STRATEGIC PLAN FOR THE DEPARTMENT OF HEALTH FOR THE 2003 MTEF PERIOD

PART A

1. INTRODUCTION AND SIGN OFF BY THE MINISTER AND HEAD OF DEPARTMENT

1.1 The strategic plan for the 2003 MTEF period is a continuation of that of the previous period, with emphasis on improving service delivery in line with provincial priorities.

1.2 Of note is the fact that the Departmental Strategic Positioning Statement has now been compiled. This sets out in detail the services, which the Department, given adequate funding, will be required to deliver by 2010. This document provides the basis of the Departmental strategic planning and provides information on the needs of the population and links the budgeting and strategic service delivery processes.

1.3 The Department is faced with many challenges, one being the impact of HIV/AIDS on service delivery. The anticipated long term effect of this pandemic has been taken into account in the Strategic Positioning Statement. The pandemic has a number of serious implications for health care delivery in KwaZulu-Natal:

- ***Skills shortages:***

  The high prevalence amongst the productive age group implies a further loss of skilled health care workers. Already figures indicate an increase in deaths amongst KwaZulu-Natal health workers. Females in the 25-29 year age group are most at risk indicating an increase in nursing staff shortages. The cost of training personnel to replace attrition losses due to HIV/AIDS, has been taken into account in the any strategic planning process.

- ***Increased health care demand due to opportunistic infections in patients with HIV/AIDS:***

  The TB prevalence in KwaZulu-Natal is showing signs of increasing. A higher incidence rate, lower cure rate, higher incidence of multi-drug resistance cases, as well as a higher case fatality rate are all possible effects of the HIV/AIDS pandemic.

- ***An increased number of maternal HIV/AIDS orphans:***

  This vulnerable group will, apart from the social welfare requirements, place increasing demands on health care due to malnutrition, and poverty-related diseases.

- ***An increase in infant and child mortality and a decrease in life expectancy.***

1.4 The Department continues to be guided by its **Vision and Mission:**

VISION

The vision of the Department is to achieve optimal health status for all persons in the Province of KwaZulu-Natal.

MISSION

To develop a sustainable, co-ordinated and comprehensive health system at all levels based on the Primary Health Care approach through the District Health System.

In accordance with the above, the aim of the Strategic Plan for the 2003 Medium Term Expenditure Framework period is to continue to give impetus to the drive for improved service delivery to meet the needs of the people of this Province, especially the poor and underserved in the peri-urban and rural communities. In addition, the Department will continue striving to establish an integrated, accessible, affordable, equitable, efficient and cost effective health service within the Province as envisaged in the Strategic Positioning Statement.

1.5 As indicated by our signatures below, we as Minister of Health and Head of the KwaZulu-Natal Department of Health, confirm that we have participated in the compilation of this strategic plan and that we are fully committed to ensuring its implementation.

.....	**.....**
DR Z. MKHIZE	**PROF. R.W. GREEN-THOMPSON**
MINISTER OF HEALTH	**HEAD OF DEPARTMENT**
KWAZULU-NATAL	**DEPARTMENT OF HEALTH**
	KWAZULU-NATAL

2. LEGISLATIVE AND OTHER MANDATES

The core functions of the Department of Health are to provide information, education and actions in order to prevent the occurrence of disease; and in the event of disease, to provide appropriate and cost-effective curative care. In carrying out these functions, the department is governed by, inter alia, the following Acts, rules and regulations:

- The Constitution of the Republic of South Africa, 1996, (Act 109 of 1996)
- National Health Act (Act No.63 of 1977)
- Mental Health Act (Act 18 of 1973)
- Provincial Health Act, 2000 (Act 4 of 2000)

- Public Finance Management Act (Act 1 of 1999) and Treasury Regulations
- Division of Revenue Act
- Public Service Act and Public Service Regulations
- KwaZulu-Natal Procurement Act 2001 (Act 3 of 2001)

3. POLICIES, PRIORITIES AND STRATEGIC GOALS

The Department of Health will continue to apply the following policy priorities in the 2003/04 Budget period:

3.1 KEY POLICY PRIORITIES OR SHIFTS THAT SHOULD BE TAKEN INTO ACCOUNT IN THE 2003/04 BUDGET

The following policy priorities are taken into consideration in this strategic plan and the budgeting process:

a. Ensuring that the emphasis on prevention of disease is given high priority;

b. Ensuring that HIV/AIDS and tuberculosis are given specific attention;

c. The continued development and upgrading of basic services in the under-served areas through the primary health care approach to ensure equity of access;

d. Ensuring that quality services are provided at all its institutions, especially at clinics;

e. A shift towards equity allocation between the Districts;

f. Maintaining the present services at lower cost;

g. Expanding the Emergency Medical Rescue Services into the underserved areas of the Province.

