in January 2007 and as at 31 December 2007 the Department had identified 73 patients with XDR-TB.

Detection and treatment of MDR-TB is an integral part of the general TB Control Programme. Although the management of MDR-TB under programmatic conditions is feasible and cost effective when implemented in the context of a well-functioning DOTS Programme and based on the South African policy guidelines, the challenges of achieving such integration should not be underestimated. This is already evident in the large percentage of MDR-TB cases in the Western Cape who interrupt their treatment and the inability of primary health services to do rapid follow-up of MDR defaulters and improve case-holding. The MDR-TB interventions in the province must be considerably strengthened, especially in light of the emerging XDR-TB epidemic

4.1.4.5 **Infection Control**

Another increasing issue is the implementation of effective infection control measures at hospitals and at primary health care facilities. The recent emergence of XDR-TB in South Africa has highlighted the call for strengthened infection control measures to interrupt the transmission of TB in health care settings. The high incidence and prevalence, of both HIV and TB, necessitate more concerted efforts to prevent the spread of TB, MDRTB and XDR TB. Infection control is in place in all facilities though it needs strengthening to deal with the emerging MDR/XDR epidemic.

4.Table 2.20: Situation analysis for HIV & AIDS, STIs and TB control [HIV1]

Strategic Objective	Measurable Objective		Performance Measure/ Indicator	Province wide value 2004/05	Province wide value 2005/06	Province wide value 2006/07	Metro District 2006/07	Cape Winelands District 2006/07	Overberg District 2006/07	Eden District 2006/07	Central Karoo District 2006/07	West Coast District 2006/07	National target 2003/04
			Strategic Goal:	**Decrease the number of new infections in the age group 15-24 years**									
To implement an effective prevention strategy	Provide PMTCT services to all pregnant women at 1st Antenatal booking visit.	1	Fixed PHC facilities offering PMTCT	74	74	74	22	93	94	100	100	93	50
	Provide VCT services at all fixed PHC facilities in the province.	2	Fixed PHC facilities offering VCT	100	100	100	100	100	100	100	100	100	90
	Provide PEP for occupational exposure at all hospitals in the province.	3	Hospitals offering PEP for occupational HIV exposure	100	100	100	100	100	100	100	100	100	100
	Provide PEP for sexual assault at al hospitals in the province.	4	Hospitals offering PEP for sexual abuse	77.3	89.7	92.3	90	100	100	100	100	86	100
	Distribute Male Condoms from all PHC Facilities and non PHC facilities to all adult males 15years and above.	5	Male condom distribution rate from public sector health facilities	15.6	19.9	34.9	50.1	6	11.3	9.3	10	7.5	7
	Issue of STI partner notification slips to all new STI clients.	6	STI partner treatment rate	20.6	18.5	19.75	20.1	18.6	23.5	18	16.4	16.4	27
	Administer Nevirapine to babies of mothers who accept PMTCT intervention.	7	Nevirapine newborn uptake rate	97%	97%	98%	97.3%	98.9%	99.7%	106.5%	100%	97%	20
	Administer Nevirapine to HIV positive women in labour who accept PMTCT intervention.	8	Nevirapine uptake- antenatal clients	77.40%	75.40%	89.90%	93.90%	75%	76.60%	83.10%	91.30%	84.70%	
	Provide HIV pre-test and post-test counselling services in fixed PHC facilities.	9	Clients HIV pre-test counselled rate in fixed PHC facilities	2	1.5	2.5	2.5	2.4	2.8	2.3	1.5	2.5	80
	Determine acceptability of HIV testing in those pre test counselled.	10	HIV testing rate (excluding antenatal)	New Indicator	New Indicator	New Indicator	New Indicator	New Indicator	New Indicator	New Indicator	New Indicator	New Indicator	
			Strategic Goal	**Reduce morbidity and mortality amongst HIV affected persons**									
To provide ART to patients in need	Accredit facilities to provide ART.	11	ART service points registered	30	43	50	29	5	3	7	2	4	
	Increase number of patients on ART.	12	ART patients- Total registered	7 670	16 343	26 111	20 003	2 596	537	2 148	219	608	
	Improve quality of ART service provision.	13	Fixed facilities with any ARV drug stock out	Not reported	Not reported	0	0	0	0	0	0	0	0
	Accredit facilities to provide ART.	14	Fixed facilities referring patients to ARV sites for assessment	Not reported	Not reported	100	100	100	100	100	100	100	N/A
	Monitor turn around times and engage NHLS as needed.	15	CD4 test at ARV treatment service points with turnaround time > 6 days	Not reported	Not reported	Not available	Not available	Not available	Not available	Not available	Not available	Not available	N/A
	Monitor expenditure on a monthly basis and variances.	16	Dedicated HIV/AIDS budget spent	105%	101%	95.1%	103%	103%	100%	100%	100%	100%	

Strategic Objective	Measurable Objective		Performance Measure/ Indicator	Province wide value 2004/05	Province wide value 2005/06	Province wide value 2006/07	Metro District 2006/07	Cape Winelands District 2006/07	Overberg District 2006/07	Eden District 2006/07	Central Karoo District 2006/07	West Coast District 2006/07	National target 2003/04
			Strategic Goal:	**Reduce morbidity and mortality due to TB**									
To strengthen the implementation of the DOTS strategy	Strengthen the TB community DOT Programme.	17	% TB cases with a DOT supporter	90%	93%	81%	90%	71%	91%	91%	88%		100%
	Ensure that TB patients remain in care.	18	TB treatment interruption rate	11.5%	11.9%	11.1%	11.5%	12%	8.2%	9%	10.2%	82%	10%
	Monitor turn around times and engage NHLS as needed.	19	TB sputa specimens with turnaround time less than 48 hours	74%	72%	67%	73%	59%	65%	69%	46%	63%	
	Ensure a regular and uninterrupted TB drug supply.	20	New smear positive PTB cases cured at first attempt	68.6%	69.3%	71.2%	69.3%	71.5%	83.6%	78.3%	70.9%	72.9%	65
To address TB/HIV, MDR and XDR-TB to ensure the adequate treatment and management of these patients	Ensure a standardised TB Drug.resistant recording and reporting system to monitor progress s in the implementation of the M(X)DR-TB Programme	21	New MDR TB cases reported- % annual change[1]	Not reported	Not reported	Not available	Not available	Not available	Not available	Not available	Not available	Not available	

Note:

1. It is estimated that there were 696 MDR cases in the province in 2007. The rate of annual change in these statistics will be ascertained next year when there are two years of Provincial data.

4.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

The Provincial Department of Health has committed itself to a comprehensive HIV and AIDS, and TB programme that addresses, via all relevant departments of the its government and all sectors of society, all aspects of the HIV and AIDS and TB dual epidemics.

4.2.1 HIV and AIDS and Sexually Transmitted Infections (STI)

The provincial strategy draws on the National HIV and AIDS and STI Strategic Plan (NSP) for South Africa, 2007 - 2011. The NSP 2007 - 2011 has two primary aims:

1) Reduce the number of new infections by 50% by 2011.
2) Reduce the impact of HIV and AIDS on individuals, families and society by expanding access to an appropriate package of treatment, care and support to 80% of all people diagnosed with HIV.

The National Department of Health has identified overall targets and the financial implications for implementing the NSP, which focuses on

- Prevention
  - o Social mobilization for social and behavioural change
  - o Interventions such as PMTCT, VCT, female condoms
- Decreasing morbidity and mortality of HIV and AIDS of which ART is one of the components.

The provincial programme is co-ordinated by the Provincial AIDS Council, which has representation from all relevant stakeholders in the province and is chaired by the provincial Minister of Health. The Provincial Inter-Departmental AIDS Committee (PIDAC), co-ordinates the government sector response, and is convened by the provincial Department of Health.

In addition to its co-ordinating and leadership role in the provincial programme, the Department of Health is responsible for the development and implementation of policies, strategies and activities within the Department to curb and manage the HIV and TB epidemics. The programme relates to the three broad strategic goals.

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Decrease the number of new infections in the age group 15-24 years	Reduce morbidity and mortality amongst HIV affected persons	Implement Care & support programmes for people living with HIV & AIDS
Community mobilisation	Anti-retroviral treatment (ART)	Home-based care / community ARV adherence support. (See section on disease prevention and control)
Lifeskills and peer education (Education Department)	Ongoing management of HIV positive clients not on ART.	Palliative hospice care (See section on disease prevention and control)
Voluntary counselling and testing (VCT)	In-patient management of HIV and AIDS disease.	Social support (Department of Social Services)
Sexually transmitted infections (STI) management		Orphans/ vulnerable children (Department of Social Services)
Condom/barrier methods		
Post exposure prophylaxis (PEP)		
Prevention of mother-to-child transmission (PMTCT)		

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4.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.22: Analysis of constraints and measures to overcome them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
HIV/AIDS/TB	• Demand for services exceeds the capacity of the government to provide services in prevention, care and support and treatment	• The Department has developed a comprehensive prevention strategy, which will help decrease new infections. This will see such interventions as VCT being provided at many more non-medical sites to alleviate the strain on the public sector. Non-government organisations (NGOs) working with women, children and vulnerable groups will be further engaged to assist with targeted prevention interventions. • The Department will implement a strategy for the Provincial Interdepartmental AIDS Committee (PIDAC), which will commit other government departments to implement appropriate targeted actions aimed at the downstream and upstream factors associated with the HIV and TB epidemics.
	• The difficulty of recruiting and retaining the appropriate Human Resources	• Human resources employed through the HIV and AIDS programme will be integrated into health services to strengthen services generally.
	• Adequate infrastructure	• The Department has employed a project manager through Global Funding to assist the departments of Health and Public Works to improve the planning and implementation of PHC infrastructure projects. This will significantly improve PHC infrastructure challenges globally.
	• The Department's ability to take over the activities currently funded by Global Fund into the equitable share in a phased manner thus not overburdening the state	• The Department has a structured exit strategy from Global funding to slowly taking over the Global Fund financial commitments over a four-year period from 2006 to 2010.

4.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.23: Provincial objectives and performance indicators for HIV & AIDS, STI and TB control [HIV2]

Strategic Objective	Measurable Objective		Performance Measure/ Indicator	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (target)	2009/10 (target)	2010/2011 (target)
Strategic Goal :	**Reduce morbidity and mortality amongst HIV affected persons**									
To provide ART to patients in need	Increase number of clients in need of ART starting treatment to 65 000 by 2011	1	Cumulative number of clients on ART	7 670	16 343	26 111	35 863	45 756	55 652	65 652
		2	Cumulative number of clients on ART via the Conditional Grant	4 870	10 448	17 180	27 702	38 852	51 329	65 652
		3	Cumulative number of clients on ART via the Global Fund	2 800	5 895	8 931	8 161	6 904	4 323	0
Strategic Goal:	**Decrease the number of new infections in the age group 15 -24 years**									
To implement an effective prevention strategy.	Increase number of clients tested for HIV to 360 000 by 2011	4	Number of persons tested for HIV, excluding antenatal	Not applicable	144 075	245 271	288 000	324 000	340 000	360 000
	Train 15 000 peer educators in schools by 2010	5	Number of badged peer educators via Global Fund	Not applicable	4 410	7 967	10 602	15 035	15 035	15 035
	Distribute 600 000 female Condoms to designated sites in the province by 2011	6	Female condom distribution from primary distribution sites	Not applicable	120 617	254 426	360 000	400 000	500 000	600 000
	Decrease Mother to child HIV transmission to 4% by 2011	7	PMTCT transmission rate	Not applicable 60/600	6.10% 444/7 099	5.40% 429/7 961	5.00% NA	4.50% NA	4.00% NA	4.00% NA
Strategic Goal:	**Reduce morbidity and mortality due to TB**									
To strengthen the implementation of the DOTS Strategy	Increase routine sputum collection in all TB patients at 2 months to 80% by 2011	8	Smear conversion rate at 2 months for new smear positive PTB cases	59.30%	62%	67.40%	70%	73%	75%	80%

Table 2.24: Performance indicators for HIV & AIDS, STI and TB control [HIV3]

Strategic Objective	Measurable objectives		Performance Measure/ Indicator	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (target)	2009/10 (target)	2010/2011 (target)	National target 2007/08
Strategic Goal: Decrease the number of new infections in the age group 15 -24 years											
To implement an effective prevention strategy.	Provide PMTCT services to all pregnant women at 1st Antenatal booking visit.	1	Percentage fixed PHC facilities offering PMTCT (PMTCT facility rate)	74% 213/288	74% 213/288	74% 213/288	74% 213/288	80% 230/288	85% 245/288	90% 259/288	100%
	Provide VCT services at all fixed PHC facilities in the province.	2	Percentage fixed PHC facilities offering VCT (VCT facility rate)	100% 290/290	100% 290/290	100% 290/290	100% 290/290	100% 290/290	100% 290/290	100% 290/290	100%
	Provide PEP for occupational exposure at all hospitals in the province.	3	Percentage Hospitals offering PEP for occupational HIV exposure	100% 40/40	100% 40/40	100% 40/40	100% 40/40	100% 40/40	100% 40/40	100% 40/40	100%
	Provide PEP for sexual assault at al hospitals in the province.	4	Percentage Hospitals offering PEP for sexual abuse	77.3% 30/39	89.7% 35/39	100% 40/40	100% 40/40	100% 40/40	100% 40/40	100% 40/40	100%
	Distribute Male Condoms from all PHC Facilities and non-PHC facilities to all adult males 15years and above.	5	Male condom distribution rate from public sector health facilities[1] (rate)	15.6	19.9	34.9	40	50	60	70	11
	Issue of STI partner notification slips to all STI clients treated new.	6	STI partner treatment rate (%)	20.6%	18.5%	19.7%	22%	22%	23%	30%	40%
	Administer Nevirapine to babies of mothers who accept PMTCT intervention.	7	Nevirapine newborn uptake rate	97% 7 400/7 623	97% 9 261/9534	98% 10 519/10 701	98%	95%	95%	95%	70%
	Administer Nevirapine to HIV positive women in labour who accept PMTCT intervention.	8	Nevirapine uptake-antenatal clients[3]	75%[3] 6 474/8 617	75.40% 7 796/10 342	89.80% 8 555/9 520	90.00%	90.00%	90.00%	90.00%	
	Provide HIV pre-test and post-test counselling services in fixed PHC facilities.	9	Clients HIV pre-test counselled rate in fixed PHC facilities (%)	2% no data	1.3% 173 423/ 13 068 303	2.5% 252 383/ 12 180 933	2% 220 698/ 11 863 906	3.0% 370 154/ 12 338 462	3.5% 453 438/ 12 955 385	4.0% 544 126/ 13 603 154	100%
	Determine acceptability of HIV testing in those pre-test counselled.	10	HIV testing rate (excluding antenatal)	-	New Indicator	New Indicator	95.5% 210 730/ 220 698	95.5% 353 497/ 370 154	95.5% 433 034/ 453 438	95.5% 519 641/ 544 126	
Strategic Goal: Reduce morbidity and mortality amongst HIV affected persons											
To provide ART to patients in need	Accredit facilities to provide ART.	11	ART service points registered	30	43	50	63	70	78	88	
	Increase number of patients on ART.	12	ART patients- Total registered	7 670	16 343	26 111	35 863	45 756	55 652	65 652	608
	Improve quality of ART service provision.	13	Fixed facilities with any ARV drug stock out	Not reported	Not reported	0	0	0	0	0	0

Strategic Objective	Measurable objectives		Performance Measure/ Indicator	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (target)	2009/10 (target)	2010/2011 (target)	National target 2007/08
To provide ART to patients in need	Accredit facilities to provide ART.	14	% Fixed facilities referring patients to ARV sites for assessment	Not reported	Not reported	100% 290/290	100% 290/290	100% 290/290	100% 290/290	100% 290/290	100%
	Monitor turn around times and engage NHLS as needed.[4]	15	CD4 test at ARV treatment service points with turnaround time > 6 days[4]	Not reported*	Not reported	Not available	Not available	Not available	Not available	Not available	0
	Monitor expenditure on a monthly basis and variances.	16	Dedicated HIV/AIDS budget spent (Percentage)	105%	101%	103%	100%	100%	100%	100%	100%
Strategic Goal: Reduce morbidity and mortality due to TB											
To strengthen the implementation of the DOTS strategy	Strengthen the TB community DOT Programme	17	% TB cases with a DOT supporter	90%	93%	81% 72 216/89 155	90%	95%	98%	100%	100%
	Ensure that TB patients remain in care.	18	TB treatment interruption rate	11.5%	11.9%	11% 2 097/18 839	10%	9%	8%	7%	4%
	Monitor turn around times and engage NHLS as needed.	19	TB sputa specimens with turnaround time less than 48 hours	74%	72%	67%	75%	80%	85%	90%	
	Increase the number of people cured for PTB at first attempt	20	New smear positive PTB cases cured at first attempt	68.6%	69.3%	71.9% 13 477/18 839	74%	75%	76%	77%	85%
To ensure a standardized TB Drug resistant recording and reporting system to monitor progress in the implementation of the M(X)DR-TB Programme	Ensure a standardized TB Drug resistant recording and reporting system to monitor progress s in the implementation of the M(X)DR-TB Programme	21	New MDR TB cases reported- % annual change[5]	Not reported	Not reported	Not available	Not available	Not available	Not available	Not available	-30%

Notes:

1. No. 8 Rate: Number of male condoms per male 15 years and older per year.
2. No.12 Until 2006/07, the Nevirapine administration rate was reported. As from 06/07 NVP coverage rate was reported. The denominator for the coverage rate for 06/07 is based on the provincial and region specific sero-prevalance, derived from the 2006 HIV Antenatal Survey; namely Western Cape 15.7%, Metropole 18.2%, Cape Winelands 12.6%, Overberg 14.1%, Eden 13%, Central Karoo 6.5%, West Coast 9.1%
3. In 03/04 the Nevirapine administration rate to women was calculated as follows (Self administered Nevirapine + NVP in labour)/ deliveries on PMTCT programme.
   In 2004/05 due to change in protocol, the Nevirapine Administration Rate changed to NVP administrated in Labour/ PMTCT deliveries- Transfer-in during deliveries
4. This is in the process of being addressed
5. Data was systematically collected from 1January 2007. This indicator will there only be available from 1January 2008 It is estimated that there were 696 MDR cases in the province in 2007. The rate of annual change in these statistics will be collected next year when there is two years worth of provincial data and thus would be better able to predict the rate of annual change

Table 2.25: National Health System Priority 4: Priority Health Programmes

Activity	Indicators	National Targets 2007/08	Provincial progress 2007/08	National Targets 2008/09	Provincial projection 2008/09
Implementation of the National Strategic Plan for HIV and AIDS	Increase the proportion of health facilities providing Comprehensive HIV care including ART	10%	11%	25%	14.4%
Implementation of the TB crisis plan	Increase in smear conversion rate in selected provinces and districts	10% above baseline	70.7%	10% above baseline	73.0%
	Increase in cure rate in selected provinces and districts[1]	10% above baseline	74%	10% above baseline	75%

Note:

1. This relates to the cure rate for the province

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

There is a nominal increase of R3.860 million or 1.62 per cent to Sub-programme 6: HIV and AIDS in 2008/09 in comparison to the revised estimate of 2007/08.

Table 2.26: Trends in provincial public health expenditure for HIV and AIDS [HIV4]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total	94 39 000	122 655 000	168 579 000	237 607 000	241 467 000	293 176 000	421 636 000
Total per person	20.32	26.00	31.94	43.79	43.30	51.15	71.56
Total per uninsured person	27.27	34.82	42.82	58.73	58.08	68.62	96.03
Constant 2006/07 prices							
Total	104 709 389	126 922 124	168 579 000	229 531 233	222 986 493	262 035 013	365 113 368
Total per person	22.54	26.90	31.94	42.31	39.98	45.71	61.97
Total per uninsured person	30.25	36.03	42.82	56.74	53.64	61.33	83.16

Table 2.27: Trends in provincial public health expenditure on HIV and AIDS and Global Fund (Sub-programmes 2.6 and 2.10) [HIV4]

The Global Fund allocation decreases by R3.640 million in 2008/09 in comparison to 2007/08.

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total	119 506 000	172 355 000	249 129 000	345 287 000	345 507 000	366 796 000	432 349 000
Total per person	25.72	36.53	47.20	63.64	61.95	63.99	73.38
Total per uninsured person	34.53	48.93	63.28	85.35	83.11	85.85	98.47
Constant 2006/07 prices							
Total	132 565 632	178 351 169	249 129 000	333 551 415	319 063 865	327 835 139	374 390 231
Total per person	28.53	37.80	47.20	61.48	57.21	57.19	63.54
Total per uninsured person	38.30	50.63	63.28	82.45	76.75	76.73	85.27

5. MATERNAL CHILD AND WOMEN'S HEALTH, AND NUTRITION

5.1. SITUATION ANALYSIS

5.1.1. Women's Health

Women's health has been on the agenda of global health organizations for the last 20 - 30 years and the status given to Women's health is captured in the United Nations Millennium Development Goals (MDGs).

Goal 5 of the MDGs require countries to improve maternal health services by reducing the maternal mortality ratio by three quarters between 1990 and 2015. It is for this reason amongst others that the National Committee on Confidential Enquiry into Maternal Deaths (NCCEMD) was introduced in South Africa to enable all provinces to report all maternal deaths. According to the Burden of Diseases study (2007) non-pregnancy related sepsis, mostly HIV and AIDS remains the most common cause of maternal death, followed by hypertensive disorders and obstetric haemorrhage.

5.1.1.1 Antenatal Care

Research has proven that the earlier the pregnant woman books at the ANC clinic the better the outcome for both mother and unborn child, hence the emphasis by the National and Provincial Department of Health on the importance of booking earlier than 20 weeks.

The province has good coverage for antenatal care. This indicator has been more than 80% for the last few years and in 2006/07 was 87.1%, more than the targeted 85%. This means that over 85% of women attended antenatal care services before they gave birth. The biggest challenge however is to ensure that women attend antenatal care services before 20 weeks gestation. Booking before 20 weeks of gestation assists in early problem identification.

Basic Antenatal Care (BANC) is a national quality improvement programme, which was introduced in 2006. This programme focuses on early identification of pregnant women at risk and early referral to the appropriate level of care. Currently, 2007/08, less than 40% of women in the province attend antenatal care before 20 weeks. BANC has to date been rolled out to 61 primary Health Care clinics out of 342 PHC clinics and 11 of the 13 Midwife Obstetric Units (MOUs) in the province.

5.1.1.2 Maternal Health

The province has 51 birthing units, i.e. facilities where deliveries take place, which include MOUs and level 1, 2 and 3 facilities. Most of these birth units are in the Cape Town Metro District with the obstetric bed capacity of 455 maternity beds (2004/05). The Comprehensive Service plan (CSP) proposes two new facilities with sixty level 1 bed obstetric units to strengthen maternal services at district level. Due to the increase in service pressures, Metro District Health Services (MDHS) has developed business plans for two of the sub-districts to strengthen and improve the sub district obstetric services including neonatal services (refer to 3.2.2.3. Obstetrics and Neonatology).

Based on a comparison of the first two quarters of 2007/08, the teenage delivery rate has increased from 7.8% 2006/07 to 8.7%, but is still below 10.1%.

According to National Committee on Confidential Enquiry into Maternal Deaths (NCCEMD), the Western Cape has been estimated to have a Maternal Mortality Ratio (MMR) of 70.7 per 100 000 live births however, the latest (2006) Maternal Mortality Ratio has significantly decreased to 57.4 per 100 000 live births. The NCCEMD enquiry has identified the following top five conditions causing mortality amongst pregnant women in the Western Cape and the country. Non-pregnancy related infections are the most prevalent cause of death among women in the Western Cape followed by hypertensive disorders, non-pregnancy related infections including HIV/AIDS.

- Hypertensive conditions of pregnancy
- Obstetric haemorrhage
- Pre-existing maternal disease
- Pregnancy related infections

The province will implement the Saving Mother Report III recommendations to reduce MMR.

5.1.2 Reproductive Health

5.1.2.1 Contraceptive Services

Contraceptive use is influenced by a number of factors including socio-economic development, urbanisation, women's education and status in society, cultural norms and beliefs and the knowledge and attitudes of individuals. Contraceptive, maternal, child, adolescent and overall women's health services together with STI and HIV prevention and management are integral components of sexual and reproductive health care.

5.1.2.2 Cervical Cancer Screening Services

Cervical cancer is one of the few cancers that can be prevented by early diagnosis of the pre- cancerous lesion through a very inexpensive investigation, the Pap smear, which examines the cervical histology. The national policy prescribes that women aged 30 years and over should receive one Pap smear every 10 years[6]. Therefore in any one year at least 10% of women aged 30 years and over should be screened. Since the public sector provides services for the uninsured, the province should be screening around 8% of the target population on an annual basis. The ultimate goal for the programme is to incrementally reach this target. Over the last three years this indicator has improved from 3.1% in 2004/05 to 6.3% in 2006/07. This is still lower than the target set by national policy of 8%. To address this the province is exploring partnerships with Independent Practitioner Associations (IPA's) and other service providers. The target for 208/09 is the national target of 8%.

[4]Maternal Mortality Ratio: The number of women who die as a result of childbearing, during the pregnancy or within 42days of delivery or termination of pregnancy in one year, per 100 000 live births that year (HST)

[6] Please note that the National Policy has changed from screening women aged 30-59 years to screening women aged 30 years and over, therefore as of 08/09 the age group for this indicator will change accordingly, including on RMR data collection tool.

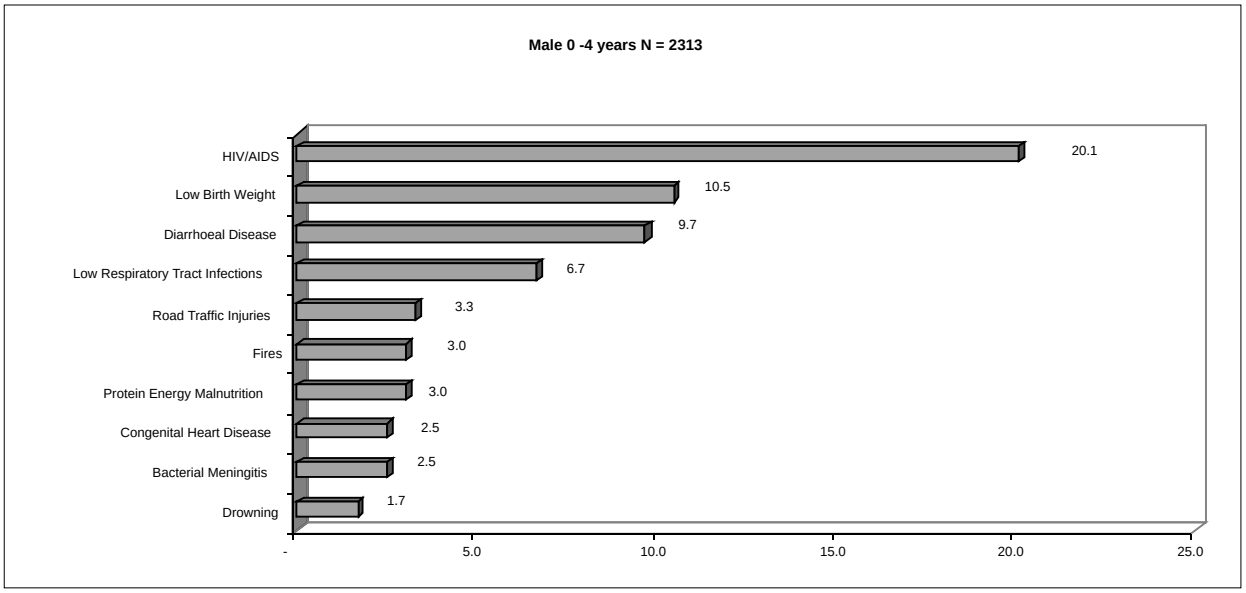
5.1.2.3 **Termination of pregnancy (TOP) services**

Thirty four of the 40 acute adult hospitals in the province provide termination of pregnancy services. There are 60 CHCs in the province, of which 5 are designated as TOP providing facilities. Of the 5 designated CHCs, 3 are functional i.e. designated and provide TOP services. Some health professionals remain unwilling to provide TOP services due to conscientious objection and this hampers access to termination of pregnancy services even in designated facilities. Second trimester TOPs in public health facilities have increased slightly from 25% in the first two financial quarters of 2006/07 to 27% in the same period in 2007/08.

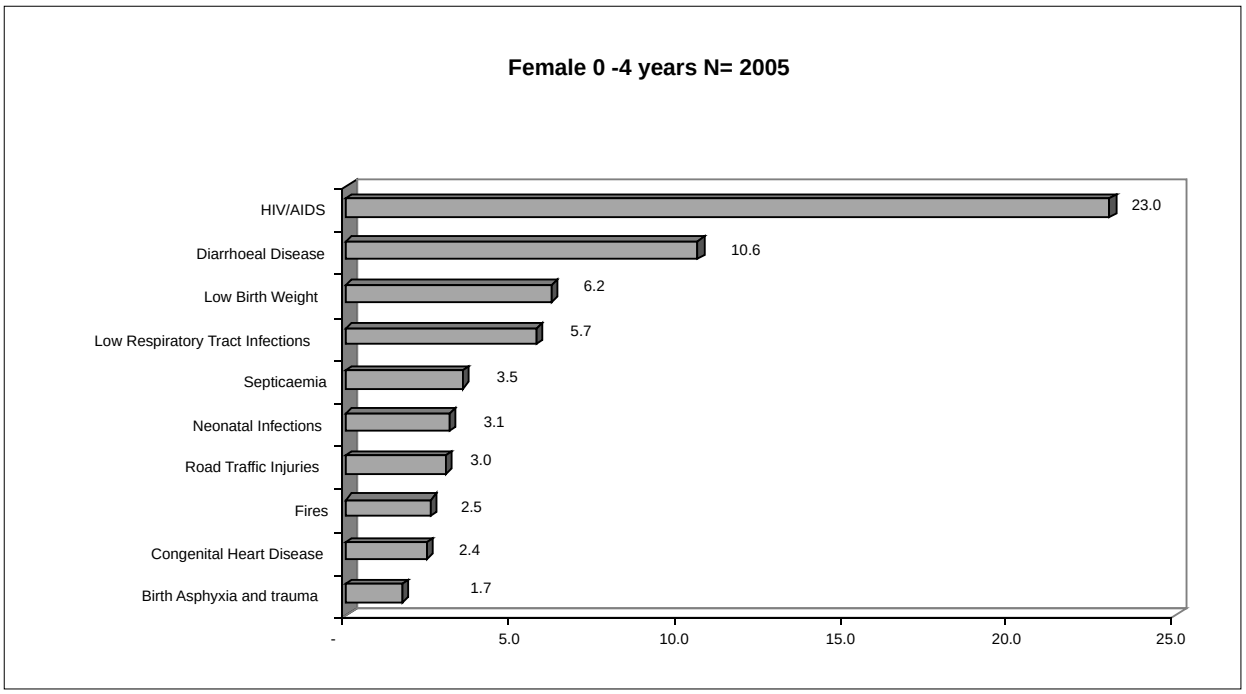
5.1.3 **Child Health**

According to the Medical Research Council, Burden of Disease study of 2000, the majority of child deaths occur in infancy (under one year of age) and in the young child (1 to 4 years of age) age group. In fact the under five deaths account for a significant percentage of all deaths in children. As shown in Figure 2.5, below HIV and AIDS, diarrhoea, lower respiratory tract infections (LRTI), undernutrition and perinatal problems (low birth weight, neonatal infections, perinatal asphyxia and birth trauma) account for almost 50% of under-5 deaths in the Western Cape. In addition to deaths directly attributable to under nutrition, malnutrition plays an important synergistic role in diarrhoea and respiratory infections.

Figure 2.7 Under five leading causes of death for the Western Cape, 2000



Bradshaw *et al*, 2004. Estimates of Provincial Mortality 2000. Western Cape Province. SA Burden of Disease Study, MRC.



SOURCE: Bradshaw et al.2004 Estimates of Provincial Mortality 2000. Western Cape Province. SA Burden of Disease Study, MRC

Underlying the most common childhood infections and infestations including diarrhoeal disease are environmental risk factors that include inadequate sanitation and water supply, poor hygiene practices, and poorly ventilated, crowded and smoky living spaces. Often these risk factors are beyond the mandate of the Department of Health and highlight the importance of the key PHC strategy of intersectoral collaboration in order to address child health.

5.1.3.1 **Screening and prevention of childhood diseases**:

1) **Immunisation**

Immunisation is a critical intervention to prevent communicable diseases. Immunisation coverage of 90% of children under one year with all required vaccines of immunisation ensures that there is herd immunity in the community thus decreasing the likelihood of infectious disease outbreaks or epidemics. For the last three financial years, the province achieved this target for fully immunised and measles immunisation coverage. While the target has been achieved an immunisation survey undertaken 2 years ago revealed lower coverage in certain areas. The department thus decided to monitor more closely the proportion of sub-districts with fewer than 80% children under one who are fully immunised through the implementation of the WHO Reach Every District (RED) strategy.

2) **Developmental Screening**

Developmental screening is being done at PHC facilities within the province. This is currently recorded on the Routine Monthly Report (RMR) as total number of children screened and total number referred. This programme needs to be strengthened and data needs to be collected at ages of 6 weeks, 9 months and 18 months.

3) **School Health**

The National School Health policy and implementation guidelines was completed during 2003 and implemented during 2004. The aim of the policy is to implement phase 1 of grade R/1 (assessments for hearing, eye, gross motor and anthropometry (weight and Height). This assessment enables identification of problems appropriate management and referral. During May 2006 a rapid assessment was done of school health in the non-Metro districts. A decision was made to extend school health services to the rest of the province in line with the national policy. By July 2007 the number of sub-districts implementing at least phase 1 of the National School Health policy (September 2007) were as follows: Metro: 100%; Cape Winelands: 60%; Eden: 87%; Central Karoo: 54%; Overberg: 100% and West Coast: 40%.

5.1.3.2 **Childhood Disease Management**

1) **Integrated Management of Childhood Illness**

The Integrated Management of Childhood Illness (IMCI) is a critical intervention to ensure good quality care for children in the PHC platform in particular. This is a World Health Organisation (WHO) strategy, which has been adapted for use in South Africa. Currently 82% of PHC facilities are implementing the strategy.

2) **Neonatal Health**

The focus on perinatal care has identified major areas of concern regarding care of women during pregnancy, labour and the newborn period. The Perinatal Problem Identification Programme (PPIP) is an audit programme instituted in maternity care facilities, which describe the magnitude of the problem of perinatal deaths in SA as well as identifying the causes and areas where the health system has broken down. In addition findings of the programme are used to make recommendations on how to address perinatal mortality.

5.1.3.3 **Priority disease: Infantile diarrhoea.**

The province experiences a significant peak in infantile diarrhoeal disease during the summer months. For example there was a 143% increase in admissions for diarrhoeal disease in J1 Ward at the Khayelitsha District Hospital hub currently situated at Tygerberg Hospital between February and March 2007.

A diarrhoeal task team was established in 2005 to monitor management of diarrhoeal disease during the peak season. The task team comprising members from communication, health promotion, health programmes and City of Cape Town has addressed the resulting service pressures through a six-pronged strategy namely:

1) Problem identification - identification of 'hotspots" in all districts
2) Community-based services
   a. Improved water and sanitation
   b. Community Awareness/education
   c. Social mobilisation and inter-sectoral coordination
3) Improve PHC management and referral
4) Improve management and transportation of the critically ill children through Emergency Medical Services
5) Improve management of hospital provision
6) Research, monitoring and evaluation.

5.1.4 Integrated Nutrition Programme (INP)

The problems of poverty and underdevelopment in the Western Cape Province are often hidden behind an image of relative affluence as portrayed in comparative studies between the Provinces. The health status of the children appears to be better than elsewhere in the country. However, disparities exist in the province**.** These include certain areas where up to 80% of the population lives in informal housing, have no medical aid and live below the household subsistence level where the children's health status is poor. These disparities are reflected by infant mortality rates, which between sub-districts range from 13 per 1 000 live births to 56 per 1 000 live births with a provincial IMR of 35 per 1 000 live births. Nutrition services are available at all levels of care in PHC facilities and **h**ospitals. Community-based nutrition services are delivered at schools, crèches, and old age homes.

5.1.4.1 Malnutrition

There is good evidence that malnutrition increases the likelihood of mortality from a number of different diseases and may be associated with over half of all childhood mortality. Table 2.28 below shows that the Western Cape has slightly less for under nutrition compared to the national average.

Conversely due to the “nutritional transition" which the province is undergoing, the province has higher prevalence of obesity for both men and women. This is further exemplified by the relatively high proportion of deaths due to cardiovascular diseases compared to the rest of the country.

Table 2.28: **National and Provincial Nutrition Status Indicators**

Indicator	National Status	Provincial Status	Interpretation
Stunting (1- 9yr)	21.6%	14.5%	Low Height for age, (Severe stunting - Height for age less than the international reference value of 3 standard deviations) High percentage is an indication of bad environmental conditions and chronic malnutrition
Wasting (1- 9yr)	3.7%	0.7%	Low weight for height (weight for height that is less than the international reference value by more than 2 standard deviations) Reflects current under nutrition and disease
Underweight: Moderate Severe	10.3% 1.4%	8.6% 1%	Low weight for age (Weight for age that is less than the international reference value by more than 2 standard deviations) Poverty and poor dietary intake and current under nutrition
Low birth weight	8.3%	9.1%	High percentage points to a deficient health status in pregnant women
Vitamin A Deficiency	33%	21%	Poverty and poor dietary intake and current under nutrition
Child Iron Deficiency	21.4%	28.6%	Poverty and poor dietary intake and current under nutrition
Obesity	Men=8% Women=23%	Men=16%, women=30.6%	Weight for age more than 2 standard deviations above the international reference value / BMI of above 30 Increased risk for Chronic diseases of lifestyle.
Overweight	Men=21.1% Women=29%	Men = 23.6%, women= 26.1%	
Infant mortality Rate	43/1000 live births	35/1000 Live Births	Reflects magnitude of problems of Diarrhoea, Respiratory infections, malnutrition, caring capacity of mothers, ante natal and post natal health
Source: SA Health review 2006, NFCS 1998,SAVCG1994, SADHS 2003			

The results in South African Youth behaviour risk survey 2002 amongst learners' grades 8 - 11, confirm the need for emphasis on prevention and management of obesity. This age group in the province shows a higher prevalence of obesity for both women and men as compared to the national average. The role of nutrition in reducing the burden of disease specifically in the management of healthy lifestyles is becoming increasingly important.

Obesity is associated with an increased risk of cardiovascular diseases of 2.8% in men and 3.4% in women (Willet and Dietz 1999), hypertension and certain type of cancers of the reproductive system in women and with rectum, colon and prostate cancers in men. A study in children in the Western Cape showed that current levels of obesity were associated with inactivity as measured by television time, lower fitness levels and lower intake of daily fruit and vegetables. (Lambert et al 2000).

5.1.4.2 **Micronutrient supplementation Vitamin A**

The vitamin A supplementation programme is implemented to protect immunity, prevent blindness and reduce the risk of children dying from the common childhood illnesses. The vitamin A supplementation policy for children changed in all public health facilities from those medically-targeted (children identified per set criteria) to blanket cover (all children under 5 year) as of 1 April 2004.

5.1.4.3 **Infant and Young Child Feeding**

The baby friendly hospital initiative (BFHI) is one of the key strategies for child survival. The number of facilities declared baby friendly have increased from 11 facilities (including two private facilities) in 2005/06 to 14 facilities in December 2006**.**

The Department expects to accredit an additional 3 facilities in 2007/08. A feeding cup has been developed for cup feeding and was implemented in 2007 in BFHI facilities.

Infant and Young Child Feeding policy issues specifically, infant feeding in the context of PMTCT and HIV and AIDS needs to be addressed.

5.1.4.4 **Food service management**

Food service management is often an under emphasised aspect of health care. The provincial food service management policy was approved in March 2005 and includes the development of a monitoring tool with evaluation criteria for food services. Monitoring of the implementation is ongoing in the province. The results of a foodservice audit undertaken during 2007 indicate that the foodservice policy has been implemented and 23 out of a total of 38 facilities (60%) scored above 75% on the food service monitoring tool.

5.1.4.5 **Community-based Nutrition programmes**

Community-based nutrition programmes are direct means of improving nutrition and a means of focussing attention on nutrition concerns and policies. The Western Cape has implemented six projects ranging from nutrition rehabilitation of malnourished children, linkages with community IMCI and multidisciplinary crèche based projects. A national framework for community based nutrition programming has been drafted and interventions will be implemented and expanded in future plans.

Table: 2.29 Situation analysis indicators for MCWH & Nutrition [MCWH1]

Strategic objective	Measurable Objective		Indicator	Province wide value 2004/05 (actual)	Province wide value 2005/06 (actual)	Province wide value 2006/07 (actual)	Metro District 2006/07	Cape Winelands District 2006/07	Overberg District 2006/07	Eden District 2006/07	Central Karoo District 2006/07	West Coast District 2006/07	National target 2003/04
Strategic goal: Reduce child and neonatal morbidity and mortality													
Reduce Morbidity and Mortality from Vaccine preventable diseases	Improve child Immunisation status such that at least 90% of all children under one year are fully immunised	1	Fixed PHC facilities with DTP-Hib vaccine stock out (Percentage)	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	
		2	Full Immunisation coverage under 1 year (Percentage)	91.3%	91.3%	92.9%	92%	80%	89%	92.6%	92.8%	84.3%	90%
		3	Measles coverage under 1 year (Percentage)	91.7%	90.7%	93.7%	91.2%	78%	89%	92.4%	92.6%	84.5%	
Improve resistance to disease in children <1 year	Increase vitamin A supplementation coverage in children <1year to at least 90%	4	Vitamin A coverage under 1 year (Percentage)	Not available	26.5%	68.63%	59.79%	89.16%	69.33%	87.57%	76.98%	73.36%	90%
	Increased facilities certified as Baby friendly to at least 35%	5	Facilities certified as baby friendly (Percentage)	12%	15%	19%	31%	11%	0	11%	0	11%	15%
Improve prevention and management of common childhood illnesses	Facilities implementing IMCI	6	Fixed PHC facilities implementing IMCI (Percentage)	79%	81%	82%	82%	63.3%	89%	75%	77%	93%	65%
Improve access of health services to youth	Ensure that health services are certified as youth friendly	7	Fixed PHC facilities certified as youth friendly (Percentage)	2%	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	
Strategic goal: Improve women's Health and Decrease Morbidity and Mortality during pregnancy, birth and post delivery													
To reduce morbidity and mortality in women at risk of cervical cancer	Increase cervical cancer screening coverage in women aged 30 years and over to be at least 8%	8	Cervical cancer screening coverage (Percentage)	38.9%	5.5%	6.3%	3.9%	6.8%	5.4%	5.9%	9.5%	5.6%	
To reduce morbidity and mortality in women as a result of abortions	Improve access to TOP services to 100% of all acute hospitals	9	Hospitals offering TOP services (Percentage)	86%	92%	87.2%	100%	100%	100%	83%	100%	100%	100%
		10	CHC's offering TOP services (Percentage)	45%	80%	5.7%	6.8%	0	0	0	0	0	
Decrease morbidity and mortality during pregnancy, birth and post delivery	Increase access to safe delivery services	11	Total deliveries in facilities	87 903	90 393	95 292	95 289	56 360	15,228	4 154	11 699	1 396	
		12	Facility Delivery rate (Percentage)	New Indicator	New Indicator	New Indicator	94%						
	Decrease teeneage deliveries to <10% of all deliveries	13	Institutional delivery rate for women under 18 years (Percentage)	11%	10.1%	10.1%	13.0%	10.3%	8.4%	9.2%	9.6%	13.3%	

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	National Health Act Public Finance Management Act Medium Term Strategic Framework National Spatial Development Framework Accelerated Shared Growth Initiative of South Africa Strategic Priorities for the National Health System (2004 – 09) Sexual Offences Act 23 of 1957 Choice of Termination of pregnancy Sterilisation Act INP Broad Guidelines for Implementation Strategic priorities Integrated Nutrition programme 2009
Provincial	IKapa elihlumayo (PGDS) Healthcare 2010 Standardised maternal Guidelines Management of survivors of rape and sexual assault
Divisional	**EIGHT DIVISIONAL PRIORITIES:** **Implementation of the DHS:** 1) Strengthed district health system 2) Community-based services 3) District hospitals 4) Chronic disease management **Priority Health Programmes** 5) TB 6) HIV and AIDS 7) Women's Health 8) Child Health

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5.2.2 Strategic Goals and Objectives

5.2.2.1 Women's Health

Strategic goal : Improve women's health and decrease morbidity and mortality during pregnancy, birth and post delivery.

Strategic objectives

1) Improve early antenatal booking rate (below 20weeks of gestation).
2) Implement the Saving Mothers(SM) Report III recommendations.
3) Reduce mortality in women as a result of septic abortions.
4) Increase facilities certified as Baby friendly.
5) Increase access to safe delivery services.
6) Reduce morbidity and mortality in women at risk of cervical cancer.

5.2.2.2 Child Health

Strategic goal: Reduce child and neonatal morbidity and mortality.

Strategic objective

1) Improve perinatal care to reduce neonatal morbidity and mortality.
2) Reduce morbidity and mortality from vaccine preventable diseases.
3) Improve resistance to disease in children <1 year.
4) Improve prevention and management of common childhood illnesses.
5) Improve access of health services to youth.

5.2.2.3 Nutrition

Strategic goal: Improve the nutritional status of prioritised groups

Strategic objectives

1) Improve the nutritional status of people on ART.
2) Improve food service management in all public hospitals.

5.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.31: Analysis of constraints and measures to overcome them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
Human resources	• Inadequate organisational capacity for nutrition services.	• Develop and implement a HR plan for nutrition services i.e. dieticians in line with the CSP.
	• Inadequate organisational capacity for Expanded programme on Immunisation, youth and adolescent health.	• Increase organisational capacity for Expanded programme on Immunisation, youth and adolescent health.
Nutrition Supplementation	• Increased pressures on services arising from emerging chronic diseases of lifestyles.	• Review resource allocation and management of chronic diseases in accordance with BOD findings.
Resource management	• No identified budget for child and women's health programmes in districts.	• Create specific budgets with financial responsibilities and objectives.
Monitoring and Evaluation	• Flow, accuracy, timeliness and completeness of data for all programmes.	• Integrated planning and management of data/information with the Directorate: Health Information Management.

5.4 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.32: Provincial objectives and performance indicators for MCWH and Nutrition [MCWH2]

Strategic Objectives	Measurable objectives	Measure / Indicator		2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (target)	2009/10 (target)	2010/2011 (target)
Strategic goal: Improve women's Health and decrease Morbidity and Mortality during pregnancy, birth and post delivery										
To improve antenatal care	Increase antenatal booking rate below 20 weeks to at least 65% by 2011.	1	Percentage of women booking below 20 weeks	Not applicable	Not applicable	37%	45%	50%	60%	65%
	Implement BANC at PHC Clinics/ facilities to 100% by 2011.	2	% of PHC Clinics/ facilities offering BANC	Not measured	Not measured	3% (9/290)	49% (116/290)	61% (178/290)	80% (232/290)	100% (290/290)
To implement the Saving Mothers(SM) recommendations	Increase number birthing Units/ facilities implementing SM recommendations to 95% by 2011.	3	% of Birthing Units/ facilities implementing SM recommendations	Not measured	Not measured	Not measured	Not measured	86% (44/51)	90% (46/51)	95% (49/51)
To reduce second trimester TOP's and morbidity and mortality in women as a result of abortions	Decrease number of second trimester TOPs.	4	% of second trimester TOPs	Not measured	Not measured	Not measured	New indicator	27%	25%	24%
Strategic goal: Reduce child and neonatal morbidity and mortality										
To improve Perinatal Care to reduce neonatal morbidity and mortality	Increase number of Birth Units/ facilities with functional Perinatal problem identification programme (PPIP).	5	% of Birthing Units/ facilities with functional PPIP	Not measured	Not measured	Not measured	40% (21/51)	71% (36/51)	90% (46/51)	96% (49/51)
To assess the health status of learners grade 1.	Increase the number of schools where phase 1 is implemented.	6	Percentage of schools visited to do screening	Not measured	Not measured	60% 661/1102	70% 772/1102	80% 882/1102	85% 937/1102	90% 992/1102
Strategic goal: Improve the nutritional status of prioritised groups										
To improve the nutritional status of prioritised groups	Improve the nutritional status of people on ART.	7	Number of ART sites implementing the Nutrition Supplementation Programme	17	34	39	44	70	78	88
	Improve Food service management in all public hospitals.	8	Number of facilities scoring above 75% of the standard	Not available	5	18	23	34	38	41

Table 2. 33:Performance indicators for Maternal Child and Women's Health and Nutrition [MCWH 3]

Strategic objective	Measurable Objective	Indicator		Province wide value 2004/05 (actual)	Province wide value 2005/06 (actual)	Province wide value 2006/07 (actual)	Province wide value 2007/08 (estimate)	Province wide value 2008/09 (target)	Province wide value 2009/10 (target)	Province wide value 2010/11 (target)	National target
Strategic goal: Reduce child and neonatal morbidity and mortality											
To reduce morbidity and mortality from vaccine preventable diseases	Improve child Immunisation status such that at least 90% of all children under one year are fully immunised.	1	Fixed PHC facilities with DTP-Hib vaccine stock out	Not available	Not available	Not available	6.7%	<2%	<2%	<2%	0
		2	Full Immunisation coverage under 1 year	91.3% 83 352	91.3% 83 352	92.9% 83 352	93% 84 904	93% 93 750	93%	93%	90%
		3	Measles coverage under 1 year	91.7% 83 717	90.7% 82 804	93.7% 85 543	93% 84 904	93% 93 750	93%	93%	90%
To improve resistance to disease in children <1 year	Increase vitamin A supplementation coverage in children <1year to at least 90%.	4	Vitamin A coverage under 1 year	Not available Not available	26.5% 25 054	68.63% 66 419	90% 82 166	89% 90 726	90%	90%	80%
To improve prevention and management of common childhood problems.	Facilities implementing IMCI.	5	Fixed PHC facilities implementing IMCI	79% 270	81% 277	82% 280	83% 283	84% 287	85% 290	86% 294	70%
To improve access of health services to youth.	Ensure that at least X% of health services are certified as youth friendly.	6	Fixed PHC facilities certified as youth friendly	2	Not available	Not available	Not available	Not available	Not available	Not available	30
Strategic goal: Improve women's Health											
To reduce morbidity and mortality in women at risk of cervical cancer.	Increase cervical cancer screening coverage in women aged 30 years and over to be at least 8%.	7	Cervical cancer screening coverage	38.9%	5.5%	6.3%	7.5% 65050/ 867338	8.0% 72449/ 905618	8.5%	9%	15%
Strategic goal: Decrease Morbidity and Mortality during pregnancy, birth and post delivery											
To reduce morbidity and mortality in women as a result of abortions	Improve access to TOP services by increasing TOP facilities to 100% of all acute hospitals and 8.5% of CHC.	8	Hospitals offering TOP services[1]	86%	92%	85% 32/40	88% 35/40	88% 35/40	90% 36/40	93% 37/40	100%
		9	CHC's offering TOP services	45%	80%	5% 3/60	5% 3/60	8.5% 5/60	8.5% 6/60	8.5% 6/60	80%
To increase the number of BFHI facilities	Increase the number of facilities certified as Baby friendly to at least 35%.	10	Facilities certified as baby friendly(%) Number	12% 35/290	15% 44/290	19% 55/290	22% 64/290	26% 75/290	31% 90/290	36% 104/290	30%
To increase access to safe delivery services	Improve facility delivery rate to 95%.	11	Total deliveries in facilities	87 903	90 393	95 289	83 384	85 000			
		12	Facility Delivery rate	New Indicator	New Indicator	New Indicator	94%	95%	95%	95%	
	Decrease teenage pregnancy to <10% of all deliveries.	13	Institutional delivery rate for women under 18	11%	10.1%	10.1%	10%	10%	8.1%	8.0%	13%

Notes:

1. Prior to 2007/08 the denominator was the hospitals designated to provide TOP services not all acute hospitals and specialised hospitals.

5.5 EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Funding for Sub-programme 2.7: Nutrition increases by a nominal amount of R1.214 million or 7.33 per cent in 2008/09 in comparison to the revised estimate of the 2007/08 budget.

Table 2.34: Trends in provincial public health expenditure for INP [MCWH4]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total	15 442 000	13 700 000	15 136 000	16 568 000	17 782 000	18 827 000	19 768 000
Total per person	3.32	2.90	2.87	3.05	3.19	3.28	3.36
Total per uninsured person	4.46	3.89	3.84	4.10	4.28	4.41	4.50
Constant 2006/07 prices							
Total	17 129 504	14 176 618	15 136 000	16 004 888	16 421 067	16 827 207	17 117 991
Total per person	3.69	3.01	2.87	2.95	2.94	2.94	2.91
Total per uninsured person	4.95	4.02	3.84	3.96	3.95	3.94	3.90

6. DISEASE PREVENTION AND CONTROL

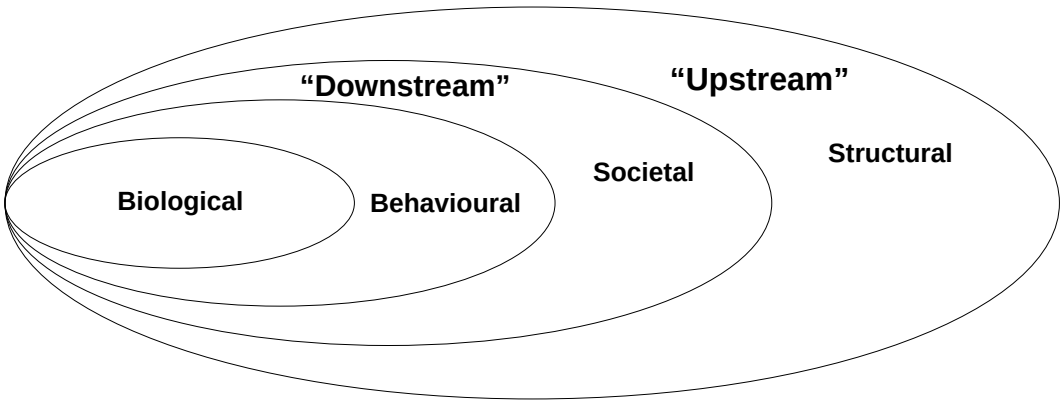
6.1 SITUATION ANALYSIS

6.1.1 Burden of Disease

It is vital that the Western Cape Department of Health does not confine itself to addressing disease, but also to improving health status. The major determinants of health are often beyond the reach of the health sector and include a range of socio-structural ('upstream') factors such as income inequality, poverty, access to basic services and social behavioural norms. This is shown in figure 2.8 below as societal and structural factors.

