GAUTENG HEALTH DEPARTMENT

DEPARTMENTAL STRATEGIC PLAN

Draft 2

2003-2004

10 December 2002

Part A. Strategic overview

Part B. Budget programme and sub-programme plans

2.4 District Hospitals

3. Emergency medical services

4. Provincial hospital services

4.1 General (Regional) hospitals

4.2 Tuberculosis hospitals

4.3 Psychiatric hospitals

4.4 Chronic medical/Dental training hospitals/Other specialised services

5. Central hospital services

5.1 Garankuwa Hospital

5.2 Pretoria Academic Hospital

5.3 Chris Hani Baragwanath hospital

5.4 Johannesburg hospital

6. Health Sciences and training

7. Health Care Support Services

8. Health facilities management

Part A. Strategic overview

1. FOREWORD BY THE EXECUTIVE AUTHORITY

FOREWORD BY THE EXECUTIVE AUTHORITY

It is my pleasure to introduce the Departmental three-year strategic plan for the Medium Term Expenditure Framework. This plan is guided by the priorities of the National Health Ministry and the Provincial Government. The plan also takes account of the inter-sectoral priority programmes, thereby ensuring that services are integrated and co-ordinated for easy access by communities and that we optimise the benefits of available public resources.

Health is an investment in our human resources and is conditionality for sustainable social and economic growth. Working together with other departments, the Department's vision of *Health for a Better Life* is geared towards improving the productivity and quality of the provincial human capital, and optimising the health status and life expectancy of our residents. The public health system remains the provider of the vast majority of people, with more than 9 million visits made annually to our primary health care clinics. The 28 provincial hospitals run a total of 16 020 approved beds, of which 2 587 are in specialised hospitals for psychiatric care, rehabilitation or infectious diseases. Collectively, these hospitals admit 643 377 patients, with an additional 4.1 million visits made to outpatient and emergency departments.

Although Gauteng has one of the highest expenditure per capita for health, the health profile of the province indicates that the greatest burden of disease remains those related to poverty and lifestyle of developing communities. This is as a result of the inherited inequity and inappropriateness of services, which were hospital biased. Our primary aim is to intercept and reduce the poverty cycle by targeting those most vulnerable to illness: historically disadvantaged communities, children, women, disabled people and the elderly.

We have identified various strategic objectives to tackle priority areas that would enhance the health status of the people in Gauteng. These include:

1. Maintaining health and preventing diseases through activities such as good nutrition, immunisation programmes and health education. A major focus will be on expanding and strengthening existing programmes for maternal and child care. Examples include the Kangaroo Programme to enhance the survival of the new born babies, the Integrated Management of Childhood Diseases (IMCI) strategy, Antenatal Care services for pregnant mothers and integrated nutrition programme focusing on crèches, primary school children at risk and children at risk for protein energy malnutrition.

2. Detecting disease development early and preventing the spread of the diseases by screening those at risk for cervical and breast cancer. Support of victims of trauma and violence will receive a special focus to ensure that effective counselling and rehabilitation enable the survivors to attain optimal mental and physical rehabilitation.

3. Reducing the burden of diseases of lifestyle e.g. hypertension, diabetes through health promotion, appropriate screening and effective interventions that will enhance optimal functionality. More support will be provided at district level for the management of chronic illnesses including mental health care. Our aim is to ensure that we prevent complications such as heart attacks, strokes, blindness and other disabilities.

4. Consolidating programmes that will limit the impact of communicable diseases: tuberculosis, sexually transmitted disease and HIV/AIDS. Our focus areas will be to strengthen the intersectoral, inter-governmental local programmes for HIV/AIDS, the prevention of new infections, the improvement of treatment of opportunistic infections and

home-based care. The prevention of Mother -to- Child Transmission programme will be an intervention in this MTEF. This programme will be an overall part of strengthening our maternal and child health services.

The clinical and professional expertise in our health services is as important as the hospitality and support services in ensuring excellent high quality client centred care. The Quality Assurance Programme, which includes setting provincial norms and standards and an Accreditation System to assess compliance, affirms our commitment to the National Patients Right Charter and the Departmental Service Pledge. While the patient complaints procedure is now formalised, our continued focus is to ensure that our regions and institutions have taken steps to make the complaints system more user friendly and to strengthen the hand of the consumer. The role of the Clinic Committees and Hospital Boards in the programme as well as the link with the Performance Management System will receive greater attention.

The progress made with the decentralisation of authority to regions and institutions necessitates a greater focus on our monitoring and support systems. This MTEF will see dedicated efforts to strengthen Primary Health Care services, both at clinic, health centre and district levels. The process of devolution of the District Health Services and the Transformation of Emergency Services also requires that the monitoring and support system should be extended to local government which will be playing an important role in these areas through service level agreements. Greater emphasis will be on making the services more responsive, more accountable and more appropriate to communities whilst taking full advantage of areas where we can attain benefits from economies of scale, equity and value for money.

Our staff remains our most important resource. In this MTEF period, more focussed attention will be placed on workplace health and safety programs. Staff retention programme will be implemented with a special emphasis on those categories with scarce skills. We will continue to provide a staff development and training program linked to our priority services as well as administrative, support and management areas.

Given the budget that is linked to the departmental outputs and specific targets, the strengthening of financial management systems, controls and capacity building will continue. The overall management information system will be integrated to monitor continuous progress and trends in complying with various policy and legislative requirements.

There are still many challenges ahead, given the inherited poverty in our communities as well as inequity and backlogs in the available services. The policy thrust of strengthening primary health care, stabilising hospital services with a focus on regional hospitals and restructuring of the emergency medical services remains. Underpinning our service improvement plan is ensuring that the standard of quality and client focus remains high on our agenda at all levels.

Building on the partnerships with the non-governmental organizations, the private sector and leaders of community institutions in our province, I remain optimistic that the goals we have set for ourselves are necessary, affordable, and achievable. These goals can be attained with the support of our managers, professionals and support staff in our service. The Khanyisa Awards for service excellence will continue to acknowledge that consistent progress is being attained in the interest of *Health for a Better Life* for our clients. We remain committed to building on the achievements made.

FOREWORD BY THE HEAD OF THE DEPARTMENT

Building on achievements

The Gauteng Department of Health employs more than 40 000 people and has a budget of R7.2 billion: almost a third of the budget of the entire province. Our Province is the economic heartland of the country, and any developments, including those in the health sector, have major strategic significance for our country and beyond. Our primary constituency is vulnerable and poor communities, whose lives are most adversely affected by preventable diseases, including HIV/AIDS. Our services aim to reach the broad citizenry of Gauteng with a range of interventions that include health promotion and public health programmes to influence lifestyle and behaviour change, primary health care, hospital and emergency medical services and a vast range of clinical and non-clinical support services.

This strategic plan, covering the period of Medium Term Expenditure Framework gives us the opportunity to re-commit ourselves to the vision of *Health for a Better Life.* In the accompanying strategic plan, we re-commit ourselves to the goals of improving the health status of the people of Gauteng, quality health service provision and ensuring value for public monies received.

The strategic planning process is ongoing and commenced with the second term of government and the new legislative framework. In 1999, the Department of Health identified its priorities for the five-year term of governance. The priorities were influenced by:

- The priorities of the National Department of Health;
- The Provincial Cabinet priorities;
- Key health problems and challenges for the health sector;
- Existing and proposed legislation.

We have made progress in developing strategic plans, linked to budgets. All our senior managers have been involved in the process of revising this MTEF strategic plan, and this process was cascaded to the district and hospital level. The information from our service delivery units fed into a two-day strategic planning retreat of senior managers in August 2001 to discuss the details of the strategic plan. The broad outcomes of the retreat were communicated to all managers during August and September 2001, and each division, region and service delivery unit had to produce outputs linked to the strategic objectives.

Our environmental analysis and review shows that while there has been progress on all fronts, this progress must be seen within the context of a relentless HIV/ AIDS epidemic, inherited inequities and the difficulties of balancing needs, the expectations of the public at large and resource availability in general.

Our values, key priorities, strategies and resource requirements are outlined in this strategic plan. Intensive and on-going support for the HIV/AIDS expanded programme will remain a key focus for the period of the MTEF, in partnership with other government departments and all relevant stakeholders. We will continue to focus our attention on health programmes that have the greatest impact on health. This requires the strengthening of all management systems in the Gauteng Department of Health, service delivery and our ability to monitor and evaluate. Key prerequisites for our ability to mitigate the effects of AIDS are management commitment and involvement as well as dedicated financial resources.

Quality healthcare is of great significance in the healthcare sector, and will remain a strategic priority for the MTEF period. We will also aim to maximise revenue from patient fees, through the implementation of a shared debt management centre. Special efforts will be made

to reduce the backlog of infrastructure and equipment, but this requires significant funding. The success of all the programmes of the Gauteng Department of Health is dependent on access to comprehensive, accurate health information. A minimum set of management information will therefore be a major priority.

Lastly, specific interventions to facilitate a supportive staff environment to ensure productive and satisfied employees will be embarked on. These are detailed in the main report.

Our senior managers have worked around the clock to finalise the strategic plan, which would not have been possible without their hard work, dedication and loyalty.

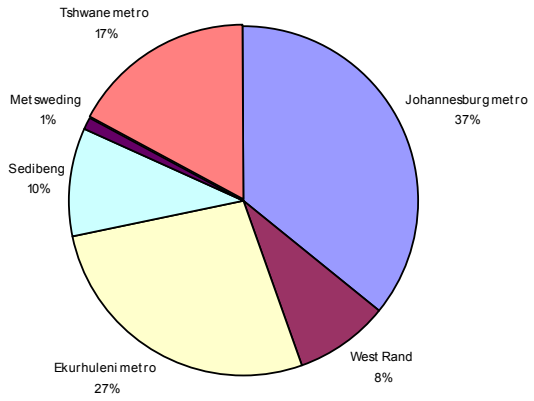
We look forward to a renewed commitment to service excellence, tackling the challenges of the HIV/AIDS epidemic, improved quality of care and improvement in management systems. We approach the period of the MTEF with enthusiasm and with the knowledge that the Gauteng Department of Health is well positioned to tackle the numerous challenges and opportunities.

3. SECTORAL SITUATION ANALYSIS

3.1 Demographic and Health Profile

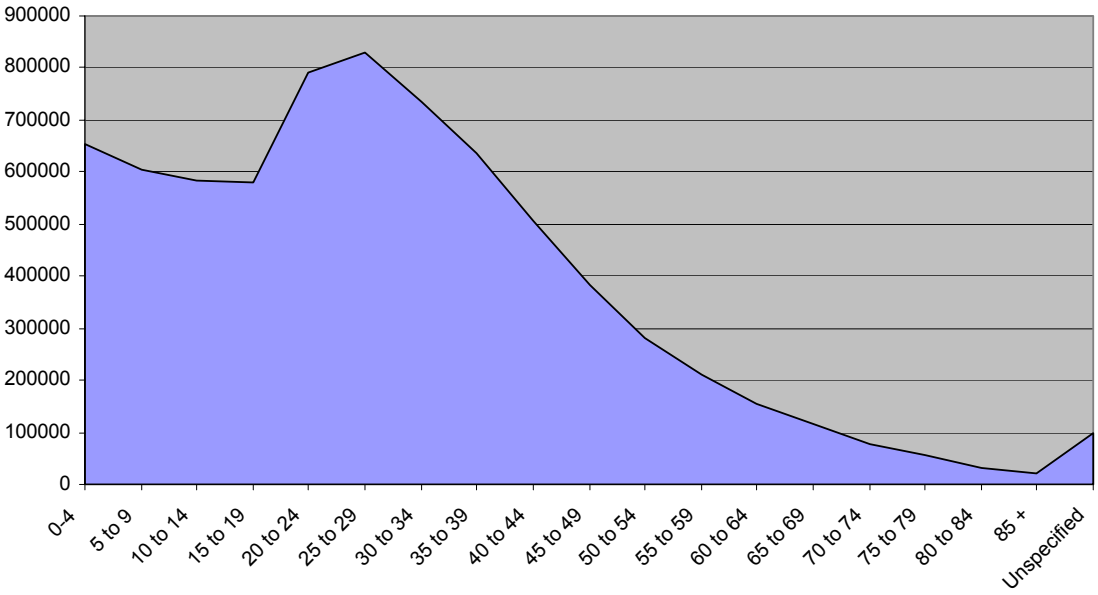
Gauteng has a total population of 7 367 333 within the area of 16 952 478 59 sq kilometres (km²). Ninety seven percent of Gauteng population are living in urban areas and 3 % in non-urban areas comprising of high concentration of Africans (70%) and whites (23%). Population distribution varies in different districts, Fig 1 show a high concentration of population in Johannesburg Metro (37%) and Ekurhuleni Metro (27%) followed by Tshwane Metro (17%). Gauteng has 73.3% of the uninsured population

Fig 1: Gauteng Total Population per District



Gauteng has proportionately more people (69%) in the economically active age groups (15-64 yrs), compared to the national average (60%). Only 25% of the population constitute the less than 15 years age group, compared to 34% for South Africa as a whole. This reflects the more advanced phase of the demographic transition in Gauteng where the total fertility rate has decreased from 3 in 1991 to 2.3 in 1998, compared to the South African rate that has decreased from 3.3 in 1991 to 2.9 in 1998. It is also a reflection of adults migrating into the province in search of employment.

