



# **WESTERN CAPE DEPARTMENT OF HEALTH**

## **FIVE-YEAR STRATEGIC AND PERFORMANCE PLANS 2005/2006**



**MARCH 2005**

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## STRATEGIC OVERVIEW

### 1. OVERVIEW OF STRATEGIC PLAN

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

#### **Healthcare 2010:**

In the face of increasing need for service and limited resources the Department further developed the restructuring plans commenced in 1994 through the Provincial Health Plan and the subsequent Strategic Position Statement (SPS) into Healthcare 2010.

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

### 2. VISION

“Equal access to quality health care.”

### 3. MISSION

“To improve the health of all people in the Western Cape and beyond, by ensuring the provision of a balanced health care system, in partnership with all stakeholders, within the context of optimal socio-economic development.”

#### 4. VALUES

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

- Integrity
- Openness and transparency
- Honesty
- Respect for people
- Commitment to high quality service.

#### 5. SECTORAL SITUATION ANALYSIS

##### 5.1 Summary of service delivery environment and challenges

##### 5.1.1. Major demographic characteristics

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

The remainder of the population is distributed more sparsely, in approximately equal proportions between the other three regions, i.e. Boland/Overberg, South Cape/Karoo and West Coast Winelands (Sanders:2004)

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

Total population											
District	2 001	2 002	2 003	2 004	2 005	2 006	2 007	2 008	2 009	2 010	%Public Pop
<b>Cape Town</b>	2 893 248	2 938 222	2 983 897	3 030 285	3 077 397	3 125 243	3 173 835	3 223 186	3 273 307	3 324 209	68.40
<b>W Coast</b>	282 672	287 057	291 510	296 032	300 625	305 289	310 026	314 836	319 722	324 683	81.00
<b>Boland</b>	629 490	639 265	649 192	659 273	669 512	679 911	690 471	701 196	712 088	723 150	80.00
<b>Overberg</b>	203 517	206 672	209 875	213 129	216 433	219 789	223 196	226 657	230 172	233 741	83.00
<b>Garden R</b>	454 924	461 989	469 164	476 451	483 851	491 366	498 999	506 751	514 623	522 619	81.00
<b>Central Karoo</b>	60 485	61 425	62 379	63 349	64 333	65 333	66 348	67 379	68 427	69 490	89.00
<b>Western Cape</b>	<b>4 524 336</b>	<b>4 594 629</b>	<b>4 666 017</b>	<b>4 738 519</b>	<b>4 812 150</b>	<b>4 886 930</b>	<b>4 962 876</b>	<b>5 040 005</b>	<b>5 118 338</b>	<b>5 197 892</b>	<b>0.730</b>
Uninsured population											
District	2 001	2 002	2 003	2 004	2 005	2 006	2 007	2 008	2 009	2 010	
<b>Cape Town</b>	1 978 982	2 009 744	2 040 986	2 072 715	2 104 939	2 137 666	2 170 903	2 204 659	2 238 942	2 273 759	
<b>W Coast</b>	228 964	232 516	236 123	239 786	243 506	247 284	251 121	255 017	258 975	262 993	
<b>Boland</b>	503 592	511 412	519 353	527 419	535 610	543 928	552 377	560 957	569 670	578 520	
<b>Overberg</b>	168 919	171 537	174 197	176 897	179 639	182 424	185 253	188 125	191 042	194 005	
<b>Garden R</b>	368 488	374 211	380 023	385 925	391 919	398 007	404 189	410 468	416 845	423 321	
<b>Central Karoo</b>	53 832	54 668	55 517	56 380	57 256	58 146	59 050	59 968	60 900	61 846	
<b>Western Cape</b>	<b>3 302 777</b>	<b>3 354 088</b>	<b>3 406 199</b>	<b>3 459 122</b>	<b>3 512 870</b>	<b>3 567 456</b>	<b>3 622 893</b>	<b>3 679 194</b>	<b>3 736 374</b>	<b>3 794 444</b>	

Source: Census 2001

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

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

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

\*Census 2001denomination

\*\*Includes Flush toilets with septic tank and chemical toilets

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

**Table 3: Socio-demographic characteristics of the population**

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

Source: Census 2001

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

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



### 5.1.2. Epidemiological profile

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

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

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

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

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

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

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

Source: Sanders: 2004

**Table 6: Major causes of death in the Metropole**

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

Source (Groenewald et al, 2003)

**Note:** Years of Life Lost (YLL) is a measure of premature mortality and has been estimated using age weightings, discounting and standard life expectancies. It is a particularly useful measure of premature or preventable deaths.

Although detailed information on mortality is only available for the Cape Town Metro Region, this represents approximately two thirds of the population of the Western Cape and the relationships between socio-economic context, social capital and health are likely to be similar across the Province.

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

Group I: 19% infectious diseases, including 6% HIV/AIDS;

Group II: 54% non communicable diseases; and

Group III 19% injuries.

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

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

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

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

### **HIV and AIDS**

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

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

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

### **5.1.3 Major health service challenges and progress**

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

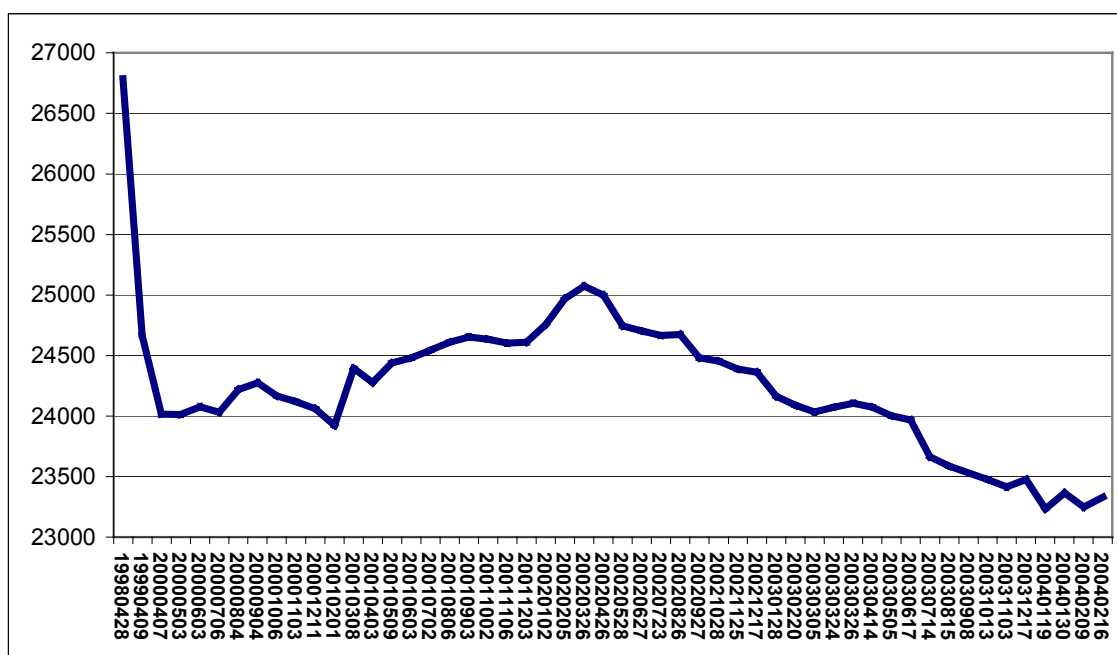
An important issue to be addressed is the fact that from 1 April 2005 the Province will be responsible for providing the Personal Primary Health Care (PPHC) services in the rural areas that were previously provided by the municipalities. Local government will continue to provide a service in the Metropole for the next three years during which time the issue of funding for these services must be resolved between provincial and national government.

From 1 April 2005/06 the Works funding for Health will be transferred to the Health Department. It will be a significant challenge to manage this process effectively to ensure the funding is optimally utilized for the provision, maintenance and upgrading of the infrastructure.

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

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

**Figure: Personnel numbers in Provincial Health Facilities from 1998 to 2004**



#### 5.1.4. Intra and inter provincial equity in the provision of services

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

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

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

### 5.1.5 Resource trends

The Department's total budget for 2005/06 is R5.742 billion and constitutes 27,9% of the Province's total budget. Compared to the 2004/05 revised estimate there is a nominal year-on-year increase in 2005/06 of 11.2%, in 2006/07 of 6.8% and in 2007/08 of 5.8%. Table 8 below reflects the Department's budget for the MTEF period

**Table 8: Health Department budget as a percentage of Provincial budget**

	Audited 2001/02	Audited 2002/03	Audited 2003/04	Main appropriation 2004/05	Adjusted appropriation 2004/05	Revised estimate 2004/05	2005/06	% change from revised estimate	2006/07	2007/08
R'000										
Health	3 701 245	3 951 022	4 547 304	4 936 827	5 166 386	5 166 386	5 742 503	11.15%	6 133 707	6 488 103
Province Total	12 506 446	14 497 660	16 352 467	18 278 811	18 657 434	18 467 105	20 612 932	11.62%	22 319 267	23 703 170
Percentage of Health budget in relation to Provincial total	29.59%	27.25%	27.81%	27.01%	27.69%	27.98%	27.86%		27.48%	27.37%

Source: Western Cape Government Budget 2005

The sources of the Department's funding are:

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

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

**Table 9: Funding sources of the Western Cape Health Department**

	Audited 2001/02	Audited 2002/03	Audited 2003/04	Main appropriation 2004/05	Adjusted appropriation 2004/05	Revised estimate 2004/05	2005/06	% change from revised estimate	2006/07	2007/08
Treasury funding	R'000									
Equitable share	2 218 619	2 364 128	2 826 872	3 135 544	3 317 679	3 317 679	<b>3 638 900</b>	9.68%	3 935 890	4 205 323
Conditional Grants	1 365 432	1 467 022	1 555 421	1 645 171	1 645 171	1 645 171	<b>1 870 576</b>	13.70%	1 994 555	2 082 486
<b>Total Treasury Funding</b>	<b>3 584 051</b>	<b>3 831 150</b>	<b>4 382 293</b>	<b>4 780 715</b>	<b>4 962 850</b>	<b>4 962 850</b>	<b>5 509 476</b>	11.01%	<b>5 930 445</b>	<b>6 287 809</b>
<b>Departmental Receipts</b>	<b>117 194</b>	<b>119 872</b>	<b>165 011</b>	<b>156 112</b>	<b>203 536</b>	<b>203 536</b>	<b>233 027</b>	14.49%	<b>203 262</b>	<b>200 294</b>
<b>TOTAL RECEIPTS</b>	<b>3 701 245</b>	<b>3 951 022</b>	<b>4 547 304</b>	<b>4 936 827</b>	<b>5 166 386</b>	<b>5 166 386</b>	<b>5 742 503</b>	11.15%	<b>6 133 707</b>	<b>6 488 103</b>

Source: Western Cape Government Budget 2005

**Table 10: Conditional grant allocation for 2005/06**

CONDITIONAL GRANT	ALLOCATION 2005/06	% OF TOTAL HEALTH BUDGET FOR 2005/06
Hospital management and quality improvement grant [HMQIG]	R 17 608 000	0.3%
Health professions training and development grant [HPTDG]	R 323 278 000	5.6%
Comprehensive HIV and AIDS grant	R 82 451 000	1.4%
Integrated nutrition programme grant	R 5 288 000	0.1%
National tertiary services grant [NTSG]	R 1 214 684 000	21.2%
Hospital revitalisation grant [HRP]	R 172 038 000	3.0%
Provincial infrastructure grant [PIG]	R 55 229 000	1.0%
<b>Total conditional grants</b>	<b>R 1 870 576 000</b>	<b>32.6%</b>

Source: Western Cape Government Budget 2005

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

**Table 11: Cost of medical inflation in comparison to CPIX**

PERIOD	CPIX	MEDICAL INFLATION
May 2001 – May 2002	9.2%	11.5%
May 2002 – May 2003	7.4%	9.8%
May 2003 – May 2004	5.6%	10.2%

Source: Western Cape Health Department: Budget Review 2003/2004: 13

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

**Table 12: Trends in provincial service volumes [A2]**

Indicator	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)
PHC headcount in PHC facilities	10 346 283	11 986 838	12 064 857	12 959 900	12 238 113	13 146 000
OPD headcounts	1 594 017	1 578 701	2 055 286	1 757 842	1 698 156	1 849 779
<b>Hospital separations</b>						
District hospitals	98 981	128 972	122 476	141 785	123 222	140 505
Regional hospitals	137 624	155 823	147 002	169 617	166 434	188 948
Central hospitals	114 953	126 163	125 001	133 691	125 450	111 795

Table 12 illustrates the trend in the distribution of funds between the respective programmes in the Department. Funding has been made available to implement the Language Policy. An amount of R2,3 million has been allocated for this purpose in 2005/06. A new sub-programme 2.10, the Global Fund has been established to effectively manage the donor funds for the comprehensive plan for the management, care and treatment of people living with HIV and AIDS.

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

PROGRAMME	2002/03		2003/04		2004/05		2005/06		2006/07		2007/08	
	R'000	%	R'000	%	R'000	%	R'000	%	R'000	%	R'000	%
1. Administration	121,273	3.1%	215,644	4.7%	221,859	4.3%	195,618	3.4%	207,943	3.4%	220,216	3.4%
2. District health services	993,592	25.1%	1,144,699	25.2%	1,317,462	25.5%	1,611,684	28.1%	1,704,433	27.8%	1,793,938	27.6%
3. Emergency medical services	152,910	3.9%	185,695	4.1%	205,041	4.0%	254,470	4.4%	270,501	4.4%	286,461	4.4%
4. Provincial hospital services	974,273	24.7%	1,053,048	23.2%	1,176,200	22.8%	1,276,765	22.2%	1,357,199	22.1%	1,437,268	22.2%
5. Central hospital services	1,476,202	37.4%	1,607,089	35.3%	1,791,789	34.7%	1,936,056	33.7%	2,057,004	33.5%	2,177,830	33.6%
6. Health sciences and training	65,381	1.7%	71,116	1.6%	75,058	1.5%	83,648	1.5%	88,917	1.4%	94,163	1.5%
7. Health care support services	66,597	1.7%	73,837	1.6%	90,934	1.8%	87,457	1.5%	92,965	1.5%	98,457	1.5%
8. Health facilities management	100,794	2.6%	196,176	4.3%	288,043	5.6%	296,805	5.2%	354,745	5.8%	379,770	5.9%
<b>Total</b>	<b>3,951,022</b>	<b>100.0%</b>	<b>4,547,304</b>	<b>100.0%</b>	<b>5,166,386</b>	<b>100.0%</b>	<b>5,742,503</b>	<b>100.0%</b>	<b>6,133,707</b>	<b>100.0%</b>	<b>6,488,103</b>	<b>100.0%</b>

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

### 5.1.6 Policy changes and trends

#### Mental Health Care Act, Act 17 of 2002

The Mental Health Care Act became operational from 15 December 2004 and has resulted in the Department developing new policies to achieve the objectives of the Act and its regulations. Of particular importance are the provisions of the Act that prescribe the procedure that must be followed in the admission of mentally ill persons and relate to the principles of unfair discrimination as contained in the Constitution. As required the province has developed a policy regarding the establishment of a Mental Health Care Review Board and is in the final stages of appointing the members of the Board which it is anticipated will be in place by 1 April 2005.

### National Health Act, Act 61 of 2003

The National Health Act has been developed so as to comply with the obligations imposed by the Constitution and establish a structured and uniform health system within the Republic. This Act has been assented to but has not yet commenced and the regulations, which must accompany the Act, have not yet been finalised by the National Department. The provincial Department will therefore develop new policies, which are in line with the regulations, as soon as the scope and nature of the national regulations become evident.

### Court Decisions

As the South African legal system is based on the Rule of Law it may become necessary that the provincial Department of Health is obliged by virtue of a court decision to supplement, amend or develop new policies regarding specific health issues.

Over the past three years there have been no court cases that have impacted on the services offered by Health. There have, however, been cases involving the National Department of Health which potentially affect the services offered by the provincial departments, e.g. the Treatment Action Campaign v National Department of Health. However, because of the expanded HIV and AIDS programme in the Western Cape the Department was not directly affected by the judgement handed down on this case.

Medico-legal and other litigation, e.g. labour relations issues, involving the Department may impact the manner in which services are provided or how personnel practice is refined. However, there have been no medico-legal or labour relations judgements against the Department over the past two years.

## **5.2 Summary of organisational environment and challenges**

A key issue in the capacity of the Department to provide the required service relates to the ability to recruit and retain appropriately qualified personnel. The introduction of the scarce skills and rural allowances will promote this. The training of nurses has been affected by the problems experienced in the renovation of the Western Cape College of Nursing (WCCN) which resulted in there being no intake of nurses during 2004 but the situation was relieved by the provision of bursaries for an additional 150 nursing students at the University of the Western Cape.

The Department has started discussions with Higher Education Institutions (HEI) to look at the proposed relocation of the WCCN to the newly formed Cape Peninsula University of Technology (CPUT) by way of a transitional arrangement (agency agreement) and later to a permanent transfer.

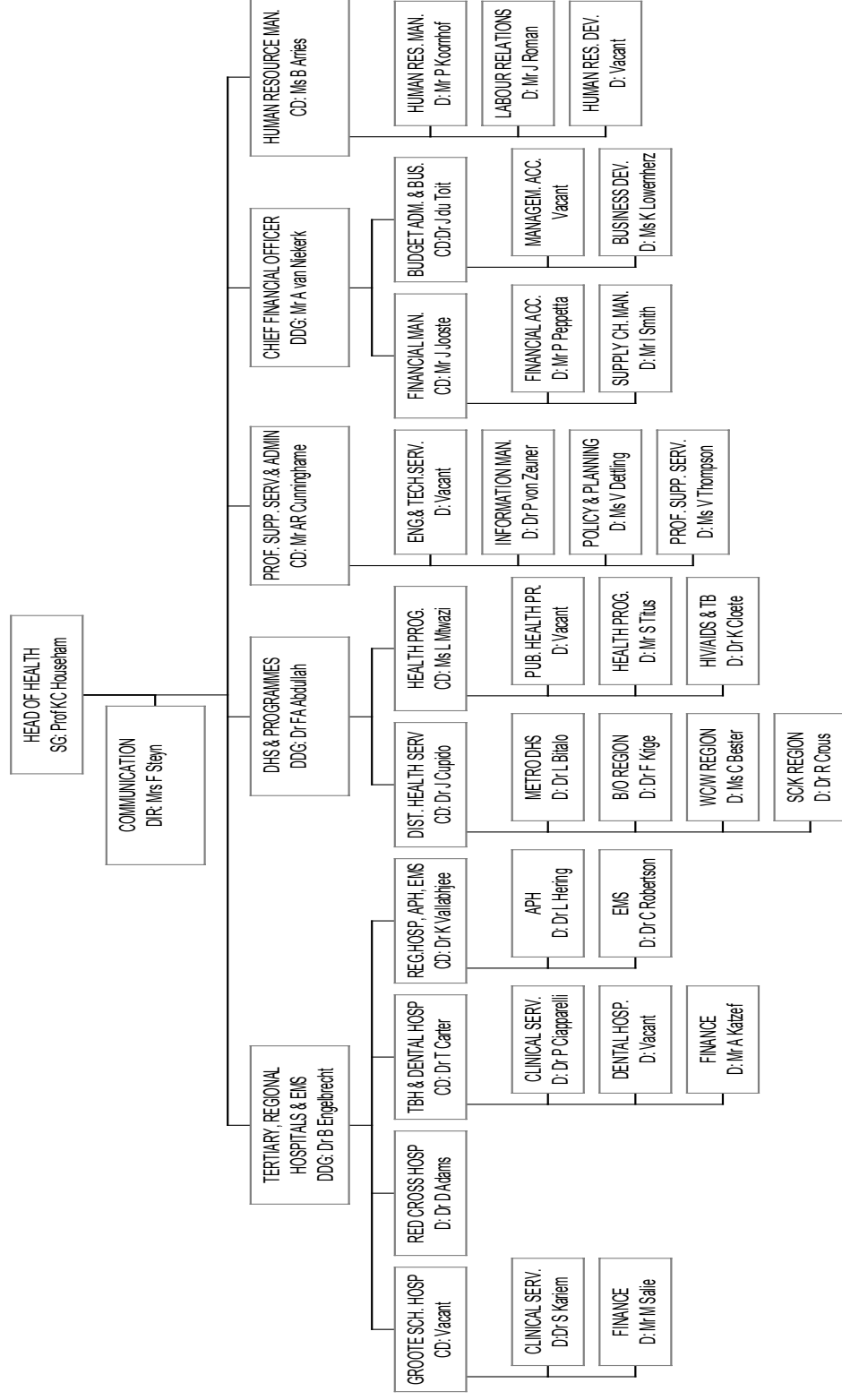


In order to optimise the utilisation of personnel resources a personnel restructuring exercise has been embarked upon which is developing new staff establishments to ensure that there are the correct numbers and skill mix of personnel at the respective institutions in relation to the projected patient activities.

The introduction of performance agreements for personnel at all levels of the Department within the Staff Performance Management System (SPMS) is fostering a culture of performance management which will benefit service delivery.

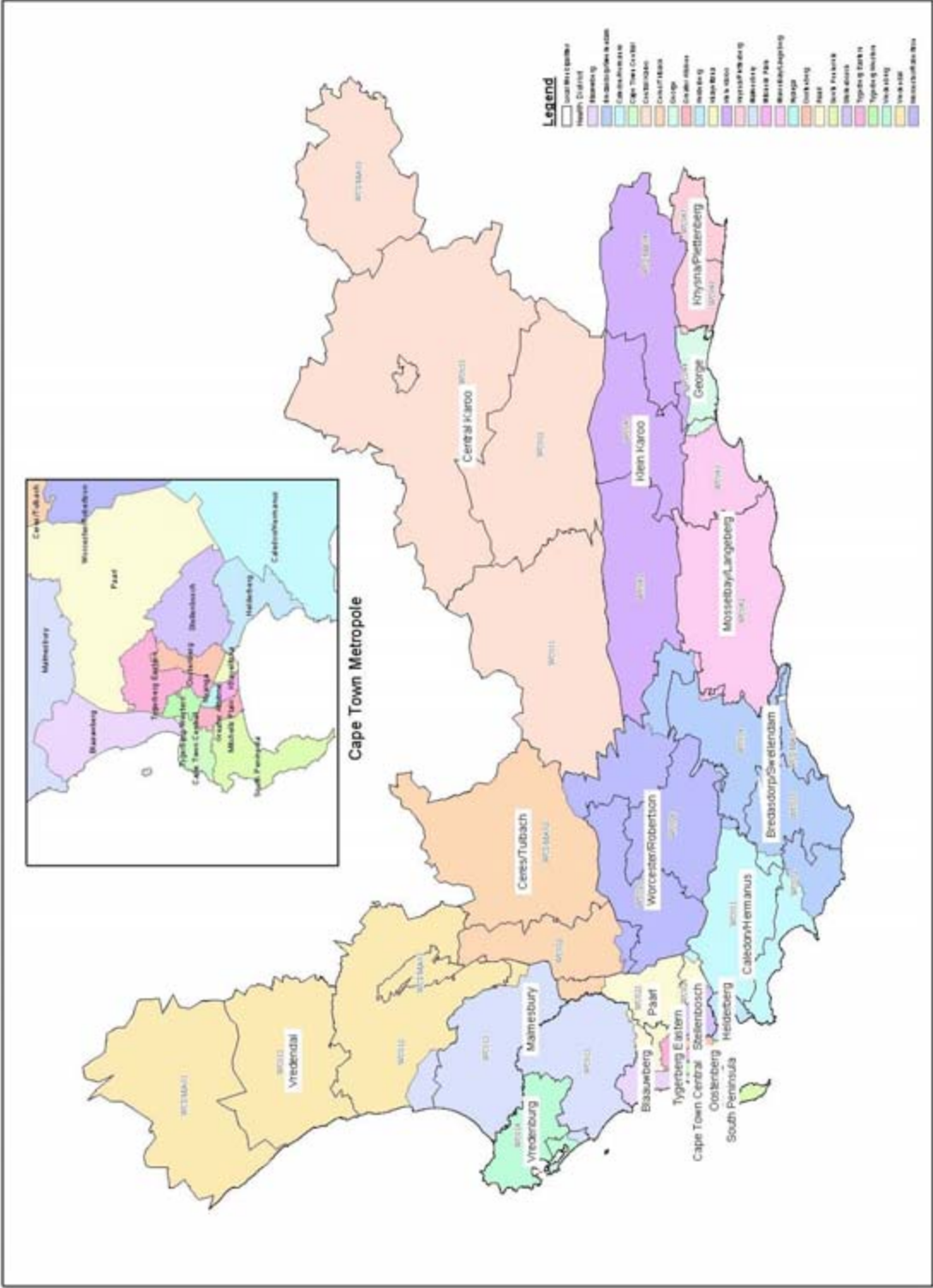
The following organisational chart illustrates the structure of the senior management in the Department and therefore the functional areas of responsibility.