3.2 POLICY OPTIONS THAT ARE PROPOSED IN LINE WITH DEPARTMENTAL MEDIUM TERM POLICY PRIORITIES

No new policy options are proposed but the following policies introduced in 2002 are in the process of being rolled out throughout the Province:

- The roll-out of the Counselling and Voluntary Testing for HIV/AIDS;
- The roll-out of, and sustaining the programme to prevent the transmission of HIV/AIDS from mother to child;
- The continuation of the establishment of Crisis Centres throughout the province:
- The provision of anti-retroviral drugs to rape survivors.
- The increase in the intake of student nurses to combat the high attrition rate.

3.3 CONTINUATION OF POLICIES STILL IN EXISTENCE

The following policies, which have been introduced since 1995, will be continued in the 2003 MTEF period:

- Implementation of Primary Health Care through the District Health System;
- The immunisation of all newborns and children;
- Continuation with the appointment of Community Services Doctors, Community Services Pharmacists, Community Services Dentists, as well as other Community Services professionals;
- A major drive is in place in respect of the management of HIV/AIDS. Special funds have been set aside to establish/extend certain projects which include Hospice programmes, Drop-In Centres, voluntary Aids testing, promotional material and media releases;
- The use of Community Health Workers to disseminate information on health promotion at grass roots level;
- Continuation of a vigorous capital works and maintenance programme in an effort to upgrade facilities;
- Provision of an Integrated Nutrition Scheme;
- Improved financial discipline and revenue generation.

3.4 STRATEGIC GOALS

The strategic goals, which the Department has formulated for the improvement of service delivery within the 2003 Medium Term Expenditure Framework period are in line with the Provincial priorities and the National Health ten-point plan.

3.4.1 The goals of the **National Health's ten point plan** are as follows:

- Improving quality of care
- Reinforcing the Primary Health Care and District Health System approach
- Decreasing morbidity and mortality Rates
- Revitalisation of hospital services
- Improving resource mobilisation and management of resources without neglecting the attainment of equity in resource allocation
- Improving human resource management and human resource development
- Reorganisation of support services
- Improving communication and consultation with the Health services and between the Health System and communities
- Legislative reform
- International co-operation in conjunction with and through the National Department of Health.

3.4.2 The **Provincial priorities** are listed below:

- Reducing poverty and inequality
- Investing in infrastructure
- Re-engineering service delivery
- Addressing the impact of HIV/AIDS
- Strengthening governance
- Human capability development.

3.4.3 In summary, **this Department's goals** for the current year and the 2003 Medium Term Expenditure Framework are:

- To continue to provide and improve the quality of health care in the Province;
- To continue to enhance Primary Health Care services through the District Health System approach with special emphasis on underserved areas;
- To continue with the vigorous campaign in regard to HIV/AIDS and the roll-out of the CVT and the PMTCT programmes, as well as the introduction and provision of anti-retrovirals to rape survivors;
- To continue to strive towards decreasing morbidity and mortality rates, especially amongst infants and mothers and to encourage preventative rather than curative treatment;
- To continue investing in the health infrastructure through the Clinic Upgrading and Building Programme and the revitalisation of hospital facilities;
- Working towards resource mobilisation and management of resources to attain equity in resource allocation;
- Striving towards improving Human Resource Management and Human Resource Development through the training of sufficient personnel to meet the needs of the Department;
- To continue to improve access to Support Services through effective monitoring and improved distribution systems;
- To continue to encourage and improve communication and consultation with the Health services and between the Health System and Communities;

The more detailed descriptions of the objectives falling under the above goals will be discussed in detail under Part B of this Strategic Plan.

5. SECTORAL SITUATION ANALYSIS

5.1 SUMMARY OF SERVICE DELIVERY ENVIRONMENT AND CHALLENGES

The provision of Health Services in KwaZulu- Natal influences and is in turn influenced by a number of factors. The following resume is a broad analysis of the service delivery environment in which the Department operates, taking into consideration the external factors that have/may impact on the demand for its services, as well as those factors that have/may affect its ability to provide services.

Information from the Provincial Budget Statements for the 2002/03 financial year and other sources indicates that KwaZulu-Natal is the most populous province in South

Africa, with the second largest poverty gap in the country. This reveals grossly insufficient resources and an inability to provide adequate services of a reasonable quality, resulting in, inter alia, more expenditure for health care. (Appendix 1 details the demographic and socio-economic profile of the Province).

In order to meet its service delivery demands, this Department is faced with many challenges for the 2003 MTEF period, the major one being that of HIV/AIDS. It is essential that a more efficient and cost-effective way be found to manage the crisis in this Province. The current cost of managing HIV/AIDS and its concomitant opportunistic diseases especially tuberculosis, is becoming crippling. Currently patients, suffering from end-stage disease are being maintained in expensive, high care beds resulting in uneconomical use of funding.