Fig 2: Gauteng Age Distribution Population 1996

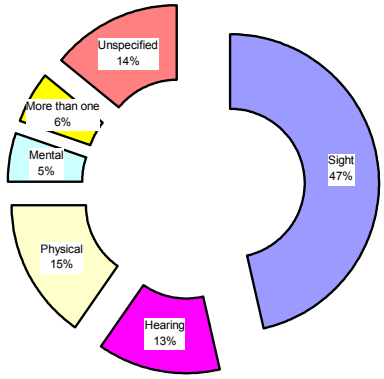


Twenty five percent of households in Gauteng live in informal housing while only 58.8% (1998) have access to potable water inside their homes. Approximately 1% of the households did not have access to toilets (SADHS).

The effects of urbanisation, unemployment and social dislocation increases the risks for the spread of sexually transmitted infections (STI) and HIV infection, interpersonal violence, substance abuse, poverty related diseases and chronic diseases related to lifestyle, as well as mental illness.

As indicated in fig 3, approximately 6% of Gauteng population has disabilities with high percentage of population with sight disability followed by physical and hearing disabilities.

Fig 3: Gauteng Disabled population



3.2 Epidemiological profile

Child health

The infant mortality rate for Gauteng has decreased from 49 per 1000 live births in 1990 to 36.3 per 1000 live births in 1998. This trend may be reversed in the light of the HIV epidemic

The Expanded Programme on Immunisation (EPI) has markedly reduced the risk of children dying from vaccine preventable conditions. The immunisation coverage for children less than 1 year of age has increased from 72.4% in 1998 to 76% in 2001. A target of 80% has been set for 2003. **Twenty Acute Flaccid Paralysis (AFP)** cases were detected between January and November 2002. An EPI coverage survey is planned for the first six months of 2003 to measure coverage more accurately.

Saving babies: the Perinatal Mortality Reduction Prevention Programme

The 2001 facility based second Perinatal care survey of South Africa showed a peri-natal mortality rate of 38 per 1000 deliveries and low births weight rate of 21.8% in the Gauteng province. The implementation of the Perinatal Problem Identification Programme (PPIP) in the province is a priority to reduce preventable causes of perinatal morbidity and mortality. The programme has been implemented at the Chris Hani Baragwanath, Johannesburg, Pretoria Academic, Leratong, Sebokeng and Tembisa Hospitals (six sites). The Kangaroo mother care ward aimed at reducing neonatal deaths is being implemented in eight health facilities. 15 health workers were trained in Human Genetics.

Prevention of maternal mortality

The 2001 Perinatal care survey show a maternal mortality ratio of 133 per 100 000 live births. The table below show an increased numbers of reported maternal deaths from 164 in 2000 to 202 in 2001 with 5.6 deaths per 100 000 female population and 133 deaths per 100 000 live births. The

major direct cause of deaths has been identified as hypertension in pregnancy and obstetric haemorrhage of death, with a decrease of early pregnancy related deaths due to ectopic pregnancies and septic abortions from 11.6% in 1998 to 6% in 2000.
The total of 194 935 live births, (13.9%) of the total national births registration) have been registered for Gauteng province during 2001.

Table 1: Gauteng maternal deaths trends 1998-2001

	1998	*1999*	*2000*	*2001*
Deaths	***131***	***138***	***164***	***202***
Deaths per 100 000 Female pop	***3.63***	***3.82***	***4.55***	***5.6***

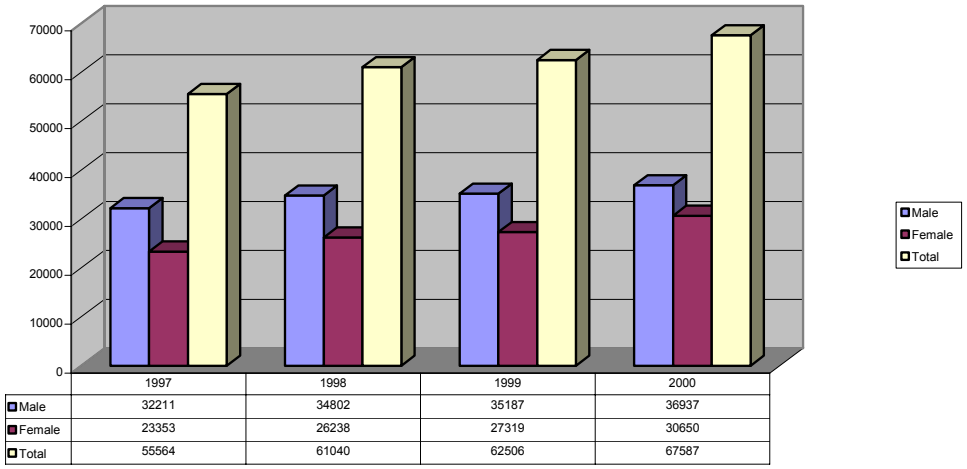
A high percentage (94.8%) of women received antenatal care by trained health workers and 94% of women delivered in a health facility.

Deaths rate

The crude death rate of Gauteng 1994 was 6.1 for every 1000 people. In 1997, the life expectancy at birth for Gauteng was 65.8 years (South Africa: 64.4 years).

Deaths registration indicate that Gauteng deaths has increased from 754 deaths per 100 000 population in 1997 to 917 deaths per 100 000 population in 2000. There is an increased deaths amongst males as compared to males as indicated in fig 4. Between 1997 and 2000 the deaths leading former magisterial districts has been identified as Johannesburg, Pretoria, Vanderbijlpark, Brakpan, Krugersdorp and Heidelberg

Fig 4:Gauteng recorded deaths 1997-2000



	1997	1998	1999	2000
Male	32211	34802	35187	36937
Female	23353	26238	27319	30650
Total	55564	61040	62506	67587

Our improved water, sanitation and access to health services has led to the decline of infectious diseases of childhood as the major cause of death. The major causes of death, disability and illness now are shown to be chronic diseases and trauma / violence-related injuries; with deaths due to AIDS projected to overtake these causes in the near future. Mental illness is recognised internationally and nationally as a major cause of illness and social disability.

3.3 Broad public health service structure and extent of private health sector activity

Growth in utilization and access to Primary Health Care has increased by 43% from 9640812 in 2000 to 13 755 883 in 2001.

There are **four cross-borders areas in Gauteng Province** – two large areas cross borders with North West Province –one in City of Tshwane with Odi/Moretele and Mabopane(NW) and the other in West Rand District Council area with Fochville and Wedela(NW). The other two areas are small and borders with Mpumalanga, namely Etwatwa Ext 17 (Ekurhuleni) and Ekangala (Metsweding). Work has been done to determine an overall framework for cooperation in these cross-boundary municipalities.

Table: Fixed public primary health care facilities (clinics plus community health centres)[1]

PHC facilities[1]	Health District	Fixed PHC facilities[1]	Mobile clinics	Population per facility
Province wide	6	266	107	27697
Least served health district	Sedibeng District Council	32	12	280018
Best served health district[2]	Metsweding District Council	7	8	12559

1. Include both provincial and Local Authority PHC facilities

The 28 provincial hospitals run a total of 16 744 approved beds, of which 2 587 are in specialised hospitals for psychiatric care, rehabilitation or infectious diseases. Collectively, these hospitals admitted 710 689 patients in 2001/2002 and delivered 117 768 babies. An additional 4.1 million outpatient visits were made to these institutions of which approximately 964 043 visits were for emergency care (casualty visits).

Table: Public hospitals

Hospital type	**Number**	**Number of beds**	**Beds per 1000 population[1]**	**Beds per 1000 uninsured people[2]**
District[3]	8	1257	0.170	0.231
General (regional)	11	6767	0.864	1.171
Central	4	6532	0.886	1.201
Sub-total acute hospitals	23	14157	1.921	2.603
Tuberculosis	1	220	-	-
Psychiatric	3	2367	-	-
Chronic medical and other specialised	1	220	-	-
Sub-total	**28**	**16744**	**-**	**-**
Private Aided /Contracted hospitals **(Tuberculosis)**	6	1495	**-**	**-**
Private Aided/ Contracted hospitals **(Psychiatric)**	8	3500	**-**	**-**
Private Aided Contracted hospitals Sub-total	**14**	**4995**	**-**	**-**
Grand Total	**42**	**21 739**	**-**	**-**

Population based on 1996 census (Difficult to determine resident people for Gauteng)
Uninsured people based on 1996 census population

3.4 Public health personnel

The numbers of public health personnel and vacancy rates by main category are indicated below: There is an indication of high vacancy rate (36.3%) for clinicians as compared to 7.7 % for nurses.

Table: Public health personnel[1]

Categories	Number employed	% of total number employed	Number per 1000 population[1]	Number per 1000 uninsured people[2]	Vacancy rate	% of total personnel budget	Average annual cost per staff member
Medical officers	2023	4.5%	0.275	0.372	**36.3%**	#	#
Medical interns	644	1.4%	0.087	0.118			
Medical specialists	1975	4.4%	0.268	0.363			
Dentists/Dental specialists	243	0.5%	0.033	0.045			
Professional nurses	8631	19.1%	1.172	1.587	**7.7%**		
Staff nurses	2352	5.2%	0.319	0.433			
Nursing assistants	5609	12.4%	0.761	1.031			
Student nurses	1794	4.0%	0.244	0.330			
Senior Manager	**54**	0.1%	----	----	**3%**		
Managers (levels 9-12) excluding prof. group	**184**	0.4%	----	---	**27.4%**		
Allied health professionals and technical staff[3]	2136	4.7%	0.290	0.393	**38.4%**		
Administrators and support staff (levels 1-8)	**19537**	43.2%	----	----	**14%**		
Total	**45182**	100	6.133	8.308			

1. Population based on 1996 census (Difficult to determine resident people for Gauteng)
2. Uninsured people based on 1996 census population
3. This group comprises 'health therapists' (e.g. physiotherapists, speech therapists, occupational therapists, clinical psychologists, radiographers, environmental health officers) and specialised auxiliary service staff and pharmacists

Data still being verified

3.4 Trends in provincial public health expenditure

The trends in provincial public health expenditure in both current and constant prices are indicated below:

Table: Trends in Provincial public health expenditure in current prices (R million)

Expenditure	1996/97	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06
	Actual	Actual	Actual	Actual	Actual	Actual	Estimate	Budget	MTEF projection	
Total	4,643,129,118	2995, ,177,317	5,476,218,244	5,776,464,898	5,942,207,983	6,837,575,624	7,468,044,000	7,845,239,000	8,306,592,000	8,770,545,(
% of total spent on										
- DHS	15%	15%	18%	19%	25%	22%	23%	24%	25%	2
- PHS	23%	27%	24%	23%	20%	18%	27%	27%	26%	2
- CHS	55%	55%	54%	53%	50%	47%	36%	36%	35%	3
- Personnel	60%	59%	60%	41%	57%	54%	52%	55%	55%	5
Total Capital	130,503,619	164,325,829	169,728,777	229,946,749	253,929,392	530,014,659	744,862,000	540,448,000	510,942,000	532,681,(
Health as total % of total public expenditure										

1. The trends show an increase in the amount spend on Primary Health Care Services

2. Similarly the spending on Central hospital services shows a decrease while the budget for Provincail health services remains constant

Table: Trends in Provincial public health expenditure in current prices (R million)

Expenditure	1996/97	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03	Average Annual change (%)	2003/04 (budget estimate)
	Actual	Actual	Actual	Actual	Actual	Actual	Estimate		
Total	10,815,421,841	10,070,225,178	9,272,767,199	8,674,244,339	8,245,479,410	7,823,035,493	7,401,168,868	#	7,845,239,000
Total per person	1,387	1,291	1,189	1,112	1,057	1,003	949		1,006
Total per uninsured person								#	