## 5.3 ORGANISATIONAL CHART: SENIOR MANAGEMENT STRUCTURE

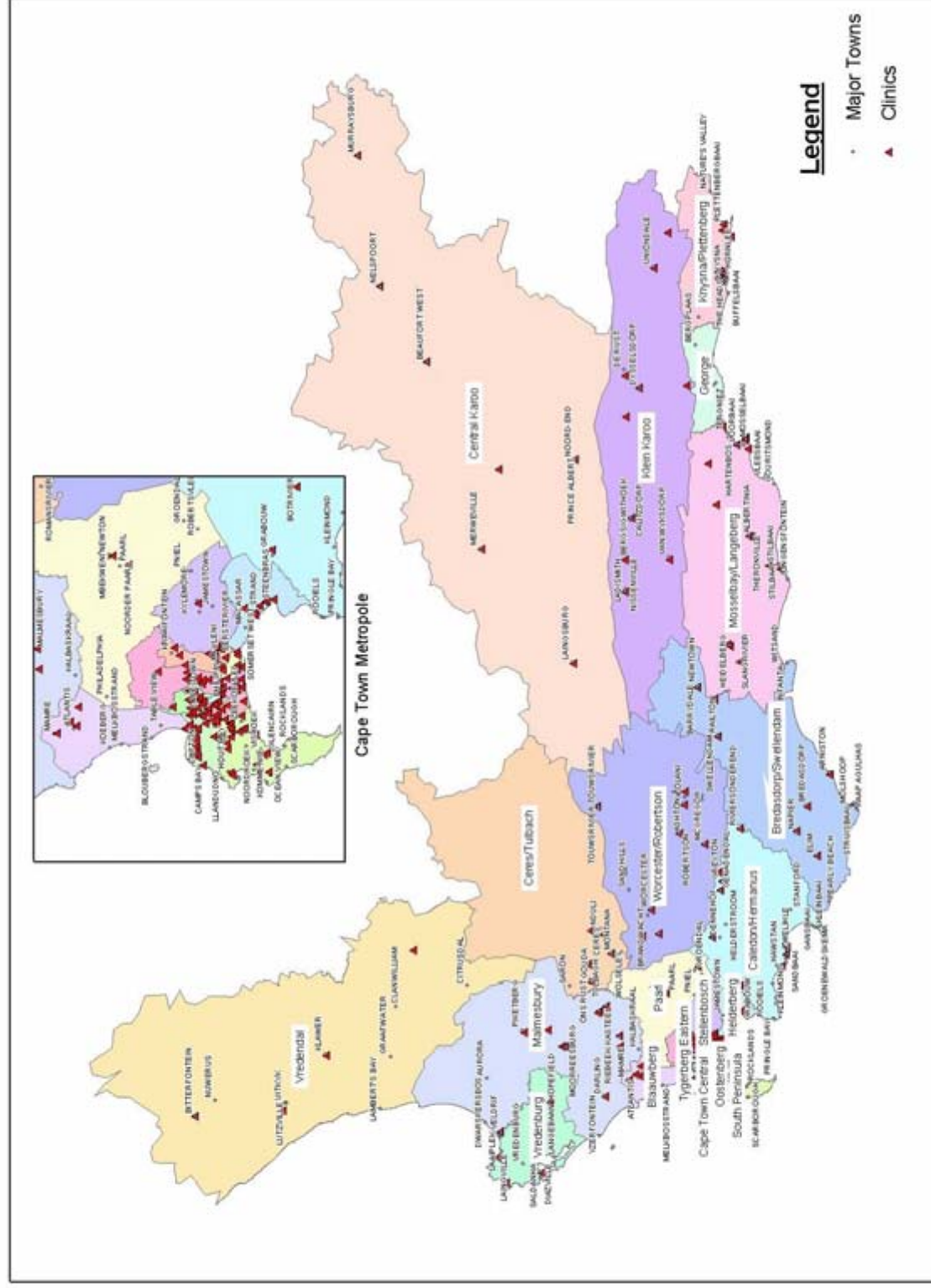


5.4 Maps of the Western Cape

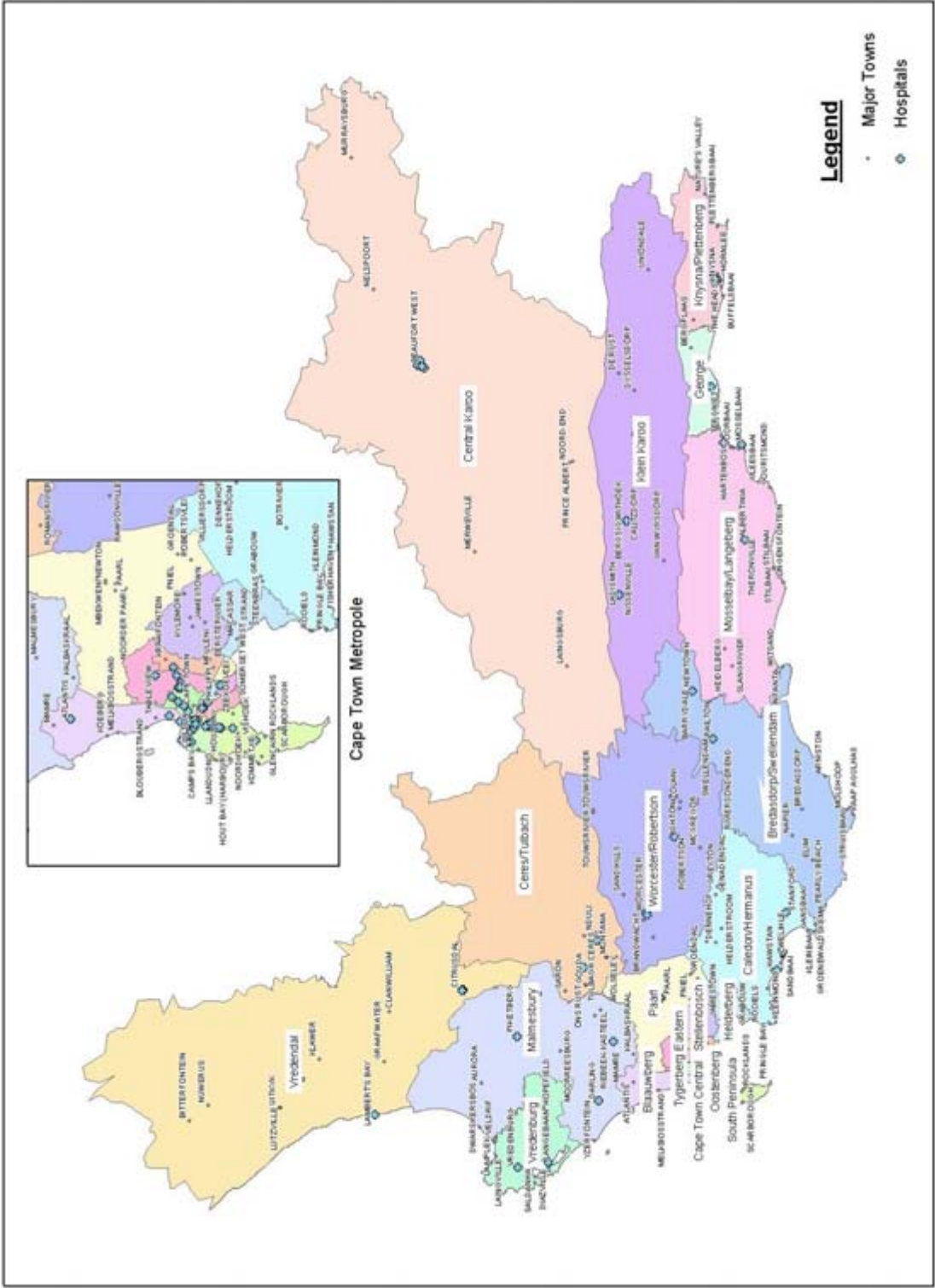
DISTRICTS: WESTERN CAPE PROVINCE



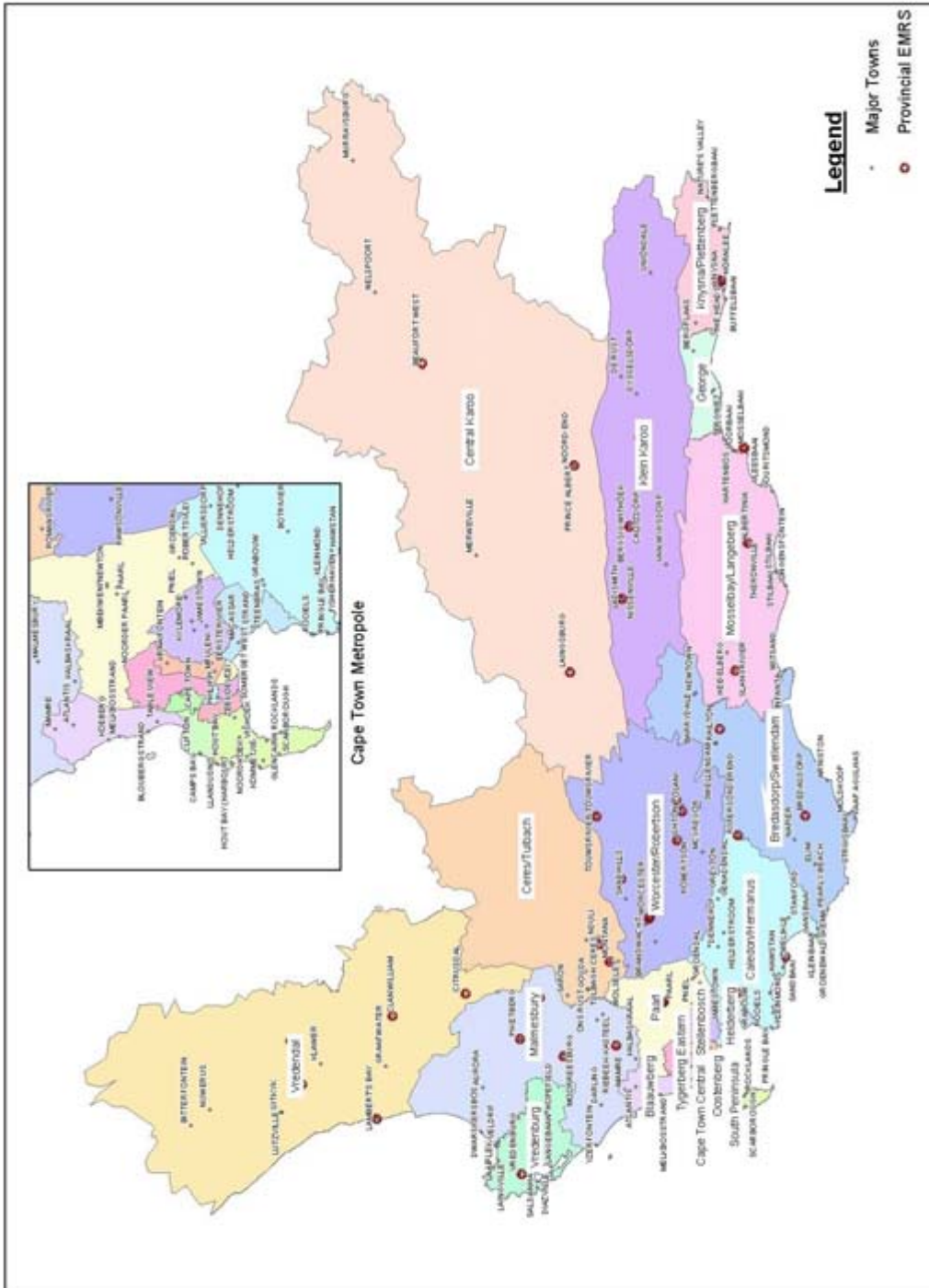
# PROVINCIAL PRIMARY HEALTH CARE CLINICS IN THE WESTERN CAPE



HOSPITALS IN THE WESTERN CAPE



EMERGENCY MEDICAL SERVICES IN THE WESTERN CAPE



## **6. LEGISLATIVE AND OTHER MANDATES**

### **6.1 THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA, 1996, ACT 108 OF 1996**

The provincial department of Health has by virtue of Schedule 4 Part A of the Constitution obtained a concurrent legislative mandate with the national department regarding Health Services. Part A of Schedule 5 furthermore empowers the provincial Department with exclusive legislative competence on ambulance services, which is a health related matter.

Section 27 of the Constitution furthermore obligates the Department to provide basic health services, including reproductive health care for its citizens while section 28 prescribes that children have the right to basic health services. The aforementioned Constitutional provisions therefore obligate the Department of Health to provide these services.

### **6.2 OTHER NATIONAL LEGISLATION**

The following is a list of legislation, which prescribes the specific services to be rendered by the Department. Some of the legislation has a very specific and direct impact on the Department whereas others have a more peripheral impact:

#### **6.2.1 ACADEMIC HEALTH CENTRES ACT, 86 OF 1993 (not implemented)**

To provide for the establishment of academic health centres and for the control, administration and management thereof and for matters connected therewith. This Act will however be repealed by the National Health Act, Act 61 of 2003 as soon as it commences.

#### **6.2.2 ATMOSPHERIC POLLUTION PREVENTION ACT, 45 OF 1965**

To provide for the prevention of the pollution of the atmosphere, for the establishment of a National Air Pollution Advisory Committee, and for matters incidental thereto.

#### **6.2.3 BASIC CONDITIONS OF EMPLOYMENT ACT, 75 OF 1997**

To give effect to the right to fair labour practices referred to in section 23(i) of the Constitution by establishing and making provision for the regulation of basic conditions of employment; and thereby to comply with the obligations of the Republic as a member state of the International Labour Organisation, and to provide for matters connected therewith.

#### **6.2.4 BIRTHS AND DEATHS REGISTRATION ACT, 51 OF 1992**

To regulate the registration of births and deaths and to provide for matters connected therewith.

#### **6.2.5 BROAD BASED BLACK ECONOMIC EMPOWERMENT ACT, 53 OF 2003**

This Act provides for acknowledgement of black economic empowerment ideals and the advancement of the principles of black economic empowerment.



**6.2.6 CHILD CARE ACT, 74 OF 1983**

To provide for the establishment of children's courts and the appointment of commissioners of child welfare; for the protection and welfare of certain children; for the adoption of children; for the establishment of certain institutions for the reception of children and for the treatment of children after such reception; and for the contribution by certain persons towards the maintenance of certain children; and to provide for incidental matters.

**6.2.4 CHIROPRACTORS, HOMEOPATHS AND ALLIED HEALTH SERVICE PROFESSIONS ACT, 63 OF 1982**

To provide for the control of the practice of the professions of chiropractor and homeopath and allied health professions, and for that purpose to establish a Chiropractors, Homeopaths and Allied Health Service Professions Interim Council and to determine its functions; and for matters connected therewith.

**6.2.8 CHOICE ON TERMINATION OF PREGNANCY ACT, 92 OF 1996**

To determine the circumstances in which and conditions under which the pregnancy of a woman may be terminated and to provide for matters connected therewith.

**6.2.9 COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 130 OF 1993**

To provide for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, or for death resulting from such injuries or diseases; and to provide for matters connected therewith.

**6.2.10 CORRECTIONAL SERVICES ACT, 8 OF 1959**

This Act covers all aspects relating to the provision of correctional services within the country.

**6.2.11 DIVISION OF REVENUE ACT (annually)**

This Act stipulates and provides for the annual division of equitable share funding for the provinces.

**6.2.12 THE HEALTH ACT, 63 OF 1977**

This Act was assigned to the provinces in 1994 and is therefore deemed to be provincial legislation. It provides for measures for the promotion of the health of the inhabitants of the Republic; the rendering of health services; defines the duties, powers and responsibilities of certain authorities which render health services to the Republic; provides for the co-ordination of such health services; and to provide for incidental matters. This Act will be repealed by the National Health Act of 2003 which has been assented to but has not yet commenced.

**6.2.13 THE NATIONAL HEALTH ACT 61 OF 2003**

This Act will provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national,



provincial and local governments with regard to health services and also provide for matters incidental thereto. This Act will replace the 1977 Act as soon as it commences.

**6.2.14 DOMESTIC VIOLENCE ACT, 116 OF 1998**

To provide for the issuing of protection orders with respect to domestic violence, and for matters connected therewith.

**6.2.15 DRUGS AND DRUG TRAFFICKING ACT, 140 OF 1992**

To provide for the prohibition of the use or possession of, or the dealing in, drugs and of certain acts relating to the manufacture or supply of certain substances or the acquisition or conversion of the proceeds of certain crimes; for the obligation to report certain information to the police; for the exercise of the powers of entry, search and seizure and detention in specified circumstances, for the recovery of the proceeds of drug trafficking; and for matters connected therewith.

**6.2.16 EMPLOYMENT EQUITY ACT, 55 OF 1998**

To provide for employment equity and to provide for matters incidental thereto.

**6.2.17 ENVIRONMENT CONSERVATION ACT, 73 OF 1989**

To provide for the effective protection and controlled utilisation of the environment and for matters incidental thereto.

**6.2.18 FOODSTUFFS, COSMETICS AND DISINFECTANTS ACT, 54 OF 1972**

To control the sale, manufacture and importation of foodstuffs, cosmetics and disinfectants and to provide for incidental matters.

**6.2.19 HAZARDOUS SUBSTANCES ACT, 15 OF 1973**

To provide for the control of substances which may cause injury or ill-health to or death of human beings by reason of their toxic, corrosive, irritant, strongly sensitising or flammable nature or the generation of pressure thereby in certain circumstances, and for the control of certain electronic products; to provide for the division of such substances or products into groups in relation to the degree of danger; to provide for the prohibition and control of the importation, manufacture, sale, use, operation, application, modification, disposal or dumping of such substances and products; and to provide for matters connected therewith.

**6.2.20 HEALTH DONATIONS FUND ACT, 11 OF 1978**

This Act covers matters relating to the donation of funds for health service purposes.

**6.2.21 HEALTH PROFESSIONS ACT, 56 OF 1974**

To establish the Health Professions Council of South Africa, to provide for control over the training of and for the registration of medical practitioners, dentists and practitioners of supplementary health service professions; to provide for the control over the training of and for the registration of psychologists; and to provide for matters incidental thereto.

**6.2.22 HUMAN TISSUE ACT, 65 OF 1983**

To provide for the donation or the making available of human bodies and tissue for the purposes of medical or dental training, research or therapy or the advancement of medicine or dentistry in general; for the post-mortem examination of certain human bodies; for the removal of tissue, blood and gametes from the bodies of living persons and the use thereof for medical or dental purposes; for the control of the artificial fertilisation of persons; and for the regulation of the import and export of human tissue, blood and gametes; and to provide for matters connected therewith. This Act will however be repealed by the National Health Act, Act 61 of 2003 as soon as it commences.

**6.2.23 INQUESTS ACT, 58 OF 1959**

To provide for the holding of inquests in cases of deaths or alleged deaths apparently occurring from other than natural causes and for matters incidental thereto, and to repeal the Fire Inquests Act, 1883 (Cape of Good Hope) and the Fire Inquests Law, 1884 (Natal).

**6.2.24 LABOUR RELATIONS ACT, 66 OF 1995**

To change the law governing labour relations and, for that purpose –

- to give effect to section 27 of the Constitution;
- to regulate the organisational rights of trade unions;
- to promote and facilitate collective bargaining at the workplace and at sectoral level;
- to regulate the right to strike and the recourse to lock out in conformity with the Constitution;
- to promote employee participation in decision-making through the establishment of workplace forums;
- to provide simple procedures for the resolution of labour disputes through statutory conciliation, mediation and arbitration (for which purpose the Commission for Conciliation, Mediation and Arbitration is established), and through independent alternative dispute resolution services (sic) accredited for that purpose;
- to establish the Labour Court and Labour Appeal Court as superior courts, with exclusive jurisdiction to decide matters arising from the Act;
- to provide for a simplified procedure for the registration of trade unions and employers' organisations, and to provide for their regulation to ensure democratic practices and proper financial control;
- to give effect to the public international law obligations of the Republic relating to labour relations;
- to amend and repeal certain laws relating to labour relations; and
- to provide for incidental matters.

**6.2.25 MEDICAL, DENTAL AND SUPPLEMENTARY HEALTH SERVICES**

This Act covers all aspects regarding the registration and other professional matters relating to this specific class of clinicians.

**6.2.26 MEDICAL SCHEMES ACT, 131 of 1998**

To consolidate the laws, relating to registered medical schemes; to provide for the establishment of the Council for Medical Schemes as a juristic person; to provide for the appointment of the Registrar of Medical Schemes; to make provision for the registration and control of certain activities of medical schemes; to protect the interests of members of medical schemes; to provide for measures for the co-ordination of medical schemes; and to provide for incidental matters.

**6.2.27 MEDICINES AND RELATED SUBSTANCES CONTROL ACT, 101 of 1965**

To provide for the registration of medicines intended for human and for animal use, for the registration of medical devices, for the establishment of a Medicines Control Council, for the control of medicines, Scheduled substances and medical devices and for matters incidental thereto.

**6.2.28 THE MENTAL HEALTH CARE ACT, 2002**

To provide for the reception, detention and treatment of persons who are mentally ill and to provide for incidental matters.

**6.2.29 NATIONAL HEALTH LABORATORIES SERVICE ACT, 37 OF 2000**

To provide for the establishment of a juristic person to be known as the National Health Laboratory Service. To provide for the abolition of the South African Institute for Medical Research, the National Institute for Virology, the National Centre for Occupational Health, certain forensic chemistry laboratories and all provincial health laboratory services and to provide for matters connected therewith.

**6.2.30 NATIONAL POLICY FOR HEALTH ACT, 116 OF 1990**

To provide for control measures with a view to promoting the health of the inhabitants of the Republic, and for that purpose to provide for the determination of a national policy for health, for the establishment of a Health Matters Committee and Health Policy Council, and for matters connected therewith. This Act will be repealed once the National Health Act, 2003 becomes operational.

**6.2.31 NON PROFIT ORGANISATIONS ACT, 46 OF 1978**

This Act covers all aspects relating to the registration and administration of non profit organizations.

**6.2.32 NUCLEAR ENERGY ACT, 46 OF 1999**

To provide for the establishment of the South African Nuclear Energy Corporation; to provide for responsibilities for the implementation and application of the Safeguards Agreement entered into by the Republic and the International Atomic Energy Agency in support of the Nuclear Non-Proliferation Treaty; to regulate the acquisition and possession of nuclear fuel, certain nuclear related material, as well as the importation and exportation of that fuel, material and equipment in order to comply with the international obligations of the Republic; to prescribe measures regarding the discarding of radioactive waste and the storage of irradiated nuclear fuel; and to provide for incidental matters.

**6.2.33 NURSING ACT, 50 OF 1978**

To consolidate and amend the laws relating to the professions of registered or enrolled nurses, nursing auxiliaries and midwives and to provide for matters incidental thereto.

**6.2.34 OCCUPATIONAL HEALTH AND SAFETY ACT, 85 OF 1993**

To provide for the health and safety of persons at work and for the health and safety of persons in connection with the use of plant and machinery; the protection of persons other than persons at work against hazards to health and safety arising out of or in connection with the activities of persons at work; to establish an advisory council for occupational health and safety; and to provide for matters connected therewith.

**6.2.35 PHARMACY ACT, 53 OF 1974**

To establish the Interim Pharmacy Council of South Africa; to provide for the training and registration of pharmacists, pharmacist interns, pharmacy students, unqualified assistants and pharmaceutical technicians, to provide for the control of the practice of the pharmaceutical profession and to provide for matters incidental thereto.

**6.2.36 PREFERENTIAL PROCUREMENT POLICY FRAMEWORK ACT, 5 OF 2000**

To give effect to section 217 (3) of the Constitution by providing a framework for the implementation of the procurement policy contemplated in section 217(2) of the Constitution; and to provide for matters connected therewith.

**6.2.37 PREVENTION OF FAMILY VIOLENCE ACT, 133 OF 1993**

To provide for the granting of interdicts with regard to family violence; for an obligation to report cases of suspected ill-treatment of children; that a husband can be convicted of the rape of his wife; and for matters connected therewith.

**6.2.38 PROMOTION OF ACCESS TO INFORMATION ACT, 2 OF 2000**

To give effect to the constitutional right of access to information held by the State and any information that is held by another person and that is required for the exercise or protection of any rights; and to provide for matters connected therewith.

**6.2.39 PROMOTION OF ADMINISTRATIVE JUSTICE ACT, 3 OF 2000**

To give effect to the constitutional right to fair and reasonable administrative action by an organ of state.

**6.2.40 PROMOTION OF EQUALITY AND PREVENTION OF UNFAIR DISCRIMINATION ACT, 4 OF 2000**

To give effect to section 9 read with item 23(1) of Schedule 6 to the Constitution of the Republic of South Africa, 1996, so as to prevent and prohibit unfair discrimination and harassment; to promote equality and eliminate unfair discrimination; to prevent and prohibit hate speech; and to provide for matters connected therewith.

**6.2.41 PROTECTED DISCLOSURES ACT, 26 OF 2000**

To make provision for procedures in terms of which employees in both the private and the public sector may disclose information regarding unlawful or irregular conduct by their employees or other employees in the employ of their employers; to provide for the protection of employees who make a disclosure which is protected in terms of this Act; and to provide for matters connected therewith.

**6.2.42 PUBLIC FINANCE MANAGEMENT ACT, 1 OF 1999**

To regulate financial management in the national government and provincial governments; to ensure that all revenue, expenditure, assets and liabilities of those governments are managed efficiently and effectively; to provide for the responsibilities of persons entrusted with financial management in those governments; and to provide for matters connected therewith.

**6.2.43 PUBLIC SERVICE ACT, 1994**

To provide for the organisation and administration of the public service of the Republic, the regulation of the conditions of employment, terms of office, discipline, retirement and discharge of members of the public service, and matters connected therewith.

**6.2.44 SEXUAL OFFENCES ACT, 23 OF 1957**

To consolidate and amend the laws relating to brothels and unlawful carnal intercourse and other acts in relation thereto.

**6.2.45 SKILLS DEVELOPMENT ACT, 97 OF 1998**

To provide an institutional framework to devise and implement national, sector and workplace strategies to develop and improve the skills of the South African workforce; to integrate those strategies within the National Qualifications Framework contemplated in the South African

Qualifications Authority Act, 1995; to provide for learnerships that lead to recognised occupational qualifications; to provide for the financing of skills development by means of a levy-grant scheme and a National Skills Fund; to provide for and regulate employment services; and to provide for matters connected therewith.

**6.2.46 SKILLS DEVELOPMENT LEVIES ACT, 9 OF 1999**

To provide for the imposition of a skills development levy; and for matters connected therewith.

**6.2.47 SOUTH AFRICAN MEDICAL RESEARCH COUNCIL ACT, 58 OF 1991**

To provide for the continued existence of the South African Medical Research Council and for the management thereof by a Board and for matters connected therewith.

**6.2.48 SOUTH AFRICAN POLICE SERVICES ACT, 68 OF 1978**

This Act establishes the South African Police Services and also covers all ancillary matters.

**6.2.49 STERILISATION ACT, 44 OF 1998**

To provide for the right to sterilisation; to determine the circumstances under which sterilisation may be performed and, in particular, the circumstances under which sterilisation may be performed on persons incapable of consenting or incompetent to consent due to mental disability; and to provide for matters connected therewith.

**6.2.50 TOBACCO PRODUCTS CONTROL ACT, 83 OF 1993**

To prohibit or restrict smoking in public places, to regulate the sale and advertising of tobacco products in certain respects and to prescribe what is to be reflected on packages; and to provide for matters connected therewith.

**6.2.51 UNIVERSITY OF CAPE TOWN ACT, 38 OF 1959**

This Act establishes the University of Cape Town and also covers all ancillary matters.

**6.3 PROVINCIAL LEGISLATION**

**6.3.1 WESTERN CAPE HEALTH FACILITY BOARDS ACT, 7 OF 2001**

The aim of the Act is to provide for Boards at provincial facilities, which are comprised of members, which are representative of the community, which the facility serves as well as members of staff of such a facility. The Boards have a prescribed set of powers and functions, which stipulates the scope of their authority.

**6.3.2 NOMINATION PROCEDURE REGULATIONS ISSUED IN TERMS OF THE WESTERN CAPE HEALTH FACILITY BOARDS ACT, 2001**

The Regulations stipulate the procedure, which the Department must follow when calling for nominations for Board members.

**6.3.3 EXHUMATION ORDINANCE. 1980**

The ordinance stipulates the procedure, which must be complied with when applying for the exhumation of a body.

**6.3.4 HOSPITALS ORDINANCE OF 1946**

The Ordinance prescribes who manages a provincial hospital as well all incidental matters connected thereto.

**6.3.5 REGULATIONS GOVERNING PRIVATE HEALTH ESTABLISHMENTS**

This Regulation governs the licensing and inspection aspects related to all private health establishments within the province.

**6.3.6 TRAINING OF NURSES AND MIDWIVES ORDINANCE, 4 OF 1984**

The Ordinance provides for the establishment and control of nursing colleges for the training of nurses and midwives, and for matters incidental thereto.

**6.3.7 COMMUNICABLE DISEASES AND NOTIFICATION OF NOTIFIABLE MEDICAL CONDITION REGULATIONS**

Prescribes the obligations to be complied with in the event of the outbreak of a communicable disease.

**6.3.8 PROVINCIAL TREASURY REGULATIONS**

The Regulations govern the spectrum of financial regulation in the provincial sphere.

**6.4 POLICY MEASURES****New Policies instituted by the Provincial Department of Health**

***HIV and AIDS Policy: Providing anti-retrovirals to HIV positive pregnant women*** through the implementation of the prevention of mother-to-child transmission (MTCT) programme which is a flagship programme in the Western Cape. The programme will save more than a thousand babies from HIV each year in the Western Cape.

***HIV and AIDS Policy: Voluntary Counseling and Testing (VCT):***

The VCT programme is a means to break the vicious cycle of fear, stigma and denial related to HIV and AIDS. The VCT programme also serves as the foundation to the development of a more holistic approach to treating patients who are HIV positive.

***HIV and AIDS Policy: Post Exposure Prophylaxis (PEP):***

An agreement was reached in the Provincial Bargaining Council during October 2001, whereby the Department agreed to cover the cost of prophylaxis in cases where an employee has been

exposed to the HIV during working activities. The Department has finalised a new *Protocol for the Management of Health Care Workers following an Accidental Needle-stick Injury or Exposure to Blood and Blood Stained Fluids*. This Protocol also spells out a recommendation for PEP as well as the prescribed Drug Regimens.

***Policy on the Management of Survivors of Rape and Sexual Assault:***

A Policy and Standardised Management Guidelines with regard to above were published during 2001. Specific health facilities have been identified in all four regions where the survivors of Rape and Sexual Assault will be treated. Central to the policy on medical, psychological and forensic management is the recognition that the management of rape survivors requires special training and expertise, as well as an integrated management approach. The policy aims to provide health managers and health workers with a clear framework on the management of female and male survivors (14 years and older) of rape and sexual assault within the PHC services of the Western Cape Health Department. The policy is further supported by the *Standardised Guidelines for the Management of Rape Survivors in the Western Cape Province*. For children younger than 14 years a *Child Abuse Policy and Management Guidelines* have been developed and published in September 2001 as part of the Paediatric Integrated Case Management Guidelines. *Treatment Guidelines for the use of AZT (Zidovudine)* have also been developed and published in October 2001 for the prevention of HIV transmission to children who have been sexually abused.

***TB Policy:***

The aim of this policy is to improve the overall management of TB in the Western Cape through the development and maintenance of a simplified paper register and a new patient-based *Electronic Register*. It will improve the tracking of patients and the monitoring of this service. Both of these new systems are linked to training interventions done at regions and involve all relevant role-players. It was implemented during 2001 in all three rural regions of the Western Cape.

***TB / DOTS: Policy:***

The purpose of this policy is to improve the management of TB through the appointment of *TB Coordinators* for every health district. TB Coordinators were appointed at the end of May 2002. Community Directly Observed Treatments (DOTS) have been expanded to include farms.

***Management and Control of Eye Conditions at Primary level:***

Training programmes in Primary Eye Care has been implemented in all regions. 350 registered nurses and 35 Home Based Carers have been trained in the early identification of eye conditions and Primary Prevention of Chronic Diseases.

***Implementation of National programmes for control and management of Chronic Diseases like Diabetes and Hypertension.***

Training programmes in the control and management of above have been instituted.



**Development and Implementation of Home Based Care:**

Training for Home-Based Carers has been instituted in all regions to care for all chronically ill patients in the Province.

**Health Promotion Policy:**

A Provincial Policy has been developed to enable the people of the Western Cape to increase control over and to improve their health. This policy affirms commitment to promoting a multi-disciplinary, people-oriented approach at local level, embracing national and international initiatives and strategies and outlines a multi-sectoral strategic approach to improve the health of the Western Cape population.

**Kangaroo Mother Care (KMC):**

A policy was developed on KMC and instituted in specified institutions in the Western Cape. KMC is an intervention for the care of the low birth weight (LBW) infant and consists of four components i.e. Kangaroo position, -nutrition, -support and – discharge. Kangaroo Mother Care has been shown to be a safe, effective and affordable method of caring for LBW infants in many contexts around the world, in our own country and in our own province.

**Provincialisation of Emergency Medical Services (EMS).** This process was anticipated to be completed by July 2002 when the Unicity EMS Staff would be transferred to province. Due to unforeseen labour related matters the intended transfer could not be completed within the anticipated framework. EMS staff in all the rural areas have however been transferred over the past year. The completion of this process will improve deployment of resources and reduce emergency care response time. Please note that we do no longer refer to *Ambulance Drivers*, but to *Emergency Care Practitioners*. Provincial legislation on the issue of emergency medical services is currently being drafted.

**Contraceptive Policy**

The Western Cape was extensively involved in the development of the National Contraceptive Policy Guidelines which were adopted and published in September 2002. The policy framework for the provision and use of contraception was developed to address the identified current major reproductive health challenges. All sections of the policy framework are in line with international agreements and national legislation and policies. The policy embraces the new definitions of sexual and reproductive health and the integrated comprehensive reproductive health care paradigm. The sections focus *inter alia* on the rights of the clients, the needs of the providers, guiding principles, etc. The aim of the policy is to ensure respect for the individual and to protect, promote and fulfill the right to contraceptive services.

**Revised Sterilisation Policy and Standardised Provider Guidelines**

The Western Cape sterilisation policy and provider guidelines were revised and published in September 2002. The policy and comprehensive provider guidelines are based on the latest

evidence and best practice standards and aim to provide effective guidance for health personnel to:

- Promote and enhance equitable, accessible, cost-effective and user-friendly sterilisation services;
- Ensure clients receive a high quality service based on the best evidence currently available;
- Promote respect for the individual and to protect and promote personal human dignity and particularly for those individuals who are incompetent/incapable of giving consent due to severe mental disability, by ensuring that decisions about sterilisation are made in a responsible and considerate manner.

## **7. BROAD POLICIES, PRIORITIES AND STRATEGIC GOALS**

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

### **7.2 National Department of Health**

#### **7.2.1 Free health services**

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

- 1) Family planning services;
- 2) Health advisory services,
- 3) Immunizations to combat notifiable infectious diseases, excluding vaccination for foreign travel;
- 4) Treatment of infectious, formidable and/or notifiable diseases, e.g. pulmonary tuberculosis, Leprosy, Meningococcal meningitis;
- 5) The preparation of medical reports required in cases with legal implications such as rape, assault, drunken driving, post mortems, etc.
- 6) Oral health services: the screening, preventive and promotive services offered at schools and also scholars classified according to a means test and referred by the school nursing services or oral health services;
- 7) Patients are transported free of charge in certain instances;
- 8) Certified psychiatric patients and state patients;
- 9) School children classified (as H1 patients) according to a means test;
- 10) Children committed in terms of section 15 and 16 of the Child Care Act, Act 74 of 1983;
- 11) Children under the age of six years. This applies to children classified as H0, H1, H2 in terms of a means test;

- 12) Immigrants residing permanently in the country, visitors, foreigners with study permits, temporary work or visitors permits as well as persons from neighbouring countries who enter South Africa illegally;
- 13) Pregnant women classified as H0, H1 and H2 patients;
- 14) Termination of pregnancies is free to hospital patients (H0, H1, and H2 patients) as well as full paying and private patients. This includes free ambulance and patient transport services.
- 15) Primary health care services are rendered free to permanent residents and who are classified as H0, H1 or H2 patients.