The Provincial Government of the Western Cape (PGWC) mandated the Western Cape Department of Health to lead an initiative to define the components of the burden of disease in the Province and to provide evidence-based recommendations as to how these can be reduced. In particular the aim is to focus on inter-sectoral collaboration that addresses the critical determinants, especially the upstream determinants, of this burden in order to build and sustain health security.

Figure 2.8: Determinants of Disease



The burden of disease reduction project resulted in collaboration between the Provincial government, Local Government, and a wide range of academic institutions, non-governmental organisations.

Key findings

As data collection on morbidity is not routinely collected, it was necessary to use mortality data to obtain an estimate of the burden of disease in the Western Cape. This analysis indicated that there are five main contributors to the burden of disease: major infectious diseases (HIV and Tuberculosis), mental disorders (including substance misuse), injuries (road traffic incidents and violence), cardiovascular diseases and diseases of childhood. In addition to the surveillance work team, five workgroups were formed tasked with gathering evidence on upstream risks and interventions related to the five main contributors to the burden of disease.

While mental disorders do not cause significant premature death directly, it is acknowledged that mental illness, through its association with unsafe sex, substance abuse and risk-taking behaviour is an 'upstream' risk factor for premature deaths due to HIV, injuries, cardiovascular disease and childhood diseases. The Medical Research Council has found that mental disorders are the third leading contributor to the burden of disease in South Africa and local prevalence data from the Stress and Health Survey (SASH) indicate that the annual prevalence of mental illness in the Western Cape is 22.4%.

The five prevention workgroups provided comprehensive reviews of the evidence and identified several areas in which the burden of disease could be dramatically reduced. Most of these factors fall into six categories:

1) **Reduction of alcohol and drug abuse (**by addressing both demand and supply factors)
2) **Improving early childhood development outcomes** (by addressing nutrition, parenting skills, access to pre-school and maternal mental health)
3) **Adolescent Development programmes** (including recreational and physical activities, mentoring, health lifestyle development and life skills training)
4) **Creating healthy social norms related to health** (including reducing gender imbalances, improving adherence to chronic medication, promoting safe sex, promoting breastfeeding and challenging the norms related to alcohol use)
5) **Reducing multiple deprivation** (ensuring access to quality housing, water and sanitation; improving road and personal safety and increasing access to social grants)
6) **Health system interventions** (health service interventions ranging from health promotion to secondary prevention were highlighted by all five groups, in particular for Mental Health, HIV and TB and Child Health).

In the case of mental health and major infectious diseases, health sector level interventions could have potentially substantial impact at population level. The reason for this is that more downstream health sector interventions targeting individuals can have important secondary or recursive prevention effects in reducing the burden of disease at the population level by interrupting the transmission of infectious agents or the propagation of psychological trauma within family units.

6.1.2 Environmental and Port Health:

Maintaining environmental and Portal Health is important in disease prevention. Service rendering at the three major harbours in the Western Cape i.e. Cape Town, Saldanha and Mossel Bay and at the Cape Town International Airport has reverted to the Provincial Department of Health in terms of the National Health Act, 2003 (Act 61 of 2003). The number of ships assessed on average for a clearance certificate monthly has risen from 65 to 90.

In terms of the National Health Act, the co-ordination of environmental health services is a provincial function. In planning for the 2010 World Cup the province is compiling an Environmental Health and a Port Health Plan. This process is ongoing and updated on a regular basis.

The National Department has developed indicators for Municipal Health Services to be implemented on DHIS in 2008.

6.1.3 **Prevention of Blindness**

To be in line with the National Vision 2020 Plan, the Province put in place a draft Eye Care Plan that looks at the following areas:

- Ensuring that eye care screening is integrated as part of the PHC package and school health services.
- Training of ophthalmic nurses and ophthalmic technical assistants.
- Ensuring the provision of district eye care services including a high volume cataract surgery site, refraction services, low vision and community-based services. Besides the other tertiary hospitals that are also doing cataract surgery, Eerste River Hospital has been identified as the high volume cataract surgery site. In 2006 Eerste River Hospital performed 1 019 cataract operations in comparison to 895 in 2005 and up to December 2007, 1 622 operations were done, this is an increase of just over 70%. They have also acquired a laser machine, which was donated by the Rotary Service Club in July 2006 and performed 41 diabetic related laser procedures in the latter half of 2006.

6.1.4 **Social Capital**

The social capital strategy is consistent with the *Ikapa Elihlumayo* framework, which defines the Social Capital Formation Strategy (SCFS) as one of the lead strategies. The departments of Health, Education Community Safety, Cultural Affairs and Sport, Social Services and Poverty Alleviation, and Local Government and Housing are grouped together in the Social Sector Cluster with the latter department filling the role of lead department in the strategy: Social Capital Formation. Strategies that are jointly decided upon at central level will need to be implemented in a coordinated manner at the service delivery interface.

The Western Cape Health Department developed its own plan, which was implemented in 2005 in two urban renewal areas Mitchell's Plain and Khayelitsha, and the budget that was allocated for this was R7 million.

The rural regions were also given R1 million each to start funding clinic health committees. In 2006 and 2007 the projects were expanded to include support groups for chronic diseases of lifestyle.

6.1.5 **Social Transformation**

In the Premier's State of the Province Address (SOPA) 2007, the Premier highlighted focus areas for the year 2007/2008 to give effect to the Provincial Growth and Development Strategy (PGDS). Twenty-one priority areas were identified where the Provincial Government of the Western Cape (PGWC) will focus its interventions (resources, collaboration with stakeholders and service delivery) on facilitating social regeneration initiatives.

1) Manenberg
2) Mitchells Plain
3) Khayelitsha
4) Hanover Park
5) Nyanga
6) Elsies River
7) Bishop Lavis
8) Delft
9) Kleinvlei
10) Gugulethu
11) Philippi
12) Muizenberg
13) Vredenburg
14) Paarl
15) Oudtshoorn
16) Matzikama
17) Theewaterskloof
18) Kannaland
19) Cedarberg
20) Central Karoo
21) Witzenberg

Community mobilisation jamborees were run in all the priority areas by the various PGWC departments. Health's contribution was to run screening services for chronic diseases, awareness programmes and there were stalls for community-based services to market departmental services. Furthermore various interactions with communities were done in an effort to assist them to establish coordinating structures. The Health Department was given the responsibility of setting up these structures in Kleinvlei, Delft and Hanover Park.

Table 2.36 : Situation analysis indicators for non-communicable disease control [PREV1]

Strategic goal: To ensure the delivery of a good quality Disease control programme in all the districts of the Western Cape													
Strategic Objectives	**Measurable objectives**		**Indicator**	**Province wide value 2004/05**	**Province wide value 2005/06**	**Province wide value 2006/07**	**Metro District 2006/07**	**Cape Winelands District 2006/07**	**Overberg District 2006/07**	**Eden District 2006/07**	**Central Karoo District 2006/07**	**West Coast District 2006/07**	**National target 2006/07**
To provide capacity to render disease control services	Ensure that all districts have at least one trauma centre for victims of violence.	1	Trauma centres for victims of violence (number)	41	41	41	13	6	4	7	4	7	1 per district
	Ensure all districts have a health care waste management plan.	2	Health districts with health care waste management plan implemented (number)	6	6	6	1	1	1	1	1	1	All districts
To provide programmes for the prevention of occupational diseases	Increase the percentage of hospitals providing occupational health programme to 100%.	3	Hospitals providing occupational health programmes (percentage)	35	35	77	100	100	100	100	100	100	100
To ensure the involvement of schools in promoting health	Increase the number of schools implementing Health Promoting Schools programme.	4	Schools implementing Health Promoting Schools Programme (HPSP) (percentage)	Not available	Not planned	Not planned	Not planned	Not planned	Not planned	Not planned	Not planned	Not planned	50
To be ready to deal with epidemics and disasters	Ensure all districts have an integrated epidemic preparedness and response plan.	5	Integrated epidemic preparedness and response plans implemented (Y/N)	Y	Y	Y	Y	Y	Y	Y	y	y	y
	Ensure adequate outbreak response in line with Provincial guidelines.	6	Outbreaks responded to within 24 hours (percentage)	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	New indicator	1 day
		7	Malaria fatality rate (percentage)	2.3	Not available	No malaria	N/A	N/A	-	N/A	0	0	0.25
		8	Cholera fatality rate (percentage)	0	Not available	No cholera	N/A	N/A	-	0	0	0	0.5
To improve the vision of people with cataracts	Increase the cataract surgery rate to be in line with the national target of 1400/1million.	9	Cataract surgery rate (number /million population)	757	1 276	1 287	-	-	-	N/A	N/A	-	1400
		10	Number of cataract operations.	-	5 928	6 030	-	-	-	-	-	-	

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The strategic goal is to improve community-based prevention and health promotion and the objectives to be strengthened are:

- The promotion of healthy lifestyles and the reduction of risk-taking behaviour especially among children and youth
- Improved self-management by clients of chronic and other diseases
- Child Survival: The prevention of childhood illnesses, injury and unnatural death
- Implementation of health promotion programmes for the divisional priorities
- Expansion of the health promoting schools programme
- Implementation of activities for prioritised calendar health days
- Continuance of the jamboree campaigns started in the 21 identified social transformation priority areas.

6.2.2.1 **Promotion of healthy lifestyles**

The campaign to promote healthy lifestyles addresses the key behavioural factors for protection of long-term health in the population, in particular: sexual decision-making; the abuse of tobacco, alcohol and drugs; nutrition; regular physical activity. Recognising the underlying social and environmental determinants of risk-taking behaviour, and the impact of poor mental health on the capacity of individuals to make healthy choices, the campaign will collaborate with the provincial Social Capital and Social Transformation Programmes for the integration of health knowledge and action across sectors, as well as strengthening the capacity of the health sector to promote healthy living through facility- and community-based services.

Community-based health screenings for early identification of existing or incipient cardio-vascular disease and diabetes is an integral part of the Healthy Lifestyles campaign. Since March 2007 more than 4 000 people have been screened. Approximately 8% of them were referred to a health facility for further attention. The campaign aims in particular to strengthen interaction with schools to support the development of healthy decision-making among learners of the pre-adolescent and early adolescent age groups.

The 'Vuka, Move for your Health' campaign remains as a lead project of the Healthy Lifestyles campaign. Health Promotion will continue to drive the promotion of physical activity in support groups for clients with chronic diseases through further training of facilitators. A key objective for 2008 is the extension of the Vuka campaign into schools.

6.2.2.2 **Health Promoting Schools Programme**

The Health Promoting Schools Programme (HPSP) addresses the overall health of learners and staff in the whole-school environment, by extension supporting the health of parents and the surrounding community. Currently confined to the Metropole, the programme in 2007 was particularly active in promoting recreational activities as a preventive measure against substance abuse and school violence; in the implementation of a de-worming and hygiene promotion project and in the promotion of the mental and physical health of educators through self-care.

The Health Promoting Schools Programme objectives for the year are to extend the programme to the rural areas and to strengthen the capacity of existing health promoting schools to integrate health into the schooling environment through both curricula and extra-curricula activities. In 2007 the Western Cape programme finalised a resource package for health promoting schools developed on behalf of the national department. This will be used in 2008 to promote the adoption of HPSP by schools and for training support. The programme has also developed a tool to assess the status, progress and support needs of HPSP schools this will be implemented in 2008 and serve as the basis for strategic development.

6.2.3 Mental Health Promotion

Substance abuse

Analysis by the Medical Research Council report on risk factors for the burden of disease has shown that alcohol misuse is the third highest risk factor for the burden of disease in South Africa, preceded only by unsafe sex and interpersonal violence, both of which are strongly linked to alcohol misuse (MRC 2007). Furthermore, as the Western Cape has fewer cases of HIV than other provinces, and due to the high prevalence of alcohol misuse in the Western Cape, alcohol is likely to be the leading risk factor for the burden of disease in the Western Cape. In terms of purely mental health services, the 'tik' epidemic has also resulted in major burden, with 'tik psychosis' blocking beds and disrupting emergency units around the Province.

The Department of Health will continue to strengthen its mandate to provide detoxification services and medical emergencies associated to substances. Provide health personnel with ongoing training to be able to recognise and detect risks associated with substance use, and intervene briefly and refer appropriately.

In addition, Department of Health will continue to support Department of Social Development as the lead department in substances, and partner on identified projects. Saartjie Baartman, is one such pilot project to run over the next 3 years, in which Departments of Health and Social Development have partnered with the SANCA Western Cape NPO. The Saartjie Baartman project offers an out-patient rehabilitation substance abuse programme to be run by a full multidisciplinary team; Department of Health will fund or provide services of a sessional psychiatrist (already in place), sessional medical officer, a full-time mental health nurse and a full-time psychologist. There is strong support within the health sector for the view that a more heath-orientated model of addressing people presenting with substance abuse will result in more positive results.

6.2.4 Environmental Health

The strategic goal for Environmental Health is to improve the co-ordination and monitoring of Municipal Health Services (MHS).

The objective for 2008/2009 will be:

- Refine the monitoring and evaluation for municipal health services. The National indicators have been finalized and will be implemented as from 1st January 2009. Sinjani will be utilized to capture the data and quarterly reports will be made available. An annual report will also be submitted.
- Continue with the monitoring of the MHS of local authorities in the Province.

- Ensure that the necessary facilities at all 2010 FIFA World Cup events, Fan Park venues and tourist facilities comply with relevant legislation and standards.
- Render all Port Health services as determined by the International Health Regulations Act and expand the service in order to align it with 2010 requirements.

6.2.5 **Prevention of Blindness**

The key strategic objectives for 2008/09 are:

- To allow Eerste River Hospital to continue as a high-volume cataract surgery centre in the province. In implementing the CSP, clients who are not appropriately placed with the cataract surgery waiting list of tertiary hospitals will be identified to have their surgery at Eerste River Hospital.
- To train of staff on visual acuity in order to be able to pick up cases to be referred.
- To establish refraction services in the Province, especially in the Metropole.
  Two refraction sites have been established in the Metropole. Bonang, the social service arm of the South African Optometric Association, will service the Northern Metropole and Cape Peninsula University of Technology School of Optical Dispensing will service the Southern Metropole on a preferred service bid provider contract.
- To expand the training and establishment of a community-based eye screening service.

6.2.6 **Social Capital**

Social Capital will prioritise the following areas for 2008/2009

- Expand Health Promoting Schools by funding NPOs for more school health workers.
- Support the Chronic Diseases of Lifestyle project and link it to existing chronic disease support groups.
- Establish and sustain Health Committees through the finalisation and implementation of the policy related to Health Committees and Health Facility Boards.
- Sustain the projects implemented at the two urban renewal nodes: Khayelitsha and Mitchell's Plain.

6.2.7 **Social Transformation**

The Department of Health has been given the responsibility of coordinating the social transformation interventions of Kleinvlei, Delft and Hanover Park communities.

Three strategies are used to address the needs of these communities:

1) Community mobilisation
2) Mobilisation of inter-departmental and inter-governmental teams within these communities
3) Service delivery jamborees.

The process of community mobilisation will be linked to the interventions that are in line with the divisional priorities. Furthermore, the implementation of these strategies is done through consultative processes within these communities which include community empowerment and training.

6.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.37: Analysis of constraints and measures to overcome them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
HEALTH PROMOTION	• Inadequate staffing	• Implementation of the Comprehensive Service Plan
ENVIRONMENTAL HEALTH	• Grey areas in National Health Act, 2003 • No line function over Las who render municipal health services. • Minimum guidance from National Department regarding Municipal Services excluding food control.	• Clarity to be sought from National Department • Constant liaison with EH and Municipal managers • Attend National Meetings
MENTAL HEALTH (SUBSTANCE ABUSE)	• Linkages between Health, Social Development and the other Departments	• An active substance abuse forum with clear roles

6.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.38: Provisional objectives and performance indicators for non-communicable disease control [PREV 2]

Strategic Goal: Ensure adequate disease prevention and control										
Strategic Objectives	**Measurable objectives**		**Indicator (Performance Measure)**	**Province wide value 2004/05 (actual)**	**Province wide value 2005/06 (actual)**	**Province wide value 2006/07 (actual)**	**Province wide value 2007/08 (estimate)**	**Province wide value 2008/09 (target)**	**Province wide value 2009/10 (target)**	**Province wide value 2010/11 (target)**
To implement the National Health Act provisions dealing with Environmental health	Monitor municipal environmental health services	1	% Water samples conforming to standards	84.10%	85%	88%	90%	90%	90%	90%
		2	% Sewage effluent samples complying to requirements	53.90%	55%	60%	65%	70%	75%	75%
		3	% Food samples conforming to Act 54/72	72.70%	75%	78%	80%	85%	85%	85%
		4	% Households with effective refuse removal service (minimum of one r efuse removal per week)	88.60%	88.59%	89%	90%	90%	90%	90%

Table 2. 39: Performance indicators for Disease Prevention and Control [PREV 3]

Strategic goal: To ensure the delivery of a good quality Disease cont rol programme in all the districts of the Western Cape											
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**		**Province wide value 2004/05 (actual)**	**Province wide value 2005/06 (actual)**	**Province wide value 2006/07 (actual)**	**Province wide value 2007/08 (estimate)**	**Province wide value 2008/09 (target)**	**Province wide value 2009/10 (target)**	**Province wide value 2010/11 (target)**	**National target 2007/08**
To provide capacity to render disease control services	Ensure that all districts have at least one trauma centre for victims of violence.	1	Trauma centres for victims of violence (number)	41	41	41	41	41	41	41	1 per district
	Ensure all districts have a health care waste management plan.	2	Health districts with health care waste management plan implemented (number)	6	6	6	6	6	6	6	All districts
To provide programmes for the prevention of occupational diseases (see above note)	Increase the % of hospitals providing occupational health programme to 100%.	3	Hospitals providing occupational health programmes (percentage)	35%	35%	77%	80%	90%	100%	100%	100%
To ensure the involvement of schools in promoting health	Increase the number of schools implementing Health Promoting Schools programme.	4	Schools implementing Health Promoting Schools Programme (HPSP) (percentage)	7%	Not planned	11.8%	Not available	7%	20%	25%	30%
To be prepared to deal with epidemics and disasters	Ensure all districts have an integrated epidemic preparedness and response plan.	5	Integrated epidemic preparedness and response plans implemented (Y/N)	Y	Y	Y	Y	Y	Y	Y	Y
	Ensure adequate outbreak response l line to Provincial guidelines.	6	Outbreaks responded to within 24 hours.	New indicator	New indicator	New indicator	90%	95%	95%	95%	
		7	Malaria fatality rate (percentage)	2.3%	Not available	No malaria	4.5%	0	0	0	0
		8	Cholera fatality rate (percentage)	0%	Not available	No cholera	0	0	0	0	0
To improve the vision of people with cataracts	Increase the cataract surgery rate to be in line with the national target of 1 400/1million.	9	Cataract surgery rate (No/million population)	757	1,276	1,287	1,400	1,273	1,291	1,307	1,400
		10	Number of cataract operations.	-	5,928	6,030	6,811	7,100	7,400	7,700	

7. FORENSIC PATHOLOGY SERVICES (SUB-PROGRAMME 2.8)

7.1 SITUATIONAL ANALYSIS

After the transfer of the "Medico-legal Mortuaries'" from the South African Police Service to Provincial Departments of Health on 1 April 2006 the Department of Health, Provincial Government Western Cape established a new Forensic Pathology Service (FPS) in the Province. This service is rendered by two M6 academic forensic pathology laboratories in the Metro, three referral FPS laboratories and smaller FPS laboratories and holding centres in the West Coast, Cape Winelands, Overberg, Eden and Central Karoo Districts.

The Western Cape FPS is managed through a central unit that is responsible for the management and coordination of the service. The FPS is being developed as a new service with sufficient human resource and infrastructure capacity to improve the service delivery.

7.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

In terms of section 27(2) of the Health Act 2003, the provincial Departments of Health are responsible for implementation of the entire FPS, excluding forensic laboratories (which is a national responsibility), in compliance with national policies and law. This is a culmination of a cabinet decision on 29th April 1998 to transfer the medico-legal mortuaries from SAPS to Health. The priorities of the FPS in the Western Cape are the following:

1) Implementing a new FPS in accordance with policy, statutory and legal requirements (Code).
2) Implementing the human resource plan in accordance with the implementation plan.
3) Training and orientation of personnel in accordance with the human resource development plan.
4) Determining the equipment needs and procuring the required equipment in accordance with supply chain prescripts.
5) Determining the vehicle needs and procure in accordance with Government Motor Transport fleet management prescripts.
6) Developing a facilities plan and develop a schedule for the renovation and construction of facilities.
7) Developing, piloting and implementing a forensic pathology information management system.

Strategic objectives for 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 as well as the Forensic Pathology Services Code.

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7.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The high workload and related stress of performing approximately 10 000 medico-legal autopsies per annum continues to impact on the ability to recruit and retain personnel to the FPS. This will need to be addressed by providing additional specialist posts of suitable grading as provided in the proposed human resource plan for the FPS, ensuring adequate grading of forensic pathology support posts as well as ensuring dedicated employee wellness programmes within the FPS. The National Strategic Plan for FPS, (linked to that the Healthcare 2010 Plan) proposes 123 forensic pathologists (FP's) for South Africa (SA). There are approximately 30 registered and practising forensic pathologists in SA at present. There are eight University training centres in South Africa, only six of which train post-graduate students. The average output of these centres is not even one qualified student (forensic pathologist) per year.

To expedite full implementation, the Forensic Pathology academic training centres must be resourced and supported in the short- to medium-term, to enable the training of registrars; whilst continuing optimum, competent service delivery.

A high percentage of staff in the new FPS are new to the Department of Health and the FPS and orientation of these staff as well as comprehensive basic training is required in order to ensure continued service delivery to the community.

The human resource plan for the service will be implemented with an increase in personnel to 275 filled posts out of an establishment of 306 in 2008/2009 financial year. Building and infrastructure will be upgraded in accordance with the Infrastructure plan, and incident response time will be decreased by ensuring 56 vehicles in active service on the road.

7.4 SPECIFICATION OF MEASUREABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 40: Provincial objectives and performance indicators for Forensic Pathology Services

Sub-programme 2.8:	**Forensic Pathology Services**	**Strategic Goal:**	The establishment of an FPS for the Province that is designed to contribute positively to ensure the development of a just South African Society, to assist with the fight against and prevention of crime, to assist with the prevention of unnatural death, to establish the independence of the medical and related scientists and to ensure an equitable, efficient and cost effective service.						
Strategic objective	**Measurable objective**	Performance measure/indicator	ACTUAL 2004/5	ACTUAL 2005/6	ACTUAL 2006/7	ESTIMATE 2007/8	TARGET 2008/9	TARGET 2009/10	TARGET 2010/11
To provide an effective and efficient forensic pathology service in accordance with the statutory requirements.	Adequate staffing through the recruitment of personnel as per the Human Resource Plan	Percentage of posts filled according to Human Resource Plan	Not reported	Not reported	98% (166/170)	97% (231/239	90% (275/306)	92% (282/306)	92% (282/306)
	Improved quality of service	Percentage of autopsies performed	New indicator implemented during 2007/8 Financial Year Baseline not yet available	New indicator implemented during 2007/8 Financial Year Baseline not yet available	New indicator implemented during 2007/8 Financial Year Baseline not yet available	New indicator implemented during 2007/8 Financial Year Baseline not yet available	70% 7 000/10 000)	72% (7 200/10 000)	75% (7 500/ 10 000)
	Improved response time	Average response time (From receipt of call to arrival on scene)	Service still with SAPS	Service still with SAPS	New indicator implemented during 2007/8 Financial Year Baseline not yet available	New indicator implemented during 2007/8 Financial Year Baseline not yet available	40 minutes	38 minutes	35 minutes
	Improved quality of service	Percentage of personnel budget spent on training			4 9%	2%	2%	2%	2%

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

The allocation to Sub-programme 2.8: Forensic Pathology Services in 2008/09 decreases by a nominal amount of R65.230 million or 50.34 per cent in comparison to the revised estimate of 2007/08. The allocation to forensic pathology services includes a conditional grant of R55.535 million.

Table 2.41: Trends in public health expenditure for Sub-programme 2.8: Coroner Services (Forensic Pathology Services)

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total	843 000	2 004 000	51 966 000	129 582 000	64 352 000	68 305 000	77 055 000
Total per person	0.18	0.42	9.84	23.88	11.54	11.92	13.08
Total per uninsured person	0.24	0.57	13.20	32.03	15.48	15.99	17.55
Constant 2006/07 prices[2]							
Total	935 123	2 073 718	51 966 000	125 177 778	59 426 865	61 049 682	66 725 352
Total per person	0.20	0.44	9.84	23.07	10.66	10.65	11.32
Total per uninsured person	0.27	0.59	13.20	30.94	14.29	14.29	15.20

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

Programme 2 is allocated 34.31 per cent of the total vote in 2008/09 in comparison to the 36.28 per cent that was allocated in the adjustment estimate for 2007/08. This translates into a nominal increase of R221.4292 million or 8.07 per cent.

Table 2.42: Trends in public health expenditure District Health Services Total programme 2) [DHS9]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total excluding capital	1 330 397 000	1 629 951 000	1 922 792 000	2 743 457 000	2 964 886 000	3 282 884 000	3 641 039 000
Total capital	88 515 000	40 765 000	89 898 000	84 243 000	254 332 000	294 033 000	430 456 000
Grand total	**1 418 912 000**	**1 670 716 000**	**2 012 690 000**	**2 827 700 000**	**3 219 218 000**	**3 576 917 000**	**4 071 495 000**
Total per person	305.38	354.14	381.29	521.18	577.26	624.00	691.01
Total per uninsured person	409.93	474.25	511.26	698.97	774.34	837.22	927.32
Constant 2006/07 prices							
Total excluding capital	1 475 782 969	1 686 656 415	1 922 792 000	2 650 212 616	2 737 970 537	2 934 177 943	3 152 937 631
Total capital	98 187 931	42 183 200	89 898 000	81 379 756	234 866 879	262 800 983	372 750 998
Grand total	**1 573 970 900**	**1 728 839 615**	**2 012 690 000**	**2 731 592 372**	**2 972 837 417**	**3 196 978 926**	**3 525 688 629**
Total per person	338.75	366.46	381.29	503.46	533.08	557.72	598.38
Total per uninsured person	454.73	490.75	511.26	675.21	715.07	748.29	803.00

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This indicator therefore measures only priority one responses ignoring the majority of other priority responses. Targets are achieved in the five rural districts in 58% of priority one responses in built up areas, and 62.6% in out-of-town areas. In 26.3% of the priority one responses in the metropolitan area of Cape Town in 2007, the target of 15 minutes was achieved with an average response time of 30.38 minutes for priority one (life threatening) emergencies and 75.65 minutes for priority two and three (limb threatening) emergencies. Clearly a review is necessary taking account of the sensitivity of the indicator. A more appropriate target for priority one calls in urban areas would be approximately 25 minutes.

Meeting targets requires a management response taking account of complex factors including shortage of staff, number of vehicles, communication systems and working processes requiring attention. Computer-aided dispatch and tracking systems have resulted in improved information on performance, which allows analysis of the issues in more detail. The 2004 Barry Johns report indicated that an improvement of approximately 15% in response times could be derived through efficiency measures using the current resources and that further improvement in response times would require increased resources.

Prioritisation of responses is a difficult task because members of the public may either be unable or unwilling to accurately assess the nature and severity of the illness or injury.

Analysis indicates that 18% of emergency telephone calls received by the Tygerberg Communications centre are recorded as not answered by the digital telephone system and analysis shows that this is largely due to the 112 centre dropping calls after two rings and dialling again. Behaviour of persons calling in an emergency may also be the reason that calls are terminated before they can be answered. This results in a percentage of calls that are registered as unanswered. This behaviour must be acknowledged and a concerted effort made to meet the public requirement to answer calls within two rings. Currently 35% of calls are answered within the target of 12 seconds. The National Health System, NHS, Benchmark in the United Kingdom is 5 seconds.

EMS conducted an exercise called Operation 'Fika Msinya' or 'Árrive Quickly' during October 2007, which maximised the available ambulance resources over three days in the Cape Metro and analysed the response time performance. The exercise was repeated in January 2008.

These exercises revealed that a percentage of performance is related to resourcing and that the remainder is related to command and control, information communication technology and dispatch efficiency. The finding supports the need to invest in communications technology and emphasises the urgency of refining computer-aided dispatch and other processes.

The percentage of inter-facility transfers in the rural areas is 8%, which matches the CSP with respect to patients being seen at the appropriate level of care, but in the metropolitan area the percentage is 42%**.** Inter-facility transfers currently incur the longest mission times for the following reasons:

- Patients may not be ready for transfer on arrival of the ambulance.
- Patients may have complex medical conditions requiring stabilisation before transport.
- The patient has to be located within the institution.
- Receiving hospitals may not have the necessary trolleys or beds.
- Doctors and nurses refuse to accept patients.
- Patients have to be taken to wards through complex passages and lifts.

This emphasises the need to address the critical interface between emergency medical services and the casualty or hospital ward. During 2008 a concerted effort will be made to address all the challenges outlined above.

Table 3.1: Situation analysis indicators for EMS and Patient Transport [EMS1]

Strategic goal: To render effective and efficient pre-hospital emergency services including inter-hospital transfers and patient transport in the Western Cape													
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Province wide value 2004/05**	**Province wide value 2005/06**	**Province wide value 2006/07**	**Metro District 2006/07**	**Cape Winelands District 2006/07**	**Overberg District 2006/07**	**Eden District 2006/07**	**Central Karoo District 2006/07**	**West Coast District 2006/07**	**National target 2003/04**
To ensure the provision of sufficient resources for the rendering of an effective and efficient emergency and patient transport service	Provide target number of ambulances and patient transporters by 2010.	1	Total number of rostered ambulances[1.]	213	197	205[1]	82	38	19	29	13	24	
		2	Rostered ambulances per 1 000 people	0.045	0.041	0.039	0.021	0.052	0.083	0.050	0.190	0.077	
		3	Percentage hospitals with patient transporters	5.00	5.00	0[2]	0	0	0	0	0	0	
		4	Average kilometres travelled per ambulance (per annum)	57 258	58 231	71 433	65 941	66 371	86 381	82 720	70 830	78 072	
		5	Total kilometres travelled by all ambulances	12 195 954	11 471 507	13 439 511	4 456 225	2 888 500	1 772 508	2 334 430	84 967	1 902 881	
	Provide target number of appropriately trained operational emergency staff.	6	Percentage locally based staff with training in BAA	33%	48%	46%	43%	48%	33%	53%	63%	47%	
		7	Percentage locally based staff with training in AEA	-	38%	45%	46%	44%	59%	36%	28%	44%	
		8	Percentage locally based staff with training in ALS (Paramedics)	7%	8%	9%	11%	8%	8%	11%	9%	9%	
	Achieve normative response times in metro and urban areas.	9	Percentage P1 (red calls) calls with a response time of < 15 minutes in an urban area	-	30.0%	37.6%	14.4%	28.6%	76.6%	61.4%	74.5%	71.1%	
		10	Percentage P1 (red calls) calls with a response time of < 40 minutes in a rural area	-	70.0%	64.4%	Not applicable	49.0%	71.7%	70.9%	54.3%	69.5%	
		11	All calls with a response time within 60 minutes	Not Available	Not Available	61 721	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	
	Adhere to the prescribed staffing of ambulances.	12	Percentage of operational rostered ambulances with single person crews. [2]	0%	0%	0%	0%	0%	0%	0%	0%	0%	
	Ensure the effective and efficient utilisation of resources.	13	Percentage of ambulance trips used for inter-hospital transfers	14.0%	20.0%	15.0%	37.4%	11.1%	8.4%	4.7%	5.5%	15.4%	
		14	Percentage green code patients transported by ambulance	37.0%	29.0%	34.8%	33.0%	59.0%	72.0%	61.0%	46.0%	63.0%	
		15	Cost per patient transported by ambulance	502.00	557.00	741.00	See note 3						
		16	Percentage ambulances with less than 200 000 kilometres on the clock[4.]	-	-	49%	55%	42%	52%	38%	61%	42%	
		17	Number of EMS emergency cases- Total	453 288	374 485	392 395	213 466	59 199	26 538	56 727	11 786	24 679	

Notes:

1. This reflects the total ambulance fleet. The fleet size was initially decreased to reduce the burden of older vehicles and maintenance costs.
2. The Western Cape policy is to have Patient transport in EMS and not in hospitals.
3. The formula for the calculation of EMS costs at district level has not been developed.
4. There is a schedule of ambulance replacements.

3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Vision

Equal Access to 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 can be rapidly accessed who respond in time to place the right patient in appropriate care within the shortest possible time, resulting in the best possible outcome.

3.2.1 Strategic priorities

The strategic priorities of EMS are aligned with the priorities of the National Department of Health and address the burden of trauma and violence and match the direction of the CSP.

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

EMS has three strategic priorities for 2008/9:

1) **Training**

Training of EMS personnel is the fist priority in EMS. In order to deliver the required number of personnel with the necessary skills to provide quality care both initial and continuous training will have to be accelerated towards 2010. A training task team comprising Province and CPUT members has mapped out the target numbers to be trained to achieve targets of personnel.

2) **Communications**:

To consolidate the electronic computer-aided communications systems including automatic vehicle location to support the call taking and dispatch needs of the service and ensure efficient dispatch within all districts.

The provision of a modern computerised communication system to manage EMS resources is a top priority, central to the efficient deployment of resources and to achieving appropriate response times. 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 access.

The EMS is currently engaged in discussions with the South African Police Services to explore combined call taking services to mutually improve the efficiency of dispatched resources. The EMS also strongly advocates the roll out of the 112 Emergency Number System.

A significant initiative is to integrate the pre-hospital and emergency unit information process and develop improved emergency medicine data from which to manage the program.

3) **Personnel:**

In the ambulance services the priority is to establish a personnel establishment appropriate to the effective delivery of pre-hospital 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.

The EMS has a shortage of 1 086 personnel (2006) of which 751 are operational personnel (not supervisors or administrative personnel). A training programme has been developed to bridge the gap. Seventy-five student emergency care practitioners were appointed as the first step towards increasing the numbers. The aim is to have 200 annually.

3.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

3.3.1 Finance

Funding for EMS has improved over the last three years and this commitment continues over the MTEF period. These funds will enable EMS to move progressively closer to the targets and service levels outlined in the National EMS Framework.

The funding given to the EMS for additional personnel to address metropolitan response times will be used to appoint student emergency care practitioners (ECPs). These students will train on the mid-level worker programme as emergency care technicians. The priority one response times in the metropolitan area should be achieved at least 60% of responses by the end of the 2008/09 year.

Funds for additional medical equipment provided over the past MTEF period have addressed a large proportion of the major shortages in defibrillators and other electronic EMS equipment.

An additional 14 ambulances will be procured for the metropolitan area at a cost of R4.8 million in order to move towards the peak shift requirements for ambulances. The current peak availability in the Metropole is between 35 and 40, while the target is 75 ambulance vehicles.

Funds will continue to flow for the Red Cross Air Mercy Service (AMS) in order to continue its excellent role of transferring acute emergencies from rural areas to referral hospitals. The AMS in 2006 was strengthened with the helicopter service established in Oudtshoorn.

3.3.1 Human Resources

The EMS has a calculated 1 086 personnel (2006) shortage based on an activity and population based model to meet response time targets. The model assumes 100% efficiency, which places a very significant management challenge to the EMS.

Table 3.2: Distribution of the operational staff during 2007 and the projected model staff numbers required to meet performance targets

DISTRICT	NUMBER OF PERSONNEL 2006	NUMBER OF PERSONNEL 2007	MODEL 2010
Central Karoo	48	44	80
Eden	139	140	209
West Coast	126	121	154
Winelands	142	167	225
Overberg	115	110	121
Total rural areas:	**570**	**582**	**789**
Metro	369	365	669
TOTAL PERSONNEL	**939**	**947**	**1,458**

Note: The model excludes the 232 rescue personnel required.
This table excludes supervisors or managers.
Figures are as of December 2007, i.e. before the recruitment of all Student ECPs and replacement staff.

EMS will receive funding to address the service plan human resource gap over the next three years to 2010.

Student ECP's will be recruited in 2008 to facilitate training and selection of the best EMS candidates for the service.

Emergency Medical Services has re-established intermediate life support and advanced life support short course training.

Additional paramedics and intermediate life support (ILS) personnel will be appointed in the metropolitan area.

The service plan makes provision for the appointment of 232 medical rescue personnel to ensure that the function of medical rescue is adequately staffed and that Medical Rescue response time targets are met. A number of rescue personnel will be appointed in 2008 (Gap 212).

EMS will attempt to address management capacity through development. Discussions have been initiated to explore coaching as a tool to management development.

International recruitment of Western Cape EMS staff is a challenge to achieving targets.

3.3.1 **Support and Information Systems**

The institution of computer-aided dispatch and automatic vehicle location systems (vehicle tracking) has improved the management of the mobile EMS resources and improved efficiency both in financial management and service delivery.

Information management has been improved and information on performance and service volumes will soon be available in real-time via a web portal. In 2008 mobile data terminals will be installed with electronic patient record software on the metropolitan ambulances at a cost of approximately R2 million.

The EMS has initiated a project with District Health Services to improve coordination between health management structures to ensure appropriate referral and distribution of patients. This will be piloted early in 2008 in a rural and urban setting.

3.3.4 **Infrastructure**

Emergency Medical Services infrastructure in terms of ambulance bases is showing progressive improvement, however, there is an urgent need for a larger training facility to enable the EMS to meet training targets for 2010.

Government Motor Transport continues to replace ambulances through their fleet management system and the EMS fleet has benefited from this system. EMS continues to get good support from GMT although the age of the fleet has shown a gradual tendency towards higher odometer readings at disposal (>200 000km), which is being managed in cooperation with Government Motor Transport. EMS will institute mobile small repair response vehicles in order to improve operational fleet availability and reduce response times.

4. EMERGENCY MEDICINE

4.1 SITUATIONAL ANALYSIS

4.1.1 Function of Emergency Medicine

The function of the Emergency Medicine Division within EMS is to provide clinical governance and coordination of emergency medicine within the Emergency Departments of the health facilities.

The Head of Emergency Medicine has a parallel responsibility for the education and training of undergraduate and postgraduate students and registrars respectively in emergency medicine.

It is envisaged that the Head of Emergency Medicine will in future coordinate or directly manage emergency medicine training and education across the fields of medicine, emergency care and nursing in order to create continuity and consistency between professions related to emergency care.

Emergency medicine physicians will play an important role in improving ambulance response times by reducing EMS turnaround times in Emergency Departments and improving the quality of referral.

4.1.2 Existing Services and Performance

Emergency care is provided in all health institutions at all levels but the service is fragmented, poorly coordinated and provided to different standards in different institutions.

The Division of Emergency Medicine has the vision to create a virtual platform of emergency care with standards with respect to equipment, training, clinical protocol and referrals across the entire Province.

4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

4.2.1 Strategic Priorities

The emergency medicine initiatives in the Directorate EMS to establish emergency medicine consultant posts and a focal point to drive the prevention of trauma and violence will drive quality emergency care and free up resources within the system by decreasing burden and increasing efficiency.
The strategic priorities of Emergency Medicine include:

- Establishing Emergency Medicine as a specialty within the hospital environment
- Establishing Emergency Medicine as a discipline and defined clinical block within the undergraduate training and education programme
- Establishing the Cape Triage Score as a tool in Emergency Departments in the Western Cape
- Establishing acute admission and referral protocols within and between institutions
- Establishing clinical emergency medicine protocols
- Establishing a focal point for the prevention of trauma and violence.

4.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

4.3.1 Finance

Emergency Medicine has until now been funded as part of the EMS budget. A first step will be to provide Emergency Medicine with a separate finite budget against which it can launch services and be held accountable. An amount of R3.2 million will be allocated to appoint seven emergency medicine specialists.

4.3.2 **Human Resources**

Emergency medicine specialists will graduate from the University of Stellenbosch and Cape Town in late 2007 and early 2008. There is a need to recruit specialists for regional hospitals in the Metro in the first instance. Once these specialists have established themselves, rural regional hospitals will be targeted in 2009 and beyond. Central hospitals also require emergency medicine specialists and an action plan is being drawn up to implement this. In addition, to provide a broad base of specialist support for District Hospitals and CHCs, specialists will be employed by EMS on a rotational basis.

The first phase would be to recruit (2008-2009) one specialist to serve the following hospitals:

- Paarl
- New Somerset
- Victoria.

Four EMS specialists will be recruited and will rotate through EMS, regional hospitals and GF Jooste, Karl Bremer, Eerste River, Helderberg Hospitals and nine 24-hour CHCs.

For ease of human resource processes and administration and to minimise the impact on the CSP staffing numbers, all posts will be created on the establishment of EMS.

The plan is to consolidate all registrars in emergency medicine, all EMS doctors, all EMS quality management practitioners and all EMS education and training instructors within the Division of Emergency Medicine.

The vision is to standardise and improve continuity and consistency in emergency care through co-ordinated emergency medicine training for all health professionals in the Department of Health.

The training of emergency medicine specialists is continuing. There is a complement of thirty-two registrars to provide qualified emergency physicians to staff and lead emergency units.

Trauma and violence are the biggest burden of disease in the Western Cape. They account for 21% of deaths and up to 40% of hospital admissions. The intention is to provide a focal point for violence and trauma prevention in the province. The aim is to develop strategies in broader society to prevent trauma and violence and thus reduce the financial burden on health services.

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6. SUB PROGRAMME 3.2: PLANNED PATIENT TRANSPORT (PPT or HEALTH Non-Emergency Transport HealthNET)

6.1 SITUATIONAL ANALYSIS

Function of Planned Patient Transport HealthNET

Planned patient transport provides for local out-patient transport (within the boundaries of a town or local area) and inter-city/town out-patient transport, i.e. into referral centres. Currently planned patient transport is provided by the EMS funded from Sub-programme 3.2.

As of April 2005 Planned Transport Services was separated from Emergency Ambulance Services. Out-patient transport is a particular problem of the rural areas. Poor rural communities do not have access to local health facilities because of the lack of public transport infrastructure. Therefore, long distance transfers are required to get patients in to referral centres for treatment. There is limited public transport and no rural OPD transport system except that provided by EMS. Patient access to health institutions is severely limited by poor public transport infrastructure. PPT services in the Western Cape transfer approximately 70 000 out-patients annually with an increasing trend as capacity improves.

The HealthNET is a service in development and is being remodelled in a joint initiative between EMS, Hospital Services and the District Health Services in order to cope with increasing demand. HealthNET has taken over the patient transport load previously performed inappropriately by ambulances e.g. previously in the West Coast District eight ambulances were used every day to transport out-patients to the N7 route so that they could access patient transport to Cape Town.

HealthNET faces particular challenges with respect to special categories of patients such as dialysis and disabled patients. Dialysis patients must reach dialysis sessions exactly on time or miss their dialysis slot, but the co-ordination of transport is difficult. Paraplegic patients must attend scheduled visits at central hospitals for periodic investigations. The requirement to meet specific appointment times and transport these patients with specific wheel chairs determines the fleet configuration and vehicle design.

HealthNET has adapted transport vehicles with self-loading stretchers to improve efficiency and safety for personnel and is remodelling vehicles to accommodate wheel chairs by installing hydraulic lift mechanisms.

HealthNET has assumed responsibility for all the previous hospital transport contracts in the Cape Town Metropole necessitating rapid expansion of the service. The demands on the Metropolitan HealthNET service are growing daily with the objective of providing efficient patient transfers to care and relieving the load of minor patients on the emergency services.

6.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The Department has centralised the management of PPT within EMS to promote a better co-ordinated and more efficient service. It is essential that the level of service provided is acceptable to all stakeholders and that information is made known to the general public, for example what transfer times that can be expected in rural and urban areas.

It is important to note that appropriate discretional patient referral and referral back from academic complexes to regional and district hospitals could result in a significant reduction in demands for the rural service.

An incremental increase in funding will result in a gradual improvement in performance targets.

6.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

6.3.1 Finance:

The 2007/08 financial year is the third year since the budget for PPT was separated from the Emergency Services. Significant steps have been taken to improve funding of EMS in the last two years and the commitment continues over the MTEF period. A portion of these funds will be used to improve PPT. Eight new patient transporters were delivered in 2007 to service the metropolitan area and six more will be delivered during 2008.

The expansion of the PPT System in rural areas will continue in cooperation with District Health Services.

6.3.2 Human resources:

The personnel deployed in the function of PPT were separated from emergency ambulance personnel from 1 April 2005. A manager on contract continues to manage the function of PPT and develop necessary systems. The organisational structuring of PPT has been completed. However, further posts will have to be created to accommodate the need for additional drivers as the system evolves.

6.3.3 Support systems:

A PPT hub has been created at Tygerberg Hospital to focus and structure the movement of PPT vehicles within and outside the Metropolitan Area. A second hub, purely to address Metropolitan PPT, has been established at Heideveld Day Hospital.

Planned Patient Transport vehicle design has been reviewed and multipurpose PPT vehicles that accommodate the range of wheelchair, sitting or stretcher patients likely to use the service have been delivered.

6.3.4 **Information systems:**

The TRANSMETRO computer software, which records the movement of patients in relation to vehicles has been upgraded to a WINDOWS based system. A web-based hospital booking system for out-patients has been designed and developed to facilitate the parallel booking of out-patient visits and PPT. The system has been implemented in Tygerberg, Groote Schuur and Red Cross Children's Hospitals.

Table 3.3: National Health System Priority 3: Quality of Care

Activity	Indicators	National Targets 2007/08	Provincial progress 2007/08	National Targets 2008/09	Provincial projection 2008/09
Improving access to services	Transport systems	30% of planned patient transport fleet deployed.	Currently meeting the demand for out-patient transfers with HealthNET and implementing improvements to existing routes.	50% of planned patient transport fleet deployed.	The HealthNET System should meet 100% of the planned requirement.
		30% of EMS road ambulance fleet deployed.	The EMS Fleet is deployed on a full maintenance lease with Government Motor Transport and as such is renewable. The Metropolitan Fleet will be augmented by twenty ambulances which await delivery.	50% of EMS road ambulance fleet deployed.	The Ambulance Fleet will be 229 at the beginning of 2008 and with additional vehicles should support the target of 60% response time achievement.
		Flying doctor services started or SLA effected. 25% of full operational activity effected.	EMS has a 40 year relationship and current SLA with the Red Cross Air Mercy Service delivering rotor wing operations in Oudtshoorn and Cape Town and fixed wing operations throughout the Province.	50% of full operational activity effected.	In the light of the current road and health facility network the Western Cape will not institute a flying doctor service.
		Air EMS service started or SLA effected. 25% of full operational activity effected.	EMS has a 40 year relationship and current SLA with the Red Cross Air Mercy Service delivering rotor wing operations in Oudtshoorn and Cape Town and fixed wing operations throughout the Province.	50% of full operational activity effected.	Complete.
		Private sector agreements in place for patient referrals. 5% of referrals carried on private transport.	EMS currently has an agreement with ER24 who are resident in the Cape Town Communications Centre. Meetings with other Private Sector Providers are planned.	15% of referrals carried on private transport.	Agreements/SLA under discussion

Table 3.4: Provincial objectives and performance indicators for EMS and patient transport services [EMS2]

Strategic Objectives	Measurable objectives		Measure / Indicator	Province wide value 2004/05 (actual)	Province wide value 2005/06 (actual)	Province wide value 2006/07 (actual)	Province wide value 2007/08 (estimate)	Province wide value 2008/09 (target)	Province wide value 2009/10 (target)	Province wide value 2010/11 (target)
Strategic goal: To render effective and efficient pre-hospital emergency services including inter-hospital transfers and patient transport in the Western Cape										
To improve response times to emergency scenes in areas	Increase the number of all responses in under 30 minutes.	1	Percentage of all emergency responses in under 30 minutes	New indicator	-	54% (217 869/ 397 002)	44% (167 124/ 378 142)	50%	60%	70%
	Increase the percentage of telephone calls answered within 12 seconds to 70% by 2010.	2	Percentage of telephone calls answered within 12 seconds	New indicator	-	-	35% (Metro Only 147 911 /422 604)	50%	60%	70%
To improve planned patient transport	Increase the number of patients transported by HealthNET per 1 000 uninsured population to a target of 30 by 2010.	3	The number of patients transported per 1 000 uninsured population	-	-	10.8 (37 837/ 3 492)	27.7 (102 131/ 3 684)	28	30	30
Strategic goal: To facilitate clinical governance and coordination of Emergency Medicine within the Emergency Departments of all health institutions.										
To improved quality of care in Emergency Departments	Implement the Cape Triage Score system in the emergency departments of all hospitals.	4	The percentage of hospitals with implemented and functional CTS	New indicator	-	-	20% (8/39)	50% (19/39)	100% (39)	100% (39)
	Appoint emergency medicine consultants in key emergency departments and EMS.	5	The number of emergency medicine consultants appointed	New indicator	-	-	1	9	12	12
Strategic goal: To render effective and efficie nt pre-hospital emergency services during the FIFA World Cup										
To s trengthen EMS services in order to meet FIFA 2010 requirements and standards	Implement a connection between ambulance MDTs and 10 Hospital Emergency Departments IT Systems by 2010	6	Number of emergency departments with established electronic connectivity	New indicator	-	-	0	4	8	10
	Procure base station trunking radios for 10 Hospital Emergency Departments by 2010 [1]	7	The percentage of hospitals with trunking radios	New indicator	-	-	0 (0/10)	50% (5/10)	100% (10/10)	100% (10/10)

Notes:

1. EMS uses trunked radio systems to cater for large range of users. Communication between health facilities is critical in managing major incidents and mass casualty incidents. Radio communication ensures communication in case telephone (cellular and landline) systems fail. EMS currently uses this digital radio system in the metropolitan Area.

Table 3.5: Performance indicators for EMS and patient transport [EMS3]

Strategic Objectives	Measurable objectives		Measure / Indicator	Province wide value 2004/05 (actual)	Province wide value 2005/06 (actual)	Province wide value 2006/07 (actual)	Province wide value 2007/08 (estimate)	Province wide value 2008/09 (target)	Province wide value 2009/10 (target)	Province wide value 2010/11 (target)	National target 2007/08
Strategic goal:	**To render effective and efficient pre-hospital emergency services including inter-hospital transfers and patient transport in the Western Cape**										
To ensure that there are sufficient resources to render an effective and efficient emergency and patient transport service	Provide target number of ambulances and patient transporters by 2010.	1	Total number of rostered ambulances [1.]			205	222	240	260	260	
		2	Rostered ambulances per 1 000 people [2.]	0.045	0.041	0.039	0.042 (222/5278)	0.044	0.046	0.046	0.3
		3	Percentage hospitals with patient transporters [3.]	5.00%	5.00%	0%	0%	0%	0%	0%	%100
		4	Average kilometres travelled per ambulance (per annum).	57 258	58 231	71 433	58 651 (13 020 522/ 222)	60 000 (14 400 000/ 240)	60 000 (15 600 000/ 260)	60 000 (15 600 000/ 260)	
		5	Total kilometres travelled by all ambulances.			14 643 765	13 020 522	14 400 000	15 600 000	15 600 000	
	Provide target number of appropriately trained operational emergency staff.	6	Percentage locally based staff with training in BAA.	33%	48%	46%	47% (448/947)	42% (460/1 097)	40% (439/1 097)	30% (329/1 097)	100
		7	Percentage locally based staff with training in AEA.		38%	45%	42% (396/947)	46% (504/1 097)	44% (482/1 097)	50% (548/1 097)	
		8	Percentage locally based staff with training in ALS (Paramedics).	7%	8%	9%	11% (103/947)	12% (131/1 097)	16% (175/1 097)	20% (219/1 097)	
	Achieve normative response times in metro and urban areas.	9	Percentage P1 (red calls) calls with a response time of < 15 minutes in an urban area [4.]		30.0%	37.6%	50% (41 779/ 83 559)	60% (51 000/ 85 000)	80% (72 000/ 90 000)	90% (85 500/ 95 000)	100
		10	Percentage P1 (red calls) calls with a response time of < 40 minutes in a rural area [4.]		70.0%	64.4%	65% (11 415/ 17 562)	75% (15 000/ 20 000)	80% (17 600/ 22 000)	80% (19 200/ 24 000)	100
		11	All calls with a response time within 60 minutes [4.]	Not Available	Not Available	61 721	57% (215 862/ 378 142)	59% (236 000/ 400 000)	62% (254 200/ 410 000)	65% (273 000/ 420 000)	
	Adhere to the prescribed staffing of ambulances.	12	Percentage of operational rostered ambulances with single person crews.	0%	0%	0%	0% (0/222)	0%	0%	0%	
	Ensure the effective and efficient use of resources.	13	Percentage of ambulance trips used for inter-hospital transfers [4.]	14.0%	20.0%	15.0%	21% (79,409/ 37 8142)	21% (84,000/ 400 000)	20% (82,000/ 410 000)	20% (84,000/ 420 000)	30
		14	Percentage green code patients transported by ambulance [4.]	37.0%	29.0%	34.8%	26% (102 930/ 398 029)	30% (120 000/ 400 000)	30% (123 000/ 410 000)	30% (126 000/ 420 000)	
		15	Cost per patient transported by ambulance [4.]	502.00	557.00	741.00	866.00 (344 695 000/ 398 029)	982 (393 114 000/ 400 000)	1063 (435,843,000/ 410 000	1135 (476 856 000/ 420 000)	
		16	Percentage ambulances with under 200 000 kilometres on the clock [4.]				40% (89/222)	50% (120/240)	50% (130/260)	50% (130/260)	100
		17	Number of EMS emergency cases-Total [5.]	453,288	374,485	392,395	398,029	400,000	410,000	420,000	

Notes:

1. This indicator reflects the total ambulance fleet. The number of vehicles being rostered is managed tightly according to peak demands, which change during the hours of the day and days of the week. This allows for optimal efficiency.
2. This measure/indicator would be better represented as a ratio of an ambulance per unit population.
3. It is not planned that any hospital runs patient transport and that all transport is performed by the HEALTHNET Service.
4. Replacement of ambulances is planned at 200,000km or three years but this figure will change dynamically during a financial year.
5. Estimated incidents for outer years.