 # Data still being verified

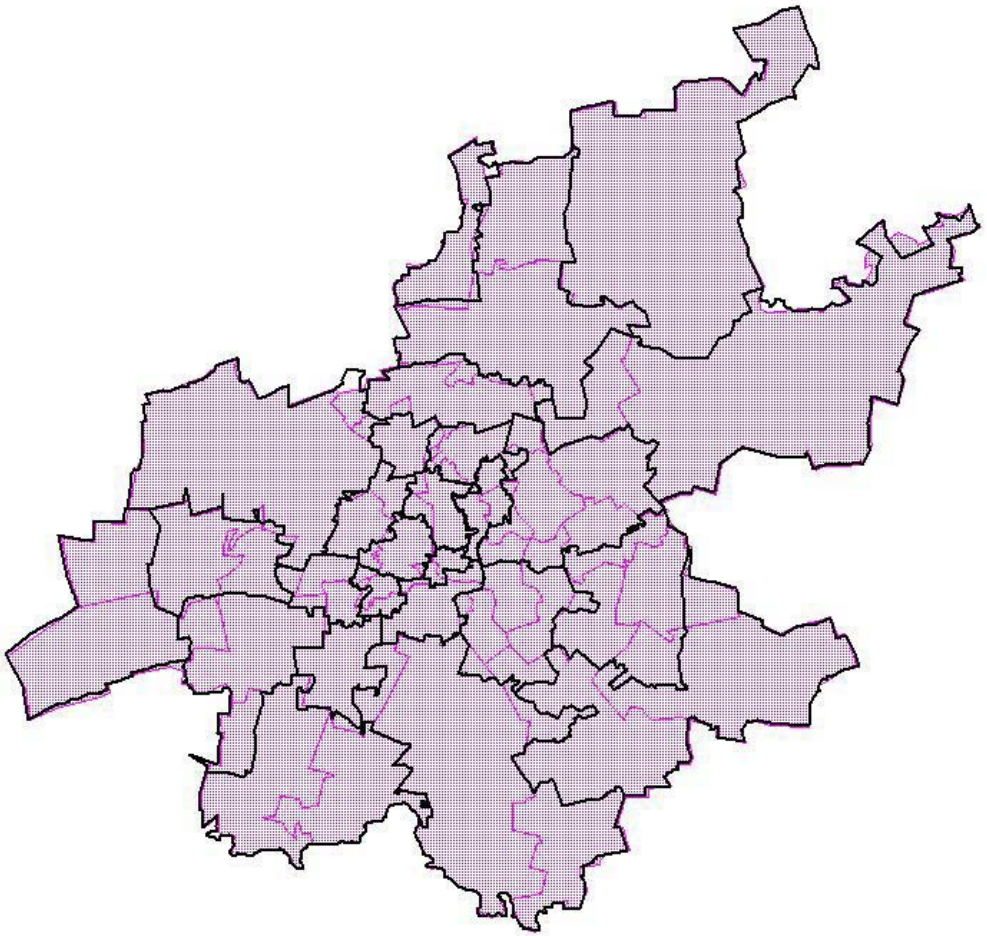
Polpulation =7,8 million according to 2002-2003 Budget Statement 1

CPI according to the Reserve Bank	CPI	CPIX
	1996	7.4%
	1997	8.6%
	1998	6.9% 7.0%
	1999	5.2% 6.90%
	2000	5.4% 7,80%
	2001	5.7% 6.60%
	2002	6.0%

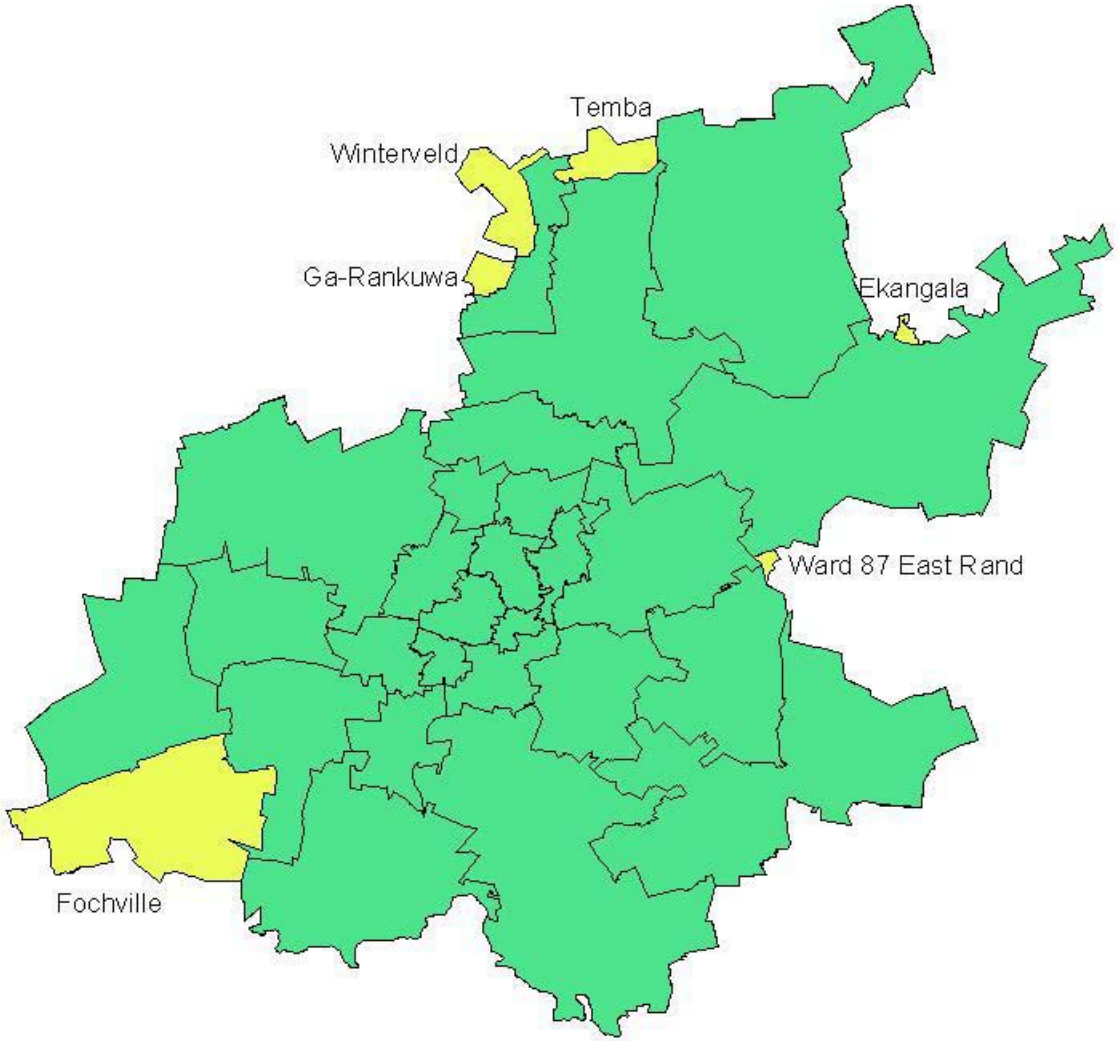
3.6 Health District Geographical Information system

Comparison between old (in violet) and new (in black) Gauteng Health Districts

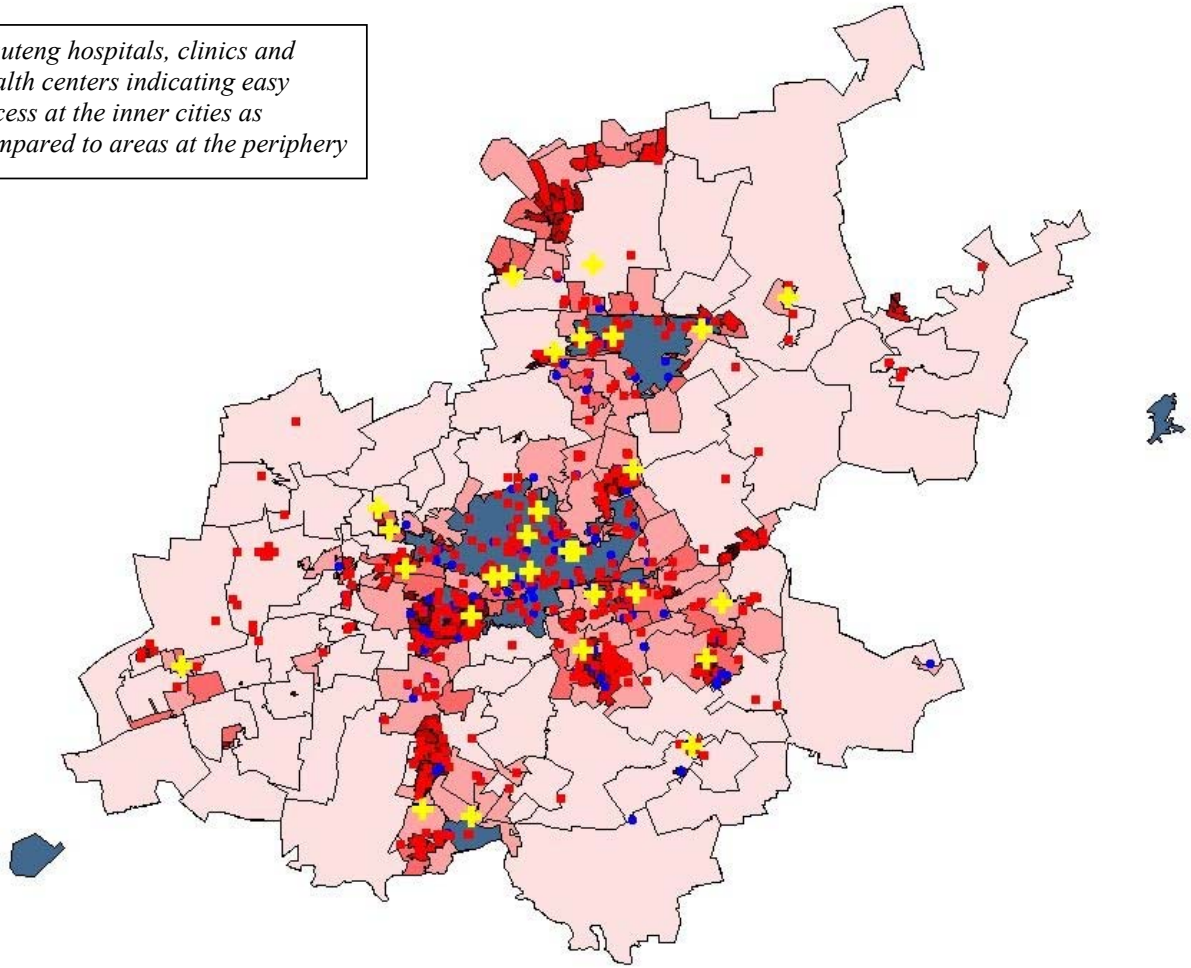
Note that boundaries cannot fit into each other, data collected according to the old district cannot fit in the new districts



Cross boundary zones (outside Gauteng, but belonging to Gauteng municipalities)

