MEDIUM TERM EXPENDITURE FRAMEWORK 2003/4 – 2005/6

Department of Health:
Provincial Administration Western Cape

PART A

STRATEGIC OVERVIEW

PART B

STRATEGIC PLAN

I N D E X

FOREWORD: **Minister of Health**
Head of Department

PART A

	Page
SITUATIONAL ANALYSIS	**1**

PART B

		Page
1.	**HEALTH ADMINISTRATION**	**16**
	1.1 Office of Minister	
	1.2 Management	
	1.2.1 Central Management	
	1.2.2 Decentralised	
2.	**DISTRICT HEALTH SERVICES**	**37**
	2.1 District Management	
	2.2 Community Health Clinics	
	2.3 Community Health Centres	
	2.4 Community based services	
	2.5 Other Community Services	
	2.6 HIV/Aids Campaign	
	2.7 Nutrition	
	2.8 Coroner services	
	2.9 District Health	
3.	**EMERGENCY MEDICAL SERVICES**	**76**
	3.1 Emergency Transport	
	3.2 Planned Patient Transport	

4. PROVINCIAL HOSPITALS SERVICES 82

4.1 General Hospitals
4.2 TB Hospitals
4.3 Psychiatric Hospitals
4.4 Chronic Medical Hospitals
4.5 Dental Training Hospitals

5. CENTRAL HOSPITAL SERVICES 104

5.1 Central Hospital Services
Groote Schuur
Tygerberg
Red Cross
5.2 Provincial Tertiary Services

6. HEALTH SCIENCES AND TRAINING 112

6.1 Nursing College
6.2 EMS Training College
6.3 Bursaries
6.4 Primary Health Care Training
6.5 SETA

7. HEALTH CARE SUPPORT SERVICES 124

7.1 Laundry Services
7.2 Engineering Services
7.3 Forensic Services
7.4 Orthotic & Prosthetic Services
7.5 Medpas Trading Account

8. ANNEXURES

A. Hospitals Establishments: Occupational Classification
B. Evolution of Expenditure by Budget Programme and Sub-Programme in current prices
C. Composite Staffing Profile of all Hospitals in the Western Cape (Excluding PAH)

MEDIUM TERM EXPENDITURE FRAMEWORK 2003/4-2005/6
STRATEGIC PLAN

PART A
1. STRATEGIC OVERVIEW

Introduction

The coming period presents both an opportunity to consolidate gains achieved by the Department until now and also affords the Department the opportunity of charting a brave and ambitious way forward. The coming three years are also crucial, because while the earlier year(s) present us with opportunities for consolidation, the outer years of the funding envelope begin to throw up the challenge of putting the plans envisioned in the Strategic Position Statement (Healthcare 2010) into action. Failure to initiate this ambitious project at an early enough stage may lead to a crippling inertia, which could potentially derail the process of comprehensive and thorough re-engineering even before it commences.

Policies

Since the implementation of the **Provincial Plan for Health in 1995**, the Department has on a number of occasions been able to refine various policies, both with regard to organizational form, as well as program for implementation. Highlights in this regard have been the development of the **Strategic and Service Delivery Improvement Plan (SSDIP 2000)** and the development of the **Strategic Position Statement (SPS 2001/2).** The former draws heavily on the **Five Year Strategic Plan of National Department of Health**, whose ten-point plan clearly defines the 10 major areas of intervention for the coming five years:

- Reorganization of Support Services
- Legislative reform
- Improving Quality of Care
- Revitalization of Hospital Services
- Speeding up of delivery of an essential package of services through the District Health System
- Decreasing morbidity and mortality rates through specific interventions
- Improving resource mobilization and the management of resources without neglecting the attainment of equity in resource allocation
- Improving human resource development and management
- Improving communication and consultation within the Health System and between the health system and the communities served and
- Strengthening cooperation with International partners.

Using the above framework a Strategic Plan was developed at the beginning of 2002 which by and large encapsulates the spirit of the National 10-point plan while at the same time concretizing the issues germane to the Province. Issues highlighted in this document include:

- Improving service delivery and quality of care

- Control of the AIDS epidemic and its impact
- Control of the TB epidemic
- Reshaping the Health Service

The strategic position statement takes as its point of departure the fact that the present configuration of Health Service provision is neither affordable nor sustainable. From there it sets out to develop the framework for "…an integrated network of vertical support from Tertiary level down to District level." It is within this context that the Department developed its present vision, namely "Better care for Better Health, all day, Everyday! Ten key challenges are then set in order to concretize this vision. It is the successes achieved in these crucial areas of intervention which will ultimately determine the successful implementation of the above mentioned policies. The reconfiguration of the services is crucial in order for the Provincial Department to deal with the impending HIV/AIDS epidemic and is just as important in ensuring adequate levels of affordable service at the appropriate level.

These crucial steps then are:

1. Reshape services by:
    - Reducing Tertiary, Chronic Psychiatric and TB Beds;
    - Increasing Regional and District beds; and
    - Redefining District beds to take account of Home Based Care and Step down.

2. Define the development required for PHC and Home Based Care and analyse how the expected increase in demand will be managed.

3. Develop a comprehensive service plan starting with the forthcoming three year MTEF service plan.

4. Identify and focus upon service priorities including but not limited to quality of care, HIV/AIDS, TB and Trauma.

5. Determine whether the preferred scenario is suitable in terms of Equity, Access, Patient Satisfaction, Technical Quality, Affordability and Sustainability.

6. Strengthen systems to facilitate management decision making and service delivery (for example – monitoring and evaluation of key indicators).

7. Develop implementation plans and link to performance contracts of managers.

8. Address operational inefficiencies at all levels of service.

9. Correct human resource distortions including how to address shortages of certain skills and ensure that specialists are available to work within appropriately functioning regional hospitals.

10. Link infrastructure planning to the service plan ensuring that maintenance, equipment (replacement and maintenance) and capital development are appropriately funded and planned.

11. Develop inter governmental department planning (for example – How to effectively involve Education, Welfare and Local Government)

Macro-economic Framework

Any predictions and planning involves some degree of risk and has to be informed by the macro-economic conditions and expectations relevant at the time. In a Report prepared for Standard Bank Group Economist Dr Iraj Abedian concluded that "…*South Africa is relatively better-placed to soften the blows and set itself to improve its relative position among the emerging economies."*(SA Economy: Current Outlook, 1 December 2001 @www. Standardbank.co.za). This had been brought about in the main through improvement in the public deficit, improvement of productivity, an improvement in the country's investment grading, amongst others.

SECTORAL SITUATION ANALYSIS

1. POPULATION CHARACTERISTICS

Table A1: POPULATION AND GEOGRAPHIC AREA BY HEALTH REGION 2000

Region	Estimated Population*		Area*		
	Number	%	km²	%	Density
West Coast / Winelands	549 328	13	33 594	26	16
Boland / Overberg	466 423	11	31 591	24	14
South Cape / Karoo	462 417	11	62 173	48	7
Metropole	2 707 858	65	2 169	2	1 248
Province	4 187 035	100	129 527	100	32

* Rounded-off to the nearest whole number.
Figures are derived from the 1996 census & projections are based on methods developed by Statistics SA.

The Western Cape forms almost 10% of the total South African population with a marginal predominance of women (51%) than men (49%). The majority of the population resides in urban areas (89%) compared to the national average of 54%. The population by race is markedly different from the national profile in that persons classified African form 21% and Coloured 54% of the total provincial population, while the national figures show a predominance of persons classified African (77%) and lesser proportion of Colourds (7%). The annual population growth rate and crude birth rates are lower than the national figures.

Literacy levels are notably higher in the Western Cape as well as employment rates. The average household size is also smaller.(SSDIP p32)

Poverty is spread unevenly in the province, and interestingly does not follow the urban/rural

break.

Poverty : relative % of households < R18 000 per year				
Boland	Metro	South Cape	West-Coast	Province
46%	36%	30%	36%	36%

The medical aid coverage is difficult to assert with certainty, but clearly varies between urban and rural regions : it is put at 35% for the Metro, and 20% for the rural regions giving an average of just under 30% coverage for the province.

The population of the Western Cape is growing, both through natural increase and through migration, especially from the Eastern Cape. The major population growth has been a result of the urbanisation process, with large informal settlements in the Metropole area and next to towns along the route between Port Elizabeth and Cape Town. This growth poses unique challenges to established communities and to local and provincial governments in both provinces. (AnRep)

Another unique feature pertaining to the Western Cape is the immigration of indigent patients from the Northern provinces. In many instances these are formerly employed persons, now utilizing State services because of an inability to pay for private care. Many of these patients are liable to suffer from illnesses which require chronic medication (diabetes mellitus, hypertension, hypercholesteroaemia) and will in time require protracted periods of hospitalization (for ischaemic heart disease, peripheral vascular insufficiencies, etc.)

2. MAIN PUBLIC HEALTH CONCERNS

2.1 TUBERCULOSIS

Tuberculosis (TB) remains one of the key health problems in the Province. The rates in the Western Cape continue to be amongst the highest reported in the Southern African Region and indeed in the world.

The population growth, migration into the province, poverty and overcrowding together with substance abuse and a significant number of people with highly infectious TB who do not complete treatment, have all had a marked effect on the increasing incidence of TB in the province. However the key factor at present and in future is almost certainly going to be the HIV/AIDS epidemic.

Over the past 5 years the DOTS strategy has been successfully introduced throughout the Province. While the number of TB patients and the incidence rates have increased substantially during this period (Table A2), the expected cure rates as predicted by the conversion rates, are improving in all regions (Table A3).

.

Table A2: PREVALENCE OF TB IN THE WESTERN CAPE 1995 - 2000

	1995	1996	1997	1998	1999	2000
Pulmonary	19 625	19 831	20 387	21 314	22 939	24 600
Primary	5 143	4 489	5 105	5 654	6 228	6 276
Other	1 198	1 651	2 017	1 875	2 369	2 789
Total	25 966	25 971	27 509	28 843	31 536	33 665
Population	3 883 006	3 956 875	4 032 149	4 108 860	4 187 035	4 266 704
Per 100 000	669	656	682	702	753	785

TB SMEAR CONVERSION RATES :

Smear conversion rates are calculated after 2 – 3 months of treatment, based on the sputum result at the time. They are a good predictor of future cure rates. They tend to be used since cure rates are only available 6 months after the patient has completed treatment (i.e. one year after starting treatment and being entered into the TB patient register!).

Table A3 : Smear Conversion Rates Per Region 2000 And 2001

	Metropole		West Coast / Winelands		South Cape / Karoo		Boland / Overberg	
	2000	2001	2000	2001	2000	2001	2000	2001
New Smear Positives	75.1	78.5	79.6	81.7	73.4	77.2	68.6	74.6
Retreatment Smear Positives	66.9	72.2	70	70.1	67.1	68.7	60.4	71.4

These smear conversion rates indicate that TB control is improving throughout the province and that 6 and 9 month cure rates can be expected to improve.

2.2 HIV /AIDS

Although the prevalence of the HIV infection in the Western Cape is lower at 8,7% than for the rest of the country (24,5%), the prevalence of HIV infection is rising steadily.

Table A4 : HIV Prevalence Rate Amongst Pregnant Women

1994	1995	1996	1997	1998	1999	2000	2001
1.2	1.7	3.1	6.3	5.2	7.1	8.7	8.6

The latest ANC survey shows that the prevalence of HIV increased in the urban areas from 8.8% in 2000 to 9.4% in 2001, but decreased in the rural areas from 8.6% to 7.3% in the same period.

Of particular concern is the increase in prevalence in the under 20 age group, as it is a proxy of new cases.

HIV prevalence varied significantly between districts (less than 1% to 22.4%) showing that there are sub-epidemics progressing at different rates.

2.3 Trauma

Trauma represents a significant burden on the health services. Whilst statistics are difficult to collate, according to the Health Systems Trust (1998), the rate of Injury Deaths reached in 1995, 163 per 100 000 compared to 104 for South-Africa. There is no indication that the situation has improved since that time.

2.4 Major causes of death

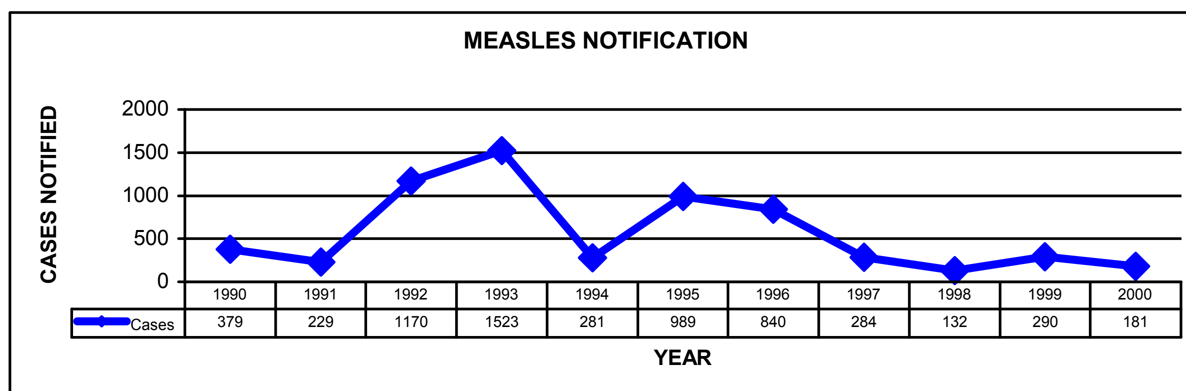
The major causes of death relate to injuries, diseases of poverty and chronic diseases.
Injury is the main cause of deaths in the Western Cape.(23%), followed by ischaemic heart diseases (9%).
Children under 5 die mainly of causes associated with low-birth weight, perinatal conditions, injuries and diarrhoeal diseases.
Maternal mortality rate was 2.17 per 100 000 women, the lowest rate in the country.

NOTIFIABLE MEDICAL CONDITIONS 1995 - 2000

Table A5 : Notifiable Medical Conditions 1995-2000

Disease	1995	1996	1997	1998	1999	2000
Congenital Syphilis[1]					1.0	0.8
Measles[2]	25.5	21.2	7.0	3.2	6.9	4.3
Haemophilis Influenza[2]	0.8	0.3	0.3	0.5	0.4	0.2
Meningococcal Infections[2]	7.3	6.7	7.4	4.2	4.3	4.5
Pesticide Poisoning[2]	0.7	1.2	0.9	1.3	2.4	1.1
TB Meningitis[2]	3.4	2.9	3.2	3.0	3.2	4.0
Pertussis[2]	1.9	1.3	0.4	0.8	0.9	0.3
Hepatitis A[2]	7.9	8.5	6.9	6.0	5.6	4.6
Hepatitis B[2]	3.2	2.2	2.2	2.4	1.3	1.5
Other Hepatitis[2]	2.1	2.0	1.5	1.5	1.0	0.7

The table confirms the marked downward trend in Measles, Haemophilis Influenza and Whooping Cough and indicates a possible rise in TB Meningitis. This rise in the reported incidence of TB Meningitis may reflect the effect of the HIV epidemic. Congenital Syphilis is still an important public health problem.