7. PAST EXPENDITURE TRENDS AND RECONCILATION OF MTEF PROJECTIONS WITH PLAN

An earmarked allocation of R392 153 has been made to Emergency Medical Services and includes funding allocated to Programme 3 (R384.794 million) and to Sub-programme 6.2 Emergency Medical Services Training Colleges (R7.359 million)

In 2008/09 Emergency Medical Services is allocated 4.47 % of the vote in comparison to the 4.56 % allocated in the revised estimate of the 2007/08 budget. This amounts to a nominal increase of 11.96 % or R41.230 million.

Table 3.6: Trends in provincial public health expenditure for EMS and patient transport [EMS4]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total excluding capital	198 170 000	255 851 000	277 844 000	344 796 000	386 026 000	428 489 000	475 621 000
Total capital	7 027 000	213 000	9 093 000	20 638 000	12 385 000	15 800 000	13 550 000
Grand total	**205 197 000**	**256 064 000**	**286 937 000**	**365 434 000**	**398 411 000**	**444 289 000**	**489 171 000**
Total per person	44.16	54.28	54.36	67.35	71.44	77.51	83.02
Total per uninsured person	59.28	72.69	72.89	90.33	95.83	103.99	111.41
Constant 2006/07 prices							
Total excluding capital	219 826 045	264 751 965	277 844 000	333 077 103	356 481 772	382 975 144	411 861 381
Total capital	7 794 912	220 410	9 093 000	19 936 557	11 437 123	14 121 733	11 733 548
Grand total	**227 620 957**	**264 972 375**	**286 937 000**	**353 013 660**	**367 918 895**	**397 096 877**	**423 594 928**
Total per person	48.99	56.17	54.36	65.06	65.97	69.27	71.89
Total per uninsured person	65.76	75.22	72.89	87.26	88.50	92.94	96.48

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

1. AIM

Delivery of hospital services, which are accessible, appropriate, effective and provide general specialist services, including a specialised 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 providing a platform for training of health workers and research.

Sub-programme 4.2 Tuberculosis hospitals

Conversion of present Tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may be hospitalised in conditions which allow for isolation during the intensive phase of the treatment, as well as the application of the standardised multi-drug resistant (MDR) and XDR (extremely resistant) TB protocols.

Sub-programme 4.3 Psychiatric hospitals

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

Sub-programme 4.4 Rehabilitation services

Rendering of high intensity specialised rehabilitation services for persons with physical disability including the provision of orthotic and prosthetic services.

Sub-programme 4.5 Dental training hospitals

Rendering of affordable and comprehensive oral health service and training, based on the primary health care (PHC) approach.

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Table 4.1: Proposed bed expansion in regional hospitals in 2008/09

HOSPITAL	DISCIPLINE	BEDS
New Somerset	Psychiatry	3
Mowbray Maternity	Obstetrics	20 (L1)
Worcester	Day theatre	14
Worcester	High Care	3
Worcester	Psychiatry	6
George	Day theatre	18
George	Psychiatry	4
George	Neonatology	4
George	Orthopaedics	6
George	Medicine	6
George	Surgery	6
George	Obstetrics and gynaecology	6
Tygerberg (Level 2)	Neonatology	30
Tygerberg	Obstetrics	12
Tygerberg	Post anaesthetic high care	2
Tygerberg	Obstetrics high care	2
Tygerberg	Paediatric high care	2
Groote Schuur (Level 2)	Psychiatry	4
Groote Schuur	Post Anaesthetic High Care	2
Groote Schuur	Day theatre	12
Red Cross (Level 2)	Post anaesthetic high care	2
TOTAL		164

Note: The 164 beds in Table 4.1 includes 20 level 1 beds, 44 day surgery beds and 13 high care beds.

- Beds designated as regional hospital (level 2) beds have been redefined and become operational at level 1 within Tygerberg, Groote Schuur and the Red Cross Children's Hospitals.

3.1.3 **Trauma and Emergency:**

- Trauma and emergency services in particular continue to be under severe strain with high volume and more serious illness amongst patients seen. An average annual increase of 6% has been reported. This has increased the waiting time for elective surgery.
- There has been an increased need for intensive care unit (ICU) services and ventilation of patients.
- The number of operations lasting between 30 and 60 minutes has increased.
- Various options are being investigated to relieve the pressure within the trauma and emergency areas**.** This includes ensuring the introduction a triage system and phasing in elements of the acute caseload management policy.

3.1.4 **HIV and AIDS and TB:**

- In line with the national key strategies the rollout of HIV and Aids management and treatment protocols has been implemented at hospitals.
- The HIV and AIDS pandemic contributes significantly to the load on the services. The impact is felt at all acute hospitals, TB and chronic medical hospitals. The impact of AIDS patients on treatment,who are living for longer periods, on the specialised (including psychiatric) services is becoming more apparent.
- Tuberculosis rates remain high and co-infection of TB and HIV has resulted in uncommon forms of presentation and late diagnosis of the disease. The increase in the severity of TB will be addressed in Sub-programme 4.2 TB Hospitals.

3.1.5 **Obstetric, gynaecology and neonatal services:**

- There has been a significant increase in deliveries at some hospitals over the last five years.
- The decrease in the use of family planning and sterilisations and increase in migration as related contributory factors require additional research.
- There is a shortage of trained midwives and medical officers.
- Pressure on gynaecology services is exacerbated by the lack of theatre services in level 1 and 2, appropriate skills, available theatre time and referral pathways within the system. A work group consisting of clinicians and managers has been tasked with developing strategies to address this issue.
- Termination of pregnancy remains a pressure area within the regional hospitals.
- The service pressures in neonatology and seasonal pressures in paediatrics are currently addressed by a core team consisting of managers and clinicians. They are developing strategies to create additional level 1 beds, neonatal beds in regional hospitals and strengthen anaesthetic services for regional paediatric services.

3.1.6 **Outreach and Support:**

- Various options are being investigated to relieve the pressure within the trauma and emergency areas**.** This includes ensuring the introduction a triage system and phasing in elements of the acute caseload management policy. A policy for outreach and support by clinical staff to other institutions and the rural areas has been developed which will enhance service delivery.
- Specialists appointed in the rural regional hospitals are providing outreach and support in the rural regions and play a vital role in ensuring appropriate referrals to secondary and tertiary hospitals.
- Outreach and support, training and retraining staff at levels 1 and 2 are vital to the success of the Comprehensive Service Plan (CSP), ensuring that patients are initially appropriately treated at the correct level of care.

3.1.7 **Human Resource Management:**

- In the 2007/08 financial year the number of filled posts in this sub-programme has remained static. The newly filled posts have essentially balanced the number of staff lost through attrition. The total staff complement continues to be supplemented by the recruitment of staff via agency services.

- The recruitment of personnel with scarce nursing skills in the areas of theatre and midwifery is vital to sustain service delivery.
- The lack of key staff hinders the optimal provision of health services. The range of strategies adopted both nationally and provincially will to some extent improve the ability to recruit and retain staff, especially professional nurses and medical officers.
- Increasing the number of professional health workers will remain a priority.

3.1.8 **Health Training:**

- Training and development of staff has been a specific focus and all hospitals have increased their expenditure on training.
- Training of nurses absorbs the largest share of training budgets since a concerted effort is being made to increase the number of qualified nursing staff.
- Nurse Training Schools have been opened at George, Worcester and Mowbray Maternity Hospitals. The Mowbray Maternity Nursing School will focus specifically on training in midwifery.

3.1.9 **Hospital Revitalization Project:**

- The revitalisation of George, Worcester and Paarl Hospitals is continuing.
- At George Hospital, the focus area has been the completion of infrastructure. Health technology implementation, quality assurance, organizational development and monitoring and evaluation are being addressed in parallel. Funding the full commissioning of new services within the current budget envelope remains a challenge and a range of strategies and policy options for funding have been considered.
- The correction of the staff establishments in line with the expansion of services and the CSP will be addressed.
- At Worcester Hospital, the infrastructure is at various stages of completion with a new kitchen, sterilisation unit and services floor, training centre and various new wards. Monitoring and evaluation processes have been established to ensure progress towards the revitalisation goals.
- Paarl Hospital has commenced infrastructure projects at the specialist out- patients' block, new theatre and new kitchen.

3.1.10 **Financial Performance:**

- The increased patient load at the hospitals within this sub-programme has resulted in a significant escalation in the cost of goods and services: consumables, blood products, medication and related medical items and laboratory tests.
- The increasing burden of disease impacts on the cost of treatment.
- Failure to recruit and retain staff has resulted in a significant dependency on agency staff, which drives up the cost of providing services. A detailed analysis of agency costs has been undertaken to have better control of the use of agencies and ensure that the Department's own staff are optimally used before the services of agency staff are engaged. A Departmental approach to the holistic management of agency services has been developed.
- Expenditure within regional hospitals projects a continuous growth. Cost containment measures have been developed and are being applied in all hospitals to increase efficiency.

Table 4.2: Situation analysis indicators for General (Regional) hospitals [PHS3]

Strategic goal:	To render a comprehensive package of general specialist hospital services to the population of the Western Cape					
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**National target 2003/04**
To provide sufficient capacity to render quality general specialist services in regional hospitals.	Provide sufficient theatre capacity in regional hospitals for the performance of specialist surgical procedures, including a target caesarean section rate of 33%.	1 Caesarean section rate for regional hospitals (Percentage = caesarean sections/total deliveries*100)	28%	32%	33%	22%
	Provide sufficient resources to render comprehensive out-patient services at a target rate of approximately 1.2 out-patients per in-patient day.	2 Patient day equivalents (Number of PDEs)	993 273	924 692	942 460	
		3 OPD Total head count (OPD + Trauma/casualty/emergency)	946 095	754 690	807 344	
	Implement quality assurance measures to minimise patient risk in regional hospitals.	4 Regional hospitals with patient satisfaction survey using DoH template (percentage of regional hospitals)	100%	100%	100%	20%
		5 Mortality and morbidity meetings every month (percentage of regional hospitals)	100%	80%	100%	90%
		6 Clinical audit meetings every month (percentage of regional hospitals)	100%	100%	100%	
		7 Complaints resolved within 25 days (percentage = total complaints resolved in regional hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	
		8 Case fatality rate in regional hospitals for surgery separations (total surgery fatalities/total operations*100)	1.70%	1.74%	1.70%	2.50%
To ensure the effective and efficient rendering of sustainable regional hospital services	Manage bed utilisation to achieve an average length of stay of approximately 4 days and a bed occupancy rate of 85% in regional hospitals.	9 Average length of stay	3.6	3.6	3.4	4.8
		10 Bed utilisation rate (based on usable beds)	90%	98%	99%	72%
		11 Total separationsl[2]	180 855	188 166	196 904	
	Ensure the cost-effective management of regional hospitals at a target expenditure of approximately R1500 per PDE.	12 Expenditure per patient day equivalent[3]	R838	R890	R965	R1 128

Notes:

1 Comprehensive out-patient services include the headcount at casualty/emergency/trauma units.
Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

2 Per definition Day cases are included in separations and therefore included in total patient days (Day cases=1 separation=.5 in-patient day.)[3] 2006/07 prices

3.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

3.2.1 Strategic goal:

To provide appropriate and accessible regional hospital services for acute patients in the Western Cape.

3.2.2 Strategic objectives:

1) To provide sufficient capacity to render quality general specialist services in regional hospitals.
2) To ensure the effective and efficient provision of sustainable regional hospital services.
3) To provide sufficient bed capacity to render quality general specialist services in regional hospitals.

The main focus areas to address the strategic objectives for the hospitals in this sub-programme include:

- Service reconfiguration in terms of the objectives within the Comprehensive Service Plan including the clear definition and function of level 2 services in the central hospitals
- Improved financial management to ensure the delivery of an effective and efficient health service within the allocated budget
- Improved human resource management and development
- Improved information management and monitoring and evaluation systems
- Improved infrastructure and equipment
- Improved service delivery and governance of service by means of a quality of care plan.

3.2.3 Service reconfiguration in terms of the Comprehensive Service Plan (CSP) per discipline:

- In line with CSP, the major objectives in this sub-programme include the reconfiguration of services within these hospitals and the expansion and strengthening of rural regional hospitals. Service reconfiguration per discipline is being undertaken to facilitate optimal health care provision and improve the level of efficiency.
- In line with the CSP, the majority of level 2 services, particularly within the Cape Metro district, will be provided in the central hospitals. This will require the reclassification of existing in-patient and out-patient services and the reconfiguration of services according to the package of care provided. Level 2 services in central hospitals are now funded from the provincial equitable share in Programme 4, Sub-programme 4.1.
- Management structures have been reconfigured to co-ordinate the delivery of services.
- Heads of level 2 clinical services will be appointed for each major discipline to co-ordinate clinical services across the platform in each of the drainage areas. This will cost an estimated R6.4 million.

3.2.3.1 Surgery:

1) A head of level 2 surgical services will be appointed to co-ordinate clinical services across the platform in each of the drainage areas.
2) Training and retraining of specific staff components will be done to address the shortage in specific operating skills.
3) Theatre time, space and staff will be increased to address the bottlenecks in the system.

4) Day surgery capacity will be increased at Groote Schuur Hospital, to relieve bed pressures and improve efficiencies.
5) A plan to increase the availability of anaesthetics capacity to enable surgery to be performed is being developed.
6) Referral protocols are being developed by a core team to address referrals across the service platform, levels of care and between hospitals.

3.2.3.2 **Medicine:**

1) The reconfiguration of the platform for internal medicine in the Metro has been finalised per drainage area. A workgroup has been convened to co-ordinate the service shifts, resolve the issues related to the final drainage areas, agree on the points of service entry and enhance the sub-acute plans per institution.
2) Dedicated level 2 specialists will manage the separated secondary internal medicine services within the central hospitals.
3) In George Hospital an additional six medicine beds will be opened at a cost of R1.803 million. This will bring the number of medical beds in line with the CSP to relieve pressure on the trauma and emergency unit.
4) On completion of the HRP project at Worcester hospital, 66 medicine and surgery beds will move back from Brewelskloof Hospital to Worcester Hospital in 2008. Staffing for the 66 beds will move from Brewelskloof Hospital to Worcester Hospital but the staff capacity will be increased to correct the staffing ratio to enable the admission of more acutely-ill patients at a cost of R2.225 million.
5) A head of level 2 medical services will be appointed to co-ordinate clinical services across the platform in each of the drainage areas.

3.2.3.3 **Obstetric and gynaecology services:**

1) A cross-programme approach involving programmes 2, 4 and 5 has been developed to address the increased workload in obstetric services within the Metro. This will allow a co-coordinated approach across the obstetric platform in line with the CSP. The total package of obstetric services has been reviewed and funding provided to alleviate some of the service pressures.
2) Treatment protocols and the establishment of clear referral pathways across levels of care will be implemented.
3) Wesfleur Hospital will refer its obstetric and gynaecology patients to Somerset Hospital in keeping with the CSP. Somerset Hospital will be further resourced to manage this load.
4) Level 2 obstetrics services are to be shifted from Karl Bremer Hospital to Tygerberg Hospital. These service shifts now reflect in the Programme 4 budget and reporting structure.
5) The shift of management responsibility for midwife obstetrics units (MOUs) from Mowbray Maternity Hospital to the District Health Service will be finalised by 1 April 2008.
6) The appointment of an additional specialist at Mowbray Maternity Hospital will ensure outreach and support to level 1 services and intensified training of interns, medical officers and family physicians.
7) The medical officer provision at Mowbray Maternity Hospital will be increased as the existing provision is inadequate to meet service pressures.
8) Currently, Victoria Hospital does not have the appropriate infrastructure to render obstetric services. Therefore Mowbray Maternity Hospital will absorb its obstetrics load and Victoria Hospital will continue to render gynaecology services.

9) To address the pressure in the absence of new hospitals in Khayelitsha and Mitchells Plain, the possibility of using available space at Lentegeur Hospital as a post-natal facility, level 1 Khayelitsha beds currently situated in Tygerberg Hospital for obstetrics and the creation of level 1 beds in Mowbray Maternity Hospital is being investigated.

10) A head of level 2 obstetric and gynaecology services will be appointed to co-ordinate clinical services across the platform in each of the drainage areas.

3.2.3.4 **Paediatric and neonatal services:**

1) The expansion of the level 1 service is vital to address the seasonal service pressures on paediatrics and to decrease the referrals to levels 2 and 3.

2) Extending the hours for PHC services for children at certain clinics and direct referrals to Somerset Hospital from identified drainage areas in the Metro West will reduce the service pressures at the Red Cross Children's Hospital.

3) Neonatology services will be expanded. This will include Kangaroo Mother Care at Karl Bremer Hospital and level 2 services at Tygerberg Hospital and Groote Schuur Hospital.

4) Additional medical officers will be employed at Mowbray Maternity to address the escalating workload.

5) The skills and competency of level 1 clinicians, specialists rendering outreach and support and the family physicians are the key drivers in improving this service.

6) A head of level 2 paediatrics and neonatal services will be appointed to co-ordinate clinical services across the platform in each of the drainage areas.

3.2.3.5 **Orthopedic services:**

1) The services to be provided at levels 1 and 2 are being defined by a dedicated workgroup.

2) The appointment of a coordinating clinician for orthopaedic services will ensure that orthopaedic services are holistically managed across the provincial service platform. A clinical head of orthopaedic services will be appointed to manage the level 2 services across each of the drainage areas in the Metro.

3) According to the CSP, level 2 orthopaedic services will be relocated ultimately from GF Jooste, Somerset and Victoria Hospitals to Groote Schuur Hospital. However, significant level 1 orthopaedic capacity must be further developed at these hospitals to avoid inappropriate referrals and provide accessible first level hospital care.

4) Additional theatre capacity, including day surgery, will be a key enabler for the reorganization of these services according to the CSP.

5) Level 2 specialists for the Metro West will be based at Groote Schuur Hospital and Metro East at Tygerberg Hospital.

6) The costing of level 2 orthopaedic services has been undertaken to ensure that the service level is appropriately funded.

3.2.3.6 **Anaesthetic services:**

1) A plan has been developed to strengthen the anaesthetic services in the Metro. This includes the appointment of additional specialists at regional hospitals with an outreach, support and service responsibility within district hospitals and ensuring adequate numbers of trained medical officers at district hospitals.
2) A second specialist anaesthetist will be appointed at the rural regional hospitals to strengthen these services as well as the capacity to perform outreach and support to district hospitals.
3) The strengthening of anaesthetic capacity is a key enabler to expand and strengthen surgical, obstetric, gynaecology, orthopaedic, ENT and other services.

3.2.3.7 **Ear, nose and throat (ENT) services:**

1) Over the past two years, the ENT services in the province have been strengthened by a team including a specialist and experienced medical officer visiting different facilities to provide an OPD and surgical service. Approximately 1 200 procedures were performed in each year, which made a significant contribution to reducing waiting lists for ENT procedures such as tonsillectomy.
2) Specialist ENT surgeons will be appointed at Somerset and George Hospitals, and Paarl and Worcester hospitals will share a specialist. These specialist surgeons will provide a service at the regional hospitals and through outreach and support build the services at level 1 facilities. This will build on the momentum developed by the project of the last two years.

3.2.3.8 **Psychiatric services (See also Sub Programme 4.3):**

1) Demand for services by the acutely disturbed psychiatric patient escalated during the past year largely due to an increase in substance abuse, HIV and Aids and other stressors in society.
2) Seventy-two-hour observation and clinical management of psychiatric patients within regional and district hospitals will be strengthened. This requires the creation of safe observation rooms, low-secure areas within wards; the training and support of medical officers, appointment of mental health nurses; regular visits and liaison support by specialists from the associated psychiatric hospitals; and the development of clinical protocols to better manage difficult patients.
3) The expansion of community-based services including group home beds is a critical factor in decanting people with chronic psychiatric and intellectually disability that are currently blocking acute beds within the psychiatric hospitals. This will lead to a more efficient patient flow between general and psychiatric hospitals and a reduction in the waiting time for acute beds in psychiatric hospitals. Forty beds will be established at William Slater for Metro West and 49 beds at Stikland for Metro East.

3.2.4 Service configuration in central hospitals

3.2.4.1 Regional hospital (Level 2) beds in central hospitals:

1) A systematic approach has been adopted to distinguish level 2 from level 3 beds within the central hospitals. The largest concentration of level 2 beds will be within the central hospitals. The budget allocation for level 2 services within central hospitals is reflected within Programme 4 from 2008/09 onwards.
2) A technical team from the three central hospitals will monitor the implementation of the differentiated level 2 and level 3 services with the involvement of relevant clinicians and management. This includes the definition of level 2 and level 3 packages of care and development of clear referral guidelines.

The table below reflects the number of level 2 beds in the central hospitals in 2007/2008 and the planned distribution for 2008/09.

Table 4.3: Number of level 2 beds in central hospitals

Hospital	2007/08	2008/09 Target
Groote Schuur Hospital	172	190
Red Cross Children's Hospital	61	63
Tygerberg Hospital	724	772
Total	**957**	**1 025**

3.2.4.2 Regional hospital (Level 2) services in Tygerberg Hospital:

Current services:

Tygerberg Hospital provides the full range of generalist specialist services to its drainage area, which includes the following Cape Town Metro sub-districts: Tygerberg, Eastern, Northern and Khayelitsha north of Spine Road.

Outreach and support is provided to hospitals in the secondary care drainage area including, Eerste River, Helderberg, Karl Bremer, Paarl and Worcester Hospitals.

1) **Teaching, training and research:** Tygerberg level 2 hospital forms part of the teaching, training and research platform for the University of Stellenbosch, the University of the Western Cape, the Cape Peninsula University of Technology as well as the University of Cape Town.

2) **Service pressures** have been particularly marked in specific areas such as obstetrics, neonatology, trauma, emergency medicine and critical care. Trauma and emergency cases have increased by 32% from approximately 4 400 per month in 2002 to a projected average of 5 800 in 2007. Total obstetric deliveries continue to increase by 17% per annum with consequent pressures on the neonatology service. Current total deliveries average 626 per month. In addition, the rising incidence of complicated pregnancies, in particular pregnancy-induced hypertension (PIH) accounts for rising numbers of sick neonates who need intensive medical management.

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Tygerberg Regional (L2) Hospital key strategies in 2008/09

The key strategies for this financial year will be in line with the key performance areas:

1) **Comprehensive Service Plan Implementation (CSP)**

- Refine and conclude the differentiation of secondary and tertiary services at Tygerberg Hospital as outlined in the Comprehensive Service Plan.
- This will see further progress in the separation of level 2 and level 3 in-patient and out-patient services. The monitoring and evaluation of the effectiveness of clinical management at the appropriate levels of care will be an important means of ensuring optimal efficiency and quality of care.
- The operational plan will designate and implement 772 level 2 beds and 538 level 3 beds by the end of the 2008/09 year. Out-patient clinics will be differentiated into level 2 (general specialist) clinics and level 3 (sub-specialist) clinics.
- Level 2 Head: Clinical Services for the Metro East will be appointed, starting with those for general medicine and general surgery. Appointments will be at principal specialist level at an annual cost to employer of approximately R550 000 per post.
- Level 2 cost centre management and reporting will be in line with the CSP related transformation.

2) Completion of the consolidation at Tygerberg Hospital of the general specialist (level 2) services currently rendered by Karl Bremer Hospital. There are a number of disciplines that will shift progressively during the year beginning with completion of the shift of level 2 obstetric services in the first quarter of the 2008/09 financial year.

3) **Ensure a well-functioning hospital**

- Ensure a comprehensive theatre management system to improve efficiency and outcomes.
- Conclude the level 2 cost centre management exercise to ensure the management of both personnel as well as non-personnel costs at cost centre level.
- Continue the process of digitalisation of critical support disciplines such as radio-diagnostic, imaging and nuclear medicine equipment and systems.
- Improve functioning of the Emergency Centre (EC) on the first floor of the hospital. This will provide for trauma as well as non-trauma surgical and medical emergencies. The Emergency Centre at Tygerberg Hospital is not currently functional. It does not have adequate infrastructure since the hospital was not originally intended to have an emergency centre. The necessary upgrading is a priority.

4) **Ensure a well-functioning system**

- Develop and progressively implement outreach and support to level 1 facilities, in particular to Karl Bremer and Helderberg Hospitals, according to CSP principles. This needs to be formally structured with clear plans and outcomes.
- Provide on-going training and general specialist advice to referring level 1 institutions and service providers.
- Ensure implementation and compliance with accredited provincial clinical guidelines.
- Improve capacity to deal with level 2 referrals from level 1 referral facilities.

5) **Improve service delivery and clinical governance**

- Improve the working environment and quality of care through infrastructural improvements particularly in the general specialist wards, Central Sterilization Services Department, the planned level 2 theatre complex and the kitchen.
- Implement a comprehensive theatre management system to improve efficiency and outcomes, which will benefit both level 2 and level 3 surgical services.
- Implement a service delivery plan to deal with the increased service pressures in obstetrics and neonatology, reprioritise 12 obstetric ward beds internally and commission an additional two obstetric high care beds (L3) and 30 neonatal ward beds in 2008/09.
- Re-organise the first floor area comprising the current Trauma Unit, Resuscitation Unit, medical emergencies and surgery admission ward.
- Develop an adult post-operative high care unit (PHCU) in the main theatre recovery room area and have two high care beds adjacent to A1 Surgical ICU. The two-bed PHCU unit would be crucial to improving surgical outputs in current theatre resourcing, and therefore crucial to reducing waiting lists for key procedures where high care is required post-procedure. The PHCU will service both level 3 and level 2 surgical cases.
- Open two paediatric high care beds in A9 adjacent to A9 Paediatric ICU (PICU). This will provide a crucial facility for post-operative care of children who have undergone surgery as well as provide a step-down facility to relieve pressure on the PICU. These beds will also service level two paediatric surgery cases.
- Implement a paediatric sedation service for radiological investigations and procedures, which will service both level 2 and level 3 patients at a cost of R1 million.
- Progressively implement level 2-specific morbidity and mortality meetings.

3.2.4.3 **Regional Hospital (Level 2) Services in Groote Schuur Hospital:**

Groote Schuur Hospital provides general specialist services as defined by the level 2 package of care. The following are some of the highlights and challenges of the level 2 service that Groote Schuur Hospital provides:

1) **Service pressures in specific areas:**

- There have been a number of areas where the burden of disease has placed an enormous burden on the provision of clinical services. The following areas experienced significant additional pressure during the year: renal dialysis, trauma and emergency, psychiatry, and obstetric and neonatology services.
- Trauma cases increased from an average of 2 729 in 2006/07 to an estimated 2 856 in 2007/08. This increase of 5% in case numbers has had the knock-on effect of increasing the service pressures on the ICU as well as theatre environment.
- There has been an increase of 3% in obstetric cases compared with 2006/07. The bed occupancy rate of obstetrics was on average 128% during 2007/08. The increase in obstetric case load in turn led to major pressures being experienced in the neonatal services. The bed occupancy rate in the neonatology wards on average during 2007 was 115 %.

2) **General service analysis:**

In examining the capacity to render essential level 2 services, it is important to examine the overall service indicators specifically for the level 2 services at Groote Schuur Hospital.

- The level 2 PDEs increased by 7.9 % compared to 2006; the final total PDEs for 2007 was 59 795.
- Over the same period, the total level OPD head count at Groote Schuur Hospital is projected to increase from 63 720 (excluding the service group attendances) in 2006 to 71 124.
- The average length of stay for the 2007/08 financial year (estimates include April to November 2007) was 3 days. This is a significant decrease from 2006 when it was 4.5 days and probably indicates the pressure on beds.
- The bed occupancy rate for the level 2 beds at Groote Schuur Hospital was 90.9 %.
- It is expected that the trauma unit will see approximately 3 000 admissions during 2007/08.
- The number of deliveries during this period is expected to be approximately 4 800 whilst 1 000 neonates are to expected to be admitted.
- 120 000 radiological investigations are expected to be completed including 8 500 ultrasounds scans.

3) **Implementation of the CSP at Groote Schuur Hospital:**

The level 2 operational head of medicine has been appointed at Groote Schuur Hospital and progress has been made in implementing the medical level 2 services. The post of the level 2 head of surgical services is in the process of being filled. The following actions give some indication of the activities that have taken place so far in the implementation of the CSP:

- A total of 172 beds designated as level 2 services
- Finalisation of the level 2 package of care full range of clinical services
- The progressive implementation of laboratory protocols
- Protocols and policies established in respect of patient selection, admission, and transfer between level 2 and level 3 services (further work to be done in terms of differentiating level 2 out-patient care in consultation with the users)
- Theatre days for level 2 surgery specified to include five days of day surgery
- Further work done on the need to split billing, administration and the monitoring of level 2 expenditure in terms of expenditure control
- Overall expected level 2 outputs to be achieved in 2007/8 include: 80 000 OPD visits and 10 000 in-patient admissions.

4) **Outreach and support :**

This continues to be a priority for Groote Schuur Hospital. A total of 45 full time equivalents (FTEs) are performing work outside of Groote Schuur Hospital on a daily basis. Whilst this number is constantly changing it represents a significant workload commitment of the hospital to the general services in the Metro.

5) **Nursing :**

The non-availability of nursing staff continues to be a problem. During the year there was an ongoing campaign to attract nursing staff to Groote Schuur Hospital. There was a road show to all the nursing colleges in an attempt to recruit nursing staff to Groote Schuur Hospital. This has met with partial success; the vacancy rate (and therefore filled by agency staff) was around 9% for 2007.

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3) **Ensure a well functioning system**

- The service pressures in psychiatry have generally escalated. There will be four more beds at Groote Schuur Hospital. Increased efforts will be made to strengthen coordinated efforts across the service platform.
- Identify and quantify patients requiring primary level care follow up for chronic disease management, who are currently being managed at central hospitals. This process has already begun and discussions with the programme 2 services to have these patients devolved to PHC have been held.
- Take steps towards consolidating orthopaedic services at Groote Schuur Hospital for Metro West. Opening a second urgent theatre list will improve the throughput of trauma cases, which will relieve service pressures across the platform, is also considered as a critical CSP leverage for the platform. One of the challenges foreseen is the potential non-availability of nursing staff. Agency staff may have to be used in the interim.

4) **Improve service delivery and clinical governance**

- Additional theatre time and space will be made available for day surgery to address bottlenecks in the level 2 surgical services. A daily slate will be able to accommodate most specialities who are able to use this service, e.g. urology, gynaecology, orthopaedics, GIT, etc.
- Neonatology: There will be a re-organisation of neonatal services to enable kangaroo high care. This will be done in conjunction with a shift of level 1 services and in liaison with Mowbray Maternity and Tygerberg Hospitals.

Table 4.4: Funds allocated to the Central Hospitals over the MTEF period (Level 2 services reflected as Programme 4)

Budget	2004/05	2005/06	2006/07	2007/08 Adjusted Estimate	2008/09	2009/10	20010/11
Modernisation of Tertiary Services + Office DDG	3 017	22 053	1 907	5 353	37 156	40 128	42 937
Programme 5							
Groote Schuur Hospital (GSH)	**772 370**	**838 628**	**910 050**	**990 009**	**1 098 238**	**1 186 097**	**1 269 124**
Programme 4					274 455	296 376	317 075
Programme 5	772 370	838 628	910 050	990 009	823 783	889 721	952 049
Red Cross Children's Hospital (RCCH)	**232 848**	**245 946**	**270 594**	**303 657**	**348 330**	**376 197**	**402 531**
Programme 4					73 871	52 700	55 566
Programme 5	232 848	245 946	270 594	303 657	274 459	323 497	346 965
Tygerberg Hospital (TBH)	**793 353**	**873 487**	**940 299**	**1 022 787**	**1 136 466**	**1 227 383**	**1 313 300**
Programme 4					470 569	535 332	573 676
Programme 5	793 353	873 487	940 299	1 022 787	665 897	692 051	739 624
Total	**1 801 588**	**1 980 114**	**2 122 850**	**2 321 806**	**2 620 190**	**2 829 805**	**3 027 892**
Programme 4					818 895	884 408	946 317
Programme 5	1 801 588	1 980 114	2 122 850	2 321 806	1 801 295	1 945 397	2 081 575
Sum GSH + RCCH + TBH	**1 798 571**	**1 958 061**	**2 120 943**	**2 316 453**	**2 583 034**	**2 789 677**	**2 984 955**
Programme 4					818 896	884 408	946 317
Programme 5	1 798 571	1 958 061	2 120 943	2 316 453	1 764 138	1 905 269	2 038 638
Cost of level 3 beds as % of total cost of central hospitals					**68.30%**	**68.30%**	**68.30%**

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3) **Tertiary services at George Hospital:**

Given the distance of George Hospital from the central tertiary hospitals in Cape Town, it has been found to be more cost effective to provide certain tertiary services such as oncology and renal dialysis at George. However, George Hospital is not funded from the NTSG for these tertiary services and the equitable share budget currently funds these services to the value of R10 million. The province will obtain national recognition of George Hospital as a developing tertiary hospital so NTSG funding for the tertiary services already provided can be allocated.

3.2.6 Improved financial management to ensure the deliverance of an effective and efficient health service within the allocated budget

1) The analytical review of this sub-programme shows that the increase in hospital funding does not match the increasing demand on health services. Therefore it is necessary for appropriate priorities to be selected and maximum efficiency obtained to optimise health care delivery.
2) Analysis based on outputs by comparable hospitals has been undertaken as a first step towards equitable budget allocations.
3) All hospitals have established cost containment measures to minimise the risk of overspending. This includes service protocols, designated gatekeepers to approve expensive procedures and limiting the number of expensive procedures.
4) The risk areas identified in the Auditor-General's report will have to be addressed.

3.2.7 Improved Human Resource Management and Development

1) Addressing the human resource deficits to strengthen service delivery will contribute to the overall improved quality of health care.
2) The human resource plan in line with the CSP objectives has to be finalised and implemented.
3) Well-trained, skilled staff must be appointed and retained.
4) The training and development of health care workers must be continued.
5) The salaries of specialists working in the rural regional hospitals are being incrementally improved in order to retain their skills as they reduce inappropriate referrals to central hospitals and build capacity in the respective rural regions with a structured outreach and support programme. The upgrading of the second specialists to senior specialist level for each of the disciplines in the rural regional hospitals will cost an additional R300 000 per annum.
6) The use of agency staff will be monitored on an ongoing basis. It is hoped that the implementation of the occupational specific dispensation for nurses will reduce the dependency on agency staff.
7) Ward clerks will be appointed at Somerset Hospital to relieve nurses from administrative tasks at a cost of R320 000.
8) **Nurse Training:**

The nurse training school at George Hospital will increase the training of nursing assistants, professional nurses and midwifery courses.

3.2.8 Improved information management and monitoring and evaluation systems

1) Benchmarking hospital costs and outputs across similar hospitals is being increasingly used to improve efficiency and productivity.
2) Improving on data collection, analysis and reporting will include better management decisions and equitable budget allocations.
3) The focus will fall on clear objectives, indicators, and outputs, which reflect what is delivered with the limited health rand within this programme.

3.2.9 Improve infrastructure and equipment

1) Sustain the improved infrastructure that has resulted from the revitalization programme at Paarl, Worcester and George Hospitals.
2) Continue the upgrading of rural regional hospitals through a systematic national infrastructure initiative of hospital revitalisation. Resources would need to be allocated to commission additional services in a phased manner over the MTEF period.
3) Ensure adequate maintenance of the improved infrastructure.

3.2.10 Improve service delivery and governance of service by means of a quality of care plan

1) Disease management: Understand the burden of disease and implement patient care models to minimize the impact of the burden of disease.
2) Improve on processes; for example, patient flow and bed management.
3) Improve the triage patient system to prioritize emergencies appropriately.
4) Manage the patient referral system optimally to ensure that the right patient is treated at the right level of care.
5) Apply clinical guidelines and clinical governance to improve the quality of care. This will include regular morbidity and mortality monitoring and clinical audit processes.
6) Manage infection and prevention control processes.
7) Monitor outreach and support within the different disciplines.
8) Strengthen hospital facility boards at each institution to promote ownership of facilities by communities and increase accountability of institutional management to communities. New boards have been appointed by the provincial minister in the last year.
9) Improve quality of patient care by
   - assessing client satisfaction surveys and implement recommendations;
   - assessing the implementation of the Patient's Rights Charter;
   - refining the patient complaints and compliments procedure;
   - offering care for the carers by:
     - monitoring of safety and security risks
     - assessing staff satisfaction surveys
     - offering EAP support to staff working in a stressful environment
     - improving the physical working environment.

3.3 CONSTRAINTS AND CHALLENGES WITH MEASURES PLANNED TO OVERCOME THEM.

3.3.1 Service Reconfiguration

1) The Comprehensive Service Plan envisages significant reconfiguration of services and a consequent change in practice, as well as redeployment of staff. This will require effective communication and a change management strategy, as well as due labour processes at all levels.
2) The availability of services within a revised service platform will be communicated to the general public.
3) Service reconfiguration will promote the optimal use of the health rand, but will not reduce the public demand for health services. This will need to be addressed through engaging other role players in influencing upstream factors such as healthy lifestyles, safe sex and responsible drinking and safe driving.
4) Service configuration will aim at ensuring that the patient is treated optimally at the appropriate service level.

3.3.2 Financial management

1) The increased patient load at the regional hospitals results in a significant escalation in the cost of goods and services (consumables, blood products, medication and laboratory tests). A dedicated drive to monitor these cost drivers has been implemented at all hospitals with clear protocols on the use of blood, blood products and laboratory tests for patients.
2) The failure to recruit and retain staff results in a significant dependency on agencies, which increases the cost of essential services. A detailed analysis of agency costs has been undertaken within the programme, to enable improved control of agency utilization.
3) Cost containment measures will be applied in all hospitals to improve efficiencies and all hospitals have management plans to reduce costs with maximum efficiency gains while attempting to minimise the negative impact on service delivery.
4) As with other services in the Department the availability of adequate funding to match the need for services places strain on the management of these facilities.
5) From 2008/09 the equitable share funding for level 2 services in Programme 5 has been shifted to Sub-programme 4.1, which allows a more accurate determination of the cost of those services.

3.3.3 Human Resource Management

1) Availability of key staff is a key rate limiting step to the provision of services within the current platform and for 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. Additional staff has been appointed in all staff categories with the bulk of these appointments in nursing and medical staff categories.
2) There will be continuous professional development of all staff to ensure optimal performance.
3) Nurse training has been the main objective for recruitment and retaining of nursing staff.
4) Enhancement of a culture of cooperation within a team development approach aims at ensuring well-organised care processes.
5) Finalisation of the organisational development structure and matching and placing of staff will reduce the personal anxieties of staff within the change management process of the CSP.
6) Chief operating officers (COO) will be appointed at regional hospitals to strengthen management at institutional level. This is in keeping with the CSP.

3.3.4 **Information management systems**

1) The monitoring and evaluation processes within the programme are to be strengthened to improve planning and implementation of objectives.
2) Better data and information systems must ultimately be linked to the budget process to ensure equitable budget allocations based on measurable deliverables.
3) In some cases the quality of hospital data is sub-optimal due to various contributing factors lack of dedicated and trained information management staff and/ or technical systems. Systematic attempts are being made to improve management information for decision making. All the regional hospitals will have designated information officers to strengthen information management at institutional level.

3.3.5 **Improved infrastructure and equipment**

1) Capital gains from HRP funding have been significant. However, the maintenance cost for new buildings and equipment must be adequately funded.
2) Funding the HRP sites appropriately is vital for sustaining the new hospitals. These hospitals are expected to provide a full package of patient care in rural areas. This includes adequate outreach and support to level 1 services to improve the quality of care and ensure appropriate referrals.

Table 4.5: NHS Priority 3: Quality of Care:

Activity	Indicators	National Targets 2007/08	Provincial progress 2007/08	National Targets 2008/09	Provincial projection 2008/09
Hospital improvement plans	Clinical audits	Clinical audits routinely monitored in all level 2 hospitals, 35% of district hospitals	Clinical protocols applied. Mortality and morbidity processes in place. The Department has structured reporting systems. Reports on facilities are convened at the Provincial Head Office.	Clinical audits routinely monitored in all hospitals.	Clinical governance with remedial strategies in place.
	Complaints mechanisms	Complaints mechanisms routinely managed in all level 2 hospitals, 35% of districts (level 1 hospitals and PHC facilities)	Complaints and compliments procedures in place for all hospitals. Complaints reported and appropriately managed. Reporting is done to the Provincial Head Office in a structured manner. Apply Batho Pele principles.	Complaints mechanisms routinely managed hospitals	Remedial strategies in place.
	Infection control	Infection control management effected in all level 1 hospitals and CHCs, 35% of all clinics	Implement Provincial Infection control policies.	Infection control management effected in all clinics	Remedial strategies in place.
	Telemedicine	Hub and spoke systems developed in accordance with STP	Hub and spoke is derived from the CSP. A policy framework and implementation document for digital imaging has been drafted for comment. It is proposed that the resulting network will support telemedicine.	Hub and spoke systems developed in accordance with STP	Hub and spoke configuration to be finalised as part of implementation that will concentrate on revitalisation of hospitals.

3.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.6: Provincial objectives and performance indicators for general (regional) hospitals [PHS4]

Strategic goal:	Provide sufficient infrastructure for the rendering general specialist services in regional hospitals **.**								
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**
To provide sufficient bed capacity to render quality general specialist services in regional hospitals	Provide a total of 2 503 beds in regional hospitals by 2010.	1 Number of beds in regional hospitals	2 076	1 856	1 943	1 371[1]	2 418	2 450	2 503
		2 Total number of patient days[2]	677 908	673 128	697 602	495 919	750 185	760 113	776 556

Notes

1. GFJooste, Karl Bremer and Helderberg Hospitals were shifted from Programme 4.1 to Programme 2.9 from 2007/2008.
2. Total number of patient days includes day cases (Day case = 1 separation = .5 in-patient day)

Table 4.7.1: Performance indicators for general (regional) hospital for 2004/05 2007/08 [PHS5]

Strategic goal:	1.1 To render a comprehensive package of general specialist hospital services to the population of the Western Cape										
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target 2007/08**
To provide sufficient capacity to render quality general specialist services in regional hospitals	Provide sufficient theatre capacity in regional hospitals for the performance of specialist surgical procedures including a target caesarean section rate of 33%	1	Caesarean section rate for regional hospitals (percentage = caesarean sections/total deliveries*100)	27.5%	32.0%	33.0%	34.3%	Refer to Table 4.7.2			18%
	Provide sufficient resources for the rendering of comprehensive[1] out - patient services at a target rate of approximately 1.2 out-patients per in-patient day Provide sufficient resources to cater for emergency care in regional hospitals.	2	Patient day equivalents (Number of PDEs)	993 273	924 692	942 460	689 988				
		3	OPD head count (total)[1]	946 095	754 690	807 344	582 207				
	Implement quality assurance measures to minimise patient risk in regional hospitals	4	Regional hospitals with patient satisfaction survey using DoH template (percentage of regional hospitals)	80%	80%	100%	100%				100%
		5	Mortality and morbidity meetings every month (percentage of regional hospitals)	100%	80%	100%	100%				100%
		6	Clinical audit meetings every month (percentage of regional hospitals)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	100%				100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved in regional hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	100%				
		8	Case fatality rate in regional hospitals for surgery separations (total surgery fatalities/total operations*100)	1.70%	1.74%	1.70%	1.80%				2%
To ensure the effective and efficient rendering of sustainable regional hospital services	Manage bed utilisation to achieve an average length of stay of approximately 4 days and a bed occupancy rate of 85% in regional hospitals	9	Average length of stay	3.60	3.60	3.40	3.86				4.1
		10	Bed utilisation rate (based on usable beds)	90.0%	98.0%	99.0%	97.6%				75%
		11	Separations - Total[2]	180 855	188 166	196 904	128 505				
	Ensure the cost effective management of regional hospitals at a target expenditure of approximately R1500 per PDE	12	Expenditure per patient day equivalent[3]	838	890	965	R1 019				1 128

Notes:
1. Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3 Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.
2. Per definition Day cases are included in separations and therefore included in total patient days (Day cases=1 separation=.5 in-patient day.)
3. 2006/07 prices
4. Note that the level 2 outputs increase in 2008/09 as a result in the shift of level 2 services in the central hospitals to Programme 4.

Table 4.7.2: Performance indicators for general (regional) hospital for 2008/09 to 2010/11 [PHS5]

Strategic goal:	1.1 To render a comprehensive package of general specialist hospital services to the population of the Western Cape										
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target 2007/08**
To provide sufficient capacity to render quality general specialist services in regional hospitals	Provide sufficient theatre capacity in regional hospitals for the performance of specialist surgical procedures including a target caesarean section rate of 33%.	1	Caesarean section rate for regional hospitals (percentage = caesarean sections/total deliveries*100)	Refer to Table 4.7.1				33%	33%	33%	18%
	Provide sufficient resources for the rendering of comprehensive[1] out-patient services at a target rate of approximately 1.2 out-patients per in-patient day Provide sufficient resources to cater for emergency care in regional hospitals (new objective),.	2	Patient Day Equivalents (number of PDEs)					1 050 258	1 064 158	1 087 178	
		3	OPD total head count (OPD + trauma/ casualty/ emergency)[1]					900 221	912 135	931 876	
	Implement quality assurance measures to minimise patient risk in regional hospitals.	4	Regional hospitals with patient satisfaction survey using DoH template (percentage of regional hospitals)					100%	100%	100%	100%
		5	Mortality and morbidity meetings every month (percentage of regional hospitals)					100%	100%	100%	100%
		6	Clinical audit meetings every month (percentage of regional hospitals)					100%	100%	100%	100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved in regional hospitals within 25 days/ total complaints received*100)					100%	100%	100%	
		8	Case fatality rate in regional hospitals for surgery separations (total surgery fatalities/total operations*100)					1.80%	1.80%	1.80%	2%
To ensure the effective and efficient rendering of sustainable regional hospital services	Manage bed utilisation to achieve an average length of stay of approximately 4 days and a bed occupancy rate of 85% in regional hospitals.	9	Average length of stay					4	4	4	4.1
		10	Bed utilisation rate (based on us able beds)					85%	85%	85%	75%
		11	Total separationsl[2]					187 546	190 028	194 139	
	Ensure the cost effective management of regional hospitals at a target expenditure of approximately R1500 per PDE.	12	Expenditure per patient day equivalent[3]					1 440	1 513	1 555	1 128

Notes:

[1] Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3 Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

[2] Per definition Day cases are included in separations and therefore included in total patient days (Day cases=1 separation=.5 in-patient day.)

[3] 2006/07 prices

3.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Programme 4 is allocated 26.68% of the vote during 2008/09 in comparison to the 17.23% that was allocated in the revised estimate of the 2007/08 budget. This translates into a nominal increase of 77.03% or R1 003.388 million. This is largely the result of the reallocation of the shift of the equitable share for level 2 services provided in central hospitals from Programme 5 to Programme 4 (R818.896 million), with the balance resulting form additional amounts for ICS and occupation specific dispensation carry through. Additional funding is also allocated to Programme 4 from Programme 7 for orthotics and prosthetics now in sub-programme 4.4.

The nominal increase to Sub-programme 4.1 from the revised estimate of 2007/08 to 2008/09 is R910.118 million or 125.05%. Included in Sub-programme 4.1 is an earmarked allocation of R74.715 for 2008/09 for the purpose of the health professionals' remuneration review.

Table 4.8: Trends in provincial public health expenditure for general (regional) hospitals [PHS6]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total excluding capital	750 742 000	795 425 000	909 634 000	727 782 000	1 637 900 000	1 801 692 000	1 951 667 000
Total capital	173 353 000	134 037 000	191 900 000	196 899 000	260 284 000	217 188 000	148 770 000
Grand total	**924 095 000**	**929 462 000**	**1 101 534 000**	**924 681 000**	**1 898 184 000**	**2 018 880 000**	**2 100 437 000**
Total per person	198.88	197.02	208.68	170.43	340.37	352.20	356.49
Total per uninsured person	266.97	263.84	279.81	228.57	456.58	472.54	478.39
Constant 2006/07 prices							
Total excluding capital	832 783 190	823 097 553	909 634 000	703 046 207	1 512 544 477	1 610 317 308	1 690 035 269
Total capital	192 297 040	138 700 100	191 900 000	190 206 813	240 363 347	194 118 415	128 826 561
Grand total	**1 025 080 230**	**961 797 652**	**1 101 534 000**	**893 253 020**	**1 752 907 824**	**1 804 435 723**	**1 818 861 830**
Total per person	220.62	203.87	208.68	164.64	314.32	314.79	308.70
Total per uninsured person	296.15	273.02	279.81	220.80	421.64	422.35	414.26

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Table 4. 9: Situation analysis indicators for TB hospitals [PHS3]

Strategic goal:	**To render comprehensive TB hospital services to the population of the Western Cape**					
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**National target 2003/04 [1]**
To provide sufficient capacity to render quality TB hospital services	Provide sufficient resources to render in-patient and out-patient TB hospital services amounting to approximately 424 000 patient day equivalents (PDE) by 2010.	1 Patient Day Equivalents (Number of PDEs)	282 413	293 059	306 287	
		2 OPD Total head count	4 091	3 784	3 839	
	Implement quality assurance measures to minimise patient risk in TB hospitals.	3 TB hospitals with patient satisfaction survey using DoH template (Percentage of TB hospitals)	100%	100%	100%	
		4 Mortality and Morbidity meetings every month (Percentage of TB hospitals)	100%	80%	100%	
		5 Clinical audit meetings every month (Percentage of TB hospitals)	100%	100%	100%	
		6 Complaints resolved within 25 days (Percentage = total complaints resolved in TB hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	
To ensure the effective and efficient rendering of sustainable TB hospital services.	Manage bed utilisation to achieve an average length of stay of approximately 100 days and an optimum bed occupancy rate of 90% in TB hospitals by 2010.	7 Average length of stay	72.4	75.5	76	
		8 Bed utilisation rate (based on usable beds)	77%	79%	83%	
		9 Total separations	3 867	3 340	4 006	
	Ensure the cost effective management of TB hospitals at a target expenditure of approximately R320 per PDE.	10 Expenditure per patient day equivalent [2]	R244	R233	R249	

Notes:

[1] The National Department of Health did not provide national targets for TB hospitals

[2] 2006/07 prices

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HOSPITAL	BEDS 2007/2008	BEDS 2008/2009	INCREASE IN BEDS
Brooklyn Chest Hospital	327	367	40
DP Marais Hospital	260	300	40
ID Malmesbury	41	51	10
TOTAL	**628**	**718**	**90**

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4.2.2.6. **To improve the psychosocial element of care for patients within TB Hospitals.**

- Clinical psychologists will be employed at the Metro, the Cape Winelands and the Southern Cape centres.
- Counsellors will be employed at all the MDR TB centres.
- Recreational facilities will be established at all M(X)DR TB centres.
- A register with detailed incident reporting of all patients who abscond will be kept and an appropriate response will be ensured.

4.2.2.7 **Improve the infection control strategy for the prevention of transmission of tuberculosis in health care facilities.**

- Risk assessments according to the Facility Risk Assessment Tool for TB to be done at all hospitals.
- Infection control measures in all hospitals will be strengthened through improved ventilation systems and ultraviolet germicidal irradiation (UVGI) lights in all high-risk areas.
- All hospitals are to have an infection control officer trained on TB infection control and prevention and monitoring of the implementation of the infection control plans.
- All hospitals are to have an infection control plan.

4.2.2.8 **Strengthen the occupational health and safety programme within TB hospitals to protect and care for staff**

- Increased measures to protect staff and patients from contracting TB and MDR TB must be put in place. This is going to require significant additional resources.
- Medical surveillance system with notification system must be put in place at each TB hospital.

4.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

- The impact of the HIV epidemic on the management of TB clients will have to be managed effectively.
- The general skills and competencies of clinicians to deal with patients with complex clinical presentations at all levels of care will have to be upgraded.
- The major challenge will be the protection of health workers against occupational exposure of TB, especially MDR TB. All the TB Hospitals 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.
- 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.
- Facility boards will need to be appointed for all the TB hospitals. This will increase community participation and also provide mechanisms for greater accountability of the TB hospital services to the community.