The Strategic Positioning Statement has identified a more sustainable method of managing this problem through the re-categorisation of bed types within the District Health Service. It is intended that this policy should be put in place from the 2003/04 financial year. The provision of hospice step-down beds, and increasing the number of TB, and longterm care beds will result in a far more effective, efficient and economical management of funds. Although this process will require additional funding, the savings in the longterm would outweigh the initial expenditure.

The Department is currently initiating this policy for the management of HIV/AIDS and it is anticipated that positive progress will be made in the current financial year and the 2003 Medium Term Expenditure Framework period.

Other challenges which have, and will continue to have an impact on the service delivery of the Department during the current financial year and the 2003 MTEF period are, inter alia:

- the provision of sufficient clinics and Community Health Centres to meet the needs of the Province;
- the expansion of the Emergency Medical Rescue Services to those areas of the Province where access is extremely poor or non-existent;
- the need to improve and maintain the health infrastructure in a safe and acceptable condition within the limited funds provided;
- the management of malaria and waterborne diseases;
- skills shortages in the Professional cadres resulting from HIV/AIDS and personnel emigrating to other countries as well as a shortage of Community Health Workers;
- the provision of adequate plant, safe medical equipment and sufficient medicines taking into consideration the high foreign exchange rate in relation to the Rand, as well as the probability of increased medical inflation within the local market environment;
- supporting the policy of accommodating tenders from small businesses, which results in increased costs to the department.

5.2 SUMMARY OF ORGANISATIONAL ENVIRONMENT AND CHALLENGES

The Department is faced with a number of challenges relating to the internal environment, the main one being the lack of capacity in the management and professional cadres. A gap analysis has indicated acute shortages of medical personnel, especially nurses. The Department is addressing this issue by increasing the intake of nurses and providing bursaries in the required categories.

Other organisational matters include:

- Improving Resource mobilisation and management of resources without neglecting the attainment of equity in resource allocation;

- Reorganisation of Support services to meet the challenge of devolving procurement functions to the institutions, improved distribution of drugs and other stock items, as well as improving information systems.

The above information is discussed in more detail under the Strategic Goals of the Department in Part B. An organogram and maps indicating the organisational boundaries, i.e. health District boundaries are attached as annexures to the Plan.

5.3 DESCRIPTION OF THE STRATEGIC PLANNING PROCESS

5.3.1 The Department is aware of the importance of encouraging participation in the formulation of it medium and long-term goals in providing a health service in the Province. To this end, various mechanisms have been put in place to encourage participation by personnel and the community.

5.3.2 The strategic planning process for the 2003/04 MTEF period commenced with the formulation of the Strategic Positioning Statement. The process followed included wide participation with all service delivery components in all the Districts, as well as senior management at Head Office. The Strategic Positioning Statement provides an overview through sophisticated assumptions of the long-term trends, envisaged requirements and challenges to the Department in 2010.

5.3.3 The Strategic Positioning Statement has addressed possible ways of effecting more cost-effective patient management in hospitals by introducing different categories of beds at lower levels of nursing care. In the long-term, this will result in savings, making the provision of health services more affordable. The strategic planning process for 2003/04 has as a guideline the Strategic Positioning Statement principles and findings, which will influence future strategic plans to a greater extent than the present one.

5.3.4 The strategic planning process in this Department incorporates managers from all the institutions, districts and service delivery components and is used to inform the budgeting process of the Department. Once a year, the health managers, including the NGO's from the districts and the members of the Health Portfolio Committee participate in an exercise whereby the Department's activities are prioritised according to a set of approved criteria. During 2001/02 a Strategic Planning and Resource Committee was set up in each district in order to strengthen the bond between service delivery planning and the financial planning process.

5.3.5 Based on the above exercise, the **Department's Activities for the 2003/04** are set out below in priority order. The figures shown in brackets reflect the 2002 ranking.

1. Clinics and Mobile Clinic Services (1)

These facilities are the first level of Primary Health Care and provide services mainly to those patients who do not require admission to a more sophisticated facility.

2. Health Promotion (7)

Through communication, this service/activity encourages the general population to live more healthy lifestyles, thereby playing a preventative rather than a curative role in health management.

3. Community Health Centre Services (3)

These facilities provide a 24-hour health care service and have a doctor in attendance. They provide facilities for, inter alia, childbirth and those cases that cannot be treated at the clinic level, but do not necessarily require hospitalisation for more than 24 hours.

4. Clinic Building and Upgrading Programme (2)

This programme is specifically geared to provide access to health services in the underserved areas of the Province and to upgrade the present clinic infrastructure.

5. HIV/AIDS : Awareness and Prevention (4)

KwaZulu-Natal has the highest incidence of HIV/AIDS in South Africa. This service provides for the special programmes for education in and the prevention of HIV/AIDS.

6. District Hospital Services (8)

These facilities cater for patients who require admission to a hospital for treatment at a general practitioner level.

7. Environmental Health (10)

This service ensures that, inter alia, the standards of food, domestic housing,

water supplies, sanitation and refuse management are maintained in order to provide a safe environment for the general population. The inspection of ports and border posts, also fall under this activity.