STRUCTURE OF THE HEALTH SERVICE

Table A6 : Distribution of Primary Health Care and Hospital facilities by regions :

Region	Boland			Metro			S Cape			W Coast			**Total**
Type	LA	PAWC	PAWC & LA	LA	PAWC	PAWC & LA	LA	PAWC	PAWC & LA	LA	PAWC	PAWC & LA	
Clinics	48	5	2	86	1		43	2	3	34	4	2	230
Satellite Clinic				14			1			32		1	48
Mobile Service	38			6			35			37	1		117
Community Health Centre	3	1			33		4	2	3		2	2	50
Community Health Centre / Clinic						8							8
Reproductive Health Service				4	7								11
Midwife Obstetrics Unit		1		1	10								12
District Hospital		7			2			6			6		21
Provincial Aided Hospital					6			5			3		14
Regional Hospital		1			6			1			1		9
Psychiatric Hospital					4								4
Psychiatric / TB Hospital								1					1
TB Hospital		1			1							2	4
Academic Hospital					3								3

Due to boundary issues, facilities per district have not been finalised. They will be available with the Part B of the report.

PRIMARY HEALTH CARE – HEAD COUNTS

Region	Year		
	1998/99	**1999/00**	**2000/01**
Boland/Overberg	1,061,551	1,125,849	1,450,794
Cape Metropole	6,185,139	6,451,613	7,222,750
Southern Cape/Karoo	1,365,759	1,436,116	1,672,141
West Coast/Winelands	1,245,160	1,332,705	1,641,153
Total	9,857,609	10,346,283	11,986,838

In order to put in perspective the supply of services for PHC, it is useful to look at the increase in PHC attendances in all regions. This increase in utilisation highlights the urgency of an integration of PHC services and the development of a District system to ensure a more rational use of resources.

HOSPITALS

Table A7 : Beds per type of hospital

Hospital Type	Hospitals	Beds	Beds/1000 People	Beds/1000 Uninsured
District	28	1,639	0.54	0.39
General	9	1,831	0.60	0.43
Central	3	2,662	0.88	0.63
			-	-
TB	7	1,151	0.38	0.27
Psychiatric	4	2,314	0.76	0.55
Other	7	771	0.25	0.18
	58	10,368	3.42	2.46

Table A8 : Bed Occupancy in Acute hospitals

		Year						
Type	**Region**	**1994/95**	**1995/96**	**1996/97**	**1997/98**	**1998/99**	**1999/00**	**2000/01**
Academic	Metro	72%	73%	75%	71%	68%	74%	82%
Regional	Boland	83%	89%	105%	116%	116%	104%	101%
	Metro	69%	63%	71%	78%	80%	85%	89%
	S Cape	84%	85%	83%	87%	86%	92%	88%
	W Coast	78%	78%	80%	91%	88%	83%	82%
District	Boland	71%	61%	62%	64%	64%	66%	68%
	Metro	72%	69%	93%	80%	61%	69%	58%
	S Cape	66%	61%	64%	64%	62%	65%	62%
	W Coast	68%	70%	72%	74%	65%	68%	63%

Bed occupancy is very high is Regional hospitals and relatively low in District hospitals. The MTEF plan aims at redressing this imbalance (see later section).

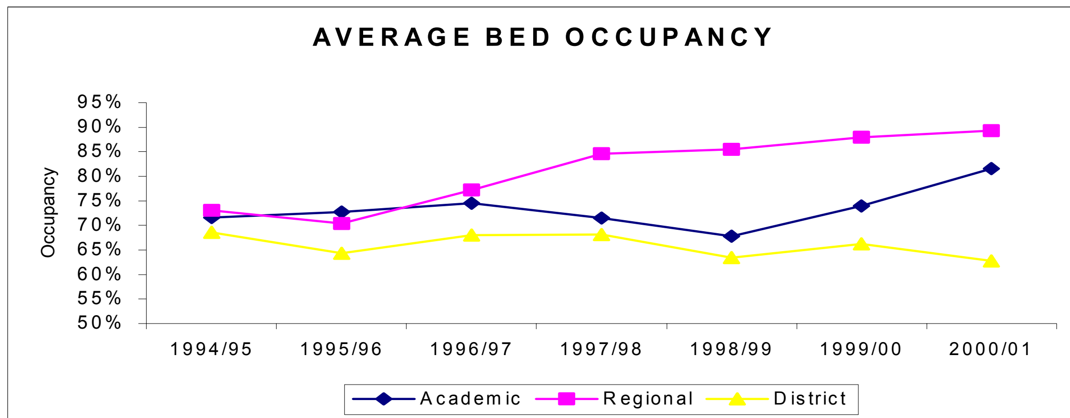


Table A9 : AVERAGE LENGTH OF STAY IN ACUTE HOSPITALS

		Year						
Type	**Region**	**1994/95**	**1995/96**	**1996/97**	**1997/98**	**1998/99**	**1999/00**	**2000/01**
Academic	Metro	4.90	4.96	5.62	6.00	6.16	6.68	5.95
Regional	Boland	4.90	4.90	4.90	4.90	4.54	4.36	3.97
	Metro	8.76	7.60	6.89	6.18	5.38	5.15	5.56
	S Cape	3.91	4.02	4.35	4.24	4.23	3.71	3.54
	W Coast	3.78	3.88	4.23	4.36	4.24	4.10	3.86
District	Boland	4.03	3.48	3.30	3.39	3.24	3.31	3.05
	Metro	3.39	3.21	2.79	2.50	2.46	2.57	2.02
	S Cape	4.52	4.05	4.19	4.19	3.77	3.72	2.90
	W Coast	4.09	3.98	4.09	3.63	3.28	3.28	3.12

The high occupancy rate cannot be explained by long length of stay. These are well within the national targets and have been decreasing over the years.

SPECIALISED HOSPITALS

Table A10 : BED OCCUPANCY

		Year					
Type	**Region**	**1995/96**	**1996/97**	**1997/98**	**1998/99**	**1999/00**	**2000/01**
Psychiatric	Metro	79%	82%	92%	83%	84%	87%
	S Cape	71%	72%	87%	71%	77%	98%
Special	Boland	91%	85%	92%	99%	101%	0
	Metro	77%	77%	76%	72%	81%	75%
	W Coast	100%	101%	100%	100%	100%	102%
TB	Boland	70%	70%	70%	72%	74%	82%
	Metro	88%	92%	90%	91%	82%	84%
	S Cape	106%	91%	108%	96%	93%	97%

Bed occupancy rates in Specialised hospitals is generally high.

PUBLIC HEALTH PERSONNEL

TABLE A11	Number Employed	% of Total	Number /1000 Population	Number /1000 Uninsured
Medical Specialists	454	1.8%	0.10	0.14
Registrars	568	2.3%	0.13	0.18
Medical Practitioners	738	3.0%	0.16	0.23
Nurses	10125	41.3%	2.25	3.12
Other Professionals	1152	4.7%	0.26	0.36
Other Personnel	11505	46.9%	2.55	3.55
Total	24542	100.0%	5.45	7.56

PRIVATE HEALTH CARE

Table A12 : Total No. of Private Hospital Beds and availability per Region

	Total No. of Beds	Beds per 1000 Private Patients
Metro	3498	2,51
Boland Overberg	298	2,42
West Coast/ Winelands	304	2,08
South Cape/Karoo	436	3,66
Total	**4536**	**2,54**

Medical Aid Coverage
The Province has a comparatively large proportion of people covered by medical aids, yet seventy percent of the population remains dependent on Public Health Care. As mentioned earlier the coverage varies significantly between the Metro where it is at 35% and the rural regions where it is 20%. However, the impact of the Medical Schemes Act and the cost of contributions, means that coverage for PHC services is likely to be very different from that for hospital services. Recent figures are not available.

Medical aid coverage by province	**Coverage of population by medical aid schemes**	
Province	**1995**	**1999**
	%	%
Western Cape	28.50	29.40

MAJOR HEALTH SERVICE CHALLENGES

The current configuration of services both at PHC and hospital level raises concern about the ability of the system to sustain an increasing demand, due to population growth and TB and AIDS epidemic, with a diminishing budget.

Overall, the sustainability of the service depends on the ability to treat patients at the lowest appropriate level of care. This in turn is dependent on the availability of appropriately trained health workers for each level for them to be able to render the defined package of service.

The following challenges will need to be addressed during the MTEF:

- A reshaping of the services to ensure that 90% of health contacts are initiated at District level (PHC and District hospital), with another 8% at regional hospital level and only a small minority (2%) at tertiary level.

- Integration of services at a PHC level, for a better utilisation of resources. This is the level which carries the brunt of the TB and AIDS epidemics. It is also the level which needs to develop its capacity to deal with the demand for mental health services, in order for the psychiatric hospitals to focus on acute rather than chronic cases.
- District hospitals need to be resourced adequately (skills and other resources) to allow them to render the package of service and decrease the number of referrals to regional hospitals. A system of support of district hospitals by regional hospitals need to be set up
- Regional hospitals need to be staffed properly for each of the general specialties to decrease referrals to tertiary hospitals. In turn the regional hospitals must receive adequate support from the tertiary hospitals. Particular emphasis will be placed on rural regional hospitals.
- Shortage of health workers in specific areas : nurses, and in particular theatre and trauma nurses, and pharmacists needs to be addressed.
- The significant decrease in the conditional grant for tertiary services together with the need for these services to cater for a bigger proportion of patients from outside of the Western Cape needs to be addressed in a way which will not destroy essential services, nor affect the other function of these services , that of training future health professionals.
- Within that period of increasing demand, reducing funding and restructuring, to ensure that quality of care is not compromised. This in turn requires the setting up of appropriate systems of support and monitoring , but also a special emphasis on addressing the issue of staff morale which has a huge bearing on quality of care.

CONCLUSION

The ever-growing demand on quality health services within the Province in the face of relatively diminishing resources, has necessitated a significant shift in the manner in which the Department renders its services. The way forward as spelt out in the Vision 2010 document makes it clear that services need to be restructured in a manner which allows for many more contacts at Primary and secondary level with a concomitant reduction in Tertiary service contacts, particularly for people of the Western Cape. This reduction at Tertiary level will in turn be augmented by an increase in Tertiary services to patients from other Provinces which will be funded through the National Tertiary Services Grant.

Simultaneously the Primary Health Care network has to be substantially reinforced, particularly at community and preventive level to bring about the aversions from the higher levels of care we are striving towards. This process will neither be easy or

universally accepted, but will have to be embarked upon if this Department is to meet its future obligations. This process of reshaping and re-engineering has become so urgent that it would not be hyperbole to contend that the very future of this Provincial Department is at stake. To this end we see this cycle of the Medium Term Planning Framework as a vital stepping stone in this direction.

Finally it has also to be recognized that a far deeper level societal change also has to bring about a situation where our most valuable health resources devoured as a result of trauma, violence and preventable illnesses. We therefore see these challenges as requiring integrated, combined responses from all levels of our society and not as piecemeal efforts from disjointed structures.

PROGRAMME 1: ADMINISTRATION

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

SUB-PROGRAMME 1.1 OFFICE OF THE PROVINCIAL MINISTER

Rendering of advisory, secretarial and office support services.

SUB-PROGRAMME 1.2 MANAGEMENT

Policy formulation, overall management and administration support of the Department and the respective regions and institutions within the Department in accordance with the Public Service Act, 1994, as amended, the Public Finance Management Act, 1 of 1999, (as amended by Act 29 of 1999) and other applicable legislation.

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.

Situation analysis

The Health Service is managed by a combination of a central head office in Cape Town and decentralised (regional) offices in Bellville, George, Worcester and Malmesbury.

The central head office determines policy and ensures that the health service functions in harmony with both national and provincial policy and directives. Human resource management and financial administration policies and procedures are determined and co-ordinated at the central head office.

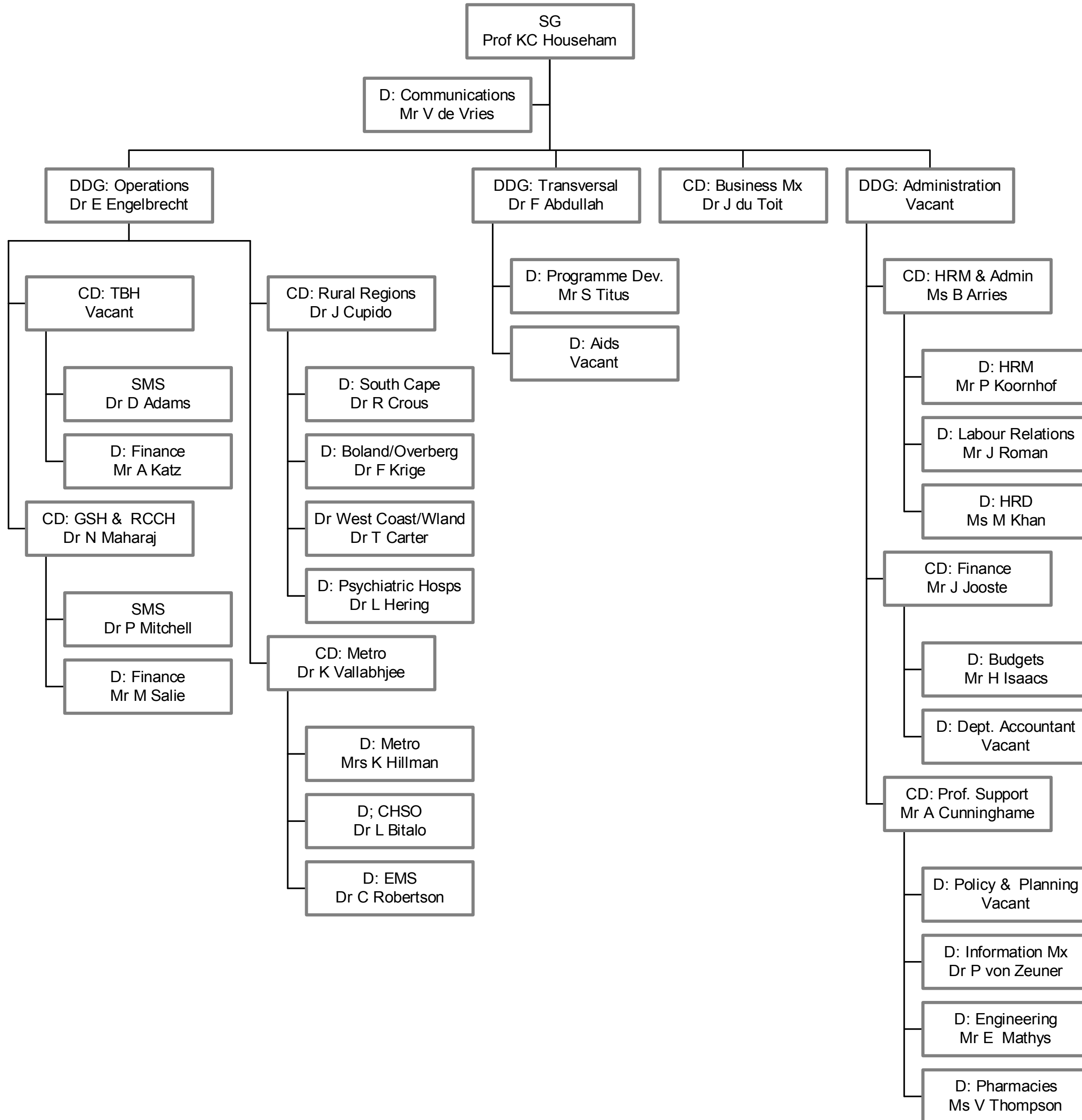
The central head office also provides overall policy determination, management and direction for Health Programme Development, including HIV/AIDS.