#### 7.2.2 The Uniform Patient Fee Schedule (UPFS)

The regulations relating to the UPFS in terms of which patient fees are determined are amended annually and published in the Provincial Gazette. In terms of the regulations published in the Provincial Gazette 6198 on 30 December 2004, the provincial Health Department provides free health services to the following categories of patients [subject to conditions specified in the Gazette], in addition to the free services outlined in Annexure C of Finance Instruction G of 2003, dated 23 December 2003, as determined by the National Department of Health:

- Social pensioners
- Formally unemployed.

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

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

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

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

**Table 14: Tariff categories**

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

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

### 7.3 The Millennium Development Goals

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

The United Nations Millennium Declaration (September 2000) reads as follows:

"We will spare no effort to free our fellow men, women and children from the abject and dehumanising conditions of extreme poverty, to which more than a billion of them are currently subjected."

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

**Table 15: Millennium development goals**

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
1. Eradicate extreme poverty and hunger.	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children under 5 years of age.
		Proportion of the population below minimum level of dietary energy consumption.

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
2. Achieve universal primary education.	Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.	Net enrolment ratio in primary education.
		Literacy rate of 15 – 24 year-olds.
3. Promote gender equality and empower women.	Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.	Ratio of girls to boys in primary, secondary and tertiary education.
		Ratio of literate females to males of 15 – 24 year-olds.
4. Reduce child mortality.	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.	Under-5 mortality rate (U5MR).
		Infant mortality rate.
		Proportion of one-year old children immunised against measles.
5. Improve maternal health.	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	Maternal mortality ratio.
		Proportion of births attended by skilled health personnel.
6. Combat HIV and AIDS, malaria and other diseases.	Have halted, by 2015, and begun to reverse the spread of HIV and AIDS, malaria and other diseases	HIV prevalence among 15 – 24 year old pregnant women.
		Condom use rate of the contraceptive prevalence rate.
		Number of children orphaned by HIV and AIDS.
		Proportion of the population in malaria risk areas using effective malaria prevention and treatment measures. (Prevention to be measured by the % of under 5 year olds sleeping under insecticide treated bednets and treatment to be measured by % of under 5 year olds who are appropriately treated.
		Prevalence and death rates associated with TB.
		Proportion of TB cases detected and cured under DOTS.
7. Ensure environmental sustainability.	Halve, by 2015, the proportion of people without sustainable access to safe drinking water.	Proportion of people with sustainable access to an improved water source.

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
	By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers.	Proportion of urban population with access to improved sanitation.
8. Develop a global partnership for development.	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.	Official development assistance
		Proportion of exports admitted free of duties and quotas.
	In co-operation with pharmaceutical companies, provide access to affordable , essential drugs in developing countries.	Proportion of population with access to affordable essential drugs on an established basis.

#### 7.4 National Department of Health five-year priorities

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

**Table 16: National Department of Health five-year priorities**

PIORITY	ACTIVITY
1. Improve governance and management of the NHS	<ul style="list-style-type: none"> <li>Review and strengthen communication within and between health departments.</li> <li>Strengthen corporate identity, public relations and marketing of health policies and programmes.</li> <li>Strengthen governance and maintenance structures and systems.</li> <li>Strengthen oversight over public entities and other bodies.</li> <li>Adopt Health Industry Charter</li> </ul>
2. Promotes healthy lifestyles.	<ul style="list-style-type: none"> <li>Initiate and maintain healthy lifestyles campaign.</li> <li>Strengthen health promoting schools initiative.</li> <li>Initiate and maintain diabetes movement.</li> <li>Develop and implement strategies to reduce chronic diseases of lifestyle.</li> <li>Implement activities and interventions to improve key family practices that impact on child health.</li> </ul>
3. Contribute towards human dignity by improving quality of care.	<ul style="list-style-type: none"> <li>Strengthen community participation at all levels.</li> <li>Improve clinical management of care at all levels of the health care delivery system.</li> <li>Strengthen hospital accreditation system in each province in line with national norms and standards.</li> </ul>
4. Improve management of communicable diseases	<ul style="list-style-type: none"> <li>Scale up epidemic preparedness and response.</li> <li>Improve immunisation coverage.</li> </ul>

PIORITY	ACTIVITY
and non-communicable illnesses.	<ul style="list-style-type: none"> <li>• Improve the management of all children under the age of 5 years presenting with illnesses such as pneumonia, diarrhoea, malaria and HIV.</li> <li>• Updated malaria guidelines, integrate malaria control into comprehensive communicable disease control programme and ensure reduction of cases.</li> <li>• Implement TB programme and review recommendations.</li> <li>• Accelerate implementation of the Comprehensive Plan for HIV/AIDS.</li> <li>• Strengthen free health care for people with disabilities.</li> <li>• Strengthen programmes on women and maternal health .</li> <li>• Strengthen programmes for survivors of sexual abuse and victim empowerment.</li> <li>• Improve risk assessment of non-communicable illnesses.</li> <li>• Improve mental health services</li> </ul>
5. Strengthen primary health care, EMS and hospital service delivery systems.	<ul style="list-style-type: none"> <li>• Strengthen primary health care.</li> <li>• Implement provincial EMS plans.</li> <li>• Strengthen hospital services.</li> </ul>
6. Strengthen support services	<ul style="list-style-type: none"> <li>• Strengthen NHLS.</li> <li>• Ensure availability of blood through South African National Blood Service</li> <li>• Transfer forensic labs including mortuaries to provinces.</li> <li>• Implement health technology management system.</li> <li>• Strengthen radiation control.</li> <li>• Quality and affordability of medicines.</li> <li>• Establish an integrated disease surveillance system.</li> <li>• Integrate non natural mortality surveillance into overall mortality surveillance system.</li> <li>• Establish an integrated food control system.</li> </ul>
7. Human resource planning, development and management.	<ul style="list-style-type: none"> <li>• Implement plan to fast-track filling of posts.</li> <li>• Strengthen human resource management.</li> <li>• Implement national human resource plan.</li> <li>• Strengthen implementation of the CHW programme and expand mid level worker programme.</li> <li>• Strengthen programme of action to mainstream gender.</li> </ul>
8. Planning, budgeting, monitoring and evaluation.	<ul style="list-style-type: none"> <li>• Implement SHI proposals as adopted by Cabinet.</li> <li>• Strengthen health system planning and budgeting.</li> <li>• Strengthen use of health information system.</li> </ul>
9. Prepare and implement legislation.	<ul style="list-style-type: none"> <li>• Implement Mental Health Care Act</li> <li>• Implement National Health Bill</li> <li>• Implement Provincial Health Acts</li> <li>• Traditional healers, Nursing &amp; Risk Equalisation Fund Bills implemented.</li> </ul>
10. Strengthen international relations.	<ul style="list-style-type: none"> <li>• Strengthen implementation of bi and multi-lateral agreements</li> <li>• Strengthen donor co-ordination</li> <li>• Strengthen implementation of NEPAD strategy and SADC.</li> </ul>

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

1) **Improve governance and management of the National Health System:**

Governance and management of the District Health System are being strengthened through the development of District offices in the Metropole and the appointment of facility managers at the major metropolitan community health centres. Following a long process of consultation, the decision has been made to provincialise the provision of Personal Primary Health Care (PPHC) by the rural municipalities with effect from 1 April 2005. Local government will continue to provide and partially fund PHC services in the Metropole for the next three years.

2) **Promote healthy lifestyles:**

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

3) **Contribute towards human dignity by improving quality of care:**

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

4) **Improve management of communicable diseases and non-communicable illnesses:**

- HIV and AIDS: The Western Cape has achieved significant increase in anti-retroviral treatment access and universal coverage for the PMTCT intervention, through successful



partnerships and multi-sectoral efforts. The Province also introduced a dual therapy PMTCT regimen (AZT from 34 weeks plus single-dose Nevirapine to the mother, and AZT for 1 week and single-dose Nevirapine for the baby), universally across the province by May 2004.

- The incidence of tuberculosis (TB) in the Western Cape continues to be amongst the highest in the world, exacerbated by the HIV/AIDS pandemic. The Department has made significant progress in the implementation of the WHO DOTS Strategy and is working towards the overall goal of achieving an 85% cure rate. This is reflected in the steady improvements in the TB cure rates from 65% in 1997 to 68% in 2002.

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

- Initiatives planned to strengthen Primary Health Care are e.g. to establish facility management, to computerise PHC services and to develop an infrastructure plan for PHC.
- Infrastructure plans for Emergency Medical Services are being developed.
- It is planned that hospital services, particularly regional hospital services providing level 2 services be strengthened. This will be achieved in the application of the Generic Staffing Models.

6) **Strengthen support services**

- A service level agreement was signed with the National Health Laboratory System (NHLS) on 23 June 2004 and has been implemented.
- Blood products in the Western Cape are provided by the Western Province Blood Transfusion Services.
- The Province is managing the transfer of the forensic mortuaries, provincial plans are currently being consolidated and financial implications confirmed. Transfer will be effected when conditional grant funding has been confirmed.
- Medicines and Pharmacy legislation is currently being implemented. Audits have been conducted to determine the shortfall and the financial implications of legal compliance is being confirmed.

7) **Human resource planning, development and management:**

- New staff establishments are being developed in the Generic Staffing Models. The aim of these models is to create establishments that linked to the projected patient activity and an appropriate skill mix.
- An Employment Equity Plan has been developed and implemented.
- In order to improve and ensure compliance with the Employment Equity Act The Department has divided the hospitals or regions into clusters each cluster 's numerical goals has been determined per race, gender and occupational group. The Department is also in the process of drafting a policy on Affirmative Action which will put forward further initiatives to achieve the targets set. .

8) **Planning, budgeting, monitoring and evaluation:**

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

9) **Prepare and implement legislation:**

- Mental Health Act: considerable work is being done to implement this legislation.
- National Health Act 61 of 2003: this has not yet been implemented but the implications of the Act on the functioning of the services has been assessed as far as possible at this stage.
- The Provincial Health Act for the Western Cape will be drafted once the National Health Act is implemented and the regulations published.

10) **Strengthen international relations:**

- The Department has a number of co-operation agreements with various donor agencies, e.g. the European Union for home-based care, the Global Fund for TB/HIV and Medicin Sans Frontiers for the prevention of mother to child transmission programme.

## 7.5 **iKapa elihlumayo**

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

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

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

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

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

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

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

### 7.5.2 Strategic Infrastructure Plan

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

### 7.5.3 Social Capital Formation (SCF) in Health

#### **Introduction and background**

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

The concept of *bonding* social capital is further defined as *bridging* social capital that applies to the horizontal links between individuals or groups sharing similar demographic characteristics,

and *linking* social capital refers to linkages that cross different communities/ individuals. An important aspect of linking social capital is that it spans different levels of power in society.

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

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

### **Situational analysis**

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

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

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

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

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

**Internal social capital** is an important issue in the quality of care and is reflected in issues such as patient waiting times and service times and human resource issues. The reciprocal relationship with patients is damaged when health care personnel feel overwhelmed and supported in their tasks. Improvements in the health services are key to building social capital.

Seven million rand has been allocated to the funding of specific projects to target the further development of social capital while a further R74m has been allocated to Programme 2 to provide additional capacity in primary health care. Further shifts in the budget will occur as the service platform is finalised and the staff establishments are redefined. It is argued that the optimal use of the whole health budget will in this manner contribute greatly towards social capital formation.

**Specific lines of response:**

In addition to Healthcare 2010 which is the broad response of the Department to social capital formation, four issues have been identified with which to link the progress in social capital formation:

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

Diarrhoeal disease

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

- Assist the communities to address the water and sanitation problems by engaging the relevant departments (linking social capital).
- Engage with community structures to educate and empower the people, particularly mothers regarding the importance of early presentation of children with diarrhoeal disease to the

health services. The Department of Health does not seek to create new or additional community structures but rather to make use of existing structures and to strengthen these where necessary.

- Engage with Education Department regarding the teaching of hygiene at schools,
- Extend the hours of child health services at selected community health centres.
- Ensure that each PHC facility has a functioning oral rehydration programme.

#### Immunisation

Immunisation coverage in the province is not optimal. Community Integrated Management of Childhood Illness (IMCI) workers provide an additional interface between 'formal' health delivery structures and the community. They provide a framework for closer co-operation between community and service delivery promoting a trusting relationship. The effectiveness of this approach is illustrated by the initiative in December 2004/ January 2005 to immunise children in Fish Hoek in response to an outbreak of measles. By effectively involving the schools and community leaders and effective communication, parents co-operated and approximately 4 000 children were immunised. This initiative builds on such examples.

#### Management of chronic diseases

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

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

#### Trauma

The role of the Department of Health in relation to Trauma currently is as a recipient of the heavy disease burden as Health treats patients who are the victims of Trauma but is not able to influence the incidence of Trauma which is an outcome of the breakdown of Social Capital. However, Health is a vital link in the chain of Trauma management and prevention in that it can provide data that could assist other departments in formulating strategies to prevent Trauma. Health will monitor, identify areas to be targeted by intervention and act as a 'conscience' to government in this regard.

#### **The way forward for Health and social capital formation**

The Department of Health has made a concerted effort to analyse social capital formation and its implications for the Department. It is clear that social capital plays a fundamental role in the prevention of disease and the promotion of health. As the successful functioning of the Department rests on an effective and efficient Primary Health Care service so does the

development of social capital. The Department's Healthcare 2010 and social capital formation strategy are therefore closely aligned and both have a primary health care focus.

## 7.6 Healthcare 2010

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

The technical model is based on a set of inter-related variables such as population size, patient activities and the financial envelope. It was developed in order to substantially improve the quality of the health services and to bring the Department's expenditure within budget. Failure to restructure would mean that existing inefficiencies would continue and that the projected deficit on the Provincial Health budget would be R1,1 billion (in April 2001 rands) in 2010.

7.6.2 It is useful to revisit the assumptions on which this modeling was based:

- The reason for basing financial calculations on 2001 rands is that the service modeling was based on 2001 data.
- It is assumed that macro-economic factors such as inflation, exchange rates etc will be accounted for.
- It is of significant importance that it was **assumed that the Local Government contribution towards Primary Health Care (PHC), excluding environmental health, would continue at existing levels.**
- Conditional grant funding would be used according to the requirements of the Division of Revenue Act (DORA).
- Patients would be treated at the level of care most appropriate to their requirements within a reshaped service platform.
- The focus of service delivery is to the population of the Western Cape and a quantum of tertiary services to other provinces.

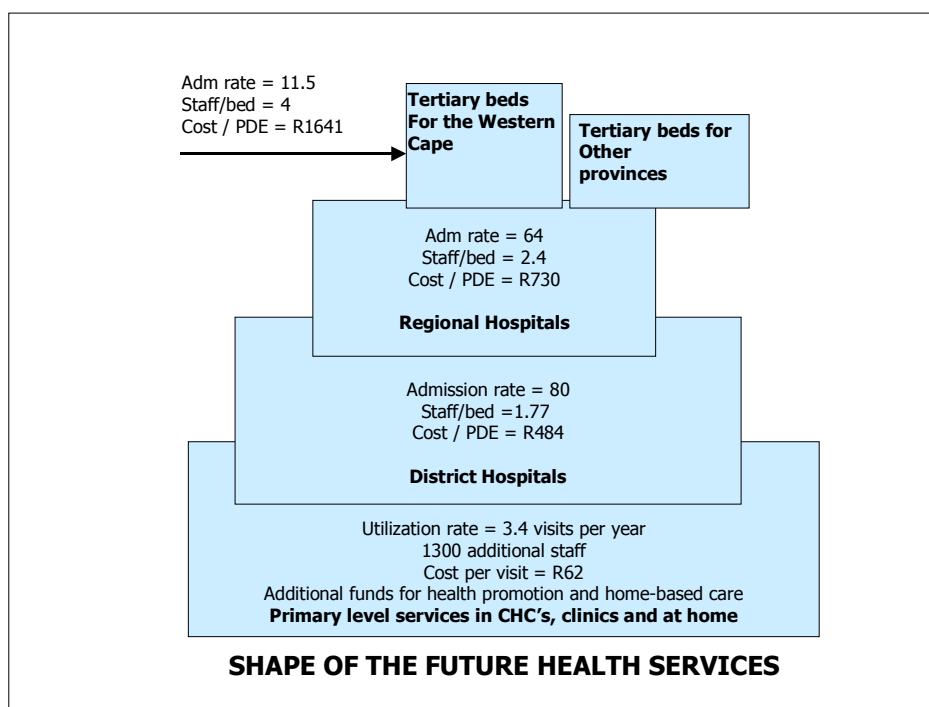
7.6.3 The underlying principles of Healthcare 2010 are:

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

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

The following diagram illustrates the intended shape of the service based on the principle that 90% of health contacts will occur at the primary level, 8% at secondary level and 2% at tertiary level. It is important to note that a measure of overlap between the levels of care is provided at each level.

**Figure 2: The proposed shape of future health services**



#### 7.6.5 Implementation of Healthcare 2010

**The strategic goals of the Department are:**

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

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

- The service delivery plan;
- The personnel plan;
- The infrastructure plan; and
- The financial plan.



**The personnel plan**

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

Generic staffing models for hospitals have been developed to create staffing establishments that provide for an appropriate number and skill mix of personnel in relation to the patient activities. The models are being consulted with the hospitals and considerable progress has been made on the models for primary health care.

**The service plan**

The service plan and the personnel plan are clearly closely inter-related. It is anticipated that the service plan will be finalized by June 2005 and that there will be significant progress with the restructuring of the staff establishments by the end of the 2005/06 financial year.

It must be noted that in earlier planning documents one of the steps to implement Healthcare 2010 was the transfer of the Metro Regional Hospitals from sub-programme 4.1 to sub-programme 2.9 i.e. from level 2 regional hospitals to level 1 district hospitals. Similarly it was planned that in 2006/07 the secondary level beds currently funded in the central hospitals in Programme 5 would be consolidated and transferred to Sub-programme 4.1. This was based on the fact that hospitals are allocated to the respective programmes by type, i.e. level 1 hospitals are classified as district hospitals and level 2 hospitals as regional hospitals and level 3 as central hospitals.

However, on reflection this methodology was deemed to be unsatisfactory to reflect reality and the requirements of Healthcare 2010. The service plan, in line with Healthcare 2010 aims to allocate funding for activities per level of care. Therefore the criteria according to which funding will be allocated will be according to the number of activities per level of care within a particular health care facility. For this reason the current classification of hospitals in sub-programmes 2.9, 4.1 and 5.1 will be maintained until the detail of the service plan is approved and implemented.

As part of the planning process the Department is making provision to provide for the required services within the existing structures by 2007/08 and within the planned infrastructure by 2010, for example it is planned to accommodate the necessary level 1 beds in existing hospitals until such time as the Khayelitsha and Mitchell's Plain hospitals are built and commissioned.

**The infrastructure plan**

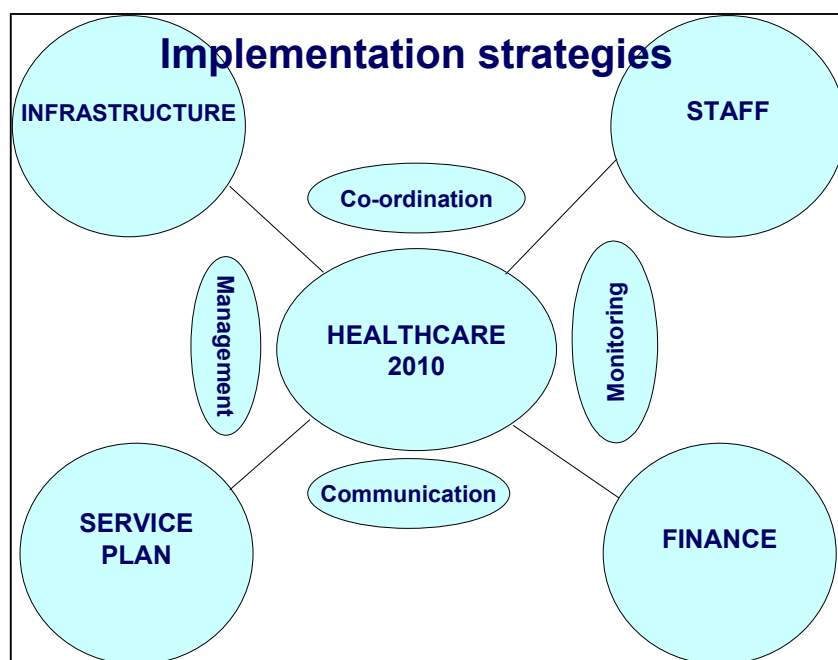
The infrastructure plan for hospitals has been compiled and similar plans for Primary Health Care and the Emergency Medical Services are being compiled. Planned patient transport is a key issue to facilitate the accessibility of services to patients and is being addressed.

### Finances

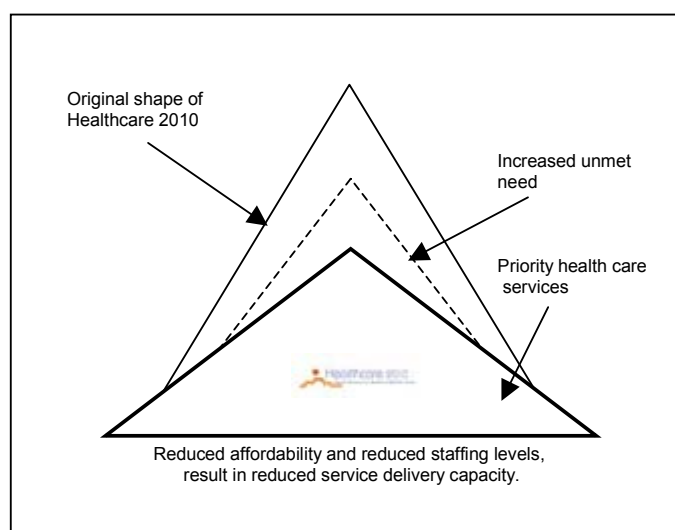
Key financial projects that are being addressed are revenue generation, the conclusion of service level agreements with Local Government regarding the delivery of Primary Health Care, excluding environmental health. Another important project that is being addressed is the review of the Joint Agreements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

- 7.6.6 The framework of Healthcare 2010 was reviewed by the Department in June 2004 and found to still be valid. In the analogy that the Department of Health is a vehicle that provides essential health services, the four plans can be regarded as the wheels of the car, each playing a vital and related role in the success of the journey. The Head of Department is driving the vehicle and facilitating the appropriate management, communication, co-ordination and monitoring of all the relevant role-players.

**Figure 3: Healthcare 2010 implementation projects**



Although the shape of the Healthcare 2010 service is appropriate the size of the service is dependent on the available funding. This concept is clearly illustrated in Figure 4.

**Figure 4: Shape of the affordable service**

The impact of reduced funding on the Health Department would be that the services in line with Healthcare 2010 would be reshaped to optimize the use of the resources but that the size of the service would be reduced, resulting in an unmet need.

## 8. INFORMATION SYSTEMS TO MONITOR PROGRESS

There are 77 systems in the master systems inventory of which some could be used to a greater or lesser extent for evaluation, monitoring and reporting purposes. The list of systems below is identified as playing a major role in the current processes. There are also a number of unofficial databases (not approved by the Departmental Information Technology Committee) that are in use by some of the managers. Unfortunately these databases cannot be reported on.

**Table 17: Key computer systems**

Type of system	Name of system	Brief description	Functionality	Reliability	Structure
Transaction processing system	1 LOGIS	National system supported by a 3 <sup>rd</sup> party for the supply chain management purposes within the department.	1. System is a real time system writing to a national database for procurement, stock management and payment purposes.	System upgraded and reliable if connectivity to BAS is active.	Consistently structured by the National department. System changes only through the national department.
		In use at all sites except the Academic hospitals.	2. Since 1 April 2004 an interface to BAS for accounting purposes has been implemented.		
			3. Reporting at various levels available		

Type of system	Name of system	Brief description	Functionality	Reliability	Structure
	2 Syspro	An off the shelf supply chain management system utilized at the 3 Academic hospitals.	1. System is a real time system writing to a provincial database for procurement, stock management and payment control purposes of consumables and assets.	Syspro reliable and stable.  Cost centre requisitioning system still in pilot phase.	National requirements used in system.  Structure in the process of being checked against the LOGIS system.
			2. System interfaces with a cost centre requisitioning system.		
			3. The Requisitioning system is cost centre profile specific and budget restrictive.		
			4. Reporting at procurement, cost centre, store and item level available.		
			History retained on the system		
	3. J.A.C.	J.A.C. Pharmacy system is used at the academic hospitals and ARV store for pharmaceutical products	The system is used for the procurement, stock management and issuing of pharmaceuticals to sub stores, cost centers (wards) and patients.	System is reliable	Item structure according to the national standards for drugs and mapped to the BAS item structure.
			System sends information at patient level through to the Billing system		
			Standard and ad hoc system operational and statistical reports available.		
Accounting Information System	BAS	BAS (Basic Accounting system) managed National level through Treasury.	Transversal system for accounting purposes of the department	LOGIS –BAS interface currently problematic  Not yet proven in this province as the system is still new to the staff	National structure.  System changes only through the national department.
Operational Information Systems	1. Delta 9	A decentralized patient administration and Billing system utilized at the regional and district hospitals as an interim measure	1. Decentralised system registers a patient with a different number for each site visited.	Data used for Hospital Minimum data set as well as NTSG.	As no central database or master file structure is in use the consistency across hospitals has not been evaluated..
			2. Register inpatient data such as transfers, deaths discharges,	Patient data reliable if entered in real time.	On taking over data to new systems, each site has to be separately programmed indicating inconsistency

Type of system	Name of system	Brief description	Functionality	Reliability	Structure
			3. Registers out patients head counts (not visits) not real time transaction dependant	No formal data quality process has been conducted	
			4. Has a patient OPD and theater scheduling function that is in use only at Karl Bremer hospital	Billing data reliable if correctly interpreted and entered by staff member	
			5. Billing of patient visits and inpatients by means of an interface.		
			6. Data used for reporting on hospital statistics and patient fees.		
			7. Standard reports available for patient information and fees.		
			8. Ad-hoc reports have to be compiled by 3 <sup>rd</sup> party.		
Operational Information Systems	2. Clincom & Billing	A centralized Patient administration and billing system in use at the Academic hospitals and 3 non academic pilot sites	1. Central registration of a patient allocating a unique patient number that will be utilized throughout the province.	Data used for Hospital Minimum data set as well as NTSG.	Consistency of data built into system by means of master files.
			2. All inpatient & outpatient administrative transactions are registered real time	Patient Data passed a formal data quality check and is reliable up to the level of Speciality and level of care.	Structure maintained by province by means of change control processes.
			3. Patient billing done by system according to patient income and account specifications		
			4. Services chargeable on system.	Billing data in the process of being quality checked, but not reliable yet	
			5. Interface with the pharmacy module for medication charges.		
			6. Able to register non-patient as boarder and escorts and services to private doctor patients.		
			7. Cash collection and cash management function for patient and non-patient cash.		
			8. Billing of patients and addressing the billing policies & regulations automatically		
			9. Interface with Clinical (Cradle), Laboratory (Disa*lab) and Meals ordering systems.		
			10. Standard operational and statistical reports available on system		

Type of system	Name of system	Brief description	Functionality	Reliability	Structure
			11. Ad hoc statistical and operational reports available by means of a report writing tool		
Information reporting systems	1. DHIS	A national Access based system supported by a 3 <sup>rd</sup> party for entering hospital and epidemiology data, i.e. minimal hospital data set, National Tertiary Services Grant, etc.	Capturing of monthly statistical data from health facilities from reports (sheets) at district or regional offices Ability to report on captured data	No longer fully reliable. The access database cannot manage the data and reports do not display all relevant data	Consistently structured, but maintained through 3 <sup>rd</sup> party programmers
	2. SINJANI	A Western Cape Provincial web-based system for entering hospital and epidemiology data.	Capturing of monthly statistical data from health facilities at any facility with internet / intranet access. (at source of service)  Ability to report on captured data at various levels of service provision.	Reliability in the process of being evaluated. System in pilot phase. Database structure reliable.	Consistently structured, and maintained by the department of health
	3. Electronic TB register	National electronic register to register patients with pulmonary TB and their treatment outcomes (including sputum smears)	System registers and reports on all pulmonary TB patients. Data entered at district level from registers Reports easy to withdraw.	Data reliable if correctly entered into system	Structured consistently. Changes on system the responsibility of the National department.
	4. Electronic Epidemiology information System	A national system for notifiable diseases	Capturing data from forms on to the system at district level. Reporting on data	Not reliable. System is DOS based and should be rewritten or another system identified for this purpose	Consistently structured.
	5. HEISS	Information Management system for Cost centers utilized at Groote Schuur and Red Cross Children's hospital.	1. System utilized data input from various feeder systems electronically or manually to register cost center information 2. System reports on cost of various consumable and services expenses per cost centre level up to hospital level.	System stable. Reliability of the information dependant on the correctness of the data input.	Consistent. The cost centre structure complies with the national structure.

## 9. DESCRIPTION OF THE STRATEGIC PLANNING PROCESS

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

- 9.2 The consultation process included the following:
- A media conference, addressed by top management explaining the concept and inviting engagement and comment;
  - Over eighty engagements with representative stakeholder groups;
  - Media interviews and response to media queries, i.e 21 articles and letters directly related to Healthcare 2010 occurred between October 2002 and February 2003;
  - Advertisements were placed in the English and Afrikaans media on 22 February 2004, to remind stakeholders that the closing date for comments was 28 February 2004.
  - Representatives from senior and middle management considered all the inputs
- 9.3 A submission was made to the Provincial Cabinet who resolved that the Department of Health should proceed with the detailed planning and implementation of Healthcare 2010 on 26 March 2003.
- 9.4 Subsequently an information booklet titled: Healthcare 2010: Health Western Cape's plan for ensuring equal access to quality health care was published in English, Afrikaans and Xhosa.
- 9.5 In preparing the strategic plan for 2005/06 a Strategic Planning Review session was held at Ongegund on 27 and 28 June 2004. This meeting was attended by the MEC for Health, the Head of Department, the Department's top management, programme managers and representatives from the Directorates: Information Management, and Policy and Planning. In addition to this representatives from the Strategic Planning Cluster at the National Department of Health and the National and Provincial Treasury were invited.

At this review session the principles and implications of Healthcare 2010 were revisited and confirmed. It must be noted that an important assumption of Healthcare 2010, i.e. that the funding currently provided by Local Government for PHC services will remain in the health sector, may no longer be valid, in which case there would be a significant shortfall in the PHC funding.

## **PROGRAMME 1: ADMINISTRATION**

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

2. **PROGRAMME STRUCTURE**

- 2.1 **SUB-PROGRAMME 1.1 OFFICE OF THE PROVINCIAL MINISTER**

Rendering of advisory, secretarial and office support services.