8. Communicable Disease Control (5)

This service/activity is aimed at improving the awareness and control of communicable diseases and covers immunisation of children for, inter alia, polio, measles and HIB.

9. Community-Based Care (New)

This service is aimed at the provision of health services by Community Health Workers and other community health care-givers. The service will play an increasingly important role in combating HIV/AIDS and TB as well as playing a role in the health promotion campaigns of the Department.

10. Training and Education (HRD) (6)

This service/activity provides training for doctors, nursing and ambulance personnel, health workers and personnel in health management, administration and health promotion.

11. HIV/AIDS: PMTCT and CVT (New)

The PMTCT activity is aimed at high level intervention to prevent transmission of HIV/AIDS from HIV positive mothers to their babies. The intervention *per se* is not the main cost driver of this programme but a holistic approach, which includes counselling, follow-up systems, formula feeding and family counselling. The aim of the CVT programme is to make the population aware of their HIV status to ensure that planning can be done effectively to deal with the problems and challenges associated with HIV/AIDS in the broader sense, taking into consideration the socio-economic implications.

12. Integrated Nutrition Services (11)

This service/activity supports a number of feeding schemes for the poor providing supplementary nutrition in order to prevent diseases that accompany inadequate nutrition.

13. Regional Hospital Services (12)

These services cater for those patients who need admission to hospital for treatment at specialist level.

14. TB Hospitalisation (9)

This activity provides hospitalisation for patients especially suffering from resistant strains of tuberculosis as well as those who become TB infected as a result of HIV/AIDS.

15. Emergency Medical Rescue Services (14)

This service provides emergency transport and paramedic personnel for victims of, inter alia, trauma, maternity, motor vehicle and other accidents.

16. Patient Transport Services (13)

This service/activity provides transport to indigent patients who have no other means of transport.

17. Maintenance of Buildings and Equipment (15)

This activity ensures the maintenance of existing buildings and equipment in order to avoid the necessity for major works and replacements at a later stage.

18. Malaria Control (16)

Malaria is endemic in parts of the Province of KwaZulu-Natal and its incidence is monitored and controlled by means of this service.

19. Central Hospital Services (18)

This service provides the facilities and expertise needed for sophisticated medical procedures as well as a platform for training health workers.

20. Mental Health Hospitalisation (17)

This activity provides facilities for those patients requiring psychiatric care and psychological management. This also includes the management of substance abuse.

21. Convalescent Hospitalisation (19)

This service/activity provides facilities for those patients who require nursing care with minimal supervision by doctors. It is becoming increasingly important because of the increased HIV/AIDS incidence necessitating care for the terminally ill.

PART B

BUDGET PROGRAMME AND SUB-PROGRAMME PLANS

6.1 INTRODUCTION TO PART B:

This section of the Strategic plan details the planning of the individual budget programmes and sub-programmes.

6.2 STRATEGIC GOALS AND OBJECTIVES

The strategic objectives, which drive the budgeting process are indicated under the relevant strategic goals mentioned in Part A of this Strategic Plan.

6.2.1 Strategic Goal 1: Improving Quality of Care

- Strengthening and reaffirming the Batho Pele programme in the Department, incorporating the principles in the Patient's Charter, health and safety at work and the care and consideration of the disabled.
- Improving management at all levels of health services.
- Developing and implementing clinical management guidelines, with clinical audits at all facilities based on uniform health indicators for the Province.
- Strengthening the Quality Improvement Programme in institutions and training health personnel in strategies to improve the quality of care rendered.

6.2.2 Strategic Goal 2: Management of HIV/AIDS

- Continuing with the campaign against HIV/AIDS and rollout of the CVT and PMTCT programmes.
- Introduction and provision of anti-retrovirals to rape survivors.

6.2.3 Strategic Goal 3: Primary Health Care and District Health System

- Monitoring and evaluating the package of services which has been put into place for the Clinics and Community Health Centres.
- Continue implementation of the package of services for the District Hospitals.
- Continue training staff in appropriate clinical and non-clinical skills to provide required package of services.
- Continue to put in place and monitor referral systems with reference to the level of care.
- Monitoring to ensuring that the quality of service is maintained.

- Provision of Primary Health Care services in underserved areas.

- Roll-out of community based care.

6.2.4 Strategic Goal 4: Decreasing Morbidity and Mortality Rates and Improving Health Status:

- Interdepartmental/intersectoral collaboration will be encouraged, especially with regard to provision of safe water and sanitation.

- Combat infant morbidity and mortality resulting from:

  - Poor nutrition
  - Diarrhoeal Diseases
  - Trauma
  - Infectious diseases

- Combat maternal morbidity and mortality by encouraging ante-natal visits to clinics.

- Improve general health status of the population through preventative rather than curative treatment of trauma, HIV/AIDS, cholera and malaria, and management of substance abuse.