Professional Support Services and Communication with staff and external publics are likewise co-ordinated and directed from the central head office.

The departmental management organisation chart is shown on the following page.

DEPARTMENT OF HEALTH

Management organisational chart



Policies, priorities and broad strategic objectives

Departmental policy is to keep the central head office as small as possible commensurate with its functions of policy making, overall management and administration.

The regional offices are required to ensure that the policies and procedures are implemented at institutional level. They are also responsible for co-ordinating activities to ensure effective and efficient delivery of quality health services. They provide decentralised management that is vital to keeping the Department in touch with the needs of communities – particularly in rural areas.

Currently a major strategic objective is to bring the Department into budget without the need to curtail service delivery. The Department has developed a Strategic Position Statement (SPS) that will lead to a major realignment of services over the next 8 years. This initiative is dealt with more fully under the heading **Healthcare 2010**.

The 2003/4 financial year will be a year of consolidation, with the emphasis on fiscal discipline rather than expanding services. The bold measures contemplated in **Healthcare 2010** can be implemented in earnest only when the Department is able to live within its means.

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

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

Better communication with staff at all levels, as well as with external publics like the Media, is also considered a key objective. The recently established Communications Directorate is making progress in this regard, and it has been allocated a modest budget for the 2003/4 financial year.

Constraints and measures planned to overcome them

The inability to remain within budget is the biggest constraint facing the Department. Stringency measures necessary to curb over-expenditure have a detrimental effect on service delivery, staff morale and efficiency. As personnel is the main cost driver, the freezing of vacant posts in non-critical areas and the more efficient use of human resources will have the maximum impact on cost containment.

A major constraint is the lack of both office accommodation and parking at Head Office. The parking is a particular problem as it makes the Department head office difficult to access by the public we are required to serve and by our own staff from outside of Head Office. Hopefully Public Works will provide a solution – the alternative is further fragmentation of the head office function with a resulting loss of efficiency.

Personnel shortages are a major problem. Financial, personnel and information management are all seriously short staffed. The matter is made worse by short staffing at institution level. The problem will be corrected as the SPS is implemented and the "Profiler" is applied to correct establishments.

Planned quality improvement measures

In line with the SPS a human resource plan is being worked out. The plan will align hospital establishments with the "Profiler" model that was used to develop the SPS. Ideally this will lead to the ideal personnel mix for each institution by 2010. The result will be an increase in clinical personnel, particularly nurses. This will directly improve the quality of health care.

The Department is in the process of installing a new Hospital Information System (HIS). The Academic Hospitals are already using the system and in the next year a start will be made in rolling the system out to all of the provincial hospitals. The system provides up to date data to enable informed decision making that will benefit patient care and hospital management.

The Department has produced business cases to access the Revitalisation Grant. Major upgrades to George, Worcester and Vredenburg Hospitals are planned to commence in 2003/4. Funding in terms of the grant will provide for new and upgraded buildings, new medical equipment and organisational development.

HEALTHCARE 2010

"Equal access to quality care"

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

- the need to bring expenditure to within budget, and simultaneously,
- the need to substantially improve the quality of care of the health service.

The **Healthcare 2010** initiative was launched with the idea that these two objectives were achievable simultaneously through an all-round increase in efficiency. The in-depth analysis that followed proved conclusively that the two objectives are indeed attainable, and simultaneously! The time scale for achieving this objective is 8 years – hence the **2010**.

Healthcare 2010 is a conceptual framework that flowed from the development of the Departments SPS. It is not a detailed strategic plan. It is envisaged that a detailed strategic plan will be formulated and documented after consultation with all stakeholders. The underlying principles of **Healthcare 2010** are as follows:

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

Healthcare 2010 was developed using the following assumptions:

- The funding envelope for Health stays the same with local government contributions unchanged.
- Funds allocated for conditional grants will be used accordingly.
- Patients will be treated at the most appropriate level of care with a changed configuration of services.
- Admissions are not reduced but patients will be diverted to appropriate levels of care.
- The focus is on the provision of services to the population of the Western Cape (plus a quantum of tertiary services to other provinces).

In view of the consequences of no restructuring, this is not an option. Without restructuring inequities and inefficiencies will continue. Quality of care will remain compromised and by 2010 the projected deficit will be R1,1 billion in April 2001 rands!

Restructuring is essential because of the need to secure basic access to quality services for the whole population of the province. In addition the disease profile is

changing and intra-provincial and inter-provincial inequities must be addressed. Finally the current pattern of services is unaffordable with respect to both capital stock and operational expenditure.

The shape of **the Healthcare 2010** conceptual framework is based on the principle that 90% of Health patient contacts will occur at primary level, 8% at secondary level and 2% at tertiary level. The "90+8+2" model does not reflect directly the budget allocations or bed numbers.

Healthcare 2010 is based on a scientific modelling. This model takes into account the costs for the various types of health contacts including PHC, hospital costs and the distribution of admissions with an 85% bed occupancy rate. The model uses accepted norms that will ensure the effective treatment of all patients. The following tables indicate the reshaping of the Health services based on the scientific modelling:

Possible shift of patients to more appropriate levels of care:

Level 3 to level 2	44,366
Level 2 to level 1	45,328
Level 1 to PHC	55,486

Possible implications for acute bed numbers per level of care:

Bed Level	Current	2010	Difference
Level 3	1597	1285	-312
Level 2	2455	2692	+237
Level 1	2080	2421	+341
TOTAL	6132	6398	+266

Possible implications for chronic bed numbers:

Type	Current	2010	Difference
Psychiatric	2314	1313	-1001
TB	1151	792	-359
TOTAL	4235	2805	-1360

The above shifts are used as a provisional starting point for the projected indicators used in the various programmes. **As the consultation process with stakeholders has just begun, these indicators must be regarded as provisional and are subject to amendment after the consultation process.**

In order to reduce the beds for the hospitalisation of patients with TB, there will be increased provision for community-based care. TB DOTS contacts are to increase from 138,000 to 2,7 million. Similarly there will be greater community-based care for patients with mental illness with an additional R50 million funding and an additional 832,000 patient contacts.

Healthcare 2010 will strengthen PHC in the following ways:

- Increase spending at PHC level by R400 million – R60 million allocated to home based care and R40 million for prevention and promotion.
- Promote the "Healthy City" concept to reduce the burden on the health system.
- PHC visits remain over 3 per person per year against the national target of 2,9
- PHC attendances increase from 11 to 13 million.
- 1306 additional staff which include 156 doctors, 638 nurses and 513 nurse assistants.
- Additional mid-level health workers and support from community-based organisations.

In terms of **Healthcare 2010** there will be increased district and regional beds with appropriate funding. Tertiary beds will be fewer but will be better funded for personnel, equipment and maintenance. Tertiary beds will be decreased to accommodate the R230 million reduction of the conditional grant. The staff mix for each type of hospital will be more appropriate according to the staffing model. Staff will be redeployed where appropriate.

The projected **Healthcare 2010** efficiency gains are as follows:

- Overall cost per patient day equivalent (PDE) decreases form R858 to R814.
- Average length of acute bed stay decreases form 4,2 to 3,7 days.
- Funding for equipment and maintenance will increase from 2,3% to 7,8% of total expenditure (256% absolute increase).
- Bed occupancy rate will increase from 81% to 85%.
- 2,6 million people from neighbouring provinces will have access to tertiary health care in the Western Cape.

The projected financial implications of **Healthcare 2010** are as follows:

- Reduction of expenditure by restructuring = R502 million.
- Total expenditure in 2010 = R3,789 billion (in 2001 rands).
- Deficit = R630 million.
- Additional funding for AIDS = R541 million.
- Shortfall R89 million.
- The possible impact of increased revenue generation is not included.

Healthcare 2010 will take to its conclusion the restructuring that has been taking place since 1994. The planning is based on scientific modelling and accommodates the R230 million cut in tertiary services as resolved nationally. It provides adequate beds to service the Western Cape and neighbouring populations dependant on the province. It provides for an improved teaching platform. Quality and efficiency will improve, not deteriorate. Implementation will require hard decisions to be taken now to yield positive results later.

Political endorsement for implementation has already been obtained and a communication strategy adopted. The process of stakeholder consultation has begun. Consultation will allow for genuine input and amendment of Health Care 2010 if such inputs add value and are within the underlying principles of the conceptual framework. This process will be time bound with a fixed end point.
It must be noted that in view of the consultation process ALL targets for 2010 quoted in this document are provisional and are subject to amendment after the consultation process.

Implementation will be achieve by the simultaneous execution of four inter-linked plans, namely;

1. **Infrastructure Plan.** This will provide buildings, equipment and maintenance in line with service requirements that match community needs for accessible services.
2. **Asset Plan.** Maximise the value of assets by fully utilising existing facilities and exploiting PPP's for under-utilised capital stock by asset swops where possible and garnering additional funding.
3. **Human Resource Plan.** This will be developed to staff facilities appropriately, which will require complete revision of the existing staff establishments.
4. **Financial Implementation Plan.** This will link the allocated budgets to measurable, time bound objectives for the MTEF period and beyond.

The implementation of **Healthcare 2010** will proceed in incremental but not constant steps over an eight year period. The broad steps are as follows:

- Determine packages of services per level and location.
- Match services with the necessary facilities and equipment.
- Shift services according to the identified need.
- Staff the facilities with the appropriate staff, where necessary upgrade skills.
- Link funding to services to ensure sustainable quality services.

To summarise:
Patients will be managed at appropriate levels; in upgraded facilities that are more accessible; that have an appropriate staff mix with greater skills and better morale; where significantly more funds are allocated for equipment, drugs and consumable items.

The anticipated results are increased quality of patient care with greater patient satisfaction, an improved teaching platform and improved health indicators.

SUB-PROGRAMME 1.2 MANAGEMENT

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Policy & Planning: Develop and document provincial health policy and draft legislation	Provincial health policy meets local needs whilst complementing national policy. Legislation enacted as necessary	Policies documented, distributed and understood. Legislation adopted by Provincial Parliament	**Targets:** SPS documented and communicated. Prov. Health Ordinance amended. Prov. Health Bill drafted	Directorate records. Parliamentary records	Policies documented. Bills drafted and legislation passed	Policies documented. Bills drafted and legislation passed	1 (year)	Policy and Planning records	Yes
Policy & Planning: Provide legal administration support	Provide professional legal advice and input into official documents and contracts	Litigation avoided or resolved in favour of Department where unavoidable	**Target:** No litigation/ All cases successfully defended	Policy and Planning records	Number of cases of litigation Number of cases successfully defended	Number of cases of litigation Number of cases successfully defended	1 (year) 1 (year)	Policy and Planning records	Yes
Policy & Planning: Provide health services planning	Develop & document plans in line with policy that ensure optimum service delivery	Health services that are equitable, accessible affordable and provide quality care.	**Target:** Widely accepted and workable strategic plan based on SPS	Policy and Planning records	Widely accepted and workable strategic plan based on SPS	Widely accepted and workable strategic plan based on SPS	1 (year)	Policy and Planning records	Yes
Information Management: Ensure the availability of health service information	Collect and collate data from all health institutions	Information available and published to monitor effectiveness, efficiency and economy of health services	% of prescribed information collected, collated and published and/or disseminated **Target:** 100%	Information Management data bases and quality and completeness of publications	% of prescribed information collected, collated and published and/or disseminated	Amount of prescribed information collected, collated and published and/or disseminated	Total requirement for publishing ond/or dissemination of information.	Information Management records	Yes
Information Management: Develop and maintain health information systems	Develop and activate new HIS in co-operation with IT	Real time availability of patient and other health care information	% of new HIS operational **Target:** 50% (in 2003/4)	HIS MANCO progress reports	% of new HIS operational	Extent of HIS operational in 2003/4	Total extent of envisaged HIS	HIS MANCO progress reports	Yes
Information Management: Ensure availability of effective computer systems	Ensure hardware and software needs are met in conjunction with IT	Health services have effective IT systems	% of legitimate requests for IT systems realised **Target:** 80%	DITCOM records	% of legitimate requests for IT systems realised	Total number of legitimate requests for IT systems realised	Total number of legitimate requests for IT systems	DITCOM records	Yes