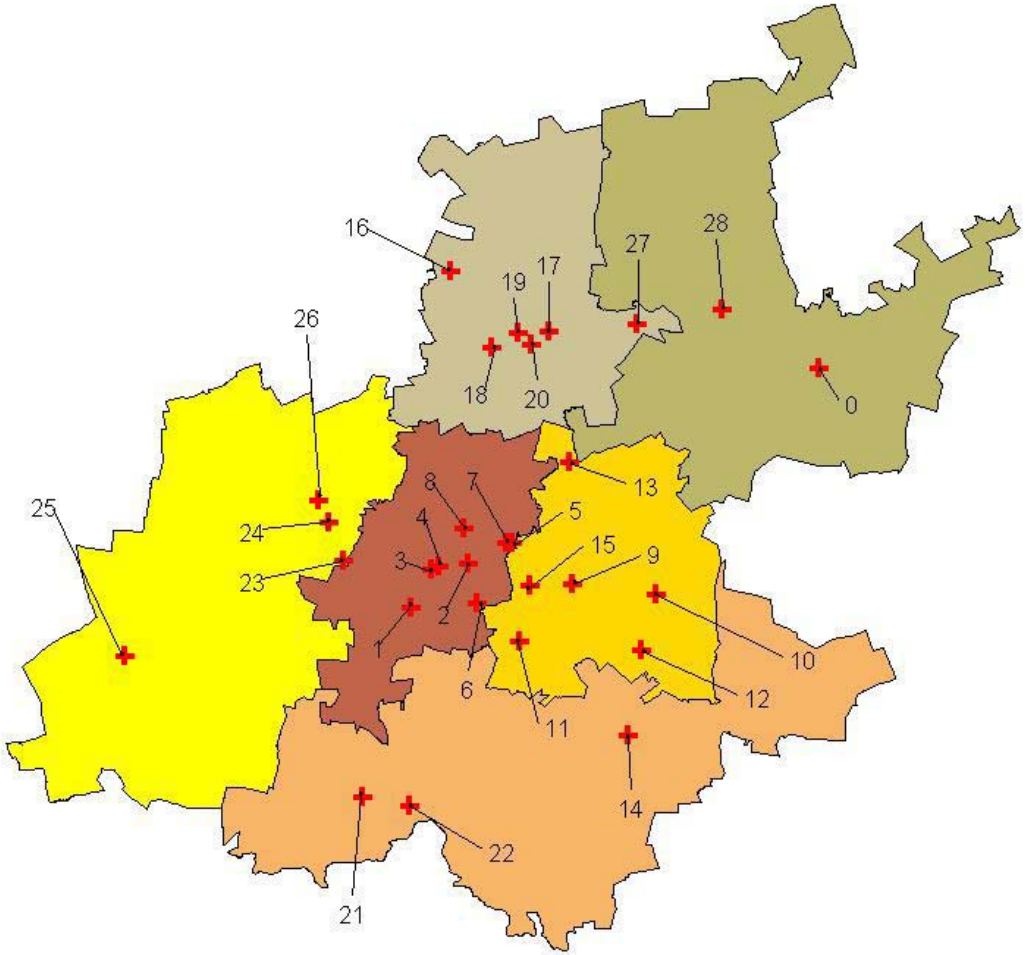


Gauteng hospitals, clinics and health centers indicating easy access at the inner cities as compared to areas at the periphery



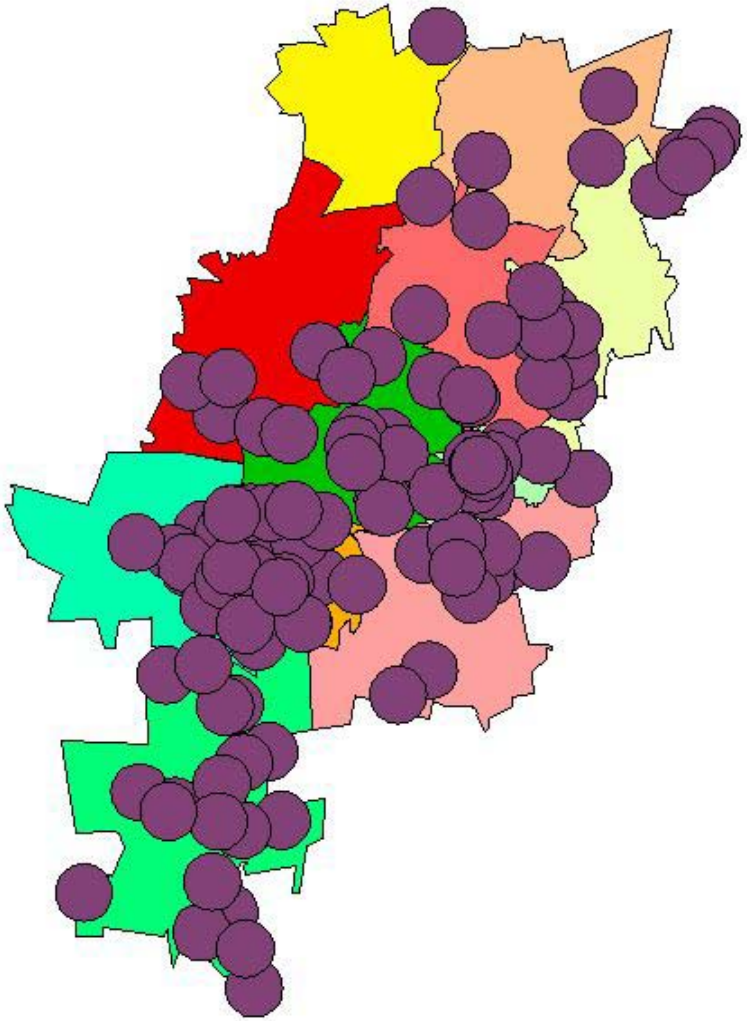
Gauteng Hospitals

1 ChrisHaniBara
2 Johannesburg
3 Coronation
4 Helen Joseph
5 Edenvale
6 South Rand
7 Sizwe Tropical
8 Tara H Moros
23 Leratong
24 Dr. Yusaf Dad
25 Carltonville
26 Sterkfontein
9 Tambo Memor
10 Far East Rand
11 Natalspruit
12 Pholosong
13 Tembisa
14 Heildelburg
15 Germiston
21 Sebokeng
22 Kopanong
27 Mamelodi
28 Cullinan
16 Ga-Rankuwa
17 Pretoria Acade
18 Kalafong
19 Pretoria West
20 Weskoppies
0 Bronkhorstspru



Central Wits

This map indicate Gauteng catchment areas and high concentration of facilities in the inner cities. This is an example to indicate the situation that makes it impossible to determine population per facility



2Km Buffer

Central Wits

- Johannesburg 5
- Johannesburg 1
- Johannesburg 10
- Johannesburg 11
- Johannesburg 2
- Johannesburg 3
- Johannesburg 4
- Johannesburg 6
- Johannesburg 7
- Johannesburg 8
- Johannesburg 9

N

W E

S

10 0 10 20 30 40 50 60 Kilometers

Department: Gauteng Dep of Health
Source: Gauteng Dep of Health (HIS)
Compiled by: Francois Venter

3.6 Health service challenges

Our strategic thrust of improving the health of the people in Gauteng, the provision of quality and cost effective health services and value for public monies through effective organisation remains. This strategic thrust is informed by the National Department of Health Ten-point Plan and the strategic priorities of the Gauteng Provincial Government.

The Department faces the following key challenges in providing an efficient and effective quality health service:

Health Status

- Implementation of the AIDS strategy including coping with the impact of AIDS Epidemic, HIV/AIDS orphans and measuring the impact of our awareness campaign.
- Reversal of the deteriorating health status indicators, in part due to the HIV/AIDS epidemic.

Health Services

- Strengthening Primary Health Care (PHC).
- Providing care at an appropriate level and ensuring that patients enter the health care system at the PHC level.
- Improving perception and actual quality of frontline services.
- **High expenditure patterns**
  The reasons for these higher than average costs can be found in the inherited infrastructure, the uniqueness of Gauteng's highly urbanised, industrialised, densely populated and multicultural environment

- **Current Factors Contributing to High Costs**

  In order to overcome the past inequities, the Gauteng Department of Health desegregated all the previously racially divided hospital services to all persons irrespective of race. However, one of the unintended consequences of the opening of all hospitals was the marked shift of patients to previously advantaged hospitals, because of their much better infrastructure and facilities. These were usually tertiary level hospitals that now had to care for large numbers of patients without any concern for whether the level of care was appropriate or affordable

  The gap or divide between hospital services and district-based services has remained a problem area in Gauteng

  Attempts by the Gauteng Health Department to treat persons at the appropriate level of care with entry through the first or primary level and subsequent referral has met with a great deal of resistance from communities and patients and even at times personnel. Doctors in academic hospitals seem to fear that their patients' care will be compromised at lower levels of care.

- **Over-supply of private hospital beds**

  Gauteng Province is over supplied with acute Private Sector beds. The impact of these beds on the public sector beds is not clear but private sector and Medical Aid expenditure on health care is very high.

- **Mal-alignment between the current economic realities and affordable and sustainable service provision**

  The National Health Planning Framework (NHPF) suggests that the provision of services in its current form is NOT affordable, sustainable, or equitable within the South African current (economic) reality.

  According to the NHPF, the results or implications of bringing health expenditure within the projected budget envelope in 2010, while at the same time ensuring that access to care is equitable, will require the rationalisation of the overall number of beds in the country and a redistribution of resources to improve bed supply in under-served areas (both within and between provinces)

Value for money

- Implementation of an effective Performance Management System (PMS).
- Retaining highly skilled professionals who are currently leaving to the private sector and overseas.
- Implementing Cost Centre management given the size of the Department.
- Development of an effective Integrated Management Information System (MIS).
- Effective monitoring systems in the light of decentralisation of management of our institutions. Management of the migration process to the Gauteng Shared Service Centre (GSSC)
- In order to address these, and other challenges the key strategic priorities for Gauteng Health for the Medium Term Expenditure Framework (MTEF) period are summarised in the table below.

4. BROAD POLICIES, PRIORITIES AND STRATEGIC GOALS

4.1 Vision

'Health for a better life'.

4.2 Mission

The mission of the Department of Health is 'to promote and protect the health of our people, especially those most vulnerable to illness and injury. Through innovative leadership, we provide quality health services and strive to:

- Ensure a caring climate for service users;
- Create a positive work environment;
- Obtain the greatest benefit from public monies;
- Forge partnerships with others;
- Provide excellent training for health workers.

Our work is reflected in the enhanced well-being of our staff and clients, the social and economic development of our province and a more just society.

4.3 Departmental values

- Services should be provided on an **equitable** basis to all. Our key focus should be on the needs of the poor in order to redress inequities.
- Nobody should be denied **access** to essential health care due to financial, geographical or other barriers.
- Health services should be of high **quality**, combining sound treatment with a caring and supportive environment.
- The Department will ensure the provision of **sustainable services** within available resources.

- Treatment should be **appropriate** to the health condition, needs and circumstances of the client; and services should be **integrated** for total care and client convenience.
- Expenditure on primary, secondary and tertiary care should be allocated in a way that ensures that priority health needs of all people are met in a **cost-effective** manner.
- The Department should develop procedures to **account** to, and **involve,** individual clients, communities and the Legislature.
- The Department will create a healthy work environment, support employees through progressive human resource management practices and ensure good work ethics and discipline.
- **Participatory management** and sound labour relations will be encouraged to enhance departmental effectiveness.

4.4 Legislative Mandate of the Department

National Legislation and policies

- The Department receives its mandate from Section 27 of the Constitution, which states that
  everyone has a right to health care services, and from relevant public service legislation.
- Public Service Act 1994
- Labour relations Act, 1983
- The Public Finance Management Act, Act 1 of 1999
- Employment Equity Act
- Skills Development Act, Act No 99 of 1998
- Access to information Act, Act No 2 of 2000
- Criminal Procedure Act, 1977
- Inquest Act, 1959
- The Mental Health Act, Act 18 of 1973 as amended.
- Medical Dental and Supplementary Health Services Professions Act (Act 56 of 1974) as amended
- The Health Act (63 of 1977), currently under revision, defines in more detail the role of the various spheres of government in health service provision.
- Child care Act, 1983
- Human Tissue Act, 1983

- Sterilization Act, Act 44 of 1988
- Choice of Termination of Pregnancy Act, 1996
- Nursing Act (Act 50 of 1978) as amended in 1997
- Medicines and Related Substance Control Act (Act 101 of 1965) as amended in 1997
- Pharmacy Act (Act 53 of 1953) as amended in 1997
- Medical Schemes Act 1998
- Patients' Rights Charter, 2000
- White Paper on the transformation of the health sector.
- The Batho Pele principles of consultation, service standards, access, courtesy, information, openness, transparency and redress are a clear focus in the delivery of improved and quality social service delivery. The Batho Pele White Paper also mentions that "a guiding principle of the public service in South Africa will be that of service to the people."