- 2.2 **SUB-PROGRAMME 1.2 MANAGEMENT**

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

### **Sub-programme 1.2.1 Central Management**

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

### **Sub-programme 1.2.2 Decentralised Management**

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

3. **SITUATION ANALYSIS**

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

The central head office determines policy and ensures that the health service functions in harmony with both national and provincial policy and directives. Human resource and financial management policies and procedures are determined and co-ordinated at the central head office. The central head office also provides overall policy determination, management and direction for Health Programmes. Professional Support Services and Communication, with staff and public, are likewise co-ordinated and directed from the central head office.

From an epidemiological perspective, the migration into the Western Cape remains an issue of concern as whilst the province receives funding for patients from other provinces for tertiary services, albeit insufficient at present, no financial provision is made for these patients who



require primary and secondary level care. This places an additional financial strain on the limited provincial resources.

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

Extensive groundwork has been done over the past year on the implementation of Healthcare 2010. It is anticipated that the Service Plan which will outline the way in which the services should be reshaped, will be finalised by June 2005. This will include addressing issues such as service packages and begin to address referral guidelines. Once the Service Plan is in place it will be possible to commence restructuring the staff establishments in line with the Generic Staffing Models. It is anticipated that significant progress will be made with the latter process by the end of 2005/06.

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

In terms of Finance a key challenge over the strategic planning period is the implementation of the Basic Accounting System (BAS) and cost centre management.

The functioning and restructuring of the Cape Medical Depot is a key issue in this financial year to ensure that demand is managed, client management is improved and there is greater interaction with the pharmaceutical industry.

#### 4. POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

**Table B1: Strategic objectives for Programme 1**

<b>STRATEGIC GOAL:</b>
To conduct the strategic management and overall administration of the Department of Health.
<b>STRATEGIC OBJECTIVES</b>
To render advisory, secretarial and office support services to the Office of the Provincial Minister.
To formulate policy and provide overall management and administrative support to the Department and the respective regions and institutions within the Department.

#### 5. CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The inability to meet the demand for services within the allocated financial resources remains the most significant constraint and challenge for the Department. Stringency measures implemented to curb over-expenditure have had a detrimental effect on service delivery, staff

morale and efficiency. As personnel is the main cost driver, not filling vacant posts in non-critical areas and the more efficient use of human resources have the maximum impact on cost containment. For this reason also the availability of accurate financial management is key to the effective management of the Department and services as a whole.

Recruitment of specific skills remains a problem. The financial, human resources and business management components are short staffed both at head office and institutional level. Recruitment of appropriate numbers of certain clinical personnel, e.g. pharmacists, theatre nurses, etc, remains a problem. It is anticipated that the application of the Generic Models to the various establishments will determine the appropriate number and mix of staff for a particular level of service delivery within the envelope of affordability, therefore optimising the use of human resources.

Reshaping the service to direct patients to the most appropriate level of care is difficult to effect particularly in the absence of bridging funds, as service delivery cannot be interrupted. The process therefore has to be managed incrementally.

Legal compliance with the Pharmacy and Medicines legislation by July 2005 will be a challenge as it will demand upgrading of infrastructure, training and licensing of identified dispensers, additional human resource requirements, training and registration of Pharmacists Assistants as well a re-engineering of the drug supply chain. All of which has not been additionally funded from the National fiscus.

## **6. PLANNED QUALITY IMPROVEMENT MEASURES**

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

The Department created a Directorate: Professional Support Services with the intention that it provide an enabling and co-ordinating service to nursing, allied health professionals, medico-legal, forensic services, pharmaceutical services and quality assurance to facilitate the optimal utilisation of these services and therefore contribute significantly to improved quality of care.

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

It has been decided to prioritise the filling of key financial personnel posts throughout the department to increase the capacity at all levels to facilitate the procurement process and the billing/financial management processes. It is argued that this will contribute significantly to improving both service and financial efficiencies.

The Department has produced business cases to access the Revitalisation Grant. Major upgrades have commenced at George, Worcester and Vredenburg Hospitals. Funding in terms of the grant will provide for new and upgraded buildings, new medical equipment and organisational development in many hospitals in the province over the next decade and beyond.

Specific quality improvement measures for include:

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

## **7. RESOURCE INFORMATION**

The allocation to Administration is 3.4% of the vote in 2005/06. As Administration is an enabling programme for rest of the Department and should remain at this level in comparison to the other programmes.

An amount of R51 million is the earmarked in the 2005/06 budget for medical equipment of which R11 million will resort in Programme 1 for use in other clinical programmes, it is envisaged that this allocation for equipment will continue to address the equipment backlog.

## **PROGRAMME 2: DISTRICT HEALTH SERVICES**

### **1. INTRODUCTION**

The imperatives created by the provincial goal of addressing social capital through the re-orientation of the district health services has created a new set of challenges for the Provincial Health Department. The starting point for transforming primary health care facilities and health programmes is the creation of local management capacity and expertise at the ground level to enhance participation and local networking in the provision of district health services. It also implies a re-orientation of the service delivery model to a community empowerment model with partnerships being developed between the health services and non-government organisations (NGOs) community based organisations (CBOs) and communities.

The district health services must interact with key vulnerable groups in the community including women, children, youth, the poor and the disabled. Services and programmes for these vulnerable groups must be given priority in the district health system. This can only be achieved by engagement with representative groups and social networks interacting with these groups in the communities we serve.

In addition, the district health services, acting as key institutions in the community, must supplement efforts toward broader projects of tackling inequity, unemployment and poverty as well as building community empowerment. The aim is to transform the district health service into a major role-player in communities. At the same time, the district health service must become the foundation of a highly effective health system as envisaged in Healthcare 2010.

The institutional framework necessary for successfully transforming current reality is the District Health System which will be implemented in this financial year. The writing into law of the National Health Act provides the legislative basis (and imperative) to proceed along this path.

### **2. PROGRAMME DESCRIPTION**

To render Primary Health Care Services (Act 63 of 1977) and District Hospital Services including preventive, promotive and community based care with a view to establishing these services as a foundation stone for the entire health service. To integrate district health services with the strategy to build and strengthen social capital.

### **3. PROGRAMME STRUCTURE**

#### **Sub-programme 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.

**Sub-programme 2.2 Community health clinics**

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

**Sub-programme 2.3 Community health centres**

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

**Sub-programme 2.4 Community based services**

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

**Sub-programme 2.5 Other community services**

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

**Sub-programme 2.6 HIV/AIDS**

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

**Sub-programme 2.7 Nutrition**

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

**Sub-programme 2.8 Coroner services**

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

**Sub-programme 2.9 District hospitals**

Rendering of a hospital service at district level.

**Sub-programme 2.10 Global Fund**

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

**PRIMARY HEALTH CARE SERVICES**

**4. SITUATION ANALYSIS**

**4.1 Demographic profile**

The population of the Western Cape has relatively good access to basic services and facilities. Socio-economically, the average income and unemployment figures suggest also a disparity between this province and national figures. However, despite the relative advantages of the “average” citizens in the Province, the disparity in income and access to services amongst the people of the Western Cape results in large numbers of people in the Province who suffer poverty and want.

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

**Table B2: Infant Mortality Rate (per 1000 live births) in 2002**

Area	IMR (per 1000 live births)
South Africa	56
Western Cape Province	31
Cape Town Metro District	25
Khayelitsha sub-district	44
South Peninsula sub-district	13

Population statistics estimate that 4,5 million people live in the Western Cape, of which 64% live within the Cape Town Metro (a mere 2% of the province's surface area) and the remainder of the population across the three rural regions. Migration and urbanisation also significantly influence the demographic profile of the province and create new challenges, including high levels of violence, drug and alcohol addiction and high-risk sexual behaviour.

Collectively the documented effects of unhealthy lifestyles and an inability to deal decisively with infectious diseases such as tuberculosis has contributed to what is known as the triple burden of disease (infectious diseases including HIV, non-communicable diseases and injuries). Of the infectious diseases, HIV has fuelled TB and significantly increased the burden of visits and admissions in the health services.

## 4.2 Burden of Disease

### HIV and TB:

The HIV prevalence rate continues to rise and has been recorded as being at 13,1% in the latest antenatal survey data. The incidence of new smear positive tuberculosis cases was measured at 429 per 100 000 in 2001, with a total incidence of tuberculosis of 917 per 100 000.

### Maternal, Child and Women's Health:

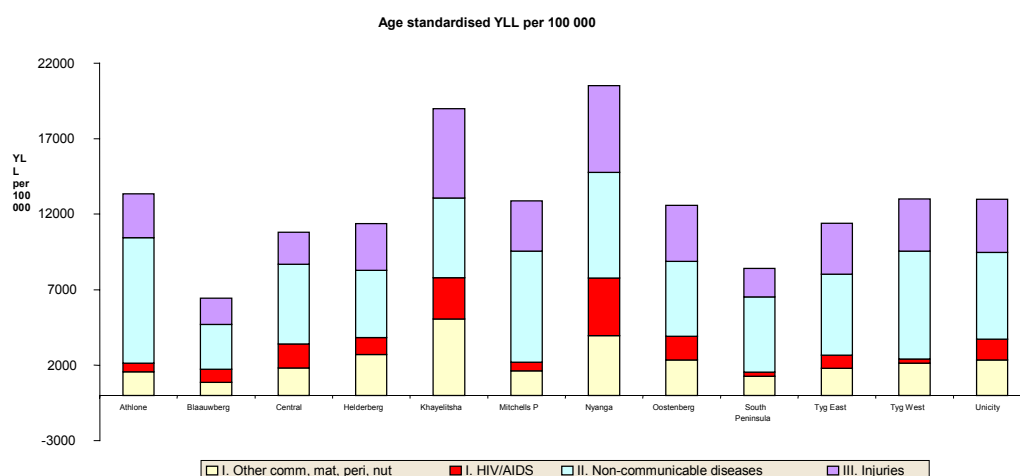
The under five mortality rate in the Province has been measured at 46 per 100 000 with the main contributing causes being infectious diseases (diarrhoeal disease, parasitic infections, respiratory diseases) as well as non-communicable diseases (under/mal-nutrition and trauma being the main causes)

### Chronic disease:

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

### Violence and trauma:

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



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

## 4.3 Health System

### 4.3.1 District Health Systems

Within the health districts no formalised governance and management structures as determined by the National Health Act of 2003 have been created. A decision to provincialise management of District Health services which includes personal PHC services has been made by the Provincial Health Department in keeping with the requirements of the National Health Act and the Local Government: Municipal Demarcation Act.

Management systems in many districts are rudimentary, poorly coordinated between local and provincial government and incapable of improving service delivery to a significant degree, given the degree of fragmentation and overlap. The process of developing joint district health

<sup>1</sup> Data courtesy of Social Capital Formation in Health Concept Document (2004)

plans has improved this situation in some of the districts. The Department will focus on improving this situation during the next year. Processes are already under way in this regard.

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

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

**Table B3: Primary Health Care services expenditure per local authority (R millions)<sup>2</sup>**

	Metro	Boland	Central Karoo	Eden	Overberg	Westcoast	Total
<b>METRO</b>	93 231						93 231
<b>DM</b>		4 386	1 636	5 154	692	1 968	13 836
<b>LM</b>		9 762	797	12 886	2 774	4 870	31 090
<b>Province</b>	287 600	83 022	10 429	47 756	17 307	29 877	475 991
<b>TOTAL</b>	<b>380 831</b>	<b>97 170</b>	<b>12 862</b>	<b>65 796</b>	<b>20 773</b>	<b>36 715</b>	<b>614 148</b>

Source: Survey conducted 2000-2001

Given the “narrow” definition of PHC in the Health Act, 2003 considerable debate has occurred regarding the responsibility for funding Personal Primary Health Care services as opposed to Environmental Health Services which are clearly the responsibility of Local Government, (Health Act 61 of 2003 & the Local Government: Municipal Demarcation Act of 1998). A key issue has been the funding that Local Government currently invests in the provision of preventative PHC services and that if the province assumes sole responsibility for providing PPHC, there would be a funding gap of approximately R180 million unless additional funding is allocated to the Province. This has been addressed by both the Provincial and National Treasuries. The gap is addressed in the 2005/06 budget for the rural municipalities but not for the City of Cape Town.

### **Existing provincial and local government services:**

The level of service provision appears to be adequate on a provincial level with a per capita attendance at a Primary Health Care (PHC) facility of 3,8 visits per annum, including DOTS. However, there are inequalities between the various districts. The District Health Expenditure Review (DHER) conducted in 2001 indicated the areas with the lowest number of PHC attendances are Boland and Overberg, i.e. 2,8 and 2,6 respectively, and the area with the highest utilisation rate is the Central Karoo with an attendance rate of 4,3. The utilisation rate for the Central Karoo must be viewed in the context that this district has the lowest population density in the province and a large proportion of the population is serviced by mobile units. Note that the attendance rate of 4,3 refers to attendance or utilisation in the *total* population in contrast to the utilisation rate for the Central Karoo of 5,8 reflected in Table 2.5 which refers to the *uninsured* population.

<sup>2</sup> Information is not supplied per district as requested as the Local Government information is being updated.



#### 4.3.2 Primary Health Care facilities

The Western Cape primary health care service comprises 252 fixed and 131 mobile clinics and 64 community health centres. Although the majority of clinics are subsidised by the Province they are managed currently by local government. The provincial Department of Health (DOH) is responsible for the majority of community health centres. These facilities serve a population of 4.5 million spread over 129 370 km<sup>2</sup>.

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

Seventy three per cent of the population depends on the public health sector for their health care. The rest of the population has medical insurance and generally utilises private health care, which is well-developed. There is one doctor per 21 237 population in the primary care system and 123 doctors in district hospitals.

At the level of the district health services, there is a severe shortage of health professionals including doctors, nurses and pharmacists. At this level there is great difficulty with the recruitment and retention of health professionals and many facilities suffer chronic staff shortages and poor organisation. The increase in access within primary care over the last eight years has resulted in a three-fold rise in the number of attendances at district level facilities (particularly community health centres in the metro area) without a concomitant increase in resources or staffing levels.

Insufficient attention has been paid to the organisation and development of primary health care services and a lack of management capacity has arisen at the PHC level. Together with a lack of computerisation of these facilities and the neglect of physical infrastructure development, the primary health care service in the Province are a major challenge for the Department.

Currently the network of PHC facilities is inadequate for the needs of new residential developments in the Western Cape. Considerable overlap of functions between district hospitals and the larger community health centres in the Metropole has forced a revision as to the location of facilities rendering twenty-four hour services in the Metropole. One of the major areas of service reconfiguration will be occurring in this area within the coming year, with the possibility of rationalising of facilities per sub-district being explored particularly with regard to trauma and emergency, maternity and forensic services.

**Table 2.3: District health service facilities by health district [DHS1]**

Health district <sup>1</sup>	Facility type	No.	Population <sup>2,5</sup>	Population per PHC facility <sup>5</sup>	Per capita utilisation <sup>6</sup>
<b>WEST COAST</b>	Non fixed clinics <sup>3</sup>	37	239 786		
	Fixed Clinics <sup>4</sup>	44			
	CHCs	2			
	<b>Sub-total clinics + CHCs</b>	46		5212	
	District hospitals	7			
<b>BOLAND</b>	Non fixed clinics <sup>3</sup>	21	527 419		
	Fixed Clinics <sup>4</sup>	36			
	CHCs	6			
	<b>Sub-total clinics + CHCs</b>	42		12 558	
	District hospitals	4			
<b>OVERBERG</b>	Non fixed clinics <sup>3</sup>	13	176 897		
	Fixed Clinics <sup>4</sup>	21			
	CHCs	2			
	<b>Sub-total clinics + CHCs</b>	23		7691	
	District hospitals	4			
<b>EDEN</b>	Non fixed clinics <sup>3</sup>	30	385 925		
	Fixed Clinics <sup>4</sup>	30			
	CHCs	9			
	<b>Sub-total clinics + CHCs</b>	39		9896	
	District hospitals	6			
<b>CENTRAL KAROO (Rural development node)</b>	Non fixed clinics <sup>3</sup>	6	56 380		
	Fixed Clinics <sup>4</sup>	10			
	CHCs	1			
	<b>Sub-total clinics + CHCs</b>	11		5125	
	District hospitals	4			
<b>METROPOLE</b>	Non fixed clinics <sup>3</sup>	24	2 072 715		
	Fixed Clinics <sup>4</sup>	71			
	CHCs	48			
	<b>Sub-total clinics + CHCs</b>	119		17 417	
	District hospitals	3			
<b>Province</b>	Non fixed clinics <sup>3</sup>	131	3 459 122		
	Fixed Clinics <sup>4</sup>	212			
	CHCs	68			
	<b>Sub-total clinics + CHCs</b>	280		12 354	
	District hospitals	28			

#### 4.3.3 District hospitals

Historically a very strong network of hospitals has existed in the Western Cape, but the location and staffing of many of these hospitals has proven to be inappropriate for the creation of a District Health System. During the past decade concerted efforts have been made to strengthen Regional Hospital services in the rural regions. These efforts have generally been successful despite challenges in recruiting and retaining staff. There still exists some overlap in function between some of the bigger District Hospitals and the Regional Hospital, particularly in towns where a single hospital cannot fulfil the functions of both Regional and District Hospital, e.g. George. In the Metropole the creation of a similar support network of hospitals has been less successful, because of the continued drain on resources by the Central/Tertiary hospitals and the inequitable distribution of facilities.

## **5. POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES**

### **5.1 Policy Context**

Three broad policy developments inform the provision of primary health care and district hospital services. These are the National Health Act, assented to during 2004, the Healthcare 2010 strategy, adopted in 2003, and the provincial objective of social capital formation as described in iKapa Elihlumayo. The National Health Act will establish the district health system and with it new boundaries, governance structures, planning and reporting formats.

There are a number of reforms to this programme which result from the implementation of first steps towards HealthCare 2010 including the expansion of community based services, strengthening funding to clinics, improving the management and efficiency of community health centres and increasing the number of district hospital beds.

A number of new programmes will be introduced to give meaning to the provincial objective of social capital formation and include interventions aimed at dealing with social ills, inequality, and long term health promotion and environmental issues with a special emphasis on targeting vulnerable groups including women, youth, the poor and the disabled.

Programme 2 is a key role-player in the Department's Social Capital Formation initiatives. The Primary Health Care (PHC) focus on which Healthcare 2010 is based is the foundation for this initiative. In addition to this there are the four focus areas: prevention and management of diarrhoeal disease and immunization in children (IMCI) and the prevention and effective management of chronic diseases, including HIV and AIDS. In addition to this, the Department will play an important role in providing data regarding the nature and incidence of Trauma to assist other departments focus their efforts appropriately in Trauma prevention.

Within the context outlined above, a strategy for building social capital through the development of a divisional plan towards the long-term realization of HealthCare 2010 has been developed. The Western Cape Department of Health has committed itself to "improving the health of all people in the Western Cape, by ensuring the provision of a balanced health care system, in partnership with all stakeholders, within the context of optimal socio-economic development". The people that the department serves, live and work within a broader social and economic context, which can either support or break-down their overall health and well-being.

To meet the healthcare needs of the people in the Western Cape, the Department's activities and programmes must be integrally linked to their needs, to their ability to access services and to their willingness to be involved and participate in managing their own health and the overall health of their community. This is central to the ideology of social capital, that is, building a community rich in social cohesiveness, together working towards (social action) improving health outcomes and in so doing, improving the community climate for success. Increased

social cohesion provides the Department with an opportunity to strengthen and further grow the networks with the communities it has, and establish a platform for real dialogue with local communities. Linked to this notion is the focus on equity and the provision of and access to resources. Focusing on equitable delivery mechanisms should point clearly to a more broad-based, integrated health promotion and comprehensive health care approach.

Linked to this, Healthcare 2010 forms the cornerstone of Departmental restructuring interventions. It envisages that 90% of patient contacts will be managed at Primary Health care level by 2010. In keeping with this aim and considering the burden of disease, the following priorities have been identified by the Division: District Health Services and Health Programmes as the main focus areas for the next five years.

#### System Priorities:

- 1) Strengthening the District Health System
- 2) Community based services<sup>3</sup>
- 3) District hospitals
- 4) Chronic disease management<sup>4</sup>

#### Programme Priorities:

- 5) TB
- 6) HIV and AIDS
- 7) Women's health
- 8) Child health

## 5.2 Key Strategies

### 5.2.1 Implementation of the District Health System

**Table B4: Strategic objectives for the implementation of the District Health System**

<b>STRATEGIC GOAL</b>
Implement a quality PHC service to all the people of the Western Cape.
<b>STRATEGIC OBJECTIVES:</b>
1) Take over the rural Local Government Primary Health Care services from 1 April 2005.
2) Decentralise management capacity (appoint facility and sub-district management structures).
3) Implement PHC facility infrastructure plan (IT and physical infrastructure).
4) Implement district and sub-district governance structures.

The structure of the Division: District Health Services and Programmes will be amended with a view to addressing the policy environment and to bring in necessary public health expertise. There will also be a review of the management structures and staff establishments of primary health care facilities particularly in the Metro. Significant funding has been made available for

<sup>3</sup> Home-based care is a priority programme that will drive community-based services

<sup>4</sup> the broader management of chronic diseases will be a priority programme within Health programmes

taking over the full financial responsibility of primary health care services in the five rural districts. Funding has been allocated to promote community participation (in terms of the National Health Act) and the implementation of the governance and managerial arrangements as well as for direct community participation at the facility and district level. Further computerization of the community health centers will take place in the year with a view to networking all community health centers, patient administration and access to hospital information.

The district health system is the vehicle for moving from disaggregated services to comprehensive integrated systems. The National Health Act formalises this through the provision of legislative imperatives. Responding to the high need for primary care services, Healthcare 2010 shifts the focus from the provision of primary level services at secondary and tertiary levels, towards community and primary level care at district level. In line with National health priorities, efforts to increase community participation at all levels will ensure that members of the community contribute towards building human dignity and therefore improving the quality of care.

In addition, as the district health system grows, so the provision of health care services will become more responsive to the needs of the community, and the inequities present in the system will decrease. With this, it is likely that the overall health of the population will improve, and social capital inherent within communities will be conserved and grown as individuals are more able and free to engage with one another.

Five critical areas relating to strengthening the District Health System have been identified. These are:

- Establishment of district and sub-district governance structures (e.g. functional clinic committees)
- Decentralisation of management (appointment of facility managers, the development of sub-district management teams)
- Computerization of facilities (ICT roll-out)
- Revitalization of infrastructure where required; and
- Rationalisation of Trauma and Emergency services in the Metropole.

Recommendations regarding the composition of the sub-district management structures have been developed as part of the broader Departmental restructuring process. As part of the Healthcare 2010 significant expansion and reconfiguration of the existing facilities is being considered because of greater demands caused by rapid migration into the Province.

### 5.3 Community-based care:

**Table B5: Strategic objectives for community based care**

<b>STRATEGIC GOAL</b>
Implement a comprehensive community-based service package in all sub-districts of the Western Cape
<b>STRATEGIC OBJECTIVES:</b>
1) Provide home-based care for all category 3 clients..
2) Provide community-based support for all categories of clients with a health care need.
3) Provide step-down care to all clients in need of care.

Expansion and improvement of community-based services are planned. These improvements include a new integrated model for home-based and step-down care (including hospice), expansion of the current service and an improvement of the management of NGO partners. This service will be funded initially mainly from the European Union for home-based care, and from the Global Fund for step-down care. From a service design and delivery perspective the implementation of a structured Home-based Care programme offers exciting opportunities, both with regard to the quality of services, and also as an additional interface with communities and consumers.

Creating a different service platform for the community within a re-shaped primary health care context implies that a comprehensive de-institutionalised package of care should be designed for those members of the community requiring health within the home environment, support group, a day care facility, schools, old age home, step- down facility and hospice. Community health workers and mid-level workers from within the communities can and must be mobilised, empowered and trained appropriately to provide a wider package of service that includes prevention of diseases, promotion of health, advocacy, development, support, basic care and basic rehabilitation.

The package of care envisaged should include services provided through contracting NPOs and developing Service Level Agreement (SLA) to ensure effective and efficient forms of service delivery whilst maintaining a developmental approach to the communities.

#### Key Strategies

- Provision of home-based care for all category 3 clients (requiring frail care) by trained home-based care workers, 20% of whom fulfil a specialised role, while 80% perform a generalised role.
- Community based care at household level for non-category 3 clients – TB DOTS, ARV adherence support, child and women's health support, rehabilitation service;
- Expansion of group homes, step-down facilities, hospice care, day care centres (institutions within communities including residential care institutions)
- Establishment of service delivery mechanisms at formal institutions/provincially-aided/non-departmental health facilities (step-down facilities/palliative care);
- Development of an alternative platform for service delivery in non-health facilities (prisons, old-age homes, schools).

These health workers will be supported and employed by non-profit organizations. This will form part of the department's contribution towards economic growth and development and social capital development. In collaboration with sister departments including the Western Cape Education Department, the Department of Social Services and Poverty Alleviation and the Department of Correctional Services, these strategies will realise the objectives of building social capital within these non-health institutions.

#### 5.4 District Hospitals

**Table B6: Strategic objectives for district hospitals**

<b>STRATEGIC GOAL</b>
Provide adequate level 1 bed coverage per capita in every sub-district in the Western Cape..
<b>STRATEGIC OBJECTIVE</b>
1) Increase the number of district beds in the Metropole.
2) Increase the number of theatre cases per level 1 bed facility.
3) Increase the number of admissions in level 1 bed facilities.

#### Policy context

The Department intends to improve the accessibility of level one district hospital beds and increase the capacity of district hospitals to provide a more effective and efficient service is currently measured by the number of theatre cases and admissions to all current existing level one beds. National Department of Health priorities provide for two key strategies to address this service platform, namely, the Hospital Revitalisation Programme and the Core Package for District Hospitals.

#### Key Strategies

The priority is increasing the number of level one beds in the Cape Metropole. A new district hospital in Khayelitsha and additional district hospital beds at Lentegeur in Mitchell's Plain are planned to address acute bed needs in these two under-privileged areas.

The HealthCare 2010 strategy encourages the decanting of inpatient admissions from secondary and tertiary hospitals to the district level hospital. An amount of R20m has been made available in the 2005/06 financial year for the commissioning of 120 additional district level beds. These beds will be in Tygerberg, Karl Bremmer and Lentegeur Hospitals and will form the nucleus of the new Khayelitsha Hospital when it is ready for commissioning.

## 5.5 Chronic Disease Management

**Table B7: Strategic objectives for chronic disease management**

<b>STRATEGIC GOAL</b>
Implement a comprehensive package of care for all clients with a common chronic disease.
<b>STRATEGIC OBJECTIVES</b>
1) Provide alternative methods of delivery of medicines to clients.
2) Implement a generic package of care for all clients with long-term health needs.
3) Implement appropriate prevention strategies to decrease the incidence of chronic illnesses.

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

Steps to improve the management of chronic diseases at the primary care level include the setting up of primary and secondary prevention, health education and rehabilitation services.

### Key Strategies

- Including simple chronic disease management at all clinics and arranging for the possible dispensing of repeat medicine scripts at the clinic level.
- Introducing family medicine as a specialty in the community health centres with intern rotations, registrar training and the possible creation of GP practices for chronic patients.
- The computerisation of patient data for chronic diseases and on line access to previous medical records and lab investigations done at hospitals.
- Improvement of the pharmacy systems for chronic disease patients.
- Alternative chronic medicine supply through a chronic dispensing unit.

## 6. ANALYSIS OF CONSTRAINTS AND MEASURES TO OVERCOME THEM

**Table B8: Constraints and measures to overcome them**

SYSTEM PRIORITIES	CONSTRAINTS	MEASURES TO OVERCOME THEM
<b>STRENGTHEN THE DISTRICT HEALTH SYSTEM</b>	<ul style="list-style-type: none"> <li>• National Health Act regulations being promulgated.</li> </ul>	<ul style="list-style-type: none"> <li>• Creation of District Health Councils</li> </ul>
	<ul style="list-style-type: none"> <li>• Failure to reach consensus with partners re DHS governance.</li> </ul>	<ul style="list-style-type: none"> <li>• Intervention of political principals to resolve issues around DHS governance.</li> </ul>
<b>COMMUNITY BASED SERVICES</b>	<ul style="list-style-type: none"> <li>• Availability of physical infrastructure.</li> </ul>	<ul style="list-style-type: none"> <li>• Infrastructure planning in progress.</li> </ul>



SYSTEM PRIORITIES	CONSTRAINTS	MEASURES TO OVERCOME THEM
	<ul style="list-style-type: none"> <li>Programme for decanting mental health patients to be developed in conjunction with Programme 4 managers.</li> </ul>	<ul style="list-style-type: none"> <li>Coherent strategy for decanting of mental health patients developed in conjunction with Programme 4 managers</li> </ul>
	<ul style="list-style-type: none"> <li>Continued availability of donor funding for HBC.</li> </ul>	<ul style="list-style-type: none"> <li>Training and capacitation of NPO's rendering HBC services</li> </ul>
	<ul style="list-style-type: none"> <li>Complexity of procurement procedures.</li> </ul>	<ul style="list-style-type: none"> <li>Training of home-based carers and technical assistants.</li> </ul>
	<ul style="list-style-type: none"> <li>Availability of professional staff.</li> </ul>	<ul style="list-style-type: none"> <li>Efforts being made to focus on recruitment of certain professional categories.</li> </ul>
<b>DISTRICT HOSPITALS</b>	<ul style="list-style-type: none"> <li>Availability of Hospital Revitalisation Project funding.</li> </ul>	<ul style="list-style-type: none"> <li>Development of feasible Business Plans; and</li> <li>Secure HRP funding.</li> </ul>
<b>CHRONIC MEDICATION SUPPLY</b>	<ul style="list-style-type: none"> <li>Recruitment and retention of pharmacy personnel.</li> <li>Regulations relating to dispensing medications.</li> </ul>	<ul style="list-style-type: none"> <li>Seed funding for business plan for CDU.</li> </ul>

## 7. SUB-PROGRAMME 2.6: HIV & AIDS, STI & TB CONTROL AND SUB-PROGRAMME 2.10: GLOBAL FUND

### 7.1 SITUATION ANALYSIS

All aspects of the national and provincial strategies have been implemented and scaled up over the last 5 years. An extensive Voluntary Counselling and Testing (VCT) service exists at all health facilities in the province with nearly 200 000 people being tested every year. An effective prevention of mother-to-child transmission (PMTCT) programme has also been implemented at all antenatal care facilities with the majority of women receiving dual or triple therapy combinations (depending on their CD4 counts) and many women opting for formula. Programmes exist to distribute more than 20 million condoms a year and to treat 100 000 sexually transmitted infections (STIs).

In terms of treatment and care, there is almost full geographic access to antiretroviral treatment and more than 6 000 patients already on treatment. There is also a comprehensive network of NGO run hospice/step down care facilities in almost every sub-district area and all of these are linked to home-based care services. All the NGOs providing hospice, step-down and home based care and subsidised by the Provincial Health department. The Department is gearing up local authority clinics to provide first contact ambulatory care for HIV positive patients including and up to conducting a CD4 count with a view to referral to an ARV centre.