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Medico-legal: Limit expenditure on medico-legal claims	Provide expert medico-legal advice to legal practitioners to limit pay-outs	Minimal yet fair compensation paid	% of amount claimed paid out. **Target:** 30%	Medico-legal Advisor's records	% of amount claimed paid out.	Total amount paid to settle medico-legal claims	Total amount of original claims	Medico-legal Advisor's records	Yes
Medico-legal: Improve quality of care to reduce medico-legal risk	Notify institutions of claims received and remedial action to prevent recurrence	Circulars advising institutions of remedial measures to be implemented	% of claims resulting in advice to institutions. **Target:** 100%	Medico-legal Advisor's records	% of claims resulting in advice to institutions	Number of instances where advice is given	Total number of claims	Medico-legal Advisor's records	Yes
Pharmacy Services: Ensure availability and dispensing of essential drugs	Maintain effective drug selection, procurement, distribution and dispensing service	Essential drugs of required quality available dispensed as required	% of indicator drugs immediately available and dispensed to patients **Target:** 100%	Statistical returns.	% of indicator drugs immediately available and dispensed to patients	Total indicator drugs immediately available	Total number of indicator drugs	Statistical returns	Busy setting up.
Pharmacy Services: Ensure good pharmacy practice and efficient drug dispensing service to patients	➢ Recruitment and retention of pharmacists ➢ Training and registration of Pharmacists assistants ➢ Increase the number of pharmacy support personnel	Sufficient trained personnel to meet service and legal requirements Increased ratio Pharmacist: Pharmacist assistants	% of pharmacist posts filled % Pharmacists assistants trained / in training % increase in Pharmacy Support personnel **Targets:** 90% 50% Increase by 20%	PERSAL Training Records PERSAL	% of pharmacists posts filled % of assistants in training % increase in Pharmacy support personnel	Pharmacists posts filled Assistants trained and in Training Total number of additional support personnel employed	Pharmacists required for effective service Total no of assistants No of initial support personnel employed.	PERSAL Training record PERSAL	Yes (needs cleaning) Yes Yes
Pharmacy Services: Ensure good pharmacy practice	➢ Upgrading of facilities to meet requirements	Adequate facilities that meet Pharmacy Council requirements	% of facilities that meet GPP standards **Target:** 70%	Facility Audit reports	% of facilities that meet GPP standards	No of facilities that meet GPP standards	Total no of facilities	Facility Audit reports	Yes

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Human Resource Management Ensure effective management of human resources	Establish, implement and audit the application of HRM policies and procedures.	Human resources effectively managed in support of health service delivery	Number of personnel problems arising from the inefficient application of HRM policies and procedures.. **Target:** Nil	HRM audits	Develop policies Implement policies Draft manuals Draft job descriptions Training of staff Training of HRM staff Audit application of policies	Policies as determined by legislation and collective agreements.	2003/2004	Research	Yes Research documentation Legislation Collective agreements
Human Resource Management The development and maintenance of an effective organisational structure for the Department	Execute workstudy investigations Conduct job design Execute job evaluation Execute establishment control and administration	Ensure the effective organisational structure and human resources needs to render an efficient service within the Department on a decentralised basis.	Approved structure and establishment implemented on PERSAL. **Target:** Persal 100% accurate	Persal	Alignment of structure and posts and incumbents. Restructuring of organisation in terms of needs – Health Care 2010 Application of establishment control	All the structures of the Department to be addressed	2003/2004 2004/2005	Investigations Persal	Yes
Human Resource Management Effective human resources provisioning and utilisation	Execute recruitment and selection processes Conduct compensation management Application of condition of services and benefits to all employees Execute termination of services Implement and maintain a performance management system	Ensure a efficient and motivated workforce for the Department	The execution of all procedures with regard to recruitment,selection, appointments, conditions of service and the assessment of staff should be in terms of approved departmental standards. **Target:** 90% efficiency.l	HRM records	Ensure the efficient application of the following practices: Advertising Selection Appointments Transfers Salary administration Performance management Exit management	All 24500 employees of the Department	Timeframes in accordance with personnel administration practices and cycles	HRM records	Yes

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Labour Relations Develop and communicate policy and procedures	Consultation Needs analysis. Monitor labour environment	Uniformity of approach to ensure stability in labour relations.	Incidents of unrest resulting from lack of uniform approach. **Target:** No of person-days lost as a result of labour action	Labour Relations records	Number of incidents of unrest or grievances resulting from lack of uniform approach	Number of incidents of unrest or grievances resulting from lack of uniform approach	1 (year)	Labour Relations records	Yes
Labour Relations Provide functional training in labour relations	Managers and supervisors trained.	Potential labour problems dealt with (averted) at source	Number of incidents not dealt with at source. **Target:** Nil	Labour Relations records	Number of incidents not dealt with at source.	Number of incidents not dealt with at source.	1 (year)	Labour Relations records	Yes
Labour Relations Provide labour advisory service	Provide specialist advice to managers	Disputes, discipline and other issues resolved without compromising health service.	% of incidents resolved without compromising health service **Target:** 100%	Labour Relations records	% of incidents resolved without compromising health service	Number of incidents resolved without compromising health service	Total number of incidents	Labour Relations records	Yes
Human Resource Development Ensure appropriate development of human resources to support health service delivery.	Compare skills requirement with skills available. Provide training and bursaries to address skills needs.	Personnel are suitably qualified, trained and skilled to provide the desired level of health care.	Number of personnel trained. Number of bursaries awarded. **Targets:** 4000 persons trained 450 bursaries awarded	HRD records	Number of personnel trained. % of need Number of bursaries awarded. % of need	Number of personnel trained. Number of bursaries awarded.	1 (year) Total need 1 (year) Total need	HRD records	Yes
Human Resource Development Provide an Employees Assistance Programme	Develop policies and implementation strategy. Establish EAP	Personnel with problems assisted to enable them to return to full productivity	% of personnel who have access to EAP **Target:** 10% in 2003/4	HRD records	% of personnel who have access to EAP	Number of staff who have access to EAP	Total persons employed	HRD records	Yes

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Finance: Production of Annual Financial Statements	Collection of financial information to produce the statements	Statement reflecting the state of the financial affairs of the Department.	Annual Financial Statements accepted by Auditor General	PFMA	Timeous submission of statements	Produced Financial Statement	Financial Statement	FMS	yes
Finance: Monthly Revenue Statistical Monitoring	Collection of outstanding revenue data to produce a report	Report indicating outstanding revenue	Monthly submission of a credible report on outstanding revenue	Fees Systems	Timeous submission of reports	Produced report	Reports	Billing System	yes
Finance: Contract Administration	Identification of items regularly required to be procured by means of contracts	Awarded contract	Timeously concluded term and other contracts	Tender Board Law Regulations/ Instructions	Timeous conclusion of contracts	No of contracts concluded	Contract concluded	Sub Directorate: Procurement	Yes
Finance: Monthly Budget Monitoring	Collation of expenditure and revenue data to produce a report	Report indicating expenditure vs budget and revenue collected vs budget	Timeous monthly report indicating under and overspending and under and over recovery of revenue	PFMA	Timeous submission of reporting	Produced report	Reports	FMS	yes
Finance: Revenue Systems	Determination of requirements to secure/procure adequate billing systems	Billing System to address revenue recovery requirements	Revenue generated from appropriate systems introduced	Billing Systems	Functional systems	System implemented	System	Sub Directorate Systems	yes

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Business Manager: Provide for licensing of private hospitals and inspections	Regulation 187 Inspections and monitoring PHLC	Safe and sustainable private hospitals providing quality health care	Compliance with Regulation 187 **Target:** 100% compliance	Inspections and reporting in terms of R187	Level of compliance with R187	Number of hospitals in full compliance	Total number of private hospitals	Business Manager: Sub-directorate: Licensing and Inspections	Yes
Business Manager: Initiate and implement PPP's	Identify, evaluate, contract	Quality services at lower cost with risk transfer	Number of PPP's Input cost Payback period **Targets:** 10 PPP's R4 million outlay Average payback 2 years	Business Manager and institutional expenditure	Number of PPP's Input cost Payback period	Number of PPP's Established cost Established cost	1 (year) 1 (year) Annual saving	Business Manager and institutional expenditure	Yes
Business Manager: Provide private beds in Provincial Hospitals	Convert surplus beds for private and Medical Aid patients	Increased revenue	Increase in revenue **Target:** R5 million in 2003/4	FMS	Increase in revenue	Additional revenue from private beds	1 (year)	FMS	Yes
Business Manager: To support the process of creating a private network of beds within provincial hospitals	To convert surplus beds were there is capacity to contain private and medically funded patients To create financially sound revenue business plans so that projects breakeven or show a surplus within the first financial year of operation.	Increased revenue collection Profitable and sustainable private bed network	Increase in Revenue: **Target** : R 5 mill benefit in 2003/2004 in total Maximum revenue collection: **Target** 100% revenue collected against accounts raised Adherence to Revenue generation Policy criteria when policy is in place	• FMS and institutional records such as: • Account information and clinical audit • Monthly utilisation and managed care stats Monthly Financial information– in accordance with the new responsibility code	• Increase in revenue • Sound financially viable private network of beds that consistently generate surplus revenue	Additional revenue from private beds	1 (year)	FMS Account information and clinical audit Monthly utilisation and managed care statistics Monthly Financial information according to responsibility code.	Once the revenue generation policy is in place: Yes

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Business Manager: Provide Managed Care	Policy, protocols, procedures, UPFS and improved billing	Optimal care, reduced expenditure, increased revenue	Reduced expenditure, increased revenue **Target:** R5 million benefit in 2003/4	FMS and institutional records	Reduced expenditure, increased revenue	Reduction in expenditure plus increase in revenue (i.e. gross benefit)	1 (year)	Calculated from FMS and institutional records	Yes
Business Manager: Provide for Regulation of Private Healthcare Establishments	Licensing of Private Healthcare Establishment	Licensed and registered private healthcare establishments complying with all applicable health legislation	Compliance with R187 **Target:** All private healthcare establishments falling within the ambit of R187	Reports from public and other healthcare role players and site inspections in terms of R187	Level of compliance with R187	Total hospitals in full compliance	Total number of private healthcare establishments	Business Manager; Sub-directorate: Licensing	Yes
Business Manager: Provide for Regulation of Private Healthcare Establishments	Inspection of Private Healthcare Establishments	Safe and ethical private health establishments providing quality health care and a safe environment for patients, staff and the public	Compliance with R187, all applicable health and health professional regulations **Target:** All private healthcare establishments falling within the ambit of R187	Annual compulsory inspections, pre- and random inspections, and reports from public and other healthcare role players and compliance R187	Level of compliance with R187 and applicable health and health professional regulations	Total hospitals in full compliance	Total number of private healthcare establishments	Business Manager; Sub-directorate: Inspectorate	Yes
Business Manager: Provide Contract Management	To support the drafting and management of contracts for services purchased or provided as well as agreements with educational institutions	Efficient contract management value to the DOH and reducing risk. Improved service standards. Clear terms of interaction.	All tenders for services will be followed by a service level agreement and facility based contract management be done. Lower turnover of contractors/no termination of contracts due to poor performance.	• Condition for awarding tenders for services. • Number of contracts entered into. • Number of service level agreements.	• Number of service level agreements • Number of performance based agreements • Timeframe for joint agreements with universities	Number of service level agreements.	1 (year)	Tender Committee Procurement	Yes

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Business Manager: Provide for Provide for Public Private Interaction	To remain part of the PPI workgroup of National Health. To chair the Public Private Forum and with private sector roleplayers	Communicate effectively and regularly with Private healthcare sector roleplayers. Meet regularly with National PPI workgroup	1. Meeting every month. 2. Initiatives undertaken jointly with private sector. 3. Western Cape involvement of National Government.	Minutes and documentation from meeting.	• Level of communication • Number of roleplayers involved. • Meetings of workgroup attended. • Benefits to the Western Cape.	Number of meetings attended. Number of benefits to Western Cape.	1 (year)	Minutes Documents Released	Yes
Business Manager: To monitor and evaluate revenue generation projects to ensure compliance with revenue generation policy	Create tools for monthly evaluation of revenue projects	Accurate billing through clinical audits Accurate managed care information Accurate financial information UPFS training at the relevant institutions Delta 9 roll out of the billing module Evaluation tools in policy document for revenue generation projects	Adherence to Revenue generation Policy criteria when policy is in place Minutes and documentation from meetings and various steering committees Training schedules Monitoring and evaluation tools **Target:** monthly stats on revenue generation projects	FMS & institutional records Clinical audit reports Managed care reports Training schedule Minutes and document Policy (Revenue Generation)	Number of training sessions completed Number of institutions with case management personnel in place Monthly reports from all institutions with private beds	Monthly reports from institutions with: Managed care stats Financial report Billing statistics	1 (year)	Institutional records	

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Communications Maintain effective and efficient internal communication	Develop practical internal communications media and channels	Prompt communication of news and information. Regular face-to-face meetings between the S-G and staff at various health facilities	Number of bulletins, briefings, newsletters **Target:** Altogether 22 per year. Number of face-to-face meetings at health facilities. **Target:** 45 per year	Printed or e-mail copies of communications issued. Notes of meetings	Percentage of target achieved plus feedback from target audience	Number of items published	6-monthly cycles	Communications records	Yes
Communications Maintain effective public relations	Maintain active and mutually beneficial relationships with the Media and Health's external stakeholders	Daily inter-action with Media. Regular engagement with external stakeholders	Extent of coverage of Health matters in news media. **Target:** Good news coverage exceeds bad news coverage. Number of engagements with stakeholders. **Target: E**ngage at least on stakeholder per month.	Statistics of coverage and copies or transcripts of news items. Up-to-date stakeholder database with full details about stakeholders and records of mtgs.	Extent to which target achieved Extent to which target achieved plus feedback from stakeholders	Coverage measured in full Cape-Times-size pages Number of successful engagements	6-monthly cycles	Communications records	Yes
Communications Practise sound issue identification and management	Compile and maintain a database of Issues that can impact on Health Western Cape's reputation	Identification and analysis of issues; preparation of holding statement and position paper for each major issue	Number of identified and recorded issues **Target:** That all major issues have: holding statement; position paper; list of anticipated questions and answers.	Up-to-date Issues Identification and Management database	Extent to which target achieved	Number of completed Issue Papers	6-monthly cycles	Communications records	Yes
Communications Assist with awareness and promotions campaigns for Programmes and other Health directorates	Prepare communication plans on ad-hoc basis	Compiled and accepted communication plans	Number of implemented communications plans **Target:** Coverage of all awareness/ promotions campaign in at least two of the mass media	Copies of press articles; details or transcripts of radio/TV coverage	Extent to which target achieved	Number of plans implemented	6-monthly cycles	Communications records	Yes