6.2.5 Strategic Goal 5: To continue investing in the Health Infrastructure and the Revitalisation of Health Services:

- Provision of clinics in underserved areas.

- Improve maintenance of hospital and clinic facilities.

- Replacement of obsolete/broken equipment through the medical equipment replacement programme.

- Improve decentralisation of hospital management and capacity building.

- Consolidating levels of care and referral patterns.

- Changing levels of service in terms of the Strategic Positioning Statement by introducing Acute Step-down beds and Hospice Step-down beds, which will result in more cost-effective management of patients.

- A Government to government initiative has been undertaken with Cuba to provide Cuban Doctors, which will continue to have a positive impact.

6.2.6 Strategic Goal 6: Improving Human Resource Development

- Ensuring the provision of sufficient nurses, pharmacists and medical staff for future needs by providing funds for bursaries and doubling the intake of nurses at the colleges, and introducing internships for the different therapies.

- A Government initiative has been undertaken with Cuba to train South African medical students in Cuba to assist with the shortage of professional personnel.

6.2.7 Strategic Goal 7: Rationalisation of High Level Services

- Tertiary and Central Health Services, presently taking place at various institutions will be rationalised and consolidated at Inkosi Albert Luthuli Central Hospital and Grey's Hospital. This will assist in pooling the scarce resources and will result in the optimal utilisation of expensive equipment.

ORGANISATIONAL MANAGEMENT

In order to support the strategic objectives for the improvement of service delivery, it is intended that the following organisational plans be continued during the Medium Term Expenditure Framework period.

6.2.8 Strategic Goal 8: Improving Resource Mobilisation and Management of Resources without neglecting the attainment of Equity in Resource Allocation

- Optimising the balance between personnel and other operational expenditure.
- Optimising the utilisation of physical resources.
- Optimising an equitable and efficient use of resources.
- The Department is continually enforcing optimal utilisation of its resources in terms of the Employment Equity Act and the Public Service Guidelines. Special attention is also given to institutional performance management and to employee assistance programmes.

6.2.9 Strategic Goal 9: Reorganisation of Support Services

- The Province has transferred its Procurement System and is in the process of devolving and delegating some of these improved procurement functions to institutional management.
- The supply of drugs and other stores items is being improved through effective monitoring and improved distribution systems.

The Department is also in the process of improving its health information systems, telemedicine, as well as its managerial electronic requirements.

7. PROGRAMME AND SUB-PROGRAMME PLANS

The Department continues through its budgeting and strategic planning process to make progress in achieving the strategic goals set out above. To this end the Strategic Positioning Statement will form the basis for improving the delivery of health care services in an effective, efficient and economical manner. The Strategic positioning Statement, which has been implemented in the current financial year will guide the strategic planning process to an increasing extent over the future financial years.

Each Programme is discussed below, with emphasis being placed on the service delivery and training programmes. Historical data includes expenditure and estimates from 2000/01 until 2005/06 the final year of the current Medium Term Expenditure Framework period.

7.1 TRENDS IN PROVINCIAL PUBLIC HEALTH EXPENDITURE

The following tables reflect the global trends in Provincial Public Expenditure in both current and constant prices.

TABLE 1: EVOLUTION OF EXPENDITURE BY PROGRAMME AND SUB-PROGRAMME – NOMINAL TERMS

PROGRAMMES	Year - 2 2000/01 (actual)	Year - 1 2001/02 unaudited	Base year 2002/03 Adj.budget	Average annual change (%)	Year 1 2003/04 (budget)	Year 2 2004/05 (MTEF projection)	Year 3 2005/06 (MTEF projection	Average annual change (%)
	R '000	R '000	R '000		R '000	R '000	R '000	
Programme 1: Administration	103,783	133,468	144,677		154,082	164,897	176420	
Programme 2: District Health Services	2,734,315	3,326,700	3,630,479		3,545,788	3,839,391	4095290	
Programme 3: Emergency Medical Services	154,158	158,336	182,981		243,355	260,437	278636	
Programme 4: Provincial Hospital Services	1,730,950	2,020,760	1,904,271		2,398,214	2,566,553	2745898	
Programme 5: Central Health Services	639,081	556,323	920,713		755,383	808,406	864895	
Programme 6: Health Sciences and Training	174,367	210,109	232,461		278,039	297,555	318348	
Programme 7: Health Care Support Services	-	-	5,000		1	1	1	
Programme 8: Health Facilities Management	234,771	624,071	398,598		430,978	461,229	493459	
TOTAL PROGRAMMES	5,771,425	7,029,767	7,419,180		7,805,840	8,398,469	8,972,947	