4.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.11: Provincial objectives and performance indicators for TB hospitals [PHS4]

Strategic goal:	Provide sufficient infrastructure for the rendering TB hospital services.								
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**
To provide sufficient bed capacity to render quality TB hospital services	Provide a total of 1287 beds in TB hospitals by 2010.	1 Number of beds in TB hospitals	998	1 008	1 008	1 008	1 100	1 287	1 287
		2 Total number of patient days [1]	281 050	291 798	305 008	310 427	341 275	422 780	422 780

[1] Total number of patient days includes Day cases (Day case = 1 separation = .5 in patient day)

Table 4.12: Performance indicators for TB hospitals [PHS5]

Strategic goal:	To render comprehensive TB hospital services to the population of the Western Cape									
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target 2007/08[1]**
To provide sufficient capacity to render quality TB hospital services	Provide sufficient resources for the rendering of in-patient and out-patient TB hospital services amounting to approximately 424 000 patient day equivalents (PDE) by 2010.	1 Patient day equivalents (number of PDEs)	282 413	293 059	306 287	302 604	342 608	424 380	424 380	
		2 OPD total head count	4 091	3 784	3 839	3 848	4 000	4 800	4 800	
	Implement quality assurance measures to minimise patient risk in TB hospitals.	3 TB hospitals with patient satisfaction survey using DoH template (percentage of TB hospitals)	100%	100%	100%	100%	100%	100%	100%	
		4 Mortality and morbidity meetings every month (percentage of TB hospitals)	100%	80%	100%	100%	100%	100%	100%	
		5 Clinical audit meetings every month (percentage of TB hospitals)	100%	100%	100%	100%	100%	100%	100%	
		6 Complaints resolved within 25 days (percentage = total complaints resolved in TB hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	100%	100%	100%	100%	
To ensure the effective and efficient rendering of sustainable TB hospital services	Manage bed utilisation to achieve an average length of stay of approximately 90 days and a bed occupancy rate of 90% in TB hospitals.	7 Average length of stay	72.4	75.5	76.0	75.0	80	85	85	
		8 Bed utilisation rate (based on usable beds)	77%	79%	83%	84.4%	85%	90%	90%	
		9 Total separationsl	3 867	3 340	4 006	4 140	4 266	4 974	4 974	
	Ensure the cost effective management of TB hospitals at a target expenditure of approximately R320 per PDE.	10 Expenditure per patient day equivalent[2]	R244	R233	R249	R331	R330	R289	R307	

Notes:
[1] The National Department of Health did not provide national targets for TB hospitals
[2] 2006/07 prices
Note regarding 2008/09 Target: The number of TB beds will increase. Due to the increase in MDR/XDR TB cases it is assumed that the average length of stay and bed utilisation rate will also increase. The increase in beds will be determined by available infrastructure and the budget allocation.

4.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS

There is a nominal increase of R18.763 million or 18.09% to TB hospitals in the 2008/09 budget in comparison to the revised estimate of 2007/08. Included in the funding for Sub-programme 4.2 for 2008/09 is an earmarked allocation of R7.004 million for the purpose of the health professionals remuneration review.

Table 4.13: Trends in provincial public health expenditure for TB hospitals [PHS6]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total excluding capital	62 049 000	66 116 000	76 379 000	103 700 000	122 463 000	137 159 000	150 329 000
Total Capital							
Grand Total	**62 049 000**	**66 116 000**	**76 379 000**	**103 700 000**	**122 463 000**	**137 159 000**	**150 329 000**
Total per person	13.35	14.01	14.47	19.11	21.96	23.93	25.51
Total per uninsured person	17.93	18.77	19.40	25.63	29.46	32.10	34.24
Constant 2006/07 prices							
Total excluding capital	68 829 723	68 416 152	76 379 000	100 175 453	113 090 381	122 590 050	130 176 568
Total Capital							
Grand Total	**68 829 723**	**68 416 152**	**76 379 000**	**100 175 453**	**113 090 381**	**122 590 050**	**130 176 568**
Total per person	14.81	14.50	14.47	18.46	20.28	21.39	22.09
Total per uninsured person	19.89	19.42	19.40	24.76	27.20	28.69	29.65

5. SUB-PROGRAMME 4.3: PSYCHIATRIC HOSPITALS

5.1 SITUATIONAL ANALYSIS

"In terms of population health, mental illness results in significantly greater disability than most physical illness and as such accounts for a large proportion of the Burden of Disease. According to the World Health organisation, 25% of people will develop a mental or behavioural disorder in their life-time and 10% of the adult population worldwide will have a mental disorder at any given point in time (WHO 2004). In the Western Cape Province, more than 22% of all disability has an emotional or cognitive origin" (Statistics South Africa 2001 in J. Corigall et al. 2007).

- In keeping with WHO recommendations, International practice, the Comprehensive Service Plan of the Western Cape and the Mental Health Act 17 of 2002, the Department seeks to integrate mental health services, wherever possible, in primary care and general health care settings.
- The specialist hospitals aim to provide equal access to specialist mental health care services to improve the quality of life for people with severe mental illnesses and intellectual disabilities :
  1) firmly linking a smaller specialist psychiatric hospital platform to a community based network supporting client independence;
  2) enabling mental health service users to access mainstream health services at all levels of care;
  3) delivering a quality of service, which respects staff and patients' dignity, balancing rights and responsibilities;
  4) moving beyond a quality of care approach to quality of life approach.
- Physical infrastructure and human resource management are two important leverages to further re-engineer the specialist psychiatric hospital services to meet the Comprehensive Service Plan targets.

5.1.1 Hospital estate management and physical infrastructure

- The management of the physical infrastructure is a challenge. The state of the physical facilities significantly influences the therapeutic interventions and maintenance is constantly challenged by the destructiveness of severely, mentally ill people who often present with behaviour problems.
- The psychiatric hospitals have large estates with numerous wards and buildings. Unfortunately, these have been allowed to deteriorate over decades. In addition, they were designed for custodial, lifelong care and not for modern, acute service delivery.
- Already significant consolidation has taken place and most of the worst wards have been decommissioned. However, the wards identified for retention now require significant internal changes to convert them from chronic to acute care facilities and to create a safe, therapeutic environment.
- The major changes still required are to take place in future in the two intellectual disability services at Lentegeur and Alexandra Hospitals.
- Units still to be commissioned include:
  1) Two 20-bed forensic units for juveniles; one for people with normal intelligence; and another for intellectually disabled people at Lentegeur Hospital
  2) Two adolescent units for intellectually disabled people with challenging behaviour, one each at Alexandra and Lentegeur Hospitals

3) Four acute adult admission wards, two each at Alexandra and Lentegeur Hospitals for men and women with mental illness and moderate to profound intellectual disability
4) Existing psychiatric wards requiring increased safety for more acutely ill patients
5) Providing arger out-patient services, especially at Alexandra Hospital and appropriate consultation and therapeutic areas to accommodate increased specialist day and out-patient services.

- Sufficient ward space to allow for decanting of patients whilst building operations are in progress is a challenge. Currently all wards are occupied.
- In the psychiatric hospitals, wards were historically designed for long-term residential care. Day area space that makes it possible to separate patients into smaller groups and provide therapeutic programmes safely in the wards needs to be developed.
- All acute units need to include more safety features such as CCTV and panic buttons.

5.1.2 **Services and alignment to the Comprehensive Service Plan (CSP)**

5.1.2.1 **Acute adult services**

- The acute, adult in-patient services in the specialist hospitals are configured at the bed numbers and service mix envisaged in the CSP. They remain oversubscribed and less severely ill patients continue to make way for more acutely ill patients before they have had sufficient time for adequate recovery.
- During December 2007 an additional 20 male acute beds were commissioned at Valkenberg Hospital to relieve some immediate pressure. This required the transfer of 20 chronic patients to an unused ward in Alexandra Hospital.
- The only additional in-patient services still to be commissioned are those in the district and regional hospitals. On review of progress made, these hospitals are managing high caseloads despite the lack of physical infrastructure.
- The lack of appropriate residential care facilities for discharged, vulnerable patients impacts on the ability to manage the acute services effectively. The net result is that these people remain in acute beds as evidenced in the increasing average length of stay and readmission rates in the acute services. The rapid development of step down/residential facilities is a key factor in relieving the pressure on acute psychiatric hospitals and allowing the acutely ill access to this specialist service.
- There is concern that in managing the large caseload of acutely psychotic patients, people with serious illnesses such as depression and anxiety disorders are not being referred to the neuroclinic services for treatment earlier in their illness. These services must be better promoted and marketed at a community level, and adequately resourced.
- An innovative strategy of assertive community teams (ACT) for the three adult psychiatric hospitals was introduced in January 2007. This is an intensive specialist support service for the patients identified as unstable, high frequency service users.

  The ACT teams begin their contact with the patients and their support networks prior to discharge and then follow up with weekly home visits to the patients, out-patient visits or telephone calls. They identify early signs of relapse and help to establish stronger support networks around the patient. Their key finding early in this initiative is the value of the home visits in predicting successful discharge and recovery. The primary supporting family member plays a crucial role in-patient adherence to treatment and recovery. This initiative is linked to a prospective research study to evaluate its impact.

- To support the smooth transition from hospital to home for those patients requiring more intensive rehabilitation in a residential setting, there is a plan to commission two step down facilities over the first six months of 2008. One each in Metro West (40) and Metro East (49) comprising a total of 89 step down places. This initiative crosses programmes as it is a joint venture between district health services and the psychiatric hospitals and will also involve contracting an NPO to run the service with support and outreach being provided essentially by the Assertive Community Teams.

5.1.2.2 **Substance abuse services**

- These services in the Associated Psychiatric Hospitals are at CSP levels with a specialist alcohol rehabilitation unit and an opiate detoxification unit at Stikland Hospital, which are Provincial specialist services. Out-patient services will be further developed. Outreach and support to other levels of care within the Department as well as to services within the Social Development and NPO sectors will be strengthened.
- The general acute services have picked up an increased workload due to the increase in TIK (methamphetamine) psychosis. The combination of mental illness and substance abuse is growing. This is difficult to manage as patients begin abusing substances as soon as they have been discharged which results in a rapid relapse.
- The changing face of drug abuse and addiction is marked by the increased availability of illicit drugs to South African youth.
- Tik is different from the substances of abuse that the Department has historically been used to treating. Many of the current facilities are ill prepared for this epidemic and the challenge is to gear up the service to adequately respond.
- TIK use is associated with high rates of health and mental health complications, like psychosis, cognitive deficits, anxiety and depression, as well as behavioural problems such as violence and high risk HIV behaviour.
- Withdrawal can be protracted (often lasting for several months). These patients tend to relapse and for which there is no specific proven effective medication.

5.1.2.3 **Child and adolescent services**

- The CSP in-patient services are in place in terms of the two adolescent units at Lentegeur Hospital. One is for psychotic adolescents requiring further rehabilitation referred from the Tygerberg Hospital unit and the other for the in-patient neuroclinic.
- The strengthening of these services requires improved access to training in child and adolescent services for professionals in the multidisciplinary team, especially nurses.
- The development of general specialist services for children and adolescents at regional hospital level remains a priority.

5.1.2.4 **Forensic psychiatric services**

- The waiting list for places in the male observation services remains at 60 - 70 or a waiting time of four to five months. Further improvement will only be possible when the new expanded capacity is available as envisaged in the HRP.

- In late 2006, a 20-bed step down forensic hostel was opened at Lentegeur Hospital for those people who are potential candidates for conditional discharge but do not have a community placement. The unit is functioning well and will be handed over to a suitable NGO to run with support and outreach services from the Lentegeur Hospital forensic team.

5.1.2.5 **Intellectual Disability Services**

- The greatest amount of work remaining in terms of meeting the CSP targets is within the intellectual disability service arena.
- Currently, there are 860 operational beds for in-patient services. The CSP target is 500. Approximately 50% of these patients are suitable for old age homes, nursing homes or group homes. Once they have been appropriately relocated, it will be possible to restructure the services to provide care to people with mental illness and intellectual disability as well as people with moderate to profound intellectual disability and severe challenging behaviour.
- More comprehensive therapeutic modalities will receive specific focus in this financial year.

5.1.3 **Human Resources**

- The change in acuity of services to be rendered and the challenge of integrating mental health care into all levels of care requires well trained and skilled specialists as well as generalists in the multidisciplinary team context.
- The specialist psychiatric hospitals will require more highly-skilled professionals in all disciplines; these professionals form a base of expertise for the development of mental health services both provincially and nationally.
- It is essential that service delivery models are improved to suit local conditions. This should be done in collaboration with the Department of Psychiatry at the universities of Cape Town and Stellenbosch. Sharing of information and expertise as well as the encouragement of service based research should be strengthened.
- In terms of nurse training, the establishment of the APH College based at Stikland Hospital in 2006 provides a firm platform for providing specialist training to a range of professionals in psychiatry with specific emphasis on the formal training of professional nurses.
- In collaboration with the Stellenbosch University (SU), professional nurse students have enrolled with Stellenbosch University for a one-year certificate course in psychiatry. College tutors have been accredited to lecture on behalf of SU and take responsibility for providing formal lectures on the Tygerberg Faculty of Health Sciences campus. The tutors supervise the students in their clinical placements. The curriculum for training registered professional nurses who do not have psychiatric training was submitted to the South African Nursing Council (SANC) for accreditation. The curriculum has been accepted. The SANC will accredit facilities in March 2008 in time for the course to begin in June/July 2008. Stellenbosch University will remain the moderating and assessing body for the academic programme. The College will become a campus of the Western Cape College of Nursing.

- As the College may only be accredited by one accreditation body and SANC does not accredit short courses, the courses offered by the College will be transferred to the APH nurse in-service training components. However, College staff will still support these units in providing the courses. They include short one to five day courses to a range of health care personnel from APH, PGWC and NPO services on mental health topics such as basic psychiatry and interpersonal skills etc. These courses will be formalised and application made to Umlazi, the accreditation body for short courses.
- Twice a year the College presents a mental health update for professionals, which is accredited for continuing professional development.

Table 4.14: Situation analysis indicators for psychiatric hospitals [PHS3]

Strategic goal:	**To render specialist psychiatric hospital services to the population of the Western Cape**					
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**National target 2003/04** [1]
To provide sufficient capacity to render comprehensive specialist psychiatric hospital services	Provide sufficient resources to render comprehensive specialist psychiatric hospital services to in-patients and out-patients amounting to approximately 584 000 patient day equivalents per annum by 2010.	1 Patient Day Equivalents (Number of PDEs)	652 693	649 818	647 315	
		2 OPD total head count	22 121	19 238	20 573	
	Implement quality assurance measures to minimise patient risk in specialist psychiatric hospital services.	3 Patient satisfaction survey using DoH template (percentage of specialist psychiatric hospitals)	36%	12%	100%	
		4 Mortality and morbidity meetings every month (percentage of specialist psychiatric hospitals)	85%	0%	100%	
		5 Clinical audit meetings every month (percentage of specialist psychiatric hospitals)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	
		6 Complaints resolved within 25 days (percentage = total complaints resolved in specialist psychiatric hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	
To ensure the effective and efficient rendering of sustainable specialist psychiatric hospital services	Manage bed utilisation to achieve an average length of stay of approximately 130 days and a bed occupancy rate of 90% by 2010.	7 Average length of stay	118	125.1	129.74	
		8 Bed utilisation rate (based on usable beds)	83%	83%	86%	
		9 Total separationsl	5 648	5 145	4 907	
	Ensure the cost effective management of specialist psychiatric hospitals at a target expenditure of approximately R600 per PDE.	10 Expenditure per patient day equivalent[2]	R435	R444	R464	

Notes:

1. The National Department of Health did not provide national targets for specialist psychiatric hospitals
2. 2006/07 prices

5.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

5.2.1 Strategic Goal:

To provide specialised psychiatric hospital services for acute and chronic patients.

5.2.2 Strategic Objectives:

- To align psychiatric services with the requirements of the Mental Health Care Act and the CSP.
- To reduce the current number of chronic psychiatric patients in specialized hospitals.

5.2.3 Policy

- The Comprehensive Service Plan envisages the provision of psychiatric beds at regional and district hospitals and the development of community based services. The number of specialist psychiatric hospitals will remain unchanged; however, the remaining beds will be used for a range of specialised services with increased patient acuity requiring more skilled personnel. There will be no long-term residential care.
- Regulations promulgated on 15 December 2004, 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 plays 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 have been established at provincial level.
- 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. Mental health care users can present themselves at any health care facility for treatment. They 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. This policy poses a significant challenge, particularly in busy emergency units of general hospitals.
- Funds will be allocated to strengthen mental health services outside of the specialist hospitals to support community-based and PHC services as well as to capacitate district and regional hospitals to provide acute services.

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- Treatment protocols for mental health problems at regional and district hospital level have been published and are reviewed annually. All the APH hospitals have 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 the inclusion of second-generation antipsychotic as well as newer antidepressants onto provincial code. They have also provided the clinical guidelines for their use.
- Regular reports in accordance with the Mental Health Care Act of 2002 are submitted to Mental Health Review Board.

5.5. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.15: Provincial objectives and performance indicators for psychiatric hospitals [PHS4]

Strategic goal:	**Provide sufficient infrastructure for the rendering of specialist psychiatric hospital services**								
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**
To provide sufficient bed capacity to render quality specialist psychiatric hospital services.	Provide a total of 1 763 beds in specialist psychiatric hospitals by 2010	1 Number of beds in specialist psychiatric hospitals	2 127	2 096	2 015	1 962	1 893	1 823	1 763
		2 Total number of patient days [1]	645 245	643 405	639 948	630 194	621 851	598 856	579 146

[1] Total number of patient days includes Day cases (Day case = 1 separation = .5 in patient day)

Table 4.16: Performance indicators for specialist psychiatric hospitals [PHS5]

Strategic goal:	**To render specialist psychiatric hospital services to the population of the Western Cape**									
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target 2007/08[1]**
To provide sufficient capacity to render comprehensive specialist psychiatric hospital services	Provide sufficient resources to render comprehensive specialist psychiatric hospital services to in-patients and out- patients amounting to approximately 584 000 patient day equivalents per annum by 2010	1 Patient Day Equivalents (Number of PDEs)	652 693	649 818	647 315	636 366	627 405	603 855	583 645	
		2 OPD Total head count	22 121	19 238	20 573	18 516	16 664	14 998	13 498	
	Implement quality assurance measures to minimise patient risk in specialist psychiatric hospital services	3 Patient satisfaction survey using DoH template (Percentage of specialist psychiatric hospitals)	36%	12%	100%	100%	100%	100%	100%	
		4 Mortality and morbidity meetings every month (percentage of specialist psychiatric hospitals)	85%	0%	100%	100%	100%	100%	100%	
		5 Clinical audit meetings every month (percentage of specialist psychiatric hospitals)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	100%	100%	100%	100%	
		6 Complaints resolved within 25 days (percentage = total complaints resolved in specialist psychiatric hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	100%	100%	100%	100%	
To ensure the effective and efficient rendering of sustainable specialist psychiatric hospital services	Manage bed utilisation to achieve an average length of stay of approximately 130 days and a bed occupancy rate of 90% by 2010	7 Average length of stay	118.0	125.1	129.7	129.0	130	130	130	
		8 Bed utilisation rate (based on usable beds)	83%	83%	86%	88.0%	90%	90%	90%	
		9 Separations –Total	5 648	5 145	4 907	4 885	4 783	4 607	4 455	
	Ensure the cost-effective management of specialist psychiatric hospitals at a target expenditure of approximately R600 per PDE	10 Expenditure per patient day equivalent[2]	R435	R444	R464	R506	R556	R626	R688	

Notes:
1. The National Department of Health did not provide national targets for psychiatric hospitals.
2. 2006/07 prices

5.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

There is a nominal increase of R44.330 million or 13.30% in the funding for psychiatric hospitals in 2008/09 in comparison to the revised estimate of the 2007/08 budget. Included in the 2008/09 budget for Sub-programme 4.3 is an earmarked allocation of R29.606 million for the purpose of the health professionals' remuneration review.

Table 4.17: Trends in provincial public health expenditure for psychiatric hospitals [PHS6]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total excluding capital	256 210 000	279 060 000	300 496 000	333 370 000	377 700 000	423 023 000	463 649 000
Total capital							
Grand Total	**256 210 000**	**279 060 000**	**300 496 000**	**333 370 000**	**377 700 000**	**423 023 000**	**463 649 000**
Total per person	55.14	59.15	56.93	61.44	67.73	73.80	78.69
Total per uninsured person	74.02	79.21	76.33	82.40	90.85	99.01	105.60
Constant 2006/07 prices							
Total excluding capital	284 208 664	288 768 398	300 496 000	322 039 449	348 792 996	378 089 739	401 494 293
Total capital							
Grand Total	**284 208 664**	**288 768 398**	**300 496 000**	**322 039 449**	**348 792 996**	**378 089 739**	**401 494 293**
Total per person	61.17	61.21	56.93	59.36	62.54	65.96	68.14
Total per uninsured person	82.11	81.97	76.33	79.60	83.90	88.50	91.44

6. SUB-PROGRAMME 4.4: REHABILITATION SERVICES

6.1 SITUATION 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, and Nelspoort Hospital.
- In 2006/07, Maitland Cottage Hospital, which is closely linked to the Red Cross Children's Hospital, was shifted to Programme 5, while the Booth Memorial Hospital, Sarah Fox Hospital and St Joseph's Home were shifted to Programme 2.
- In 2007/2008, Nelspoort was moved to Programme 2.
- Only the Western Cape Rehabilitation Centre remains in this sub-programme and for this reason the sub-programme is now designated Rehabilitation Services.
- In 2008/09 the Orthotic and Prosthetic services will be moved from Programme 7 to Sub-programme 4.4 to resort under the Western Cape Rehabilitation Centre.
- The Western Cape Rehabilitation Centre (WCRC) provides essential specialised in- and out-patient rehabilitation services to persons from the Western Cape and neighbouring provinces, and plays a key role in reducing the impact of disabling conditions and the burden of disease. Community re-integration and improved quality of life are key outcomes. As the provision of orthotic and prosthetic devices plays a key role in enablement of persons with disabilities, these services will in future resort under the WCRC.

6.1.1 THE WESTERN CAPE REHABILITATION CENTRE (WCRC)

- The Western Cape Rehabilitation Centre is a 156-bed provincial specialised facility providing high intensity rehabilitation services for persons with a wide variety of physical disabilities such as spinal cord afflictions, head injury, amputation, stroke or cerebral palsy, amongst others.
- The in- and out-patient services of the Western Cape Rehabilitation Centre continue to expand. Average bed occupancy has increased from 57% (2004/05) to more than 80% in 2007/08 and out-patient visits from 3 004 (2004/05) to more than 5 000 in 2007/08.
- The specialised wheelchair seating outreach clinics have increased from 12 in 2005/06 to 96 clinics in 2007/08, with the number of children being attended to increasing from 140 to 960 over the same period.
- Service efficiencies have been increased through the introduction of specific referral- and client-flow management structures and systems, and outsourcing of the outreach clinics to an NGO.
- The management of the orthotic and prosthetic service will be taken over by the management of the Western Cape Rehabilitation Centre. It is planned that the services provided will be rationalised and made more cost effective and efficient.

Table 4. 18: Situation analysis tables for specialized rehabilitation services [PHS3]

Strategic goal:	**To provide high intensity specialis ed rehabilitation services for persons with physical disabilities.**						
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**National target 2003/04** [1]
To provide sufficient capacity to render comprehensive high intensity rehabilitation services	Provide sufficient resources for the rendering of high intensity rehabilitation services to in-patients and out-patients amounting to approximately 53 000 patient day equivalents per annum by 2010.	1	Patient day equivalents (number of PDEs)	235 002	277 907	47 130	
		2	OPD Total head count	2 944	4 740	5 206	
	Implement quality assurance measures to minimise patient risk in the WCRC.	3	Patient satisfaction survey using DoH template (percentage of chronic hospitals)	36%	12%	100%	
		4	Mortality and Morbidity meetings every month (percentage of chronic hospitals)	85%	0%	100%	
		5	Clinical audit meetings every month (percentage of chronic hospitals)				
		6	Complaints resolved within 25 days (percentage = total complaints resolved in chronic hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	
Ensure the effective and efficient rendering of sustainable high intensity rehabilitation services.	Manage bed utilisation to achieve an average length of stay of approximately 40 days and a bed occupancy rate of 90% by 2010.	7	Average length of stay	57.6	54.6	43.3	
		8	Bed utilisation rate (based on usable beds)	85%	83%	80%	
		9	Total s eparations	4 111	5 059	1 049	
	Ensure the cost effective management of the Western Cape Rehabilitation Centre at a target expenditure of approximately R1 800 per PDE.	10	Expenditure per patient day equivalent[2]	R261	R360	R1 171	

Notes:

[1] The National Department of Health did not provide national targets for specialised rehabilitation hospitals

2 2006/07 prices

3 The drop in separations and PDEs in 2006/07 is owing to the shift of most hospitals to other programmes as referred to above

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6.3 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4. 19: Provincial performance objectives and performance indicators for rehabilitation services [PHS4]

Sub-programme 4.4:	**Rehabilitation services**		**Strategic goal:**	**Provide sufficient infrastructure for the rendering of high intensity rehabilitation services at the Western Cape Rehabilitation Centre**						
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**
To provide sufficient bed capacity at the WCRC to render high intensity rehabilitation services	Provide a total of 156 beds in the WCRC by 2010.	1	Number of beds in WCRC	752	911	156	156	156	156	156
		2	Total number of patient days [1]	233 967	276 144	45 395	49 090	51 246	51 246	51 246
	Provide prthotic and prosthetic services		**Strategic goal:**	**To rendering specialised orthotic and prosthetic services.**						
To render an orthotic and prosthetic service for the Province	Manage a combination of in-house and out-sourced services	3	Number of orthotic and prosthetic devices manufactured	4 109	4 616	4 467	5 000	6 300	6 910	6 910
To provide quality orthotic and prosthetic devices	Training of and liaison with physiotherapists and occupational therapists	4	Percentage of orthotic and prosthetic devices requiring remanufacture.	3% (123/4 109)	3% (138/4 616)	2% (89/4 467)	2% (100/5 000)	2% (126/6 300)	2% (138/6 910)	2% (138/6 910)
To provide a responsive orthotic and prosthetic service	Increase productivity and outsourcing where cost effective	5	Number of patients on waiting list for orthotic and prosthetic services for over 6 months.	705	800	758	600	450	360	220

Notes:

[1] Total number of patient days includes Day cases (Day case = 1 separation = .5 in-patient day)

2. The drop in beds between 2005 and 2006 reflects mainly the acute services from the Old Conradie site that were absorbed by other facilities within the metro.

Table 4.20: Performance indicators for rehabilitation services [PHS5]

Strategic goal:	**To provide high intensity specialised rehabilitation services for persons with physical disabilities.**									
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target 2007/08**[1]
To provide sufficient capacity to render comprehensive high intensity rehabilitation services	Provide sufficient resources for the rendering of high intensity rehabilitation services to in-patients and out-patients amounting to approximately 53 000 patient day equivalents per annum by 2010.	1	Patient Day Equivalents (Number of PDEs)	235 002	277 907	47 130	50 833	53 079	53 079	53 079	
		2	OPD Total head count	2 944	4 740	5 206	5 228	5 500	5 500	5 500	
	Implement quality assurance measures to minimise patient risk in the WCRC.	3	Patient satisfaction survey using DoH template (percentage of chronic hospitals)	36%	12%	100%	100%	100%	100%	100%	
		4	Mortality and morbidity meetings every month (percentage of chronic hospitals)	85%	0%	100%	100%	100%	100%	100%	
		5	Clinical audit meetings every month (percentage of chronic hospitals)	0%	0%	0%	100%	100%	100%	100%	
		6	Complaints resolved within 25 days (percentage = total complaints resolved in chronic hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	100%	100%	100%	100%	
Ensure the effective and efficient rendering of sustainable high intensity rehabilitation services.	Manage bed utilisation to achieve an average length of stay of approximately 45 days and a bed occupancy rate of 90% by 2010.	7	Average length of stay	57.6	54.6	43.3	48.1	45	45	45	
		8	Bed utilisation rate (based on usable beds)[2]	85%	83%	80%	86.2%	90%	90%	90%	
		9	Total aeparations	4 111	5 059	1 049	1 020	1 139	1 139	1 139	
	Ensure the cost-effective management of the Western Cape Rehabilitation Centre at a target expenditure of approximately R1 800 per PDE.	10	Expenditure per patient day equivalent[2]	R261	R360	R1 171	R1 441	R1 728	R1 873	R1 989	

Notes:

1 The National Department of Health has not provided national targets for rehabilitation services

2 A 75% bed utilization rate is the limit set in the PPP contract. PDEs exceeding this result in additional expenditure to the Department.

6.4 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

There is a nominal increase of R23.480 million or 30.97% in the 2008/09 allocation to chronic hospitals/rehabilitation services in comparison to the revised estimate of the 2007/08 budget. A contributing factor is the allocation of funds from Sub-programme 7.3 Orthotic and Prosthetic Services to Sub-programme 4.4.

Included in the 2008/09 budget for Sub-programme 4.4 is an earmarked allocation of R2.122 million for the purpose of the health professionals' remuneration review.

Table 4.21: Trends in provincial public health expenditure in rehabilitation services [PHS6]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total excluding capital	55 265 000	96 569 000	55 202 000	75 822 000	99 302 000	111 219 000	121 897 000
Total capital							
Grand Total	**55 265 000**	**96 569 000**	**55 202 000**	**75 822 000**	**99 302 000**	**111 219 000**	**121 897 000**
Total per person	11.89	20.47	10.46	13.97	17.81	19.40	20.69
Total per uninsured person	15.97	27.41	14.02	18.74	23.89	26.03	27.76
Constant 2006/07 prices							
Total excluding capital	61 304 367	99 928 601	55 202 000	73 244 968	91 701 991	99 405 382	105 556 035
Total Capital							
Grand Total	**61 304 367**	**99 928 601**	**55 202 000**	**73 244 968**	**91 701 991**	**99 405 382**	**105 556 035**
Total per person	13.19	21.18	10.46	13.50	16.44	17.34	17.91
Total per uninsured person	17.71	28.37	14.02	18.11	22.06	23.27	24.04

7. SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

7.1 SITUATION ANALYSIS

The University of the Western Cape Oral Health Teaching platform (OHTP) comprises the Tygerberg Oral Health Centre (OHC), Mitchells Plain OHC, the Red Cross Children's Hospital dental clinic, Groote Schuur Hospital maxilla-facial unit and satellite centres at Mitchells Plain CHC, Guguletu dental clinic, Bottelary clinic and its mobile dental services (including services provided on the Phelophepa Health Care Train). The operational service plan for oral health has been approved and will be implemented in phases.

7.1.1 Population characteristics and equity

Projected increase in public oral health services demand is based on four factors:

1) According to the recent census figures, the Western Cape is experiencing a high growth rate especially in the urban areas.
2) There is increased socio-economic depression in the communities that need 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 inflow to the province
5) There is an increase in referrals from both the private and public sector PHC facilities to the OHTP, because of the expertise available at these sites.

7.1.2 Service facilities, utilization and gaps

- As a service facility the OHTP has become the *de facto* referral centre for more complex patients. The OHTP package of care consists of primary, secondary, tertiary and quaternary services. The OHTP is not funded to deliver PHC services.
- The Tygerberg OHC and Mitchells Plain OHC and the satellite clinics of the OHTP at the Mitchell's Plain CHC and the Red Cross Children's Hospital are the only specialised children's clinics offering comprehensive oral health services for children and children with special needs.
- It is also the screening site for children that require treatment under general anaesthetic and conscious sedation.
- The OHTP provides specialised dental treatment for medically compromised and maxillofacial services at the Red Cross Children's Hospital, Tygerberg and Groote Schuur OHCs.
- The outreach programme of the OHTP at Guguletu is serviced by staff and students from the OHTP on a rotational basis and takes comprehensive oral health care to the lower level of service. This outreach programme sees in excess of 18 000 patients per year.
- Patients from all over the province, as well as neighbouring provinces and countries, seek treatment at the OHTP. The majority of them are referred from the public sector oral health service clinics for tertiary and quaternary services.

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The OHTP and the University of the Western Cape is committed to producing the following oral health professionals on average per year for the next MTEF period:

- 110 dentists
- 25 oral hygienists (diploma level)
- 8 oral hygienists (degree level)
- 6 registrars per year
- 16 M.Sc. (Dent) students in the four clinical disciplines
- 25 Diploma in Conscious Sedation and Pain graduates comprising medical officers and dentists to reduce the burden of services related to general anaesthesia.

In addition the OHTP will provide continuing professional development courses for both public and private sector oral health professionals. The OHTP provides the facilities for teaching and practical training for radiographers and dental assistants at the two training centres for the students of the Cape Peninsula University of Technology.

7.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

- A comprehensive oral health service plan (COHSP) was developed and approved by the Department.
- The plan will be implemented in phases over time within the available resources. While most of the elements will rightly fall under Programme 2, the plan has been described in this section to give a full picture and because the OHTP will be providing technical support with the implementation of the plan and the evaluation of services.

Strategic Goal:

- To provide accessible and quality dental services for the Western Cape population.
- To provide for the training of oral health personnel at different levels for the PGWC and the country.

Strategic Objective:

- To provide dental services efficiently and effectively within the available resources.
- To conduct research primarily for public health programmes.
- To facilitate and support the monitoring and evaluation of public sector services at a district level.

7.2.1 Comprehensive Oral Health Service Plan (COHSP)

Strategies to address the key oral health problems of the Western Cape include the following.

7.2.1.1 Fluoridating the oral environment

1) **Water fluoridation**

It is unlikely that progress will be made with widespread water fluoridation in the Western Cape in the short to medium term.

2) **School fluoride rinsing and/ or both brushing programme**

In view of the delay in implementing water fluoridation a programme of rinsing with fluoride was considered. However, due to the need to establish a sound oral hygiene practice at an early age it was decided that both the brushing programme would be more appropriate.

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PRIORITY	SERVICE	STAFF CATEGORY
1. Primary prevention	Water fluoridation Dental health education Fluoride rinsing/brushing programmes	Oral hygienists Dental assistants Dental therapists Dentists Speech therapists Dieticians, etc
2. Basic treatment package [clinical procedures]	Examination Intra-oral X-rays Simple fillings Emergency pain relief and treatment of sepsis Dentures	Oral hygienists Dental therapists Dentists Dental technicians

[illegible]

[illegible]

7.2.1.7 **Service package**

The package of care to be provided at PHC facilities will be in line with the national policy. The package of care must therefore consist of promotive and primary preventative services as well as basic treatment services. School children and pre-school children will be the priority patient groups.

The distribution of workload across the levels of care will be as follows:

- 90% primary care
- 8% secondary care
- Tertiary and quaternary care will account for 2% of services provided

7.2.1.8 **Human Resources required by regions**

Staffing required was based on a utilisation-based approach. The level of utilisation was employed to calculate and compare the required staff numbers per category of staff to the CSP staffing model. There was not a significant difference in the estimated staffing costs between the CSP staffing and the numbers derived from the modelling. In order to contain costs the CSP staffing model was accepted.

Provision was also made for additional posts at the Head Office and oral health manager posts at district level.

7.2.1.9 **Cost of the approved oral health plan**

The human resources required were costed using existing salary grades and required number of posts. A normative approach was used to calculate the non-staff costs. The total estimated budget for 2010 therefore amounts to R146 157 679, which includes an amount of R8.115 million for capital costs. Compared to the allocation for 2007/08 ® 81 342 000) this represents a deficit of R 64 815 679.

Denture provision:

The unabated provision of dentures is in conflict with the underlying principle of the National Oral Health Strategy as well as the proposed Oral Health Plan, which advocates the prevention of oral disease, conservation of dentition and ultimately the prevention of edentulousness, i.e. dental disability.

Although, in reality, the demand for dentures is not being fully met, the current limited denture provision will be continued. This will ensure the provision of about 2 000 sets of dentures per year. While current funding levels do not permit expansion of denture services other options such as PPPs and donors may be considered to expand the service.

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3) **Transport**

Availability of transport designated for the oral health programme is of crucial importance.

4) **Oral Health Information**

The routine collection of oral health indicator information at facilities should be facilitated by the incorporation of an oral health module in the Clinicom system.

7.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The following measures are planned to address the constraints highlighted above:

7.3.1 The Western Cape COHSP will be implemented in phases within the available resources.

7.3.2 Oral health infrastructure requirements will be addressed in the departmental infrastructure planning processes.

7.3.3 The Oral Health HR requirements will be considered as part of the broad departmental HR plan initiatives.

7.3.4 Measures will be considered for the purpose of creating an exit strategy for oral health services delivered at Correctional Service facilities.

7.4 PLANNED QUALITY IMPROVEMENT MEASURES

Planned quality improvement measures are designed to incrementally implement the Provincial Quality of Care policy. The three components to be addressed are:

7.4.1 Patient Satisfaction

- A client based survey will be developed to assess the level of satisfaction with services rendered at the OHC.
- Complaints mechanism will be put in place (PALS).
- The Hospital Board will be established in line with the Facilities Boards Bill thereby making the OHC accessible to the community and facilitating community participation in decision-making.
- Waiting lists will be reduced through the transfer of skills and services to the other levels of care, general improved efficiency and PPI (dentures and orthodontics).

7.4.2 Care for the Carer

- Establishment of a staff support unit (EAP).
- Implementation of an employee satisfaction survey.

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7.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.23: Situation analysis and performance indicators: Academic Dental Services [PHS4]

Strategic goal:	**To establish an effective and efficient dental service delivery platform with sufficient resources for the teaching and training of dental professionals**									
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target 2007/08[1]**
To provide sufficient capacity to render quality dental services	Provide sufficient resources to render in-patient and out-patient dental hospital services.	1 Number of patient visits per annum	160 000	179 211	195 203	189 689	193 800	197 700	201 600	
		2 Number of theatre cases per annum	1 400	1 363	1 500	1 700	1 900	2 000	2 000	
		3 Number of patients provided with dentures per annum	900	2 282	1 335	1 385	1 410	1 450	1 450	
To provide sufficient resources for the teaching and training of dental professionals	Optimise the number of students trained on the platform per annum.	4 Number of students graduating per annum	217	201	216	200	200	200	200	

Notes

[1] The National Department of Health did not provide national targets for dental hospitals

7.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

There is a nominal increase of R6.697 million or 10.82% in the 2008/09 allocation to dental training hospitals in comparison to the revised estimate of the 2007/08 budget. Included in the 2008/09 budget for Sub-programme 4.5 is an earmarked allocation of R1.040 million for the purpose of the health professionals' remuneration review.

Table 2.24: Trends in provincial health expenditure for dental training hospitals [PHS6]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total excluding capital	52 375 000	58 735 000	55 924 000	61 915 000	68 612 000	76 844 000	84 221 000
Total capital							
Grand Total	**52 375 000**	**58 735 000**	**55 924 000**	**61 915 000**	**68 612 000**	**76 844 000**	**84 221 000**
Total per person	11.27	12.45	10.59	11.41	12.30	13.41	14.29
Total per uninsured person	15.13	16.67	14.21	15.30	16.50	17.99	19.18
Constant 2006/07 prices							
Total excluding capital	58 098 547	60 778 370	55 924 000	59 810 638	63 360 829	68 681 674	72 930 710
Total capital							
Grand Total	**58 098 547**	**60 778 370**	**55 924 000**	**59 810 638**	**63 360 829**	**68 681 674**	**72 930 710**
Total per person	12.50	12.88	10.59	11.02	11.36	11.98	12.38
Total per uninsured person	16.78	17.25	14.21	14.78	15.24	16.08	16.61

PROGRAMME 5: HIGHLY SPECIALISED CENTRAL HOSPITAL SERVICES

1. AIM

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

2. PROGRAMME STRUCTURE

Sub-programme 5.1 Central hospital services

Rendering of *only* highly specialised tertiary and quaternary health services to the Western Cape and beyond and providing a platform for the training of health science students and workers, as well as research.

3. SITUATION ANALYSIS

3.1 **Context of central hospitals services**:

The central hospitals in the Western Cape are:

1) The Red Cross War Memorial Children's Hospital (RCCH)
2) Tygerberg Hospital
3) Groote Schuur Hospital

These hospitals provide tertiary and quaternary health services to those patients referred from the Western Cape Province, surrounding provinces, the rest of the country and from African countries. Each hospital provides in addition general specialist services and forms part of the Metro East services (where Tygerberg Hospital is included) and Metro West services (where Groote Schuur and RCCH are included) level 2 platform of general specialist services.

As from the 2008/09 financial year Programme 5 will fund only the expenditure on highly specialised tertiary and quaternary health care services, as defined within the province as well as the service costs related to teaching and training at this level. Funding for level 2 general specialist services and related training has been allocated from this financial year in Programme 4. The central hospitals will receive funding from Programme 5 for tertiary and quaternary services as provided for by the National Tertiary Services Grant (NTSG) with supplementation from the provincial equitable share and from Programme 4.1 for acute regional (general specialist) hospital services funded from the provincial equitable share. The province is obliged to supplement the funding of tertiary and quaternary services due to the shortfall in funding received from the NTSG.

Central hospitals contain highly specialised services appropriate to the disease burden of the province and the country, and include paediatric surgery, cardiology, cardiothoracic surgery, neurology, neurosurgery and radiation therapy for cancer patients. A full list of services is provided in Table 5.1. The central hospitals play an important role to support the whole health care delivery system.

Clinicians in central hospitals have a responsibility to reach out and support the health services at other levels and monitor patterns of disease. It is important to note that all future specialists are largely trained currently in the tertiary services platform, with rotation to the general specialist services platform. Specialists and registrars play an important role in the training of all under-graduate medical and other health sciences students. This is particularly significant as the Western Cape trains 30% of the medical graduates in the country.

3.2 Ikapa Elihlumayo, social, human and intellectual capital

A key strategic imperative of the Provincial Growth and Development Strategy is the focus on integrated development and the deepening of social capital, especially amongst the poor, women and children. The role of the central hospitals and in particular tertiary services in this context is listed below:

- The Western Cape health services provided a platform for 5.64 million health science student hours during 2007 of which 58% were in the central hospitals. This is a significant contribution towards human and intellectual capital and provides health professionals for the country as a whole.
- The central hospitals service platform provides access for research by Institutions of Higher Education (HEI). This contributes to the intellectual development, human capital and continuous improvement of services at all levels of care. Relevant research has resulted in many international publications. Several medical congresses are hosted in Cape Town due to the presence of Health Sciences Faculties in the Western Cape. This contributes to economic development.
- The clinicians involved in service delivery are increasingly enhancing the capacity at referring institutions through a system of outreach and support, in-service training of health workers and advocacy.
- 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 that advise families, general practitioners and specialists across the country.

3.3 Tertiary services

Tertiary and quaternary services cater for the most specialised care required in the referral chain. As these services are highly specialised and expensive, it is important for the system to be strengthened to ensure the correct and appropriate referral of these patients. Such services include advanced diagnostic procedures and patient management. This level of care is defined by the specialized skills and/or equipment required. The central hospital tertiary component amongst other services provides the only intensive care services in the province.

This is an important component of critical care in the province, requiring close co-operation across services.

Tertiary services form part of the Services Division for Secondary, Tertiary and Emergency Care in the Department of Health.

The vision for tertiary services is:
The component of the healthcare system where highly specialised healthcare is equitably available to all the people of the Province and beyond, providing balanced, appropriate and accessible quality care, training and research that responds appropriately to the burden of disease, ensuring satisfied staff and patients.

3.4 Package of services

Table 5.1 below lists the range of services being provided at the three central hospitals. These services were differentiated as level 2 (general specialist) and highly specialised level 3 services during 2007, Table 5.3. It must be noted that tertiary services are not limited to beds. There are on average more out-patients than there are admissions.

Table 5.1: Range of services in Central Hospitals during 2007

Specialty	**Sub-specialty**
Critical Care (General Intensive Care)	Adult critical care
	Paediatric critical care
Obstetrics	Obstetrics
Gynaecology	Oncology
	General Gynaecology
Medicine	Allergology
	Cardiology
	Clinical haematology/oncology
	Dermatology
	Emergency medicine
	Endocrinology
	Gastro-enterology
	General Medicine
	Geriatrics
	Hepatology
	Infectious diseases
	Nephrology
	Neurology
	Pulomology
	Rheumatology
Orthopaedics	Arthroplasty
	Hand surgery
	Orthopaedics
	Spinal unit
Paediatric Orthopaedics	Paediatric hand surgery
	Paediatric orthopaedic trauma
	Paediatric orthopaedics
Child Psychiatry	**Child psychiatry**
Paediatric Surgery	Neonatal surgery
	Paediatric burns
	Paediatric cardiothoracic surgery
	Paediatric neurosurgery
	Paediatric ophthalmology

Specialty	Sub-specialty
	Paediatric otolaryngology
	Paediatric plastic and reconstructive surgery
	Paediatric surgery
	Paediatric trauma
	Paediatric urology
Paediatrics	General paediatrics
	Paediatric cardiology
	Paediatric clinical haematology/oncology
	Paediatric dermatology
	Paediatric emergency medicine
	Paediatric endocrinology
	Paediatric gastro-enterology
	Paediatric infectious diseases
	Paediatric nephrology
	Paediatric neurology
	Paediatric pulmonology
Psychiatry	
Radiation Medicine	
Surgery	Burns
	Cardiothoracic surgery
	General surgery
	Neurosurgery
	Ophthalmology
	Plastic and reconstructive surgery
	Trauma surgery
	Urology
	ENT

3.5 Burden of Disease

The figure below indicates the major case loads in terms of admissions over the past 5 years, and during the past 12 months.

Table 5.2: Top 10 activities in the Central Hospitals

TOP 10 ADMISSIONS OVER 5 YEARS	
Obstetrics	72 856
General Surgery	33 453
Trauma	31 450
Neonatology	27 712
Emergency Paediatrics	27 428
General Orthopaedics	27 077
General Medicine	26 525
Gynaecology	25 456
Emergency Medicine	25 410
Ophthalmology	22 674
TOP 10 ADMISSIONS LAST 12 MONTHS	
Obstetrics	18 413
Neonatology	8 542
General Surgery	7 940
Emergency Paediatrics	7 674
Trauma	7 585
General Medicine	7 115
General Orthopaedics	6 251
Gynaecology	6 173
Ophthalmology	5 247
Emergency Medicine	5 153

Note: Total admissions over the respective periods.

3.6 Service trends over time

An analysis of service trends over time demonstrates the changes in services over the past 5-year period:

1) The total number of separations (admissions) has increased over the years, despite a reduction of beds. This is particularly evident at Tygerberg Hospital.
2) The average length that patients stay in hospital has decreased, which is evidence of increased efficiency.
3) Trauma separations have increased dramatically in the Tygerberg Hospital drainage area, which is largely due to an increase in interpersonal violence.
4) The total number of deliveries (babies born) in the Tygerberg Hospital drainage area shows a dramatic increase of nearly 50% over the 5-year period.
5) The mortality rate in the hospitals has remained relatively stable, despite major trauma cases and an increase in the acuity of patients. This reflects the commitment of both clinicians and managers.

3.7 Restructuring of Central Hospitals

The Comprehensive Service Plan (CSP) outlines a framework for the restructuring of central hospitals. The changes include the following:

- Establish a unitary Western Cape tertiary service with a shared vision and rendered at three hospitals.
- Establish separate beds, which provide tertiary and secondary care services respectively.
- Ensure equitable access to tertiary services through single waiting lists for elective procedures.
- Establish a framework for the management of waiting lists.

Table 5.3 below indicates the current situation, with table 5.4 indicating the change that will be effected in 2008/09.

Table 5.3: Number of planned beds in central hospitals by level of care [2008/09] [CHS1]

Central hospital complex	Level 3 and 4 beds	Level 2 beds	Total beds
Groote Schuur Hospital	685	190	875
Tygerberg Hospital	538	772	1 307
Red Cross Children`s Hospital	237	63	300
TOTAL	**1 460**	**1 025**	**2 485**

During 2007/08 28 beds were re-opened and during 2008/09 a further 68 beds will be opened.

A CSP Working Group for Tertiary Services has been established as the mechanism to ensure that the service plans are constructed and that the academic implications of the service changes are considered and planned. The Working Group includes the Head of the Division, chief executive officer of Tygerberg Hospital and, both deans of the Health Sciences faculties of the medical schools of the Universities of Cape Town and Stellenbosch.

3.8 System of Co-ordinating Clinicians

The Department in 2004 adopted a strategy to improve clinical governance (quality and safety of care, uniform clinical guidelines, seamless patient care management, ensuring the right patient gets managed at the right level right and with the right skills and at the right costs) through a system of co-ordinating clinicians. One co-ordinating clinician for each major discipline, such as paediatrics or anaesthetics has been appointed from current staff and who spend 50% of their time on these functions across all levels of care and across the whole province. There has been a particular focus on District Health Services and level 2 services. This system will be assessed during 2008.

3.9 Situation analysis for each hospital

This section describes the situation analysis for each of the Central Hospitals. The situation analysis tables, Tables 5.6 - 5.9, and the tables of measurable objectives and performance indicators in paragraph 8 provide indicator trends for each hospital over time as well as projected trends over the MTEF period.

3.9.1 Red Cross War Memorial Children's Hospital

3.9.1.1 Vision

Red Cross War Memorial Children's Hospital strives to be a leader in specialised health care for children.

3.9.1.2 Role

Red Cross War Memorial Children's Hospital is a key clinical and academic resource for the province, country, Africa and international community with regard to child health care. It is a national referral centre for paediatric liver and kidney transplants, as well as separation of conjoined twins. The Red Cross Children's Hospital provides 352 000 hours towards training of 9% of all health sciences students in the province, largely focusing on future specialists and supporting professional cadres in paediatric care. It provides the only dedicated specialised burns unit for children in the province and the only centre where paediatric cardiac surgery is being performed. It plays a vital role in clinical governance of child health services in the province.

3.9.1.3 Situation analysis

- Service outputs and challenges:
  - Approximately 21 000 patients were admitted and treated, and 189 000 patients received care as out-patients during 2007/08.
  - Acute medical emergencies and trauma accounted for 29.7 % of which trauma accounted for 5,5% of total outpatient headcounts during the period April to November 2007 and reflects the service pressures experienced. These are defined as level 2 services.
  - During the period April 2007 to September 2007 admissions of patients under one and five years of age accounted for 49% and 75% of total admissions, respectively. Managing these patients requires specialised skills, care and equipment. It is important to note that the national policy is that children younger than 6 years of age are entitled to free health services which impacts on revenue generation by this hospital.

- The seasonal burden of disease was a key factor causing service pressures during 2007/08:
  - The seasonal effect and burden of diarrhoeal disease is felt markedly during the summer months (January to May) when bed occupancy rates in the rehydration ward are often well over 100%. This service in future should be catered for in less specialized facilities, once established. Red Cross Children's Hospital plays a leading role towards prevention programs and building skills and capacity at referring levels to manage diarhoeal disease.
  - During most of the winter months (June to October), paediatric burn cases escalate considerably and the bed occupancy rate in the burns ward increases to between 90% and 95%. A significantly higher number of admissions (almost double compared to the baseline number of admissions during the summer months) and out-patient visits are recorded during the winter months. During this period acute respiratory infections are the leading cause for admissions.
- The recruitment of skilled nursing staff, especially paediatric critical care nurses, remains a challenge. As a result of the shortage of skilled staff, capacity in the Paediatric Intensive Care Unit was sufficient to maintain 18 beds compared to the 25 in the CSP. Nursing staff account for 48% of the total staffing complement at Red Cross Children's Hospital. The overall nurse: bed ratio is 1.8 for the hospital as a whole.
- Theatre outputs for 2006/07 averaged approximately 720 operations per month. On average, 278 (38,6%) operations per month lasted longer than 1 hour, indicating the complexity of performed surgery. During the first 6 months of the 2007/08 year 168 cardiothoracic operations were completed. Emergency operations accounted for 40% of total operations performed for the first two quarters of the 2007/08 year. The current surgical mortality rate is 0.4%. Monthly surgical mortality and morbidity meetings help ensure that a quality service is maintained.

3.9.1.4 **Maitland Cottage Home**

Maitland Cottage Home, which operates as an extension of the Red Cross Children;'s Hospital, renders specialist orthopaedic surgery and post-operative care, as well as rehabilitation for children with orthopedic conditions. The clinical operations and inputs at Maitland Cottage Home are of a sub-specialist nature and therefore fall within the activities of Programme 5. This service model provides high levels of efficient orthopaedic services. Maitland Cottage Home is a provincially aided hospital and receives a subsidy of approximately 90% of agreed expenditure. The Maitland Cottage Home is the main responsibility of the Maitland Cottage Home Society and is managed by a management committee, which manages the affairs of the society. The subsidy and management of Maitland Cottage Home is overseen by Red Cross War Memorial Children's Hospital.

Maitland Cottage Home has 85 beds and during the first half of the 2007/08 financial year had 475 admissions and performed 220 operations. Maitland Cottage services include 10 highly specialised paediatric orthopaedic beds, recently transferred from Groote Schuur Hospital, a specialist club foot clinic and provides services to children with special orthopaedic needs from Eros Cerebral Palsy School, Astra School, Agape, Filia Training College and Tembaletu Day Centre.

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- **Outreach and support** is provided to hospitals in the secondary care drainage area including, Eerste River Hospital, Helderberg Hospital, Karl Bremer Hospital, and tertiary care outreach to Paarl Hospital and Worcester Hospital.
- **Teaching Training and Research**

  Tygerberg hospital provides the teaching training and research platform for the University of Stellenbosch largely, but also the University of the Western Cape, the Cape Peninsula University of Technology as well as the University of Cape Town. Approximately 24.7% of all student training hours in the province take place in Tygerberg Hospital at an additional service cost of 100.4 million.

3.9.2.3 **Situation analysis**

- **TBH challenges in the 2007/08 financial year:**
  - **Service pressures:** these have been particularly marked in specific areas such as obstetrics, neonatology, trauma, emergency medicine and critical care. Trauma and emergency cases per month have increased from (rounded) 4 400 in 2002 to a projected average 5 800 in 2007, which is an increase of 32%. Obstetric deliveries continue to increase by 17% per annum with consequent loading of the neonatology service. Current deliveries average 626 per month. In addition, the rising incidence of complicated pregnancies, in particular pregnancy-induced hypertension adds a qualitative load and accounts for rising numbers of sick newborns who need intensive medical management. This poses a substantial challenge to its ability to sustain levels of service delivery to meet these increased demands.
  - **Nursing**: the shortage of nurses continues to hamper the effective delivery of clinical services. Nurses account for 45% of the total staffing complement at TBH. The overall nurse: bed ratio is 1.17 for the hospital as a whole. Total nursing full-time equivalents (FTEs) as at September 2007 were 1 664 including agency nurse FTEs of 252. There have been particular challenges in specialised nursing such as intensive / high care, theatres and oncology. The availability of nursing resource in theatres is the major rate-limiting step to running more operating lists at TBH. Use of agency nurses has been strictly controlled due to financial constraints and staffing is limited in most clinical areas especially after-hours.
  - **Budget challenge:** The increased service demand coupled with prominent financial constraints has forced difficult choices at both management and clinical level. The budget for 2007/08 of R938.2 million presented obvious challenges when compared with that of R941.6 million for 2006/07. Many measures to improve cost effectiveness have been implemented and have included the pioneering of a system of “gate-keepers” for the use of blood products and NHLS investigations. The focus of budgetary management in the clinical services has been to improve cost-effectiveness without reducing access to care i.e. to do more despite fewer resources by driving cost-efficiencies aggressively.
  - **Critical Care:** the hospital continues to experience a significant shortage of ICU and high care beds relative to demand. Pressures are intense on all critical care resources but those experienced in paediatric ICU have been particularly acute. These bed shortages have consequences such as the enforced cancellation of elective surgery and the diverted pressure of non-trauma cases having to be accommodated in the resuscitation unit.