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
HIV/AIDS: Prevent mother to child transmission	Treatment protocols. Appropriate drugs. Infant feeding.	Children HIV negative.	Number of mothers receiving treatment **Target:** 3000	Directorate: HIV/AIDS records	Number of mothers receiving treatment	Number of mothers receiving treatment	1 (year)	Directorate: HIV/AIDS records	Yes
HIV/AIDS: Provide for diagnosis and treatment of STD's	Free syndromic management drugs through selected GP's	Reduction in STD's	Number of patients receiving treatment **Target:** 12,000	Directorate: HIV/AIDS records	Number of patients receiving treatment	Number of patients receiving treatment	1 (year)	Directorate: HIV/AIDS records	Yes
HIV/AIDS: Provide voluntary counselling and testing (VCT)	Increase number of VCT sites. Promote VCT	People aware of their HIV status and able to act accordingly.	Number of people presenting for VCT **Target**: 20,000	Directorate: HIV/AIDS records	Number of people presenting for VCT	Number of people presenting for VCT	1 (year)	Directorate: HIV/AIDS records	Yes
HIV/AIDS: Promote the role of NGO's in prevention and management of HIV/AIDS	Policy and guidelines. Provincial funding for NGO's	AIDS prevention programme sustainable and cost effective.	Number of NGO's funded for HIV/AIDS interventions **Target:** ?	Directorate: HIV/AIDS records	Directorate: HIV/AIDS records	Number of NGO's funded	1 (year)	Directorate: HIV/AIDS records	Yes
HIV/AIDS: Provide treatment for opportunistic infections	Prophylactic therapy on EDL. Dedicated AIDS clinics	Reduction of opportunistic infections	Number of dedicated AIDS clinics. **Target:** 6	Directorate: HIV/AIDS records	Number of dedicated AIDS clinics.	Number of dedicated AIDS clinics.	1 (year)	Directorate: HIV/AIDS records	Yes
HIV/AIDS: Increase use of condoms	Greater accessibility. Free condoms. Male & Female condoms.	Reduced transmission of HIV	Number of condoms issued. **Target:** 18 million (in 2003/4)	Records of distribution agencies	Number of condoms issued.	Number of condoms issued.	1 (year)	Records of distribution agencies	Yes

PROGRAMME 1: ADMINISTRATION

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

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
1.1 Office of the Provincial Minister	1,463	2,516	2,302	2,723	2,870	2,990
1.2.1 Central Management	62,038	86,330	93,753	203,004	213,933	222,881
1.2.2 Decentralised Management	36,913	30,652	44.469	43,776	46,133	48,062
Total programme	**876,701**	**951,988**	**1,025,083**	**1,139,615**	**1,200,965**	**1,251,198**

Table: Evolution of expenditure of budget programme in constant 2002/03 prices (R million)[1]

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget)[2]
Total[3]	1,653	2,672	2,302	23,9%	2,588
Total per person[4]	0,39	0,63	0,53	22,5%	0,60
Total per uninsured person[5]	0,54	0,87	0,74	22,5%	0,83

PROGRAMME 2 : DISTRICT HEALTH SERVICES

PROGRAMME DESCRIPTION

To render Primary Health Care Services (Act 63 of 1977) and coroner services

PROGRAMME DESCRIPTION:

2.1 District management

Planning and administration of services, managing personnel- and financial administration and the co-ordinating and 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.

2.2 Community health clinics

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

2.3 Community health centres

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

2.4 Community based services

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

2.5 Other community services

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

2.6 HIV/AIDS

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

2.7 Nutrition

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

2.8 Coroner services

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

2.9 District hospitals

Rendering of a hospital service at primary health care level

****

PRIMARY HEALTH CARE SERVICES

This section deals with sub-programmes 2.1, 2.2, 2.3, 2.4 and 2.5

Aim:

- Planning and administration of services, co-ordination and management of community health services rendered by local authorities and non-governmental organisations
- Rendering of primary health care services

Situation Analysis

Attendances at Primary Health Care facilities has been steadily increasing over the years both in the Metro and the rural regions. This increase is partly explained by the increase in TB and AIDS. In addition, there is a deliberate policy to have PHC level patients treated at PHC level rather than in District Hospitals OPD. An additional factor is the fact that an increasing number of chronic patients are attending PHC facilities for their specialised medication in-between their six-monthly visits to specialists, translating in a significant financial pressure on PHC services. The impact of migration is difficult to quantify but there is indication that it affects more specifically the South Cape and the Metro regions. , as a result calculation of exact utilisation rates may be misleading. However utilisation rates (excluding DOTS visits, and based on Western-Cape uninsured population) are at 3.6 above the national norm .

Integration of services between Province and Local government has still not be formalised. Following several years of work by the Bi-Ministerial Task Team (Health and Local Government), it was decided to use transfer to the City of Cape Town as a pilot. Consultants were appointed, several technical task teams were set up and the Western Cape Cabinet gave an in principle approval to explore further the possibilities of transfer. However, the process was stopped following concerns of Treasury about risk-sharing and the financial implications of such a transfer, concerns based largely on the differences in salary packages between province and local government. Much inefficiency remains due to the non-integration of services.

In the Metro, PHC services rendered by the Province remain very doctor dominated. Whilst this is partly due to the lack of district hospitals in the Metro, the province acknowledges the problem and aims at a redressing of the skill mix to increase the role of nurses in the delivery of PHC services.

In the rural regions, District Surgeons contracts have been re-negotiated and their services, during the week, integrated within the existing PHC facilities.

A detailed situation analysis of PHC services, the scope, the quantum, their staffing and funding is being carried out in all regions and will inform Service Level Agreements due to be finalised in March 2003.

Table: District health service facilities by health district

Health district[1]	Facility type	No.	Average population per facility[2]	District hospital beds (no.)	District hospital beds per 1000 people[2]	District hospital beds per 1000 uninsured people[3]
Boland	Visiting points[4]	41	---	---	---	---
	Clinics[5]	54	---	---	---	---
	CHCs	3	---	---	---	---
	Sub-total clinics + CHCs	57	9,883	---	---	---
	District hospitals	4	140,828	272	0.48	---
Central Karoo : Rural development Node	Visiting points[4]	9	---	---	---	---
	Clinics[5]	8	---	---	---	---
	CHCs	1	---	---	---	---
	Sub-total clinics + CHCs	9	6,241	---	---	---
	District hospitals	4	14,042	129	2.30	---
Klein Karoo	Visiting points[4]	27	---	---	---	---
	Clinics[5]	40	---	---	---	---
	CHCs	8	---	---	---	---
	Sub-total clinics + CHCs	48	7,938	---	---	---
	District hospitals	4	63,507	448	1.18	---
Metro – City of Cape Town	Visiting points[4]	19	---	---	---	---
	Clinics[5]	86	---	---	---	---
	CHCs	41	---	---	---	---
	Sub-total clinics + CHCs	127	25,885	---	---	---
	District hospitals	2	1,643,727	93	0.03	---
Metro : Urban Node Included in above section	Visiting points[4]	2				
	Clinics[5]	14				
	CHCs	4				
	Sub-total clinics + CHCs	18				
	District hospitals	0				
Overberg	Visiting points[4]	14	---	---	---	---
	Clinics[5]	23	---	---	---	---
	CHCs	3	---	---	---	---
	Sub-total clinics + CHCs	26	6,117	---	---	---
	District hospitals	4	39,758	205	1.29	---
West-Coast	Visiting points[4]	53	---	---	---	---
	Clinics[5]	18	---	---	---	---
	CHCs	2	---	---	---	---
	Sub-total clinics + CHCs	20	11,733	---	---	---
	District hospitals	7	33,522	369	1.57	---
Province	Visiting points[4]	163	---	---	---	---
	Clinics[5]	229	---	---	---	---
	CHCs	58	---	---	---	---
	Sub-total clinics + CHCs	450	16,312	---	---	---
	District hospitals	27	173,395	1,516	0.32	0.45

Table: Basic infrastructural services in district facility network by health district

Health district[1]	Facility type	No.	No. (%) with electricity supply from grid	No. (%) with piped water supply	No. (%) with fixed line telephone
Province	Clinics[2]	229	100%	100%	100%
	CHCs	58	100%	100%	100%
	District hospitals	27	100%	100%	100%

Table: Physical condition of district facility network*

Facility type	No.	Average 1996 NHFA condition grading[1]	Any later provincial audit grading (with date)	Outline of major rehabilitation projects since last audit
Visiting points[2]		---		
Clinics[3]		---		
CHCs				

*Clinics not covered by NHFA

Table: Personnel in district health services by health district[1]

HEALTH DISTRICT	PERSONNEL CATEGORY	NUMBER FTE	NUMBER PER 1000 PEOPLE
BOLAND	Medical officer	56.07	0.10
	Professional Nurses	253.15	0.45
	Clinical support	203.37	0.36
	Junior & Senior admin	39.60	0.07
	General Assistant	103.00	0.18
	Pharmacist	8.44	0.01
	Pharmacy assistant	5.00	0.01
	Dentists	6.11	0.01
	Dental assistant	7.09	0.01
	Health educator/SASO	15.20	0.03
	Lay Counsellor	24.37	0.04
	Home-Based Carers	14.00	0.02
	Psychiatrist	5.24	0.01
	Other Specialists	1.00	0.00
	Mental Health Nurse	4.08	0.01
	Orthopedic Nurse	0.09	0.00
	Physio	8.22	0.01
	Psychologist	1.23	0.00
	OT	1.16	0.00
	Social worker	0.06	0.00
	Dietician	2.38	0.00
	Speech Terapist	0.07	0.00
	TOTAL	**760.96**	**1.35**

HEALTH DISTRICT	PERSONNEL CATEGORY	NUMBER FTE	NUMBER PER 1000 PEOPLE
CENTRAL KAROO	Medical officer	5.53	0.10
	Professional Nurses	26.00	0.46
	Clinicical support	19.00	0.34
	Junior & Senior admin	6.00	0.11
	General Assistant	8.03	0.14
	Pharmacist	2.00	0.04
	Pharmacy assistant	4.00	0.07
	Dentists	1.00	0.02
	Dental assistant	1.00	0.02
	Health educator/SASO	7.50	0.13
	Lay Counsellor	1.00	0.02
	Home-Based Carers	14.00	0.25
	Psychiatrist	1.08	0.02
	Other Specialists	0.04	0.00
	Mental Health Nurse	0.40	0.01
	Orthopedic Nurse	0.50	0.01
	Physio	1.10	0.02
	Psychologist	0.03	0.00
	OT	0.08	0.00
	Social worker	1.23	0.02
	Dietician	1.40	0.02
	Speech Terapist	0.10	0.00
	TOTAL	**101.01**	1.80
KLEIN KAROO	Uncomplete information		
			3287454.00
METRO	Management and Central adm	210	0.06
	Medical officer	128	0.04
	Professional Nurses	784	0.24
	Clinical Support	416	0.13
	Junior & Senior admin	321	0.10
	General Assistant	362	0.11
	Pharmacist	29	0.01
	Pharmacy assistant	0	0.00
	Dentists	15	0.00
	Dental assistant	9	0.00
	Health educator/SASO	104	0.03
	Lay Counsellor		0.00
	Community base	24	0.01
	Physio	4	0.00
	Radographer	12	0.00
	Social worker	3	0.00
	Dietician	2	0.00
	TOTAL	2423	0.74
Urban Node	Medical officer	37	0.06
(included in Metro)	Professional Nurses	196	0.29
	Clinical support	120	0.18
	Junior & Senior Admin	54	0.08
	General Assistant	87	0.13
	Pharmacist	6	0.01

HEALTH DISTRICT	PERSONNEL CATEGORY	NUMBER FTE	NUMBER PER 1000 PEOPLE
OVERBERG	Medical officer	5.04	0.03
	Nursing staff	82.24	0.52
	Clinical Support	6.00	0.04
	Junior & Senior admin	9.13	0.06
	General Assistant	10.75	0.07
	Pharmacist	2.40	0.02
	Pharmacy assistant	4.45	0.03
	Dentists	1.23	0.01
	Dental assistant	1.19	0.01
	Health educator/SASO	21.55	0.14
	Lay Counsellor	0.00	0.00
	Home-Based Carers	1.63	0.01
	Psychiatrist	0.03	0.00
	Orthopedic Nurse	1.42	0.01
	Physio	1.75	0.01
	TOTAL	**148.80**	0.94
WEST COAST	Medical officer	3.01	0.01
	Professional Nurses	71.54	0.30
	Clinical support	57.25	0.24
	Junior & Senior Admin	5.63	0.02
	General Assistant	11.15	0.05
	Pharmacist	2.25	0.01
	Dentists	1.95	0.01
	Dental assistant	2.00	0.01
	Health educator/SASO	10.60	0.05
	Lay Counsellor	25.40	0.11
	Home-Based Carers	2.50	0.01
	Psychiatrist	3.11	0.01
	Other Specialists	1.00	0.00
	Mental Health Nurse	5.84	0.02
	Orthopedic Nurse	2.70	0.01
	Physio	1.45	0.01
	Psychologist	1.60	0.01
	OT	2.00	0.01
	Social worker	2.20	0.01
	Dietician	0.03	0.00
	TOTAL	**213.22**	0.91

Policies, Priorities and broad strategic objectives

The overall policy direction for the whole department is to treat patients at the most appropriate level, and the policy framework for 2010 (currently under consultation) envisages a very significant increase in funding for community-based (from R6 millions to R60 milllions) and facility-based care at PHC level. It also plans to allocate R40 millions for Prevention and Promotion. The Prevention and Promotion work will be undertaken with a cross-sectoral approach involving other departments in the Province. Altogether the PHC budget would increase by R439 millions by 2010.

This vision means that a number of patients currently treated in hospital, due to lack of capacity at PHC level will be over-time shifted to PHC level.

The priorities over the next 3 years are thus :

- to build capacity at PHC level
- to incrementally develop a Home-Based Care system
- to ensure optimal deployment of resources, including appropriate skill mix
- to improve quality of care
- to ensure more equitable allocation of resources between regions and between districts.

Constraints and measures planned to overcome them

Human Resources :

- The province suffers from a shortage of nurses, training and retaining nurses is a serious challenge. The province has now moved to a system of bursaries which allows a greater number of nurses to be trained. A particular concern is the need for Clinical Nurse Practitioners, urgently needed if the predominance of doctors at PHC level in the Metro is to be addressed.
- One of the implications of Healthcare 2010 is that a number of chronic patients, currently hospitalised in the Psychiatric hospitals will be discharged to be cared for in the community. Mental Health skills need to be developed at PHC level for these patients, but also for the high number of undiagnosed patients, as burden of disease analysis indicates that mental health will become one of the main health challenges.
- The increasing role of PHC services requires that the scope of skill mix at this level increases. In particular the role of health allied workers : psychologists, physiotherapists, occupational therapists … needs to be analysed and the implications quantified.
- The role of mid-level workers, and their potential impact on the staff team skill mix needs to be analysed.

A human resource planning exercise is currently underway to quantify the needs and plan the required responses.

Financial Pressures :

- Whilst it is envisaged that PHC will receive additional resources, the issue of sequencing needs to be addressed : the additional funding for PHC will be made possible by a decrease in funding in the academic hospitals. This in turn relies on an increased capacity of

level 2, level 1 and PHC services to minimise the referrals up. Defining the appropriate steps of restructuring so that services at one level are not being cut if there is not the capacity at the lower level to cater for the patients is one of the major challenge to overcome.