## 7.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

### 7.2.1 Combat TB epidemic

**Table B9: Strategic objectives to combat the TB epidemic**

<p><b>STRATEGIC GOAL</b></p> <p>Obtain a cure rate of 85% for new sputum positive (NSP) cases.</p> <p>Decrease the number of TB deaths by 50%.</p>
<p><b>STRATEGIC OBJECTIVES</b></p> <ol style="list-style-type: none"> <li>1) Implement the Healthcare 2010 TB bed plan, including the provincialisation of TB beds.</li> <li>2) Increase the cure rate of NSP cases.</li> <li>3) Increase the community DOT contacts.</li> <li>4) Implement integrated TB and HIV strategy.</li> </ol>

#### Policy Context

Building upon the Millennium Development Goals established by the United Nations Development Programme, the National Department of Health has identified TB control as one of the key national priorities for 2004 – 2009 (medium-term goals). While Healthcare 2010 speaks mostly to increasing TB beds to 1 166 (to be largely managed by community-based care), it also proposes an increase in the number of TB DOTS contacts (in community-based care) to 2,7 million by 2009.

#### Key Strategies

- Provincialisation of all four non-provincial TB hospitals is seen as the key process in the establishment of an appropriate TB in-patient care platform, in line with the overall departmental 2010 hospital bed plan.
- Improvement of cure rate to 73% of all new smear positive TB cases identified. The key challenge to achieve this target will be the appropriate staffing levels in PHC facilities to deliver on this target and to integrate the functioning of facility level services with community level services on the one hand and the comprehensive intra-facility PHC delivery on the other hand.
- Increase in community DOTS to 40% of all treated TB cases forms part of the broader strategy to develop an integrated community-based care service delivery system, that will be able to provide for the significant numbers of patient contacts, required in 2010.

## 7.2.2 Combat HIV pandemic

### Policy Context

**Table B10: Strategic objectives for combating the HIV pandemic**

<p><b>STRATEGIC GOAL</b></p> <p>Decrease the number of new infections in age group 15 – 24 years, reduce morbidity and mortality amongst HIV infected persons.</p>
<p><b>STRATEGIC OBJECTIVES</b></p> <ol style="list-style-type: none"> <li>1) Implement an effective prevention strategy.</li> <li>2) Increase Voluntary Testing and Counselling (VCT) coverage in the adult population over 15 years of age.</li> <li>3) Provide ARV treatment to over 80% of clients in need of treatment.</li> <li>4) Provide adequate HBC and palliative care to terminal HIV positive clients.</li> </ol>

Funds will be made available as conditional grant and earmarked amounts to expand prevention, treatment and care of patients with this disease.

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

A key partnership that will run for five years during the MTEF period is with the Global Fund. This funding which is significant will greatly augment the Department's ability to respond to the HIV pandemic and supports the Department's comprehensive strategies.

### Key Strategies:

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

- As a preventive strategy, the expansion of the voluntary counselling and testing (VCT) programme, which aims to attain a coverage target of greater than 6% of the adult population over the age of 15 years remains the key strategy for the department. The provision of condoms, the management of sexually transmitted infections (STIs) and the focus on prevention of mother-to-child transmission (PMTCT) will continue into the next MTEF cycle.
- With its partners the Western Cape Education Department and the Department of Social Services and Poverty Alleviation, major investments in the roll-out of peer education (therefore linking closely to the focus on youth) and social mobilisation campaigns will contribute increasingly to higher awareness levels translating ultimately to more

responsible sexual behaviour. These lifestyle interventions amongst the youth will contribute significantly to the development of social capital in this vulnerable population.

- Increasing the number of clients that have commenced ARV treatment, and delivering a comprehensive package of care at all PHC clinics for clients identified through the VCT programme are the two primary drivers of the Department's treatment strategy.
- Providing care and support to clients is integrated within the community-based strategy, and will focus on providing home-based care and hospice/step-down care for those clients.

### 7.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

**TableB11: Constraints and measures to overcome them in combating TB, HIV and AIDS**

PROGRAMME PRIORITIES	CONSTRAINTS	MEASURES PLANNED TO OVERCOME THEM
TB-New sputum positive (NSP) CURE RATE	<ul style="list-style-type: none"> <li>• Inadequate funding for Programme.</li> <li>• Unresolved issues re DHS governance.</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of funding for expansion of TB services.</li> <li>• Agreement with Local Government on PHC governance and funding.</li> </ul>
HIV – ARV TREATMENT	<ul style="list-style-type: none"> <li>• Inadequate physical facilities.</li> <li>• Insufficient Health personnel..</li> </ul>	<ul style="list-style-type: none"> <li>• Recruitment and training of medical and nursing personnel.</li> <li>• Viability of PHC platform.</li> <li>• Physical infrastructure requirements addressed.</li> </ul>

## 8. SUB-PROGRAMME 2.7: MATERNAL, CHILD AND WOMEN'S HEALTH (MCWH) AND NUTRITION

### 8.1 SITUATIONAL ANALYSIS

#### Nutrition

The problems of poverty and underdevelopment in the Western Cape Province are often hidden behind the image of relative affluence as portrayed in comparative studies between the Provinces. These development problems will have to be addressed as a matter of urgency to overcome the Province's own disparities and inequalities and to enable the Western Cape as an integral part of South Africa to contribute to the reconstruction and development of the country as a whole.

Although the Western Cape has the highest income per capita there are very poor areas, which have been set up as informal settlement areas. Amongst the economically active population, many of the workers are seasonal workers and amongst these there is a large percentage of substance abuse. Screening tools for detecting alcoholism suggest rates in excess of 60% amongst farm workers (London, 1995). A study in a typical rural town in the

province found a Foetal Alcohol Syndrome (FAS) prevalence of 4,8% amongst Grade 1 school children (FARR, 1997). Research (unpublished, 1998) indicates that this has increased to 8%. Twelve percent of the Western Cape is arable land; hence, not much land is available to the poor for food production. A high percentage of the people residing in the province live under the poverty line, mainly in rural areas and in informal settlements on the periphery of towns and cities.

One out of every four children is stunted suffering from chronic malnutrition. One out of every ten children is underweight for age in the province and approximately 15% are born with a low birth weight. Anaemia and marginal vitamin A are widespread micronutrient deficiencies among children and there is a high prevalence of parasite infestation in some areas.

The province is in the “nutrition transition” with obesity and associated diseases of lifestyle becoming serious public health problems. TB is the most important infectious disease causing death in all ages. The occurrence in the Western Cape is 917 per 100 000 people, and the total number of reported TB cases is more than 40 000, representing 20% of the TB cases in South Africa. (Central Unit, National Tuberculosis Programme).

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

### **Epidemiology:**

#### **Statistics: Actual maternal deaths reported in the Western Cape Province**

- 1998 = 34
- 1999 = 34
- 2000 = 50

#### **Description of rates over last 5 years**

- System in operation since 1998
- Estimated MMR for SA = 150/100 000
- MMR in WCP (2000) = 49,7/100 000

Maternal death is a health ‘disadvantage’ for families, communities and the population at large. It is an indicator of women’s health status and a prime determinant of infant health. In accordance with the Global Safe Motherhood Initiative the Maternal Death Notification System was instituted and a Confidential Committee of Enquiry established to address the high maternal mortality in South Africa.

The analysis of maternal deaths provides valuable information on the extent of the problem, what are the avoidable factors, missed opportunities and breakdowns in the health care system that could lead to a maternal death. This information allows health care providers to

review their current provision of services, reassess clinical guidelines and plan facility audits. Areas needing more research are identified. The information is vital in creating awareness amongst families and communities about maternal mortality so that they can assist in the prevention of maternal deaths.

## 8.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

### 8.2.1 Women's health

**Table B12: Strategic objectives for the promotion of women's health**

<p><b>STRATEGIC GOAL</b></p> <p>Decrease the number of new infections in age group 15 – 24 years, reduce morbidity and mortality amongst HIV infected persons.</p>
<p><b>STRATEGIC OBJECTIVES</b></p> <ol style="list-style-type: none"> <li>1) Increasing cervical cancer screening coverage in women aged 30 – 59 years.</li> <li>2) Increase facilities offering services for rape survivors and victims of sexual abuse..</li> <li>3) Increase ante-natal booking rate below 20 weeks..</li> </ol>

#### Policy Context

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

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

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

#### Key Strategies

- Increasing cervical cancer screening coverage is seen as a key element to reducing both morbidity and mortality in women. This indicator reflects a commitment to improve services at a number of levels, both at the community interface as well as within facilities. At a community level, surveillance will have to improve and this element combines with increasing awareness around the public's need to present for routine screening. This will in turn depend on the strength of both the Health Promotion programme as well as the strength of community structures and their level of community engagement. (Social capital).
- Increased facilities offering services for rape survivors and victims of sexual abuse: This key strategy forms part of a broader strategy to improve trauma and emergency services.

The aim of creating a single consolidated platform for the management of trauma and emergency services per sub district has been discussed previously.

- Improving antenatal services for pregnant women both in terms of accessibility and quality is a key strategy. By increasing antenatal booking rate below 20 weeks the Department aims to improve outcomes for both mother and infant. By reducing peri-natal mortality, infant mortality can be reduced.

### 8.2.2 Child and youth health

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

**Table B13: Strategic objectives to reduce child mortality**

<b>STRATEGIC GOAL</b>
Reduce child mortality.
<b>STRATEGIC OBJECTIVES</b>
1) 90% full immunization coverage of children below one year.
2) Reduce incidence of underweight for age below 5 years.
3) Increase % of nurses who have been trained in IMCI in seeing sick children.
4) The prevention of violence and unintentional injuries to children..
5) The strengthening of family practices that prevent childhood illnesses, e.g. diarrhoea and pneumonia through household IMCI.
6) The promotion of child safe communities.
7) The promotion of a healthy environment and behaviour through the implementation of health promoting schools.

#### Policy Context:

- The Millennium Development Goals seek to reduce the under-five years mortality rates by two-thirds in 2015. It also seeks to halve the proportion of people who suffer from hunger, which is measured by the prevalence of underweight children under-five years of age.
- Strategic Priorities of the National Health System (2004-2009), aim at eliminating Polio by December 2005 and ensuring that no baby dies from measles. The immunisation average of 80% in every district is targeted as well as full implementation of the IMCI strategy within all PHC facilities.

#### Strategies:

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

### 8.2.3 Youth Health

#### Policy Context:

- Millennium Development Goals seek to halve and begin to reverse the spread of HIV/AIDS in pregnant women between the ages of 15-24 years by 2015.
- Strategic Priorities of the National Health System (2004-2009) has provided strategic direction regarding health care of youth and adolescence.
- Ikapa Elihlumayo developmental priorities include building social capital with emphasis on youth. This strategy seeks to sustain human and economic development through life skills development, which will impact on behaviour modification. Technical and vocational education, entrepreneurship, leadership and internship have also been cited as mechanisms that will contribute towards poverty alleviation.

#### Strategies:

- Increase the number of facilities certified as youth friendly.
- Decrease the delivery rate for women below 18 years.
- Reduce new HIV infections in women between 15 and 24

## 8.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

**Table B14: Constraints and measures planned to overcome them regarding women's and child health**

PROGRAMME PRIORITIES	CONSTRAINTS	MEASURES PLANNED TO OVERCOME THEM
WOMENS' HEALTH	<ul style="list-style-type: none"> <li>• Inadequate and poorly trained personnel</li> <li>• Poor quality of laboratory assessments.</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of additional funding for recruitment of personnel.</li> <li>• Quality of laboratory work being performed by NHLS.</li> </ul>
CHILD HEALTH	<ul style="list-style-type: none"> <li>• Availability of funds for training and replacement of personnel.</li> </ul>	<ul style="list-style-type: none"> <li>• Funding for IMCI and PHC training.</li> </ul>

## 9. DISEASE PREVENTION AND CONTROL

### 9.1 SITUATION ANALYSIS

Disease prevention and control includes oral health, communicable diseases, excluding HIV and AIDS, sexually transmitted infections (STI's) and TB, chronic diseases, geriatrics and disabilities.

The issues related to disease prevention and control have previously been integrated within PHC programmes. As this is the first time that it has been addressed in a consolidated manner the issues are in the process of being researched. However, the following issues are highlighted.



Key focus areas of this programme are:

- 1) Prevention of infectious diseases such as those prevented by immunisation and those promoted by poor hygiene such as infantile diarrhoeal disease.
- 2) Provision of services for chronic care and to the elderly.
- 3) Dealing with the increased incidence of sexual abuse of children and rape cases.
- 4) Preparations for dealing with epidemics and environmental disasters.
- 5) The implementation of the provisions of the National Health Act dealing with the provision of Port Health Services.
- 6) The health promoting schools programme.

#### 9.1.1 **Diarrhoeal disease and infectious diseases prevented by immunisation**

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

#### 9.1.2 **Chronic disease prevention and treatment**

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

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

The Global Youth Tobacco survey revealed that the prevalence of tobacco use was significantly higher in the Western Cape to the national average (46.9% compared to 34.3%).

In addition, a significant problem, most marked in some of the rural areas of the Western Cape is alcohol abuse. Recent studies reported that the winery areas of the Western Cape have the highest prevalence of Foetal Alcohol Syndrome (FAS) worldwide (40.5-46.4 per 1,000 children). A critical issue in relation to FAS is the 'dop' system that was historically established by using alcohol as a medium of payment and social control over employees. This has aggravated widespread alcohol abuse, which has enormous impact on the social as well as the physical well being of farming communities (London, 1999).

The Province has made progress in gearing up services for chronic diseases and the elderly. Strategies for the future include linking all 15 of the big Community Health Centres in the Metropole to a chronic dispensing unit, thereby ensuring the continuous availability of medicine to users. Further it is intended to focus more specifically on healthy lifestyles to

reduce the increasing burden of disease resulting from non communicable diseases in the next five years.

#### 9.1.3 **Treatment of patients subjected to sexual abuse and rape victims**

Between April 2002 and March 2003 a total number of 6 502 cases of rape and 4 402 cases of child abuse were reported in the Province representing a 62% increase over the previous year. Dedicated services for victims of sexual abuse and child abuse are located in the district hospitals and 24-hour Community Health Centres. The programme will be strengthened despite the difficulty in recruiting suitably trained personnel.

#### 9.1.4 **Port health**

Surveillance at the three major harbours in the Western Cape, i.e. Cape Town, Saldanha and Mossel Bay, as well as at the Cape Town International Airport has reverted to the provincial Department of Health in terms of the new Health Act. In terms of this mandate an average of 65 ships are assessed and provided with clearance certificates on a monthly basis.

#### 9.1.5 **Health promoting schools programme**

In view of the renewed focus, an assessment of the current state of the Health Promoting Schools programme is currently being undertaken. The health promoting schools policy and the revised school health policy will be implemented during the period of this plan.

### 9.2 **POLICIES, PRIORITIES AND STRATEGIC GOALS**

#### 9.2.1 **Building Healthy Communities**

##### Policy Context

- Health care 2010 recognises the limitations of the medical model of health care in influencing the physical, social and economic environment in improving health holistically. It is for this reason that it advocates for collaboration and partnerships with all relevant stakeholders in building healthy communities and realising the true definition of health according to the World Health Organisation (health is the physical, social and mental well-being and not merely the absence of disease and infirmity).
- The strategic priorities for the National Health System (2004-2009) have included the promotion of healthy lifestyles as one of its indicators and targets. Intervention strategies are focused at nutrition, substance abuse, tobacco use, health promoting schools, and household and community component of IMCI.
- The Western Cape strategy of Ikapa Elihlumayo and Social Capital formation focuses on building healthy communities through intensive collaboration between the public sector and the civil society. This strategy aims at the development of the community through social and economic empowerment with special emphasis on women and youth.
- As a support department in the Social Capital Formation strategy, the foundation of the Department of Health's strategy is the promotion of an efficient and effective Primary Health Care service which will provide equal access to quality healthcare and is also the foundation of Healthcare 2010.

- The Department has also identified four key short-term social capital formation issues, i.e.
  - 1) The Integrated Management of Childhood Illnesses (IMCI) with specific emphasis on the management of diarrhoeal disease.
  - 2) The strengthening of the immunisation campaign.
  - 3) The management of chronic diseases to ensure continuity of care.
  - 4) In view of the significance of the problem of trauma in the Province, Health will collaborate with other departments to assist in the formulation of strategies to reduce the levels of trauma.

These initiatives will be amended, taking into account lessons learned during the remaining period of the five-year plan.

#### General Strategies

- The prevention of violence and unintentional injuries to children.
- The promotion of child safe communities
- The promotion of healthy environment and behaviour through the implementation of health promoting schools.
- The strengthening of family practices that prevent morbidity and mortality from childhood illnesses e.g. diarrhoea and pneumonia through household IMCI.
- Youth risk behaviour modification in substance abuse, teenage pregnancy and women contracting HIV between the ages of 15-24years.

### 9.2.2 Strategies developed to address the identified 'social capital issues:

#### 9.2.2.1 Diarrhoeal disease

##### Activities and outputs

##### 1) **Improve water and sanitation:**

- Support local intersectoral initiatives around provision of potable water and sanitation, like the Khayelitsha Water And Sanitation Forum.
- Engage Local Government and other government departments around provision of potable water in at risk communities.
- Raise community awareness around sanitation issues and support advocacy initiatives related to sanitation issues.
- Strengthen support other government Departments e.g. Education Department by the development of teaching materials and inclusion of health and hygiene in the school curriculum.
- Eliminate inequitable distribution of Environmental Health Officers through recruitment and redeployment.
- The short-term emphasis is on encouraging hand washing at household level.
- Improvement maternal education which studies have shown to substantively reduce the incidence of childhood diarrhoea.

##### 2) **Community awareness/ education:**

The focus areas of the awareness/ education are:

- The seasonal nature of the incidence of diarrhoeal disease;

- The mixing and administration of the sugar-salt solution to all children with loose and watery stools;
- The importance of early presentation of children with danger signs to the health services;
- The importance of hand washing in breaking the transmission of diarrhoeal disease.

3) **Improved PHC facility diarrhoeal disease case management:**

Each PHC facility to have:

- A functional oral rehydration (ORT) corner that is set-up and managed in accordance to standard WHO guidelines;
- The capacity to stabilize severely dehydrated children, prior to referral to the next level of care

4) **Extended hours child health services in selected Community Health Centres:**

Proposed outcomes

- Improve access to basic services through collaboration with other government departments as well as local government;
- To provide support to community-based interventions by providing logistical support, supervision/monitoring and funding;
- Improved knowledge about hygiene and sanitation matters amongst learners and adults;
- Reduce the incidence of one of the commonest childhood killers by improving maternal knowledge base and community awareness;
- Improve patient care through improved human resources (both qualitative and quantitative) in health facilities;
- Improve efficiency and effectiveness of service delivery in PHC facilities as well as hospital based services;
- Improve access through more effective use of resources, better planning and better communication with healthcare providers and the public;
- The abovementioned contributions all contribute towards social capital formation by providing for human capital development in communities); by developing bridging social capital through improving the access of communities to authority structures (Woolcock/ Szreter model)
- Ultimately all of these contributions will improve health outcomes in the communities.

### 9.2.2.2 Immunisation

Activities/outputs

- Training of community IMCI (Integrated Management in Childhood Illnesses) workers. These workers are a 'subset' of workers currently engaged in community health activities within communities.
- Collaborate with Local Authorities regarding the need for immunization and the preparatory work for immunization campaigns.
- Work with the Department of Education to promote awareness and improve knowledge of immunization. Influence teachers and community leaders.

- Improve the outbreak response times during high-risk periods by means of improved communication.
- IMCI strategy to be implemented in all PHC facilities.

#### Proposed outcomes

- Improved resilience to disease amongst children.
- Reduced incidence of infectious diseases and concomitant infections.
- Improved morbidity and mortality rates amongst under 5 year olds in impoverished communities.

## **10. RESOURCE INFORMATION**

The funding for Programme 2 will increase significantly during 2005/06 with a 19.2% nominal increase. This reflects to a large extent the increases related to the provincialisation of PHC services and increases in HIV and AIDS funding. The issue of funding for PHC services within the Cape Metro remains to be resolved. Funds will be progressively released to fund initiatives in Social Capital Formation and community outreach. As is outlined in Healthcare 2010 the funds to be allocated in Programme 2 must enable the Department to divert patient contacts to more appropriate levels of care. The current budget projections indicate this is feasible but the challenge will be to ensure adequate capital budgets for the period to enable the physical facilities, equipment and other infrastructure to be upgraded.

## **PROGRAMME 3: EMERGENCY MEDICAL SERVICES**

### **1. AIM**

The rendering of pre-hospital Emergency Medical Services including Inter-Hospital Transfers, Medical Rescue and Planned Patient Transport.

### **2. PROGRAMME STRUCTURE**

#### **Sub-programme 3.1: Emergency Medical Services (EMS)**

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

#### **Sub-programme 3.2: Planned patient transport**

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

### **3. SUB PROGRAMME 3.1: EMERGENCY MEDICAL SERVICES**

#### **3.1 SITUATIONAL ANALYSIS**

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

##### **3.1.1 Functions of EMS**

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

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

### 3.1.2 Existing services and performance:

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

The average response times in the rural or out of town areas in the Western Cape approach the National norm of 40 minutes (60% of responses within target), however, it must be noted with caution that averaging smoothes the profile. In individual cases there can be significant deviations from the mean. Response times in the Metropolitan area of Cape Town, however, deviate significantly from the National norm of 15 minutes, where the average is 90 minutes and may on occasion extend up to six hours.

The response times above reflect the deficiencies in personnel and vehicles; and vehicle costs in the Metropolitan area. It is calculated from mathematical formulation using emergency rates and ambulance turnaround times that the required personnel in the Western Cape is close to 1 800 (currently 1 200). There are 547 (175 in the South Cape, 133 in the West Coast, 239 in the Cape Winelands and Overberg) personnel in the rural areas and 412 in the Metropolitan area. The number of ambulances in the rural areas (149) is adequate but the Metropolitan area has a fleet of 56 ambulances where 75 are needed.

Rescue is not staffed as a separate function particularly in the rural areas and rescue duties are performed over and above ambulance duties which may result in delays in rescue response.

Computer Aided Dispatch has been implemented in the Metropolitan Area of Cape Town. The five rural districts/divisions are still using rudimentary communications systems. Neither area uses dynamic vehicle tracking as a dispatch aid.

The Red Cross Air Mercy Service flies approximately 300 000km and rescues and transports 1 000 patients (508 fixed wing, 86 rescues and 334 helicopter transfers) at a cost of R8 000 per patient, or R27 per km. The rescue services respond to approximately 2 000 road traffic entrapments, 75 water related incidents and 700 wilderness search and rescue incidents per year. The Western Cape has 30 rescue vehicles with 40 Jaws of Life in 35 towns.

During 2003 the Western Cape EMS attended seven major incidents involving mass casualties, which excludes road traffic accidents and one case of anthrax, one case of viral haemorrhagic fever and several cases of meningococcal meningitis

- 3.1.3 It is anticipated that the transfer of the City of Cape Town operational personnel to the Province will be completed by March 2005 by recruitment and appointment. The City of Cape Town administrative staff will remain under operational control until a solution to their placement can be found. The operational control agreement with the City of Cape Town will be reviewed before the commencement of the City's new financial year.

In addition to the above the human resource capacity, physical infrastructure and operating resources will be upgraded.

### 3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

#### Vision

*Quality Emergency Care - Fast*

#### Mission

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

**Table B15: Strategic objectives for Emergency Medical Services**

<b>STRATEGIC GOAL</b> Rendering Emergency Medical Services including ambulance services, special operations, communications and air ambulance services.
<b>STRATEGIC OBJECTIVES</b> <ol style="list-style-type: none"> <li>1) To provide emergency medical services within response times that complies with national norms.</li> <li>2) To develop a personnel establishment appropriately qualified to deliver effective emergency services.</li> <li>3) To effectively manage a fleet of well-equipped and cost-effective emergency vehicles.</li> </ol>

#### 3.2.1 Strategic priorities

EMS has two broad strategic priorities;

**Communications:** to establish electronic computer aided communications systems including automatic vehicle location to support the call taking and dispatch needs of the service and ensure efficient response.

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

The provision of a modern computerised communication system to manage Emergency Medical Services (EMS) resources is the top priority, central to the efficient deployment of resources in achieving appropriate response times. Vehicle tracking will be operational in all ambulances by 2006. A new communications centre will be installed in the Metropolitan Area of Cape Town and will be phased in to the rural areas over the next two years. Electronic communications systems are essential to rapid response, efficient deployment and co-ordination with other emergency services. All of these matters contribute to improved patient care.



A joint initiative with the Departments of Local Government, Housing and Community Safety, to establish a Disaster Management and Emergency Medical Services Communication Centre.

### **3.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM**

#### **3.3.1 Finance**

Finance is a significant constraint in terms of achieving the targets and service levels outlined in the National EMS Framework.

EMS is a personnel and equipment (ambulances/communications/medical) intensive service. National EMS policy challenges provincial budgeting for services to be in line with the National framework.

The additional funding provided must improve response times in the Metropolitan Area by at least 30 minutes of total mission time.

It is not within the current resource allocation to EMS or the Department to achieve National Response Time Targets in the Metropolitan Area of Cape Town and the prioritisation of EMS funding will have to be seriously reviewed by the Department.

#### **3.3.2 Human Resources**

Human resourcing of EMS services is the major short coming. International models determine that the personnel number required to crew an ambulance twenty-four hours a day is eleven. Many of the services in the Western Cape consist of four personnel in small towns who are expected to provide a twenty-four hour service.

The Medium Term Expenditure projections for EMS within Health again does not accommodate major increases in personnel expenditure. Improvement of EMS services over the next three years will therefore require significant improvement in management and operational efficiencies as well as augmented finance.

#### **3.3.3 Support and Information Systems**

The institution of Computer Aided Dispatch and Automatic Vehicle Location Systems (Vehicle Tracking) will substantially improve the management of the mobile EMS resources and improve efficiencies both in financial management and service delivery.

Provincial Treasury has committed funding to this function for two years to initiate essential systems.

#### **4. SUB PROGRAMME 3.2: PLANNED PATIENT TRANSPORT**

##### **4.1 SITUATIONAL ANALYSIS**

###### **Function of Planned Patient Transport**

Rendering Planned Patient Transport including Local Out-Patient Transport (within the boundaries of a given town or local area) and Inter-City/Town Out Patient Transport (into referral centres).

Planned patient transport is rendered currently by the Emergency Medical Services from within an existing budget and infrastructure. No separate structure exists to deliver Outpatient Transport. Outpatient transport is a particular problem of the rural areas where poor rural communities do not have access to local health facilities because of the lack of public transport infrastructure and long distance transfers are required to get patients in to referral centers for treatment.

Outpatient transport is currently outsourced in the metropolitan areas. No rural OPD transport system exists except for that provided by EMS. Patient access to health institutions is severely limited by poor patient transport infrastructure.

Planned Patient Transport Services in the Western Cape currently transfers approximately 37 000 outpatients annually.

Patients need transport to health facilities in rural areas and between towns in order to reach referral centres. Public transport in rural areas is poorly developed resulting in poor access by poor rural communities to health services. Patient transport infrastructure needs to be created in and around towns and between towns.

The utilization and allocation of the Health Department Fleet, which totals some 1 000 vehicles including EMS, is being investigated.

The limitations of the PPT system include:

- Lack of separate structure
- No dedicated management
- Poor co-ordination because of deficiencies in electronic booking systems
- Limited small vehicles with only sitting patient capacity
- Limited personnel, drivers.
- Long distances requiring long driving hours
- Limited patient moving equipment, wheel chairs, self loading stretchers etc

It must be noted that a significant reduction in demands for the service could result from appropriate discretionary patient referral and referral back from academic complexes to regional and district hospitals.

## 4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

**Table B16: Strategic objectives for Planned Patient Transport**

<b>STRATEGIC GOAL</b>
To provide planned patient transport, including outpatient transport and transfers between institutions and levels of care.
<b>STRATEGIC OBJECTIVE</b>
1) To separate the management of planned patient transport from EMS.
2) To secure sufficient funding to provide an appropriate service.

The Department of Health has made a strategic decision to separate patient transport from the EMS. As from April 2005 the functions of the Emergency Ambulances Services and Planned Patient Transport (PPT) will be separated through a process over the next two years and be managed separately. The PPT (HealthNET, i.e. Health Non Emergency Transport) will undergo significant changes over three years. The ICT components of PPT will be improved and integrated with hospital booking and referral systems.

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

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

- Funding for additional ambulance personnel, ambulances and related costs to improve response times
- Treasury funding for computer aided dispatch and automatic vehicle location systems
- Development of an effective patient transport system.

## 4.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

### 4.3.1 Finance:

2005 will be the first year that the budget for PPT is separated from the Emergency Services.

During the 2005/6 financial year the investment in Patient Transport within different Health programs will be investigated to quantify the total available for the function with a vision to consolidate these budgets in the future in the management of a unitary system of Planned Patient Transport.

EMS currently has a restraint in terms of PPT budget but once consolidated it is possible that sufficient funds exist to deliver on the function.

#### **4.3.2 Human resources:**

The personnel deployed in the function of PPT will be separated from Emergency Ambulance personnel from 1<sup>st</sup> April 2005.

An evaluation of PPT driver jobs will need to be conducted during 2005.

An investigation into the human resources deployed and available within the Health Department must be conducted during 2005.

A contract manager has been appointed to manage the function of PPT and develop systems necessary to the function.

#### **4.3.3 Support systems:**

A PPT Hub will be created at Tygerberg Hospital from 1<sup>st</sup> April 2005 to focus and structure the movement of PPT vehicles within and outside the Metropolitan Area.

PPT vehicle design will be revisited to look at multipurpose PPT Vehicles to accommodate the range of wheelchair, sitting or stretcher patients likely to use the service. Procurement of these new vehicles is not planned until 2006.

#### **4.3.4 Information systems:**

The TRANSMETRO computer software which records the movement of patients relative to vehicles will be upgraded to a WINDOWS based system in 2005.

A hospital booking system for outpatients will be designed and developed in 2005 to facilitate the parallel booking of outpatient visits and PPT.

### **5. RESOURCE INFORMATION**

Emergency Medical Services are a major challenge for the Department. An external review has identified inadequate resource allocation as the major reason for inadequate response times. For this reason the Department will have to prioritise this service and seek through increased efficiency but also by the allocation of additional funds to improve the current levels of service. Despite an increase of 24% in nominal terms in the 2005/06 financial year, additional funding will have to be identified in future years to address the shortfalls.

The Department of Health is working with the Departments of Local Government, Housing and Community Safety in establishing a Disaster Management and Emergency Medical Services Communication Centre.