- **Renal Services**: significant pressures have been experienced as a result of a rising incidence of chronic renal failure in the community. Globally this disease is increasing at a rate of 8% per annum. In South Africa as elsewhere the incidence is related to an alarming increase in hypertension, diabetes and cardiovascular disease in the population. In the last year, acceptance rates for patients assessed for renal dialysis has dropped to as low as 23%. Currently Tygerberg has 42 patients on haemodialysis, 47 patients on peritoneal (home) dialysis, and a small number of patients at any one time on acute dialysis in the ICUs.
- **Vitreoretinal (VR) Surgery**: this service has also been under significant pressure, with a waiting list of three months for some types of VR surgery, for retinal conditions that pose a major risk to sight. As vitreoretinal surgery is urgent and vision saving R1.5 million is required for two extra theatre lists per week. The Western Cape public sector has only two full-time VR surgeons. The rate-limiting step is theatre lists currently TBH runs 1.5 days of theatre lists under general anaesthetic for VR surgery. There is a need to expand the number of lists.

- **Service configuration and outputs**
  - Between April and September 2007, Tygerberg made significant progress towards the CSP configuration of level 2 and level 3 beds. A total of 364 level 2 beds have been designated to the level 2 disciplines and these are being operationalised as level 2 beds. The target for 2008/09 is to have designated 645 level 2 beds by 1 April 2008. In addition, progress has been made with planning for differentiating out-patient care by level - a spatial plan for level 2 and 3 clinics has been developed and consulted with users.
  - Based on activity for the year to date, overall outputs (rounded) expected to be achieved in 2007/08 by Tygerberg Hospital include:
    - 448 000 OPD headcounts
    - 49 000 adult admissions
    - 12 000 paediatric admissions
    - 29 000 operations
    - 125 hip replacements
    - 50 knee replacements
    - 8 cochlear implants
    - 950 cardiology procedures (including 110 pacemakers, 320 intra-aortic balloons, 320 stents and), open heart operations
    - 7 000 deliveries.
  - It is projected that over 100 000 radiology investigations will be performed in 2007/08. Specialised investigations by radiologists include 11 000 ultrasound investigations, 4 400 invasive investigations e.g. arteriography, 13 000 CT scans and some 3 000 MRI studies.
  - The Trauma Unit in 2007/08 managed some 21 000 injured patients of whom, 8 900 required admission. Some 350 severely burnt patients have been admitted to the provincially unique Adults Burns Unit, of whom one third required intensive care.
  - Over 10 000 paediatric emergencies were managed and over 6 000 adults with medical emergencies admitted.

- In terms of obstetric services the total number of deliveries at TBH in 2007/08 is expected to increase to 7 600. It is anticipated that 9 700 neonates will be admitted to the neonatal wards, with at least 450 of these requiring intensive care and 3 100 requiring high care treatment.
- During 2007/08, Tygerberg Hospital trained 36 enrolled nursing assistants to staff nurses, 19 staff nurses to professional nurses, 12 professional nurses in ICU nursing, two in theatre technique, two in neonatal critical care, one in infection control, 18 in nursing administration, ten in nursing education, and seven in staff nurses as theatre technicians.

3.9.3 Groote Schuur Hospital

3.9.3.1 Vision

The vision of Groote Schuur Hospital is to be a leading academic hospital, striving to provide outstanding quaternary, tertiary and secondary care for the people of the Western Cape and beyond, with excellence in governance, teaching and research.

3.9.3.2 Role

Groote Schuur Hospital provides the largest quantum of adult tertiary services in the province, and is one of two National Referral Centres for highly specialised services such as heart and liver transplants.

3.9.3.3 Situation analysis

- **Challenges during the 2007/08 financial year were as follows:**
  - **Nursing**: the shortage of nurses continued to hamper the effective delivery of clinical services. Nurses form 39% of the total staffing complement at GSH and as such are the primary occupational staff category delivering the clinical services. Currently the total nurse:bed ratio is 1.51 nurse per bed, which is lower than the target of 1.7.
  - **Financial challenge**: The increased service demand was not matched by a concomitant increase in resource allocation resulted in difficult choices at both management and clinical level. Measures to increase savings were implemented, for example a “gate-keeper” for laboratory investigations and blood product requests.
  - **Service pressures**

    Service pressures were experienced in trauma, emergency obstetric and neonatal units and acute psychiatry, all providing emergency care. Elective surgical admissions were curtailed at times mainly due to nursing staff shortages. Groote Schuur Hospital performed 24 000 elective surgical operations during the year. Despite this, the wait for certain elective procedures remains prolonged. Only 40% of the patients requiring dialysis can be accommodated currently. The hospital offered an extra emergency theatre slate for a five-day period over the festive season, which alleviated service pressures.
- **Service outputs**
  - In-patient and outpatient activities involve all the specialties and sub-specialties.
  - The projected annual in-patient load for 2007/08 was approximately 44 000 admissions and 478 000 out-patient attendances.
  - The number of out-patient visits increased in medicine, surgery and radiation oncology.
  - Efforts to reduce the out-patient workload were initiated with outreach activities being provided at some secondary level hospitals. Steps were taken to ensure that patients with repeat prescriptions are seen at their nearest health centre.

- George Hospital was registered as a satellite facility of Groote Schuur Hospital in which specialists from the hospital provide services twice monthly for oncology services. Patients were cared for in co-operation with local medical officers as well as with private specialists in George employed on a sessional basis.

- **Highly specialised services offered at Groote Schuur Hospital include:**
  - Groote Schuur Hospital is the only public sector hospital in South Africa able to offer a fully comprehensive full-time cardiac service that includes electrophysiological and advanced cardiac arrhythmia device implantation and management.
  - Groote Schuur Hospital serves as the national reference centre for neurogentics, for complex patients with myasthaenia gravis, and for patients requiring epilepsy surgery for intractable epilepsy.
  - The comprehensive stroke unit offers comprehensive care and is serviced by a multidisciplinary unit. The unit offers an annual stroke training course for nurses from various parts of the country.
  - Complex interventional gastrointestinal procedures such as double balloon endoscopy, anal endoscopy, argon plasma coagulation, and stenting of the duodenum and colon.
  - Transplant services for cardiac, liver and renal transplants
  - During 2007/08 Groote Schuur Hospital acquired equipment purchased with funds from the modernisation of tertiary services grant. This enabled the hospital to introduce new diagnostic investigations and interventional procedures as well as to improve efficiencies in the theatre environment and to modernize equipment in radiology.
  - A varian linac used in radiotherapy of cancer patients was installed and taken into service during the year.

- **Teaching, training and research**

  Groote Schuur Hospital provides the teaching training and research platform for the University of Cape Town, largely, but also the University of Stellenbosch, the University of the Western Cape, and the Cape Peninsula University of Technology. The cost of accommodating under- and postgraduate students at Groote Schuur Hospital has been calculated at R85m (18,2% of the total cost of clinical training across the province).

Table 5.4: Situation analysis indicators for central hospitals [CHS2]

Strategic goal	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant					
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**National target 2003/04**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals perform highly specialised surgical procedures including a target caesarean section rate of 36%.	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	35%	36%	36%	32%
	Provide sufficient resources for the rendering of comprehensive highly specialised out-patient sevices at a target rate of 1.1 out-patient per in-patient day.[1]	2	Patient day equivalents (number of PDEs)	1 116 712	1 092 450	1 117 316	Not available
		3	OPD Total head count (number of head count at OPD clinics)	1 102 678	1 029 093	964 193	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4	Patient satisfaction survey using DoH template (percentage of central hospitals)	100%	100%	100%	100%
		5	Mortality and Morbidity meetings at least once a month (percentage of central hospitals)	100%	100%	100%	100%
		6	Clinical audit meetings at least once a month (percentage of central hospitals)	100%	100%	100%	100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved in central hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	Not available
		8	Case fatality rate in central hospitals for surgery separations (total surgery fatalities/total operations*100)	3%	3.10%	2.97%	3.6%
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9	Average length of stay	6.04	5.6	5.40	6.8
		10	Bed utilisation rate (based on usable beds)	82.10%	81.80%	83.00%	75%
		11	Total separations[2]	119 250	122 649	127 671	Not available
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2,800 per PDE.	12	Expenditure per patient day equivalent[3]	R1 794	R1 876	R1 900	R1 877

Notes:

1. Comprehensive out patient services include the headcount at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.
2. Per definition Day cases are included in separations and therefore included in total inpatient days (Day cases=1 separation=.5 in patient day.)
3. 2006/07 prices
4. The central hospitals were only reported as separate hospitals in the APP from 2006/07.

Table 5.5: Situation analysis indicators for Groote Schuur Hospital[CHS2]

Strategic goal:	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant				
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2006/07**	**National target 2003/04**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces.	Provide sufficient theatre capacity in central hospitals perform highly specialised surgical procedures including a target caesarean section rate of 36%.	1	Ceasarean section rate (percentage = caesarean sections/total deliveries*100)	43.0%	32%
	Provide sufficient resources for the rendering of comprehensive highly specialised out-patient sevices at a target rate of 1.1 out-patient per in-patient day.[1]	2	Patient day equivalents (number of PDEs)	436 967	Not available
		3	OPD Total head count (number of head count at OPD clinics)	417 801	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4	Patient satisfaction survey using DoH template (percentage of central hospitals)	100%	100%
		5	Mortality and morbidity meetings at least once a month (percentage of central hospitals)	100%	100%
		6	Clinical audit meetings at least once a month (percentage of central hospitals)	100%	100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved in GSH within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not available
		8	Case fatality rate in GSH for surgery separations (total surgery fatalities/total operations*100)	4.10%	3.6
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9	Average length of stay	6.1	6.8
		10	Bed utilisation rate (based on usable beds)	82.00%	75%
		11	Total separations[2]	45 089	Not available
	Ensure the cost effective management of Groote Schuur Hospital at a target expenditure of approximately R2,800 per PDE.	12	Expenditure per patient day equivalent[3]	2 079	1 877

Notes:

[1] Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

[2] Per definition day cases are included in separations and therefore included in total in-patient days (Day cases=1 separation=.5 in patient day.)

[3] 2006/07 prices

Table 5. 6: Situational analysis indicators for Tygerberg Hospital [CHS2]

Strategic goal:	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant			
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2006/07**	**National target 2003/04**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals perform highly specialised surgical procedures including a target caeserean section rate of 36%.	1 Ceasarean section rate (percentage = caesarean sections/total deliveries*100)	28.0%	32%
	Provide sufficient resources for the rendering of comprehensive highly specialised out-patient sevices at a target rate of 1.1 out-patient per in-patient day.[1]	2 Patient day equivalents (Number of PDEs)	536 918	Not available
		3 OPD total head count (Number of head count at OPD clinics)	395 928	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4 Patient satisfaction survey using DoH template (percentage of central hospitals)	100%	100%
		5 Mortality and morbidity meetings at least once a month (Percentage of central hospitals)	100%	100%
		6 Clinical audit meetings at least once a month (percentage of central hospitals)	100%	100%
		7 Complaints resolved within 25 days (percentage = total complaints resolved within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not available
		8 Case fatality rate in for surgery separations (total surgery fatalities/total operations*100)	4.50%	3.6%
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9 Average length of stay	6.25	6.8
		10 Bed utilisation rate (based on usable beds)	81.00%	75%
		11 Total separations[2]	60 751	Not available
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2,800 per PDE.	12 Expenditure per patient day equivalent[3]	1 754	1 877

Notes

[1] Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

[2] Per definition day cases are included in separations and therefore included in total in-patient days (Day cases=1 separation=.5 in patient day.)

[3] 2006/07 prices

Table 5.7: Situational analysis indicators for Red Cross Children's Hospital [CHS2]

Strategic Goal:	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant			
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2006/07**	**National target 2003/04**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals perform highly specialised surgical procedures including a target caesarean section rate of x%.	1 Caesarean section rate (percentage = caesarean sections/total deliveries*100)	Not applicable	Not applicable
	Provide sufficient resources for the rendering of comprehensive highly specialised out-patient services at a target rate of one out-patient per in-patient day.[1]	2 Patient day equivalents (number of PDEs)	143 431	Not available
		3 OPD total head count (number of head count at OPD clinics)	150 464	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4 Patient satisfaction survey using DoH template (percentage of central hospitals)	100%	100%
		5 Mortality and morbidity meetings at least once a month (percentage of central hospitals)	100%	100%
		6 Clinical audit meetings at least once a month (percentage of central hospitals)	100%	100%
		7 Complaints resolved within 25 days (percentage = total complaints resolved within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not available
		8 Case fatality rate for surgery separations (total surgery fatalities/total operations*100)	0.44%	3.6%
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9 Average length of stay	3.90	6.8
		10 Bed utilisation rate (based on usable beds)	84.00%	75%
		11 –Total separations[2]	21 831	Not available
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2,800 per PDE.	12 Expenditure per patient day equivalent[3]	1 845	1 877

Notes:

[1] Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

[2] Per definition day cases are included in separations and therefore included in total in-patient days (Day cases=1 separation=.5 in patient day.)

[3] 2006/07 prices

3.10 Resources analysis and planning

3.10.1 Management

A Chief Executive Officer (CEO), who has financial and human resource delegations to operate these facilities, heads each central hospital. A finance personnel management instrument (FPMI) has been developed supporting the CEO with information for planning, monitoring and decision-making in terms of resources. Each hospital compiles a business plan for the year.

3.10.2 Allocation of Funds

The sources of funding for Programme 5 are shown in the table below. There was a nominal increase of 1.78% to Programme 5 in 2007/08 compared to the allocation in 2006/07. This represented a reduction of 3.72% or a R90 million challenge. The projected over expenditure was partially addressed in the adjustment estimates of the provincial expenditure by R62 million. In the 2007/08 financial year the programme therefore reduced its expenditure in total by R28 million, and managed an increased service load. Ninety (90) acute beds were closed during 2007 to assist the hospitals come within the allocated budget. In the 2008/09 financial year the funds allocated in this programme are solely for level 3 services and thus are funded by the whole National Tertiary Services Grant (NTSG) and a portion of the Health Professions Training and Development Grant (HPTDG). In addition R30.434 million for Modernisation of Tertiary Services is added together with the R88.779 million from the provincial equitable share. This amount should be provided for by the NTSG. The balance of the budget to fund the central hospitals will come from Programme 4.1. The CEOs of each central hospital remain responsible and accountable for all the services and resources in the hospital. The funding allocated to each hospital is outlined in Table 5.16 and indicates a modest increase in funding for all three hospitals. This will assist in stabilising the hospitals in 2008/09.

Table 5.8: Funding sources for Programme 5 (Nominal amounts)

Fund	2006/7 Audited	2007/08 Adjusted Estimate	2008/9
	R'000	R'000	R'000
National Tertiary Services Grant	1 272 640	1 335 544	1 486 054
Health Professions Training and Development Grant	199 677	210 144	196 028
Modernisation of Tertiary Services (MTS)	13 173	51 206	30 434
Equitable Share	637 510	724 912	88 779
TOTAL	2 123 000	2 321 806	1 801 295
Capital funding allocated in Programme 8	41 092	55 762	67 244
TOTAL including Capital	2 164 092	2 377 568	1 868 539
Share of Departmental budget	34%	32%	22%
Total Departmental budget	6 419 515	7 427 305	8 641 973

Notes: The equitable share allocation to Programme 5 is transitional pending an appropriate NTSH allocation.

The 2008/09 amounts are for the level 3 component of the central hospitals only. The rest of the funding for the central hospitals level 2 component is located in Programme 4.1. Modernisation of Tertiary Services funds are earmarked for health technology in radiation medicine and medical imaging. The 2008/09 HPTDG allocated in Programme 5 is only for service costs related to training in the level 3 component.

The funding gap that has developed between costs of the service and the funding of the NTSG and HPTDG, has resulted in increased pressure on the equitable share. There is significant under-funding of the NTSG and the HPTDG. The cumulative backlog since 2001 has been estimated at R667 million as a result of previous cuts in the NTSG to address re-distribution to other provinces. A study to determine both the cost of providing tertiary services and the service costs of training health sciences students was concluded in 2007/08. Reference is made in the text below to the outcomes of this study.

The funding of the NTSG has decreased accumulatively from 2001 by R285 million which impacts on the capacity to deliver these services. A costing study completed during 2007/08 to determine what the department requires to render the current services in central hospitals, demonstrated a shortfall of R1billion, including the cost of overheads and improved maintenance. This amount correlates with estimates by the National Department of Health.

Mismatch between the need for training more health science students and the funding to provide a platform for training: The Western Cape institutes of higher education currently educate approximately 30% of all medical officers in the country with the service platform carrying 5,64 million student hours. The HPTDG is for the **service** costs related to training and has been cumulatively reduced by R110 million since 2001. This clearly impacts both on the capacity to train students and the quality of the training of health science professionals. A recent study confirms that the cost to the department of training health science students amounts to R450 million in comparison to the HPTDG allocation of R333 million in 2007/08, which is thus a shortfall of R120 million.

Modernisation of tertiary services (MTS)

The amount of R51m for health technology in the MTS conditional allocation was fully spent in 2007/08. Among other things this was used to establish an integrated nuclear medicine system with connectivity across the three central hospitals. This allows medical staff to read and report on investigations at any one of the hospitals and therefore assists with training and support, as well as forming an integral component towards establishing a Western Cape Nuclear Medicine Service for the three central hospitals. The MTS further paid for 50% of the MRI scanner for RCCH, to be fully established in 2008. The MTS assisted with designing a strategic plan for digitization of health technology, informed by experience in both the USA and the rest of South Africa. Groote Schuur Hospital acquired a neuro-navigation system, a fluoroscopy unit and several pieces of radiological equipment for the hospital. Tygerberg Hospital acquired a CT scanner each for the in-patient and emergency services, a fluoroscopy suite and several medical imaging pieces of equipment.

3.10.3 Personnel trends

Table 5.9: Personnel trends in 2007/08 and compared to 2006/07

	GSH 2006/07	GSH 2007/08	TBH 2006/07	TBH 2007/08	RCCH 2006/07	RCCH 2007/08
Total staff: Full time equivalents (FTEs) inclusive of agency and joint staff	3 931	3 896	4 115	4 151	1 044	1 115
Total nurse to bed ratio	1.52	1:51	1.69	1.17	1.78	1.85
Average nurse agency FTEs/month	250	231	211	268	87	35

Note: Staff working hourly shifts or sessions are converted to full time equivalents (FTEs) for comparison and monitoring purposes.

The dependency on nursing agencies for the highly specialised areas (largely intensive care, theatre, midwifery, emergency) continues. Several strategies have been embarked upon to address this issue. It is hoped that the occupation specific dispensation for nurses will halt the loss of nurses.

4. ANALYSIS OF CHALLENGES AND CONSTRAINTS

The main challenges for 2008/09 are as follows:

1) Implementation of the CSP.
2) Dealing with the increased service load as well as the changes in disease and caseload patterns. These are more marked in obstetric and neonatal services, psychiatry and emergency care, as well as highlighting the need to improve on surgical outputs so as to improve efficiencies and impact on patient outcome.
3) Recruiting and retaining well-qualified and experienced health professionals, especially nurses and key medical professions, as well as financial support staff.
4) Attaining employment equity targets in highly specialized fields where formal education extends ten years beyond the basic medical qualification.
5) Strengthening support systems for improved information, human resources and financial support, as well as managerial and leadership skills at all these services.
6) Concluding the Joint Agreements, which will regulate the relationship between the Department and four institutions of higher education.

5. POLICIES, PRIORITIES, STRATEGIC GOALS

The priorities and strategies outlined below aim to take the services forward as well as to deal with the challenges identified.

5.1 Key Strategies

The key strategies for the 2008/09 financial year are outlined as follows:

5.1.1 Implementation of the Comprehensive Service Plan

- The key approach will be to continue with reshaping, re-engineering and re-prioritising.
- A technical team from the three central hospitals will continue to plan, action and monitor the systematic implementation of the differentiation of level 2 and level 3 services by clinicians and management. Services designated as level 2 will now function within the parameters set towards attaining the efficiencies required.
- There will furthermore be clear mechanisms towards prioritisation in a fair and legitimate manner. Adherence to referral guidelines, diagnostic and treatment packages will be monitored.
- Service and clinical governance across the platform will have to be designed and implemented. Its relation to academic governance will be defined.
- Progress towards a single Western Cape Tertiary Service will be monitored and governance structures established in conjunction with the relevant health sciences faculties.
- Aligning the hospital information and other support systems to support differential levels of care in each hospital will require additional information management capacity costing **R1 million**.
- The paediatric cardiac care service will be embedded and surgical outputs improved as per priorities.
- Identified highly specialised services will be centralised into single services for the province across the platform. This includes nuclear medicine, paediatric cardiac care and transplant services.
- Co-operation across the institutions will move towards collective planning and implementation.
- Several infrastructure changes will be required, as outlined in the sections for each hospital.

5.1.2 Ensure well-functioning hospitals

Monitoring and evaluation capacity as well as co-ordination capacity will be strengthened in the programme and in each hospital.

A provincial strategy will be refined to improve surgical outputs. Emphasis will be on improving theatre management, implementing enabling theatre policies, theatre list prioritization, and post anaesthetic high care capacity. Improving surgery outputs is a key enabler to move forwards towards implementing the service re-design in the central hospitals. A limited capacity will be established in each hospital and additional funding has been allocated to provide for this need.

Groote Schuur and Tygerberg Hospitals will each commission an additional theatre for urgent cases.

The lack of theatre and intensive care nurses to adequately staff operating theatres and intensive care units results in increased waiting times and waiting lists. As described above there is a dependency on agency staff for nurses who often do not have the required experience or commitment.

Several strategies will be followed during 2008/09 to deal with bottlenecks at institutional level.

- The Cape Peninsula University of Technology has been approached to assist with the training of theatre technicians, a mid-level category or worker to support theatre nurses.
- The nursing environment will be improved through ensuring functional basic equipment and hospital beds.
- Theatre management will be strengthened at Tygerberg and Groote Schuur Hospitals with theatre managers acting to improve efficiencies and the throughput of theatres.
- Nursing mentors in theatres and intensive care units will provide support for enrolled nurses, enrolled nursing assistants, professional nurses and student nurses.
- The implementation of the Acute Case Load Management Policy will be monitored so as to ensure an appropriate response to major service pressures. There will be specific focus on assessing discharge management strategies.
- There will be full implementation of the Cape Triage Score system in all emergency centres aimed at streamlining and prioritizing patients requiring emergency care.
- A co-ordinating clinician in each of surgical and anaesthetic services will ensure provincial wide pre-, intra- and post-operative safety and also to identify areas where systems can be streamlined.
- Admission criteria for critical care environments will be implemented.

5.1.3 **Ensure a well-functioning healthcare system**

Strategies to deal with the increased demand for services will include the following:

- Co-ordinating clinicians in paediatrics and child health, mental health, anaesthetic services, internal medicine, surgical services, and obstetrics and gynaecology will enhance clinical governance and facilitate both the treatment of patients at the level of care appropriate to their needs and the clinical outcomes.
- High caseload conditions will be identified, and together with co-ordinating clinicians and referring levels of care, there will be a move towards strengthening prevention strategies, as well as ensuring enhanced capacity at referring levels of care.
- Obstetrics and neonatal services in the Metro are particularly challenged and focused interventions will address both supply and demand factors. Increased level 1 and MOU capacity will be immediate relief factors during 2008.
- Waiting lists
  - o A clear waiting list management framework with pilots in certain key services will be established during 2008.
- Outreach and Support
  - o Each more specialised level of care has the responsibility for outreach and support to less specialised levels of care. Whilst these are in place with many good examples, these arrangements need to be formalised and structured.

5.1.4 Improve service delivery and clinical governance

- Each hospital will conclude a business plan with a quality improvement component. This includes client and staff satisfaction surveys once for the year, with clear action response plans. Infection prevention and control remains a key priority and the provincial infection prevention and control policy will be implemented in all central hospitals.
- The hospitals are committed to enhance managerial governance and clinical governance. Each central hospital has a facility board, supported by the CEO and the hospital.
- A provincial strategy for clinical governance will be refined. In tertiary services the implementation will be characterised by closer co-operation between managers and clinicians, with responsibilities and accountabilities clearly outlined, as well clear priority setting engagements.
- Managerial competencies will be enhanced through several strategies. The hospital leadership programme by UCT business school provides an important basis for managers and clinicians alike. Sixty people participate in this training every year.
- A range of priority clinical guidelines will be developed.
- The Programme will augment renal dialysis capacity and the vitreo-retinal surgery (a sight saving procedure) capacity during 2008/09. The Province is currently unable to dialyse more than 50% of patient qualifying for renal dialysis. It will also advocate a comprehensive programme addressing renal care in the province managing hypertension and diabetes well and early detection of renal disease.

5.2 Finalisation of Joint Agreements between the Department and the four Institutes of Higher Education

The final drafts for the bilateral and multilateral agreements have been concluded although to date agreement between the parties has not been achieved. If agreement is reached these will replace outdated Joint Agreements dating back to 1926 and cover the four institutes of higher education: the University of Stellenbosch, University of Cape Town, University of the Western Cape, and the Cape Peninsula University of technology.

5.3 Attaining employment equity targets

Whilst employment equity targets have been achieved largely in nursing and administration, the main challenge remains in management and medical specialists in highly specialised fields where formal training alone extends beyond ten years after obtaining the basic medical qualification. The co-operation of the universities is crucial for training a representative group of medical students, which is the source of applicants for registrar posts (specialists in training) and ultimately specialists. Both health science faculties with medical schools (US and UCT) have committed their institutions to this priority.

5.4 Modernisation of Tertiary Services

The R30 million funding for Modernisation of Tertiary Services will be used largely for digitisation of medical equipment, to take steps towards the implementation of a strategic solution of the Picture Archiving and Communication System (PACS), as well as the final payment of the MRI scanner for Red Cross Children's Hospital. The PACS system will assist central hospitals and hospital revitalisation sites to enhance telemedicine.

6 STRATEGIC PRIORITIES BY HOSPITAL

This section outlines the range of strategic priorities for each of the central hospitals according to the key performance areas outlined above.

6.1 Red Cross War Memorial Children's Hospital

The key strategic objectives for 2008/09 are aligned to the key performance areas of the Division of Secondary, Tertiary and Emergency Care.

6.1.1 Implementation of the Comprehensive Service Plan

The Hospital will be implementing the CSP, focusing on the following areas:

- Further strengthening and consolidation of the paediatric cardiac services into a single discipline tertiary service between Tygerberg and Red Cross War Memorial Children's Hospitals
- Consolidation of defined tertiary paediatric services such as nephrology and surgical services
- Operation and further consolidation of tertiary services transferred to the Hospital, which would include endocrinology and neurosurgery
- Establishment of the Emergency Centre as a level 2 service
- Completion of the designation and registration of level 3 and level 2 wards and clinics by 1 April 2008 in order to facilitate cost centre management and report in line with the service transformation in accordance with the CSP.

6.1.2 Ensure a well-functioning hospital

- Strengthen nurse capacity by training various categories of nurses including paediatric intensive care, theatre paediatric nurses amongst others. Resources will be allocated to substitute for nurses on training programmes.
- Commence infrastructural upgrades that will include:
  - The renovation and upgrade of a surgical ward at an approximate cost of **R8.2 million** as part of the comprehensive ward upgrade schedule.
  - Completing phase 1 of the new theatre complex with the new Central Processing Unit (CSSD, Sterilisation). This project is jointly funded by the Department and from donor funding, with the Department funding providing **R6 million** towards the Central Processing Unit in 2008/09. This project will allow the hospital to continue delivering an eminent quality surgical service.
  - Installation and commissioning of a new MRI machine and establishing a dedicated paediatric MRI service for the Western Cape. The Modernisation of Tertiary Services funding will provide an amount of **R6.2 million** for this purpose in 2008/09.

6.1.3 **Ensure a well-functioning health system**

- Continue to play a pivotal role in providing leadership and monitoring the response of the health service to the diarrhoeal season and acute respiratory infections especially in the metropole area.
- Provide outreach and support to referring hospitals such as Somerset Hospital, Victoria Hospital, and Mowbray Maternity Hospitals. Further, to assist with building the capacity at less specialized levels to provide health care to children as the CSP is implemented.

6.1.4 **Improve service delivery and clinical governance**

- Conduct one comprehensive client satisfaction survey and implement action plans to address specific client concerns.
- Strengthen infection, prevention and control strategies with particular focus on hand washing, awareness and training.
- Commence surgical activities in the new theatre complex by the end of 2008. Maintain quality surgical outputs by performing approximately 750 operations a month. Focus on increasing laparoscopic surgery and applying more advanced surgical techniques.
- Advanced spinal and cardiac surgery forms part of the services rendered by Red Cross Children's Hospital. During 2007 Red Cross Children's Hospital initiated additional cardiac surgery and R1.5 million will be allocated for this purpose and additional highly specialized spinal surgery during the 2008/09 financial year.
- As a dedicated paediatric cardiac centre, perform a target of 300 cardiothoracic procedures during 2008/09.
- It is envisaged that approximately 12 to 15 transplants (dependant on organ availability) will be performed as part of the paediatric transplant services during 2008/09.
- Maintain 18 operational beds in the paediatric Intensive Care Unit and intermittently increase this number to operate a maximum of 20 beds.
- Continue operating the Provincial paediatric burns unit and comprehensively treat over 2 600 burned children a year, also supporting accident and prevention programs like the Child Accident Prevention Foundation of South Africa (CAPFSA).
- Admit and treat approximately 20 000 in-patients (level 3 and level 2) for the year 2008/09.
- Provide care to approximately 100 000 children visiting specialist clinics in the out-patients department at the end of 2008/09.
- Attend to over 35 000 children with medical emergencies and injuries in the emergency centre. These are designated as level 2 services and will be funded by and reported on in Programme 4.1.
- Continue with clinical audit as part of quality assurance by holding monthly departmental morbidity and mortality meetings and establishing and participating in the Child Health Problem Identification Program (CHIP).
- Obtain an ICD 10 coding rate of 80% for in and out-patients, which will enable disease profiling.

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6.2.4 **Improve service delivery and clinical governance**

- Improve the working environment and quality of care through infrastructural improvements particularly in the ward areas, porter's deck, Central Sterilization Services Department, the theatre complex and the kitchen.
- Implement a comprehensive theatre management system to improve efficiency and outcomes.
- Develop a Post Anaesthetic Adult High Care Unit (PHCU) within the main theatre recovery room area as well as 2 High care beds adjacent to A1 Surgical ICU. The (initially) two-bed PHCU unit would be crucial to improve surgical outputs within current theatre resources, and therefore crucial to reduce waiting lists for key procedures where high care is required post-procedure.
- Open two Paediatric high care beds in A9 adjacent to A9 Paediatric ICU (PICU). This will provide a crucial facility for postoperative care of children who have undergone surgery as well as provide a step-down facility to relieve pressure on the PICU.
- Renal services: every attempt will be made to match the approximately 20 renal transplants achieved in 2007/08 compared with only 10 in 2006/07 in order to provide access to new dialysis patients. The aim will be to increase the number of renal dialysis slots at approximately 40 for haemodialysis and 45 for peritoneal dialysis. Continuing managerial support will be provided to clinicians with regards patient selection for dialysis. There is a process underway to access private donor funding to expand access to dialysis services. Finally, strategies are to be implemented in collaboration with District Health Services and Health Programmes in respect of prevention of the underlying diseases that lead to chronic renal failure.
- Vitreoretinal surgery services: will be augmented by extra theatre lists at TBH.
- Institutionalise morbidity and mortality meetings and develop as well as implement service improvement plans based on the findings of these meetings.
- Maintain the prevalence of tracer pathogens at international standards.
- Conduct one comprehensive client satisfaction survey and regular service monitoring based on the patient complaints system. Ensure that the quality improvement plan addresses the outcome of these.

6.3 Groote Schuur Hospital

The key strategic objectives for 2008/09 are aligned with the key performance areas of the Division of Secondary, Tertiary and Emergency Care.

6.3.1 Implementation of the Comprehensive Service Plan

- All beds in the hospital will be designated either as level 2 or level 3.
- During 2008/09 level 2 beds will be managed according to level 2 performance parameters, protocols and criteria. The management team for level 2 services will be strengthened by appointing a head of clinical services for each discipline as appropriate, with responsibility for the whole Metro West platform. These objectives are outlined in Programme 4.1.
- Out-patient clinics will be differentiated into level 2 and level 3 in 2008/09.
- Clinical output data and financial expenditure data will be reported on according to the level of care.
- Cost centre management will be aligned accordingly.
- Further refinement of level three services will occur via the CSP Work Group for Tertiary Services.
- The implementation of revised referral mechanisms to level three services, to achieve equity of access, will be effected across the platform.
- Groote Schuur will continue to actively participate in the implementation of the Provincial Human Genetics Service Plan.
- Groote Schuur Hospital will continue to participate in strengthening the Infectious Diseases platform and respond to the management of amongst other diseases, HIV and AIDS and MDR and XDR TB in collaboration with health personnel at the various institutions.

6.3.2 Ensure a well-functioning hospital

- Digitisation of equipment will continue, to achieve full digitization by 2010.
- Financial management will be improved by the strengthening of the cost centre management system as well as specific projects related to monitoring and controlling high cost consumables, blood and laboratory expenditure.
- The implementation of effective theatre management systems and cost effective use of blood products and laboratory tests will be promoted.
- The triage system for out-patients will be improved through the development of a more structured system.
- Cost centre requisitioning will begin in theatres and will be progressively rolled out to clinical areas. The availability of real time information and budgets will enable improved control of highly expensive consumables.
- Formal collaboration between clinical executive officers at central hospitals with regard to sharing of best practice has commenced with regards to cost containment. This will be expanded to include other aspects of management.
- Information management will continually be assessed and improved, both in terms of the input of data and the extraction of relevant information for analyses. International Classification of Disease coding (ICD10) has been implemented for all in-patient and out-patient activities. Data capturing and data quality will be improved and strengthened by feedback to staff and continuous quality improvement.

- Security management will be improved through the creation of a contractors' desk. Access control to the vulnerable areas of the hospitals will be improved to decrease theft, particularly copper theft which threatens to destabilize clinical services. The hospital will explore additional safety functions such as implementation of fire drills.
- Forensic services currently located in Salt River will be relocated to the old Moore Paragon building, which will enable the development of a consolidated forensic service on the this site.
- The allocation of space to the NHLS in the New Main Building of Groote Schuur Hospital will be finalised.

6.3.3 Ensure a well-functioning health system

Groote Schuur Hospital will, in keeping with the outreach policy strengthen and formalise outreach from level 3 to level 2 and from level 2 to level 1 (district hospital services), greatly assisted by the outcomes of a recent audit of needs of hospitals supported by Groote Schuur Hospital.

Expanded outreach will continue in the human genetics program as well as in infectious diseases management.

Groote Schuur Hospital will participate in the chronic disease management project of patients in the Metropole. This project aims to ensure that the patients with chronic conditions are treated at the appropriate level of care according to agreed upon protocols. A requirement of this project is the development of case definitions and management plans for patients at various levels. This will require close collaboration between clinicians at the various levels of care.

6.3.4 Improve service delivery and clinical governance

- During 2008/09, the hospital will strive towards organisational stability. A key requirement for stability would be to improve relationships between management and clinicians, to develop an organizational culture of co-operation towards a single vision, as well as to ensure fair and legitimate priority setting processes in the hospital.
- Improved theatre management and prioritisation of theatre cases will receive attention, with an increased focus on fair and legitimate decision-making in the face of limited resources.
- Day surgery services will be extended from 1½ to five days a week and an urgent theatre list to operate 40 hours per week will be introduced, at an additional cost. This will provide additional theatre time for the orthopaedic caseload.
- Four additional beds will be commissioned in the acute psychiatric admission ward. This will relieve pressure on acute beds on the psychiatric platform and will ensure a faster turn around time in acute psychiatric wards, which will in turn relieve pressure in emergency units at district hospitals.
- At least one comprehensive client satisfaction survey will be conducted, with action plans in response to the findings. Infection, prevention and control strategies will furthermore be firmed up, together with more comprehensive morbidity and mortality assessments and responses.
- Specific attention will be on improving infection control in the neonatal wards including the development and implementation of feeding policies, the purchase of equipment to maintain temperature control of feeds and the correction of the personnel establishment.

- Haemodialysis for chronic renal failure in patients who qualify for renal transplant requires attention and three additional renal stations are planned.
- Clinical audits, in support of regular morbidity and mortality meetings, will be conducted in specified areas to assess clinical processes, usage of high cost consumables, levels of care in various wards.
- Clinical risk management will continuously be improved via the process of progressive expansion of mortality and morbidity meetings.

7. NATIONAL HEALTH SYSTEM PRIORITIES

Table 5.10: National Health System Priority 3: Quality of care: central hospitals:

Activity	Indicators	National Targets 2007/08	Provincial progress 2007/08	National Targets 2008/09	Provincial projection 2008/09
Hospital improvement plans	Clinical audits	Clinical audits routinely monitored in all level 3 and 2 hospitals, 35% of district hospitals	Clinical protocols applied. Mortality and morbidity processes in place. The Department has structured reporting systems and reports for facilities are collated at Head Office.	Clinical audits routinely monitored in all level 1 hospitals	Morbidity and mortality meetings held in each discipline. Clinical protocols developed, applied and monitored. Regular reporting.
	Complaints mechanisms	Complaints mechanisms routinely managed in all level 3 and 2 hospitals, 35% of districts (level 1 hospitals and PHC facilities)	Complaints and compliments procedures are in place for all hospitals. Complaints are reported and managed. Reporting to Head Office in a structured manner. Batho Pele principles are applied.	Complaints mechanisms routinely managed in all districts (level 1 hospitals and PHC facilities)	Complaints mechanisms established in all central hospitals. Targets have been set for each hospital in the relevant tables.
	Infection control	Infection control management effected in all level 3, 2 and 1 hospitals and CHCs, 35% 0f all clinics	Provincial Infection Prevention and Control (IPC) Committee established and Provincial Policy adopted. Each Central Hospital has an Infection Prevention and Control Committee.	Infection control management effected in all clinics	Each hospital to establish an IPC committee inclusive of all relevant parties, with clear monitoring and focused prevention strategies.
	Telemedicine	Develop implementation plans for skills decentralisation using telemedicine, flying doctors services and private sector practitioners. Hub and spoke systems developed in accordance with STP	Hub and spoke is derived from the CSP. A policy framework and implementation document for digital imaging has been drafted. Web based reporting of NHLS test results is being implemented.	Hub and spoke systems developed in accordance with STP	The strategic plan provides for a hub and spoke configuration. Central hospitals internally, across and towards regional hospitals will now be systematically rolled out. Change management is necessary to get clinicians operating in a digital imaging environment.

8. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

The following tables illustrate the performance for all beds in central hospitals until 2007/08. A separate table is provided to illustrate the performance targets from 2008/09 where the performance relates only to the tertiary activities that are funded by Programme 5.

Table 5.11.1: Provincial objectives and performance indicators for central hospitals for 2004/05 to 2007/08 [CHS3]

		Strategic Goal:	**Provide sufficient infrastructure for the rendering of highly specialised hospital services.**						
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**
Central hospitals									
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 1460 level 3 beds in central hospitals by 2010.	1 Number of beds in central hospitals	2 405	2 472	2 479	2 417	Refer to Table 5.11.2		
		2 Total number of patient days in central hospitals[1]	720 781	778 816	740 321	737 508			
Groote Schuur Hospital									
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 685 level 3 beds in Groote Schuur Hospital by 2010.	1 Number of beds in Groote Schuur Hospital	-	-	919	867			
		2 Total number of patient days in Groote Schuur Hospital[1]	-	-	275 342	268 987			
Tygerberg Hospital									
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 515 level 3 beds in Tygerberg hospital by 2010.	1 Number of beds in Tygerberg hospital	-	-	1 283	1 262			
		2 Total number of patient days[1]	-	-	379 770	382 323			
Red Cross Children's Hospital									
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 260 level 3 beds in Red Cross Children's Hospital by 2010.	1 Number of beds in Red Cross Children's Hospital.	-	-	277	288			
		2 Total number of patient days	-	-	85 210	86 198			

Notes:

[1] Total number of patient days includes Day cases (Day case = 1 separation = .5 in patient day)

Table 5.11.2: Provincial objectives and performance indicators for central hospitals for 2008/09 to 2010/11 [CHS3]

			Strategic Goal:	Provide sufficient infrastructure for the rendering of highly specialised hospital services.						
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**
Central hospitals										
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 1460 level 3 beds in central hospitals by 2010.	1	Number of L3 beds in central hospitals	Refer to Table 5.11.1				1 460	1 460	1 460
		2	Total number of patient days in Central hospitals[1]					442 307	452 965	452 965
Groote Schuur Hospital										
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 685 level 3 beds in Groote Schuur Hospital by 2010.	1	Number of L3 beds in Groote Schuur Hospital					685	685	685
		2	Total number of patient days in Groote Schuur Hospital[1]					207 521	212 521	212 521
Tygerberg Hospital										
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 515 level 3 beds in Tygerberg hospital by 2010	1	Number of L3 beds in Tygerberg hospital					538	515	515
		2	Total number of patient days[1]					162 987	159 779	159 779
Red Cross Children's Hospital										
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 260 level 3 beds in Red Cross Children's Hospital by 2010.	1	Number of L3 beds in Red Cross Children's Hospital.					237	260	260
		2	Total number of patient days					71 799	80 665	80 665

Notes:

[1] Total number of patient days includes Day cases (Day case = 1 separation = .5 in patient day)

Table 5.12.1: Performance indicators for Central Hospitals for 2004/05 to 2007/08 [CHS4]

Strategic goal:	**To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant**										
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target[4] 2007/08**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals perform highly specialised surgical procedures including a target caesarean section rate of 36%.	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	35%	36%	36%	36%	Refer to Table 5.12.2			25%
	Provide sufficient resources for the rendering of comprehensive highly specialised out-patient sevices at a target rate of 1.1 out-patient per in-patient day.[1]	2	Patient day equivalents (number of PDEs)	1,116,712	1,092,450	1,117,316	1,053,565				Not available
		3	OPD total head count (Number of head count at L3 OPD clinics)	1,102,678	1,029,093	964,193	1,116,742				Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4	Patient satisfaction survey using DoH template (percentage of central hospitals)	100%	100%	100%	100%				100%
		5	Mortality and morbidity meetings at least once a month (percentage of central hospitals)	100%	100%	100%	100%				100%
		6	Clinical audit meetings at least once a month (percentage of central hospitals)	100%	100%	100%	100%				100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved in central hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	Not requested prior to 2007/08	Not requested prior to 2007/08	100%				100%
		8	Case fatality rate in central hospitals for surgery separations (total surgery fatalities/total operations*100)	3.00%	3.10%	2.97%	3.0%				3%
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9	Average length of stay	6.04	5.60	5.80	6.00				5.30
		10	Bed utilisation rate (based on usable beds)	82.1%	81.80%	83.0%	82.90%				75.0%
		11	Total separations[2]	119 250	122 649	127 671	122 881				Not available
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 800 per PDE.	12	Expenditure per patient day equivalent[3]	R1 794	R1 876	R1 900	R2 129				1,877

Notes:

1 Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

2 Per definition day cases are included in separations and therefore included in total in-patient days (Day cases=1 separation=.5 in patient day.)

3 2006/07 prices.

4 National target refers to Central Hospitals and not Level 3.

Table 5.12.2: Performance indicators for Central Hospitals for 2008/09 to 2010/11 [CHS4]

Strategic goal:	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant										
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2004/05**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target[4] 2007/08**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals perform highly specialised surgical procedures including a target caesarean section rate of 36%.	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	Refer to Table 5.12.1				43%	43%	43%	25%
	Provide sufficient resources to render comprehensive highly specialised out-patient services at a target rate of 1.1 out-patient per in-patient day.[1]	2	Patient day equivalents (number of PDEs)					604,486	603,953	609,953	Not available
		3	OPD Total head count (number of head count at L3 OPD clinics)					486,538	452,965	452,965	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4	Patient satisfaction survey using DoH template (percentage of central hospitals)					100%	100%	100%	100%
		5	Mortality and morbidity meetings at least once a month (percentage of central hospitals)					100%	100%	100%	100%
		6	Clinical audit meetings at least once a month (percentage of central hospitals)					100%	100%	100%	100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved in central hospitals within 25 days/ total complaints received*100)					100%	100%	100%	100%
		8	Case fatality rate in central hospitals for surgery separations (total surgery fatalities/total operations*100)					3.0%	3.0%	3.0%	3%
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9	Average length of stay					5.80	6.00	6.00	5.30
		10	Bed utilisation rate (based on usable beds)					83.0%	85.0%	85.0%	75.0%
		11	Total separations[2]					75,830	75,494	75,494	Not available
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 800 per PDE.	12	Expenditure per patient day equivalent[3]					R2,752	R2,879	R2,955	1,877

Notes:

1 Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

2 Per definition day cases are included in separations and therefore included in total in-patient days (Day cases=1 separation=.5 in patient day.)

3 2006/07 prices.

4 National target refers to central hospitals and not level 3.

Table 5.13.1: Performance indicators for Groote Schuur Hospital for 2004/05 to 2007/08 [CHS4]

Strategic goal:	**To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant**							
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target[4] 2007/08**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals perform highly specialised surgical procedures including a target caesarean section rate of 46%.	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	43%	44%	Refer to Table 5.13.2			25%
	Provide sufficient resources to render comprehensive highly specialised out-patient services at a target rate of 1.1 out-patient per in-patient day.[1]	2	Patient day equivalents (Number of PDEs)	436,967	412,446				Not available
		3	OPD total head count (number of head count at L3 OPD clinics)	417,801	478,768				Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4	Patient satisfaction survey using DoH template (percentage of central hospitals)	100%	100%				100%
		5	Mortality and morbidity meetings at least once a month (percentage of central hospitals)	100%	100%				100%
		6	Clinical audit meetings at least once a month (percentage of central hospitals)	100%	100%				100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved in GSH within 25 days/ total complaints received*100)	Not requested prior to 2007/08	100%				100%
		8	Case fatality rate in GSH for surgery separations (total surgery fatalities/total operations*100)	4.10%	4.10%				3%
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9	Average length of stay	6.10	6.25				5.30
		10	Bed utilisation rate (based on usable beds)	82.0%	85.0%				75.0%
		11	Total separations[2]	45 089	43 048				Not available
	Ensure the cost effective management of Groote Schuur Hospital at a target expenditure of approximately R2,800 per PDE.	12	Expenditure per patient day equivalent[3]	R2 079	R2 273				1 877

Notes:

1 Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

2 Per definition day cases are included in separations and therefore included in total in-patient days (Day cases=1 separation=.5 in patient day.)

3 2006/07 prices.

4 National target refers to central hospitals and not Level 3.

Table 5.13.2: Performance indicators for Groote Schuur Hospital for 2008/09 to 2010/11 [CHS4]

Strategic goal:	**To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant**								
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target[4] 2007/08**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals perform highly specialised surgical procedures including a target caesarean section rate of 46%.	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	Refer to Table 5.13.1		46%	46%	46%	25%
	Provide sufficient resources for the rendering of comprehensive highly specialised out-patient services at a target rate of 1.1 out-patient per in-patient day.[1]	2	Patient Day Equivalents (number of PDEs)			283 612	283 612	283 362	Not available
		3	OPD Total head count (number of head count at L3 OPD clinics)			228 273	228 273	212 521	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4	Patient satisfaction survey using DoH template (percentage of central hospitals)			100%	100%	100%	100%
		5	Mortality and morbidity meetings at least once a month (percentage of central hospitals)			100%	100%	100%	100%
		6	Clinical audit meetings at least once a month (percentage of central hospitals)			100%	100%	100%	100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved in GSH within 25 days/ total complaints received*100)			100%	100%	100%	100%
		8	Case fatality rate in GSH for surgery separations (total surgery fatalities/total operations*100)			3%	3%	3%	3%
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9	Average length of stay			6.00	6.00	6.00	5.30
		10	Bed utilisation rate (based on usable beds)			83.0%	83.0%	85.0%	75.0%
		11	Total separations[2]			34 587	34 587	35 420	Not available
	Ensure the cost effective management of Groote Schuur Hospital at a target expenditure of approximately R2,800 per PDE.	12	Expenditure per patient day equivalent[3]			R2 752	R2 879	R2 955	R1 877

Notes:

1 Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

2 Per definition day cases are included in separations and therefore included in total in-patient days (Day cases=1 separation=.5 in patient day.)

3 2006/07 prices.

4 National target refers to central hospitals and not Level 3.

Table 5.14.1: Performance indicators for Tygerberg Hospital for 2004/05 to 2007/08 [CHS4]

Strategic goal:	**To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant**						
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2006/07**	**Estimate 2007/08**		**National target[4] 2007/08**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals perform highly specialised surgical procedures including a target caesarean section rate of 40%.	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	28%	30%	Refer to Table 5.14.2	25%
	Provide sufficient resources for the rendering of comprehensive highly specialised out-patient services at a target rate of 1.1 out-patient per in-patient day.[1]	2	Patient Day Equivalents (number of PDEs)	536 918	509 764		Not available
		3	OPD Total head count (number of head count at L3 OPD clinics)	395 928	448 890		Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4	Patient satisfaction survey using DoH template (percentage of central hospitals)	100%	100%		100%
		5	Mortality and morbidity meetings at least once a month (percentage of central hospitals)	100%	100%		100%
		6	Clinical audit meetings at least once a month (percentage of central hospitals)	100%	100%		100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved within 25 days/ total complaints received*100)	Not requested prior to 2007/08	100%		100%
		8	Case fatality rate in for surgery separations (total surgery fatalities/total operations*100)	4.50%	4.50%		3
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9	Average length of stay	6.25	6.50		5.30
		10	Bed utilisation rate (based on usable beds)	81.0%	83.0%		75.0%
		11	Total separations[2]	60 751	58 819		Not available
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 800 per PDE.	12	Expenditure per patient day equivalent[3]	R1 754	R2 070		1 877

Notes:

1 Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

2 Per definition day cases are included in separations and therefore included in total in-patient days (Day cases=1 separation=.5 in patient day.)

3 2006/07 prices.

4 National target refers to central hospitals and not Level 3.

Table 5.14.2: Performance indicators for Tygerberg Hospital for 2008/09 to 2010/11 [CHS4]

Strategic goal:	**To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant**								
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target[4] 2007/08**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals perform highly specialised surgical procedures including a target caesarean section rate of 40%.	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	Refer to Table 5.14.1		40%	40%	40%	25%
	Provide sufficient resources for the rendering of comprehensive highly specialised out-patient services at a target rate of 1.1 out-patient per in-patient day.[1]	2	Patient day equivalents (Number of PDEs)			222 749	213 038	213 038	Not available
		3	OPD Total head count (number of head count at L3 OPD clinics)			179 286	159 779	159 779	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4	Patient satisfaction survey using DoH template (percentage of central hospitals)			100%	100%	100%	100%
		5	Mortality and morbidity meetings at least once a month (percentage of central hospitals)			100%	100%	100%	100%
		6	Clinical audit meetings at least once a month (percentage of central hospitals)			100%	100%	100%	100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved within 25 days/ total complaints received*100)			100%	100%	100%	100%
		8	Case fatality rate in for surgery separations (total surgery fatalities/total operations*100)			3%	3%	3%	3
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9	Average length of stay			6.00	6.00	6.00	5.30
		10	Bed utilisation rate (based on usable beds)			83.0%	85.0%	85.0%	75.0%
		11	Total separations[2]			27 165	26 630	26 630	Not available
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 800 per PDE.	12	Expenditure per patient day equivalent[3]			R2 752	R2 879	R2 955	1 877

Notes:

1 Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

2 Per definition day cases are included in separations and therefore included in total in-patient days (Day cases=1 separation=.5 in patient day.)

3 2006/07 prices.

4 National target refers to central hospitals and not Level 3.

Table 5.15.1: Performance indicators for Red Cross Children's Hospital for 2004/05 to 2007/08 [CHS4]

Strategic goal:	**To provide highly specialised hospital services in accordance with the specifications of th e National Tertiary Services Grant**							
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target[4] 2007/08**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals to perform highly specialised surgical procedures including a target caesarean section rate of 0%.	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	Not applicable	Not applicable	Refer to Table 5.15.2			25%
	Provide sufficient resources for the rendering of comprehensive highly specialised out-patient sevices at a target rate of 1.1 out-patient per in-patient day.[1]	2	Patient day equivalents (number of PDEs)	143 431	131 354				Not available
		3	OPD Total head count (number of head count at L3 OPD clinics)	150 464	189 084				Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4	Patient satisfaction survey using DoH template (percentage of central hospitals)	100%	100%				100%
		5	Mortality and morbidity meetings at least once a month (percentage of central hospitals)	100%	100%				100%
		6	Clinical audit meetings at least once a month (percentage of central hospitals)	100%	100%				100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved within 25 days/ total complaints received*100)	75%	100%				100%
		8	Case fatality rate for surgery separations (total surgery fatalities/total operations*100)	0.44%	0.40%				3
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9	Average length of stay	3.90	4.10				5.30
		10	Bed utilisation rate (based on usable beds)	84.0%	83.6%				75.0%
		11	Total separations[2]	21 831	21 024				Not available
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 800 per PDE.	12	Expenditure per patient day equivalent[3]	R1 845	R2 279				1 877

Notes:

1 Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

2 Per definition day cases are included in separations and therefore included in total in-patient days (Day cases=1 separation=.5 in patient day.)

3 2006/07 prices.