The additional resources for PHC will also have to cope with a significant increase in demand, independently from the restructuring- this is the demand from the AIDS and TB epidemics which will place a severe burden on the services.

Planned quality improvement measures :

The department has adopted a Quality of Care policy in 2002, and the following measures are being planned to ensure its implementation :

- Client Satisfaction Surveys are currently being piloted. They will be rolled be rolled out to all provincial PHC facilities in 2003
- Complaints and compliments monitoring system implemented in all facilities (2003-04)
- Staff satisfaction surveys in selected facilities (2003), rolled-out (2004)
- Development of standards (2003)
- Training of trainers on facility supervision (2003)
- Training of facility supervisors : 2003 and 2004
- Development of Adverse Incident Monitoring System (2003)

Table: Performance indicators for Primary Health Care

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Management and support for the provision of accessible and affordable Primary Health Care Services in the Metro region	Strengthening of District Health Sys- tem with integration of provincial and local government services	Transfer of selected Community Health Centres to local government	Transfer of 35 Community Health Centres to the Unicity	Transfer approved, contracts signed with Local Authorities	Transfer of selected Community Health Centres to local government	Number of CHC's transferred	Target 35 CHC's		
	Improved management of the 24 hours Community Health Centres and Maternity Obstetrics Units	Skills mix analysis and optimal deployment	Skills mix analysis completed and optimal deployment processes initiated	Human Resource report to regional and provincial offices	Skills mix analysis per facility	Number of facilities analysed	Number of facilities targeted	HR Reports	HR

SUBPROGRAMME 2.2: COMMUNITY HEALTH SERVICES

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Improve Child Health	Improve immunisation coverage	Diphteria, Polio and Tetanus (DPT3) vaccination rate	85%	Information systems: RMR: Routine monthly returns to Regional and Provincial Offices	Immunisation Coverage at 1 yr (4.1.3)	DPT3 doses	Children < 1yr	GW 20/8 RMR & Census	Information Management
Reduce HIV and TB prevalence	Improve Sexually Transmitted Diseases treatment	Training of public and private sector providers in Syndromic Approach	All professional nurses in Primary Health Care public sector trained	AIDS Directorate report	Percentage Nurses Trained	Number of Nurses Trained	Target Number of Nurses to be Trained (? per year)	Training Register	
Reduce HIV and TB prevalence	Improve Sexually Transmitted Diseases treatment	Training of public and private sector providers in Syndromic Approach	An additional 100 general practitioners trained during the year	AIDS Directorate report	Percentage GP's Trained	Number of GP's Trained	100 (Target)	Training Register	
Reduce HIV and TB prevalence	Improve access to Voluntary Counsel-ling and Testing (VCT)	Number of sites with VCT	100 additional sites will offer VCT, bringing total number to 250	AIDS Directorate report	Percentage New VCT Sites	Number of New VCT Sites	100 (Target)	Quarterly Report	

Table: Evolution of Primary Health Care performance indicators

Objective	Indicator	2001/2	2003/4	2004/5	2005/6
Coverage of the population with optimal range of Health Services	Percentage of PHC facilities offering the full package of services	N/A	85%	100%	100%
Intra- and Interprovincial Equity with respect to PHC service delivery	No. of visits (headcount) at Public PHC per uninsured population	3,6	3,2	3,0	3,0
Optimal service delivery being achieved with respect to Preventive services	Percentage of children,< 1 fully immunised	73	80	80	90
Services delivered in good quality facilities	Percentage of PHC facilities in Audit Condition 4or5	81%	81%	81%	85%
Quality control being implemented at PHC level	Percentage of facilities visited at least once a month by a supervisor who produces a written report	N/A	N/A	60%	!00%
Adequate provision of medicines	Percentage of Public facilities without vaccines at any time	N/A	<5%	0%	0%

Table: Performance indicators for district health services as a whole*

Indicator	Province wide value	By health district**	National target
Input			
1. Population served per fixed public PHC facility***	11 761		Max. 10 000 people
2. Provincial DHS expenditure per person	R201,78		
3. Provincial DHS expenditure per uninsured person	R 280,24		
4. Total DHS expenditure (provincial plus local government) per person (if data available)	R267,76		
5. Total DHS expenditure (provincial plus local government) per uninsured person (if data available)	R371,89		
6. Number of professional nurses in fixed public PHC facilities per 1000 people	0,31		
7. Number of professional nurses in fixed public PHC facilities per 1000 uninsured people	0,43		
8. Percentage of fixed public PHC facilities offering the full package of PHC services	N/A		100% by 2004
Process			
9. Percentage of health districts with appointed manager	*		100%
10. Percentage of health districts with formal plan	*		100%
11. Percentage of fixed public PHC facilities with functioning community participation structure	*		100%
Output			
12. Number of visits (headcount) at public PHC facilities per person per year	2,76		
13. Number of visits (headcount) at public PHC facilities per uninsured person per year	3,8		3.5
14. Percentage of children under one year fully immunised	73%		90%
Quality			
15. Percentage of fixed public PHC facilities in facility audit condition 4 or 5	81%		
16. Percentage of public PHC facilities visited at least once per month by a supervisor who produces a written report	*		100%
17. Percentage of public PHC facilities supported by a doctor at least once a week	N/A		100% by 2004
18. Proportion of health districts with a formal quality improvement plan	None		
19. Percentage of public PHC facilities without vaccines at any time of year	N/A	✓	0%
Efficiency			
20. Provincial expenditure per visit (headcount) at provincial PHC facilities	N/A	✓	
21. Total expenditure (provincial plus local government) per visit (headcount) at public PHC facilities (if data available)	N/A	✓	
Outcome			
22. Number of measles cases	181	✓	

In the Metropole interim District Structures have been created with Managers being appointed from Both the Provincial Authority as well as the Local Government side to promote the transition to the DHS. This process is not yet complete and therefore cannot be exhaustively commented upon.

Transfers to Municipalities and NGO's (R'000)					
		2002/03	2003/04	2004/05	2005/06
Blaauwberg Administration	Environmental and Comprehensive health: To render primary health care services	3,317	**3 487**	3 661	3 844
Cape of Cape Town Administration	Environmental and Comprehensive health: To render primary health care services	60,306	**33 485**	35 159	36 917
Oostenberg Administration	Environmental and Comprehensive health: To render primary health care services	6,935	**7 174**	7 533	7 909
Helderberg Administration	Environmental and Comprehensive health: To render primary health care services	4,676	**4 870**	5 114	5 369
South Peninsula Administration	Environmental and Comprehensive health: To render primary health care services	9,801	**0 098**	1 0 603	11 133
Tygerberg Administration	Environmental and Comprehensive health: To render primary health care services	28,448	**29 116**	30 572	32 100
Agulhas Municipality	Environmental health: To render primary health care services	63	**67**	70	74
Breede vallei Municipality	Environmental and Comprehensive health: To render primary health care services	1,630	**1 660**	1 743	1 830
Breërivier Wynland Municipality	Environmental and Comprehensive health: To render primary health care services	835	**815**	856	899
Overstrand Municipality	Environmental and Comprehensive health: To render primary health care services	995	**1 005**	1 055	1 108
Theewaterskloof Municipality	Environmental and Comprehensive health: To render primary health care services	1,705	**1 765**	1 853	1 946
Witzenberg Municipality	Environmental and Comprehensive health: To render primary health care services	640	**595**	625	656
Langeberg Municipality	Environmental and Comprehensive health: To render primary health care services	2,156	**2 231**	2 343	2 460
Beaufort West Municipality	Environmental and Comprehensive health: To render primary health care services	1,102	**1 129**	1 185	1 245
George Municipality	Environmental and Comprehensive health: To render primary health care services	5,200	**5 410**	5 681	5 965
Mosselbay Municipality	Environmental and Comprehensive health: To render primary health care services	2,348	**2 420**	2 541	2 668
Knysna Municipality	Environmental and Comprehensive health: To render primary health care services	1,885	**1 905**	2 000	2 100
Laingsburg Municipality	Environmental and Comprehensive health: To render primary health care services	25	**26**	27	29
Oudtshoorn Municipality	Environmental and Comprehensive health: To render primary health care services	875	**878**	922	968
Plettenberg Bay Municipality	Environmental and Comprehensive health: To render primary health care services	1,864	**1 915**	2 011	2 111

Prins Albert Municipality	Environmental and Comprehensive health: To render primary health care services	260	**272**	286	300
West coast					
Cederberg Municipality	Environmental and Comprehensive health: To render primary health care services	548	**461**	484	508
Swartland Municipality	Environmental and Comprehensive health: To render primary health care services	1,576	**1 771**	1 860	1 953
Drakenstein Municipality	Environmental and Comprehensive health: To render primary health care services	3,352	**3 283**	3 447	3 620
Bergrivier Municipality	Environmental and Comprehensive health: To render primary health care services	349	**33**	35	36
Stellenbosch Municipality	Environmental and Comprehensive health: To render primary health care services	1,998	**2 184**	2 293	2 408
Saldanha Municipality	Environmental and Comprehensive health: To render primary health care services	1,559	**1 647**	1 729	1 816
Matzikama Municipality	Environmental and Comprehensive health: To render primary health care services	543	**719**	755	793
Boland Districts Municipality	Environmental and Comprehensive health: To render primary health care services	8,017	**8 340**	8 757	9 195
Overberg Districts Municipality	Environmental and Comprehensive health: To render primary health care services	6,299	**6 925**	7 271	7 635
Central Karoo District Municipality	Environmental and Comprehensive health: To render primary health care services	3,274	**3 388**	3 557	3 735
Garden Route District Municipality	Environmental and Comprehensive health: To render primary health care services	8,372	**8 404**	8 824	9 265
Westcoast District Council	Environmental and Comprehensive health: To render primary health care services	760	**7 326**	7 692	8 077
Boland Region District Municipality	Environmental and Comprehensive health: To render primary health care services	5,991	**907**	952	1 000
TOTAL		**177,727**	**155,735**	**163,522**	**171,698**
NGO'S	Rendering a community based health service at non-	**70,199**	**73,410**	**78,036**	**79,792**
	health facilities in respect of licensed homes, group				
	homes, day care centres , aids,etc.				
TOTAL		**247,926**	**229,145**	**241,558**	**251,490**

SUB-PROGRAMME 2.6 : HIV/AIDS & STI

AIM: Working against AIDS in South Africa by more effectively curtailing the spread of HIV, sharply reducing its impact on human suffering, and halting the further reversal of human, social and economic development in our province.

SITUATIONAL ANALYSIS

The Western Cape's population is estimated at 4 187 035. The 2001 Annual HIV Antenatal Survey revealed that 8.6% of women were HIV infected. The HIV prevalence in the districts of the Western Cape showed that the prevalence ranged from <1% to 22.4%. Between 2000 and 2001 there was almost doubling in HIV prevalence in four of the five sites previously examined. The HIV prevalence in the western Cape is highest among the 25-29 age group.
Sexually transmitted infections (STI) remain a public health problem of major significance in most parts of the world

Approximately 125 000 patients are treated in the province each year.

Table: Baseline data on HIV/AIDS/STI/TB control programme

Condition	1999		2000		2001	
	No.	No. per 100 000 people	No.	No. per 100 000 people	No.	No. per 100 000 people
HIV antenatal seroprevalence	7,1		8,7		8,6	
VCT uptake	702	---	7200	---	17 616	---
PMCT - HIV positive - HIV negative - counselled/tested - on nevirapine		--- --- --- --- ---	 1752 8267 10019 838*	--- --- --- --- ---	 3077 14330 17407 712	--- --- --- --- ---
STIs (total cases)	112 440	2714	121771	2884	120 589	2803
Syphilis cases						
Syphilis prevalence	4,4	---	5,1	---	2,9	---
New smear positive TB cases	13350	322	14267	338	15370	357
All TB cases reported	31573	762	33855	802	35920	835
PTB cases reported	22989	555	24717	585	26066	606

Overview of the MTCT programme from the raw data 2001 to August 2002

Rollout coverage 84% - target 100% by 2003
Total antenatal care bookings - 54156
Total number of clients accepted testing - 47059
Total number of clients tested positive - 6430

POLICIES, PRIORITIES AND BROAD STATEGIC OBJECTIVES

The overall goal is to reduce the number of new HIV/AIDS infections and to care and support those already infected.
The programme mobilises communities and aims to bring about changes in wider society i.e. changes in behaviour patterns, which will lead to the prevention and reduction of HIV.
Identification of GP's to participate in the programme.
Training of GP's in syndromic management.
According to the National DOH Voluntary HIV Counselling and Testing Guidelines (2001), Voluntary HIV Counselling and Testing is a primary and secondary prevention strategy which aims to promote awareness and understanding of one's risk for HIV infection and one's HIV status together with developing coping skills in order to:

- Prevent the spread of HIV
- Gain access to the continuum of care, treatment and support.
- Reduce stigma and discriminations through knowledge and mutual support.
- Empower people to adopt preventive behaviours.

Treatment programmes in Africa have successfully reduced mother-to-child transmission to approximately 12%.

CONSTRAINTS AND MEASURE PLANNED TO OVERCOME THEM

The partnership means bringing together autonomous and often disparate sectors to work towards a common goal.
Guide the process of having a co-ordinated and equitable NGO funding programme in the province that complies with the PFMA requirements.
Given the fact that HIV/AIDS is a developmental issue, a gender issue and a human rights issue, it becomes obvious that Department of Health's response alone is grossly inadequate and ineffectual.

The Western Cape Province is planning to implement a revised PMTCT protocol and ARV regimes for the mother and baby during 2003/04 with the goal of further reducing the transmission of HIV from mother to the baby to less than 5%. A double regimen of AZT and Nevirapine will be introduced.

PLANNED QUALITY IMPROVEMENT MEASURES

Strengthen existing VCT sites by:

- Providing ongoing training for counsellors
- Improving the counsellor mentoring system
- Improving the work conditions of counsellors
- Standardising the training programme of counsellors

VCT has to be part of the TB programme as many people with HIV/AIDS present with TB and the assumption is that many TB patients could be HIV positive but do not know their status as they have not tested.

HIV/AIDS by its very nature is a traumatic disease. It is therefore imperative that people infected and affected by this disease should receive some form of counselling, whether spiritual or psychological. The Faith Based sector therefore is best suited to provide spiritual counselling to those infected and affected.
The possibility of adding new regimen to the programme that is going to reduce the transmission more than 12% as the present protocols.