Establishing a separate structure for the provision of Planned Patient Transport is an important step towards addressing a longstanding problem. The creation of an effective planned patient transport system is a key factor in the creation of the seamless service envisaged in Healthcare 2010.

## PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

### 1. AIM:

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

### 2. PROGRAMME STRUCTURE

#### **Sub-programme 4.1 General (Regional) hospitals**

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

#### **Sub-programme 4.2 Tuberculosis hospitals**

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

#### **Sub-programme 4.3 Psychiatric hospitals**

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

#### **Sub-programme 4.4 Chronic medical hospitals**

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

#### **Sub-programme 4.5 Dental training hospitals**

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

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

**Table B17: Strategic goal for provincial hospital services**

<p><b>STRATEGIC GOAL</b></p> <p>Provide appropriate and accessible regional hospital services for acute and chronic patients in the Western Cape.</p>
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### **3. SUB-PROGRAMME 4.1: GENERAL (REGIONAL) HOSPITALS**

#### **3.1 SITUATION ANALYSIS:**

One of the key assumptions in Healthcare 2010 is that patient admissions will not be reduced, but that patients will be treated at the appropriate level of care. The configuration of health services in the Western Cape will therefore need to be adapted and restructure to ensure service delivery at the appropriate level.

Mortality data for 2003 shows that in the Western Cape infectious diseases, chronic diseases of lifestyle and trauma-related injuries comprise the top 10 causes of death.

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

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

The HIV/AIDS pandemic is a chief contributor to the load on the services both in terms of patient numbers and acuity of illness. The impact is being felt at acute hospitals, TB and chronic medical hospitals.

The policy decision to roll out the provision of anti retroviral drugs is expected to increase the direct costs of care. However, the benefits of reducing the concomitant sequelae of other AIDS related diseases will be significant.

#### **3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES**

- In line with Healthcare 2010, Level 1 and 2 services in the Metro and rural regions must be strengthened as soon as possible to avoid inappropriate referrals to tertiary level.
- The upgrading of George and Worcester Hospitals in terms of the Revitalisation Programme will be completed and Paarl Hospital will commence.
- In line with the Healthcare 2010 Infrastructure Plan, planning will commence in 2005/06 on the building of a new district hospital in the Metro Region to serve the Khayelitsha community. This will commence the restructuring and repositioning of the current so-called regional hospitals in the Cape Metropole, most of which will become large district hospitals. It is envisaged that most regional (level 2) beds in the Cape Metropole will be situated within Tygerberg Hospital in the future.

- Revitalisation of selected current Regional Hospitals in the Metro is in the process of being confirmed. It is envisaged that in time replacement hospitals will be constructed for Victoria and Hottentots Holland Hospitals. New hospitals are envisaged for the Khayelitsha and Mitchells Plain areas, as well as a comprehensive upgrade of Tygerberg Hospital. A comprehensive upgrade of Somerset Hospital should be funded from the disposal of a portion of the hospital site.
- The upgrading of George and Worcester Hospitals in terms of the Revitalisation Programme will continue. The Paarl Hospital upgrade was delayed as a result of limitations to additional Hospital Revitalisation funding in 2004/05, but the project is expected to begin in 2005/06.
- Financial strategies include:
  - Increase revenue generation at facilities including the attraction of private patients and improved billing systems
  - Other cost containment strategies will be implemented to alleviate financial pressure, (e.g. referral, treatment, and drug protocols)
  - Facilities management of non-core activities where appropriate and affordable.
- Continuous improvement in quality of care.
- The national policy of free care to disabled persons will have cost and reduced revenue implications for hospitals.
- Implementation of the new medicine legislation on 1 July 2005
- Implementation of the new Mental Health Act
- Implementation of community service for nurses
- Forge a closer working relationship and support PHC Facilities within each sub-district area.

### 3.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

#### 3.3.1 Human Resource constraints

##### Re-shaping of the Service in line with Healthcare 2010

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

##### Difficulty in attracting and retaining staff especially nurses and medical officers:

- Medical Officers have therefore become a critical resource that needs to be retained, possibly through improved career-pathing and/or by appointment at appropriate level.
- Retention and recruitment of nursing staff remains a major challenge and lack of skilled staff e.g. theatre nurses, has resulted in the discontinuation of some services i.e. a reduced number of theatres being used in affected hospitals.

##### Measures to overcome the problem:

- Training of available staff
- Marketing of facilities and available posts.
- A variety of measures to allow Institutional managers maximum flexibility and autonomy in recruiting and retaining staff at their institutions.
- Scarce Skills allowances have been granted to specific categories of staff

### 3.3.2 Goods and Services

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

Drug costs will increase as a result of inflation as well as the increased number of Stage 3 and 4 AIDS patients attending our facilities. The envisaged roll-out of ARV treatment will further increase the costs and the conditional grants and donor funding must be appropriately utilized.

Currently hospitals still depend significantly on agency staff, however, this will be addressed during 2004/05, by the filling of posts, especially for nursing.

The implementation of new legislation will have cost implications. These costs will be necessary for the upgrading of facilities and the additional training of doctors and nurses that presently dispense medicines.

### 3.4 PLANNED QUALITY IMPROVEMENT MEASURES

- Provision of adequately trained clinical personnel
- Strengthen Facility Boards at each facility– to provide communities with a greater share of ownership in overall strategic direction of facilities and to increase accountability of institutional management to communities.
- General improvements in Hospital infrastructure are to be achieved through the Revitalization Programme
- Continuous development and training of health care workers
- Improving quality of patient care by:
  - Assessment of Client Satisfaction
  - Assessment of the implementation of the Patient's Rights Charter
  - Refinement of the Patient Complaints and Complements procedure
- Improving technical quality by:
  - Morbidity and Mortality Monitoring and reporting
  - Development clinical protocols for the improvement of care
- Care for the Carers by:
  - Monitoring of Safety and Security Risks
  - Assessment of staff satisfaction
  - EAP to support staff working in a stressful environment
  - Improvement of the physical working environment
- Clinical audits
- Protocol driven clinical service
- Improved equipping of hospitals through dedicated funds from provincial treasury



#### **4. SUB - PROGRAMME 4. 2 TUBERCULOSIS HOSPITALS**

##### **4.1 SITUATIONAL ANALYSIS:**

In 2003 a total of 22 999 TB cases were reported in the Metropole Region. This is an increase of 66% in seven years, reflecting a growing population, migration, improved case detection and an increased burden of disease. However, when population growth is accounted for, the TB case detection rate has only increased by 30% over the same period, with a high of 678/100,000 population in 2003

TB/HIV co-infection has adversely affected morbidity and mortality of patients and resulted in an increase in the average length of stay (ALOS) of patients.

##### **4.1.1 DP Marais Hospital**

DP Marais Hospital is a state-aided specialised hospital, currently affiliated to Santa Western Cape TB Association.

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

##### **4.1.2 Brooklyn Chest Hospital (BCH)**

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

The number of extra-pulmonary TB cases has increased by 66% in the Metropole over the last 3 years (from 12% to 16% of all TB cases). This could be a reflection of the impact of the HIV epidemic.

Due to the high TB/HIV co-infection rates of patients admitted to Brooklyn Chest Hospital, the severity of the disease in patients is significantly higher than in the past and this has resulted in increased length of stay and increased fatalities. This creates bottlenecks within the referral system of patients from secondary and district hospitals to Brooklyn Chest Hospital, with TB patients “blocking beds” in the secondary and district hospitals whilst waiting for vacant beds at Brooklyn Chest Hospital.

Two wards [90 beds] at BCH have been converted to isolation facilities for MDR patients. These wards are equipped with germicidal ultraviolet lights and plans are in place to provide separate barriers/fences for these wards. The opening of these isolation wards has not been sufficient to deal with the demand for beds for MDR patients and consideration is being given for a third ward to be used for MDR patient.

#### 4.1.3 **Brewelskloof Hospital**

Brewelskloof hospital has 206 beds in use for TB patients with 34 beds utilised by the BCG Research Unit of the School for Child and Adolescent Health, UCT.

Brewelskloof provides TB outreach services to 21 clinics in the Boland / Overberg region – Medical Officers carry out monthly visits and the hospital also provides TB drugs to all other hospitals and clinics in the Region. The other regional services include supply of psychiatric drugs, medicine and sundries to old age homes and the repair of wheelchairs.

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

- 4.1.4 **Harry Comay SANTA Centre (TB Hospital)** in George has reduced the number of beds from 125 to 90, with a concomitant expansion of Tuberculosis services at Oudtshoorn Hospital during the past year. This has affected mainly the paediatric wards, which have been relocated because of inadequate funding and inadequate clinical management. Priority is given to patients from deep rural areas requiring streptomycin injections. It is intended that this hospital will be provincialised during 2005.

- 4.1.5 **Sonstraal Hospital in Paarl** has 90 beds and is currently managed by the Drakenstein Municipality (a category B municipality within the Boland District Municipal area.) Patients are referred to the Hospital from PHC clinics and from hospitals in the area. Acutely ill patients are first stabilised at Paarl Hospital. Multi-drug resistant patients are referred to Brooklyn Chest Hospital in Cape Town. The Province currently contributes towards the hospital's budget and it is envisaged that this hospital will be provincialised during 2005.

- 4.1.6 **The Infectious Diseases Hospital in Malmesbury** is managed by the Swartland Municipality. It has 52 beds and a personnel component totalling 19. It is envisaged that this hospital will be provincialised during 2005.

#### 4.1.7 **Multi-Drug Resistant TB**

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

The DOTS Plus survey conducted by the Medical Research Council, confirmed that the Western Cape has the lowest MDR rates in the country. The reported rates were 1% for new cases, and 4% for re-treatment cases. These rates were the same as those reported in a survey conducted in 1995.

## 4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES:

**Table B18: Strategic objectives for TB hospitals**

<b>STRATEGIC GOAL</b>
Provide accessible TB hospitals for TB patients requiring hospitalization.
<b>STRATEGIC OBJECTIVE</b>
To ensure the allocation of sufficient resources to strategically placed TB hospitals in the Western Cape to effectively manage the treatment of TB and in particular multi-drug resistant TB.

It is projected that community TB DOTS programmes will be expanded to divert more PHC attendances. The dual TB/HIV epidemic will result in more “complicated TB cases” that will require more expert clinical skills. This will be amplified with the roll-out of ARV programmes. The increased “complicated TB cases” will require hospitalisation and can be expected to have an increased length of stay.

The health facilities infrastructure plan for the province includes the upgrading of Brooklyn Chest Hospital and also to accommodate the move of D.P. Marais from the current Princess Alice Orthopaedic Hospital site to the BCH site. This upgrading should also include the creation of a stepdown/ hospice facility for the Blaauwberg area.

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

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

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

## 4.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM:

The impact of the HIV epidemic on the management of TB clients, especially in the light of the imminent large-scale introduction of ARV programmes, will have to be managed effectively. The likely emergence of complex clinical presentations will be an added challenge that the centre of excellence will have to cope with. The general skills and competencies of clinicians to deal with patients with complex clinical presentations will need to be upgraded as a matter of urgency.

The current fiscal climate has led to more constrained funding of TB Control Programme activities. The budget allocations in future will need to reflect a significant shift in this regard, if Health Care 2010 targets are to be met. Major upgrading and maintenance is required at the Brooklyn Chest Hospital site.

The lack of skilled clinicians at BCH to establish and drive the centre of excellence is of concern.

#### **4.4 PLANNED QUALITY IMPROVEMENT MEASURES:**

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

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

The general approach to improving quality of care mentioned under sub program 4.1 will also apply to TB Hospitals.

## 5. SUB-PROGRAMME 4.3 PSYCHIATRIC HOSPITALS

### 5.1 SITUATIONAL ANALYSIS

The psychiatric services embarked upon the first round of downsizing in 1997. Whilst the process was forced to accelerate due to financial limitations, there was also a changed world view and approach to the care of mentally ill and intellectually disabled people, that viewed institutional long term care as the last resort and not the best option for the client.

### 5.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

**Table B19: Strategic objectives for psychiatric hospitals**

<b>STRATEGIC GOAL</b>	
Provide specialised psychiatric hospitals for acute and chronic patients in need of psychiatric care.	
<b>STRATEGIC OBJECTIVE</b>	
1)	To align psychiatric services with the requirements of the Mental Health Act.
2)	To reduce the current number of psychiatric beds in specialised hospitals.

#### 5.2.1 Policy

The rightsizing of the specialist psychiatric hospitals will continue in line with Healthcare 2010 and is linked to the provision of psychiatric beds at Regional and District hospitals and the development of community based services:-

Regulations promulgated in terms of the Mental Health Care Act 18 of 2002 have resulted in the need to adjust many of the mental health policies to ensure compliance with obligations imposed by the Act. An important provision of the Act is the establishment of the Mental Health Review Boards which play an integral role in ensuring that the rights of the mental health care users are protected. The Department is in the process of establishing a single Review Board for the Province.

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

#### 5.2.2 Service Priorities and Broad Strategic Objectives.

##### **Bed plan**

- The number of beds in the specialist hospitals are expected to decline from the 2003 platform of 2 235 to a revised platform of approximately 1 457 in 2010, the reductions will

lead to the closure of chronic care beds predominantly in services for people with intellectual disability.

- The 2004 platform was 2 142, ninety-three beds were closed and further efficiency gains made by consolidating services.
- Whilst bed closures are expected in the specialist hospitals the number of district and regional beds for the province is expected to increase from the current 12 in the Southern Cape to a total of 300 for the province, 50 in each of the rural regions and 150 in the Metro as part of the Healthcare 2010 strategy. .
- Similarly a range of alternative community based support services, including alternative residential options is expected to develop making it possible for people and their families to obtain the necessary safe, alternative care. These include:
  - Care for the aged with mental illness and intellectual disability in old age homes.
  - Care for adolescents particularly those who no longer attend school.
  - Placement for people with severe mental illness in supervised group homes.
  - Placement for people with intellectual disability in-group homes with varying levels of supervision.
  - Supervised community residences for state patients in the forensic service who do not have stable families to which they can be discharged under supervision.
  - Frail care for the multiply disabled.
- It will be essential for Health and Social Services to implement formal agreement regarding the primary responsibility for providing financial assistance to the above groups of people to purchase these services

For the six years to 2010 it would be expected that the specialist psychiatric hospitals would thus shed 114 beds per year, however, this would take place against an increase in alternative community places and a steady increase in district and regional beds. This will only be possible if the alternative services develop at a more rapid pace.

### **Infrastructure**

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

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

### Alexandra Hospital

There is still great potential for further consolidation. With the development of occupational therapy, physiotherapy, pharmacy and outpatient services in suitably upgraded facilities close to in patient facilities and consideration being given to drawing support services closer to the core in-patient, hospital facilities. Electrified perimeter fences are essential for safety and security.

Lentegeur Hospital

The consolidation that has been part of the relocation of the Western Cape Rehabilitation Centre to this site is complete and this is the hospital within the APH group that has the best overall infrastructure development. The challenge remains the ongoing maintenance, which so easily lags given the limited budgets for this purpose.

Stikland Hospital

This service has been largely consolidated onto the Southern Site with the exception of the administration building. Ongoing maintenance, perimeter security and the inefficiencies caused by the inability to consolidate key services further due to capital constraints exacerbate the operational challenges.

Valkenberg Hospital

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

The forensic services require the urgent replacement of Ward 20, which is far from the remaining services on the Pinelands Estate (Valkenberg East) remains a key goal. Currently this building houses 15 people referred in terms of the Criminal procedures Act for Observation Services by the Department of Justice from the Western and Northern Cape Provinces as well as 35 State patients admitted in terms of the Mental Health Act after being found unfit to stand trial for alleged serious crimes due to mental illness. There is a year-long waiting list of awaiting-trial prisoners in prison requiring observation services.

The possibility of a PPP to fund the replacement of Ward 20 is currently being investigated. The building of this new unit with increased capacity for observations and linking to the medium secure facilities on the Valkenberg West site and significant improvement of security measures will provide a solution to the many challenges facing this service including the inability to recruit and retain suitable nursing care professionals.

The building of the replacement admission suite is in progress, but has been significantly delayed due to the appointed contractor being unable to deliver on time. This is against a background of fully occupied beds. A tender has been awarded for the renovation of Ward 4 in the Riverside group of wards to convert it from a low secure unit to a sub-acute secure ward.

The site also requires replacement of the water reticulation system, which has not been on the schedule annually due to lack of maintenance funds and the complete renewal of perimeter fencing with electrified fences.

### **5.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM**

#### **5.3.1 Finance and financial management**

Financial administrative capacity at hospital level remains limited and the Department does not have the critical mass of staff required with the correct skills, this means that often the system depends on one person. The acquisition of financial skills is part of the identified priorities for skills development and wherever possible the appropriate officials are afforded the opportunity to attend training and when posts are filled every attempt is made to recruit skilled people. Supply chain management is a particular focus area. Skilled people in other regions are identified and requested to assist in giving practical training. This issue will be prioritised with respect to funding in the future.

#### **5.3.2 Human resources**

The single greatest challenge is the shortage in professional nurses especially those with psychiatric skills or advanced psychiatry training. Numerous strategies are employed to address this. However, without being able to pay for scarce skills or apply other methods of improving remuneration, it is difficult for psychiatry to compete with more popular areas in addition to the overall difficulties experienced countrywide. People with psychiatric skills are particularly sought after in the international market.

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

#### **5.3.3 Support systems**

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

#### **5.3.4 Information**

Until 2003/2004 all psychiatric information systems were manual. In 2003 and beginning of 2004 DELTA 9 was introduced at Alexandra, Lentegeur and Stikland and almost simultaneously LOGIS was introduced at all four hospitals. Valkenberg is identified as the psychiatric hospital to be the HIS pilot site. Whilst the progress has been exciting, staff training is a significant challenge.



## **5.4 QUALITY IMPROVEMENT MEASURES**

### **5.4.1 Management of Organisation**

There is a deputy director at Regional level who has the quality of care co-ordination portfolio as part of her brief and the hospitals have all identified senior staff members to be their quality of care representatives, this group will meet on a monthly basis and steady incremental progress will be made in terms of quality of care initiatives.

### **5.4.2 Patient Care**

Client satisfaction surveys will be repeated annually. The UCT Department of Social Work has provided students to conduct the surveys which has been a mutually beneficial experience.

Complaints and compliments are monitored in accordance with departmental policy. Submissions have been made on time and at Hospital and Regional level trends monitored and each complaint used to improve services and identify risks.

Morbidity and mortality committees are in place at all hospitals and trends will be identified which will inform the development of indicators. Meetings will be held regularly at all hospitals.

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

The mental health service Drug and Therapeutic forum meets quarterly and represents the psychiatric services across the Provincial platform. Treatment protocols for the treatment of mental health problems at regional and district hospital level were published and will be reviewed annually. All the APH hospitals have established pharmaceutical control committees and together with this forum all aspects of drug and therapeutic management are monitored and evaluated.

### **5.4.3 Human Resource Management**

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

## 6. SUB-PROGRAMME 4.4: CHRONIC MEDICAL HOSPITALS

### 6.1 SITUATIONAL ANALYSIS

The increasing epidemics of chronic diseases as well HIV/Aids are directly increasing the demand for these services. These facilities play an important role in allowing patients requiring non-acute care to be decanted from acute hospitals to prevent acute beds at regional tertiary hospitals from being blocked.

These hospitals are managed historically through different mechanisms viz. provincially aided hospitals, contracted out services as well as provincial hospitals.

### 6.2 POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

**Table B20: Strategic priorities for chronic medical hospitals**

<b>STRATEGIC GOAL</b>
To provide appropriate facilities for patients requiring chronic medical care.
<b>STRATEGIC OBJECTIVES</b>
To create a network of appropriate stepdown facilities to manage patients requiring intermediate hospital care in order to relieve pressure on acute regional hospitals

Chronic medical hospitals will play an important role as cost effective step-down facilities in terms of Healthcare 2010. The size of the service platform is to be maintained in the short term and reviewed in the medium to long term in keeping with the direction of Healthcare 2010.

The contracts and agreements with individual hospitals will be reviewed. The mechanisms and criteria regarding the transfer to patients from acute to chronic hospitals will also be reviewed in order to accelerate this process.

A concerted effort will be made to improve the working relationship between the chronic hospitals and the home based care services to facilitate the discharge of patients who could be managed at home.

The Karl Bremer and Conradie Rehabilitation services have been consolidated into a single modernized center of excellence at the Western Cape Rehabilitation Centre (WCRC) at Lentegeur Hospital. The WCRC plans outsource non-core activities at the new facility.

### 6.3 CONSTRAINTS

- Inadequate reporting on patient activities and general institutional performance. This will be addressed by establishing an appropriate reporting framework for regular reporting on performance measures including quality of care.
- Financial pressure at the Provincially Aided hospitals. Their agreements are being reviewed as part of a provincial process.

## **7. SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS**

### **7.1 SITUATIONAL ANALYSIS**

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

#### **7.1.1 Policy and political environment**

Policies that must be taken in consideration for the purposes of planning:

- 1) Healthcare 2010
- 2) District Health System
- 3) Strategic Oral Health Planning 2003
- 4) Batho Pele service delivery principles
- 5) Higher Education Act regarding merger

#### **7.1.2 Population characteristics and equity**

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

Projected increase in public oral health services demand is based on four factors:

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

#### **7.1.3 Service facilities, utilization and gaps**

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

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

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

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

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

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

#### **7.1.4 Resource constraints**

- Dental inflation is substantially greater than medical inflation.
- There are gaps in current and projected personnel
- The infrastructure from which service are delivered are owned by the universities. Both buildings at Tygerberg hospital and Mitchell's Plain are old and functionally not optimal in terms of space or high maintenance cost.

#### **7.1.5 Health needs**

Health needs as assessed by National survey on oral health disease highlighted the following with the highest prevalence rate and incidence. The target population is children.

- 1) Caries: 60-80% of children < 6 years has tooth decay.
- 2) HIV/AIDS: the epidemic fuelled by migration and no ARV drugs.
- 3) Dentures: 50% of adults are edentulous
- 4) Trauma impact on maxillo-facial surgery

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

#### **7.1.6 Cost efficiency**

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

### **7.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES**

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

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

#### 7.2.1 **Improve accessibility to oral health services**

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

#### 7.2.2 **Improve efficiency**

- Establishment of cost centres .
- Involve clinicians in management decisions through regular meetings.
- Identify efficiency and beneficial gains in the merger and incorporation process.
  - 1) Procurement
  - 2) Administration
  - 3) Equipment
  - 4) Human resources.
  - 5) Management / organisational structure
- Use process-mapping techniques to improve priority areas where bottlenecks occur.
- Reducing theatre utility demand by creating conscious sedation clinics for minor oral surgery and children. Maximize theatre efficiency by employing session anaesthetist.
- Maintain high throughput and low attrition of students. Students trained to implement the primary health care approach. Incorporate more clinical exposure in the latter years of undergraduate training.
- Fill administration posts to improve revenue collection.

#### 7.2.3 **Improve cost-effectiveness**

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

#### 7.2.4 Primary care approach

- Focus on the expansion of preventive and promotive strategies, that over a period of time there is a positive outcome for oral health services as a whole and for services at the OHC in particular.
  - 1) Fluoridation of water
  - 2) Educational programmes to improve dental hygiene and dental awareness
- Using appropriate technology for treatment.
- To formalize participation and collaboration with community, other health service providers, health sciences faculties, other tertiary institutions as well as other university faculties.
- Use needs base or epidemiological approach to identified areas of priority.

### 7.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

- 7.3.1 An assessment of water fluoridation levels in the province conducted in 2000/1, revealed that the water quality in the urban areas of the Province was adequate in most instances. However, it was noted that the level of water fluoridation on many of the farms in the Province was inadequate. A lack of resources has, however, precluded an in-depth investigation to quantify the extent of the problem and resource constraints have similarly curtailed attempts to rectify the problem. The persistent drought in the province has also complicated matters. The finalization of the process of reorganization of environmental health services will create an opportunity to address this problem once resources are made available. A project management team will be created to drive the process in the Province.
- 7.3.2 Develop an integrated provincial service platform to meet demand based on the principles of equity and affordability. Turnkey requirement is to develop referral sites at George and Paarl with a minimum of six dental chairs per site. Rationale is to deliver services that are accessible and affordable for non-Metro areas. Allocation of activity based budget to these centres.
- 7.3.3 Reduce the theatre demand by using conscious sedation for children and minor oral surgery procedures. This is a more cost-effective manner in delivering the same services. Initially the sedation clinics would only be at COHC but roll-out to other facilities when training dentists in this regard has been completed. Presently there is only one conscious sedation unit at COHC. It is envisaged that three more units be established.
- 7.3.4 An increase of dentures for the population between 18 to 35 years would serve them well in regards to suitability for employment and their quality of life. It would be advantageous to increase the production of dentures by 15% and reduce the cost per denture through collaboration with Technicons and private entities.

## **7.4 PLANNED QUALITY IMPROVEMENT MEASURES**

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

### **7.4.1 Patient Satisfaction**

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

### **7.4.2 Care for the Carer**

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

### **7.4.3 Clinical Quality**

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

## **8. RESOURCE INFORMATION**

Programme 4 will be reviewed over the five-year period in line with the service shifts as envisaged in Healthcare 2010. Major impacts on the programme will be the repositioning of the current regional hospitals in the Cape Metro as district hospitals and the placing of the majority of the level 2 (regional) beds within Tygerberg Hospital. The service plans that will be finalised by mid 2005 will guide the revision of funding allocations within this programme, particularly sub-programme 4.1, General hospitals. Funding challenges described above will have to be addressed particularly with respect to psychiatric hospitals, sub-programme 4.4, and dental training hospitals, sub-programme 4.5.

## PROGRAMME 5: CENTRAL HOSPITAL SERVICES

### 1. AIM:

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

### 2. PROGRAMME STRUCTURE:

#### Sub-programme 5.1 Central hospital services

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

### 3. SITUATIONAL ANALYSIS:

Tygerberg, Groote Schuur and Red Cross Children's Hospital are the three Central Hospitals funded by this Programme.

The Central Hospitals consisting of Groote Schuur, Tygerberg and Red Cross Hospitals provide tertiary, secondary and quaternary services for both adults and children (28%). The tertiary and quaternary components of the hospitals provide services for the whole of the Western Cape province including other provinces particularly the Eastern Cape.

The Central Hospitals also provide a trauma and emergency services and defined level 2 services for a defined metropolitan geographic area.

**Table B21: Numbers of beds in hospitals by level of care [CHS1]**

Central /tertiary hospital (or complex)	Level 3 and 4 beds	Level 2 beds	Total beds
Groote Schuur hospital	711	195	906
Red Cross Children's hospital	250	31	281
Tygerberg hospital	580	702	1 282
<b>Total</b>	<b>1 541</b>	<b>928</b>	<b>2 469</b>

#### 3.1 Financial issues:

The central hospitals are funded by the National Tertiary Services Grant (NTSG), the Health Professions Training and Development Grant (HPTDG) and also a 25% contribution from the Equitable Share for secondary level care that they provide.



The funding for the central hospitals has been at the same level in real terms over the past few years, in spite of an increased patient load, high levels of health inflation and a wage bill that has been significantly increased by the payment of scarce skills allowances

**Table B22: The sources of funding for the Central Hospitals during 2005/06**

Source of funding	Share of Central hospitals budget	Share of fund
National Tertiary Services Grant (NTSG)	62,7%	100%
Health Professions Teaching and Training Grant (HPTDG)	10%	60%
Hospital Management and Quality Improvement Grant	0,1%	11,4%
Equitable share	27%	14,4%

After detailed representation to both the National Treasury and the National Department of Health the trend with respect to the NTSG has been reversed for 2005/06. Allocations have been augmented by R93,3 million in 2005/06, R84 million in 2006/07 and R76 million in 2007/08. However, it is important to note that the NTSG allocations decrease in real terms between 2005/06 and 2006/07 and again between 2006/07 and 2007/08.

The Health Professions Training and Development Grant (HPTDG) funds the service costs related to teaching and training across all services in the province, and for all health sciences study courses. Tygerberg Hospital is currently linked to the University of Stellenbosch and Groote Schuur and Red Cross Children's Hospitals are currently linked to the University of Cape Town. This situation will change in future whereby universities and other higher education institutions will have equal access to health institutions and will no longer be linked primarily to specific institutes of higher education. The HPTDG funds allocated to the Western Cape have not increased in accordance with inflation or increased student requirements. In fact the allocation for 2005/06 decreases by 3,9 million in comparison to 2004/05, i.e. a nominal decrease of 1%. The funding in 2006/07 remains constant which translates into a 5% decrease in real terms.

All three hospitals have experienced significant financial constraints due to the rapid reduction in the funding envelope, the burden of disease and the way the services in the province, especially the Metropole region are structured. The Metropole region lacks level 1 hospitals, which results in the inappropriate use of level 2 hospitals, and therefore diminishes the real level 2 capacity that would protect level 3 services. Fiscal controls to curtail over-expenditure have been implemented, and various re-engineering strategies have been embarked upon.

**However, the central hospitals are not sustainable in their present configuration.** Many of the service units are below the critical mass of sustainability, diminishing the capacity to provide the full package of care, and to effectively train students. This is further exacerbated

by the backlogs in equipment and health technology. The poor condition and extent of the physical infrastructure, particularly at Tygerberg Hospital, contributes significantly to making the current level of activities unsustainable.

There are opportunities to consolidate/unify highly specialized services to address the unsustainable nature of the current service platform towards increased efficiency and sustainability.

During 2004 the Department established a joint Workgroup with the Universities and clinicians to assess the services in line with current realities as well as Healthcare 2010. The outcome of this process will provide information to assist the Department in reshaping the services and will have an impact in changing the current service configuration in the Central Hospitals.

### **3.2 Disease burden**

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

Chronic diseases of lifestyle are a particular challenge and various strategies are being developed, in collaboration with District Health, to manage and contain this increasing demand.

The rapid increase in the demand for obstetric care at the central hospitals, and the regional hospitals in the metropolitan areas, is of particular concern. A strategy and enhanced capacity is required to deal with this demand, which, in the case of complicated deliveries requires is an emergency service.

### **3.3 Consumables**

Ongoing funding restrictions for consumables are an obstacle to the provision of services, even where staff is available. On average, institutions spend 21% of their total budget on consumables instead of the targeted norm of 24%, highlighting once again the unsustainable nature of the current configuration of the services.

### **3.4 Estate and Equipment**

Adequate maintenance of buildings and equipment at the central hospitals is a problem, for example Tygerberg Hospital has a maintenance backlog that was estimated at R200 million in 1999, this has escalated to R800 million in 2004/5. The increasing cost of medical equipment

and funding constraints have resulted in backlogs in the acquisition and maintenance of medical equipment in all institutions.

### 3.5 The service platform

The central hospitals provide services grouped into 9 different Departments, subdivided into 32 divisions, further subdivided into 50 units. There is a particular challenge to accommodate developments in the Health Professions Council and teaching developments. The Department aims to have an agreed mechanism whereby sub-specialisation could be better handled.