Provincial Health Legislation
- The Hospital Ordinance No 14 of 1958, as amended.
- District Health Services Act 2000.
- Emergency Medical Services Bill, 2002

4.5 Strategic Goals

4.5.1 Improve the health status of the population of Gauteng
4.5.2 Improve health services
4.5.3 Secure better value for money and effective organisation

4.6 Strategic Objectives

In order to address these challenges the key strategic objectives for Gauteng Health for the Medium Term Expenditure Framework (MTEF) period are:

Overall Strategic Goals	Strategic Objectives
1. Improve the health status of the population of Gauteng	• Improve Child Health • Improve Nutritional status of vulnerable groups • Reduce maternal mortality • Reduce mortality from cervical and breast cancer • Strengthening the Tuberculosis control programme • Reduce the incidence of sexually transmitted infections (STIs) including HIV infections and the impact of AIDS • Improve quality of life for people living with AIDS (PLWA) • Reduce the prevalence and complications of prevalent communicable and non-communicable diseases • Reduce teenage pregnancies • Promote mental well-being and improve early diagnosis, treatment and support to people with mental illness • Reduce incidence and impact of trauma and violence • Promote healthy lifestyles
2. Improve health services	• Strengthen Primary Health Care • Revitalisation of hospital services • Ensure rapid and effective Emergency Care • Provide efficient and effective clinical support • Provide high quality and user friendly hotel facilities • Improve quality of care • Equitable distribution of resources
3. Secure better value for money and effective organisation	*Human Resources* • Provide conducive work environment for staff • Enable the equitable and appropriate recruitment, training and deployment of staff • Provide the service platform for high quality tertiary training • Effective human resource and labour relations management • Implement an effective performance Management System • Ensure implementation of Employment Equity Act *Information management and communication* • Provide an effective and efficient Integrated Management Information System (MIS) to support decision-making, monitoring and clinical care *Finance* • Improve Financial Management • Improve revenue generation and retention • Implement the Fraud Prevention and risk management Plan. *Supply chain management* • Ensure effective and efficient systems for procurement and management of assets and consumables

Overall Strategic Goals	Strategic Objectives
	Infrastructure and Equipment • Construction, refurbishment and maintenance of infrastructure and equipment *Governance and policies* • Strengthen community participation and inter-sectoral programmes • Develop and implement clear policy and legislative framework for health care

4.6 2003/04 priorities

4.6.1 Improving the health of the people of Gauteng

- As part of the social services cluster the Department plays a key role in leading the implementation of the Intersectoral HIV/AIDS Programme. The main focus is on the expanded response on HIV/AIDS with emphasis on the following priority areas.
  - Strengthening the HIV prevention efforts especially in youth under 20 and babies, implementation of workplace HIV/AIDS programme
  - Developing comprehensive care, treatment and support for PWAs, care givers and affected children, with special focus on clinical care provision in large community health centres and hospitals.
  - Strengthening HIV/AIDS programme organisation in the areas of monitoring and evaluation system, local inter-sectoral programmes and capacity of departments and sectors
- We also implement different sections of the intersect oral projects (Poverty Alleviation, Early Childhood Development, Protection of Women and Children, Youth Development).
- The Department will continue to focus on improving the health status of the community, with special emphasis on vulnerable groups, mostly women and children in the following areas.
  - Strategies to reduce infant and maternal mortality rate.
  - Strengthen EPI programme across the province
  - Preventing and managing emerging and re-emerging communicable diseases
  - Implementation of Post exposure Prophylaxis (PEP) protocol in all facilities for survivors of sexual assault.

4.6.2 Improve health services

- Quality health care is one of the key priorities of government and of the Department. The initiative of implementing the service delivery programme will focus on the implementation of an extended comprehensive quality assurance programme with particular emphasis on improving customer service, reduction of waiting times, service excellence awards, Accreditation process and face-lifting of health facilities.
- Improve services for people with disabilities with special focus on promotion of access and quality of life.
- Ensure rationalisation of tertiary services.
- Strengthen public health through community health departments of universities

- Strengthening of Primary health care (PHC) services with special emphasis on the provision of comprehensive PHC package of services, and at least one 24-hour Primary Health Care facility in each sub-district
- Refurbishing and re-organisation of pharmacies and introduction of drug management systems in all the institutions

3.3 Secure better value for money and effective organization

The Department's major focus on ensuring value for money and effective organization will be on:

- Strengthening **strategic leadership and management** by ensuring that the strategic plan is communicated to, and internalised by all staff members across the Department and that the strategic objectives are translated into action with an effective monitoring and evaluation.
- Review **business processes** for improved efficiency
- Development of an effective Integrated Management Information System (MIS) with an effective monitoring and evaluation system to inform decision making.
- Ensuring the implementation of a **Performance Management** System that incorporates clear rewards and sanctions and that discipline is enforced.
- Special focus on the implementation of the Gauteng HIV/AIDS workplace strategy
- Provide support of staff through the implementation of Employee Assistance programme (EAP) across the Department
- Strategies to ensure retention of nurses and the high skilled health care professionals.
- Improving **Financial Management** by ensuring PFMA reporting through cost centers and focus on cost drivers and how to reduce costs.
- Focus on internal and external **communication.**
- Securing alternative sources of revenue and implementation of Public Private Initiatives (PPI's) to increase revenue.
- Ensuring appropriate utilisation of capital assets.
- Improved supply chain management

Part B. Budget Programmes and sub-programmes Strategic plans

PROGRAMME 1: HEALTH ADMINISTRATION

1.1 SITUATION ANALYSIS

Appraisal of existing services and performance during the past year

Human Resource Management
This financial year has seen many achievements in Human Resource Management. Amongst others are the following:

Delegation of Authority
Delegation of Human Resources (including Labour Relations) and Financial Management functions has been in operation for just over one year. A formal review is being done and will be complete in the new financial year.

Performance Management
A new Department of Public Service & Administration (DPSA) framework for Senior Management Service (SMS) is being implemented in the department. Performance Management Task Team has been established and trained on the new tool. 72 senior managers have been trained on Performance management system. Performance management system tool for staff below the SMS (i.e. levels 1 to 12) is being developed as part of the GPG process.

Employment Equity
Considerable strides have been made in attempting to comply with the Employment Equity Act 55 of 1998 and other legislative imperatives that impact on processes that address the imbalances of the past. A Central Employment Equity Committee (CEEC) and Institutional Employment Equity Committees (IEECs) were established in most Health Institutions to ensure that the provisions of the Act are adhered to as well as to identify and remove barriers that could hinder the implementation of the process. The current employment equity status of the Department indicates 84,3% black and 77.9% women with 18% of women in management positions.

Human Resource Development

Staff development including stakeholders training programmes was initiated during the financial year.

- 150 students were trained in Primary Health Care.
- 21 professional nurses completed fast-track PHC training
- 52 Health Councillors trained
- 184 middle managers (GHD/LG) trained on Public management certification course
- International cooperation on human resource development was strengthened through
- The Nursing Exchange Programme with Kings College Hospital in the United Kingdom (UK).
- Twinning between the Gauteng Health Department and Lambeth, Southwark and Lewisham Health Authority in London

- Continued twinning of Gauteng Central hospitals with similar institutions in England and France
- A workplace skills audit was conducted. A plan was developed and submitted to the Health & Welfare Sectoral Education & Training Authority (HWSETA).

Health information and communication

- Computerised Patient Information System (MIS) implemented in 9 hospitals and 5 clinics. The maintenance/rollout of this system is been undertaken by the State Information Technology Agency (SITA).
- Clinic minimum dataset was revised and rationalised.
- The hospital minimum dataset has been completed.
- The mapping of primary health care services has been completed. Maps are available on the Department Intranet with the health service database. This was carried out jointly with Italian Cooperation.

Revenue Strategy

- Patient fees are the main source of income. Revenue collected for the period April to September 2002 was on target at R74.5 million. The latest figures project that the collection of patient fees will exceed the budget by R30 million.
- The Department will continue to use the incentive scheme as a strategy to encourage and improve revenue collection at institutions.
- The amount collected above the agreed upon target will be appropriated back to the department during the 2003/2004 financial year by Treasury. This money will be used to finance operational efficiency initiatives of the department.
- The UPFS has been promulgated and is in the process of being implemented. This will contribute significantly towards the increased revenue collection during 2002/2003.

Financial Management Capacity Building

- BAS/PERSAL reconciliation done at hospitals and training has been provided to hospital staff
- Security upgrades and/or financial equipment upgrades were done in all regions
- Additional capacity employed at Central Office for the implementation of the Folateng project
- Six additional State Accountants employed at various hospitals
- The BAUD Fixed Asset Register is fully functional and up to date at the 31 hospitals, run by departmental staff
- A review of the department's policies with regards to contracting NGOs as well as an audit of a sample of NGO's contracted by the department has commenced.

- District Health Expenditure (DHER) workshops have been completed and a financial risk assessment of the devolution of PHC services to LG is in progress
- A performance management system for SMS has been implemented as a result of the HR FINCAP project
- A draft model for a rationalized staff establishment is being developed and is 85% complete.
- An Asset Manager/Clinical Engineer has been appointed for the department
- Four pharmacists and a drug controller will be employed to implement the Drug Supply project.

1.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Broad strategic Objectives

- Provide political and strategic direction and leadership
- Develop and implement policy and legislative framework for health care
- Ensure an enabling environment for quality service delivery
- Promote co-operative governance
- Provide conducive work environment for staff
- Ensure value for money and effective organisation
- Ensure equity and efficiency in distribution and use of resources
- Monitor and evaluate performance of the department

Priorities for 2003/04

- Strengthening strategic leadership and management
- Review business processes for improved efficiency
- Development of an effective Integrated Management Information System (MIS)
- Development of an effective monitoring and evaluation system to inform decision making.
- Implementation of a Performance Management System
- Implementation of Employee Assistance programme (EAP) across the Department
- Implementation of strategies to ensure retention of nurses and the high skilled health care professionals.
- Improving Financial Management.
- Focusing on internal and external communication.
- Implementation of Public Private Initiatives (PPI's)
- Ensuring appropriate utilisation of capital assets.
- Improving supply chain management
- Improving services for people with disabilities
- Refurbishing and re-organisation of pharmacies and introduction of drug management systems in all the institutions

- Improve quality of care with special focus on improving customer service, reduction of waiting times, service excellence awards, Accreditation process and face-lifting of health facilities

1.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Analysis will be provided with the final strategic plan.

1.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

The Department's major achievements in creating the environment in which the quality is delivered were as follows:

- Phase 2 quality standards for the accreditation process extended to Community Health Centres and systems of revisit to 5 hospitals has been developed
- Hospital Board members have commenced their second term of office and psychiatric hospital boards have also been established.
- The first provincial Cecilia Makiwane Nurses Excellence awards ceremony was held in June 2002, and the 2002 Khanyisa Service Excellence awards ceremony including the Kickstart awards was held in October 2002.
- Disabled access according to the national norms and standards has been established in 60% of our health facilities.
- Clinical Audit policy is being developed

In the area of capacity building

- A dedicated quality assurance Directorate has been established. The Director commenced duty on the 1st October 2002.
- The Department has managed to strengthen management systems within institutions and developed clinical guidelines and protocols.
- Norms and standards for Emergency Medical Services have been developed.
- Quality Assurance teams and Queue managers/patient liaison officers have been appointed at the four central hospitals. Directors for clinical services, Finance & Procurement services and Human Resources & Logistic services have been appointed at the four central hospitals.

The provision of quality of care is cross cutting in all the budget programmes and sub programmes. Therefore this section will provide a summary of a comprehensive quality assurance programme in the Department.

The Gauteng Provincial Government is committed to providing a social service delivery system that increases access to health and social services in order to improve the quality of life for all people in the province. Whereas considerable progress has been made in the provision of basic social services for the majority of people in the province, addressing the equitable distribution of resources and ensuring quality service delivery are still major challenges facing government.

The Batho Pele principles of consultation, service standards, access, courtesy, information, openness, transparency, and redress, remains a mandate in the delivery of improved and quality social services.