Table: Performance indicators for HIV/AIDS/STI/TB

Indicator	Province wide value	By health district	National target by 2005
Input			
1. Total dedicated expenditure on HIV/AIDS activities			
2. Percentage of public PHC facilities** where condoms are freely available			100%
3. Percentage of provincial hospitals and fixed PHC facilities** offering VCT	84,3		
4. Percentage of facilities of all types offering syndromic management of STIs	100%		
5. Number of health districts using DOTS (with names)	0 %		All districts
6. Number of TB/HIV health districts (with names)	0%		
7. Percentage of TB cases with a DOT supporter	91.1%		
Process			
8. HIV/AIDS plan formulated with stakeholders			
9. Percentage of TB cases reported on	100%		100%
Output			
10. Number of people trained in syndromic management of STIs			
11. Smear positive PTB cases as percentage of all PTB cases	85,2 %		50-70%
12. New smear positive PTB cases as percentage of expected number of cases			70%
Quality			
13. Average TB specimen turn around time	68,7%		< 48 hours
14. Percentage of TB cases who are being re-treated	34,8%		6-8%
15. Percentage of new smear positive PTB cases who interrupt treatment	15,4%		<10%
Efficiency			
16. Percentage of dedicated HIV/AIDS budget spent			100%

Outcome			
17. Antenatal HIV seroprevalence rate	8,6%		
18. Syphilis prevalance rate at sentinel sites	2,94%		
19. PTB smear conversion rate at 2 months for new cases	77%		> 85%
20. PTB smear conversion rate at 3 months for re-treated cases	70,9%		> 80%
21. Percentage of new smear positive PTB cases cured at first attempt	74,2%		> 85%
22. Percentage of TB cases that are MDR	1,1%		< 1%

** 'Public' means provincial plus local government facilities. 'Fixed' means clinics plus community health centres.

TUBERCULOSIS

AIM:

1. Policies, priorities and broad strategic objectives

Over the past 5 years the DOTS strategy has been successfully introduced throughout the Province. While the number of TB patients and the incidence rates have increased substantially during this period, the reported cure rates have remained stable at just below 70%. In an effort to improve on this, many clinic staff and health management at local authority and provincial level are now carefully monitoring outcomes every three months, encouraging accurate reporting and encouraging those involved to improve outcomes.

- Strong commitment to managing the programme well, with regular reviews of quarterly reports by clinic staff and management, as well as politicians.
- The priority is on identifying and curing the most infectious people (i.e. those who are sputum smear positive). This means that the diagnosis is primarily, but not only, laboratory, rather than chest X-ray, based.
- Standardised treatment regimens with direct observation of treatment for at least the first two months.
- Ensuring a reliable supply of TB drugs at minimal inconvenience and at no charge.
- Careful monitoring of the case finding and outcomes based on a register of smear positive patients.
- This shows a dramatic rise in extra-pulmonary TB in relation to PTB and Primary TB, and is, of course, due to the AIDS epidemic. These trends have important implications for the DOTS strategy and closer co-operation with the HIV/AIDS programme.

2. Constraints and measures planned to overcome them.

Lack of co-ordination overcome by placement of a District Co-ordinator in every proposed Health District in 2002.

There has been a steady increase in the rate of registration of new smear positive cases for the period 1996 to 2000. Compared to other countries even in sub-Saharan Africa, these are very high rates and merit further investigation. The marked increase in smear positive rates in 1997 could be **ascribed to** DOTS was introduced in 1996.

The high rate of smear positivity means that patients are presenting late; that early diagnosis is being missed and that the diagnostic criteria are too strict or that there is a laboratory reporting problem.

Such a high smear positive rate means that early diagnosis is being missed and that many patients are only starting treatment when there is significant lung damage

3. **Planned quality improvement measures**.

- The introduction of the new district based electronic register should enable us to keep a more complete record of cohorts of TB patients.
- Accurate monitoring and regular discussion of the outcomes at individual facilities can provide clues to improving performance of other facilities.
- Better documentation and relatively easy follow-up.

Key Measurable Objectives: HIV/Aids, STI's and TB

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Prevent the spread of HIV/AIDS	i.Promote an understanding of HIV status as a Primary and Secondary prevention strategy ii. Gain access to continuum of care and support	No.of facilities offering Voluntary Counselling and testing (VCT) for HIV status	!00% of facilities	Reports from Branch Special Health Projects	No. of PHC facilities offering VCT as percentage of total no. of PHC facilities in Province	No. of facilities offering VCT	Total No. of PHC facilities in Province	Reports from HIV/AIDS project Annual Report	Yes
	ii. Full utilization of funding made available for HIV/AIDS programme	Percentage of HIV budget spent in line with financial regulations	100% of budgeted amount spent per annum	Annual Reports Financial Reports	Percentage of dedicated HIV/AIDS funding spent effectively	Total Amount spent on HIV/AIDS	Total Budgeted amount for HIV/AIDS	Departmental Budget FMS	Yes
	iii. Prevention of Mother-to-Child transmission	Full integration of PMTCT programme into Provincial Obstetric services	100% of Obstetric Facilities offering PMTCT services	Branch Special projects Report HIV report	No. of Obstetric Facilities offering PMTCT services as % of Total no. of Facilities rendering obstetric services	No. of facilities rendering PMTCT services as part of an Integrated Obstetric Service to all pregnant mothers in the Province	Total No. of Obstetric facilities in Prov.	HIVAIDS reports Annual Report	Yes

PROGRAMME 2.6: EVOLUTION OF TB/HIV-AIDS/STD PERFORMANCE NDICATORS

OBJECTIVE	INDICATOR	2005 TARGET	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06
INPUT								
	Total Dedicated Expenditure on HIV/AIDS activities							
	% of PHC facilities where condoms freely available	100.00%						
	% of PHC facilities offering VCT	100.00%		84,3%				
	% of facilities offering syndromic Mx of STI's			100.00%				
	No. of Health Districts using DOTS	100.00%	0.00%	0.00%				
	No. of TB/HIV health Districts			0.00%				
	% of TB cases with a DOT supporter	100%		91.10%				

PROCESS									
	HIV/AIDS plan formulated with stakeholders								
	% of TB cases reported upon	1		100.00%					
OUTPUT									
	No. of people trained in syndromic Mx of STI's								
	No. of smear positive PTB cases as % of all cases	50-70%		85,2%					
	New smear positive PTB cases as % of expected no. of cases	70.00%							
QUALITY									
	Syphilis prevalence at sentinel sites			2,94%					
	Percentage of TB cases who are being retreated	6-8%		34,8%					
	TB treatment interruption rate	<10%		15,4%					

EFFICIENCY								
	% of dedicated HIV/ Budget spent							
OUTCOME								
	Antenatal HIV sero-prevalence rate			8,6%				
	Syphilis prevalence at sentinel sites			6,8%				
	PTB smear conversion rates at 2 mnths (new)	>85%		77.00%				
	PTB smear conversion rates at 3 mnths (reRX)	>80%		70,9%				
	Cure rates of new PTB smear positive cases	>85%		74,2%				
	% of TB cases that are MDR	<1%		1,1%				

PROGRAMME 2.7: NUTRITION

Integrated Nutrition Programme

Background

The national integrated nutrition programme functions within the framework of the Provincial Health plan. It is largely located within the framework of the District Health system and its administration rests on existing structures. Although the W cape has the highest per capita income in the country there are several very poor areas including informal settlements and rural areas where seasonal farm workers eke out an existence. In these areas there is a large element of substance abuse in particular alcohol abuse. A study of a typical town in the Province reported a FAS prevalence of as high as 4,8% amongst Grade 1 children. Only 12% of the land in the Western Cape is arable, hence not being available for food production.

Situation analysis

One in every four children in the province is stunted, suffering form chronic malnutrition. One in every ten children is underweight for age and approximately 15% are born with a low birth weight. Anaemia and Marginal Vitamin A deficiency are wider spread and there is a high degree of parasite infestation.

Table: Baseline nutrition indicators*

Indicator	Provincial status	Data source
Child stunting	14,5%	National Food Consumption Survey 1999
Child wasting	1,1%	National Food Consumption Survey 1999
Child underweight	7,4%	National Food Consumption Survey 1999
Child severe underweight	0,7%	National Food Consumption Survey 1999
Adult overweight	M25,3%F25,9%	South African Demographic and Health Survey 1998
Adult obesity	M13,1%F31,2%	South African Demographic and Health Survey 1998
Child vitamin A deficiency	21%	South African Vitamin A Consultative Group Survey 1995
Child iron deficiency	8,2%	South African Vitamin A Consultative Group Survey 1995
Iodine deficiency disorders	8%	National Iodine Deficiency Disorder Survey 1998
Exclusive breast feeding	N/A	South African Demographic and Health Survey 1998
Continued breast feeding	N/A	South African Demographic and Health Survey 1998

POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Key challenges facing the Department are contained in the major programmes identified, namely:

Disease-specific Nutrition support, Treatment and Counselling which strives to improve the nutrition knowledge of people living with chronic diseases of lifestyle.
It also strives to decrease the prevalence of malnutrition through nutrition supplementation and support.
The Growth Monitoring and Promotion programme seeks to rehabilitate malnourished children, to contribute to the health of pregnant and lactating mother, to provide improved care for children through improved care of children and early treatment of infectious diseases. This is achieved through food supplementation which is provided at clinics, breast feeding support and Promotion of the Baby-friendly Hospital Initiative, Growth Monitoring and Promotion, Nutrition Education and Promotion
The Nutrition Education & Promotion and Advocacy strategy seeks to empower people through increasing knowledge about Nutrition through publicity material, advocacy, media release and liaison visits.
The Macro nutrient Malnutrition Control Programme provides Vitamin A capsules to all health facilities, which in turn is supplied via trained personnel to children displaying signs of anaemia or those with specific infectious diseases. Mothers are also educated about the importance of Vitamin A and the problems that may arise in the case of deficiency.
The Food Services Management programme supports the 60 Hospitals in the Western Cape in providing well-balanced nutritious meals for all patients , catering for a variety of different cultures and religious denominations.
Promotion Protection and Support of Breastfeeding seeks to encourage the usage of exclusive breastfeeding up until six moths, continuation until two years as well as the development of the Baby-friendly Hospitals initiative.

Constraints And Measures Planned To Overcome Them

The loss of the leadership of the sub-component has to a large extent impacted on the programme. However the remaining personnel have attempted to keep the component functioning optimally despite constraints. A moratorium on travelling within the Regions because of overall financial constraints has impacted on the ability to achieve support at all levels. The Vitamin A programme experienced difficulties in the area of logistics initially, but these were ironed out once proper information had been passed down to grassroots level.
Problems of supply continue in the deep rural areas with respect to the PSNP, but these have been largely overcome. The problems of quality of the peanut butter have been overcome through central control

Quality Improvement Plan

Greater support of the programmes through more frequent visits to the Regions and District. Quality control measures for all products dispensed under the PSNP. Improve supply of Vitamin A to the rural clinics with ongoing training of staff.

Table: Performance indicators for the integrated nutrition programme*

Indicator	Province wide value	By health district	National target by 2005
Input			
1. Percentage of nutrition posts filled at all levels against nutrition staff establishments	90,1%		100%
Process			
2. Provincial business plan submitted and approved by national department by 15 March each year	100%		Each province
3. Provincial monthly financial reports in terms of Division of Revenue Act submitted to national department by 10th working day of following month			Each province
4. Provincial quarterly progress reports submitted to national department by 10th working day of following quarter	--		Each province
Output			
5. Percentage of new born babies given road to health chart**	75,8%		85%
6. Percentage of targeted primary schools with feeding programmes against total targeted primary schools	--		96%
7. Number of actual school feeding days as percentage of target number of school feeding days	170		156 days
Quality			
8. Percentage of facilities with maternity beds certified as baby friendly against total facilities with maternity beds	--		15%
9. Percentage of targeted schools where actual servings for school feeding comply with requirements and specifications of the standardised menu options	--		100%
Efficiency			
10. Percentage of INP conditional grant spent	84,5%		100%
11. Percentage of special allocation for poverty relief spent	100%		80%
Outcome			
12. Average percentage of children under five years of age monitored for nutrition status in district health facilities showing faltering or failure of weight gain (DHIS monthly data aggregated over the year)	--		
13. Average percentage of children under five years of age monitored for nutrition status in district health facilities diagnosed as suffering from severe malnutrition (DHIS monthly data aggregated over year)	--		
14. Percentage of stunted children under five years***	14,58%		< 20%
15. Percentage of underweight children under five years***	7,4%		< 10%
16. Percentage of wasted children under five years***	1,1%		< 2%
17. Percentage of severely underweight children under five years***	0,7%		< 1%
18. Percentage of vitamin A deficient children under five years***	21%		0%
19. Percentage of iron deficient children under five years***	8,2%		0%
20. Percentage of iodine deficient children under five years***	8%		0%
21. Percentage of infants exclusively breast fed at six months**	--		10%

^^ SA Demographic & Health Survey 1998

PROGRAMME 2

SUB-PROGRAMME 2.9: DISTRICT HOSPITALS

Aim

To provide good quality hospital services which include emergency services in all four major disciplines. To provide Hospital services to people in close proximity to where they live. District Hospitals form an integral part of the District Health System and provide outreach services to surrounding clinics and community health centres.

Situational analysis:

Rural Areas: Hospitals in good condition but under-utilised. Only one hospital needs to be substantially upgraded (Vredendal). In order to optimally utilise all hospitals a Human Resource Plan has to be developed. Because of a basic lack of trained personnel ongoing training is vital.

Metropole: Too few Level 1 beds in Metropole, which suggests that patients who should be managed at that level are being treated at Level 2 facilities with concomitant inefficient utilisation of resources.