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

- 1) Over the years Central Hospitals have reduced **beds** due to financial pressures, and in line with provincial and national policy. The number of operational beds are currently slightly less than that indicated as necessary in the Healthcare 2010 plan.
- 2) The **skills mix** and resultant wage bill could not be transformed at the same speed, calling for an urgent re-look at the organizational design of the central hospitals. The lack of specialized nurses, especially in theatre technique and Intensive Care, as well as some key scarce technical support staff such as medical physicists, clinical technologists, radiographers and pharmacists has had a limiting effect on the delivery in Central hospital services.
- 3) The number of **outpatients** currently seen is higher than the Healthcare 2010 target. The outpatient numbers include casualty and day treatment of patients. Strategies are now being designed to address this situation. The management of patients on an outpatient basis and with day surgery would be key strategies. The overall funding envelope nevertheless remains the determining factor. Ophthalmology, ENT, Allergology and Dermatology have the high numbers of outpatient services that could be devolved to more appropriate levels, depending on the availability of services.

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

Universities are major players in the Western Cape health service delivery and their role in supporting the province towards implementing Healthcare 2010 is important. The process of Joint Operational Planning is at an advanced stage, supporting the national Modernisation of Tertiary Services (MTS) process, thereby enhancing the co-operation between the Health department and the universities. The national policy decisions regarding the implementation and funding of the MTS proposals are awaited.

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

There is a need to develop decentralized decision-making in the institutions, and to have budgets and service information at that level. Whilst the structural developments of a cost center management system have progressed, there is a lack of support towards decentralized decision-making. It is planned to establish the necessary financial and information support so as to establish responsibility centers within the larger hospital organisations. However, due to financial constraints this may only be realized within the next two years.

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

#### 4. POLICIES, STRATEGIES AND BROAD STRATEGIC OBJECTIVES

**Table B23: Strategic objectives for the central hospitals**

<p><b>STRATEGIC GOAL</b></p> <p>Provide accessible and quality tertiary services for the Western Cape and beyond.</p> <p>Provide a platform for the training of health professionals.</p>
<p><b>STRATEGIC OBJECTIVES</b></p> <ol style="list-style-type: none"> <li>1) To provide tertiary and quaternary services in all the major disciplines and sub-disciplines.</li> <li>2) To align services with the affordability framework.</li> <li>3) Provide service efficiently and effectively.</li> <li>4) To distribute the Health Professions Training and Development Grant according to undergraduate and postgraduate student distribution.</li> </ol>

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

The re-negotiation of agreements with the universities and the rationalization and the consolidation of tertiary and quaternary services are major policy directives. These must be viewed in the light of the national initiative aimed at the Modernisation of Tertiary Services.

#### 4.1 **Central Hospitals: Organisational Development**

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

The Clinical Responsibility Centre will eventually function as a 'mini-hospital' in a larger hospital with its own budget, personnel establishment, procurement mechanisms and appropriate delegations. The resources and output targets will be progressively aligned towards the Health Care 2010 expectations. Information management capacity and dedicated administrative support will be required.

The institutions aim to modernise management and establish bed management, theatre management and quality management capacity.

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

#### 4.2 **Individual Central Hospitals**

##### 4.2.1 **Red Cross Children's Hospital (RCCH)**

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

- Identified sub-specialist paediatric services across Red Cross and Tygerberg Hospitals will be consolidated into single discipline departments. Implementation has already commenced in the Cardiology and Cardiothoracic services; Nephrology and Renal Transplant services; Neurology and Child Development services; and paediatric services. Other areas will follow.
- **Estate Management:**  
The community support for Red Cross War Memorial Children's Hospital has been phenomenal and the fundraising arm of the hospital, The Children's Hospital Trust has raised over R90 million since 1995 for redevelopment projects, such as:
  - a new specialist outpatients and emergency services wing – R43 million
  - a new integrated paediatric intensive care unit – R3.8 million

- specialized medical equipment – R15 million
- a new trauma and diagnostic radiology unit R16 million
- a new oncology unit – R16 million .

#### 4.2.2 Tygerberg Hospital

- During 2003, continued through 2004 Tygerberg Hospital commenced with consolidating regional services into separate wards as the first step towards strengthening capacity for regional metro hospital services. This process will continue and ultimately funding for a quantum of Level 2 services will be transferred to Sub-programme 4.1 (Regional/General hospitals).
- Once the service plan for the Metro has been finalized, the future service and infrastructure configuration of Tygerberg Hospital will be clarified and it will be possible to conduct feasibility studies and prepare a motivation for funding from the Hospital Revitalisation Fund.
- In order to ensure sustainable service delivery it is necessary for Tygerberg Hospital to expand and develop already well functioning revenue generation initiatives, e.g. the further roll-out of differentiated amenities, maximization of revenue collection and increased revenue through the Road Accident Fund.
- The principles of Healthcare 2010 include improving the quality and access to appropriate health services by strengthening level 2 services and restructuring level 3 services.
- Tygerberg hospital is experiencing an increasing load on trauma and emergency services. Therefore the creation of additional management and infrastructure capacity has been prioritised. Trauma headcounts have consistently increased over the past three years and the average for the first 4 months in the 2004/05 financial year shows an increase of 400 – 500 patients per month. The nature of trauma requires very expensive interventions and orthopedic trauma is placing a major burden on medical surgical consumables. The projections of orthopedic implants on current trends indicate an increase in this expenditure in excess of R1,5 million

#### 4.2.3 Groote Schuur Hospital

The key strategies of GSH are as follows:

- Re-engineering the institutional framework – this will include restructuring management, the interface between the hospital and higher education institutions, clinical departmental and divisional structures, and the separation of tertiary and secondary services within the institution. The consolidation of the Intensive Care Units, Wards and Trauma and Emergency Units will be completed. This will result in improved theatre management and day surgery utilization.
- Strengthen de-centralised management through five clinical centers, supported by Cost Centre Accounting.
- Strengthen revenue flows by expanding on the bed capacity and aggressive following up of road accident fund and other hospital fees.
- Establishing a step down / hospice care facility.
- Consolidate secondary services and ensure appropriate outpatient attendances.

#### 4.2.4 Other strategies:

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

## 5. **CONSTRAINTS AND MEASURES TO OVERCOME THEM**

### 5.1 **Main Challenges facing the Central Hospitals**

- Personnel structure with incorrect staff mix and shortages of scarce resources especially Nursing staff, Clinical Technologists, Pharmacists, Radiographers, Physicists and Perfusionists. Post-basic qualifications in nursing, particularly theatre and intensive care are severely lacking, causing a high dependency on agency services, which cannot always provide in the need.
- Realignment of personnel within the budget.
- Equipment shortages and problems with maintenance.
- Inadequate capacity at primary and secondary levels of care to accommodate referrals and prevent patients from moving up in the referral chain. The lack of chronic medication and professions allied to medicine personnel in other facilities has a significant impact. There is a significant increase (17%) in the demand for obstetric care, and the provision of gynecology services is very limited at less specialized facilities and Primary health Care.
- Shortages of particularly ICU and General Ward Beds.
- Long waiting times and waiting lists, especially in cardiac surgery, vascular surgery, urology cancers, and head and neck cancer surgery.

5.2 The current service platform in the Metropole region results in an inappropriately large number of outpatients being seen at the Central Hospitals. This will be addressed with Programme 4, regional general hospitals, whilst taking the financial constraints of this programme into consideration. The relocation of general specialists to regional hospitals will strengthen the capacity at the appropriate levels.

5.3 The operational and maintenance costs of the extensive and rapidly deteriorating physical infrastructure of the Central Hospitals are a significant constraint. A concerted effort is being made to enhance the capacity of the province to address the infrastructure backlogs, in line with Healthcare 2010.

5.4 Policy options identified to develop/enhance the services in the Central Hospitals:

- Implementation of managed Clinical Responsibility Centres (cost center) management to enhance financial management.
- Local, in-house post basic training of nurses in specialties such as ICU, theatre. This would require the investment of two staff members in both GSH and TBH.
- Address the bottlenecks in the system, especially day surgery, theatre efficiency, theatre time, ICU bed capacity, and radiation therapy

- Appoint full time nursing staff to reduce the use of agency personnel.
- Filling of key posts that would unlock efficiencies, including a Quality Manager, Bed Manager, and Theatre manager
- 'start-up' funds to facilitate revenue generation, such as renal dialysis
- Improve the safety of the institutions (especially GSH and TBH) regarding Fire detection and protection system
- Refresh slow and outdated information technology hardware - IT refresh
- Funding for assistive devices.
- Have direct access to Level 1 beds that would assist in appropriateness of care management.
- Advanced management training for staff

## 6. RESOURCE INFORMATION

Programme 5 is largely dependent of funding received from the National Department of Health as conditional grants for National Tertiary Services and Health Professions Training and Development. Since this funding was significantly decreased by cumulatively over R600 million for the three years preceding the 2005/06 financial year the budgets and functioning of these key hospitals have been under considerable stress. Whilst the trend has been reversed for 2005/06 to an extent with an additional R111 million the trend in real terms remains negative in the longer term.

The trend of funding allocated by the National Department of Health to the HPTDG of which 60% is allocated to Programme 5 remains negative in real terms for the MTEF period. Currently the shortfall in Programme 5 is addressed from the provincial equitable share funding that is unsustainable in the long-term.

In terms of Healthcare 2010 significant restructuring of the services within the available funding envelope remains the only option. This is essential to ensure not only the maintenance of a core of quality services to support the wider health services in the province and beyond, but also the financial stability of the entire vote.



## **PROGRAMME 6: HEALTH SCIENCES AND TRAINING**

### **1. AIM:**

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

### **2. PROGRAMME STRUCTURE**

#### **Sub Programme 6.1: Nurse Training College (WCCN)**

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

#### **Sub Programme 6.2: Emergency Medical Services (EMS) Training College**

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

#### **Sub Programme 6.3: Bursaries**

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

#### **Sub Programme 6.4: Primary Health Care (PHC) Training**

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

#### **Sub Programme 6.5: Training (Other)**

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

### **3. SITUATION ANALYSIS**

#### **3.1 Appraisal of existing services and performance during the past year**

##### **Legislative mandate**

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

##### **Assessing training needs**

The analysis of training need and scarce skills is informed by information gleaned from Persal reports which indicates valuable information including attrition trends, vacancy trends per occupational category per institution and regions, labour market trends and forces, supply and demand issues, including HRD priorities for the health sector at national, provincial and Departmental level.

**Planning**

HRD planning includes supporting the development of all employees and potential employees. This includes incorporating student interns, learnerships, functional training, life skills development, and development of a critical mass of health professionals as one of several HR strategies to sustain the health service staffing, recruitment and retention levels.

**Training strategy**

The training strategy for the Department is addressed through the annual Departmental Workplace Skills Plan (WSP). This is developed through a consultative process with inputs from the Regional and Institutional Workplace Skills Plans and reflects the prioritisation of skills needs throughout the Department.

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

**iKapa Elihlumayo**

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

**Social Capital**

Formal relationships and networks have been established with key social partners to inform the delivery of a responsive HRD agenda, and these include internal and external clients and partners. Formal relationships with the Higher Education Institutions i.e. University of Cape Town, University of Stellenbosch, and University of the Western Cape have been entered into by way of a Memorandum of Agreement for the provision of academic support to the Western Cape College of Nursing (Budget Sub-programme 6.1).

In addition a partnership has been entered into to promote a regional platform for undergraduate training of nurses with the Cape Higher Education Consortium (CHEC) comprised of the University of Cape Town, University of Stellenbosch, University of the Western Cape, Cape Technikon, and the Peninsula Technikon. At the Departmental Training Committee meeting, internal partners and organized labour address matters related to skills development and broader HRD issues that impact on the delivery of health services through provision of education, training, and development interventions.

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

The training strategy provided interventions in the following key areas:

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

Surveys are undertaken to inform Adult Basic Education and Training (ABET), management training, financial management training, skills development facilitator training, computer and generic training.

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

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

Quantitative information is reflected in Table HR 2

### **3.2 Key challenges over the strategic plan period**

- Alignment of HRD strategies with Health Care 2010 plan, key legislation and policies
- Increase the critical mass of all categories of nurses at basic level
- Budget availability for the provision of an adequate number of bursaries, for health science and support service students to meet training targets based on service needs
- Accommodation of increasing number of all health science students
- Strengthen Human Resource Development Information system
- Quality assurance of education training and development interventions
- Relocation of the Western Cape College of Nursing to the proposed Cape Peninsula University of Technology

### **3.3 Policy and Priority perspectives**

The policy on iKapa Elihlumayo and the Health Care 2010 plan frames and supports the mandate to meet the HRD needs of the Department through appropriate education, training and development interventions for health workers to enable them to render health services.

The priority is to ensure a multi-year rolling plan that supports the development and provision of a critical mass of health workers for the Department to enable it to render its core business of health service delivery.

Over a period of four years the Department embarked on a process of rationalising its four former nursing colleges through consolidation of all resources and academic functions. Consequently the consolidation outcome resulted in the closure of the four former colleges in December 1999, and the relocation of all resources and academic functions to the Western Cape College of Nursing, (WCCN), which was established in January 2000.

The final phase of the transformation agenda will see the relocation of the Western Cape College of Nursing to the Cape Peninsula University of Technology as supported by the provisions of the Higher Education Act.

At present the WCCN has both employee student nurses and bursar students, and it is expected that they conclude their training in 2005 and 2006 respectively. Further admissions will be under the auspices of the Cape Peninsula University of technology and / or the Western Cape College of Nursing

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

The establishment of learnerships in partnership with the Health and Welfare Sector Education Training Authority (HWSETA) will be further strengthened to alleviate unemployment and poverty by providing skills development and employment access opportunities.

The following table highlights the number of nurses that are expected to qualify over the MTEF period.

**Table B24: Number of nursing graduates expected at the end of each year**

<b>4<sup>th</sup> Year Students</b>	<b>2004/05 (Target)</b>	<b>2005/06 (Target)</b>	<b>2006/07 (Target)</b>	<b>2007/08 (Target)</b>
R 425 Diploma (Bursary students)	0	0	152	6
R 425 Diploma (Salaried students)	121	142	14	0
B Cur (Bursary students)	3	93	140	434
B Cur (Salaried students)	84	21	2	0
<b>Total number of qualified nurses</b>	<b>208</b>	<b>256</b>	<b>308</b>	<b>440</b>

Note: Salaried students will be phased out by the 2007 academic year

Key learnerships have already been implemented in nursing for unemployed persons and as pharmacist assistants for existing employees (SASO category).

Human resource development at a Departmental level can promote transformation through education, training and development interventions for all personnel as well as potential employees to the health sector.

However, this requires sustained commitment. As part of a coherent human resource development strategy, the gap between existing skills deficits and the desired competency levels of workers and practitioners for all occupational categories must address historical backlogs and the urgent needs of health service delivery towards narrowing and eventually eliminating skills and proper placements in workplace.

Programmes such as ABET (Adult Basic Education and Training), learnerships and management development programmes all contribute towards bridging the skills gap, while providing higher portability of skills and wider opportunities for career paths and employability.

The achievement of Health Care 2010 is reliant upon the provision of constant supply of health science professionals and support staff at sustainable levels to ensure effective service delivery. Training interventions need to be informed by health service needs and priorities and must be designed in such a way as to ensure that learners are empowered to assume the responsibilities and challenges of realities in the workplace.

#### 4. POLICIES, STRATEGIC PRIORITIES AND OBJECTIVES

**Table B25: Strategic objectives for Health Sciences and Training**

STRATEGIC GOAL
To develop qualified and skilled healthcare professionals and other health workers for the Western Cape and South Africa.
STRATEGIC OBJECTIVES
1) To train nurses and other health science students at undergraduate and post-basic level.
2) To train rescue and ambulance personnel.
3) To develop actual and potential employees by means of PHC, management, leadership and skills development training through bursary schemes and financial assistance.

#### STRATEGIC PRIORITIES

The key strategic priorities to be addressed within the Health Care 2010 plan context includes the following:

Plans to address shortfall in the number of professionals being trained in order to meet future service requirements are:

- Increase critical mass of nurses based on health service needs and priorities
- Increase critical mass of health science professionals and support staff in scarce skills, based on health service needs and priorities (pharmacists, radiographers, medical / clinical technologists, medical physicists, industrial technicians)
- Support the broadening of clinical teaching/ learning platform to widen access to health science students in support of recruitment and retention
- Secure the budget for fulltime and part-time bursaries to attain the targets for delivery in terms of Health Care 2010

- Increase the critical mass of pharmacist assistants, enrolled nurse assistants and enrolled nurses through the learnership programme

Plans to ensure the relevance and quality of training programmes are:

- Alignment of HRD strategies with policy directives of the skills development legislation, the HRD transformation agenda, and the Departmental Health Care 2010 plan for service delivery.
- A review of decentralised Primary Health Care training to assess alignment of departmental training to Health Care 2010 priorities
- Strengthen partnerships with Higher Education Institutions.

Plans to address the training skills and competencies gap, both in-service and pre-service are:

- Training programmes for clinical nurse practitioners
- Reorientation programmes for primary health care
- Training programmes for mid-level workers through short courses, learnerships, mentoring
- Enhance capacity of health science professionals through encouraging appropriate CPD training
- Programmes such as integrated management of childhood illnesses and home based care are programmes coordinated under the Chief Directorate: Programmes
- ABET programmes for staff all contribute towards bridging the skills gap, while providing higher portability of skills and wider opportunities for career paths and employability.
- The establishment of learnerships in partnership with the Health and Welfare Sector Education Training Authority (HWSETA) some of which will be intended to alleviate unemployment and poverty by providing skills development and employment access opportunities.

The training strategy should include interventions in the following key areas:

- Functional / generic training to ensure competency on the job
- Technical skills training to support specialist / dedicated areas of skills
- Management training to support effective management of all public resources and policy implementation
- Computer-based training to increase and enhance efficacy and efficiency levels
- Learnerships to alleviate unemployment and increase employability
- In-service training to ensure continuous professional development

The Western Cape College of Nursing will be transferred to the Cape Peninsula University of Technology (CPUT).

## **5. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM**

### **5.1 Budget Constraint**

Limited training budget will mean that training objectives and targets will not be met with a subsequent negative impact on service delivery. The financial management and control of training budgets in alignment with the provisions and prescripts of the Public Finance

Management Act and Treasury Regulations will ensure the effective, efficient, economic and appropriate utilisation of resources.

**Measures to overcome constraint**

Secure adequate funding to meet HRD objectives and targets, which have been aligned to service delivery needs.

Extension of a bursary scheme to support the development of a critical mass of health professionals.

**5.2 HR constraint**

New policy demands for programme managers. New appointments in HRD posts.

**Measure to overcome constraint**

Ensure continuous professional development, support and mentorship of programme managers to address skills development needs.

**5.3. HRD Information System**

Inadequate fragmented systems

**Measure to overcome constraints**

Ensure development of an effective and efficient information system as a planning and monitoring instrument.

**6. RESOURCE INFORMATION**

Health Sciences and Training has been significantly restructured over the last three financial years with funds being shifted from the Western Cape College of Nursing salaries to bursaries for nursing students. This results in R41 million being allocated to bursaries in the 2005/06 financial year. Once all nursing students receive bursaries this will stabilize. Further the envisaged transfer of the WCCN to the Cape Peninsula University of Technology will result in the majority of funding for nursing being reflected as bursary payments. It will be important to identify and earmark a percentage of the payroll of the Department for human resource development to address the challenges outlined above.

## PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

1. **AIM:** To render support services required by the Department to realise its aims

### 2. PROGRAMME STRUCTURE

**Programme 7.1: Laundry Services:**

Rendering a laundry service to hospitals, care and rehabilitation centres and certain local authorities.

**Programme 7.2: Engineering Services**

Rendering a maintenance service to equipment and engineering installations, and minor maintenance to buildings.

**Programme 7.3: Forensic Services**

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

**Programme 7.4: Orthotic and Prosthetic Services**

Rendering specialised orthotic and prosthetic services.

**Programme 7.5: Medicine Trading Account**

Managing the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities.

### 3. POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

**Table B26: Strategic objectives for Health Care Support Services**

<b>STRATEGIC GOAL</b>	
Rendering the support services required by the Department.	
<b>STRATEGIC OBJECTIVES</b>	
1)	To provide a laundry service to hospitals, care and rehabilitation centres and certain local authorities.
2)	To provide a maintenance service to equipment and engineering installations and minor maintenance to buildings.
3)	To render a specialised forensic and medico-legal service in order to establish the circumstances and causes surrounding unnatural death.
4)	To render specialised orthotic and prosthetic services.
5)	To manage the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities.



#### **4. SUB-PROGRAMME 7.1 LAUNDRY SERVICES**

##### **4.1 SITUATION ANALYSIS**

Laundry services are provided by large central laundries at Tygerberg, Lentegour and George Hospitals. Several rural hospitals have small in-house laundries. Over the past seven years much of the laundry service has been successfully outsourced resulting in significantly reduced costs. The outsourcing has not only had a direct cost benefit in that the outsourced service is less expensive, but has resulted in a substantial reduction in overtime worked at in-house laundries. However, due to the limited two-year contract periods being awarded to the private sector laundries a number of the larger operations that had the capacity to process the Department's linen have shut down. There is only one large private laundry able to process the work from the larger institutions. This is of great concern and impacts negatively on the cost of providing laundry services.

Maintaining the operational status of the Department's in-house laundries is of the utmost importance as a number of private sector laundries have failed over recent years. Fortunately the in-house laundries have been able to meet the service requirements at the affected hospitals and institutions.

No major equipment has been replaced for more than 10 years, which is of concern as the in-house laundry services are not sustainable without equipment replacements. It is envisaged that approximately R20 million will be required to replace ageing equipment and to conform to the South African National Standard (SANS) over the next 5 years.

##### **4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES**

In order to provide a cost effective service with minimum risk, a combination of in-house and outsourced laundry services has been instituted. The immediate priority is to increase the efficiency of in-house services. Large volumes of work are imperative for the strategic laundries to make them cost-competitive with the private sector. Recent productivity gains have led to a shift of work from the private sector to the in-house laundries. This was necessary to ensure that personnel resources were fully utilised.

##### **4.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM**

The relatively high salaries of in-house laundry personnel coupled with low productivity are a significant constraint to making these laundries cost competitive. A gradual reduction in staff coupled with morale building and training is improving the situation. At Tygerberg Laundry this

has shown a measure of success and additional work has been brought into the plant to improve cost effectiveness.

The lack of capacity in the private sector has a negative effect on laundry service costs. A plan to build capacity has been developed. Period contracts have been extended from 2 years to 5 years to make contracts financially viable for private contractors.

#### **4.4 PLANNED QUALITY IMPROVEMENT MEASURES**

A plan to replace ageing equipment over the next 5 years is being developed.

### **5. SUB-PROGRAMME 7.2 ENGINEERING SERVICES**

#### **5.1 SITUATIONAL ANALYSIS**

The policy is that each hospital has its own engineering workshop to provide routine day-to-day maintenance for which a minimal staff complement is provided. However, at some institutions there are no staff, or staff with limited capabilities. Two general engineering workshops (at Zwaanswyk and Bellville) and one clinical engineering workshop (at Vrijzee) provide support to the hospitals. The Bellville, Vrijzee and Zwaanswyk workshops employ engineers, technicians and artisans that are able to assist hospitals with larger and more complex maintenance and repair work. These three workshops are part of the Directorate: Engineering and Technical Support.

#### **5.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES**

All hospital equipment maintenance and repair work is done by the hospital workshop personnel and the Directorate: Engineering and Technical Support.

Maintenance of buildings is a joint venture with Public Works. The latter undertake all major construction, repair and maintenance work at hospitals. The Directorate: Engineering and Technical Support is responsible for prioritising and defining the work to be done by Public Works.

The most urgent priority is to address the backlog of maintenance and rehabilitation of hospital infrastructure. The backlog is currently estimated at over R750 million. A Healthcare 2010 Hospital Infrastructure Plan aimed at addressing the backlog and future infrastructure needs has been compiled. Work is in progress on schemes that will lead to the realisation of Healthcare 2010, the strategic plan of the Department. As part of this plan some of the most dilapidated infrastructure will be disposed of and as this is surplus to the needs of the service, the backlog will be reduced without additional recurrent expenditure.

### 5.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Inadequate funding for maintenance and rehabilitation has been a problem for many years. Coupled to this is inadequate funding for new or replacement medical equipment with the result that the hospital engineering personnel have to resort to innovative measures to keep outdated and obsolete equipment operational. In respect of buildings the focus is largely on safety and minimum functionality rather than rehabilitation and upgrading.

### 5.4 PLANNED QUALITY IMPROVEMENT MEASURES

The Hospital Revitalisation Programme and the increased availability of funds for new equipment will reduce the maintenance backlog by replacing obsolete buildings, infrastructure and equipment.

#### Physical condition of hospital network

Hospitals by type	Average 1996 NHFA condition grading <sup>1</sup>	Any later provincial audit grading (with date)	Outline of major rehabilitation projects since last audit
<b>DISTRICT HOSPITALS</b>			
Beaufort West	4		The construction of a new pharmacy and administration wing.
Caledon	4		Routine maintenance only.
Ceres	5		Routine maintenance only.
Citrusdal	4		Internal and external renovations and painting.
False Bay	4		Internal and external renovations and upgrading in progress.
Hermanus	4		Routine maintenance only.
Knysna	4		Internal and external renovations and painting.
Ladismith	4		Routine maintenance only.
LAPA Munnik	4		Routine maintenance only.
Montagu	2/3		Internal and external renovations and painting.
Mossel Bay	4		Partial internal and external renovations and painting.
Otto du Plessis	3/4		Routine maintenance only.
Oudtshoorn	4		Routine maintenance only.
Riversdale	4		External renovations and painting.
Robertson	4		Routine maintenance only.
Stellenbosch	4		Roof replaced.
Swartland	4		Roof replaced and kitchen upgraded.
Swellendam	4		Routine maintenance only.
Vredenburg	3		Comprehensive revitalisation in progress.
Vredendal	4		Casualty upgraded. Entrance upgrade in progress.
Wesfleur	2		Extensive internal and external repairs and renovations
<b>PROVINCIALY AIDED DISTRICT HOSPITALS</b>			
Clanwilliam			Ward upgraded for "private" patients.
Laignsburg			One wing converted for use as a clinic.
Murraysburg			OPD added.
Prince Albert			OPD added.
Radie Kotze			Ward upgraded for "private" patients.
Uniondale			Routine maintenance only.

Hospitals by type	Average 1996 NHFA condition grading <sup>1</sup>	Any later provincial audit grading (with date)	Outline of major rehabilitation projects since last audit
<b>GENERAL HOSPITALS</b>			
Conradie	1		None – hospital has closed.
Eben Donges	4		New CHC to replace general OPD New 90 bed ward block added. Pharmacy upgraded Comprehensive revitalisation in progress.
GF Jooste	4		Casualty upgraded OPD and staff amenities block added
George	4		New Administration block and nurses home added. New patient reception and specialist OPD added. Several wards upgraded. Comprehensive revitalisation in progress.
Hottentots Holland	3		Maternity wing upgraded.
Karl Bremer	4		Central steam installation converted to point of use electrical heating. Wards and reception upgraded for “private” and hospital patients.
Paarl	3		Casualty upgraded. Central steam installation converted to point of use electrical heating. Hospital identified for priority Revitalisation.
Somerset	4		Central steam installation converted to point of use electrical heating.
Victoria	2		Substantial external renovation of buildings. Central steam installation converted to point of use electrical heating.
<b>CENTRAL HOSPITALS</b>			
Groote Schuur	5		Major renovations and improvements to maternity block and OPD.
Red Cross	4		New specialist OPD added. Prefab buildings replaced with permanent structures. Day theatre extensively upgraded. External renovation of main hospital building. Renovation of nurses home. Central steam installation converted to point of use electrical heating.
Tygerberg	3		Pharmacy upgraded.
<b>TUBERCULOSIS HOSPITALS</b>			
Brewelskloof	4		Extensive internal and external repairs and renovations.
Brooklyn Chest	4		Ongoing internal and external renovation of wards. Installation of UV lights in progress.
<b>PROVINCIALY AIDED HOSPITALS</b>			
DP Marias SANTA	4		Ablutions upgraded.
Harry Comay SANTA	1		Minor renovations and painting.
<b>PSYCHIATRIC HOSPITALS</b>			
Alexandra	3		Administration and teaching/ clinical blocks upgraded. Standby generator replaced.
Lentegeur	4		Renovation of ward blocks in progress.
Nelspoort	3		Central steam installation converted from point of use electrical heating.
Sittkland	4		Several ward blocks renovated.
Valkenberg	3		Hospital being scaled down from 1 039 to 320 beds. New admissions ward under construction.
<b>CHRONIC MEDICAL AND OTHER HOSPITALS</b>			
KBH Rehabilitation			None – this function has been relocated to Lentegeur.
Mowbray Maternity	3		Portion of nurses’ home converted to active birthing unit and ward for private patients. Comprehensive renovations and upgrading in progress.
<b>PROVINCIALY AIDED CHRONIC MEDICAL AND OTHER SPECIALISED HOSPITALS</b>			
Booth Memorial			One wing renovated. Standby generator installed.
Die Wieg			Internal and external renovations and painting.
Maitland Cottage Home			Routine maintenance only.

Hospitals by type	Average 1996 NHFA condition grading <sup>1</sup>	Any later provincial audit grading (with date)	Outline of major rehabilitation projects since last audit
Sarah Fox			
St Joseph's Home			Routine maintenance only.
Conradie - Lifecare			Wards upgraded for use by Lifecare.

## 6. SUB-PROGRAMME 7.3 FORENSIC SERVICES

### 6.1 SITUATIONAL ANALYSIS

Forensic Services are delivered from two components – one at the University of Cape Town Medical School and the other at the University of Stellenbosch.

### 6.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

To provide a forensic pathology service to the Metropole Region and forensic pathology support service to the other regions in accordance with the provisions of the following Acts: Inquest Act, National Health Act, Human Tissue Act, Births & Death Registration Act, Prisons Act, and the Medical, Dental, & Supplementary Health Services Professions Act.

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

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

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

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

### 6.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The high workload and related stress of performing approximately 5 600 medico-legal autopsies per annum results in a high turnover of medical specialists. This could be addressed by providing additional specialist posts of suitable grading.

A present constraint is lack of employment opportunities for the specialists who are trained, in spite of a need for these specialists in rural areas. This is addressed in the proposed organisational structures for the Forensic Pathology Service (transfer of Medico-legal Service from SAPS to Health) with the creation of additional specialised capacity.