TABLE 2: EVOLUTION OF EXPENDITURE BY PROGRAMME AND SUB-PROGRAMME – REAL TERMS

PROGRAMMES	Year - 2 2000/01 (actual)	Year - 1 2001/02 (actual)	Base year 2002/03 Adj. Budget	Average annual change (%)	Year 1 2003/04 (budget)	Year 2 2004/05 (MTEF projection)	Year 3 2005/06 (MTEF projection	Average annual change (%)
	R '000	R '000	R '000		R '000	R '000	R '000	R '000
Programme 1: Administration	111,878	142,143	144,677		145,635	148,824	152,612	
Programme 2: District Health Services	2,947,592	3,542,936	3,630,479		3,351,406	3,465,154	3,542,638	
Programme 3: Emergency Medical Services	166,182	168,628	182,981		230,014	235,051	241,035	
Programme 4: Provincial Hospital Services	1,865,964	2,152,109	1,904,271		2,266,743	2,316,384	2,375,344	
Programme 5: Central Hospital Services	688,929	592,484	920,713		713,973	729,608	748,179	
Programme 6: Health Sciences and Training	187,968	223,766	232,461		262,797	268,551	275,388	
Programme 7: Health Care Support Services			5,000		1	1	1	
Programme 8: Health Facilities Management	253,083	664,636	398,598		407,352	416,272	426,868	

7.2 PROGRAMME 1: ADMINISTRATION

AIM: To provide funds for conducting the overall management of the Department.

7.2.1 SUB-PROGRAMME: OFFICE OF THE PROVINCIAL MINISTER

Objective: Policy formulation by the Minister and the Department's Management.

Outputs: To ensure that Health Services are rendered in terms of approved policies to the people of KwaZulu-Natal

7.2.2. SUB-PROGRAMME: MANAGEMENT

Objective: Organising the Department of Health, managing its personnel and Financial management services.

Output: To co-ordinate comprehensive health care services in the Province of

KwaZulu-Natal.

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	Average
	2000/01 (actual)	2001/02 unaudited	2002/03 Adj. Estimate	annual change (%)[2]	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	annual change (%)3
1. Office of the Provincial Minister	2,636	2,974	4,214		4,622	4,946	5,292	
2. Management	101,147	130,502	140,463		148,898	159,389	170,566	
Total programme	**103,783**	**133,476**	**144,677**	**-**	**153,520**	**164,335**	**175,858**	**-**

Table 7.2.2: Evolution of expenditure by budget programme and sub-programme (R million) Real Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	Average
	2000/01 (actual)	2001/02 unaudited	2002/03 Adj. Estimate	annual change (%)[2]	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	annual change (%)3
1. Office of the Provincial Minister	2,842	3,167	4,214		4,369	4,464	4,578	
2. Management	109,036	138,985	140,463		140,735	143,853	147,548	
Total programme	**111,878**	**142,152**	**144,677**	**-**	**145,104**	**148,317**	**152,126**	**-**

7.2.3 Expenditure Trends

It is the stated policy of the Department to keep the funding provided for this programme to a maximum of 2% of the total budget allocation. This has been achieved and the percentages remained more or less constant over the period under review.

The increase in the expenditure trend from 2000/01 to 2001/02 was mainly due to the improvement of conditions of service Personal profiles as well as the devolution of functions from the Department of Works to maintain Natalia building as well as funds from the Department of Finance for the payment of Auditor General fees.

The Department will remain within the revised budget allocation for the 2002/03 financial year.

7.2.4 This is a staff function and no specific performance indicators have been developed.

7.3 DISTRICT HEALTH SERVICES

AIM: To render primary health care services.

7.3.1 SUB-PROGRAMME: DISTRICT MANAGEMENT

Objective: Service planning, administration, co-ordination and monitoring of district health services, Including those rendered by District Councils and non-governmental organisations.

Output : To ensure that Health Services are rendered in terms of approved policies to the people of the relevant District.

7.3.2 SUB-PROGRAMME: COMMUNITY HEALTH CLINICS

Objective: To render primary health care services outside hospitals.

Output: To provide the first contact to health services to patients within a reasonable distance from their residences.

7.3.3. SUB-PROGRAMME: COMMUNITY HEALTH CENTRES

Objective: To render primary health care services outside hospitals.

Output: To provide the first contact to health services to patients within areasonable distance from their residences.

7.3.4 SUB-PROGRAMME : COMMUNITY BASED SERVICES

Objective: To render primary health care services for home-based care, the treatment of abuse, crisis and trauma victims as well as those patients treated by Community Health Workers.

Output: The provision of effective home-based care, treatment of abused and other trauma victims as well as the promotion of personal health.

7.3.5 SUB-PROGRAMME : OTHER COMMUNITY SERVICES

Objective: To render services for the management of environmental health including malaria, as well as specific medical programmes, for example communicable diseases and health promotion.

Output: The effective management of environmental health including malaria and other health programmes, such as communicable diseases and health promotion.

7.3.6 SUB-PROGRAMME : HIV/AIDS

Objective: To render primarily health care services mainly related to the prevention of HIV/AIDS.