4 National target refers to central hospitals and not Level 3.

Table 5.15.2: Performance indicators for Red Cross Children's Hospital for 2008/09 to 2010/11 [CHS4]

Strategic goal:	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant								
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Target 2009/10**	**Target 2010/11**	**National target[4] 2007/08**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals perform highly specialised surgical procedures including a target caesarean section rate of 0%.	1	Caesarean section rate (Percentage = caesarean sections/total deliveries*100)	Refer to Table 5.15.1		Not applicable	Not applicable	Not applicable	25%
	Provide sufficient resources for the rendering of comprehensive highly specialised out-patient sevices at a target rate of 1.1 out-patient per in-patient day.[1]	2	Patient day equivalents (Number of PDEs)			98 126	107 553	107 553	Not available
		3	OPD total head count (number of head count at L3 OPD clinics)			78 979	80 665	80 665	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals.	4	Patient satisfaction survey using DoH template (percentage of central hospitals)			100%	100%	100%	100%
		5	Mortality and Morbidity meetings at least once a month (percentage of central hospitals)			100%	100%	100%	100%
		6	Clinical audit meetings at least once a month (percentage of central hospitals)			100%	100%	100%	100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved within 25 days/ total complaints received*100)			100%	100%	100%	100%
		8	Case fatality rate for surgery separations (total surgery fatalities/total operations*100)			0.40%	0.4%	0.4%	3
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals.	9	Average length of stay			5.10	6.00	6.00	5.30
		10	Bed utilisation rate (based on usable beds)			83.0%	85.0%	85.0%	75.0%
		11	Total separations[2]			14 078	13 444	13 444	Not available
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 800 per PDE.	12	Expenditure per patient day equivalent[3]			R2 752	R2 879	R2 955	R1 877

Notes:

1 Comprehensive out-patient services include the head count at casualty/emergency/trauma units. However, the CSP does not provide for trauma and emergency units at L3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

2 Per definition day cases are included in separations and therefore included in total in-patient days (Day cases=1 separation=.5 in patient day.)

3 2006/07 prices.

4 National target refers to central hospitals and not Level 3.

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Budget	2004/05	2005/06	2006/07	2007/08 Adjusted Estimate	20080/9	2009/10	20010/11
Modernisation of Tertiary Services + Office DDG	3 017	22 053	1 907	5 353	37 156	40 128	42 937
Programme 5							
Groote Schuur Hospital (GSH)	**772 370**	**838 628**	**910 050**	**990 009**	**1 098 238**	**1 186 097**	**1 269 124**
Programme 4					274 455	296 376	317 075
Programme 5	772 370	838 628	910 050	990 009	823 783	889 721	952 049
Red Cross Children's Hospital (RCCH)	**232 848**	**245 946**	**270 594**	**303 657**	**348 330**	**376 197**	**402 531**
Programme 4					73 871	52 700	55 566
Programme 5	232 848	245 946	270 594	303 657	274 459	323 497	346 965
Tygerberg Hospital (TBH)	**793 353**	**873 487**	**940 299**	**1 022 787**	**1 136 466**	**1 227 383**	**1 313 300**
Programme 4					470 569	535 332	573 676
Programme 5	793 353	873 487	940 299	1 022 787	665 897	692 051	739 624
Total	**1 801 588**	**1 980 114**	**2 122 850**	**2 321 806**	**2 620 190**	**2 829 805**	**3 027 892**
Programme 4					818 895	884 408	946 317
Programme 5	1 801 588	1 980 114	2 122 850	2 321 806	1 801 295	1 945 397	2 081 575
Sum GSH + RCCH + TBH	**1 798 571**	**1 958 061**	**2 120 943**	**2 316 453**	**2 583 034**	**2 789 677**	**2 984 955**
Programme 4					818 896	884 408	946 317
Programme 5	1 798 571	1 958 061	2 120 943	2 316 453	1 764 138	1 905 269	2 038 638
Cost of level 3 beds as % of total cost of central hospitals					**68.30%**	**68.30%**	**68.30%**

Table 5.17: Trends in provincial public health expenditure for central hospitals [CHS5]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total excluding capital	1 805 918 000	1 980 705 000	2 123 000 000	2 352 455 000	1 801 295 000	1 945 397 000	2 081 575 000
Total Capital	14 578 000	36 131 000	41 092 000	55 762 000	67 244 000	74 395 000	62 290 000
Grand Total	**1 820 496 000**	**2 016 836 000**	**2 164 092 000**	**2 408 217 000**	**1 868 539 000**	**2 019 792 000**	**2 143 865 000**
Total per person	391.81	427.51	409.98	443.86	335.06	352.36	363.86
Total per uninsured person	525.95	572.51	549.72	595.28	449.45	472.75	488.28
Constant 2006/07 prices							
Total excluding capital	2 003 268 970	2 049 613 022	2 123 000 000	2 272 499 958	1 663 434 155	1 738 758 045	1 802 528 385
Total capital	16 171 086	37 387 985	41 092 000	53 866 766	62 097 528	66 492 806	53 939 682
Grand total	**2 019 440 056**	**2 087 001 006**	**2 164 092 000**	**2 326 366 724**	**1 725 531 683**	**1 805 250 851**	**1 856 468 067**
Total per person	434.63	442.38	409.98	428.78	309.41	314.93	315.08
Total per uninsured person	583.42	592.42	549.72	575.05	415.05	422.54	422.83

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

1. AIM

Rendering of training and development opportunities for serving and prospective employees of the Department of Health.

2. PROGRAMME STRUCTURE

Sub Programme 6.1: Nurse Training College (WCCN)

Training of nurses at undergraduate and post basic level. Target group includes actual and potential employees.

Sub Programme 6.2: Emergency Medical Services (EMS) Training College

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

Sub Programme 6.3: Bursaries

Provision of bursaries for health science training programmes at undergraduate and postgraduate levels. Target group includes actual 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 in the Department. Target group includes actual and potential employees.

3. SITUATION ANALYSIS

3.1.1 **Training needs assessment and gap analysis, both in-service and pre-service**

A skills competency profiling audit will be conducted in phases over a period of two years to address the human resource development (HRD) requirements arising from the Comprehensive Service Plan (CSP).

The analysis of training needs and scarce skills is informed by the annual Workplace Skills Plan. In addition, the HWSETA and the PSETA produce the Sector Skills Plans, which addresses HRD priorities for the public 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**.**

3.1.2 **Internal and External Partnerships**

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 formal partnership with Cape Higher Education Consortium (CHEC), which consists of the Universities of Cape Town, Stellenbosch and the Western Cape, as well as the Cape Peninsula University of Technology, to promote a regional platform for undergraduate training of nurses.

At the Departmental level, a HRD Forum has been established, as well as a training committee, to deliberate on internal HRD interventions that impact on the delivery of health services.

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

3.1.3 **Provincial Growth and Development Strategy**

The Departmental HRD Strategies/Policies are aligned to the Provincial Growth and Development Strategy with the intention of creating 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 nurses, diagnostic radiography and pharmacist assistants (basic) at training sites in the Department. This strategy addresses identified gaps and is used as a "*ladder-approach"* recruitment mechanism for nurses, diagnostic radiographers and pharmacists.

In addition, bursaries are offered to school leavers to pursue a formal qualification in the Health Sciences through full-time studies at an accredited Higher Education Institution (HEI), where after they are employed within the Department. In the 2008/09 financial year the Department plans to grant 550 new bursaries, in addition to the estimated 1 138 existing bursaries, for basic nurse training at a projected total cost of R43.9 million. In addition 125 new bursaries will be granted and an estimated 183 bursaries maintained for other health science professionals at a projected total cost of R9.5 million.

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.

3.1.4 **Social Capital: Expanded Public Works Programme**

The Expanded Public Works Programme (EPWP) is a national programme designed to provide productive employment opportunities for a significant number of the unemployed, not only to earn an income but also to develop skills and improve their potential to gain permanent employment.

4. POLICIES, PRIORITIES AND STRATEGIC GOALS

4.1.1 Legislative mandate

The provision of human resource development (HRD) services is mandated by key legislation and policy prescriptions such as example: Health Act, Nursing Strategy for South Africa, Skills Development Act, Skills Development Levies Act, HRD Strategy for South Africa, National Skills Development Strategy 2005 2010, etc.

4.1.2 Human Resource Development Strategy (HRDS)

In line with the CSP, the Department has the responsibility of ensuring that there is a constant supply of effectively trained health science professionals and support staff.

A comprehensive HRDS will form part of the Human Resource (HR) Plan that will be developed during 2008.

4.1.2.1 Aim of the HRDS

The aim is to develop a workforce that has the required skills and knowledge to deliver on the departmental mandate as well as promote continuous learning and development to meet the changing needs of the Department. There will be an increased emphasis on competencies required at primary levels of health care.

4.1.2.2 The key objectives of the strategy are to:

1) Provide a broad framework within which initiatives aimed at human resource development are located
2) Demonstrate skills and competencies required for the implementation of the CSP
3) Ensure that service delivery is of a high standard and is responsive to change so as to identify and develop clear intervention strategies to Departmental needs
4) Provide productive employment opportunities for a significant number of the unemployed persons through the development of skills as community home-based carers as part of the Expanded Public Works Programme (EPWP).

4.1.3 Addressing the shortfall in the number of professionals to meet future service requirements by:

1) Aligning HRD strategies with the CSP, key legislation and policies
2) Implementing a skills-competency profiling audit
3) Continuing delivery on the Expanded Public Works Programme
4) Increasing the critical mass of nurses based on health service needs
5) Increasing the critical mass of health science professionals and support staff in scarce skills, based on health service needs i.e. pharmacists, radiographers, medical and clinical technologists, medical physicists, industrial technicians
6) Increasing the critical mass of Emergency Medical Services staff through re-implementation of HPCSA accredited short programmes
7) Effectively placing medical interns in community service
8) Increasing the critical mass of pharmacist assistants, enrolled nurse assistants and enrolled nurses through the learnership programme
9) Implementing management leadership programmes.

4.1.4 **Ensuring the relevance and quality of training programmes by:**

1) Using HRD interventions that are in line with the CSP and training programmes that are incorporated into the Workplace Skills Plan.
2) Continuing to strengthen partnerships with Higher Education Institutions and relevant education and training providers.

4.1.5 **Addressing the training skills and competencies gap, both in-service and pre-service by implementing the following Training programmes:**

1) Training programmes for clinical nurse practitioners
2) Re-orientation programmes for primary health care
3) Training programmes for the improvement and maintenance of competences (iMocomp) of health professionals at district level
4) Training programmes for mid-level workers through short courses, learnerships, mentoring
5) ABET programmes for staff that contribute towards bridging the skills gap, while providing higher portability of skills and wider opportunities for career paths and employability
6) Learnerships in partnership with the Health and Welfare Sector Education Training Authority (HWSETA), some of which are intended to alleviate unemployment and poverty by providing access to skills development and employment opportunities
7) Continuing implementation of the comprehensive management leadership programme
8) In-service clinical development programmes for staff entering and currently employed in the EMS.

5. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.1 HRD Information System

At present the systems are fragmented and do not support planning, monitoring and evaluation. The Department of the Premier has commenced with a provincial process to develop a provincial system however the Department has taken steps to ensure an effective and efficient decentralised information system as a planning and monitoring instrument

5.2 Human Resource Capacity Constraints

Insufficient HRD staff within the Department at a decentralised level is the main constraint. The Department will embark on a capacity audit to assess the required number of staff needed to perform this function. This will all form part of the development of the Human Resource Plan.

5.3 Emergency Medical Services

The production and in-service training of EMS staff is crucial to achieve FIFA as well as CSP targets. A concerted effort is being made to improve the production of EMS practitioners. The loss of EMS staff to international recruitment remains a key challenge, especially in staff with advanced life support qualifications (paramedic staff).

6. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 6.1: Provincial objectives and performance indicators for human resource development [Hr2]

Measurable objective	Indicator (Performance Measure)	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
		Actual	Actual	Actual	Estimate	Target	Target	Target
	Strategic goal:	Rendering of education, training and development opportunities for employees of the Department of Health						
Sub-programme 6.1	**Nurse training college Western Cape College of Nursing**							
Provision of basic nurse training to meet the service demands of the Department.	Number of student nurses trained at the Western Cape College of Nursing.	540	502	513	590	965	1159	1390
Provision of post-basic nurse training to meet the service demands of the Department.	Number of professional nurse employees admitted to post-basic nurse training programmes.	26	31	30	37	40	56	**72**
	Total basic and post-basic nurse training	**566**	**533**	**543**	**627**	**1 005**	**1 215**	**1 462**
Sub-programme 6.2	**EMS Training College**							
Facilitate the provision of EMS training programmes to meet the demand of the service.	Number of new learners admitted to the National Diploma EMC programme.	35	35	35	35	60	80	90
	Number of existing learners in the National Diploma EMC programme.	35	88	119	119	85	120	130
	Number of learners graduating from the National Diploma EMC programme.	12	13	23	22	30	41	45
	Number of EMS learners admitted to short training programmes	352	504	1583	589	504	598	618
	Number of EMS learners to complete short training programmes.	342	442	1539	546	468	548	566
Sub-programme 6.3	**Bursaries**							
6.3.1 Nursing bursaries								
Funding the training of all categories of nurses through a bursary scheme to meet the service requirements.	Number of new students granted bursaries for nurse training	496	575	606	634	800	860	890
	Maintenance of existing nursing bursaries	514	679	962	936	1 260	1 350	1450
	Total number of nursing bursaries	**1 010**	**1 254**	**1 568**	**1 570**	**2 060**	**2 210**	**2340**
6.3.2 Bursaries for health science personnel other than nurses.								
Funding the training of health science professionals (excluding nurses) and support services through a bursary scheme to meet the service requirements.	Number of new students granted bursaries for health science training.	69	80	101	130	125	135	150
	Maintenance of existing health science bursaries	227	182	158	189	183	259	269
	New bursaries for serving employees	0	69	242	140	280	280	300
	Maintenance of bursaries for serving employees	64	48	263	88	190	160	160
	Total number of health science bursaries	**360**	**379**	**764**	**547**	**778**	**834**	**879**
	Total number of bursaries (Nursing + health sciences)	**1 370**	**1 633**	**2 332**	**2 117**	**2 838**	**3 044**	**3 219**

Measurable objective	Indicator (Performance Measure)	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
		Actual	Actual	Actual	Estimate	Target	Target	Target
Sub-Programme 6.4	**PHC Training**							
6.4.1 **PHCT** [1] Provision of PHC-related training interventions for personnel provided by the districts.	Number of training interventions provided to PHC personnel.	3 180	2 206	3 329	4 000	3 900 [2]	4 000 [2]	4 100 [2]
6.4.2 **iMOCOMP** The provision of training for the improvement and maintenance of competence project (iMocomp) at district level.	Number of iMocomp training interventions provided at district level.	0	0	0	0	300	500	700
Sub-programme 6.5	**Other training**							
6.5.1 Levy to HWSETA [3]	Administrative levy payable to HWSETA in terms of skills development legislation.	R 1.873 m	R 1.942 m	R 2.045 m	R 2.169 m	R 2.280 m	R 2.394 m	R 2.514 m
6.5.2 **Workplace Skills Plan** [4] The provision of training and development opportunities for personnel within the Department.	Number of training interventions provided to personnel. Including, all generic training, management & leadership development opportunities, PHC training, ABET and learnerships	15 897	12 184	11 771	16 600	16 600	16 800	17 000
6.5.3 **Management and leadership development skills** [5] Facilitate the development of appropriate management and leadership skills.	Number of management and leadership development training opportunities	731	1 217	1 559	1 500	1 600	1 600	2 000
6.5.4 **ABET** [6] Facilitate the development of human resources by means of ABET.	Number of ABET learners registered for courses	1 189	474	275	100	150	200	200
6.5.5 **Learnerships** [7] Contribute to the Provincial Growth and Development Strategy through the provision of learnerships.	**Number of learnerships for employed personnel**	**383**	**114**	**115**	**124**	190	230	230
	Nurses	197	80	80	111	135	165	165
	Pharmacist assistants	186	34	35	13	55	65	65
	Number of learnerships for unemployed personnel	**104**	**106**	**101**	**92**	**120**	**130**	**130**
	Nurses	77	65	65	25	45	40	40
	Pharmacist assistants	27	26	21	32	45	55	55
	Diagnostic radiography	0	15	15	35	30	35	35
6.5.6 **Work-integrated learning**								
Partner with Higher Education Institutions through the provision of work integrated learner (internship) opportunities	Number of work integrated learners (generic interns) placed	77	127	188	130	130	130	150
6.5.7 Expanded Public Works Programme								
Provide training opportunities for unemployed persons to facilitate access to employment.	Number of community-based health workers trained	0	0	1 009	1 805	1 840	0 [8]	0 [8]

Notes

1 This budget is decentralised to and accounted for by the regions. This is not in a separate envelope
It is recommended that PHC-related training is costed and funded by the regions and a separate funding envelope is identified within the regional budgets

2 Targets reduced to allow for specific targets to measure iMocomp interventions

3 Administrative levy payable to HWSETA in terms of skills development legislation.

4 Data collected via Quarterly Training Reports.

5 Target group is senior officials, deputy directors, and assistant directors. In addition personnel, in other categories who have financial / management responsibilities

6 Figures reflect ABET and AFET interventions from ABET level 1 to NQF level 4.

7 Learnerships: Enrolled nurse assistants, enrolled nurses, post-basic nursing. Pharmacist assistants: Subject to funding by HWSETA.

8 Funding from National treasury has been allocated up until 2008 / 2009 financial year. Thereafter policy options for additional funding will be submitted.

Table 6.2: Situational analysis and projected performance for health sciences and training [Hr4]

Programme 6:	Health sciences and training	Strategic goal:	Addressing the shortfall in the number of professionals to meet future service requirements							
Strategic objective	**Measurable objective**	**Performance measure/ Indicator**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**
		Input								
Providing education, training and development opportunities for serving and prospective employees of the Department of Health.	Provide a sufficient pool of prospective employees	1) Intake of medical students (number)	1 372	1 598	1 611	1 704	1 678	1 713	1 780	1869
		2) Intake of nurse students (number)	326	526	763	871	992	1 192	1 236	1557
		3) Students with bursaries from the province (number)	1 157	1 370	1 633	2 332	2 117	2 838	3 044	3219
		Process								
		4) Attrition rates in first year of medical school (percentage)	2.6%	3.8%	4%	2.7%	4%	4%	4%	4%
		5) Attrition rates in first year of nursing school (percentage)	10%	15%	15%	15%	15%	10%	10%	10%
		Output								
		6) Basic medical students graduating (number)	315	406	407	440	289	298	320	402
		7) Basic nurse students graduating (number).	58	84	114	133	285	304	299	400
		8) Medical registrars graduating (number).	48	51	39	47	43	44	44	44
		9) Advanced nurse students graduating (number).	107	138	202	198	199	199	199	199
		Efficiency								
		10) Average training cost per basic nursing graduate (rand)	34 663	37 674	39 214	10 450	11 500	12 650	14 000	15 300
		11) Development component of HPT & D grant spent (percentage)	0%	0%	0%	0%	0%	0%	0%	0%

Programme 6:	Health sciences and training	Strategic goal:	Addressing the shortfall in the number of professionals to meet future service requirements							
Strategic objective	**Measurable objective**	**Performance measure/ Indicator**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**
Additional Programme 6 performance measures										
		Nurse training colleges								
		Number of student nurses trained PN.	566	904	1 107	1 388	1 480	1 815	1 895	1995
		Number of student nurses trained towards ENA.	50	106	65	65	0 [2]	0 [2]	0 [2]	0 [2]
		Number of student nurses trained towards enrolled nurse	143	118	65	113	82	115	130	140
		EMS Training								
		Number trained as ambulance emergency assistants.	65	25	32	7	22	96	96	96
		Number trained as paramedics.	12	10	11	0	11	12	12	12
		Bursaries								
		Number of bursaries awarded.	1 157	1 370	1 633	2 332	2 117	2 838	3 044	3219

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.
2. 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.
3. ENA Learnership has been discontinued due to the re-prioritisation by HWSETA of learnership funding.

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

Health Sciences and Training has been allocated 2.07 % of the vote in 2008/09 in comparison to the 1.83 % allocated in the revised estimate of the 2007/08 budget. This amounts to a nominal increase of 28.85 % or R39.967 million.

Included in Sub-programme 6.1: Nurse Training College is an earmarked allocation amounting to R5.161 million in 2008/09 for the health professionals' remuneration review.

Included in Sub-programme 6.2: Emergency Medical Services Training College is an earmarked allocation of R7.359 million for the purpose of Emergency Medical Services.

Sub-programme 6.5: Training Other receives and earmarked allocation of R70.044 million for the Expanded Public Works Programme. The funds are to be used for the training of community home-based carers in ancillary health care and community health as well as for the training matriculants as data capturers. A portion of the earmarked allocation will be transferred to community-based services to fund the NPOs and NGOs to provide the learning platform through which the learners will obtain exposure and practical work-based experience required in terms of training.

Table 6.3: Trends in provincial public health expenditure for Health Sciences and Training [Hr5]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total	73 541 000	79 009 000	98 858 000	138 553 000	178 520 000	192 802 000	206 298 000
Total per person	15.83	16.75	18.73	25.54	32.01	33.63	35.01
Total per uninsured person	21.25	22.43	25.11	34.25	42.94	45.13	46.99
Constant 2006/07 prices							
Total	81 577 571	81 757 695	98 858 000	133 843 872	164 857 097	172 322 682	178 642 615
Total per person	17.56	17.33	18.73	24.67	29.56	30.06	30.32
Total per uninsured person	23.57	23.21	25.11	33.08	39.65	40.33	40.69

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.
This service has now been transferred to Sub-programme 2.8

Programme 7.4 Orthotic and Prosthetic Services

Rendering specialised orthotic and prosthetic services.
This service has now been transferred to sub-programme 4.4

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

Linen and laundry services are provided by large central laundries located at Tygerberg, Lentegeur and George Hospitals. Several rural hospitals have small in-house laundries. A large portion of the service is outsourced which has proved cost effective and ensured availability of linen. In addition outsourcing has resulted in a reduction in overtime worked at in-house laundries.

- 20 million linen items are processed annually. In-house laundries process 14 million pieces per annum and out-sourced private sector laundries process 6 million pieces per annum.
- Tygerberg Laundry is processing eight million pieces per annum; George and Lentegeur Laundries together process a further six million pieces per annum.
- Tygerberg Laundry has 163 staff, Lentegeur Laundry has 67 staff and George Laundry has 31 staff.
- All laundry personnel are multi-skilled.

3.2 POLICIES, PRIORITIES AND OBJECTIVES

In order to provide a cost effective service with minimum risk, there is a combination of in-house and outsourced laundry services. The priority has been to increase the efficiency of in-house services. Large volumes of work are imperative for the strategic laundries to be 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 are fully used.

3.3 CONSTRAINTS AND PLANNED MEASURES TO OVERCOME THEM

The relatively high level of salaries of in-house laundry personnel compared with the private sector is a significant constraint on making these laundries cost competitive. A gradual reduction in staff coupled with morale building and training has significantly improved productivity. The challenge facing the laundry service is aging, high-cost equipment that must be replaced at high cost.

3.4 PLANNED QUALITY IMPROVEMENT MEASURES

The infrastructure of the Provincial laundries has been significantly upgraded in the last two financial years. The systematic replacement of equipment will continue during the 2008/09 financial year. Replacement of this equipment increases both cost effective operations and efficiency of the laundries.

The upgrading of the Lentegeur laundry as part of the new Mitchell's Plain Hospital project is also planned. This will include the purchase of new equipment.

To ensure availability of linen in health facilities, additional linen to the value of R7 million will be purchased during the 2008/09 financial year.

3.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.1

Table 7.1: Provincial objectives and performance indicators for Laundry services

Sub-programme 7.1: Laundry Services		**Strategic Goal:** To render laundry services to hospitals, care and rehabilitation centres and certain local authorities							
Strategic Objective	**Measurable Objectives**	**Performance Measure/ Indicator**	**2004/05 Actual**	**2005/06 Actual**	**2006/07 Actual**	**2007/08 Estimate**	**2008/09 Target**	**2009/10 Target**	**2010/11 Target**
To provide a laundry service to all provincial hospitals	Manage the pieces/linen laundered by a combination of strategic in-house and out-sourced laundries.	Total number of pieces laundered:	18m	20m	20m	21m	21.5m	22m	23m
	Manage the number of pieces laundered by in-house laundries.	Number of pieces laundered: in-house laundries	14m	14m	14m	15.5m	16m	17m	18m
	Manage the number of pieces laundered by private sector.	Number of pieces laundered: outsourced services	4m	6m	6m	5.5m	5.5m	5m	5m
To provide cost effective in-house laundry service	Ensure that in-house laundries produce cost effective laundry services.	Average cost per item	R1.81	R1.74	R1.74	R2.19	R2.19	R2.19	R2.19
To provide cost effective out-sourced laundry service	Ensure that service providers produce cost effective laundry services.	Average cost per item	R1.30	R1.48	R1.47	R1.61	R1.73	R1.70	R1.70

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).

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- Distribute all available equipment operation and maintenance manuals to hospital maintenance staff.
- Implement procedures for appropriate cost allocation of maintenance work.
- Ring-fence maintenance budget to prevent misappropriation of maintenance funds for capital works, maintenance projects and other purposes.
- Undertake maintenance awareness training programme (workshop for CEO and district office managers to define the level of maintenance and budgeting for maintenance).
- Investigate the acquisition and implementation of an immovable asset management information system to enable effective maintenance planning, budgeting and decision making.
- Consolidate a comprehensive integrated immovable asset register of all Department of Health facilities, including all new facilities transferred to the Department.
- Undertake a baseline condition and suitability assessment of Department of Health facilities as a precursor to a programme of regular assessments.
- Deploy standard procedures for asset management at all levels.
- Implement the existing (Tygerberg) computerised medical equipment system throughout the province.
- With particular reference to the transfer of local authority clinics, assess the cost of instituting a rapid clinic building programme to replace facilities that are often overcrowded, functionally unsuitable and in very poor condition and perhaps delaying the start of a larger hospital project.
- Set up an Engineering and Technical Support Services Maintenance web page on the existing provincial network to consolidate all relevant documentation (policy, guidelines, manuals, etc.) in a version controlled environment.

The ability to implement these measures will depend on the availability of funding and the ability to recruit qualified and experienced maintenance management personnel.

Table 7.2 Physical condition of hospital network

Hospitals by type	Average 1996 NHFA condition grading[1]	*Estimated grading 2008	Outline of major rehabilitation projects since last audit
DISTRICT HOSPITALS			
Beaufort West	4	4	The replacement air conditioning system including ventilation. New admin, pharmacy and casualty.
Caledon	4	3	Replacement of incinerator; routine maintenance; and internal repairs & renovations including painting. Major upgrade in progress.
Ceres	5	4	Installation of new air conditioning units including incinerator; routine maintenance; and internal & external repairs and renovations.
Clanwilliam	-	3	Ward upgraded for “private” patients.
Citrusdal	4	4	Internal and external renovations and painting.
Eerste River	-	4	Routine maintenance only. Casualty upgrade planned for 2008/9
False Bay	4	4	Internal and external renovations. Extended the OPD
Hermanus	4	2	Internal and external repairs & renovations; and Routine maintenance.
Knysna	4	4	OPD Internal and external renovations and painting.
Ladismith	4	4	Routine maintenance only.
Laignsburg	-	4	One wing converted for use as a clinic.
LAPA Munnik	4	3	Routine maintenance only.
Montagu	2/3	3	Internal and external renovations and painting.
Mossel Bay	4	2	Partial internal and external renovations and painting. New causality.
Murraysburg	-	3	OPD added.
Otto du Plessis	3/4	4	Routine maintenance only.
Oudtshoorn	4	4	Routine maintenance only.
Prnce Albert	-	3	OPD added.
Riversdale	4	3	External renovations and painting. Major upgrade in progress
Radie Kotze	-	4	Ward upgraded for “private” patients.
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.
Uniondale	-	3	Routine maintenance only.
Vredenburg	3	2	Comprehensive revitalisation is progress
Vredendal	4	4	Casualty upgraded.
Wesfleur	2	4	Extensive internal and external repairs and renovations
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.
Helderberg	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.
Mowbray Maternity	3	5	Portion of nurses’ home converted to active birthing unit and ward for “private” patients. Comprehensive renovations and upgrading completed in 2007
Paarl	3	2	Casualty upgraded. Central steam installation converted to point of use electrical heating. Revitalisation in progress
Somerset	4	2	Central steam installation converted to point of use electrical heating.

Hospitals by type	Average 1996 NHFA condition grading[1]	*Estimated grading 2008	Outline of major rehabilitation projects since last audit
Victoria	2	2	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. Upgrading of the wards is on-going. New theatre block in construction.
Tygerberg	3	2	Pharmacy upgraded. Several wards renovated.
TUBERCULOSIS HOSPITALS			
Brewelskloof	4	4	Extensive internal and external repairs and renovations
Brooklyn Chest	4	2	Ongoing internal and external renovation of wards. Installation of UV lights in progress.
DP Marais	4	4	Ablutions upgraded.
Harry Comay	-	1	Minor renovations and painting.
Malmesbury	-	1	
Sonstraal	-	3	
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. The upgrading of the wards has been completed
Stikland	4	2	Several ward blocks renovated.
Valkenberg	3	2	New admissions ward has been added.
REHABILITATION HOSPITALS			
Rehabilitation Centre	-	5	
PROVINCIALLY AIDED CHRONIC MEDICAL AND OTHER SPECIALISED HOSPITALS			
Booth Memorial	-	3	One wing renovated. Standby generator installed.
Die Wieg	-	3	Internal and external renovations and painting.
Maitland Cottage Home	-	3	Routine maintenance only.
Sarah Fox	-	3	
St Josephs Home	-	4	Routine maintenance only.
Conradie - Lifecare	-	4	Wards upgraded for use by Lifecare

* The estimated 2008 grading is based on routine inspections by the Engineering personnel and the requirements of Healthcare 2010.

HFA grading

Category	Description
5	As new and 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

4.4 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.2:

Table 7.3 Provincial objectives and performance indicators for Engineering services

Sub-programme 7.2: Engineering Services		**Strategic Goal**: Rendering a maintenance service to equipment, engineering installations, and repairs & renovations to buildings.							
Strategic Objective	**Measurable Objectives**	**Performance Measurable/Indicator**	**2004/05 Actual**	**2005/06 Actual**	**2006/07 Actual**	**2007/08 Estimate**	**2008/09 Target**	**2009/10 Target**	**2010/11 Target**
Effective maintenance of buildings and engineering installations	A combination of in-house and out-sourced maintenance in co-operation with Works	Maintenance backlog as % of replacement value	8% 1.2bn/13bn	8% 1.2bn/13bn	7% 900m/13bn	7% 900m/13bn	6% 800m/13bn	6% 800m/13bn	6% 800m/13bn
Efficient engineering installations	Monitoring of plant efficiency and modification or renewal as necessary	Cost of utilities per bed	R5 560	R6 500	R6 112	R6 910	R7 300	R7 650	R8 120
Safe working environment (Buildings, machinery and equipment)	Arrange training of staff in the Occupational Health and Safety Act	Number of reportable incidents	291	300	143	220	180	160	160
Cost effective maintenance of medical equipment	Manage a combination of in-house and out-sourced maintenance	Number of jobs completed – in-house/outsourced	10 507	9 463	13 011	15 300	16 700	17 000	17 000

5. SUB-PROGRAMME 7.3 FORENSIC SERVICES

Funding for forensic services has been transferred to Sub-programme 2.8

6. SUB-PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

Funding and managerial responsibility for orthotic and prosthetic services has been transferred to Sub-programme 4.4.

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 and in smaller quantities to smaller institutions. The academic hospitals generally buy directly from suppliers and tend to use the CMD as a top-up service.

The CMD is 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 the break up of bulk stock into manageable quantities to be used at institutions.

7.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The Cape Medical Depot provides a comprehensive pharmaceutical and medical and surgical supply service to health institutions. Hence the Family Planning unit as well as the ARV depot will be incorporated as part of the Medical Depot during the 2008/09 financial year. The Medical Depot has been significantly upgraded, and as a result the depot may now be licensed as required by the Pharmacy Act. A new computerised system will be implemented to ensure that all purchases and warehouse functions and issues to institutions are properly accounted for

7.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The current depot has been significantly upgraded. Due to structural limitations of the current building a process is underway to find alternative premises to relocate the depot in the long term to ensure the efficient management of stock and to address the security of the contents of the CMD.

An organisational development investigation was undertaken and the report finalised. It is now in the process of being implemented.

Another factor that impacts on the CMDs ability to trade efficiently is the normal increase in the price of goods. Pharmaceuticals have increased in price on average by 8% per annum. Certain items have shown an abnormally high price increase, which has been masked by the unweighted averaging used.

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Sub-programme 7.5	**Medicine Trading Account**		**Strategic Goal:**		Managing the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities.				
Strategic Objective	**Measurable Objective**	**Performance Measure/ Indicator**	**2004/05 Actual**	**2005/06 Actual**	**2006/07 Actual**	**2007/08 Estimate**	**2008/09 Target**	**2009/10 Target**	**2010/11 Target**
Sufficient working capital to support adequate stock-holding.	Increase working capital in line with projected inflator.	Working capital	R36.1 m	R41.3 m	R43.8 m	R50.0 m	R54.0 m	R58.3 m	R62.9 m

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

Health Care Support Services has been allocated 1.12 % of the vote in 2008/09 in comparison to the 1.13 % allocated in the revised estimate of the 2007/08 budget. This amounts to a nominal increase of R11.575 million or 13.54%. This includes an earmarked allocation of R49.725 million to Sub-programme 7.2: Engineering Services for maintenance.

Table 7.5 Trends in Health Care Support Services expenditure [SUP2]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Current prices							
Total	82 752 000	93 075 000	92 906 000	85 511 000	97 086 000	131 643 000	158 210 000
Total per person	17.81	19.73	17.60	15.76	17.41	22.97	26.85
Total per uninsured person	23.91	26.42	23.60	21.14	23.35	30.81	36.03
Constant 2006/07 prices							
Total	91 795 150	96 313 046	92 906 000	82 604 659	89 655 591	117 659 956	137 001 077
Total per person	19.76	20.42	17.60	15.22	16.08	20.53	23.25
Total per uninsured person	26.52	27.34	23.60	20.42	21.57	27.54	31.20

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

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 Community health facilities

On 1 March 2006 the Department of Health assumed responsibility for personal primary health care (PPHC) in the rural districts. The rural Local Authority clinics infrastructure is in the process of being transferred to the Provincial Government by the Department of Transport and Public Works. A comprehensive assessment of this infrastructure is now in progress, which is based on the accommodation required to deliver services in accordance with the CSP. The gap analysis will be used to inform the prioritisation of infrastructure need. Meanwhile the prioritisation of community health service projects focuses on communities where services are either non-existent or seriously deficient (overloaded).

The PPHC facilities currently operated by the City of Cape Town in the Metro Region will continue to be operated by the City pending the resolution of the funding and transfer of the services to the Provincial Government.

3.2 Emergency Medical Services (EMS)

The EMS is a highly visible and essential service rendered by the Department. The ambulance service was previously provided by local authorities and was largely accommodated inappropriately in buildings originally designed for other purposes, which had been neglected over the years. Since provincialisation the Department has undertaken a programme of constructing new purpose-built ambulance stations. In the MTEF period work continues on this programme.

3.3 District Hospital Services

The district hospitals play a pivotal role in Healthcare 2010. Many of the district hospitals require upgrading to render services as defined CSP. Smaller upgrading projects are currently being funded from the Provincial Infrastructure Grant. This will continue in the MTEF.

The provision of new district hospitals required in terms of the CSP and the major upgrading of existing hospitals will be funded from the Hospital Revitalisation Grant. The two most urgently needed district hospitals are the Khayelitsha and Mitchell's Plain hospitals. Design work and planning on both these hospitals has reached an advanced stage. Construction on new district hospital for Khayelitsha will commence late in 2008 while construction of the hospital for Mitchells Plain will commence early in 2009.

3.4 Provincial Hospital Services

The strengthening of the rural regional hospitals was identified as a priority for the implementation of Healthcare 2010 and the CSP. The revitalised George Hospital was opened formally in June 2006, although a final phase of construction is required to complete the project. Construction work on the revitalisation of Worcester and Paarl Hospitals is progressing well and both schemes are due to be completed by the end of 2009.

The campaign to prevent the spread of TB and to provide adequate treatment for those infected requires a major improvement of the physical infrastructure. A major concern is infection control to prevent cross infection between patients and to protect the hospital personnel. Interim measures are being applied using maintenance funding. There is an urgent need for new purpose-built facilities and business cases will be submitted for the inclusion of these projects in the Hospital Revitalisation Programme. Brooklyn Chest Hospital has been accepted into the Hospital Revitalisation Programme but funding has as yet not been approved.

Planning is in progress to build a replacement the Somerset Hospital as part of a property development initiative. Architectural concept plans for a new hospital building have been drafted by the Department of Transport and Public Works and approved by the Department of Health.

The number of beds at the psychiatric hospitals has been substantially reduced over the past 10 years. The upgrading of psychiatric hospitals has been prioritised by the National Department of Health. Valkenberg Hospital has become part of the Hospital Revitalisation Programme and planning for a replacement hospital is in progress. Stikland Hospital has been identified for possible replacement in terms of a possible property transaction involving the sale of excess land.

3.5 Central Hospital Services

The CSIR has completed a report on the condition and suitability of the physical infrastructure at Tygerberg Hospital. The recommendation is that it will be more economical to construct a new hospital than to upgrade and renovate the existing hospital. Tygerberg Hospital has been accepted into to the Hospital Revitalisation Programme but has yet to be funded. The magnitude of this project implies that it will require special consideration by both the national Department of Health and Treasury.

The renovation and upgrading of the Red Cross Children's Hospital continues. The work is being funded by the Children's Hospital Trust with financial and technical assistance from the Provincial Government. New operating theatres are currently under construction.

Table 8.1: Historic and planned capital expenditure by type [HFM1]

R'000s	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Major capital (Health)	17 350	43 741	18 000	33 486	16 434	28 000	28 000	29 800
Major capital (HRP)	81 939	124 115	103 445	174 337	195 715	400 388	387 010	420 965
Major capital (IPG)	36 324	54 411	55 229	64 056	80 262	93 810	110 479	120 081
Major capital (Other)					36 511	6 216	2 536	4 038
Major capital (Donor RCCH)	9 147	11 400	16 000	0	25 000	25 000	0	0
Maintenance and minor capital	71 677	65 102	48 538	72 478	80 197	85 197	88 927	97 820
Equipment	92 679	123 948	114 436	116 000	120 000	124 000	124 000	124 000
Equipment (Donor RCCH)	9 734	3 737	0	0	0	0	0	0
Equip maintenance	50 426	55 871	58 665	64 056	67 758	71 145	74 703	78 438
Total capital	**369 276**	**482 325**	**414 313**	**524 413**	**621 877**	**833 756**	**815 655**	**875 142**

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.
3. "Major capital (other)" refers to the upgrade of the forensic and pathology service

Table 8.2: Summary of sources of funding for capital expenditure [HFM2]

R 000s	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
Equitable share	232 132	288 662	239 639	286 020	284 389	308 342	315 630	330 058
Revitalisation grant	81 939	124 115	103 445	174 337	195 715	400 388	387 010	420 965
Infrastructure grant	36 324	54 411	55 229	64 056	80 262	93 810	110 479	120 081
Donor funding (RCCH)	18 881	15 137	16 000		25 000	25 000		
Other					36 511	6 216	2 536	4 038
Total capital	**369 276**	**482 325**	**414 313**	**524 413**	**621 877**	**833 756**	**815 655**	**875 142**

Table 8.3: Historic and planned major project completions by type [HFM3]

	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)
New hospitals	1	1	0	0	0	0	0	
New clinics / CHCs	0	0	0	2	3	1	3	3
Upgraded hospitals		1	2	5	5	7	8	6
Upgraded clinics / CHCs	0	0	2	0	1	1	0	0

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	District	District
Programme 1				**Information not available by District**		
MECs office and administration[1]	-	-	-	-	-	-
Programme 2	**0**		**0**			
Clinics and CHCs	300 000	15	20 000			
Mortuaries	75 000	3	25 000			
District hospitals	2 000 000	10	200 000			
Programme 3	**0**		**0**			
EMS infrastructure[1]	85 000	5	17 000	-	-	-
Programme 4	**0**		**0**			
Regional hospitals	390 000	5	78 000			
Psychiatric hospitals[1]	910 000	7	130 000	-	-	-
TB hospitals[1]	550 000	10	55 000	-	-	-
Other specialised hospitals[1]	30 000	6	5 000	-	-	-
Programme 5	**0**		**0**			
Provincial tertiary and national tertiary hospitals[1]	1 400 000	10	140 000	-	-	-
Other programmes[1,3]	**0**		**0**			
Compliance with Pharmacy Act.	96 000	10	9 600	-	-	-
Total all programmes	**5 836 000**		**679 600**			

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 assumption is that the HRP projects will be fully funded. 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 2007.
4. The budget for clinic's and CHCs 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]

Programme 8	**Health Facilities Management**	**Strategic Goal :**	**To provide new health facilities and to provide for the upgrading and maintenance of existing health facilities**			
Strategic Objective	**Measurable Objective**	**Performance Measure/ Indicator**	**Province wide value 2004/5**	**Province wide value 2005/06**	**Province wide value 2006/07**	**National Target 2003/04**
Input						
Maintain and improve health infrastructure.	Provide funding from equitable share to fund capital projects.	Equitable share capital programme as % of total health expenditure	0.90%	0.31%	0.50%	1.5
	Increase the number of hospitals on the Hospital Revitalisation Programme.	Hospitals funded on the Revitalisation programme %	5%	8%	12%	17
	Provide adequate funding for infrastructure maintenance.	Expenditure on facility maintenance as % of total health expenditure	1.33%	0.85%	1.12%	2.5
Keep existing equipment in good condition.	Provide adequate funding for equipment maintenance.	Expenditure on equipment maintenance as % of total health expenditure	1.14%	1.03%	1.00%	2
Process						
Safeguard assets.	Up-to-date asset register	Hospitals with up-to-date asset register.	-	Reported in Programme 1	Reported in Programme 1	100
	Up-to-date asset register	Health districts with up-to-date PHC asset register (excluding hospitals)	-	Note 1	Note 1	All
Quality						
Provide appropriate PHC infrastructure.	Provide facilities with piped water supply.	Fixed PHC facilities with access to piped water	100%	100%	100%	100
	Provide facilities with mains electricity supply.	Fixed PHC facilities with access to mains electricity	100%	100%	100%	100
	Provide facilities with telephone service.	Fixed PHC facilities with access to fixed line telephone	100%	100%	100%	100
	Reduce backlog in service platform.	Average backlog of service platform in fixed PHC facilities	R270 000 000	R270 000 000	R265 000 000	30

Programme 8	Health Facilities Management	Strategic Goal :	To provide new health facilities and to provide for the upgrading and maintenance of existing health facilities			
Strategic Objective	**Measurable Objective**	**Performance Measure/ Indicator**	**Province wide value 2004/5**	**Province wide value 2005/06**	**Province wide value 2006/07**	**National Target 2003/04**
Provide appropriate hospital infrastructure.	Reduce backlog in service platform.	Average backlog of service platform in district hospitals	R22 341 281	R1 285 000 000	R1 285 000 000	30
		Average backlog of service platform in regional hospitals	R116 151 577	R660 000 000	R600 000 000	30
		Average backlog of service platform in specialised hospitals (including TB & psychiatric hospitals)	R43 071 419	R2 042 738 086	R2 039 071 405	30
		Average backlog of service platform in tertiary and central hospitals	R352 921 375	R1 400 000 000	R1 400 000 000	30
		Average backlog of service platform in provincially aided hospitals	R13 066 667	R13 066 667	R13 066 667	30
		Average backlog of service platform in tertiary and central hospitals	R352 921 375	R1 400 000 000	R1 400 000 000	30
		Average backlog of service platform in provincially aided hospitals	R13 066 667	R13 066 667	R13 066,667	30
Efficiency						
Efficient delivery of infrastructure	Timeous completion of projects	Projects completed on time %	Note 2	Note 2	Note 2	
	Projects completed within budget	Project budget over run %	Note 2	Note 2	Note 2	
Outcome						
Improve the accessibility of health care facilities of the appropriate level of care.	Adequate number of beds	District hospital beds per 1000 uninsured population	-	0,50	0,53	100
	Adequate number of beds	Regional Hospital beds per 1000 uninsured population	-	0,58	0,61	65
	Distance to PHC facility	% Population within 5km of fixed PHC facility	-	94%	94%	85

Notes

1. The PPHCs are Chief Users of district hospitals and information regarding asset registers are incorporated in the statistics for hospitals.
2. The Health Department does not have the capacity to provide this information. It is planned to create the capacity as part of the IDIP process.
3. Average backlog of service platform is for building work only and specifically excludes equipment and furniture Figures updated to reflect current building costs and backlog in terms of HRP criteria where applicable hence the major escalation in cost of district, regional and central Hospitals .

4. POLICIES, PRIORITIES AND STRATEGIC GOALS

4.1 Community health facilities

The community health facilities are to be upgraded to facilitate the shift of healthcare to the lowest appropriate level. In the MTEF period the priority will be to provide new CHCs in line with the requirements of the CSP.

During 2007/08 new CHCs were completed in Simondium, Montagu and Stanford. The construction of a new CHC for Wellington is in progress. During the MTEF period new CHCs are planned for Knysna (Witlokasie), Plettenberg Bay (Kwanakuthula), Malmesbury (Wesbank), Du Noon, Khayelitsha and Mitchells Plain.

4.2 Emergency Medical Service (EMS)

The substantial improvement of the EMS has been identified as a priority for the Department of Health. In support of this policy the intention 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.

New ambulance stations were opened in Beaufort West, Caledon, Riversdale, Hermanus, Lentegeur and Atlantis during 2007/8. The construction of a new ambulance station in Worcester is in progress. The construction of new ambulance stations for Ceres, Vredendal, De Doorns, Leeu Gamka, Bonnievale, Khayelitsha and Heidelberg are planned during the MTEF period.

4.3 District Hospital Services

The provision of adequate level 1 (District) beds in the Metropole is a priority for the Department of Health. Construction on new district hospital for Khayelitsha will commence late in 2008 while construction of the hospital for Mitchells Plain will commence early in 2009.

Hospital Revitalisation funding has been requested for new district hospitals to replace the Helderberg and Mossel Bay hospitals. Hospital Revitalisation funding has also been requested to build a replacement Victoria Hospital with additional level 1 beds. Planning is in progress to build a replacement the Somerset Hospital as part of a property development initiative. This hospital will provide level 1 and level 2 beds.

4.4 Provincial Hospital Services

Regional Hospitals are being strengthened to improve level 2 services and will expand the accessibility of general specialist services to the communities that need the services most.

The development of the area around the Somerset Hospital for the soccer World Cup 2010 will render the hospital dysfunctional. The construction of a new Somerset Hospital as part of a property development initiative is thus a priority.

All of the TB Hospitals have been provincialised. These hospitals will require urgent and significant upgrading, but funding is not available for these projects.

4.5 Central Hospital Services

The replacement of the Tygerberg Hospital will be undertaken as part of the Hospital Revitalisation Programme as soon as funding is approved by National Treasury.

The renovation and upgrading of the wards at the Red Cross Children's Hospital is a priority that will be funded from the Health Capital budget. The Children's Hospital Trust has raised R50 million and is currently constructing a new operating theatre suite and a CSSD. The Department will provide funding to cover the cost of the CSSD.

Smaller, but essential upgrading projects at Groote Schuur Hospital will be funded from the Provincial Infrastructure Grant.

5. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.1 Maintenance backlog

As stated in Programme 7 there is a serious backlog of maintenance work. The construction of new hospitals under the Hospital Revitalisation Programme to replace the most dilapidated infrastructure will substantially reduce the hospital maintenance backlog. Similarly the upgrading of facilities using Provincial Infrastructure Grant funding will reduce the backlog. Additional funding for maintenance, as recommended by the Healthcare 2010 strategy is required for the maintenance to reach the required level.

5.2 Planning, design, construction and commissioning

There is a major capacity deficiency in respect of experienced technical and professional personnel both in the Departments of Health and of Transport and Public Works. This deficiency hampers the planning, design, construction and commissioning process.

The appointment of personnel to comply with the requirements of the Hospital Revitalisation Programme has improved capacity within Health. Public Works have appointed retired engineers, architects and quantity surveyors to improve capacity.

The absence of realistic and accepted planning area and cost norms for health facilities makes it difficult to exercise control over the cost of capital projects.

5.3 Programme management and accountability

The management of this programme poses a challenge, 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 direct jurisdiction over the actions that lead to such expenditure.

The management of the Programme will be addressed as part of the IDIP process. The Department has signed an IDIP Business Plan and implementation is expected to be completed in 2008. The plan provides for the establishing of programme management capacity in Health.

Table 8.6: National Health System Priority 5: Physical infrastructure

Activity	Indicators	National Targets 2007/08	Provincial progress 2007/08	National Targets 2008/09	Provincial projection 2008/09
Hospital revitalisation	Funded hospitals in plan	69 hospitals started on site, in progress or completed	Construction work is in progress at Worcester and Paarl Hospitals. Planning is in progress for the finishing phase of George Hospital, the second phase of Vredenburg Hospital and for Khayelitsha and Mitchell's Plain Hospitals. Inception planning is in progress for Valkenberg Hospital.	69 hospitals started on site, in progress or completed	Construction work will continue on Worcester and Paarl Hospitals. Construction work will commence on the finishing phase of George Hospital, the second phase of Vredenburg Hospital. Construction of the Khayelitsha and Mitchells Plain Hospitals will commence during 2008/09 financial year.
	Approved business cases, including MTS hospitals	At least 36 new business cases completed and approved by May 2007	Business cases have been approved for the following five hospitals: Brooklyn Chest, Tygerberg, Mossel Bay, Victoria and Helderberg Hospitals.	At least 36 new business cases completed and approved by May 2008	Business cases will be submitted for Swartland and Hermanus Hospitals
	Forensic services transfers	65% of forensic mortuaries rebuilt	Repair and Maintenance projects were undertaken by National Public Works for Tygerberg, SaltRiver, Oudtshoorn and Knysna mortuaries. 5/18 (28%) facilities in process of being rebuilt. New facilities are under construction in George, Paarl, Worcester and Hermanus and Malmesbury. Planning for a new M6 Academic facility in the Metro commenced. Budget availability impacted on the planning activities as additional funding needs to be secured to be able to implement the Infrastructure schedule of works	65% of forensic mortuaries rebuilt	Construction work on the New facilities in George, Paarl, Worcester and Hermanus and Malmesbury will be completed. It is projected that the target for 2008/9 will not be achieved due to the li mited funding available. Construction of new projects is dependent on additional funding in the MTEF and beyond. Business cases will be submitted for the new M6 facility in the Metro as well as the expansion of Tygerberg (M6 Academic), Beaufort West (M1), Riversdale (Holding), Vredenburg (M1), Mosselbay (M1), Laingsburg (Holding), Stellenbosch (M3).
	Maintenance increased	Worst 50% of non revitalisation hospitals with completed essential upgrades	Major upgrades are in progress at Caledon and Riversdale Hospitals. Construction on a new OPD and ward will commence at Helderberg Hospital. The construction of new operating theatres at the Red Cross Children's Hospital has commenced. At Vredendal Hospital the upgrading of the X-ray unit and the CSSD is in progress. The fire protection at Tygerberg and Groote Schuur Hospitals is being upgraded. Major maintenance projects exceeding R2 million per project are in progress at Tygerberg, Groote Schuur, Lentegeur, Stikland and Karl Bremer Hospitals	Worst 50% of non revitalisation hospitals with completed essential upgrades	A major upgrade of the casualty unit at Eerste River is planned. The work at Caledon, Riversdale, Helderberg, Red Cross, Groote Schuur and Tygerberg Hospitals will continue.
		Maintenance expenditure increased to 3.5% in all provinces	Maintenance expenditure projections: Infrastructure 1,21% Equipment 0,97%	Maintenance expenditure increased to 3.5% in all provinces	Maintenance expenditure projections: Infrastructure 1.17% Equipment 0.93%

Activity	Indicators	National Targets 2007/08	Provincial progress 2007/08	National Targets 2008/09	Provincial projection 2008/09
	Essential equipment provision	Gap analysis in all facilities against the Essential Equipment List (EQL) completed by June 2007	Gap analysis for all current revitalisation sites, as well as Khayelitsha, completed. No EQL has yet been supplied by the National Department of Health. For District Hospitals the District Health Service Package was used as a guideline and for others room data sheets and essential equipment lists were used to determine equipment needs.	Update	Equipment planning and analysis will continue as business plans are developed for projects
		Worst 20% of hospitals with full EQL	For the past four years the Department has spent significant amounts on purchasing and upgrading equipment. This was done through a prioritisation process where needs were determined before funding was allocated. No EQLs provided yet.	Worst 20% of hospitals with full EQL	The Department will proceed with the successful equipping and upgrading of equipment through the central funding and prioritisation process.
		Worst 50% of PHC facilities with full EQL	The PHC facilities are part of the abovementioned programme, although it is more difficult to buy the equipment for PHC facilities, as most of the equipment is not seen as capital, being under R5 000. Capital funding thus cannot be used for the PHC equipment.	Worst 50% of PHC facilities with full EQL	The PHCs are included in the abovementioned process of equipping and prioritisation
PHC	Designated staff accommodated	Accommodation provided in accordance with business plan	Funding is not available to provide residential accommodation for staff. Alternatives to construction of accommodation are being considered	Accommodation provided in accordance with business plan	It is intended that pilot schemes, possibly PPPs, will be initiated.
	Intersectoral infrastructure provision	25% of facilities with infrastructure gaps addressed	New CHCs were completed during 2007/8 in Stanford, Montagu and Simondium. A new CHC for Wellington is under construction.	25% of facilities with infrastructure gaps addressed	The Wellington CHC will be completed. Planning will commence on new CHCs for Malmesbury and Plettenberg Bay.
	Facilities audited	Worst 20% of facilities receiving essential upgrades	A new casualty wing is being constructed at the Khayelitsha CHC. No funding is available to address the backlogs in respect of the clinics transferred from the municipalities.	Worst 20% of facilities receiving essential upgrades	The upgrading of the Mitchell's Plain CHC is planned. Funding has been requested to address the backlogs in respect of the clinics transferred from the municipalities.
	CHC's development	STP CHC restructuring implemented	A survey of the 183 rural clinics transferred from local authorities is in progress. All new clinics and CHC's are being developed in accordance with the Comprehensive Service Plan	STP CHC restructuring implemented	Survey will be completed. Gap analysis will be done. Priorities determined and costing completed.