Other principles underpinning planning for quality social service delivery include:

- Coordinated and integrated planning and social service delivery
- Targeting of priority vulnerable groups.
- Geographical social service integration.
- Developing and marketing of quality initiatives
- Monitoring and evaluation of service delivery improvements

The Department's focus area in creating the environment in which the quality is delivered will be as follows:

- Implementing a comprehensive quality assurance programme for the Department
- Accreditation process in hospitals and CHC's
- Strengthening complaints systems
- Conducting Client Satisfaction population based Surveys
- Strengthening implementation Patients Charter and Service Pledge
- 10% reduction of average waiting times
- Continue Service Excellence Awards and implement individual awards for those categories where awards do not already exist.
- Coordinate and implement the initiatives and efforts amongst different spheres
- Determine efforts to improve frontline services

In the area of capacity building, the focus areas will be:

- Published set of standards and criteria for clinical care;
- Develop an ethical caring workforce with appropriate incentives and motivators – the way to bring this about will be the internal customer care;
- Develop an effective reporting system to communicate all quality assurance initiatives issues
- Developing customer care units to focus on both internal and external customers,
- Providing patient education regarding their rights, realistic expectations under the responsibility,
- Developing, implement and popularise provincial standard guidelines, audit tools and accreditation process while encouraging local quality initiatives,
- Developing a quality insurance model for integration into all health professional student curricula**.**

Table 7: Service Delivery Improvement Programme Indicators and Targets

Measurable objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Ensure shorter waiting times for patients	Percentage of hospitals and large community health centres measuring waiting times	-	-Date still being verified	100	100	100
	Percentage reduction in overall waiting times	#	#	10	15	20
Reduce waiting list for highly specialized surgery	Percentage reduction in waiting list for cataract, hip replacement and cardiothoracic surgery	#	#	10	20	20
Ensure access for disabled at all facilities	Percentage of hospitals and clinics with disabled access	50	70	80	100	100
Assistive devices to people with disabilities	Percentage increase of the budget allocation in the number of assistive devices issued to disabled people	#	#	100	6	6
	Number of assistive devices supplied to people with disabilities	#	#	865	990	1119

Implementation of patient focused quality accreditation system in all clinics and hosp. Service excellence awards	Percentage of provincial hospitals and community Health Centers evaluated Existence of awards in the following categories: Khanyisa Service excellence awards • Institutional/unit level • Individual level			80 8		

 # New indicator, data not available

1.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and evolution of performance indicators for Administration

Strategic Objectives	**Measurable Objective**	**Indicator[1]**	**2001/02 (actual)[2]**	**2002/03 (estimate)[2]**	**2003/04 (target)**	**2004/05 (target)**	**2005/06 (target)**
Develop and implement clear policy and legislative framework for health care	Implement the Districts Health Act.	Number of signed agreements with local government on primary care service devolution	Internal agreement with JHB metro	4	6	-	-
Provide an effective and efficient Integrated Management Information System (MIS) to support decision-making, monitoring and clinical care	Implement the Management Information System (MIS) in all hospitals and clinics	Percentage of provincial hospitals and clinics implementing the national minimum data sets	21	30	80	100	100
Implement an effective performance Management System	Implement the prescribed staff performance management system	Percentage of provincial hospitals and clinics implementing the prescribed system Percentage levels 13 upwards with PMA's	- -	- 70	70 100	90 100	100 100
Ensure implementation of Employment Equity Act	**Improve gender representivity**	**Percentage women in middle and senior management**			**85**	**80**	**85**

Improve Financial Management	Implement inventory and asset recording system at all institutions.	Percentage of institutions with and inventory and asset system.	40	70	80	100	-
	Cost centers implemented in all hospitals	Number of hospitals implementing cost centers	-	6	7	14	28
Improve revenue generation and retention	Increase the revenue generation in patient fees	Revenue increase in revenue collected from previous year.	2	2	3	5	7
Improve quality of care	Implement patient focused quality accreditation system in all clinics and hosp.	Percentage of provincial hospitals and community Health Centers evaluated	82 Hospitals visited	40	80	90	100
	Ensure recognition of service excellence awards	Existence of awards in the following categories:	6	6	8	8	8

		Khanyisa Service excellence awards • Institutional/unit level • Individual level					
Improve quality of care	Provide assistive devices to people with disabilities	Percentage increase of the budget allocation in the number of assistive devices issued to disabled people	-	-	100	6	6
Enable the equitable and appropriate recruitment, training and deployment of staff	Appoint and maintain Public Health specialists	Number of community health specialist/registrar appointed and maintained	-	0	6 new	6 new	12
Provide efficient and effective clinical support	Improve pharmaceutical management with system.	Percentage compliance of hospital pharmacies with annual stock taking.	-	-	100	100	100
	Ensure availability of medicines on the EDL	Percentage of hospital and regional pharmacies with EDL medicines	-	-	90	100	100

Reduce maternal mortality	Provide support for survivors of violence	Number of women seen at existing medico legal centres			To be determined		
	Implement Post exposure Prophylaxis in all institutions	Percentage medico-legal facilities implementing PEP protocols			To be termined		100

1.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

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

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004'05 (MTEF projection)	2005/06 (MTEF projection)
1. Office of the Provincial Minister	23,902	2,287	2,340	3,000	3,200	3,400
2. Management	197,440	326,388	235,015	229,690	212,000	224,000
Total programme	199,830	328,675	237,355	232,690	215,200	227,400

1. Capital spending voted under the public works budget should be included. Any change in the content of the budget programme or sub-programmes should be indicated.

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

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget)[2]
Total[3]	199,830	328,675	237,355		232,690
Total per person[4]	27.12	44.61	32.22	0.00	31.58
Total per uninsured person[5]	36.75	60.44	43.65	0.00	42.79

PROGRAMME 2: DISTRICT HEALTH SERVICES

2.1 SITUATIONAL ANALYSIS

The district health system is the vehicle for facilitating the implementation of primary health care services. In line with national health policy, Gauteng has adopted primary health care as the main strategy for developing and promoting the health of our communities.

Prior to 1994 the provincial administration was responsible for hospital services, ambulances and largely hospital based curative services. The local government was responsible largely for environmental health services, promotive and preventive health care services, and limited curative health services. Private sector hospitals and health workers and non-governmental organisations also provided health services.

The District Health System is the cornerstone of the National Health System.
The Mission of the District Health System is to strengthen Primary Health Care services by improved access to quality cost efficient essential and priority health services through integration, capacity development and community participation.

More recent developments at the National level are clarifying a route on way forward to ensure development and sustainability of the District Health System.

Appraisal of existing services and performance during the past year

Strengthening Primary Health Care (PHC)

Growth in utilization and access to Primary Health Care has increased with more than 10 million annual visit made to primary health care facilities. The full Primary Health Care package of services is being offered in all municipalities. The service package includes a combination of preventive, promotive, curative and rehabilitative services, which take into account priority health programmes. Free primary health care has improved access to health care for many communities. At many clinics, hours of clinics have been extended to ensure improved accessibility, particularly for working individuals and to provide needed after hour services. Through a major effort in many areas, previously preventive and promotive clinics have been able to expand the services they deliver to improve access to more comprehensive care with referral to other levels and the establishment of gateway clinics to relieve pressure on hospital OPDs.

Pre-packed medications and other medicines (on the Essential Drug List [EDL]), and surgical sundries are being supplied to most Local Government clinics to facilitate the introduction of a more comprehensive range of services.

The District Health Information System (DHIS) is being implemented in all the Primary Health Care facilities. There are four cross-borders areas in Gauteng Province has been mapped and described as part of the overview.

Non-communicable diseases

Non-communicable diseases present a major health burden to the country. The epidemiological and health transition South Africa is undergoing has resulted in the country experiencing both poverty related diseases, trauma and an increasing number of people developing chronic diseases that are related to urbanization and lifestyle. The World Health Organisation (WHO) estimates that 40% of deaths in developing countries are due to non-communicable diseases. Our primary care clinics undertake extensive management of chronic conditions, notably hypertension and diabetes with more than one million visits in the past year. Our campaigns stress the importance of exercise, nutrition, no smoking and stress reduction

District health service facilities and infrastructure

Gauteng has a total of 266 number of Fixed clinics and Community health centres and 107 visiting points. There are six district hospitals with 858 beds.

Table: District health service facilities by health district

Health district[1]	**Facility type**	**No.**	**Average population per facility**[2]	**District hospital beds (no.)**	**District hospital beds per 1000 people**[2]	**District hospital beds per 1000 uninsured people**[3]
City Of Johannesburg	Visiting points[4]	49	---	---	---	---
	Clinics[5]	81	---	---	---	---
	CHCs	8	---	---	---	---
	Sub-total clinics + CHCs	89	28073	---	---	---
	District hospitals	1		185	0,3	---
Ekhuruleni	Visiting points[4]	12	---	---	---	---
	Clinics[5]	67	---	---	---	---
	CHCs	5	---	---	---	---
	Sub-total clinics + CHCs	72	280018	---	---	---
	District hospitals	1				---
West Rand	Visiting points[4]	12	---	---	---	---
	Clinics[5]	23	---	---	---	---
	CHCs	3	---	---	---	---
	Sub-total clinics + CHCs	26	24057	---	---	---
	District hospitals	1		140	0,2	---
Sedibeng	Visiting points[4]	12	---	---	---	---
	Clinics[5]	28	---	---	---	---
	CHCs	4	---	---	---	---
	Sub-total clinics + CHCs	32	22696	---	---	---

	District hospitals	1		126	0,2	---
City of Tshwane	Visiting points[4]	14	---	---	---	---
	Clinics[5]	32	---	---	---	---
	CHCs	3	---	---	---	---
	Sub-total clinics + CHCs	35	36329	---	---	---
	District hospitals	2		254	0,2	----
Metsweding	Visiting points[4]	8	---	---	---	---
	Clinics[5]	7	---	---	---	---
	CHCs		---	---	---	---
	Sub-total clinics + CHCs	7	12559	---	---	---
	District hospitals					---
Province	Visiting points[4]	107	---	---	---	---
	Clinics[5]	238	---	---	---	---
	CHCs	24	---	---	---	---
	Sub-total clinics + CHCs	262	27697	---	---	---
	District hospitals	6	920917	858	0,1	0,2

Data on rural development nodes and urban renewal nodes should be identified specifically.
Population used was of the census 96.
Satellite clinics are included as part of the visiting points.
Fixed clinics; both provincial and local government facilities are included.

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

Health Region	**Facility type**	**No**	**No. (%) with electricity supply from grid**	**No. (%) with piped water supply**	**No. (%) with fixed line telephone**
Johannesburg/WRDC	Clinics	104	100%	100%	100%
	CHC's	12	100%	100%	100%
	District hospitals	2	100%	100%	100%
Ekurhuleni/Sedibeng	Clinics	95	100%	100%	100%
	CHC's	9	100%	100%	100%
	District hospitals	2	100%	100%	100%
Tshwane/Metsweding	Clinics	39	100%	100%	100%
	CHC's	3	100%	100%	100%
	District hospitals	2	100%	100%	100%
Province	Clinics	238	100%	100%	100%
	CHC's	24	100%	100%	100%
	District hospitals	6	100%	100%	100%
	Satelite/Mobile	107			

** Health district information still being verified*

The table above indicate 100% availability of infrastructural services within the district facility network.

Facilities/equipment

Both Local Governments and Provincial Department face severe financial constraints, necessitating the need for a strategy to co-ordinate and pool all the resources to support the provision of primary health care. Common and agreed norms and standards for facilities and equipment, which are flexible and take account of efficiency of scope and scale, and support levels of service delivery in the districts.

The major rehabilitation projects since the last NHFA audit required as part of the table below is outlined in **programme 8 (Health facility management).**

Table: Physical condition of district facility network

ELEMENT / INSTALLATION	**AVERAGE CONDITION**	**BEST FACILITY (on average) : Khutsong CHC**	**WORST FACILTIY (on average) : Meadowlands CHC**	**WORST**	
				Condition	**Facility**
TOTAL FACILITIES	3.83	4.57	3.44	3.44	Meadowlands CHC
BUILDING OVERALL	3.83	4.67	3.51	3.51	Meadowlands CHC
Building Fabric	3.81	4.85	3.45	3.45	Meadowlands CHC
Building Mechanical	3.86	3.61	3.93	2.54	Diepkloof CHC
SITE OVERALL	3.79	4.30	3.19	3.19	Meadowlands CHC
Site Civil	3.75	4.49	3.04	3.04	Meadowlands CHC

Most of the buildings require minor repairs, but painting, roofs and ceilings, in general, required attention. This has been done very successfully through the Facility Management Units and the decentralisation of "Day-to-Day" maintenance to the Institutions. In general the electrical and mechanical installations are in an above average condition but the quality and frequency of maintenance work is a major cause of concern. The worst average condition is that of the site civil works and gardens, and this contributes to the perception that the facilities are in a state of neglect.

There is a general perception that the condition of facilities are worse than indicated in the Audits and the reason could be that the need for day-to-day hygiene-type cleaning is mistakenly confused with the need for maintenance. A dirty building does not necessarily need maintenance of repairs.