Output: An effective HIV/AIDS awareness campaign and the prevention of the spread of HIV/AIDS through specific projects, such as counselling and voluntary testing, and the prevention of mother to child transmission of the virus.

7.3.7 SUB-PROGRAMME : NUTRITION

Objective: To render services directed at providing nutrition for the malnourished members of the population, especially school children.

Output: A decrease in the malnourished members of the population, especially school children.

7.3.8 SUB-PROGRAMME : CORONER SERVICES

Objective: This sub-programme has been created pending the transfer of all forensic services to the provinces. At present the Department is only providing the post-mortem services which includes the provision of information and support in inquests and suspected unnatural deaths.

Output: Carrying out post mortem and forensic laboratory services required in all cases of suspected unnatural deaths.

7.3.9 SUB-PROGRAMME: DISTRICT HOSPITAL SERVICES

Objective: Rendering of hospital services at general practitioner level.

Output: To provide for patients who require admission to a hospital for treatment at a general practitioner level.

Table 7.3.1: Evolution of expenditure by budget programme and sub-programme (Rmillion) Nominal Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3
	2000/01 (actual)	2001/02 (unaudited)	2002/03 Adj. Estimate	annual change (%)[2]	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
2.1 District Management	26,056	31,689	42,856		50,303	53,834	57,596
2. 2 Community HealthClinics	624,615	732,585	810,602		833,544	892,054	954,389
2.3 Community Health Centres	114,683	136,224	147,938		176,994	189,418	202,654
2.4 Community Based Services	47,743	64,911	71,145		72,613	77,710	83,140
2.5. Other Community Services	204,137	310,401	164,962		197,405	211,261	226,024
2.6. HIV/AIDS	30,403	49,364	143,313		246,523	289,843	300,869
2.7 Nutrition	128,454	168,550	169,565		184,000	215,612	227,518
28. Coroner Services	-	-	-	-	-	-	-
2.9 District Hospitals	1,558,224	1,832,976	2,080,098		1,784,406	1,909,659	2,043,101
Total programme	2,734,315	3,326,700	3,630,479	-	3,545,788	3,839,391	4,095,291

Table 7.3.2: Evolution of expenditure by budget programme and sub-programme (Rmillion) Real Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	
	2000/01 (actual)	2001/02 (actual)	2002/03 Adjs.Estimate	annual change (%)[2]	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	
2.1 District Management	28,088	33,748	42,856		47,908	45,400	49,824	
2. 2 Community Health Clinics	673,335	780,203	810,602		787,849	752,296	825,596	
2.3 Community Health Centres	123,628	145,079	147,938		167,291	159,742	175,306	
2.4 Community Based Services	51,467	69,130	71,145		68,632	65,535	71,920	
2.5. Other Community Services	220,060	330,577	164,962		186,583	178,163	195,522	
2.6. HIV/AIDS	32,774	52,573	143,313		233,009	222,494	260,267	
2.7 Nutrition	138,473	179,506	169,565		173,913	166,065	196,815	
28. Coroner Services	-	-			-	-	-	
4. District Hospital Services	1,679,765	1,952,119	2,080,098		1,686,584	1,610,475	1,767,388	
Total programme	2,947,592	3,542,934	3,630,479	-	3,351,769	3,200,170	3,542,639	

7.3.3 EXPENDITURE TRENDS

The increasing trend in the expenditure/budget allocation of this programme is mainly due to:

- The policy of providing access to the less expensive, but the most important level of health services, i.e. clinics, community health centres and district hospitals.
- The commissioning of new clinics;
- The establishment and strengthening of the District management offices;
- The intended expansion of Emergency Medical Services to the underserved areas.

This programme was projecting an over-expenditure due to the following expenditure pressures which also will effect the expenditure in the future years:

- The implementation of the new policy directive to rollout the prevention of the transmission of HIV/AIDS from Mother-to-Child (PMTCT).
- The effect of the weakening Rand on the acquisition of medicine and equipment.
- To provide medical care for escalating HIV/AIDS patients at district hospital level.
- Supporting the policy of allocating contracts to SMME'S.
- Pressure to unfreeze frozen posts due to work pressure.
- The increase in the fuel price.

Additional funds have been provided in the revised estimates relieving the pressure on this programme.

2.2 Community Health Clinics To provide facilities for patients to be treated at Primary Health Care Level.	Number of headcounts at an average of 2.8 per member of the indigent population (7,323 million)p.a.		15,745,172	17,321,000		
2.2 Community Health Centres To provide facilities for patients to be treated at Primary Health Care Level.	Number of headcounts at an average of 2.8 per member of the indigent population (7,323 million)p.a.		1,736,480	1,910,000		
2.9 District Hospitals	Number of admissions to be maintained at present levels or reduced.		275,598	275,598		

7.4 EMERGENCY MEDICAL SERVICES

AIM: To render emergency medical services as well as to provide elective patient transport.