Table: Current and expected values of key district hospital indicators*

2002/03 real terms	2010	2000/01	2001/02	2002/03	2003/04	2004/05
Budget	652,734,200	282,889,742	284,435,460	281,155,000	313,411,597	319,324,145
Cost per PDE	687	458	461	482	499	541
Bed Occupancy	0.85	0.71	0.64	0.65	0.75	0.76
ALOS	2.99	2.74	2.56	2.48	2.6	2.61
Beds	2,230	1,639	1,735	1,710	1,750	1,750
OutPat/Inpat day	1.12	1.36	1.57	1.32	0.94	0.84
Outpatients	773,966	578,879	635,295	533,944	448,736	409,185
Inpatient Days	691,858	424,704	405,296	405,698	479,063	485,450
PDE's	949,846	617,663	617,061	583,679	628,641	621,845
Admissions	231,390	155,001	158,319	163,588	184,255	185,996

* Including Provincial Aided Hospitals

Table: Analysis of current composite staffing profile of District Hospitals: 2002/03*

Functional Category	Filled Posts	% of Total Staff	% of Total Salaries
ADMIN. STAFF	306	11.8%	11.1%
DOMESTIC SERVICES	768	29.6%	16.0%
HEALTH MANAGERS	15	0.6%	2.1%
HEALTH TECHNICIANS	0	0.0%	0.0%
LIFE SCIENCES	0	0.0%	0.0%
MAINTENANCE WORKERS	0	0.0%	0.0%
Junior MO	4	0.2%	
MO	71	2.7%	
Registrars	0	0.0%	
Specialists	3	0.1%	
MEDICAL PROFESSIONALS	79	3.0%	8.7%
NATURAL SCIENCES	0	0.0%	0.0%
Prof Nurse	514	19.8%	30.2%
Staff Nurse	275	10.6%	10.8%
Assistants	481	18.6%	14.6%
NURSING	1270	49.0%	55.6%
OPERATORS	29	1.1%	0.7%
SEN MANAGERS	0	0.0%	0.0%
SOCIAL SCIENCES	3	0.1%	0.2%
THERAPISTS	83	3.2%	3.3%
TRADE WORKERS	16	0.6%	0.8%
TOTAL	2591	100.0%	100.0%

*Excluding Provincial Aided Hospitals
**See Annexure A for details of posts in each functional category

Policies, strategies and broad strategic objectives

- Improved referral systems
- Improve outreach by specialists
- Improvement of Skills of Medical Officers
- Attempt to recruit Chief Medical Officers
- Improved support to Primary Health Care facilities in the district
- Prevent inappropriate level 2 admissions through support from Primary Health Care initiatives, particularly Home Based Care.

Constraints And Measures Planned To Overcome Them

- Lack of adequate equipment and consumables - improved, dedicated funding for these line items;
- Paucity of Management skills - Improved training, particularly financial and facilities management training.
- Replacement of old Hospital Boards under new Legislation
- Lack of Financial Control - Improved financial training for various levels of administrative staff
- Lack of efficient information systems – to be addressed in HIS roll-out

Planned Quality Improvement Measures

- A patient complaints monitoring system is to be implemented;
- Structured Morbidity and Mortality meeting in conjunction with service providers and managers at PHC level
- An employee assistance programme to be instituted at all District Hospitals
- Simple and sustainable monitoring systems to be introduced

Performance Indicators for District Hospitals

Indicator	Province wide value	Hospital range	National target
Input			
1. Expenditure on hospital staff as percentage of total hospital expenditure (Excluding transfer payments)	73.1%		
2. Expenditure on drugs for hospital use as percentage of total hospital expenditure	5.8%		
3. Expenditure on hospital maintenance as percentage of total hospital expenditure	1.9%		
4. Useable beds per 1000 people*	.41		
5. Useable beds per 1000 uninsured people*	.57		
6. Hospital expenditure per person*	64		
7. Hospital expenditure per uninsured person*	88		
Process			
8. Percentage of hospitals with operational hospital board	90%		
9. Percentage of hospitals with appointed (not acting) CEO in place (or Medical Superintendent)	82%		
10. Percentage of hospitals with business plan agreed with provincial health department	100%		
11. Percentage of hospitals with up to date asset register	76%		
12. Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level			
Output			
13. Separations per 1000 people*	52		
14. Separations per 1000 uninsured people*	72.3		
15. Patient day equivalents per 1000 people*	209		
16. Patient day equivalents per 1000 uninsured people*	290		
17. Patient fee income per separation			
Quality			
18. Percentage of hospitals in facility audit condition 4 or 5	81%		
19. Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months			
20. Percentage of hospitals with designated official responsible for coordinating quality management	71%		
21. Percentage of hospitals with clinical audit (M&M) meetings at least once a month	40%		
Efficiency			
22. Average length of stay	2.74		
23. Bed utilisation rate (based on useable beds)	71%		
24. Expenditure per patient day equivalent	458		
Outcome			
25. Case fatality rate for surgery separations			

PROGRAMME 2.9: EVOLUTION OF DISTRICT HOSPITAL PERFORMANCE INDICATORS

Amounts in 2002/03 real terms

OBJECTIVE	INDICATOR	SPS TARGET 2010	Expenditure 2000/01	Expenditure 2001/02	Adjustment Budget 2002/03	Original Budget 2003/04	Budget Estimate 2004/05	Budget Estimate 2005/06
INPUT								
Provide sufficient funds for non-	Expenditure on staff as % of total expenditure (Excluding transfer paym)	66.92%	73.0%	75.5%	75.9%	76.0%	72.0%	70.0%
Personnel expenditure in	Expenditure on drugs as % of total expenditure	8.4%	5.9%	6.5%	6.9%	6.8%	7.8%	7.8%
District hospitals	Expenditure on maintenance as % total expenditure	5.86%	1.9%	1.1%	1%	2.0%	3.0%	3.8%
Provide district hospitals	Useable beds per 1000 total population	0.49	0.39	0.41	0.40	0.40	0.40	0.40
Infrastructure in line with SPS	Useable beds per 1000 uninsured population	0.68	0.54	0.57	0.55	0.56	0.55	0.55
Provide sufficient funding to ensure	Hospital expenditure per capita (total population)	143	67	67	65	72	73	73
an efficient district hospitals Service for the population	Hospital expenditure per capita (uninsured population)	199	93	93	91	100	101	102
PROCESS								
Facilitate representative management	Percentage of hospitals with operational hospital board	100%	90%	90%	90%	100%	100%	100%
Facilitate decentralised management and accountability	Percentage of hospitals with appointed CEO in place (or Medical Superintendents)	100%	81%	81%	86%	86%	100%	100%
	Percentage of hospitals with business plan agreed with provincial health department	100%	100%	100%	100%	100%	100%	100%

	Percentage of hospitals with up to date asset register	100%	75%	75%	75%	80%	90%	100%
	Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level							
OUTPUT								
Ensure accessible district hospital services to the population of the western Cape	Separations per 1000 total population	52.0	36.8	37.2	38.0	42.4	42.4	42.8
	Separations per 1000 uninsured population	72.3	51.1	51.6	52.8	58.9	58.9	59.4
	Patient day equivalents per 1000 total population	209	147	145	136	145	142	138
	Patient day equivalents per 1000 uninsured population	290	204	201	188	201	197	192
Facilitate revenue generation	Patient fee income per separation							
QUALITY								
Ensure adequate infrastructure	Percentage of hospitals in facility audit condition 4 or 5	100%	81%	81%	81%	86%	100%	100%
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	100%	0%	0%	0%	36%	100%	100%
	Percentage of hospitals with designated official responsible for co-ordinating quality management	100%	20%	20%	30%	100%	100%	100%

	Percentage of hospitals with clinical audit (M&M) meetings at least once a month	100%	40%	40%	50%	85%	100%	100%
EFFICIENCY								
Ensure efficient and cost effective	Average length of stay	2.9	2.74	2.56	2.48	2.60	2.61	2.70
utilisation of resources	Bed utilisation rate based on useable beds	85%	71%	64%	65%	75%	76%	80%
	Expenditure per patient day equivalent	687.20	458.00	460.95	481.69	498.55	513.51	528.92
	Expenditure per patient day equivalent on drugs	58.00	27.00	30.00	33.00	34.00	40.00	41.00
	Cost of non-clinical services as % of total expenditure. Administration Excluded. Out-sourced services: Laundries & Security	18.5%	22%	22%	23%	22%	21%	20%

PROGRAMME 2

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)[1]

Sub-Programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
2.1 District Management	23,100	26,909	28,340	16,884	17,793	18,537
2.2 Community health Clinics	194,293	205,148	215,079	233,574	246,148	256,444
2.3 Community Health Centres	303,595	328,149	345,870	387,193	408,037	425,104
2.4 Community based services	21,461	25,416	31,886	32,849	34,617	36,065
2.5 Other Community Services	36,316	39,478	41,448	38,724	40,809	42,516
2.6 HIV/Aids Campaign	9,826	22,210	35,634	54,254	57,175	59,566
2.7 Nutrition	37,695	36,848	45,671	46,428	48,927	50,974
2.8 Coroner services			-	-	-	-
2.9 District Hospitals	250,415	267,830	281,155	329,709	347,459	361,992
2-DISTRICT HEALTH SERVICES	**876,701**	**951,988**	**1,025,083**	**1,139,615**	**1,200,965**	**1,251,198**

Table: Evolution of expenditure of budget programme in constant 2002/03 prices (R million)[1]

Programme 2: DISTRICT HEALTH SERVICES

Expenditure: Programme 2	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget)[2]
Total[3]	**990,395**	**1,011,011**	**1,025,083**	**1.7%**	**1,083,284**
Total per person[4]	235.08	237.28	238.00	0.6%	249.32
Total per uninsured person[5]	326.50	329.55	330.56	0.6%	346.28

Conversion Factors: 2002/03 Rands

1999/00	1.16
2000/01	1.13
2001/02	1.06
2002/03	1.00
2003/04	0.95
2004/05	0.92
2005/06	0.89

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

AIM

The rendering of pre-hospital Emergency Medical Services including Interhospital Transfers and Planned Patient Transport

SUB PROGRAMME 3.1

Rendering Emergency Medical Services including Ambulance Services, Special Operations, Communications and Air Ambulance services.

SITUATIONAL ANALYSIS

Emergency Medical Services are provided throughout the Province and managed by District, Division and Region.

Functions of EMS

The Emergency Medical Services is a Provincial Government funded department that provides the following functions within the Province of the Western Cape,

- Basic, Intermediate and Advanced Life Support Ambulance based Emergency Care throughout the Province
- Patient Transfers from rural hospitals into tertiary care centers in the metropolitan area
- Patient transfers for follow-up care in the Metropolitan area.
- Aeromedical Advanced Life Support Casevac based in the Metropolitan area
- Air Mercy Service transfers through the Red Cross Air Mercy Service from all centers in Africa to Cape Town
- Medical Rescue services including Mountain Rescue, High Angle Rescue, Trench Rescue, Swift Water Rescue, Heavy Motor Vehicle Rescue, Light Motor Vehicle Rescue, Air Sea Rescue, Building Rescue
- Mass Casualty and Disaster Management and Cave Rescue.
- Transfer of Infectious Disease Patients

POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

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

Strategic priorities

EMS has three broad strategic priorities;

Personnel	- to eliminate one person ambulances and establish a personnel establishment appropriate to the effective delivery of emergency care within National Norm response times
Vehicles	- to reduce the age of the fleet, decrease maintenance costs, decrease breakdowns and ensure availability of ambulances to support the function
Communications	- to establish communications systems to support the call taking and dispatch needs of the service and ensure efficient response

CONSTRAINTS

Inadequate personnel budget to adequately staff the function.

Total lack of budget to address the communications function.

Inadequate funds to replace sufficient ambulances.

Increased wage bill resulting from Job Evaluation.

PLANNED QUALITY IMPROVEMENT MEASURES

Quality cannot be significantly improved until the basic requirements of the service are addressed. Quality is related to quantity in terms of available resources to respond to emergencies.

Bigger better quality ambulances have been purchased.

More paramedics have been employed in rural areas.

Increased supervisory personnel have been employed in rural areas.

SUB PROGRAMME 3.2

Rendering Planned Patient Transport including Out Patient Transport and Inter-hospital Transport

SITUATIONAL ANALYSIS

Planned patient transport is rendered in two categories, Inter Hospital Transfers (ambulances and buses) and Out Patient Transport (buses).

Outpatient transport is currently outsourced in the metropolitan areas. No rural OPD transport system exists.

Inter-hospital transfers are separate from emergency transport in the Metropolitan Area but combined in the rural areas.

Patient access to Health Institutions is severely limited by poor patient transport infrastructure.

POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Strategic objective is to separate emergency services from planned transport.

CONSTRAINTS

No budget has been allocated to EMS for the function of OPD and Inter-hospital transport.

Communication systems are inadequate to support the system.

Key measurable objectives

Objective	Strategy	Output	Performance indicator	System used to Monitor progress	KMO	Numerator	Denominator	Source	Data available
Increase no. of 2 person crews to 90%	Recruitment Training	More trained EMS personnel	Increased no. of trained EMS personnel	HRM and EMS stats	No. of 2 – person crews has risen to 90%	Total no. of 2 – person crews	Total no. of crews in Province	EMS statistics and HRM plan	Yes
Reduce no. of ambulances involved in patient transport to 20%	Develop Planned patient transport system	Greater no. of allocated vehicles for planned Patient transport	Usage of ambulances for PPD	Log sheets for EMS	Proportion of trips under-taken by EMS for non-emergencies reduced to 32.	% of trips spent on non-emergencies	Total no of trips	EMS stats	Yes
Reduce the age of the fleet	Reduce the no. of EMS (emergency) vehicles with greater than 200 000km	Quicker turnover of vehicles	Reduction of vehicles with >200 000km	EMS vehicles logsheets	No. of vehicles with 200 000km	No. of vehicles with 200 000km	Total no. of emergency vehicles	EMS stats	Yes
Improve percentage of facilities rated as acceptable system	Acquire additional funds through budget as well as through fundraising	Acceptable facilities increased to 50% by 2004	Year-on-year increase in no. of acceptable facilities	Audit of Facilities	%of acceptable facilities per Nationally prescribed audit report	No of facilities with acceptable reports as per national Guidelines (or sample)	Total no. of facilities in Province (or sample)	Facilities Audit	Yes

EVOLUTION OF INDICATORS: EMERGENCY MEDICAL SERVICES

	2001/2	2002/3	2003/4	2004/5	2005/6
Increase no. of 2-person crews to 90%	75%	85%	88%	95%	100%
Reduce no. emergency vehicles involved in patient transport	40%	38%	30%	25%	20%
No. of vehicles replaced per annum	40	40	40	30	25
Improve condition of facilities to "acceptable" rating	<15%	15%	25%	40%	50%

Table: Evolution of expenditure by budget sub-programme in current prices (R million)[1]

Programme 3	**2000/01 (actual)**	**2001/02 (actual)**	**2002/03 (estimate)**	**2003/04 (budget)**	**2004/05 (MTEF projection)**	**2005/06 (MTEF projection)**
3.1 Emergency transport	151,481	131,673	150,594	154,946	163,287	170,117
3.2 Planned Patient Transport				5,642	5,946	6,194
Total programme	**151,481**	**131,673**	**150,594**	**160,588**	**169,233**	**176,312**

Table: Evolution of expenditure of budget sub-programme in constant 2002/03 prices (R million)[1]

Expenditure: Prog 3	**2000/01 (actual)**	**2001/02 (actual)**	**2002/03 (estimate)**	**Average annual change (%)**	**2003/04 (budget)[2]**
Total[3]	**171,126**	**139,837**	**150,594**	**-5.3%**	**152,650**
Total per person[4]	40.62	32.82	34.96	-6.3%	35.13
Total per uninsured person[5]	56.41	45.58	48.56	-6.3%	48.80