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

Indicator	Province wide value 2001/02	By health district**	National target
Input			
1. Population served per fixed public PHC facility***	✓	✓	Max. 10 000 people
2. Provincial DHS expenditure per person	R 200*	✓	
3. Provincial DHS expenditure per uninsured person	R 272*		
4. Total DHS expenditure (provincial plus local government) per person (if data available)	N/A	✓	
5. Total DHS expenditure (provincial plus local government) per uninsured person (if data available)	N/A		
6. Number of professional nurses in fixed public PHC facilities per 1000 people	✓	✓	
7. Number of professional nurses in fixed public PHC facilities per 1000 uninsured people	✓		
8. Percentage of fixed public PHC facilities offering the full package of PHC services	80%	✓	100% by 2004
Process			
9. Percentage of health districts with appointed manager	75%		100%
10. Percentage of health districts with formal plan	50%		100%
11. Percentage of fixed public PHC facilities with functioning community participation structure	75%	✓	100%
Output			
12. Number of visits (headcount) at public PHC facilities per person per year	1,9	✓	
13. Number of visits (headcount) at public PHC facilities per uninsured person per year	2,5		3.5
14. Percentage of children under one year fully immunised	76%	✓	90%
Quality			
15. Percentage of fixed public PHC facilities in facility audit condition 4 or 5	80%	✓	
16. Percentage of public PHC facilities visited at least once per month by a supervisor who produces a written report	70%	✓	100%
17. Percentage of public PHC facilities supported by a doctor at least once a week	13%	✓	100% by 2004
18. Proportion of health districts with a formal quality improvement plan	85%		
19. Percentage of public PHC facilities without vaccines at any time of year	3%	✓	0%
Efficiency			
20. Provincial expenditure per visit (headcount) at provincial PHC facilities	R 107*	✓	
21. Total expenditure (provincial plus local government) per visit (headcount) at public PHC facilities (if data available)	N/A	✓	
Outcome			
22. Number of measles cases	✓	✓	

Used 1996 population census figures

* Estimates

✓ Data still being collected or verified

Priority Programmes

The Primary Health Care services in Gauteng have focused on women and children by introducing priority programmes such as Maternal and Child Health, Reproductive Health Services (including Termination of Pregnancy), control of Communicable Diseases and Nutrition Supplementation for children. Progress includes the Youth Friendly Service Initiative. This ensures comprehensive services, (largely in the field of reproductive health), offered in several clinics around the province in such a way that youth feel comfortable using them. An NGO-run community-based project for reproductive health promotion is expanded to many areas. Children in schools have received an early morning snack, and contracts to supply food for this programme are awarded to NGOs. Another nutrition programme includes the protein-energy malnutrition scheme.

HIV/AIDS is recognised as a major national problem and it requires an inter-sectoral and dedicated effort. A comprehensive strategy involving different stakeholders (government departments and non-governmental organisations), improved access to STI care, condom distribution, life skills education, care of AIDS patients, home based care, support to persons living with AIDS, continue to form part of the Provincial Initiatives. Funds have been allocated to the Interdepartmental AIDS Programme. A major focus will be on supporting the local integrated development and implementation of a comprehensive programme in areas with vulnerable communities. There has been a noticeable impact of HIV/AIDs on Primary Health Care and the importance of the need for referral to home-based care and step-down beds to alleviate the burden on regional and tertiary hospitals.

With the increasing AIDS epidemic is the problem of TB. The directly observed tuberculosis strategy (DOTS) treatment and an improvement in the response time of TB results are interventions to address TB. Improving the cure rate and preventing multi-drug resistance in Tuberculosis through monitoring and reliable reporting system is paramount.
Several Trauma Centres 'victim friendly services' have been established to cope with the impact of violence on communities.

A process of decentralisation of chronic disease care and mental health from hospitals has started. The Environmental programme targets informal traders, and focuses on teaching of food purchase, hygiene, preparation, etc. There are numerous other examples of joint service initiatives. Extended oral health services were introduced at primary care level. Services have also been introduced in rural and informal settlements. Community-based rehabilitation workers were trained, to improve access to rehabilitation services.

Linked to the development of primary health care is the importance of efficient emergency medical services and a clear referral system to other levels of health care.

3.4 Support Services

These services support the development and delivery of Primary Health Care services.

Human Resource Development

The development of human resources is essential to ensure strengthening and delivery of comprehensive primary health care services to our communities. The area of human resources is a major challenge to effective service delivery. Functional integration has been and is a major challenge in integrating the health services of Province and Local Government. Skills

development in a number of areas such as Primary Health Care skills, priority programmes, management, health information and financial skills has occurred. While there are severe budgetary constraints, training and development is an investment and exciting progress has been made at both formal and informal levels. At an informal level, the various joint activities have provided an opportunity for networking and for sharing of information and skills.

Information

There is a district health information system (DHIS/MDS) to monitor the progress towards comprehensive and integrated service provision, and the utilisation of services, and the impact of these services.

Procurement

A challenge is to develop an efficient procurement, delivery and stock control system for both Local Government and GHD (for drug supplies, surgical sundries and equipment) in order to make best use of what exists in a co-ordinated fashion. Transport for delivery of the service is also included.

Finance

The Gauteng Department of Health has provided subsidies through transfer payments to Local Government to supplement local government own contribution for the provision of primary care services. In addition to the cash transfer payments, the GHD also supported service delivery in Local Government services, by supplying Essential Drug List (EDL) drugs, surgical sundries, paying for certain laboratory investigations and seconding personnel to work in Local Government facilities. The annual allocation of financial resources to districts has increased by between 6-8 % every year. This has allowed the Department to increase the subsidies paid to Local Government. In addition, the Medium Term Expenditure Framework (MTEF) guides the Department's planning and budgeting process and provides estimates of 3 year budget allocations. This facilitates the re-orientation of funds from hospitals and allows for a tool to monitor progress towards strengthening Primary Health Care services.

Table 1: Gauteng Provincial hospitals for referral from DHS by location and level of care

Level	Institution	Region
Central/Tertiary	GaRankuwa*	Region C
	Pretoria Academic*	Region C
	Chris Hani Baragwanath*	Region A
	Johannesburg*	Region A
Regional	Kalafong*	Region C
	Coronation*	Region A
	Edenvale	Region A
	Helen Joseph*	Region A
	Tambo Memorial	Region B
	Far East Rand	Region B
	Natalspruit	Region B
	Pholosong	Region B
	Tembisa	Region B
	Leratong	Region A
	Yusuf Dadoo	Region A
	Sebokeng	Region B
	Kopanong	Region B
District	Mamelodi	Region C
	Pretoria West	Region C
	South Rand	Region A
	Heidelberg	Region B
	Germiston	Region B
	Carletonville	Region A
Specialised	Weskoppies*	Region C
	Cullinan Rehab Centre	Region C
	Sizwe Tropical Diseases*	Region A
	Tara H Moross Centre*	Region A
	Sterkfontein*	Region A

Key challenges over the strategic plan period

Areas of concern are the growing problem of HIV/AIDS, poverty, malnutrition, chronic diseases and trauma and violence with concomitant mental illness and the higher than average cost of health care in Gauteng Province.

A recent assessment of our health care delivery network has been undertaken as part of a national planning process for long-term sustainability in health care delivery. Within the National context, Gauteng Health Service expenditure is higher than that of other provinces.

There are several implications of bringing health expenditure within the projected budget envelope by 2010.

The reasons for these costs can be found in the inherited infrastructure, is Gauteng's highly urbanised, industrialised, densely populated and multicultural environment. The urbanised environment and higher socio-economic climate tend to create different disease profiles such as a higher impact of trauma, violence and other socially related health conditions.

2.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The District health services' mandate is within the umbrella of the national DHS policy and Gauteng District health service Act, 2000.

Broad strategic priorities

- Improve health status of the population of Gauteng
- Increase access to comprehensive Primary Health Care (PHC) package through the District Health System
- Joint Provincial and Local Government District Health Service Plans
- Coordinate the process of devolution of PHC services to Local government
- Provide efficient and effective clinical support services
- Improve district-level hospital care
- Expanded response on HIV/AIDS
- Improve Nutritional status of vulnerable groups
- Develop an effective monitoring and evaluation framework for district health services
- Ensure optimal use of available resources

Priorities for 2003/04

- Implement Intersect oral projects such as Poverty Alleviation, Early Childhood
- Development, Protection of Women and Children, Youth Development.
- Strategies to reduce infant and maternal mortality rate.
- Strengthen EPI programme across the province
- Preventing and managing emerging and re-emerging communicable diseases
- Provide at least one 24-hour Primary Health Care facility in each sub-district

.

2.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Increasing population

The population of Gauteng is likely to increase at a higher rate than any of the other provinces as a result of in-migration of people into the province in search for employment, schooling or health care. Rapid urbanisation has also led to the growth of informal settlements in Gauteng with inadequate infrastructure that can lead to outbreaks of communicable diseases.
Cross- boundary flows of patients to relatively well-resourced health services in Gauteng from other provinces increases the burden on the provincial services. The fact that these are largely informal or self-referrals makes it difficult to formally attribute financial responsibility or to include people in the calculations on per capita expenditure.

Decentralisation of health care services

The gap or divide between hospital services and district-based services has remained a problem area in Gauteng Province. Restructuring, which integrates hospitals and District Services within three large Regions hopes to overcome the historic division of these services and ensure services are more appropriately provided at primary level and at a lower cost, with a shift of both patients and resources away from hospitals.

One of the unintended consequences of the accessibility of health services after 1994, was the marked shift of patients to previously advantaged hospitals, due to the perceived better quality of care at these hospitals. The result was the care for large numbers of patients without any concern for whether the level of care was appropriate or affordable. Attempts by the Gauteng Health Department to treat persons at the appropriate level of care with entry through the first or primary level and subsequent referral has met with a great deal of resistance from communities and patients and even at times personnel. Doctors in academic hospitals seem to fear that their patients' care will be compromised at lower levels of care.

In Gauteng the key challenges are decentralisation of health services to the appropriate level, integration of community health services, and rationalisation for cost efficiency. Also to expanding those services to the full package of Primary Health Care services and managing the impact of HIV/AIDs.

AIDS impact on service provision

The HIV/AIDS epidemic will have a huge impact on the health care sector in terms of increasing demand for services and affordability and the negative impact of the epidemic on health sector staff. The resultant loss of skills and time off work due to illness will further exacerbate this. People living with AIDS (PWAs) have an impact on acute beds, as they usually require a number of acute admissions prior to the terminal phase of illness. The policy is to provide this acute care in district hospitals wherever possible. During recovery from these acute episodes, use is made of lower cost "step down" beds. Once they are terminally ill with AIDS they are cared for in home-based care, hospice care or at times step down beds. The impact of TB is particularly important here.

Projections have indicated that the short-term analysis of current health sector budgets will be inadequate to respond to the epidemic. The impact of HIV/AIDS programmes is hard to measure and take a long time to manifest. However, to be effective against HIV and be able to mitigate the effects of AIDS, financial resources need to be guaranteed and sufficient.

Violence

The high rate of inter-personal violence and trauma in Gauteng puts an additional burden on health services and compromises the safety of health workers. Poverty, unemployment and urbanization increases the risks for the spread of sexually transmitted infections (STIs) and HIV infection, interpersonal violence, substance abuse, poverty related diseases and chronic diseases related to lifestyle, as well as mental illness. Gender inequalities: The cultural context and status of women in our society also determines attitudes towards domestic violence and perceptions of gender relationships. These attitudes influence the decision making in relationships (e.g. condom use); the acceptability of multiple partners and the right of women to refuse sex with their partners, which in turn put women at risk.

Decentralisation of health services through the moving of hospital polyclinics and OPDs and establishing 'gateway clinics' will shift services and resources to Primary Health Care. A Provincial Regional and District Health Plan involving targets for decentralisation to Primary Health Care services will be established.
In addition to expedite this process there needs to be a joint District Health Service Plan between Province and Local Government and rationalisation of services with clear Service Level Agreements.

Although a programme to strengthen financial capacity has been started, it will take some time before all levels will have adequate financial management capacity. The programme is being fast-tracked to improve financial management capacity at all levels.

2.4 DESCRIPTION OF PLANNED QUALITY IMPROVEMENT MEASURES

Clinical Protocols guide the management and treatment of patients, in order to ensure quality care and facilitate the referral and follow-up of patients. Another intervention is ensuring the principles of Batho Pele are adhered to.