Table 8.7: Provincial objectives and performance indicators for health facilities management [HFM6]

Programme 8	Health Facilities Management	Strategic Goal :	To provide new health facilities and to provide for the upgrading and maintenance of existing health facilities					
Strategic Objective	**Measurable Objective**	**Performance Measure/ Indicator**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Budget 2008/09**	**Projection 2009/10**	**Projection 2010/11**
Programme 8.1 Improve Community Health physical infrastructure	Provide Community Health infrastructure that is fit for purpose	Total infrastructure expenditure on community health facilities as a % of backlog (R300 million)	4.9%	8.9%	18.6%	11.4%	24.5%	31.8%
Programme 8.2 Improve EMS physical infrastructure	Improve ambulance stations	% of ambulance stations built for purpose (50 ambulance stations)	42%	47%	60%	73%	76%	76%
Programme 8.3 Improve District Hospital physical infrastructure	Provide district hospital infrastructure that is fit for purpose	Total infrastructure expenditure on district hospitals as a % of backlog (R2 billion)	2.3%	5.9%	2.6%	11.0%	11.0%	16.8%
Programme 8.4 Improve Provincial Hospital physical infrastructure	Provide provincial hospitals with the physical infrastructure that is fit for purpose	Total infrastructure expenditure on provincial hospitals as a % of backlog (R1,85 billion)	5.2%	6.7%	0.8%	14.1%	11.7%	8.0%
Programme 8.5 Improve Central Hospital physical infrastructure	Provide central hospitals with the physical infrastructure that is fit for purpose	Total infrastructure expenditure on central hosptials as a % of backlog (R1,4 billion)	2.6%	2.4%	1.1%	4.8%	5.3%	4.4%

Table 8.8: National Performance indicators for health facilities management [HFM7]

Programme 8	Health Facilities Management	Strategic Goal :	To provide new health facilities and to provide for the upgrading and maintenance of existing health facilities						
Strategic Objective	**Measurable Objective**	**Performance Measure/ Indicator**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Budget 2008/09**	**Projection 2009/10**	**Projection 2010/11**	**National Target 2007/08**
Input									
Maintain and improve health infrastructure	Provide funding from equitable share to fund capital projects.	Equitable share capital programme as % of total health expenditure	0.31%	0.52%	0.22%	0.32%	0.30%	0.29%	2.5
	Increase the number of hospitals on the Hospital Revitalisation Programme.	Hospitals funded from the Revitalisation Programme %	8%	12%	14%	14%	16%	16%	25
	Provide adequate funding for infrastructure maintenance.	Expenditure on facility maintenance as % of total health expenditure	0.85%	1.12%	1.08%	0.99%	0.94	0.95%	4
Keep existing equipment in good condition	Provide adequate funding for equipment maintenance.	Expenditure on equipment maintenance as % of total health expenditure	1.03%	1.00%	0.91%	0.82%	0.79%	0.76%	4
Process		**Process**							
To safeguard assets	Up-to-date asset register	Hospitals with up-to-date asset register.	Reported in Programme 1	Reported in Programme 1	Reported in Programme 1	Reported in Programme 1	Reported in Programme 1	Reported in Programme 1	
	Up-to-date asset register	Health districts with up-to-date PHC asset register (excluding hospitals)	Note 1	Note 1	Note 1	Note 1	Note 1	Note 1	All

Programme 8	Health Facilities Management	Strategic Goal :	To provide new health facilities and to provide for the upgrading and maintenance of existing health facilities						
Strategic Objective	**Measurable Objective**	**Performance Measure/ Indicator**	**Actual 2005/06**	**Actual 2006/07**	**Estimate 2007/08**	**Budget 2008/09**	**Projection 2009/10**	**Projection 2010/11**	**National Target 2007/08**
Quality									
Provide appropriate PHC infrastructure.	Provide facilities with piped water supply	Fixed PHC facilities with access to piped water	100%	100%	100%	100%	100%	100%	100
	Provide facilitie s with mains electricity supply	Fixed PHC facilities with access to mains electricity	100%	100%	100%	100%	100%	100%	100
	Provide facilities with telephone service	Fixed PHC facilities with access to fixed line telephone	100%	100%	100%	100%	100%	100	100
	Reduce backlog in service platform	Average backlog of service platform in fixed PHC facilities	R270 000 000	R265 000 000	R300 000 000	R255 000 000	R240 000 000	R240 000 000	15
Provide appropriate hospital infrastructure.	Reduce backlog in service platform	Average backlog of service platform in district hospitals	R1 285 000 000	R1 285 000 000	R2 000 000 000	R2 000 000 000	R2 000 000 000	R2 000 000 000	15
		Average backlog of service platform in regional hospitals	R660 000 000	R600 000 000	R390 000 000	R250 000 000	R150 000 000	R100 000 000	15
		Average backlog of service platform in specialised hospitals (including TB & psychiatric hospitals)	R2 042 738 086	R2 039 071 405	R2 030 000 000	R2 030 000 000	R2 030 000 000	R2 030 000 000	15
		Average backlog of service platform in tertiary and central hospitals	R1 400 000 000	R1 400 000 000	R1 400 000 000	R1 400 000 000	R1 400 000 000	R1 400 000 000	15
		Average backlog of service platform in provincially aided hospitals	R13 066 667	R13 066 667	R13 066 667	R13 066 667	R13 066 667	R13 066,667	15
Efficiency									
Efficient delivery of infrastructure	Timeous completion of projects	Projects completed on time %	Note 2	Note 2	Note 2	Note 2	Note 2	Note 2	
	Projects completed within budget	Project budget over run %	Note 2	Note 2	Note 2	Note 2	Note 2	Note 2	
Outcome									
Improve the accessibility of health care facilities of the appropriate level of care.	Adequate number of beds	District hospital beds per 1000 uninsured population	0.50	0.53	0.53	0.55	0.59	0.59	90
	Adequate number of beds	Regional Hospital beds per 1000 uninsured population	0.58	0.61	0.61	0.61	0.63	0.63	60
	Distance to PHC facility	% Population within 5km of fixed PHC facility	94%	94%	95%	95%	95%%	95	95

Notes

1. The PPHCs are Chief Users of district hospitals and information regarding asset registers are incorporated in the statistics for hospitals.
2. The Health Department does not have the capacity to provide this information. It is planned to create the capacity as part of the IDIP process.
3. Average backlog of service platform is for building work only and specifically excludes equipment and furniture Figures updated to reflect current building costs and backlog in terms of HRP criteria where applicable.

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

Programme 8 is allocated 7.03 per cent of the vote in 2008/09 in comparison to the 4.93 per cent that was allocated in the revised estimate of the 2007/08 budget. This translates to a nominal increase of 63.01 per cent or R234.787 million. This includes an earmarked allocation of R85,197 for the purpose of maintenance.

Table 8.9: Trends in provincial public health expenditure for health facilities management (R' Million) [HFM8]

Expenditure	2004/05 (actual)	2005/06 (actual)	2006/07 (actual)	2007/08 (estimate)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices						
Total	288 464 000	217 025 000	344 355 000	372 608 000	607 395 000	614 416 000
Total per person	62.08	46.00	65.24	68.68	108.92	107.19
Total per uninsured person	83.34	61.61	87.47	92.10	146.10	143.81
Constant 2006/07 prices						
Total	319 987 386	224 575 222	344 355 000	359 943 831	560 908 451	549 153 085
Total per person	68.87	47.60	65.24	66.34	100.58	95.80
Total per uninsured person	92.45	63.75	87.47	88.97	134.92	128.54

Table 8.10: Provisional priorities for hospital revitalisation

Priority	HOSPITAL	2010 Classification	2004 BEDS	2010 beds	ESTIMATE R'million	Start	End
1	George (completion)	Provincial	202	265	95	2003	2009
2	Eben Donges	Provincial	213	307	294	2003	2009
3	Vredenburg (phase 2)	District	56	80	180	2003	2009
4	Paarl	Provincial	250	327	427	2005	2009
5	Khayelitsha	District	0	210	509	2006	2011
6	Mitchells Plain	District	0	210	509	2006	2011
7	Valkenberg	Psychiatric	385	400	618	2006	2011
8	Brooklyn Chest	TB	305	721	452	2008	2011
9	Tygerberg	Central	1273	1199	1998	2008	2013
10	Helderberg	District	121	120	336	2008	2011
11	Victoria	District	159	180	462	2008	2011
12	Mossel Bay	District	90	90	176	2009	2011
13	Hermanus	District	37	60	120	2009	2011
14	Harry Comay	TB	90	169	150	2010	2012
15	Stikland	Psychiatric	371	298	360	2010	2013
16	Swartland (+TB Hospital)	District	85	147	210	2010	2013

Note on cost estimates: In the absence of realistic norms the cost estimates are based on cost per bed of hospitals currently under construction. This is well above the IHPF norm but below Public Works estimates. No escalation has been included.

8. CAPITAL INFRASTRUCTURE PROGRAMME

8.1 Deliverables

The tables that follow indicate the deliverables in the capital infrastructure programme.

8.2 Definitions

Inception:	Health is detailing the need and is drafting a brief for Public Works
Planning:	Public Works have received the brief from Health and are proceeding with the design.
Tender:	Public Works have completed the documentation to tender readiness.
Construction:	Project is under construction.
Start date:	Date of letter of acceptance of tender
Completion date:	Date of practical completion
Duration:	Time from start to completion.

Schedule 1 Capital Projects Funding

No	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2006/7 R000's	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's
1	Atlantis/Wesfleur Ambulance Station	ambulance station	Complete	12	Jun-06	May-07	5 178	3 172	1 663	165		
2	Bonnievale ambulance station	ambulance station	Inception	13	Jun-10	May-11	6 000				500	3 250
3	De Doorns Ambulance Station	ambulance station	Inception	12	Jun-10	May-11	6 000				500	3 500
4	Heidelberg Ambulance Atation	ambulance station	Inception	12	Jun-10	Mar-11	6 000				500	1 900
5	Leeu Gamka Ambulance Station	ambulance station	Inception	12	Jan-09	Jan-10	7 500			135	3 000	3 650
6	Montagu Community Health centre	New CHC	Complete	15	Jul-06	Sep-07	8 300	5 702	2 075	500		
7	Red Cross Hospital	CSSD relocation (Managed by Trust)	Construction	16	Feb-07	Jun-08	8 500			1 700		
8	Red Cross Hospital	Ward upgrade	Planning	12	Apr-08	Mar-09	8 900			7 000	7 000	7 000
9	Simondium Clinic	New Clinic	Complete	16	Jul-06	Nov-07	9 200	2 794	6 464	400		
10	Vredendal Hospital – Ambulance Station	ambulance station	Inception	12	Oct-08	Oct-09	7 800			800	6 500	500
11	Wellington Community Health Centre	New CHC	Construction	22	Aug-06	Jun-08	18 000	2 056		7 300		
12	Unallocated TB Infrastructure	Improvement to TB facilities								10 000	10 000	10 000
	Other completed projects							22 553	6 232			
	Total – new construction							**33 486**	**16 434**	**28 000**	**28 000**	**29 800**

Schedule 2 Provincial Infrastructure Grant

No	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2006/7 R000's	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's
1	Beaufort West	New ambulance station and DMC	Complete	15	Jul-06	Oct-07	11 250	4 147	6 450	500		
2	Beaufort West Hospital	New store	Planning	7	Feb-09	Aug-09	2 000			2 000		
3	Bredasdorp Hospital	Addition and alteration to hospital entrance and store	Planning	6	Jun-08	Dec-08	800			800		
4	Bredasdorp Hospital Ambulance Station	Ambulance station and road upgrade	Complete	18	May-07	Oct-07	1 150	77	860	15		
5	Caledon Hospital – Phase 1	New wards and ambulance station	construction	8	Feb-07	Oct-08	22 400	1 135	7 040	10 960	1 700	
6	Caledon Hospital – Phase 2	Upgrade	Planning	6	Sep-10	Oct-11	8 000					5 500
7	Caledon Hospital	Upgrading of electrical supply	Planning	20	May-08	Oct-08	1 150			1 150		
8	Cape Medical Depot	Upgrade	Complete	14	Jul-06	Sep-07	13 350	7 693	3 866	950		
9	Ceres Hospital – ambulance station	New ambulance Station	Planning	11	Oct-08	Sep-09	6 000			1 750	4 000	250
10	Du Noon Community Health Centre	New CHC	Inception	11	Aug-09	Jul-10	18 000					5 000
11	Eerste River Hospital	New casualty	Planning	4	May-08	Aug-09	20 780			11 910	7 220	700
12	Grassy Park Clinic	New clinic	Planning	11	Nov-08	Oct-09	8 500			1 000	7 000	500
13	Groote Schuur Hospital	Interim improvements	Inception	12	Apr-10	Mar-11	1 019					1 019
14	Groote Schuur Hospital	E-Floor toilets management suite & relocate dietetics	Planning	10	Aug-08	May-09	5 300		20	4 300	1 000	
15	Groote Schuur Hospital	Upgrade security	Inception	12	Apr-09	Mar-10	5 000				4 000	500

No	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2006/7 R000's	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's
16	Groote Schuur Hospital	Linear accelerator installation	Complete	6	Nov-06	Apr-07	5 704	3 700	1 904	100		
17	Groote Schuur Hospital	NMB fire detection phase 1	Construction	18	Oct-06	Apr-08	12 300	3 500	8 100	600	100	
18	Groote Schuur Hospital	NMB fire detection phase 2	Planning	24	Apr-09	Mar-11	11 000			700	1 129	9 171
19	Groote Schuur Hospital	Upgrade pharmacy store	Planning	7	Apr-09	Oct-09	2 000			150	1 850	
20	Groote Schuur Hospital	Ugrade D23 department anaesthesia	Planning	8	Apr-08	Nov-08	1 000			1 000		
21	Groote Schuur Hospital	Lift upgrading	Complete	10	Jan-07	Oct-07	2 726	200	1 926	600		
22	Groote Schuur Hospital	Upgrade trauma security	Inception	8	Apr-09	Nov-09	2 000				2 000	
23	Groote Schuur Hospital	Out-patient department upgrading	Planning	7	Nov-08	Jun-09	2 000			600	1 400	
24	Groote Schuur Hospital	Masterplan for place utilisation	Planning	12	Apr-08	Mar-09	1 000			1 000		
25	Hermanus Ambulance Station	Ambulance station	complete	9	Oct-06	Jul-07	5 780	1 318	3 362	780		
26	Hermanus Community Health Centre	New CHC	Inception	20	Oct-10	Jun-12	18 000				1 000	10 000
27	Hermanus Hospital	New ward, OPD & admin	Inception	27	Jun-09	Oct-11	40 000			1 000	4 000	19 000
28	Helderberg Hospital	New OPD & wards	Construction	9	Oct-07	Jul-08	16 470	727	5 660	12 170	750	
29	Karl Bremer Hospital	Trauma upgrade	Inception	17	Feb-09	Jun-10	15 000				5 230	2 500
30	Khayelitsha Clinic	New clinic	Inception	22	Apr-10	Mar-12	18 000				1 000	15 000
31	Knysna Hospital	Upgrade casualty & new OPD	Inception	18	Jun-10	Jan-12	16 000				500	4 691
32	Knysna – Witlokasie Community Health Centre	New community health centre	Inception	16	Jul-10	Nov-11	18 000				500	5 500

No	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2006/7 R000's	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's
33	Lamberts Bay Hospital Ambulance Station	Ambulance station upgrade	Planning	7	Apr-08	Nov-08	1 600			1 200	400	
34	Maitland Community Health Centre	New CHC	Inception	14	Apr-10	Jun-11	18 000				1 200	13 750
35	Malmesbury – Wesbank Community Health Centre	New CHC	Planning	15	Mar-09	Jun-10	18 000			1 235	11 000	3 500
36	Mitchell's Plain Community Health Centre	Trauma and pharmacy upgrade	Planning	18	Aug-08	Feb-10	15 000			6 300	8 000	700
37	Mitchell's Plain Community Health Centre	New community health centre	Inception	14	Oct-09	Dec-10	18 000				10 000	4 500
38	Mowbray Maternity Hospital	Hospital upgrading	Complete	30	Sep-04	Mar-07	56 000	14 727	3 652	200		
39	Oudtshoorn Hospital Ambulance Station	Ambulance station upgrade	Complete	8	Nov-06	Jun-07	1 114	74	1 000	40		
40	Oudtshoorn Medical Depot	Relocation of the medical depot	Complete	9	Oct-06	Jul-07	3 404	4	3 200	200		
41	Plettenberg Bay Kwanokuthula Ambulance Station	New ambulance station	Inception	10	Mar-11	Feb-12	6 000					500
42	Plettenberg Bay Kwanokuthula Community Health Centre	New CHC	Planning	11	Oct-08	Sep-09	18 000			5 700	12 000	3 800
43	Riversdale Hospital	Phase 1 upgrade.	Complete	10	Jan-07	Oct-07	5 595	760	4 735	100		
44	Riversdale Hospital	Phase 2 upgrade.	Planning	17	Apr-08	Sep-09	16 600			12 000	4 600	
45	Robbie Nurock Clinic	Replacement clinic	Inception	17	Jun-10	Nov-11	18 000				1 200	6 500
46	Stanford Clinic	New Clinic	Complete	11	Jul-06	Jun-07	5 748	3 688	1 960	100		
47	Stellenbosch Hospital	Casualty upgrade	Inception	12	Apr-10	Mar-11	6 435				500	5 500
48	Tygerberg Hospital	Fire door upgrade phase 1	Complete	14	May-06	Jul-07	3 400	6 000	531	200		
49	Tygerberg Hospital	Fire door upgrade phase 2	Planning	4	Jul-08	Nov-09	4 000			2 000	2 000	

No	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2006/7 R000's	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's
50	Tygerberg Hospital	Interim Improvement: Psychiatric ward upgrade	Planning	24	Apr-09	Mar-11	5 200			2 000	2 200	1 000
51	Tygerberg Hospital	Kitchen upgrade	Planning	12	Mar-09	Apr-10	15 000			1 200	12 400	1 000
52	Tygerberg Hospital	Helipad	Planning	7	Apr-08	Nov-08	500			500		
53	Tygerberg Hospital	Lift upgrading Block 22, Block 21, Block 53	Planning	12	May-08	Apr-09	6 400			5 800	600	
54	Vredendal Hospital	X Ray and CSSD upgrade/ construction	Construction	12	May-06	Apr-08	6 733	1 735	3 998	1 000		
55	Other completed projects							15 302	21 998			
	Total							**64 056**	**80 262**	**93 810**	**110 479**	**120 081**

Schedule 3: Hospital Revitalisation

No	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2006/7 R000's	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's
1	George – final phase	Hospital	Planning	24	Jan-09	Jul-10	94 780	15 665	10 691	13 300	42 000	17 000
2	Khayelitsha	Hospital	Planning	36	Oct-08	Sep-11	480 000	15 734	5 000	59 000	105 000	110 000
3	Mitchells Plain	Hospital	Planning	36	Mar-09	Feb-12	480 000	10 991	2 462	33 265	100 000	105 000
4	Paarl Hospital	Hospital	Construction	39	Apr-06	Jun-09	370 000	48 524	101 516	116 378	107 016	16 000
5	Paarl TC Newman CHC	CHC	Planning	10	Jan-09	Nov-09	11 000			2 000	8 000	1 000
6	Valkenberg	Hospital	Inception	78	Oct-08	Mar-15	550 000	5 277	2 990	11 300	55 000	66 000
7	Vredenburg – CHC	CHC	Planning	15	Jul-09	Sep-10	18 000				3 000	15 000
8	Vredenburg – phase 2	Hospital	Planning	16	Jan-09	Jun-10	92 000	14 626	11 984	20 384	22 335	65 965
9	Worcester Hospital	Hospital	Construction	67	Jun-03	Dec-08	243 400	57 476	53 535	31 000	8 800	1 000
10	Worcester Hospital: New phase	Hospital	Planning	13	May-08	May-09	23 220			13 000	10 220	
11	Worcester DMC	DMC	Construction	10	Nov-06	Aug-08	10 900		3 537	7 000	400	
12	Brooklyn Chest	Hospital	Inception	48	Oct-10	Sep-14	460 000				5 000	17 000
13	HRP under and over spend									86 761	(86 761)	
14	HRP Head Office								4 000	7 000	7 000	7 000
15	Other sites HMQIG							6 044				
	Total – HRP							**174 337**	**195 715**	**400 388**	**387 010**	**420 965**

Notes:

1. Funding for the construction of the Mitchell's Plain, Khayelitsha and Valkenberg Hospitals has not yet been secured.
2. The above table reflects the MTEF budget.
3. An amount of R 86 761 will be requested for roll over into 2009/10 to help with projected overspend

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: Upgrade of the forensic and pathology service

No	Name of the Project	Type of infrastructure	Current project stage	Project duration months	Start target date	Completion target date	Estimated Total cost	2007/08 R'000	2008/09 R'000	2009/2010 R'000	2010/11 R'000
1	Beaufort West New FPL	FPS Laboratory	Inception	12	Apr-08	Mar-09	4 000				
2	Cape Town Metro – Salt River replacement FPL	FPS Laboratory	Inception	24	Apr-08	Mar-10	70 000	119	6 216	2 536	4 038
3	Cape Town Metro – Upgrade of Tygerberg FPL	FPS Laboratory	Inception	24	Apr-08	Mar-11	70 000				
4	George – new FPL	FPS Laboratory	Construction	16	Jan-07	Apr-08	15 006	1 415			
5	Hermanus – new FPL	FPS Laboratory	Construction	13	Jan-07	Mar-08	11 929	771			
6	Knysna – new FPL	FPS Laboratory	Inception	18	Apr-10	Aug-11	12 800				
7	Laingsburg – new FPL	FPS Laboratory	Inception	12	Apr-09	Mar-10	4 840				
8	Malmesbury – new FPL	FPS Laboratory	Construction	13	Sep-07	Sep-08	11 853				
9	Mossel Bay new FPL	FPS Laboratory	Inception	18	Apr-09	Aug-10	11 000				
10	Oudtshoorn new FPL	FPS Laboratory	Inception	12	Apr-11	Mar-12	14 641				
11	Paarl TC Newman – new FPL	FPS Laboratory	Construction	14	Mar-07	May-08	14 905	883			
12	Riversdale new FPL	FPS Laboratory	Inception	12	Apr-08	Mar-09	4 000				
13	Stellenbosch – new FPL	FPS Laboratory	Inception	18	Apr-10	Aug-11	14 000				
14	Swellendam – new FPL	FPS Laboratory	Inception	12	Apr-11	Mar-12	8 989				
15	Vredenburg – new FPL	FPS Laboratory	Inception	12	Apr-08	Mar-09	9 260				
16	Vredendal – FPL upgrade	FPS Laboratory	Construction	6	Oct-07	Mar-08	2 000				
17	Wolseley – new FPL	FPS Laboratory	Inception	12	Apr-11	Mar-12	8 989				
18	Worcester – New FPL	FPS Laboratory	Construction	14	Mar-07	May-08	15 289	950			
	Total – new construction							**4 138**	**6 216**	**2 536**	**4 038**

Notes:
1. Money not spent in '2007/8 will be requested for roll over in 2008/9.

Schedule 5: Recurrent Maintenance

Name of the project/Programme	Type of infrastructure	Brief need/ proposed outcome	2007/08 R'000	2008/09 R'000	2009/10 R'000	2010/11 R'000
Vote 6 : Health	Community health facilities	Maintain serviceability	9 130	9 678	9 678	10 650
	District hospitals	Maintain serviceability	10 000	11 000	12 000	13 200
	Provincial hospitals	Maintain serviceability	20 928	21 725	22 533	24 770
	Central hospitals	Maintain serviceability	36 139	37 794	38 716	42 600
	Other facilities	Maintain serviceability	4 000	5 000	6 000	6 600
TOTAL			**80 197**	**85 197**	**88 927**	**97 820**

PROGRAMME 1: ADMINISTRATION

Table C1.1: Administration

Strategic Objective	Measurable Objective	Performance Measure/ Indicator	2006/07 Actual	2007/08 Estimate	2008/09 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Sub-programme 1.2:	**Management**		**Strategic Goal:** To conduct the strategic management and overall administration of the Department of Health						
To formulate policy and provide overall management and administrative support to the Department and the respective districts and institutions within the Department.	Implementation of HIS at all contracted hospitals.	Percentage of hospitals where the HIS has been implemented.	35% (14/41)	50% (20/41)	60% (24/41)	52% (21/41)	54% (22/41)	56% (23/41)	60% (24/41)
	Up-to-date asset register at all hospitals.	Percentage of hospitals with up to date asset register.	95%(39/41)	95%(39/41)	100%(41/41)	Not measured quarterly			
	All institutions with an up to date asset register.	Institutions with up to date asset register. (15)	100%(15/15)	100%(15/15)	100%(15/15)	Not measured quarterly			
	Reduction of the number of dues out at the CMD.	Number of items on dues out at the CMD<50.	<50	<50	<50	<50	<50	<50	<50
	Quality Assurance		**Strategic goal:** To render a support service to all institutions, regions and the department in order to ensure improved quality of care and the reduction of service, thus providing a safe standard of care.						
To systematically monitor and evaluate the quality of service delivery.	The percentage of facilities that have conducted an annual client satisfaction survey (CSS) per level of care.	Number of facilities which have conducted a CSS/ number of facilities.	30% (28/94)	51% (50/96)	75% (72/96)	11% (11/96)	19% (18/96)	28% (27/96)	17% (16/96)
	The percentage of regional offices which submit complaints and compliments returns.	Number of regional offices and facilities that submitted quarterly complaints and compliment returns/ number of regional offices and facilities.	83% (94/113)	100% (110/110)	100% (110/110)	100% (110/110)	100% (110/110)	100% (110/110)	100% (110/110)
	Complaints resolved rate	Number of complaints resolved / total number of complaints.	75% (2,262 / 3,014)	75% of complaints received	75% of complaints received	75% of complaints received	75% of complaints received	75% of complaints received	75% of complaints received
	Clinical audit rate	Number of facilities conducting clinical audits/ total number of facilities.	34% (32/94)	32% (31/96)	38% (36/96)	39% (37/96)	34% (33/96)	36% (35/96)	38% (36/96)

Notes:
1. Indicator extracted from Table 8.7 [HFM5] as this function is managed from Programme 1 and not Programme 8.
2. The APP format prescribes: Health districts with up-to-date PHC asset register, excluding hospitals. It is not possible to provide this information therefore the indicator has been amended to: All Other components excluding hospitals with up to date asset register.

Table C1.2: Situational analysis and projected performance for human resources (excluding health sciences and training) [Hr3]

Sub-programme 1.2.1	Administration	Strategic goal:	The recruitment and retention of an appropriate workforce for the Department of Health.								
Strategic objective	**Measurable objective**	**Performance Measure/Indicator**	**Type**	**2006/07**	**2007/08**	**2008/09**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**National target 2007/08**
To have an effective and efficient and skilled workforce	Provide sufficient staff with appropriate skills per occupational group	1. Medical officers per 100 000 people	No	37	37	37	Annual Targets				18.7
		2. Medical officers per 100 000 people in rural districts	No	13	13	13					12.2
		3. Professional nurses per 100 000 people	No	100	100	100					105
		4. Professional nurses per 100 000 people in rural districts	No	70	80	80					92.5
		5. Pharmacists per 100 000 people	No	10	15	15					34
		6. Pharmacists per 100 000 people in rural districts	No	8	12	12					24
		Process									
		7. Vacancy rate for professional nurses	%	15%	13%	13%	Annual Targets				15
		8. Attrition rate for doctors	%	25%	20%	20%					25
		9. Attrition rate for professional nurses	%	12%	10%	10%					25
		10. Absenteeism for professional nurses	%	3%	2.7%	2.7%					5
		11. Hospitals with employee satisfaction survey	%	60%	65%	65%					50
		Efficiency									
		12. Nurse clinical workload (PHC)	No	35	35	35	Annual Targets				
		13. Doctor clinical workload (PHC)	No	50	50	50					
		Outcome									
		14. Supernumerary staff as a percentage of establishment	%	0	0	0	Annual Targets				

NOTES:
1. Excludes Local Government personnel.
2. Excludes sessions, periodical and extraordinary appointments.
3. Absenteeism is calculated: Persons*261 / days sick leave * 100
4. Doctors = medical officers, specialists, registrars and medical superintendents
5. 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
6. Since July 2004, unfunded posts within the Department of Health have been abolished or frozen and the information for indicators 11, 12 and 13 would not be a true reflection of the real service need in terms various occupational classes. Furthermore the information is not obtainable from PERSAL.
7. 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 is only available for the 2006/07 financial year.
8. 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.
9. The indicators regarding pharmacists confirm the shortage of this category of personnel in the Province.
10. Attrition rate for doctors (Indicator 8) and professional nurses (Indicator 9) excludes with effect from 2007/08 terminations on contract. If the latter is included it inflates the attrition figure which does not reflect the true situation.

PROGRAMME 2: DISTRICT HEALTH SERVICES

Table C2.1: District Health Services [DHS 5, 6, 7]

Strategic objectives	Measurable objectives		Performance measure / indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Sub-programmes 2.1 - 2.3	**Strategic goal: In line with CSP targets, transform the DHS in order to ensure that the full package of good quality DHS services is delivered in all the districts of the Western Cape**									
To allocate sufficient resources to render the full package of PHC services	Allocate sufficient funds per uninsured person to sustain an average 3.87 usage rate per annum.	1	Provincial PHC expenditure per uninsured person[1]	R259	R292	R319	R319	R319	R319	R319
		2	Total PHC headcount per annum	12 180 933	12 820 136	13 384 235	3 346 059	3 346 059	3 346 059	3 346 059
		3	PHC utilisation rate (per uninsured person)	3.09	3.17	3.22	3.22	3.22	3.22	3.22
		4	PHC utilisation rate per capita	2.31	2.36	2.40	2.40	2.40	2.40	2.40
		5	PHC utilisation rate - under 5 years (uninsured person)	4.80	5.00	5.00	5.00	5.00	5.00	5.00
		6	Percentage of sub-districts offering the full package of PHC services	100%	100%	100%	100%	100%	100%	100%
	Ensure the efficient and quality delivery of the full package of PHC services.	7	Percentage fixed PHC facilities supported by a doctor at least once a week	Not available	81%	100%	100%	100%	100%	100%
		8	Supervision rate	71.8%	60.0%	100.0%	100%	100%	100%	100%
		9	Expenditure per PHC head count - Province[1]	R84	R92	R99	R99	R99	R99	R99
To establish decentralised management capacity in all six districts*	Establish a fully functional DHS management office in each of the districts by 2010.	10	The number of DHS offices created in the province	3	5	6	Annual target	Annual target	Annual target	Annual target
	Establish fully functional sub structure management structures in the metro by 2010	11	The number of DHS sub structure offices created in the metro.	-	4	4	Annual target	Annual target	Annual target	Annual target
To ensure the provision of accessible good quality district health services	Increase access to emergency care.**	12	Number of CHCs with a designated emergency units implementing the South African Triage System at all times of service delivery	-	9	15	Annual target	Annual target	Annual target	Annual target
		13	Percentage of of district hospitals implementing the South African Triage System at all times of service delivery	-	-	100%	100%	100%	100%	100%
		14	Percentage of towns with populations of more than 5000 that have access to an emergency service 24 hours a day that is less than 5km away from their home	N/A	N/A	50%	Annual target	Annual target	Annual target	Annual target
	Improve the access to PHC clinic services by extending the service hours of the community health services (CHC) in the Cape Town Metro.	15	The number of CHCs in the Metro offering nurse based extended hours to 21h30 weekdays and 8h00 to 12h00 on weekends	-	9	11	Annual target	Annual target	Annual target	Annual target
	Ensure clinical governance and quality of district health services in all six districts by 2010.	16	The number of Family Medicine registrars employed in District Hospitals	-	20	40	Annual target	Annual target	Annual target	Annual target
		17	The number of district hospitals with appointed clinical operations officers (COOs)/family physicians	-	8	20	Annual target	Annual target	Annual target	Annual target

Strategic objectives	Measurable objectives		Performance measure / indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4
To ensure the provision of accessible good quality district health services	Ensure clinical governance and quality of district health services in all six districts by 2010.	18	The number of CHCs and district hospitals with a functioning Maintenance of Competencies Programme (MOCOMP)	11	20	30	Annual target	Annual target	Annual target	Annual target
To improve information management systems.	Computerise and network with all CHCs) to ensure the maintenance of effective information management systems by 2010.	19	The number of networked CHCs with access to the primary health care information system (PHCIS) and the provincial intranet.	23	33	54	Annual target	Annual target	Annual target	Annual target
Strategic goal:	**To implement a comprehensive community-based service package in all sub-districts of the Western Cape.**									
To provide home-based care for prioritised clients in need of care	Implement exit strategy for EU partnership funding.	20	Number of PGWC funded posts in districts and sub-districts previously funded by EU	-	37	37	Annual target	Annual target	Annual target	Annual target
	Increase the number of NPOs contracted by the Department.	21	Number of NPOs funded by the Department.	85	90	110	90	110	110	110
	Increase the number of NPO appointed home carers.	22	Total number of NPO appointed home carers	1 100	1 300	2 300	1 800	2 100	2 200	2 300
	Increase number of home-based care clients seen.	23	Total number of clients seen	11 000	13 000	23 000	5 750	5 750	5 750	5 750
	Improve referral of clients from hospitals to HBC programme.	24	Number of Hospital referrals	N/A	7 200	8 200	2 050	2 050	2 050	2 050
	Improve referral of clients from PHC to the integrated HBC programme.	25	Number of PHC referrals (home-based care, TB DOTS, mental health, chronic disease and ARV Adherence clients)	N/A	N/A	14 800	3 700	3 700	3 700	3 700
To provide in-patient palliative care to prioritised clients in need of care	Sustain the funding of palliative care beds.	26	Number of palliative beds	254	269	269	269	269	269	269
	Ensure bed utilization to full capacity.	27	Number of In-patient days	74 168	83 457	83 457	20 864	20 864	20 864	20 864
		28	Bed occupancy rate	80.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
To provide sub-acute care to prioritised clients in need of care	Increase the number of sub-acute care beds.	29	Number of usable beds (adult)	84	84	84	84	84	84	84
		30	Number of usable beds (paediatrics)	60	60	60	60	60	60	60
		31	Number of In-patient days (adult)	16227 Global funding only	24 480	34 884	8 721	8 721	8 721	8 721
		32	Number of In-patient days (paediatrics)	18 360	18 360	18 360	4 590	4 590	4 590	4 590
	Ensure beds are used to full capacity.	33	Bed occupancy rate	80%	85%	85%	85%	85%	85%	85%

Strategic objectives	Measurable objectives		Performance measure / indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4
To provide chronic care to prioritised clients in need of long-term care	Increase the number of mental health clients in community mental health programmes.	34	Number of clients in community mental health programmes	N/A	1 481	1 681	1 681	1 681	1 681	1 681
	Provide in-patient chronic care to all patients in need of long-term care.	35	Number of usable beds (qdult)	280	280	280	280	280	280	280
		36	Number of usable beds (paediatrics)	114	114	114	114	114	114	114
To implement care and support programmes for people living with HIV/AIDS.	Transfer funding to district.municipalities in order to fund CBOs that are implementing HIV related projects	37	Number of MSAT projects funded via Global Fund	160	274	343	343	343	343	343
Strategic goal:	**Improve Chronic Disease Management**									
To effect the shift of appropriately identified patients to access appropriate services closest to their place of residence	Increase number of CDM clients receiving medication in a shorter time.	38	Number of patients with prescriptions issued for chronic medication through an alternative supply system	700 000	720 000	730 000	182 500	182 500	182 500	182 500
		39	Number of patients receiving medication through non-health sites (accredited NPOs)	N/A	N/A	8 000	2 000	2 000	2 000	2 000
		40	Number of patients receiving medication through home-delivery (via courier, adherence supporters)	N/A	N/A	4 000	1 000	1 000	1 000	1 000
		41	Number of CDM clients shifted from levels 1, 2 and 3 to PHC	N/A	10 000	20 000	5 000	5 000	5 000	5 000
To implement a clinical governance system for chronic diseases	Implement a coherent strategy for chronic disease management	42	Number of CHCs undertaking annual clinical audits for the management of cardiovascular risk factor management	N/A	38	40	40	40	40	40
Sub-programme 2.9 Strategic goal:	**To render the full package of district hospital services in all the districts of the Western Cape**									
To provide sufficient capacity to render quality in-patient and out-patient services in district hospitals	Provide sufficient theatre capacity and resources at district hospitals to perform caeserean sections at a rate of 10-15%	43	Caesarean section rate for district hospitals (caesarean sections/total deliveries)	14.3%	12.0%	13.0%	13.0%	13.0%	13.0%	13.0%
	Provide sufficient resources to rendering of out-patient services at a target rate of one out-patient per in-patient day	44	Total patient day equivalents (PDEs) in district hospitals	661 655	1 019 460	1 007 400	251 850	251 850	251 850	251 850
		45	OPD Total head count (Number of OPD head count + Trauma/emergency/ casualty)	695 108	822 150	755 550	188 888	188 888	188 888	188 888
	Implement quality assurance measures to minimise patient risk	46	Percentage of district hospitals with patient satisfaction survey using DoH template	36%	70%	100%	100.0%	100.0%	100.0%	100.0%
		47	Percentage of district hospitals with Mortality and Morbidity meetings every month	21%	60%	70%	70.0%	70.0%	70.0%	70.0%
		48	Percentage of district hospitals with Clinical audit meetings at least once a month	Not requested prior to 2007/08	60%	70%	70.0%	70.0%	70.0%	70.0%

Strategic objectives	Measurable objectives		Performance measure / indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		49	Percentage complaints resolved within 25 days (=total complaints resolved in all hospitals within 25 days/ total complaints received)	Not requested prior to 2007/08	-	90.0%	90.0%	90.0%	90.0%	90.0%
		50	Case fatality rate in district hospitals for surgery separations (total surgery fatalities/total operations)	0.8%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
To ensure the effective and efficient rendering of sustainable dis trict hospital services	Manage bed utilisation to achieve an average length of stay of approximately 3 days and a bed occupancy rate of 85% in district hospitals	51	Average length of stay in district hospitals	2.80	3.56	3.30	3.30	3.30	3.30	3.30
		52	Bed utilisation rate (based on useable beds) in district hospitals	71.7%	97.3%	90.0%	90.0%	90.0%	90.0%	90.0%
		53	Total separations in district hospitals	144 373	212 948	228 955	57 239	57 239	57 239	57 239
	Ensure the cost effective management of dist rict hospitals at a target expenditure of approximately R950 per PDE by 2010	54	Expenditure per patient day equivalent [1]	690	810	905	905	905	905	905
Strategic goal:	**Ensure accessibility to district hospitals in all the districts of the Western Cape**									
To provide sufficient bed capacity to ensure accessibility of district hospital services	Provide a total of 2311 beds in district hospitals by 2010	55	Number of beds in district hospitals	1 570	2 132	2 300	2 300	2 300	2 300	2 300
		56	Number of p atient days in district hospitals	411 569	757 534	755 550	188 887.50	188 887.50	188 887.50	188 887.50
		57	The ratio of total out patient headcount to in-patient days***	1.06	1.09	1.00	1.00	1.00	1.00	1.00
To provi de outreach and support to PHC platform	Provide administrative support and clinical outreach and support to the PHC platform from all district hospitals.	58	Percentage of district hospitals providing administrative support and clinical outreach and support to the PHC platform.	N/A	51%	90%	90%	90%	90%	90%

Table C2.2: HIV and AIDS [HIV 2 & 3]

Strategic objective	Measurable objectives		Performance measure/ indicator	2006/07 (actual)	2007/08 (estimate)	2008/09 (target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal:	**Decrease the number of new infections in the age group 15-24 years [HIV3]**									
To implement an effective prevention strategy	Provide PMTCT services to all pregnant women at 1st Antenatal booking visit	1	Percentage fixed PHC facilities offering PMTCT	74% 213/288	74% 213/288	80% 230/288	80%	805	80%	80%
	Provide VCT services at all fixed PHC facilities in the province	2	Percentage fixed PHC facilities offering VCT	100% 290/290	100% 290/290	100% 290/290	100%	100%	100%	100%
	Provide PEP for occupational exposure at all hospitals in the province	3	Percentage Hospitals offering PEP for occupational HIV exposure	100% 40/40	100% 40/40	100% 40/40	100%	100%	100%	100%
	Provide PEP for sexual assault at al hospitals in the province	4	Percentage Hospitals offering PEP for sexual abuse	100% 40/40	100% 40/40	100% 40/40	100%	100%	100%	100%
	Distribute Male Condoms from all PHC Facilities and non PHC facilities to all adult males 15years and above	5	Male condom distribution rate from public sector health facilities.	34.9	40	50	40	45	50	50
	Issue of STI partner notification slips to all STI clients treated new	6	STI partner treatment rate	19.7%	22%	22%	22%	22%	22%	22%
	Administer Nevirapine to babies of mothers who accepted PMTCT intervention	7	Nevirapine newborn uptake rate	98% 10519/10701	98%	95%	95%	95%	95%	95%
	Administer Nevirapine to HIV positive women in labour who accepted PMTCT intervention	8	Nevirapine uptake- antenatal clients	89.80% 8555/9520	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Provide HIV pre-test and post-test counselling services in fixed PHC facilities	9	Clients HIV pre-test counselled rate in fixed PHC facilities	3% 252 383/ 12 180 933	2% 220 698/ 118 639 06	3% 370 154/ 12 338 462	3%	3%	3%	3%
	Determine HIV testing coverage in adult population	10	HIV testing rate (excluding antenatal)	New indicator	95.5% 210 730/ 220 698	95.5% 35 3479/ 370 154	95.5%	95.5%	95.5%	95.5%
Strategic goal:	**Reduce morbidity and mortality amongst HIV affected persons**									
To provide ART to patients in need	Accredit facilities to provide ART.	11	ART service points registered	50	63	70	65	68	70	70
	Increase number of patients on ART.	12	ART patients- Total registered	26 111	35 863	45 756	37 656	38 732	41 242	45 756
	Improve quality of ART service provision	13	Fixed facilities with any ARV drug stock out	0%	0%	0%	0%	0%	0%	0%
	Accredit facilities to provide ART.	14	% Fixed facilities referring patients to ARV sites for assessment	100% 290/290	100% 290/290	100% 290/290	100%	100%	100%	100%
	Monitor turn around times and engage NHLS as needed.[4]	15	CD4 test at ARV treatment service points with turnaround time > 6 days [4]	Not available	Not available	Not available				
	Monitor expenditure on a monthly basis and variances.	16	Dedicated HIV/AIDS budget spent (Percentage)	103	100	100	100	100	100	100

Strategic objective	Measurable objectives		Performance measure/ indicator	2006/07 (actual)	2007/08 (estimate)	2008/09 (target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic Goal:	**Reduce morbidity and mortality due to TB**									
To strengthen the implementation of the DOTS strategy	Strengthen the TB community DOT Programme.	17	% TB cases with a DOT supporter	84% 75005/ 89155	90%	95%	95%	95%	95%	95%
	Ensure that TB patients remain in care.	18	TB treatment interruption rate	11% 2097/ 18839	10%	9%	9%	9%	9%	9%
	Monitor turn around times and engage NHLS as needed.	19	TB sputa specimens with turnaround time less than 48 hours	67% 23501/ 70664	75%	80%	80%	80%	80%	80%
	Ensure a regular and uninterrupted TB drug supply.	20	New smear positive PTB cases cured at first attempt	71.9% 13477/ 18839	74%	75%	75%	75%	75%	75%
To ensure a standardised TB drug resistant recording and reporting system to monitor progress in the implementation of the M(X)DR-TB Programme	Ensure a standardized TB Drug resistant recording and reporting system to monitor progress s in the implementation of the M(X)DR-TB Programme.	21	New MDR TB cases reported- % annual change	Not available	Not available	Not available				
Strategic Goal :	**Reduce morbidity and mortality amongst HIV affected persons [HIV2]**									
To provide ART to patients in need	Increase number of clients in need of ART starting treatment to 65 000 by 2011.	22	Cumulative number of clients on ART	26 111	35 863	45 756	37 656	38 732	41 242	45 756
		23	Cumulative number of clients on ART via the Conditional Grant	17 180	27 702	38 852	30 472	34 628	37 398	38 852
		24	Cumulative number of clients on ART via the Global Fund	8 931	8 161	6 904	7800	7 200	6 904	6 904
Strategic Goal:	**Decrease the number of new infections in the age group 15-24 years**									
To implement an effective prevention strategy	Increase number of clients tested for HIV to 360 000 by 2011.	25	Number of persons tested for HIV excluding antenatal	245 271	288 000	324 000	81 000	81 000	81 000	81 000
	Train 15 000 peer educators in schools by 2010.	26	Number of badged peer educators via Global Fund	7 967	10 602	15 035	10800	12 000	13 000	15 035
	Distribute 600 000 Female Condoms to designated sites in the province by 2011.	27	Female condom distribution from primary distribution sites	254 426	360 000	400 000	100 000	100 000	100 000	100 000
	Decrease Mother to child HIV transmission to 4% by 2011.	28	PMTCT transmission rate	5.4%	5.0%	4.5%	4.5%	4.5%	4.5%	4.5%
				429/7961						
Strategic Goal:	**Reduce morbidity and mortality due to TB**									
Strengthen the implementation of the DOTS Strategy	Increase routine sputum collection in all TB patients at 2 months to 80% by 2011.	29	Smear conversion rate at 2 months for new smear positive PTB cases	67%	70%	73%	73%	73%	73%	73%

Notes:

1. No. 5: Number of male condoms per male, 15 years and older per year.
2. No.7: Until 2006/07 the Nevirapine administration rate was reported. As from 2006/07 Nevirapine coverage rate was reported. The denominator for the coverage rate for 2006/07 is based on the provincial and region specific sero-prevalance derived from the HIV Antenatal survey.
3. No. 8: In 2003/04 the Nevirapine administration rate to women was calculated as follows: Self administered Nevirapine + NVP in labour / Deliveries on PMTCT programme. In 2004/05 due to a change in protocols the Nevirapine administration rate was changed from NVP administration in labour / PMTCT deliveries transfer in during deliveries.
4. No. 15: This is in the process of being addressed.
5. No.21 Data was systematically collected from 1 January 2007. This indicator will only be available from January 2008. It is estimated that there were 696 MDR cases in the Province in 2007. The annual rate of change in these statistics will be collected from 2008 when there is two years of provincial data to be able to predict the annual rate of change.