The proposed amendment of section 56 of Act 56 of 1974, will have a significant impact on the practice of Forensic Medicine and Pathology nationally. The primary aim of amending section 56 is to change the definition of unnatural deaths. The proposed amendment reads as follows:

Section 56: "The death of a person whilst under the influence of a general anaesthetic or local anaesthetic, or of which the administration of an anaesthetic undergoing or as a result of a procedure of a therapeutic, diagnostic or palliative nature or of which any aspect of such a procedure has been a contributory cause, shall not be deemed to be a death from natural causes as contemplated in the Inquest Act, 1959 (Act No. 58 of 1959), or the Births, Marriages and Deaths Registration Act, 1963 (Act No. 81 of 1963)."

The scope of what will be considered to be an unnatural death will be extended. Therefore the number of autopsies and inquest hearings to be performed will increase significantly which will in turn impact on the financial and human resources required.

#### 6.4 **PLANNED QUALITY IMPROVEMENT MEASURES**

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

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

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

### 7. **SUB-PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES**

#### 7.1 **SITUATION ANALYSIS**

The Orthotic and Prosthetic (O&P) Service is rendered from a provincial centre situated on the Conradie Hospital site. Orthotist/Prosthetists attend orthopaedic clinics throughout the province. The service in the Southern Cape/Karoo has been successfully outsourced.

#### 7.2 **POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES**

The policy is to render an effective, efficient and sustainable service through a combination of in-house and outsourced services. The immediate priority is to recruit, train and retain personnel to sustain the in-house service. The broader strategic objective is to ensure continuity of service delivery through an optimum mix of in-house and outsourced services.

### **7.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM**

A major constraint is the inability to attract and retain suitably skilled and experienced personnel. This can be attributed to a shortage of qualified Orthotist/Prosthetists and surgical boot-makers, coupled with uncompetitive salaries. The shortage is being addressed by in-house training programmes. The uncompetitive salaries are part of a larger problem of uncompetitive salaries of registered health support personnel. The outsourcing of more Orthotic services is currently under consideration – purely as a result of inability to attract and retain qualified personnel.

### **7.4 PLANNED QUALITY IMPROVEMENT MEASURES**

Quality improvement focuses on two areas:

- The reduction of waiting times which is being addressed by recruiting additional personnel and outsourcing selected services.
- Working with other professionals in the rehabilitation field to improve the quality of appliances. The relocation of the O&P Centre to the new Provincial Rehabilitation Centre at Lenteguur is under investigation.

## **8. SUB-PROGRAMME 7.5 MEDICINE TRADING ACCOUNT**

### **8.1 SITUATION ANALYSIS**

The Cape Medical Depot (CMD), operating on a trading account, is responsible for the purchasing, warehousing and distribution of pharmaceuticals and medical sundries. Orders are supplied in bulk to larger hospitals or as smaller one-off items to smaller institutions. The academic hospitals generally buy directly from manufacturers and tend to use the CMD as a top-up service, which adversely affects other institutions.

The CMD is also responsible for pharmaceutical quality control. This is achieved by means of a Quality Control Laboratory (QCL) situated at the Cape Technikon. The Pre-pack Unit currently situated at the Metro Regional Office is responsible for preparing patient ready packs.

### **8.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES**

In order to render an effective service, the CMD needs sufficient working capital to maintain adequate stock levels in the face of poor supplier performance, erratic deliveries and erratic demands.



The immediate priority is to obtain Cabinet approval for the abolition of the interest levied on working capital employed which impedes efficient performance. This will enable the CMD to adequately fund the Capital Account to meet demands.

### **8.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM**

Insufficient working capital is an on-going problem. Motivations have been made annually to augment the working capital in line with the inflationary price increase percentage for pharmaceuticals, taking into account the annual turnover of the CMD. The Capital Account was augmented by R4, 103 million during 2004/05 and it is anticipated that the R13 million shortfall will be addressed in due course. It is necessary that the working capital is augmented in line with turnover on an annual basis.

### **8.4 PLANNED QUALITY IMPROVEMENT MEASURES**

The upgrading of the CMD to comply with the Pharmacy Act is a priority and although essential is not funded in the 2005/6 year.

## **9. RESOURCE INFORMATION**

Programme 7 which reflects a disparate group of activities will have to be addressed in terms of adequate funding. Although a relatively small amount, consisting of approximately 5% of the total budget, key components require adequate funding in terms of priorities as set out in Healthcare 2010. In particular funding will have to be prioritised to deal with the likes of equipment for the strategic in-house laundry services, routine day-to-day maintenance and the augmentation of the CMD trading account working capital. With respect to the key issue of maintenance, the modelling on which Healthcare 2010 was based makes provision for adequate funding once the services have been restructured.

## PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

### 1. AIM:

To provide for new health facilities, upgrading and maintenance of existing facilities, including the Hospital Revitalisation Programme and the Hospital Infrastructure Grant.

### 2. PROGRAMME STRUCTURE

**Sub-programme 8.1: Community health facilities**

**Sub-programme 8.2: Emergency medical rescue**

**Sub-programme 8.3: District hospital services**

**Sub-programme 8.4: Provincial hospital services**

**Sub-programme 8.5: Central hospital services**

**Sub-programme 8.6: Other facilities**

Programme 8 includes: the management of capital assets, i.e. health facilities and equipment (medical equipment and furniture) in all programmes.

### ACCURACY OF INFORMATION

Where possible, audited or verified information has been used to calculate the values in the tables in this section. However, in many instances the calculations are based on estimates based on experience or trends. Further this programme was transferred from the Department of Transport and Public Works after a decision taken late in 2004. For this reason the plan reflected here is to an extent provisional and will be reviewed in detail during the 2005/6 financial year.

### 3. SITUATION ANALYSIS

The existing hospital infrastructure is not affordable. The original design capacity of the existing infrastructure is over 15,000 beds and the requirement for Healthcare 2010 is approximately 9,600 beds. Much of the theoretical excess of over 5,000 beds is located in dilapidated buildings or in institutions that are poorly located in terms of the population they serve and thus do not meet the accessibility and equity criteria for Healthcare 2010. A number of hospitals are on excessively large sites where the cost of securing and maintaining the sites is unaffordable.

In 1999, a Public Works survey estimated the backlog of maintenance and rehabilitation work at hospitals to be in the order of R500 million. The replacement value of the buildings was then estimated at R5 billion. Based on a maintenance budget of 4% of replacement cost, expenditure on maintenance should have been R200 million per annum (R300 million in 2004 rands). The fact that maintenance expenditure has been less than R200 million means that the backlog has grown since 1999. The growth is considerable if inflation is taken into

account and the backlog is now considered to be in the order of R750 million – this excludes any upgrading. An important feature of the Healthcare 2010 Infrastructure Plan is that some of the worst infrastructure will be disposed of, thereby reducing the backlog and simultaneously releasing available funding to upgrade the rest.

#### Rural hospital infrastructure

The rural hospital infrastructure is in relatively good condition. Much of the unsatisfactory infrastructure will be upgraded in the near future:

- The revitalisation of George, Worcester and Vredenburg Hospitals is proceeding well.
- The revitalisation of Paarl hospital is scheduled to commence in 2005/6.
- The major downscaling of Nelspoort Hospital and the renovation of the small remaining portion is in progress.

#### Metropole hospital infrastructure

In contrast to the rural hospital infrastructure, the Metropole hospitals are in poor condition and many are no longer fit for purpose in respect of condition, design and locality. During 2004 Conradie Hospital was finally closed with the transfer of services to Groote Schuur Hospital and the newly constructed Western Cape Rehabilitation Centre. The Healthcare 2010 Infrastructure Plan proposes the upgrading and/or replacement of many Metropole hospitals.

#### Equipment

There is an urgent need for the replacement of much of the hospital equipment. In the 2003/4 year a programme to replace defective and obsolete equipment was commenced. The programme has been assisted by donor funding (Red Cross hospital) and equipment supplied in terms of the Hospital Revitalisation Programme at the hospitals mentioned above. The need for new and replacement equipment is such that this programme will be on-going for many years.

## **4. POLICIES, PRIORITIES AND STRATEGIC GOALS**

It was decided at provincial level that the funding for the Works function for Health be transferred from the Department of Public Works to the Department of Health from 1 April 2005. The funding for the Property Management function (purchase, sale, rental and leasing of property) remains with Works. A Memorandum of Understanding must still be entered into between the Department of Transport and Public Works and the Department of Health in order to clarify the process according to which the reciprocal responsibilities of these departments will be defined.

The Department has prioritised the development of infrastructure in line with Healthcare 2010. Planning is in progress to begin construction of a district hospital to serve the community of Khayelitsha. Other current projects include Mowbray Maternity Hospital, Caledon and Riversdale Hospitals and the improvements to ambulance stations.

Finalisation of the service plan in line with Healthcare 2010 mentioned earlier will give further direction to the prioritisation of facilities that need to be upgraded, relocated or newly constructed.

The forensic mortuaries are in the process of being transferred from the South African Police Services to the Department of Health. The physical infrastructure needs to be upgraded to meet the requirements of the Occupational Health and Safety Act, for which conditional grant funding is being made available.

There are terms in the Pharmacy and Medicines Acts that relate to the infrastructure requirements. These requirements will become binding on the State as of 1 July 2005. These statutory requirements have significant financial implications and are presently unfunded.

The Department of Health has embarked upon a process to establish a Chronic Dispensing Unit to improve the provision of chronic medication. The infrastructure must be upgraded to accommodate this.

The Healthcare 2010 Hospital Infrastructure Plan (July 2004) outlines the way forward for the upgrading and replacement of hospitals. Similar infrastructure plans are being compiled for Primary Health Care facilities and Emergency Medical Services ambulance stations.

## **5. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM**

The improvement of physical facilities is heavily dependent on the success of the Hospital Revitalisation Programme. This programme got off to a slow start in all provinces but is now proceeding rapidly in the Western Cape. Every effort will be made to ensure the success of the present projects to ensure that the programme is eventually extended to include all hospitals.

Equipment maintenance is also a problem and steps have already been taken to strengthen Clinical Engineering. This includes improved salaries in an attempt to recruit and retain highly specialised personnel.

## **6. RESOURCE INFORMATION**

The funding of infrastructure is sourced from the Hospital Revitalisation Programme (HRP) conditional grant, the Provincial Infrastructure Grant (PIG), donor funding and the equitable share. Further the disposal of unwanted property will create the opportunity to further upgrade, construct and relocate hospitals and PHC facilities. As stated in the Healthcare 2010 document the Department estimates that within the funding likely to be allocated within the abovementioned funding streams and with judicious disposal of unneeded facilities and property that the infrastructure plan of the Department can be funded. This is, however, dependent on large capital projections such as the upgrading of Tygerberg Hospital, conservatively estimated at R800 million and others being fully funded through the Hospital Revitalisation Programme.

**Table B27: Provisional priorities for hospital revitalisation**

Priority	HOSPITAL	2010 Classification	2004 BEDS	2010 beds	Building ESTIMATE R'million	Start	End
1	George	Provincial	202	265	100		2006
2	Eben Donges	Provincial	213	315	160		2007
3	Vredenburg	District	56	80	60		2005
4	Paarl	Provincial	250	326	140	2005/6	2009
5	Khayelitsha	District	0	230	140	2006/7	2009
6	Mitchells Plain	District	0	230	120	2006/7	2009
7	Victoria	District	159	230	140	2007/8	2010
8	Hottentots Holland	District	121	230	140	2007/8	2010
9	Tygerberg	Central	1273	1081	400	2008/9	2014
10	Valkenberg	Psychiatric	385	315	100	2008/9	2012

**Notes on the above provisional priorities:**

1. The above priorities have been extracted from the 2004 Hospital Infrastructure Plan. This plan will be updated in 2005.
2. Estimates are for building costs only and exclude equipment
3. The estimate of R400 million for Tygerberg is the minimum necessary to upgrade the engineering services and renovate the building. Public Works have proposed a more extensive upgrading that could cost over R800 million. An audit of the hospital infrastructure will be done in 2005 to determine the condition and suitability of the hospital. The scope of work and a more accurate estimate of cost will be possible when the results of the audit are available.

## **9. CAPTIAL INVESTMENT, MAINTENANCE AND ASSET MANAGEMENT**

### **9.1 Management of the asset base**

In the Western Cape the Department of Transport and Public Works administers all Health land and permanent infrastructure in terms of the provincial Land Administration Act. This effectively makes the Head of the Department of Transport and Public Works the “owner” of all Health and land buildings. Health is defined as a “user” of these facilities. Previously the budget for the construction and maintenance of permanent physical infrastructure (land and buildings) was included in the budget of the Department of Transport and Public Works. The budget for construction and maintenance has been transferred to the Department of Health from 1 April 2005. The budget for the procurement and disposal of property remains with the Department of Transport and Public Works

### **9.2 Overview of the existing infrastructure**

The existing hospital infrastructure is not affordable. The original design capacity of the existing infrastructure is over 15,000 beds and the requirement for Healthcare 2010 is 9,577 beds. Much of the theoretical excess of over 5,000 beds is located in dilapidated buildings that are no longer fit for human habitation. Other excess beds are in institutions that are poorly located in terms of the population they serve and thus do not meet the accessibility and equity criteria for healthcare 2010. A number of hospitals are on excessively large sites where the cost of securing and maintaining these sites is unaffordable.

In 1999, Public Works estimated the backlog of maintenance and rehabilitation work at hospitals to be in the order of R500 million. The replacement value of the buildings was estimated at R5 billion. Based on a maintenance budget of 4% of replacement cost, expenditure on maintenance should be R200 million per annum. The fact that maintenance expenditure has been less than R200 million means that the backlog has grown since 1999. The growth is considerable if inflation is taken into account and the backlog is now considered to be in the order of R750 million – this excludes any upgrading. An important feature of the Healthcare 2010 Infrastructure Plan is that some of the worst infrastructure will be disposed of, thereby reducing the backlog and simultaneously deriving income to upgrade the rest.

#### **9.2.1 Rural hospital infrastructure**

The rural hospital infrastructure is in relatively good condition. It must be noted that much of the unsatisfactory infrastructure will be upgraded in the near future:

- Tenders for the revitalisation of George, Worcester and Vredenburg Hospitals have been awarded and construction has commenced.
- The revitalisation of Paarl hospital is scheduled to commence in 2005/6.
- The major downscaling of Nelspoort Hospital and the renovation of the small remaining portion is in progress.

### 9.2.2 Metropole infrastructure

In contrast to the rural hospital infrastructure, the Metropole hospitals are in poor condition and many are no longer fit for purpose in respect of condition, design and locality. The focus in Healthcare 2010 will from now on be the upgrading and/or replacement of Metropole hospitals.

### 9.2.3 Ambulance stations

Many of the ambulance stations are in poor condition and are in need of upgrading or replacement. Forty three percent of the ambulance stations are owned by municipalities. An Ambulance Station Infrastructure Plan has been drafted and the construction of new ambulance stations to replace those unfit for purpose will commence in 2005.

### 9.2.4 Primary Health Care (PHC) facilities

Many of the PHC facilities are in poor condition and are in need of upgrading. Seventy percent of the PHC facilities are owned by municipalities. A comprehensive PHC Infrastructure Plan is being drafted and will take into account the proposed shift of personal PHC to the Provincial Government.

## 9.3 **Strategic infrastructure plan**

A comprehensive Hospital Infrastructure Plan has been drafted for Provincial Hospitals.

The plans focus on the following priorities:

- 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

The following funding sources have been identified:

- Health capital
- Hospital revitalisation programme (HRP)
- Provincial infrastructure grant (PIG)
- Public private partnerships (PPP's)

The projections in the following table are provisional and may be reviewed.

**Table B28: Proposed new projects, upgrades and rehabilitation (R'000)**

New Projects	2004/05 (estimate)	2005/06 (budget)	2006/07 (projection)	2007/08 (projection)	2008/09 (projection)	2009/10 (projection)
<b>Programme 2</b>						
Khayelitsha Hospital	0	2,000,000	20,000,000	60,000,000	63,000,000	60,000,000
Mitchell's Plain Hospital	0	0	4,000,000	78,000,000	60,000,000	40,000,000
Helderberg Hospital	0	0	4,000,000	0	40,000,000	66,000,000
New Victoria Hospital	0	0	0		4,000,000	40,000,000
Browns Farm CHC	2,400,000	1 050,000	0	0	0	0
Simondium CHC	0	1,800,000	1,305,000	0	0	0
Stanford CHC	0	1,700,000	0	0	0	0
Swellendam CHC	500,000	2,400,000	0	0	0	0
Wellington CHC	600,000	1,500,000	3,100,000	0	0	0
Plettenberg Bay-Replacement Clinic Kwnaokuthula	0	0	0	2,000,000	0	0
Knysna – Replacement Clinic	0	0	0	3,500,000	0	0
Malmesbury-Wesbank New Clinic	0	0	0	3,000,000	0	0
Montagu chc	0	2,500,000	1,000,000	0	0	0
Gugulethu aids clinic	500,000	650,000	0	0	0	0
Robbie Nurock	0	0	2,000,000	3,000,000	0	0
GF Jooste-aids Centre	0	0	3,000,000	0	0	0
Table View-De Noon New Clinic	0	0	1,150,000	3,850,000	0	
New PHC facilities					7,000,000	9,000,000
<b>Programme 3</b>						
Hermanus – New ambulance Station	0	2,250,000	750,000	0	0	0
Heidelberg –New ambulance Station	0	0	1,500,000	0	0	0
Bonnievale-New ambulance station	0	0	0	1,000,000	0	0
Beaufort West-New Ambulance station	0	0	3,000,000	0	0	0
Atlantis Hospital - replace ambulance station	0	1,500,000				
Vredendal – New ambulance station					3,000,000	
Tulbagh – New ambulance station						1,000,000
<b>TOTAL (New projects)</b>	<b>4,000,000</b>	<b>17,350,000</b>	<b>44,805,000</b>	<b>154,350,000</b>	<b>177,000,000</b>	<b>236,000,000</b>

UPGRADING	2004/05 (estimate)	2005/06 (budget)	2006/07 (projection)	2007/08 (projections)	2008/09 (projections)	2009/10 (projections)
<b>Programme 2</b>						
Vredenburg Hospital	0	40,000,000	10,000,000	0	0	0
Mossel Bay Hospital	0	5,000,000	12,847,000	20,000,000	20,000,000	0
Beaufort West Hospital	200,000	0	0	0	0	0
Oudtshoorn hospital – medical depot	0	1,500,000	0	0	0	0



<b>UPGRADING</b>	<b>2004/05 (estimate)</b>	<b>2005/06 (budget)</b>	<b>2006/07 (projection)</b>	<b>2007/08 (projections)</b>	<b>2008/09 (projections)</b>	<b>2009/10 (projections)</b>
Gugulethu Aids Clinic	500,000	500,000	0	0	0	0
Ladismith Hospital	500,000	50,000	0	0	0	0
Vredendal Hospital	0	2,000,000	0	400,000	0	0
Caledon Hospital	0	5,000,000	3,000,000	0	0	0
Riversdal Hospital	0	2,000,000	10,000,000	0	0	0
Hermanus Hopital PPP	0	2,982,000	2,982,000	2,982,000	2,982,000	2,982,000
Delft-Upgrade Clinic	0	0	0	1,650,000	0	0
Eerste Rivier Hospital Stores	0	300,000	0	0	0	0
Eerste Rivier Hospital Casualty	0	6,000,000	0	0	0	0
Maitland-Upgrade Clinic	0	0	2,500,000	0	0	0
Elsies rivier clinic	0	1,200,000	2,135,000	0	0	0
Upgraded PHC facilities					8,000,000	8,000,000
<b>Programme 3</b>						
Stellenbosch Ambulance Station	0	0	600,000	0	0	0
Riversdale hospital-Ambulance station	0	1,000,000	0	0	0	0
Oudtshoorn hospital-Ambulance Station	0	0	1,000,000	0	0	0
Lentegeur hospital-Ambulance Station	0	500,000	1,000,000	0	0	0
Lambersts Bay hospital Ambulance station	0	0	300,000	0	0	0
De Doorns hospital-Ambulance Station	0	0	100,000	0	0	0
Citrusdal hospital Ambulance Station	0	30,000	0	0	0	0
Ceres hospital Ambulance station	0	200,000	0	0	0	0
Caledon Hospital-Ambulance Station	0	800,000	0	0	0	0
Bredasdorp hospital Ambulance Station	0	700,000	0	0	0	0
Swellendam Hospital Improve Ambulance Station	0	250,000	0	0	0	0
<b>Programme 4</b>						
George Hospital	56,721,000	40,000,000	20,000,000	0	0	0
Worcester Hospital	97,368,000	75,038,000	90,000,000	10,000,000	0	0
Paarl Hospital	0	15,000,000	62,474,000	90,987,000	90,000,000	0
Valkenberg Hospital Admissions	0	4,854,000	0	0	0	0
Valkenberg Hospital forensic wards	0	0	2,000,000	0	0	0
Stikland Hospital	0	3,500,000	0	0	0	0
Eben Donges Hospital	69,000,000	37,000,000	37,000,000	0	0	0
Caledon Hospital	0	3,000,000	4,000,000	0	0	0
Eerste River Hospital	0	6,000,000	0	0	0	0
Alexandra Hospital	0	0	2,000,000	10,000,000	10,000,000	0
Mowbray Maternity Hospital	0	19,163,000	10,000,000	0	0	0
Somerset Hospital Pharmacy	100,000	0	0	0	0	0
Valkenburg new admission ward	0	3,000,000	0	0	0	0
Brooklyn Chest hospital	0	0	5,000,000	10,000,000	20,000,000	5,000,000
Victoria hospital	0	0	4,000,000	24,750,000	0	0
Somerset Hospital (funded by property transaction)	0	0	20,000,000	40,000,000	40,000,000	10,000,000

<b>UPGRADING</b>	<b>2004/05 (estimate)</b>	<b>2005/06 (budget)</b>	<b>2006/07 (projection)</b>	<b>2007/08 (projections)</b>	<b>2008/09 (projections)</b>	<b>2009/10 (projections)</b>
<b>Programme 5</b>						
Tygerberg Hospital	0	0	0	16,880,000	20,000,000	20,000,000
Red Cross Hospital	0	0	0	4,000,000	4,000,000	21,000,000
Groote Schuur Hospital	0	0	0	0	0	10,000,000
<b>TOTAL (Upgrading)</b>	224,389,000	276,567,000	302,938,000	231,649,000	214,982,000	76,982,000

<b>MAINTENANCE</b>	<b>2004/05 (estimate)</b>	<b>2005/06 (budget)</b>	<b>2006/07 (projection)</b>	<b>2007/08 (projections)</b>	<b>2008/09 (projections)</b>	<b>2009/10 (projections)</b>
Community health facilities	0	5,370,000	8,015,000	9,130,000	10,000,000	11,000,000
District hospital services	0	8,723,000	13,019,000	14,830,000	16,000,000	16,000,000
Provincial hospital services	0	15,810,000	23,596,000	26,879,000	27,000,000	27,000,000
Central hospital services	0	15,000,000	22,387,000	25,879,000	30,000,000	33,000,000
Other facilities	0	3,635,000	5,425,000	6,180,000	6,000,000	6,000,000
<b>TOTAL (Maintenance)</b>	45,963,000	48,538,000	72,442,000	82,521,000	89,000,000	93,000,000
<b>Total as a % of the Departmental budget</b>	1,0	1	1,5	1,7	1,9	2,0

## **10. CO-ORDINATION, CO-OPERATION AND OUTSOURCING PLANS**

### **10.1 Interdepartmental linkages**

#### **10.1.1 Department of Social Services and Poverty Alleviation**

There is a formal liaison committee of members of the Departments of Health and Social Services that facilitates the management of the following matters:

- Evaluations for social disability grants: the requisite examinations are conducted at facilities managed by the Department of Health and in some instances Health is compensated for the practitioner's time.
- Caring for persons with profound intellectual disability.
- Licensing and inspections of facilities caring for patients suffering from substance abuse and licensing detoxification units.
- Community home-based care is a joint effort with the Department of Social Services.

#### **10.1.2 Department of Correctional Services**

- Prisoners are treated at Provincial Hospitals.
- Oral health services are rendered by dentists employed by the Department of Health.
- Payment for some of the services are recovered from Correctional Services.
- Service level agreements are being developed.

#### **10.1.3 Department of Justice**

Patients are admitted to State psychiatric hospitals to evaluate their competency to stand trial. The period of evaluation usually last thirty days.

#### **10.1.4 SAPS clinical forensic services**

Persons accused of drunken driving and also the victims of sexual abuse are examined by employees of the Health Department.

#### **10.1.5 Department of Education**

Together with the Department of Education, the Department of Health conducts lifeskills programmes, mainly to raise awareness around responsible sexual behaviour.

### **10.2 Local government linkages**

The main area of co-operation remains the provision of personal primary health care services.

### **10.3 Public entities.**

Not applicable to Health in the Western Cape.

## 10.4 Public, private partnerships, outsourcing, etc..

### 10.4.1 Public/Private Partnership (PPP)

The Department has not yet entered into PPP Concession Agreements. The following paragraphs provide an overview of current Public/private partnerships.

#### 1) **Hermanus Provincial Hospital**

The Hermanus Medi-Clinic, situated adjacent to the Hermanus Provincial Hospital, requires space to expand and therefore needs to acquire more land. The private party will, as part of the PPP, construct an additional ward on the land of the Public Hospital, and also design, build and maintain a Community Health Centre for the Provincial Hospital. Non-core services, i.e. catering, laundry, security, etc. will be shared between the parties, but procured and managed by the private party.

Concession Period: 15 years

Approximate Nett Present Value: R25, 2 Million per annum

#### 2) **Grassy Park**

The Private Party will be granted access and use of the portion of land not occupied by the Department of Health. The Department will have access and use of a Community Health Centre, which the Private Party will design, construct, build and maintain. It will also procure and manage the Facility Management of the Community Health Centre.

The Department awaits the finalisation of the rezoning process of the allocated portion of land and therefore no value has been determined. A Feasibility Study will be conducted once rezoning has been completed.

#### 3) **Swellendam**

The Private Partner will be granted the right to establish a Private Health Facility on the premises of the Provincial Hospital. The Private Party will procure, maintain the building and manage non-core and other related services, which will be shared between the parties.

Concession Period: 12 years

Approximate Nett Present Value: R3, 5 Million per annum

#### 4) **Western Cape Rehabilitation Centre (WCRC)**

The Private Party will render hard and soft Facility Management Services, being the maintenance of buildings and plant equipment and the provision of non-core services such as catering, cleaning and gardening services respectively.

Concession Period: 12 years

Approximate Nett Present Value: R31, 7 Million per annum

#### 5) **Eersteriver**

Facility Management Project including hard and soft Facility Management being the maintenance of buildings and plant equipment and the provision of non-core services such as catering, cleaning and gardening services respectively.

Concession Period: 12 years

Approximate Nett Present Value: R125, 736 Million (over concession period)

## 10.4.2 List of outsourced contracts

Name of Institution	Nature of Service/Value	Period of Contract	Current Contract Dates	Contract Commenced	Delegation
Alexandra	Pest Control	1 Year	01.04.03 - 31.03.04	01.03.02-30.04.03	APH
Alexandra	Gardening	1 Year	01.01.04 - 31.12.04	01.12.02-30.11.03	APH
Alexandra	Sanitation	1 Year	01.05.03 - 30.04.04	01.03.02-30.04.03	APH
APH Region	EAP Service	2 Years	01.09.03 - 31.08.05	01.07.02-31.08.03	APH
Lentegeur	Cleaning	2 Years	01.10.02 - 30.09.04	01.10.00-30.09.02	APH
Lentegeur	Cleaning	2 Years	01.10.03 - 30.09.04	01.06.96-30.09.00	APH
Lentegeur	Gardening	1 Year	01.04.03 - 31.04.04	01.04.02-31.03.03	APH
Stikland	Gardening	1 Year	01.08.03 - 31.07.04	01.06.02-31.05.03	APH
Valkenberg	Gardening	1 Year	01.10.03 - 30.09.04	01.10.02-30.09.03	APH
Valkenberg	Pest Control	1 Year	01.09.03 - 31.08.04	01.09.02-31.08.03	APH
Valkenberg	Waste Removal	1 Year	01.09.03 - 31.08.04	01.09.02-31.08.03	APH
Brewelskloof	Cleaning	1 Year	31.10.03 - 31.09.05		Boland/Overberg
Caledon	Cleaning	1 Year	01.01.04 - 31.12.05		Boland/Overberg
Eben Donges	Cleaning	1 Year	01.01.01 - 31.12.04		Boland/Overberg
Eben Donges	Cleaning	1 Year	01.01.04 - 31.12.04		Boland/Overberg
Robertson	Cleaning	1 Year	01.11.03 - 31.10.05		Boland/Overberg
Worcester GGS40	Cleaning	1 Year	01.07.02 - 30.06.04		Boland/Overberg
Montague	Cleaning	2 Years	01.02.02 - 01.02.04		Boland/Overberg
Ceres	Laundry	2 Years	01.04.02 - 31.03.04		Boland/Overberg
	Laundry	2 Years	01.04.02 - 31.03.04		Boland/Overberg
Groote Schuur	Porter	6 Months	01.12.03 - 31.05.04	n/a	Groote Schuur
Groote Schuur	Transport	1 Year	01.04.03 - 31.03.04	01.04.02 - 31.03.03 GSH 7/2000 earliest tender no.	Groote Schuur
Eben Donges	Laundry	5 Years	01.06.03 - 31.05.08	n/a	Head Office
Robertson				01.01.00 - 31.12.02	
Montague				01.01.00 - 31.12.02	
Alexandra	Security	1 Year	01.09.02 - 31.05.04	n/a	Head Office
Lentegeur	Security	2 Years	01.07.02 - 31.05.04		Head Office
Mowbray Maternity	Security	1 Year	01.09.02 - 30.08.03		Head Office
Stikland	Security	1 Year	01.07.02 - 31.05.04		Head Office
Valkenberg	Security	1 Year	01.07.02 - 31.05.04		Head Office
Tygerberg Laundry	Service of Washer	2 Years	01.07.02 - 31.12.04		Head Office
Karl Bremer	Gardening	1 Year	01.04.03 -	n/a	Karl Bremer

<b>Name of Institution</b>	<b>Nature of Service/Value</b>	<b>Period of Contract</b>	<b>Current Contract Dates</b>	<b>Contract Commenced</b>	<b>Delegation</b>
Karl Bremer	Laundry	1 Year	01.10.03 -		Karl Bremer
Karl Bremer	Waste	1 Year	01.02.03 - 31.01.04		Karl Bremer
Karl Bremer	Transport	2 Years	01.01.03 - 31.12.05		Karl Bremer
Metropole Reg. Office	Cleaning	1 Year	01.07.02 - 30.06.04	n/a	Metro
Paarl	Patient Transport	2 Year	01.02.04 - 31.01.06	01.06.01 - 31.07.03	Westcoast/ Winelands