2.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Measurable objectives and performance indicators for District Health Services

Strategic Objectives	Measurable objectives	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Strengthen Primary Health Care	Implement core package of primary care services in each sub-district through the DHS	Percentage of sub-district offering the full package of primary care services	100% district	83	100	100	100
		Number of visits (headcount) at public PHC facilities	10 088 739	12 million	13 million	13 million	14 million
Provide efficient and effective clinical support	Ensure availability of EDL of drugs	Proportion of essential drugs out of stock at PHC facilities?	#	#	2%	1.5%	1%
Improve Child Health	Increased Immunisation coverage among children under 1 year	Immunisation coverage for under 1 year (%)	76	76	80	90	90
		Number of measles cases	5	4	3	2	2

Improve quality of life for people living with AIDS (PLWA)	Provide home-based care services	Percentage of sub-districts offering a home-based services	3	80	90	100	100
	Provide step down/ hospice beds	Number of step-down/hospice beds	200	200	345	400	400
Reduce the incidence of sexually transmitted infections (STIs) including HIV infections and the impact of AIDS	Reduce new infections among antenatal care women	Antenatal sero-prevalence rate (%)	29.8	29.9	29.8	29.8	29.8
Strengthening the Tuberculosis control programme	Increase TB cure rate in new positive cases	Percentage of new positive TB cure rate	68	70	72	80	85
Improve quality of care	Ensure shorter waiting times for patients	Percentage of hospitals large community health centers measuring waiting times.	#	Data still being verified	100	100	100
		Percentage reduction in overall waiting times	#	#	10	15	20

 # New indicator, Data not available

2.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

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

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004'05 (MTEF projection)	2005/06 (MTEF projection)
1. District Management	512,165	550,813	482,473	536,863	600,000	633,600
2. Community Health Clinics	102,108	272,945	306,603	364,073	392,000	414,000
3. Community Health Centres	173,860	85,147	204,000	247,830	268,000	284,000
4. HIV/ AIDS	10,212	40632	81,620	140,706	258,863	308,863
5. Nutrition	62,692	64,601	60,685	60,685	57,953	61,430
6. District Hospitals	432664	333071	354117	369000	397581	420000
Total programme	1,293,701	1,347,209	1,489,498	1,719,157	1,974,397	2,121,893

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

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	Apr-03 (budget)[2]
Total[3]	1,293,701	1,347,209	1,489,498		2,012,109
Total per person[4]	175.60	182.86	202.18	0.00	273.11
Total per uninsured person[5]	237.90	247.74	273.90	0.00	370.00

SUB PROGRAMME 2.1 : DISTRICT ANAGEMENT/CLINICS/COMMUNITY HEALTH CENTRES/COMMUNITY BASED SERVICES/OTHER COMMUNITY SERVICES

2.1.1 SITUATION ANALYSIS

Prior to 1994, Gauteng Province rendered mainly curative health services and Local Government rendered Preventive and Promotive health services. The Gauteng Province decided on the Local Authority Option for delivery of Primary Health Care services through the District Health System in 1996.
In Gauteng Province there are jointly between Province and Local Authorities approximately 400 facilities rendering Primary Health Care service (excluding District Hospitals) serving a population of 8,3 million.

Since Demarcation of Local Municipalities and the second Local Government elections in December 2000, all Health Districts and Sub-Districts have been aligned with municipal boundaries.
The Gauteng Department of Health has been structured into three administrative Health Regions, each comprising a Metro and District Council area. The Health District are coterminous with Metros and District Councils and Health Sub-Districts are coterminous with municipal subdivisions of Metro and District Councils. There are three Metro areas of Johannesburg, Tshwane and Ekurhuleni with three District Councils namely Sedibeng, West Rand and Metsweding District Councils.

The City of Johannesburg area has eleven sub-district areas and Alexandra and the Inner City have been identified as Urban Renewal areas. The City of Tshwane area has three sub-district areas with large cross boundary area of Temba, Odi, Mabopane in North West Province. Ekurhuleni Metro area is a combination of nine previous local municipalities and is divided into three sub-districts. Sedibeng has three sub-districts and a growing population. The West Rand is developed in the area closest to Johannesburg and a rural area of Magaliesburg towards the NW border. Westonaria and Merafong City (a cross boundary municipality) have serious poverty in the mining area settlements. Metsweding is largely rural agricultural with exception of two towns.
Urban Renewal areas are Alexandra and the Inner City of Johannesburg. There are no rural nodes specified for health by National but specific attention is focussed on Bekkersdal in West Rand.

A legislative process for District Health Services for Gauteng Province commenced at the Health Summit in 1998, culminated in the District Health Services Act 8 of 2000, the Act makes provision for the delegation of the rendering of Primary Health Care services to Metros and District Councils. Regulations (District Health Services Act) have been drafted. The Memorandum of understanding between Province and Municipalities will be concretised by a Service Level Agreement for each municipality when delegation takes place.

The Health MinMEC decision of February 2001 states that all Provinces will devolve Primary Health Care services to municipalities, within the overall national and provincial framework. It implies a partnership between the Gauteng Health Department and the respective Local Governments with clear performance contracts. Subsequently a joint process through representatives of each Metro /District Council, Regions and Central Office with clear Terms of Reference was commenced.

There are both political and official Provincial and Local Government joint structures of the Provincial Health Authority(PHA), chaired by the MEC Health, and Provincial Health Advisory Committee(PHAC), chaired by the Head of Department, which meet on a regular basis.
Joint District management structures are being established throughout the Province.

There is well-established functional integration of Provincial and Local Government.

Primary Health Care services in Ekurhuleni and West Rand District areas , and a move towards rationalisation and integration in all Metro and District Council areas. While this has not been without challenges, the integration of services has demonstrated numerous benefits. Functional integration means that staff from local authorities and the province are working together and co-ordinating activities to provide comprehensive care to communities. The secondment of provincial personnel to local authority clinics and the building of new clinics have improved the geographical accessibility and the range of services available to many communities.
In July 2002, the National Department of Health indicated that there was a recommendation for definition of Municipal Health Services and that devolution of Primary Health Care services to Local Government will be through delegation.

Primary Health Care Services

The Primary Health Care services package Is an integrated package of essential basic health services such as maternal and child health care, environmental health, chronic disease treatment and rehabilitation and treatment of minor emergencies. It is fully comprehensive and involves a combination of preventive, promotive, curative and rehabilitative services, which take into account priority programmes as well as existing constraints at the Primary Health Care level.

The District Health Service provides access jointly between Province and Local Government a comprehensive range of services, which includes preventive, promotive, curative and rehabilitative health services. The total number of attendances has increased from 4.1 million in 1997 to 13.2 million in the 2001/2002. Apart from offering care for minor acute illnesses, clinics undertake extensive management of chronic conditions (1,48 million visits in 2000/01), ante-natal care (412 000 visits) and there were 16 674 deliveries in the primary care facilities. A total of approximately 320 000 consultations were for the treatment of sexually transmitted illnesses.

Access to services is influenced by distance, availability of health facilities, and attitudes of health workers. There are different service components for the different levels of the district health services (i.e. Community Based, Clinics and Community Health Centres) and the frequency with which they should be delivered.

Free primary health care has improved access to health care for many communities. At many clinics hours of clinics have been extended to ensure improved accessibility, particularly for working individuals and to provide needed after hour services. Through a major effort in many areas, previously preventive and promotive clinics have been able to expand the services they deliver to improve access to more comprehensive care.

Guidelines for the referral of patients to higher levels of care and for the down-referral of patients from hospitals to primary level facilities exist for the whole province. This should ensure that all patients have equal access to more specialised care of secondary or tertiary level services. The referral system also works from the hospitals back to the primary care system in their areas. As primary care is developing more and more patents are seen at their local facilities, instead of traveling to hospital outpatient departments.

Pre-packed medications and other medicines (on the Essential Drug List [EDL]), and surgical sundries are being supplied to most Local Government clinics to facilitate the introduction of a more comprehensive range of services. Detailed protocols were developed with training, which reached provincial and local government staff. The Essential Drug List (EDL) guides the rational use of drugs for improved patient care and the criteria for home oxygen revised.

The Gauteng Health Department also relies on the support and partnerships with non-governmental organisations (NGOs) to deliver services to the people of Gauteng.
Collaboration with the National Department of Health and Local Government is essential to ensure comprehensive health care services are delivered.
The health department provides health care services for the people in the neighbouring provinces.

The Batho Pele principles, the Patient Charter and the Gauteng Health Department Service Pledge provide the basis of the health department's commitment in providing appropriate and quality health services to all its clients.

NB: key challenges have been discussed under the main programme: district Health Services

2.1.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The main priorities of strengthening primary health care and improving the health status of the population of Gauteng are implemented mainly through this programme.

Strategic objectives

- Strengthening of EPI programme
- Implementation of priority public health programmes such as
  - Integrated nutrition programme,
  - Maternal and child health
  - TB control programme
  - STI's & HIV/ AIDS programme
  - Mental health
  - Youth and adolensence health
  - Chronic Diseases
  - Communicable and chronic diseases

- Ensure coordination of devolution of Primary Health Care services to Local Government
- Strengthen Primary Health Care through co-operative governance
- Develop Joint Provincial and Local Government District Health Service Plans
- Strengthen capacity to deliver Primary Health Care services
- Improve Financial Management for Primary Health Services
- Provide an effective and efficient District Health Information System
- Ensure construction of new clinics/CHC, upgrading and maintenance of Primary Health Care facilities

2.1.3 Description of planned quality improvement measures

Quality improvement measures have been discussed under programme 1.

Monitoring and evaluation of the progress towards integrated and comprehensive Primary Health Care services

- Joint reporting from Provincial and Metros/District Council areas is made at the PHA and PHAC meetings.
- There is also a progress report on the Devolution Primary Health Care services process to Local Government at the meetings.
- Information from the DHIS is also monitored for increased access and utilisation of Primary Health Care services.

2.1.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table: Format for presentation of objectives and evolution of performance indicators for sub programme 2.1

Strategic Objectives	Measurable Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Strengthen Primary Health care	Increase access to Primacy Health Care services	Percentage population served per fixed public PHC facility**	80%	85%	90%	95%	100%
		Number of professional nurses in fixed public PHC facilities per 1000 people	Data still being verufied				
		Number of professional nurses in fixed public PHC facilities per 1000 uninsured people	0.21	0.28	0.32	0.36	0.36
		Percentage of public PHC facilities supported by a doctor at least once a week (CHC/clinic))	13	13	13	13	13
		Percentage of sub-health districts with at least one 24 hour PHC facility	70	80	95	98	100

	Develop an integrated District service Plan	Number of health districts with formal plan Percentage of health districts with appointed manager	0 75	4 75	6 80	6 100	6 100
	Increase utilization of Primary health care facilities	Number of visits (headcount) at public PHC facilities per uninsured person per year	Data still being verified				
	Ensure DHS efficiency and equity in resource allocation	Provincial DHS expenditure per person Provincial DHS expenditure per uninsured person Provincial expenditure per visit (headcount) at provincial PHC facilities	Data still being verified				
	Develop quality improvement plan	Quality improvement plan in each health district	50	83	100	100	100
	Establish community health committees	Percentage sub-districts with community health committees established	70	80	100	100	100

2.1.6 SERVICE LEVEL AGREEMENTS AND TRANSFERS TO MUNICIPALITIES AND NON-GOVERNMENT ORGANISATIONS (PAYMENTS)

Table 1: Transfers to Local Government by Municipality

		Base year	**Year 1**	**Year 2**	**Year 3**
Municipality		**2002/03**	**2003/04**	**2004/05**	**2005/06**
		(estimate)	**(budget)**	**(MTEF Projection)**	
		R'000	**R'000**	**R'000**	**R'001**
District Municipalities	West Rand District Council	28 954	31 300	31 681	33 500
	Sedibeng District Council	41 472	44 850	45 307	47 900
	Metsweding District Council	8 746	9 550	9 591	10 150
Local municipalities	Johannesburg City Metro	71 886	90 050	91 200	96 300
	Ekurhuleni Metro	105 706	121 090	115 655	122 000
	City of Tswane Metro	40 965	44 260	44 936	47 500
Total: Transfers to LG by Mun.		**297 729**	**341 100**	**338 370**	**357 350**

Table 2: Transfers to Private Institutions					
		Base year	Year 1	Year 2	Year 3
Public Entity		2002/03	2003/04	2004/05	2005/06
		(estimate)	(budget)	(MTEF Projection)	
		R'000	R'000	R'000	R'001
Lifecare - Mental hospitals		155 000	167 000	176 000	186 000
Lifecare - Tubeculosis hospitals		29 180	32 250	34 100	36 000
SANTA - Tuberculosis hospitals		26 300	29 000	30 750	32 500
TB - Mine hospitals		-	4 000	4 250	4 500
Alexandra Health Care Centre		18 000	19 000	20 000	21 000
Witkoppen Clinic		1 100	1 300	1 400	1 500
Phillip Moyo Clinic		5 000	6 160	6 550	7 000
Total: Transfers to Public Entities		**234 580**	**258 710**	**273 050**	**288 500**

Table 3: Donations and Subsidies Non Governmental Organisations

		Base year	**Year 1**	**Year 2**	**Year 3**
Institution		**2002/03**	**2003/04**	**2004/05**	**2005/06**
		(estimate)	**(budget)**	**(MTEF Projection)**	
		R'000	**R'000**	**R'000**	**R'001**
NGO's - AIDS		19 117	19 117	20 400	21 600
NGO's - Integrated Nutrition Programme		54 673	54 673	54 673	54 673
NGO's - Mental Health		18 680	14 295	15 000	15 900
University Support		500	550	600	650
Total: Donations and Subsidies		**92 970**	**88 635**	**90 673**	**92 823**