Table C2.3: Maternal, child and women's health and nutrition [MCWH & N 2 & 3]

Strategic objective	Measurable Objective		Performance Measure/ Indicator	2006/07 (actual)	2007/08 (estimate)	2008/09 (target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal:	**Reduce child and neonatal mortality**									
To reduce morbidity and mortality from vaccine preventable diseases	Improve child Immunisation status such that at least 90% of all children under one year are fully immunised.	1	Fixed PHC facilities with DTP-Hib vaccine stock out	Not available	6.7	<2%	<2%	<2%	<2%	<2%
		2	Full immunisation coverage under 1 year	92.9% 83 352	93% 84 904	93% 93 750	93%	93%	93%	93%
		3	Measles coverage under 1 year	93.7% 85 543	93% 84 904	93% 93 750	93%	93%	93%	93%
To improve resistance to disease in children <1 year	Increase vitamin A supplementation coverage in children <1year to at least 90%.	4	Vitamin A coverage under 1 year	68.63% 66 419	90% 82 166	89% 90 726	90%	90%	90%	90%
To improve prevention and management of common childhood problems	Facilities implementing IMCI	5	Percentage of fixed PHC facilities implementing IMCI	82% 238	83% 241	84% 287	84%	84%	84%	84%
To improve access of health services to youth	Ensure that at least X% of health services are certified as youth friendly.	6	Fixed PHC facilities certified as youth friendly	Not available	Not available	Not available				
To improve perinatal care to reduce neonatal morbidity and mortality	Increase number of birth units/ facilities with functional Perinatal problem identification programme (PPIP).	7	Percentage of birthing units/ facilities with functional PPIP	Not measured	40% (21/51)	71% (36/51)	71%	71%	71%	71%
To assess the health status of learners grade 1	Schools where phase 1 is implemented	8	Percentage of schools visited to do screening	60% 661/1 102	70% 772/1 102	80% 882/1 102	80%	80%	80%	80%
Strategic goal:	**Improve women's Health**									
To reduce morbidity and mortality in women at risk of cervical cancer	Increase cervical cancer screening coverage in women aged 30 years and over to at least 8%.	9	Cervical cancer screening coverage	6.3%	7.5% 65 050 / 867 338	8.0% 72449 / 905 618				
Strategic goal:	**Decrease Morbidity and Mortality during pregnancy, birth and post delivery**									
To reduce mortality in women as a result of septic abortions	Improve access to TOP services by increasing TOP facilities to 100% of all acute hospitals and 8.5% of CHCs.	10	Percentage of hospitals offering TOP services	85% 32/40	88% 35/40	88% 35/40	100%	100%	100	100%
		11	Percentage of CHCs offering TOP services	5% 3/57	5% 3/57	8.5% 5/60	5%	9%	5%	9%
To increase the number of BFHI facilities	Increase the number of facilities certified as baby friendly to at least 35%.	12	Percentage of facilities certified as baby friendly	19% 55/290	22% 64/290	26% 75/290	22%	23%	25%	26%
To increase access to safe delivery services	Improve facility delivery rate to 95%.	13	Total deliveries in facilities	95 292	83 384	85 000	21250	21 250	21 250	21 250
		14	Facility Delivery rate	New Indicator	94%	95%	95%	95%	95%	95%
	Decrease teenage pregnancy to <10% of all deliveries.	15	Institutional delivery rate for women under 18 years	10.1	10	10	10	10	10	10

Strategic objective	Measurable Objective		Performance Measure/ Indicator	2006/07 (actual)	2007/08 (estimate)	2008/09 (target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
To improve the early antenatal booking rate	Increase antenatal booking rate before 20 weeks to at least 65% by 2011.	16	Percentage of women booking before 20 weeks	37%	45%	50%	50%	50%	50%	50%
	Implement BANC at PHC Clinics/ facilities to 100% by 2011.	17	Percentage of PHC Clinics/ facilities offering BANC	3.0% 10/290	49.0% 142/290	61.0% 178/290	50%	50.0%	50.0%	50.0%
To implement the Saving Mothers(SM) recommendations	Increase number birthing units/ facilities implementing SM recommendations to 95% by 2011.	18	Percentage of birthing units/ facilities implementing SM recommendations	Not measured	Not measured	86% (44/51)	86%	86%	86%	86%
To reduce second trimester TOPs and mortality in women as a result of septic abortions	Decrease number of second trimester TOPs	19	Percentage of second trimester TOPs	Not measured	New indicator	27.0%	27.0%	27.0%	27.0%	27.0%
Strategic goal:	**Improve the nutritional status of prioritised groups**									
To Improve the nutritional status of prioritised groups	Improve the nutritional status of people on ART.	20	Number of ART sites with implementing the NSP	39	44	70	70	70	70	70
	Improve food service management in all public hospitals.	21	Number of facilities scoring above 75% standard	18	23	34	34	34	34	34

Table C2.4: Disease prevention and control [PREV 2 & 3]

Strategic Objectives	Measurable objectives		Performance measure / idicator	2006/07 (actual)	2007/08 (estimate)	2008/09 (target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal:	**Ensure the delivery of a good quality disease control programme in all the districts of the Western Cape .**									
To provide capacity to render disease control services.	Ensure that all districts have at least one trauma centre for victims of violence.	1	Trauma centres for victims of violence (number)	41	41	41	41	41	41	41
	Ensure all districts have a health care waste management plan.	2	Health districts with health care waste management plan implemented (number)	6	6	6	6	6	6	6
To provide programmes for the prevention of occupational diseases.	Increase the percentage of hospitals providing occupational health programme to 100%.	3	Hospitals providing occupational health programmes (percentage)	77%	80%	90%	90%	90%	90%	90%
To ensure the involvement of schools in promoting health	Increase the number of schools implementing Health Promoting Schools Programme.	4	Schools implementing Health Promoting Schools Programme (HPSP) (Percentage)	11.8%	Not available	7%	7%	7%	7%	7%
To be ready to deal with epidemics and disasters	Ensure all districts have an integrated epidemic preparedness and response plan.	5	Integrated epidemic preparedness and response plans implemented (Y/N)	Y	Y	Y	Y	Y	Y	Y
	Ensure adequate outbreak response in line with Provincial guidelines.	6	Outbreaks responded to within 24 hours	New indicator	90%	95%	95%	95%	95%	95%
		7	Malaria fatality rate (percentage)	No malaria	0	0	0	0	0	0
		8	Cholera fatality rate (percentage)	No cholera	0	0	0	0	0	0
Improve the vision of people with cataracts.	Increase the cataract surgery rate to be in line with the national target of 1 400/1million.	9	Cataract surgery rate (no/million population)	1 287	1 400	1 273	Annual Target	Annual Target	Annual Target	Annual Target
		10.	Number of cataract operations.	6 030	6 811	7 100	1 775	1 775	1 775	1 775
Implement the National Health Act provisions dealing with environmental health.	Monitor municipal environmental health services.	11	Percentage of water samples meeting standards	88%	90%	90%	90%	90%	90%	90%
		12	Percentage of sewage effluent samples complying with requirements	60%	65%	70%	70%	70%	70%	70%
		13	Percentage of f ood samples conforming to Act 54/72	78%	80%	85%	85%	85%	85%	85%
		14	Percentage of households with e ffective refuse removal service (minimum of one refuse removal per week)	89%	90%	90%	90%	90%	90%	90%

Table C2.5: Forensic Pathology Services/ Coroner Services

Sub-programme 2.8:	**Forensic Pathology Services**		**Strategic Goal:**	The establishment of a Forensic Pathology Service for the Province that is designed to contribute positively to ensure the development of a just South African Society, to assist with the fight against and prevention of crime, to assist with the prevention of unnatural death, to establish the independence of the medical and related scientists and to ensure an equitable, efficient and cost effective service.						
Strategic objective	**Measurable objective**		Performance measure/indicator	ACTUAL 2006/7	ESTIMATE 2007/8	TARGET 2008/9	Quarter 1	Quarter 2	Quarter 3	Quarter 4
To provide an effective and efficient forensic pathology service in accordance with the statutory requirements	Adequate staffing through the recruitment of personnel in line with the Human Resource Plan	1	Percentage of posts filled according to Human Resource Plan	98% (166/170)	97% (231/239	90% (275/306)	76% (231/306)	79% (241/306)	82% (251/306)	90% (257/306)
	Improved quality of service	2	Percentage of autopsies performed	New indicator implemented during 2007/8 Financial Year Baseline not yet available	New indicator implemented during 2007/8 Financial Year Baseline not yet available	70% 7 000/1 0000)	70% (7 000/1 0000)	70% (7 000/1 0000)	70% (7 000/10000)	70% (7 000/1 0000)
	Improved response time	2	Average response time (from receipt of call to arrival on scene)	New indicator implemented during 2007/8 Financial Year Baseline not yet available	New indicator implemented during 2007/8 Financial Year Baseline not yet available	40 minutes	40 minutes	40 minutes	40 minutes	40 minutes
	Improved quality of service	4	Percentage of personnel budget spent on training	4,9%	2%	2%	0.5%	1.0%	0.25%	0.25%

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

Table C3.1: Emergency Medical Services [EMS 2 & 3]

Strategic Objectives	Measurable objectives		Performance Measure / Indicator	Province wide value 2006/07 (actual)	Province wide value 2007/08 (estimate)	Province wide value 2008/09 (target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal:	**To render effective and efficient pre-hospital emergency services including inter-hospital transfers and patient transport in the Western Cape**									
To ensure there are sufficient resources to render an effective and efficient emergency and patient transport service.	Provide target number of ambulances and patient transporters by 2010.	1	Total number of rostered ambulances	205	222	240	230	235	235	240
		2	Number of rostered ambulances per 1000 people	0.039	0.042	0.044	0.042	0.043	0.043	0.04
		3	Percentage hospitals with patient transporters	0	0	0				
		4	Average kilometres travelled per ambulance (per annum)	71 433	58 651	60 000	Annual Target	Annual Target	Annual Target	Annual Target
		5	Total kilometres travelled by all ambulances	14 643 765	13 020 522	14 400 000	3 600 000	3 600 000	3 600 000	3 600 000
	Provide target number of appropriately trained operational emergency staff.	6	Percentage locally based staff with training in BAA	46%	47% 448/947	42% 460/1 097	Annual Target	Annual Target	Annual Target	Annual Target
		7	Percentage locally based staff with training in AEA	45%	42% 396/947	46% 504/1 097	Annual Target	Annual Target	Annual Target	Annual Target
		8	Percentage locally based staff with training in ALS (Paramedics)	9%	11% 103/947	12% 131/1 097	Annual Target	Annual Target	Annual Target	Annual Target
	Achieve normative response times in Metro and urban areas.	9	Percentage P1 calls (red calls) with a response time of under 15 minutes in an urban area	37.6%	50.0% 41 779/ 83 559	60.0% 51 000/ 85 000	50.0%	50.0%	55.0%	60.0%
		10	Percentage P1 calls (red calls) with a response time of under 40 minutes in a rural area	64.4%	65% 11 415/ 17 562	75.0% 15 000/ 20 000	65.0%	65.0%	70.0%	75.0%
		11	All calls with a response time within 60 minutes	61721	215 862 (57%)	236 000 (59%)	59 000	59 000	59 000	59 000
	Adhere to the prescribed staffing of ambulances.	12	Percentage of operational rostered ambulances with single person crews	0%	0%	0%	0%	0%	0%	0%
	Ensure the effective and efficient use of resources.	13	Percentage of ambulance trips used for inter-hospital transfers	15.0%	21% 79 409/ 378 142	21% 84 000/ 400 000	20%	20%	20%	20%
		14	Percentage green code patients transported by ambulance	34.8%	26% 102 930/ 398 029	30.0% 120 000/ 400 000	30.0%	30.0%	30.0%	30.0%
		15	Cost per patient transported by ambulance.	741.00	866.00	905	Annual Target	Annual Target	Annual Target	Annual Target
		16	Percentage ambulances with less than 200 000 kilometres on the clock		40% 89/222	50% 120/240	40%	42%	45%	50%
		17	Total number of EMS emergency cases	392 395	398 029	400 000	100 000	100 000	100 000	100 000

Strategic Objectives	Measurable objectives		Performance Measure / Indicator	Province wide value 2006/07 (actual)	Province wide value 2007/08 (estimate)	Province wide value 2008/09 (target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal:	**To render effective and efficient pre-hospital emergency services including inter-hospital transfers and patient transport in the Western Cape**									
To improve response times to emergency scenes.	Increase the percentage of emergency calls responded to within 30 minutes to 20% by 2010.	18	Percentage of emergency responses within 30 minutes.	54% 217 869/ 397 002	44% 157 124/ 378 142	50%	45%	45%	47%	50%
	Increase the percentage of telephone calls answered within 12 seconds to 70% by 2010.	19	Percentage of telephone calls answered within 12 seconds.		35% (Metro only 147 911/ 422604)	50%	35%	40%	45%	50%
To improve planned patient transport.	Increase the number of patients transported by	20	The number of patients transported per 1 000 uninsured population.	10.8 37 837/ 3 492	27.7 102 131/ 3 684	28.00	Annual target			
Strategic goal:	**To render effective and efficient pre-hospital emergency services during the FIFA World Cup**									
To strengthen EMS services in order to meet FIFA requirements and standards.	Connect ambulance MDTs and 10 Hospital Emergency Departments IT Systems by 2010..	22	Number of emergency departments with established electronic connectivity	0	0	4	0	0	2	4
	Procure base station trunking radios for 10 Hospital Emergency Departments by 2010.	23	The percentage of hospitals with trunking radios	0	0	50% (5/10)	0	0	20% (2/10)	50% (5/10)
Strategic goal:	**To facilitate clinical governance and coordination of Emergency Medicine within the Emergency Departments of all health insti tutions.**									
To improve quality of care in Emergency Departments.	Implement the Cape Triage Score system in the emergency departments of all hospitals.	24	The percentage of hospitals with implemented and functional CTS		20% 8/39	50% (19/39)	30% (13/39)	40% (16/39)	50% (19/39)	50% (19/50)
	Appoint emergency medicine consultants in key emergency departments and EMS.	25	The number of emergency medicine consultants appointed		1	9	2	4	6	9

PROGRAMME 4: PROVINCIAL HOSPITALS SERVICES

Table C4.1: Sub-programme 4.1: General Hospitals

Strategic Objectives	Measurable objectives		Performance Measure / Indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter1	Quarter2	Quarter3	Quarter4
Strategic goal:	**To render a comprehensive package of general specialist hospital services to the population of the Western Cape**									
To provide sufficient capacity to render quality general specialist services in regional hospitals	Provide sufficient theatre capacity in regional hospitals for the performance of specialist surgical procedures including a target caesarean section rate of 33%.	1	Caesarean section rate for regional hospitals (Percentage = caesarean sections/total deliveries*100)	33.0%	34.3%	33.0%	33.0%	33.0%	33.0%	33.0%
	Provide sufficient resources for the rendering of comprehensive out patient services at a target rate of approximately 1.2 out patients per inpatient day.	2	Patient Day Equivalents (number of PDEs)	942 460	689 988	1 050 258	262 565	262 565	262 565	262 565
		3	OPD Total headcount (OPD + Trauma/casualty/emergency)	807 344	582 207	900 221	225 055	225 055	225 055	225 055
	Implement quality assurance measures to minimise patient risk in regional hospitals.	4	Regional hospitals with patient satisfaction survey using DoH template (percentage of regional hospitals)	100%	100%	100%	Annual Target	Annual Target	Annual Target	Annual Target
		5	Mortality and morbidity meetings every month (percentage of regional hospitals)	100%	100%	100%	100%	100%	100%	100%
		6	Clinical audit meetings every month (percentage of regional hospitals)	Not requested prior to 2007/08	100%	100%	100%	100%	100%	100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved in regional hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	100%	100%	100%	100%	100%	100%
		8	Case fatality rate in regional hospitals for surgery separations (total surgery fatalities/total operations*100)	1.70%	1.80%	1.80%	1.80%	1.80%	1.80%	1.80%
To ensure the effective and efficient rendering of sustainable regional hospital services	Manage bed utilisation to achieve an average length of stay of approximately 4 days and a bed occupancy rate of 85% in regional hospitals.	9	Average length of stay	3.40	3.86	4.00	4.00	4.00	4.00	4.00
		10	Bed utilisation rate (based on usable beds)	99.0%	97.6%	85.0%	84%	83%	86%	86%
		11	Separations - Total [2]	196 904	128 505	187 546	46 887	46 887	46 887	46 887
	Ensure the cost effective management of regional hospitals at a target expenditure of approximately R1500 per PDE by 2010.	12	Expenditure per patient day equivalent[3]	R965	R1 019	R1 440	R1 440	R1 440	R1 440	R1 440
Strategic goal:	**To provide sufficient infrastructure for the rendering of highly specialised hospital services.**									
To provide sufficient bed capacity to render quality general specialist services in regional hospitals	Provide a total of 2503 beds in regional hospitals by 2010.	13	Number of beds in regional hospitals	1 943	1 371	2 418	2 418	2 418	2 418	2 418
		14	Total number of patient days in regional hospitals[2]	697 602	495 919	750 185	186 281	184 130	189 253	190 521

Notes:
1. Comprehensive out-patient services include the headcount at casualty /trauma/ emergency units. However, the CSP does not provide for trauma and emergency units at level 3.
2. Per definition day cases are included in separations and therefore included in the total patient days (Day cases 1 separation = 0.5 in patient day)
3. 2006/07 prices.

Table C4.2: Sub-programme 4.2: TB Hospitals

Strategic Objectives	Measurable objectives	Performance Measure / Indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal:	**To render TB hospital services to the population of the Western Cape**								
To provide sufficient capacity to render quality TB hospital services	Provide sufficient resources to render in-patient and out-patient TB hospital services amounting to approximately 424 000 patient day equivalents (PDE) by 2010.	1 Patient day equivalents (number of PDEs)	306 287	302 604	342 608	85 819	85 819	85 819	85 819
		2 OPD Total headcount	3 839	3 848	4 000	1 000	1 000	1 000	1 000
	Implement quality assurance measures to minimise patient risk in TB hospitals.	3 TB hospitals with patient satisfaction survey using DoH template (percentage of TB hospitals)	100%	100%	100%	Annual Target	Annual Target	Annual Target	Annual Target
		4 Mortality and morbidity meetings every month (percentage of TB hospitals)	100%	100%	100%	100%	100%	100%	100%
		5 Clinical audit meetings every month (percentage of TB hospitals)	100%	100%	100%	100%	100%	100%	100%
		6 Complaints resolved within 25 days (percentage = total complaints resolved in TB hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	100%	100%	100%	100%	100%	100%
To ensure the effective and efficient rendering of sustainable TB hospital services	Manage bed utilisation to achieve an average length of stay of approximately 100 days and an optimum bed occupancy rate of 90% in TB hospitals by 2010.	7 Average length of stay	76.0	75.0	80.0	75.0	78.0	80.0	85.0
		8 Bed utilisation rate (based on usable beds)	83%	84%	85%	84%	84%	85%	87.0%
		9 Total separations	4 006	4 140	4 266	1 066	1 066	1 066	1 066
	Ensure the cost effective management of TB hospitals at a target expenditure of approximately R320 per PDE.	10 Expenditure per patient day equivalent[1]	R249	R331	R330	R330	R330	R330	R330
Strategic goal:	**To provide sufficient infrastructure for the rendering TB hospital services.**								
To provide sufficient bed capacity to render quality TB hospital services	Provide a total of 1 287 beds in TB hospitals by 2010	11 Number of beds in TB hospitals	1 008	1 008	1 100	1 100	1 100	1 100	1 100
		12 Total number of patient days	305 008	310 427	341 275	84 315	84 315	85 319	87 326

Note
1. 2006/07 prices

Table C4.3: Sub-programme 4.3: Psychiatric Hospitals

Strategic Objectives	Measurable objectives		Measure / Indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter1	Quarter2	Quarter3	Quarter4
Strategic goal:	**To render specialist psychiatric hospital services to the population of the Western Cape**									
Provide sufficient capacity to render comprehensive specialist psychiatric hospital services	Provide sufficient resources for the rendering of comprehensive specialist psychiatric hospital services to in patients and out patients amounting to approximately 584 000 patient day equivalents per annum by 2010	1	Patient Day Equivalents (Number of PDEs)	647 315	636 366	627 405	156 851	156 851	156 851	156 851
		2	OPD Total headcount	20 573	18 516	16 664	4 166	4 166	4 166	4 166
	Implement quality assurance measures to minimise patient risk in specialist psychiatric hospital services	3	Patient satisfaction survey using DoH template (Percentage of specialist psychiatric hospitals)	100%	100%	100%	Annual Target: 100%			
		4	Mortality and Morbidity meetings every month (Percentage of specialist psychiatric hospitals)	100%	100%	100%	100%	100%	100%	100%
		5	Clinical audit meetings every month (Percentage of specialist psychiatric hospitals)	Not requested prior to 2007/08	100%	100%	100%	100%	100%	100%
		6	Complaints resolved within 25 days (Percentage = total complaints resolved in specialist psychiatric hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	100%	100%	100%	100%	100%	100%
Ensure the effective and efficient rendering of sustainable specialist psychiatric hospital services.	Manage bed utilisation to achieve an average length of stay of approximately 130 days and a bed occupancy rate of 90% by 2010	7	Average length of stay	129.7	129.0	130.0	130.0	130.0	130.0	130.0
		8	Bed utilisation rate (based on useable beds)	86%	88%	90%	90%	90%	90%	90%
		9	Separations - Total	4,907	4,885	4,783	1,196	1,196	1,196	1,196
	Ensure the cost effective management of specialist psychiatric hospitals at a target expenditure of approximately R600 per PDE	10	Expenditure per patient day equivalent[1]	R464	R506	R556	R556	R556	R556	R556
Strategic goal:	**Provide sufficient infrastructure for the rendering of specialist psychiatric hospital services**									
Provide sufficient bed capacity to render quality specialist psychiatric hospital services.	Provide a total of 1763 beds in specialist psychiatric hospitals by 2010	11	Number of beds in specialist psychiatric hospitals	2,015	1,962	1,893	1,893	1,893	1,893	1,893
		12	Total number of patient days	639,948	630,194	621,851	155,463	155,463	155,463	155,463

Notes:
1. 2006/07 prices

Table C4.4: Sub-programme 4.4: Rehabilitation services

Strategic Objectives	Measurable objectives		Measure / Indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter1	Quarter2	Quarter3	Quarter4
Strategic goal:	**To render comprehensive high intensity rehabilitation services to the population of the Western Cape at the Western Cape Rehab ilitation Centre**									
To provide sufficient capacity to render comprehensive high intensity rehabilitation services	Provide sufficient resources to render high intensity rehabilitation services to in-patients and out-patients amounting to approximately 53 000 patient day equivalents per annum by 2010.	1	Patient day equivalents (number of PDEs)	47 130	50 833	53 079	13 270	13 270	13 270	13 270
		2	OPD total headcount	5 206	5 228	5 500	1 375	1 375	1 375	1 375
	Implement quality assurance measures to minimise patient risk in the WCRC.	3	Patient satisfaction survey using DoH template (percentage of chronic hospitals)	100%	100%	100%	Annual Target: 100%			
		4	Mortality and morbidity meetings every month (percentage of chronic hospitals)	100%	100%	100%	100%	100%	100%	100%
		5	Clinical audit meetings every month (percentage of chronic hospitals)	0%	100%	100%	100%	100%	100%	100%
		6	Complaints resolved within 25 days (percentage = total complaints resolved in chronic hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	100%	100%	100%	100%	100%	100%
To ensure the effective and efficient rendering of sustainable high intensity rehabilitation services.	Manage bed utilisation to achieve an average length of stay of approximately 45 days and a bed occupancy rate of 90% by 2010.	7	Average length of stay	43.3	48.1	45.0	45.0	45.0	45.0	45.0
		8	Bed utilisation rate (based on usable beds)	80%	86%	90%	90%	90%	90%	90%
		9	Total separations	1 049	1 020	1 139	1 139	1 139	1 139	1 139
	Ensure the cost-effective management of the Western Cape Rehabilitation Centre at a target expenditure of approximately R1 800 per PDE.	10	Expenditure per patient day equivalent[1]	R1 171	R1 441	R1 728	R1 728	R1 728	R1 728	R1 728
Strategic goal:	**To provide sufficient infrastructure to render high-intensity rehabilitation services at the Western Cape Rehabilitation Centre**									
To provide sufficient bed capacity at the WCRC to render high intensity rehabilitation services	Provide a total of 156 beds in the WCRC by 2010.	11	Number of beds in WCRC	156	156	156	156	156	156	156
		12	Total number of patient days	45 395	49 090	51 246	12 812	12 812	12 812	12 812
Strategic goal:	To render orthotic and prosthetic services to orthopaedic clinics									
To render an orthotic and prosthetic service for the province	Manage a combination of in-house and out-sourced services.	13.	Number of orthotic and prosthetic devices manufactured.	4 467	5 000	6 300	1 575	1 575	1 575	1 575
To provide quality orthotic and prosthetic services	Train and liaise with physiotherapists and occupational therapists.	14	Percentage of orthotic and prosthetic devices requiring remanufacture.	2% 89/4 467	2% 100/5 000	2% 126/6 300	2%	2%	2%	2%
To provide a responsive orthotic and prosthetic service	Increase productivity and outsourcing where cost effective.	15	758	758	600	450	113	113	113	113

Notes:
1. 2006/07 prices

Table C 4.5: Sub-programme 4.5: Dental training hospitals

Strategic Objective	Measurable Objective	Performance Measure / Indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal:	**To establish an effective and efficient dental service delivery platform with s ufficient resources for the teaching and training of dental professionals.**								
To provide sufficient capacity to render quality dental services	Provide sufficient resources to render in-patient services and out-patient hospitals services.	Number of patient visits per annum	195 203	189 689	193 800	48 450	48 450	48 450	48 450
		Number of theatre cases per annum	1 500	1 700	1 900	475	475	475	475
		Number of patients provided with dentures per annum	1 335	1 385	1 410	353	353	353	353
To provide sufficient resources for the teaching and training of dental professionals	Optimise the number of students trained on the platform per annum.	Number of students graduating per annum	216	200	200	Annual Target	Annual Target	Annual Target	Annual Target

PROGRAMME 5: CENTRAL HOSPITALS (HIGHLY SPECIALISED SERVICES)

Table C5.1: Central Hospitals

Strategic goal:	**To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant**								
Strategic Objectives	**Measurable objectives**	**Measure / Indicator**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarean section rate of 36%	1 Caesarean section rate (percentage = caesarean sections/total deliveries*100)	36%	36%	43%	43%	43%	43%	43%
	Provide sufficient resources to render comprehensive highly specialised out-patient services at a target rate of 1.1 out-patient per in-patient day[1]	2 Patient Day Equivalents (number of PDEs)	1 117 316	1 053 565	604 486	151 122	151 122	151 122	151 122
		3 OPD Total head count (number of head count at L3 OPD clinics)	964 193	1 116 742	486 538	121 635	121 635	121 635	121 635
	Implement quality assurance measures to minimise patient risk in central hospitals	4 Patient satisfaction survey using DoH template (percentage of central hospitals)	100%	100%	100%	Annual Target	Annual Target	Annual Target	Annual Target
		5 Mortality and morbidity meetings at least once a month (percentage of central hospitals)	100%	100%	100%	100%	100%	100%	100%
		6 Clinical audit meetings at least once a month (percentage of central hospitals)	100%	100%	100%	100%	100%	100%	100%
		7 Complaints resolved within 25 days (percentage = total complaints resolved in central hospitals within 25 days/ total complaints received*100)	Not requested prior to 2007/08	100%	100%	100%	100%	100%	100%
		8 Case fatality rate in central hospitals for surgery separations (total surgery fatalities/total operations*100)	3.0%	3.0%	3.0%	3%	3%	3%	3%
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9 Average length of stay	5.40	6.00	5.8	5.8	5.8	5.8	5.8
		10 Bed utilisation rate (based on usable beds)	83%	82.9%	83.0%	83.0%	83.0%	83.0%	83.0%
		11 Total separations[2]	127 671	122 881	75 830	18 958	18 958	18 958	18 958
	Ensure the cost-effective management of central hospitals at a target expenditure of approximately R2 800 per PDE	12 Expenditure per patient day equivalent[3]	R1 900	R2 157	R2 752	R2 752	R2 752	R2 752	R2 752
Strategic goal:	**Provide sufficient infrastructure to render highly specialised hospital services.**								
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 1 460 level 3 beds in central hospitals by 2010.	13 Number of L3 beds in central hospitals	2 479	2 417	1 460	1460	1460	1460	1460
		14 Total number of patient days in central hospitals[1]	740 321	737 508	442 307	110 577	110 577	110 577	110 577

Notes:
1. Comprehensive out-patient services include the head count at casualty /trauma/ emergency units. However the CSP does not provide for trauma and emergencyunits at level 3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.
2. Per definition day cases are included in separations and therefore included in the total patient days (Day cases 1 separation = 0.5 in patient day)
3. 2006/07 prices.

Table C5.2: Groote Schuur Hospital

Strategic Objectives	Measurable objectives		Measure / Indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal:	**To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant**									
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in Groote Schuur hospital to perform highly specialised surgical procedures including a target caesarean section rate of 46%	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	43%	44%	46%	46%	46%	46%	46%
	Provide sufficient resources to render comprehensive highly specialised out-patient services at a target rate of 1.1 out-patient per in-patient day[1]	2	Patient day equivalents (number of PDEs)	436 967	412 446	283 612	70 903	70 903	70 903	70 903
		3	OPD Total head count (number of head count at L3 OPD clinics)	417 801	478 768	228 273	57 068	57 068	57 068	57 068
	Implement quality assurance measures to minimise patient risk in Groote Schuur hospital.	4	Patient satisfaction survey using DoH template (percentage of Groote Schuur hospital)	100%	100%	100%	Annual Target: 100%	Annual Target: 100%	Annual Target: 100%	Annual Target: 100%
		5	Mortality and morbidity meetings at least once a month (percentage of Groote Schuur hospital)	100%	100%	100%	100%	100%	100%	100%
		6	Clinical audit meetings at least once a month (percentage of Groote Schuur hospital)	100%	100%	100%	100%	100%	100%	100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved in Groote Schuur hospital within 25 days/ total complaints received*100)	Not requested prior to 2007/08	100%	100%	100%	100%	100%	100%
		8	Case fatality rate in Groote Schuur hospital for surgery separations (total surgery fatalities/total operations*100)	4.1%	4.1%	3.0%	3%	3%	3%	3%
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in Groote Schuur hospital.	9	Average length of stay	6.10	6.25	6.00	6.0	6.0	6.0	6.0
		10	Bed utilisation rate (based on usable beds)	82.0%	85.0%	83.0%	83%	83%	83%	83%
		11	Total separations[2]	45 089	43 048	34 587	8 647	8 647	8 647	8 647
	Ensure the cost effective management of Groote Schuur Hospital at a target expenditure of approximately R2 800 per PDE.	12	Expenditure per patient day equivalent[3]	R2 079	R2 273	R2 752	R2 752	R2 752	R2 752	R2 752
Strategic goal:	**Provide sufficient infrastructure for the rendering of highly specialised hospital services.**									
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 685 level 3 beds in Groote Schuur Hospital by 2010.	13	Number of L3 beds in Groote Schuur Hospital	919	867	685	685	685	685	685
		14	Total number of patient days in Groote Schuur Hospital[2]	275 342	268 987	207 521	51 880	51 880	51 880	51 880

Notes:
1. Comprehensive out-patient services include the head count at casualty /trauma/ emergency units. However the CSP does not provide for trauma and emergencyunits at level 3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.
2. Per definition day cases are included in separations and therefore included in the total patient days (Day cases 1 separation = 0.5 in patient day)
3. 2006/07 prices.

Table C5.3: Red Cross Children's Hospital

Strategic goal:	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant									
Strategic Objectives	**Measurable objectives**		**Measure / Indicator**	**Actual 2006/07**	**Estimate 2007/08**	**Target 2008/09**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in Red Cross Children's hospital to perform highly specialised surgical procedures including a target caesarean section rate of 0%.	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
	Provide sufficient resources for the rendering of comprehensive highly specialised out-patient services at a target rate of one out-patient per in-patient day.[1]	2	Patient day equivalents (number of PDEs)	143 431	131 354	98 126	24 532	24 532	24 532	24 532
		3	OPD Total head count (number of head count at L3 OPD clinics)	150 464	189 084	78 979	19 745	19 745	19 745	19 745
	Implement quality assurance measures to minimise patient risk in Red Cross Children's hospital.	4	Patient satisfaction survey using DoH template (percentage of Red Cross Children's hospital)	100%	100%	100%	Annual Target: 100%	Annual Target: 100%	Annual Target: 100%	Annual Target: 100%
		5	Mortality and morbidity meetings at least once a month (Percentage of Red Cross Children's hospital)	100%	100%	100%	100%	100%	100%	100%
		6	Clinical audit meetings at least once a month (percentage of Red Cross Children's hospital)	100%	100%	100%	100%	100%	100%	100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved within 25 days/ total complaints received*100)	75%	100%	100%	100%	100%	100%	100%
		8	Case fatality rate for surgery separations (total surgery fatalities/total operations*100)	0.44%	0.40%	0.40%	0.40%	0.40%	0.40%	0.40%
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in Red Cross Children's hospital.	9	Average length of stay	3.90	4.10	5.10	5.10	5.10	5.10	5.10
		10	Bed utilisation rate (based on usable beds)	84.0%	83.6%	83.0%	83.0%	83.0%	83.0%	83.0%
		11	Total separations[2]	21 831	21 024	14 078	3 520	3 520	3 520	3 520
	Ensure the cost effective management of Red Cross Children's hospital at a target expenditure of approximately R2 800 per PDE.	12	Expenditure per patient day equivalent[3]	R1 845	R2 279	R2 752	R2 752	R2 752	R2 752	R2 752
Strategic goal:	**To provide sufficient infrastructure for the rendering of highly specialised hospital services.**									
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 237 level 3 beds in Red Cross hospital by 2010.	13	Number of L3 beds in Red Cross hospital	277	288	237	237	237	237	237
		14	Total number of patient days in Red Cross Children's Hospital[2]	85 210	86 198	71 799	17 950	17 950	17 950	17 950

Notes:
1. Comprehensive out-patient services include the head count at casualty /trauma/ emergency units. However the CSP does not provide for trauma and emergencyunits at level 3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.
2. Per definition day cases are included in separations and therefore included in the total patient days (Day cases 1 separation = 0.5 in patient day)
3. 2006/07 prices.

Table C5.4: Tygerberg Hospital

Strategic Objectives	Measurable objectives		Measure / Indicator	Actual 2006/07	Estimate 2007/08	Target 2008/09	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal:	**To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant**									
To provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in Tygerberg Hospital to perform highly specialised surgical procedures including a target caesarean section rate of 40%.	1	Caesarean section rate (percentage = caesarean sections/total deliveries*100)	28.0%	30.0%	40.0%	40%	40%	40%	40%
	Provide sufficient resources to render comprehensive highly specialised out-patient sevices at a target rate of 1.1 out- patient per in-patient day.[1]	2	Patient day equivalents (number of PDEs)	536 918	509 764	222 749	55 687	55 687	55 687	55 687
		3	OPD Total head count (number of head count at L3 OPD clinics)	395 928	448 890	179 286	44 822	44 822	44 822	44 822
	Implement quality assurance measures to minimise patient risk in Tygerberg Hospital.	4	Patient satisfaction survey using DoH template (percentage of Tygerberg Hospital)	100%	100%	100%	Annual Target: 100%	Annual Target: 100%	Annual Target: 100%	Annual Target: 100%
		5	Mortality and morbidity meetings at least once a month (percentage of Tygerberg Hospital)	100%	100%	100%	100%	100%	100%	100%
		6	Clinical audit meetings at least once a month (percentage of Tygerberg Hospital)	100%	100%	100%	100%	100%	100%	100%
		7	Complaints resolved within 25 days (percentage = total complaints resolved within 25 days/ total complaints received*100)	Not requested prior to 2007/08	100%	100%	100%	100%	100%	100%
		8	Case fatality rate for surgery separations (total surgery fatalities/total operations*100)	4.5%	4.5%	3.0%	3%	3%	3%	3%
To ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in Tygerberg hospital.	9	Average length of stay	6.25	6.50	6.00	6.0	6.0	6.0	6.0
		10	Bed utilisation rate (based on usable beds)	81.0%	83.0%	83.0%	83.0%	83.0%	83.0%	83.0%
		11	Total Separations[2]	60 751	58 819	27 165	6 791	6 791	6 791	6 791
	Ensure the cost effective management of Tygerberg Hospital at a target expenditure of approximately R2 800 per PDE.	12	Expenditure per patient day equivalent[3]	R1 754	R2 070	R2 752	R2 752	R2 752	R2 752	R2 752
Strategic goal:	**To provide sufficient infrastructure for the rendering of highly specialiced hospital services.**									
To provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 538 level 3 beds in Tygerberg Hospital by 2010.	13	Number of L3 beds in Tygerberg Hospital	1 283	1 262	538	538	538	538	538
		14	Total number of patient days in Tygerberg Hospital[1]	379 770	382 323	162 987	40 747	40 747	40 747	40 747

Notes:
1. Comprehensive out-patient services include the head count at casualty /trauma/ emergency units. However the CSP does not provide for trauma and emergencyunits at level 3. Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.
2. Per definition day cases are included in separations and therefore included in the total patient days (Day cases 1 separation = 0.5 in patient day)
3. 2006/07 prices.

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Table C6.1: Provincial objectives and performance indicators for human resource development [Hr2]

Measurable objective	Indicator (Performance Measure)	2006/07	2007/08	2008/09	Quarter	Quarter	Quarter	Quarter
		Actual	Estimate	Target	1	2	3	4
	Strategic goal:	Rendering of education training and development opportunities for employees of the Department of Health						
Sub-programme 6.1	**Nurse Training College Western Cape College of Nursing**							
Provide basic nurse training to meet the service demands of the Department.	Number of student nurses trained at the Western Cape College of Nursing	513	590	965	905	60	-	-
Provide post- basic nurse training to meet the service demands of the Department.	Number of professional nurse employees admitted to post Basic nurse training programmes	30	37	40	40	-	-	-
	Total basic and post basic nurse training	**543**	**627**	**1 005**	**945**	**60**		
Sub-programme 6.2	**Emergency Medical Services Training College**							
Facilitate the provision of EMS training programmes to meet the demand of the service.	Number of new learners admitted to the National Diploma EMC programme	35	35	60	60	-	-	-
	Number of existing learners in the National Diploma EMC programme	119	119	85	85	-	-	-
	Number of learners graduating from the National Diploma EMC programme	23	22	**30**	-	-	-	**30**
	Number of EMS learners admitted to short training programmes	**1 583**	**589**	**504**	**144**	144	108	108
	Number of EMS learners to complete short training programmes.	**1539**	**546**	**468**	145	134	101	88
Sub-programme 6.3	**Bursaries**							
6.3.1 Nursing Bursaries								
Fund the training for all categories of nurses through a bursary scheme to meet the service requirements.	Number of new students granted bursaries for nurse training	606	634	800	700	100	-	-
	Maintenance of existing nursing bursaries	962	936	1,260	1,260	-	-	-
	Total number of nursing bursaries	**1 568**	**1 570**	**2 060**	**1 960**	**100**	-	-
6.3.2 Bursaries for Health Science personnel other than nurses.								
Fund the training for health science professionals (excluding nurses) and support services through a bursary scheme to meet the service requirements.	Number of new students granted bursaries for health science training.	101	130	125	125	-	-	-
	Maintenance of existing health science bursaries	158	189	183	183	-	-	-
	New bursaries for serving employees	242	140	280	280	-	-	-
	Maintenance of bursaries for serving employees	263	88	190	190	-	-	-
	Total number of health science bursaries	**764**	**547**	**778**	**778**	-	-	-
	Total number of bursaries (Nursing + Health Sciences)	**2 332**	**2 117**	**2 838**	2738	100	-	-

Measurable objective	Indicator (Performance Measure)	2006/07	2007/08	2008/09	Quarter	Quarter	Quarter	Quarter
		Actual	Estimate	Target	1	2	3	4
Sub-Programme 6.4	**PHC Training**							
6.4.1 **PHC Training** [1] Provision of PHC related training interventions for personnel provided by the districts.	Number of training interventions provided to PHC personnel	3 329	4 000	3 900 [2]	858	1 248	585	1 209
6.4.2 **iMOCOMP** The provision of training for the improvement and maintenance of competence project (iMocomp) at district level.	Number of iMocomp training interventions provided at district Level	0	0	300	66	96	46	92
Sub-programme 6.5	**Training (Other)**							
6.5.1 Levy to HWSETA [3]	Administrative levy payable to HWSETA in terms of skills development legislation.	R 2 045 m	R 2 169 m	R 2 280 m	R 2 280 m	-	-	-
6.5.2 **Workplace Skills Plan** [4] The provision of training and development opportunities for personnel within the Department.	Number of training interventions provided to personnel. Including all generic training management & leadership development opportunities PHC training ABET and learnerships.	11 771	16 600	16 600	3 320	4 150	3 984	5 146
6.5.3 **Management and leadership development skills** [5] Facilitate the development of appropriate management and leadership skills.	Number of management and leadership development training opportunities.	1 559	1 500	1600	448	496	256	400
6.5.4 **ABET** [6] Facilitate the development of human resources by means of ABET.	Number of ABET learners registered for courses.	275	100	150	150	-	-	-
6.5.5 **Learnerships** [7] Contribute to the Provincial Growth and Development Strategy through the provision of learneships.	**Number of learnerships for employed personnel**	**115**	**124**	190	190	-	-	-
	Nurses	80	111	135	135	-	-	-
	Pharmacist's assistants	35	13	55	55	-	-	-
	Number of learnerships for unemployed personnel	**101**	**92**	**120**	**120**	-	-	-
	Nurses	65	25	45	45	-	-	-
	Pharmacist's assistants	21	32	45	45	-	-	-
	Diagnostic radiography	15	35	30	30	-	-	-
6.5.6 **Work integrated learning**								
Partner with Higher Education Institutions through the provision of work integrated learner (internship) opportunities	Number of work-integrated learners (generic interns) placed	188	130	130	60	20	20	30
6.5.7 Expanded Public Works Programme								
Provide training opportunities for unemployed persons to facilitate access to employment.	**Number of community based health workers trained.**	1 009	1 805	1 840	1 840	-	-	-

Notes

[1] This budget is decentralised to and accounted for by the regions. This is not in a separate envelope
It is recommended that PHC-related Training is costed and funded by the regions and a separate funding envelope is identified within the regional budgets

[2.] Targets reduced to allow for specific targets to measure iMocomp interventions

[3] Administrative levy payable to HWSETA in terms of skills development legislation.

[4] Data collected via Quarterly Training Reports.

[5] Target group is Senior Officials Deputy Directors and Assistant Directors. In addition personnel in other categories who have financial / management responsibilities

[6] Figures reflect ABET and AFET interventions from ABET level 1 to NQF level 4.

[7] Learnerships: Enrolled Nurse Assistants Enrolled Nurses Post Basic Nursing. Pharmacist Assistants: Subject to funding by HWSETA.

[8] Funding from National treasury has been allocated up until 2008 / 2009 financial year. Thereafter policy options for additional funding will be submitted.

Table C6.2: Situational analysis and projected performance for health sciences and training [Hr4]

Programme 6:	Health sciences and training	Strategic goal: Addressing the shortfall in the number of professionals to meet future service requirements.							
Strategic objective	**Measurable objective**	**Performance measure/ Indicator**	**2006/07**	**2007/08**	**2008/09**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
To provideeducation training and development opportunities for serving and prospective employees of the Department of Health.	**Provide a sufficient pool of prospective employees.**	**Input**				**1**	**2**	**3**	**4**
		1) Intake of medical students (number)	1704	1678	1713	1713	-	-	-
		2) Intake of nurse students (number)	871	992	1192	1192	-	-	-
		3) Students with bursaries from the province (number)	2332	2117	2838	2738	100	-	-
		Process							
		4) Attrition rates in first year of medical school (percentage)	2.7	4	4	-	-	-	4
		5) Attrition rates in first year of nursing school (percentage)	15	15	10	-	-	-	10
		Output							
		6) Basic medical students graduating (number)	440	289	298	-	-	-	298
		7) Basic nurse students graduating (number).	133	285	304	-	-	-	304
		8) Medical registrars graduating (number).	47	43	44	-	-	-	44
		9) Advanced nurse students graduating (number).	198	199	199	-	-	-	199
		Efficiency							
		10) Average training cost per basic nursing graduate (rand)	10 450	11 500	12650	12650	12650	12650	12650
		11) Development component of HPT & D grant spent (percentage)	0%	0%	0%	0%	0%	0%	0%
Additional Programme 6 performance measures									
		Nurse training colleges							
		Number of student nurses trained PN.	1388	1480	1815	1815	-	-	-
		Number of student nurses trained towards ENA.	65	0 [1]	0 [1]	-	-	-	-
		Number of student nurses trained towards enrolled nurse	113	82	115	115	-	-	-
		EMS Training							
		Number trained as ambulance emergency assistants.	7	22	96	96	-	-	-
		Number trained as paramedics.	0	11	12	12	-	-	-
		Bursaries							
		Number of bursaries awarded.	2332	2117	2838	2738	100	-	-

Notes:

1. ENA Learnership has been discontinued due to the re-prioritisation by HWSETA of learnership funding.

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Table C7.1: Health Care Support Services [SUP1]

Strategic Objective	Measurable Objective	Performance Measurable Indicator	2006/07 Actual	2007/08 Estimate	2008/09 Budget	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Sub-programme 7.1:	**Laundry Services**	**Strategic Goal:**	**Rendering a laundry services to Hospitals, Care and Rehabilitation Centres and Healthcare Facilities**						
Provide a laundry service to all provincial hospitals	Manage the pieces/linen laundered by a combination of strategic in-house and out-sourced laundries.	Total number of pieces laundered:	20m	21m	21.5m	5.15m	5.38m	5.47m	5.50m
	Manage the number of pieces laundered by in-house laundries.	Number of pieces laundered: in-house laundries	14m	15.5m	16m	3.8m	3.5m	4.2m	4.5m
	Manage the number of pieces laundered by private sector.	Number of pieces laundered: outsourced services	6m	5.5m	5.5m	1.42m	1.38m	1.25m	1.45m
Provide cost effective in-house laundry service	Ensure that in-house laundries produce cost effective laundry services.	Average cost per item	R1.74	R2.19	R2.19	R2.19	R2.19	R2.19	R2.19
Provide cost effective out-sourced laundry service	Ensure that service providers produce cost effective laundry services.	Average cost per item	R1.47	R1.61	R1.73	R1.69	R1.74	R1.71	R1.76
Sub-programme 7.2:	**Engineering services**	**Strategic Goal:**	**Rendering a maintenance service to equipment, engineering installations and repairs and renovations to buildings**						
Effective maintenance of buildings and engineering installations.	A combination of in-house and out-sourced maintenance in co-operation with Works	Maintenance backlog as % of replacement value	7% 900m/13bn	7% 900m/13bn	6% 800m/13bn	6% 800m/13bn	6% 800m/13bn	6% 800m/13bn	6% 800m/13bn
Efficient engineering installations	Monitoring of plant efficiency and modification or renewal as necessary	Cost of utilities per bed	R6 112	R6 910	R7 300	R1 800	R1 800	R1 900	R1 800
Safe working environment (buildings, machinery and equipment).	Arrange training of staff in the Occupational Health and Safety Act	Number of reportable incidents	143	220	180	53	41	47	39
Cost effective maintenance of medical equipment	Manage a combination of in-house and out-sourced maintenance	**Number of jobs completed – in-house/outsourced**	13 011	15 300	16 700	3 950	4 410	4 132	4 208
Sub-programme 7.5:	**Medicine Trading Account**	**Strategic goal:**	**Managing the distribution of pharmaceuticals and medical sundries to hospitals, Primary Health Centres and local authorities.**						
Adequate working capital to support adequate stockholding	Increase working capital in line with projected inflator	Working capital	R43.8m	R50m	R54m	R54m	R54m	R54m	R54m

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Table C8.1: Provincial objectives and performance indicators for health facilities management [HFM6]

Programme 8	**Health Facilities Management**	**Strategic Goal :**	**To provide new health facilities and to provide for the upgrading and maintenance of existing health facilities**						
Strategic Objective	**Measurable Objective**	**Performance Measure/ Indicator**	**Actual 2006/07**	**Estimate 2007/08**	**Budget 2008/09**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Programme 8.1 Improve Community Health physical infrastructure.	Provide Community Health infrastructure that is fit for purpose.	Total infrastructure expenditure as a % of backlog (R300 million)	8.9%	18.6%	11.4%	Note 1	Note 1	Note 1	Note 1
Programme 8.2 Improve EMS physical infrastructure.	Improve ambulance stations.	% of ambulance stations built for purpose (50 ambulance stations)	47%	60%	73%	64%	64%	68%	73%
Programme 8.3 Improve District Hospital physical infrastructure	Provide district hospital infrastructure that is fit for purpose.	Total infrastructure expenditure as a % of backlog (R2 billion)	5.9%	2.6%	11.0%	Note 1	Note 1	Note 1	Note 1
Programme 8.4 Improve Provincial Hospital physical infrastructure.	Provide provincial hospitals with the physical infrastructure that is fit for purpose.	Total infrastructure expenditure as a % of backlog (R1,85 billion)	6.7%	0.8%	14.1%	Note 1	Note 1	Note 1	Note 1
Programme 8.5 Improve Central Hospital physical infrastructure.	Provide central hospitals with the physical .infrastructure that is fit for purpose.	Total infrastructure expenditure as a % of backlog (R1,4 billion)	2.4%	1.1%	4.8%	Note 1	Note 1	Note 1	Note 1

Notes:

1. These indicators cannot be reported on meaningfully on quarterly basis. The programme is focussed on balancing annual expenditure with the budget. Furthermore they are based on an annua estimate of the backlog.

Table C8.2: National Performance indicators for health facilities management [HFM7]

Programme 8	Health Facilities Management	Strategic Goal :	To provide new health facilities and to provide for the upgrading and maintenance of existing health facilities						
Strategic Objective	**Measurable Objective**	**Performance Measure/ Indicator**	**Actual 2006/07**	**Estimate 2007/08**	**Budget 2008/09**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Input									
Maintain and improve health infrastructure.	Provide funding from equitable share to fund capital projects.	Equitable share capital programme as % of total health expenditure	0.52%	0.22%	0.32%	Note 1	Note 1	Note 1	Note 1
	Increase the number of hospitals on the Hospital .Revitalisation Programme.	Hospitals funded on the Revitalisation programme %	12%	14%	14%	16	16	16	16
	Provide adequate funding for infrastructure maintenance.	Expenditure on facility maintenance as % of total health expenditure	1.12%	1.08%	0.99%	Note 1	Note 1	Note 1	Note 1
Keep existing equipment in good condition.	Provide adequate funding for equipment maintenance.	Expenditure on equipment maintenance as % of total health expenditure	1.00%	0.91%	0.82%	Note 1	Note 1	Note 1	Note 1
Process									
Safeguard assets.	Up-to-date asset register	Hospitals with up-to-date asset register.	Reported in Programme 1	Reported in Programme 1	Reported in Programme 1	Reported in Programme 1	Reported in Programme 1	Reported in Programme	Reported in Programme 1
	Up-to-date asset register	Health districts with up-to-date PHC asset register (excluding hospitals)	Note 2	Note 2	Note 2	Note 2	Note 2	Note 2	Note 2
Quality									
Provide appropriate PHC infrastructure.	Provide facilities with piped water supply.	Fixed PHC facilities with access to piped water	100	100	100	100	100	100	100
	Provide facilities with mains electricity supply.	Fixed PHC facilities with access to mains electricity	100	100	100	100	100	100	100
	Provide facilities with telephone service.	Fixed PHC facilities with access to fixed line telephone	100	100	100	100	100	100	100
	Reduce backlog in service platform.	Average backlog of service platform in fixed PHC facilities	265 000 000	300 000 000	255 000 000	Note 3	Note 3	Note 3	Note 3
Provide appropriate hospital infrastructure.	Reduce backlog in service platform.	Average backlog of service platform in district hospitals	1 285 000 000	2 000 000 000	2 000 000 0000	Note 3	Note 3	Note 3	Note 3
	Reduce backlog in service platform.	Average backlog of service platform in regional hospitals	600 000 000	390 000 000	250 000 0000	Note 3	Note 3	Note 3	Note 3
	Reduce backlog in service platform.	Average backlog of service platform in specialised hospitals (including TB & psychiatric hospitals)	2 039 071 405	2 030 000 000	2 030 000 0000	Note 3	Note 3	Note 3	Note 3
	Reduce backlog in service platform.	Average backlog of service platform in tertiary and central hospitals	1 400 000 000	1 400 000 000	1 400 000 0000	Note 3	Note 3	Note 3	Note 3
	Reduce backlog in service platform.	Average backlog of service platform in provincially aided hospitals	13 066 667	13 066 6667	13 066 6667	Note 3	Note 3	Note 3	Note 3

Programme 8	Health Facilities Management	Strategic Goal :	To provide new health facilities and to provide for the upgrading and maintenance of existing health facilities						
Strategic Objective	**Measurable Objective**	**Performance Measure/ Indicator**	**Actual 2006/07**	**Estimate 2007/08**	**Budget 2008/09**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Efficiency									
Efficient delivery of infrastructure	Timeous completion of projects	Projects completed on time %	Note 4	Note 4	Note 4	Note 4	Note 4	Note 4	Note 4
	Projects completed within budget	Project budget over run %	Note 4	Note 4	Note 4	Note 4	Note 4	Note 4	Note 4
Outcome									
Improve the accessibility of health care facilities of the appropriate level of care.	Adequate number of beds	District hospital beds per 1000 uninsured population	0.53	0,.3	0.55	0.55	0,55	0,55	0,55
	Adequate number of beds	Regional Hospital beds per 1000 uninsured population	0.61	0.61	0.61	0.61	0,61	0,61	0,61
	Distance to PHC facility	% Population within 5km of fixed PHC facility	94%	95%	95%	95%	95%	95%	95%

Notes:

1. These indicators cannot be reported on quarterly because of capacity constraints. This will hopefully be resolved with the implementation of IDIP.
2. The PPHCs are Chief Users of district hospitals and information regarding asset registers is incorporated in the statistics for hospitals
3. These indicators cannot be reported on quarterly. They are based on an annual estimate of the backlog.
4. The Health Department does not have the capacity to provide this information. It is planned to create the necessary capacity as part of the IDIP process

ABBREVIATIONS

ABET	Adult basic education and training
ACT	Assertive community teams
AEA	Ambulance emergency assistant, same as Intermediate life support (ILS)
AMS	Air Mercy Service
ANHP	Annual National Health Plan
APH	Associated psychiatric hospitals
APP	Annual performance plan
ARMD	Age related macular degeneration
ART	Antiretroviral treatment
ARV	Antiretroviral
ASGISSA	Accelerated Shared Growth Initiative South Africa
ASSA	Actuarial Society of South Africa
BAA	Basic ambulance assistant
BANC	Basic antenatal care
BAS	Basic accounting system
BCG	Bacillus Calmette-Guérin
BFHI	Baby friendly hospital initiative
BoD	Burden of disease
BS	Budget statement
CAPFSA	Child Accident Prevention Foundation of South Africa
CBO	Community-based organisation
CBS	Community-based services
CCTV	Closed circuit television
CDM	Chronic disease management
CDU	Chronic dispensing unit
CEO	Chief executive officer
CHC	Community health centre
CHEC	Cape higher education consortium
CHIP	Child health problem identification program
CHP	Comprehensive health programme
CMD	Cape medical depot
COHSP	Comprehensive Oral Health Service Plan
COO	Chief operating officer
CPD	Continuing professional development
CPIX	Consumer price index
CPUT	Cape Peninsula University of Technology
CSIR	Council for Scientific and Industrial Research
CSP	Comprehensive Service Plan
CSS	Client satisfaction survey
CSSD	Central Sterilisation Services Department
CTS	Cape triage score
DHIS	District health information system
DHS	District health services
DoH	Department of Health
DOTS	Directly observed treatment short course
DTPW	Department of Transport and Public Works
EAP	Employee assistance programme
EC	Emergency centre
ECP	Emergence care practitioner
EMS	Emergency medical services
EN	Enrolled nurse
ENA	Enrolled nursing assistant
ENT	Ear, nose and throat
EPI	Expanded programme on immunisation
EPWP	Expanded public works programme
EU	European Union
FIFA	Federation of International Football Association
FPMI	Financial personnel management instrument
FPS	Forensic pathology services
FTE	Full time equivalent
GEMS	Government employees medical scheme
GF	Global Fund
GIAMA	Government Immovable Asset Management Act
GSH	Groote Schuur Hospital

ABBREVIATIONS

HAST	HIV and AIDS, STI and Tuberculosis
HBC	Home-based care
HCDS	Human capital development strategy
HEI	Institutes of higher education
HFA	Hospital facilities audit
HIS	Hospital information system
HIV and AIDS	Human immunodeficiency virus and acquired immune deficiency syndrome
HMQIG	Health management quality improvement grant
HPCSA	Health Professions Council of South Africa
HPSP	Health Promoting Schools Programme
HPTDG	Health professions training and development grant
HR	Human resources
HRD	Human resource development
HRDS	Human resource development strategy
HRP	Hospital revitalisation programme
HSRC	Human Science Research Council
HSS	Human settlement strategy
HWSETA	Health and Welfare Sector Education and Training Authority
IAR	Innovable asset register
ICD10	International classification of disease coding
ICS	Improvement of conditions of service
ICU	Intensive care unit
ID	Infectious diseases
IDIP	Infrastructure delivery improvement programme
ILRP	Integrated law reform project
IMCI	Integrated management childhood illness
Imocomp	Improvement and maintenance of competence project
IMR	Infant mortality rate
INP	Integrated nutrition programme
IPC	Infection prevention and control
IT	Information technology
JIPSA	Joint initiative for priority skills acquisition
KES	Key events schedule
KBH	Karl Bremer Hospita
KPI	Key performance indicator
L1	Level 1
L2	Level 2
L3	Level 3
LOGIS	Logistic information management system
LRTI	Lower respiratory tract infection
MDG	Millennium development goal
MDHS	Metro district health services
MDR	Multi-drug resistant
MEC	Member of Executive Committee
MEDS	Micro-economic development strategy
MHS	Municipal health services
MMR	Maternal mortality rate
MOUs	Midwife obstetric units
MRC	Medical Research Council
MRI	Magnetic resonance imaging
MSAT	Multi-sectoral action team
MTEC	Medium-term expenditure committee
MTEF	Medium-term expenditure framework
MTS	Modernisation of tertiary services
NCCEMD	National Committee on Confidential Enquiry into Maternal Deaths
NGO	Non-governmental organisation
NHFA	National health facilities audit
NHLS	National Health Laboratory Services
NPO	Non-profit organisation
NQF	National Qualifications Framework
NTSG	National tertiary services grant
OD	Organisation development
OHC	Oral health centre
OHTP	Oral health teaching platform

ABBREVIATIONS

OPD	Out-patient department
OSD	Occupation specific dispensation
PACS	Picture archiving and communication system
PALS	Patient advice and liaison services
PDE	Patient day equivalent
PEP	Post-exposure prophylaxis
PERSAL	Personnel salary and administration system
PGDS	Provincial growth and development strategy
PGWC	Provincial Government Western Cape
PHC	Primary health care
PHCIS	Primary health care information system
PHCU	Post-perative high care unit
PICU	Paediatric intensive care unit
PIDAC	Provincial Inter-Departmental AIDS Committee
PIG	Provincial infrastructure grant
PILIR	Policy and procedure on incapacity leave and ill-health
PM	Post mortem
PMTCT	Prevention of mother-to-child transmission
PPHC	Personal primary health care
PPI	Public-private interaction
PPIP	Perinatal problem identification programme
PPP	Public-private partnership
PPT	Planned patient transport
PSDF	Provincial spatial development strategy
PTSD	Post traumatic stress disorder
QCL	Quality control laboratory
QPR	Quarterly performance report
RAF	Road Accident Fund
RCCH	Red Cross Children's Hospital
RED	Reach every district
RMR	Routine monthly report
RN	Registered nurse
SADHS	South African Demographic and Health Survey
SANC	South African Nursing Council
SANTA	South African National Tuberculosis Association
SASH	Stress and Health Survey
SATS	South African Triage System
SCFS	Social capital formation strategy
SDIP	Sustainable development implementation plan
SIP	Strategic infrastructure plan
SLA	Service level agreement
SM	Saving mothers
SOPA	State of the province address
SSS	Scarce skills strategy
STI	Sexually transmitted infections
STP	Service transformation plan
SU	Stellenbosch University
TB	Tuberculosis
TBH	Tygerberg Hospital
TMM	Top management meeting
TOP	Termination of pregnancy
U5MR	Under 5 mortality rate
UCT	University of Cape Town
UPFS	Uniform patient fee schedule
UWC	University of the Western Cape
VCT	Voluntary counselling and testing
VR	Vitreoretinal
WC	Western Cape
WCCN	Western Cape College of Nursing
WCRC	Western Cape Rehabilitation Centre
WHO	World Health Organisation
XDR	Extreme drug resistance

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