7.4.1 SUB-PROGRAMME: EMERGENCY MEDICAL SERVICES

Objective: To render emergency medical services

Outputs : The provision emergency medical services through specialised transport and paramedic personnel.

7.4.2. SUB-PROGRAMME: PLANNED PATIENT TRANSPORT

Objective: To provide elective patient transport for indigent patients who have no other means of transport.

Output: The provision of transport for indigent patients between institutions who have no other form of transport.

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3
	2000/01 (actual)	2001/02 (unaudited)	2002/03 Adj.Estimate	annual change (%)[2]	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
3.1 Emergency Medical Services	142,958	147,081	170,113		229,484	245,211	261,581
3.2 Planned patient transport	11,200	11,255	12,868		13,871	15,226	17,055
Total programme	154,158	158,336	182,981	-	243,355	260,437	278,636

Table 7.4.2: Evolution of expenditure by budget programme and sub-programme (Rmillion) Real Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3
	2000/01 (actual)	2001/02 (unaudited)	2002/03 Adj.Estmate	annual change (%)[2]	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
3.1 Emergency Medical Services	154,109	156,641	170,113		216,904	221,310	226,281
3.2 Planned patient transport	12,074	11,987	12,868		13,111	13,742	14,753
Total programme	166,182	168,628	182,981	-	230,014	235,051	241,035

7.4.3 EXPENDITURE TRENDS

The increasing trend in the expenditure/budget allocation of this programme is mainly due to the intended expansion and upgrading of Emergency Medical Services to the underserved areas.

This programme was projecting an over-expenditure due to the following expenditure pressures which also will effect the expenditure in the future years:

- The increase in the fuel price.
- The effect of the foreign exchange rate on the acquisition of equipment.
- Pressure to unfreeze frozen posts due to work pressure.

Additional funds have been provided in the revised estimates relieving the pressure on this programme.

7.5 PROVINCIAL HOSPITAL SERVICES

AIM: To render general hospital services at a regional level.

7.5.1 SUB-PROGRAMME: GENERAL HOSPITALS

Objective: To provide hospital facilities for those patients that require treatment at Specialist level.

Output: The provision of specialist hospital services for those patients that require treatment at Specialist level.

7.5.2 SUB-PROGRAMME: TUBERCULOSIS HOSPITALS

Objective: To provide hospital facilities for those patients who require admission for tuberculosis.

Output: The hospital services for the treatment of tuberculosis including the treatment of Multi Drug Resistant patients.

7.5.3 SUB-PROGRAMME: PSYCHIATRIC HOSPITALS

Objective: To provide hospital facilities for those patients requiring mental health care.

Output: The rendering of hospital services to mentally ill patients including the management of substance abuse.

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7.5.4 SUB-PROGRAMME: CHRONIC MEDICAL HOSPITALS (LONGTERM)

Objective: To provide hospital facilities for those patients requiring long term nursing care.

Output: The rendering of hospital services to patients requiring long term nursing care.

7.5.5 SUB-PROGRAMME: DENTAL TRAINING HOSPITALS

Objective: To provide dental health services and to provide a platform for the training of health workers.

Output: To render dental health services and to provide training for oral health personnel.

Table 7.5.1: Evolution of expenditure by budget programme and sub-programme (R million) Nominal Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	Average
	2000/01 (actual)	2001/02 (actual)	2002/03 Adj.Estimate	annual change (%)²	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF Yr 2+ 6%	annual change (%)3
4.1 General Hospitals	1,375,833	1,634,424	1,508,888		1,739,985	1,864,927	1,998,039	
4.2 Tuberculosis hospitals	123,923	144,556	159,029		295,572	316,319	338,423	
4.3 Psychiatric hospitals	211,018	219,254	210,135		209,277	221,159	233,818	
4.3 Chronic medical hospitals	13,889	15,297	18,245		145,380	155,585	166,457	
4.4 Dental training hospitals	6,287	7,229	7,974		8,000	8,562	9,160	
Total programme	**1,730,950**	**2,020,760**	**1,904,271**	**-**	**2,398,214**	**2,566,552**	**2,745,897**	**-**

Table 7.5.2: Evolution of expenditure by budget programme and sub-programme (Rmillion) Real Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	Average
	2000/01 (actual)	2001/02 (actual)	2002/03 Adj.Estimate	annual change (%)²	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	annual change (%)3
4.1 General Hospitals	1,483,148	1,740,662	1,508,888		1,644,598	1,683,147	1,728,407	
4.2 Tuberculosis hospitals	133,589	153,952	159,029		279,369	285,486	292,753	
4.3 Psychiatric hospitals	227,477	233,506	210,135		197,804	199,602	202,265	
4.4 Chronic Hospitals	14,972	16,291	18,245		137,410	140,420	143,994	
4.5 Dental Training Hospital	6,777	7,699	7,974		7,561	7,727	7,924	
2. Provincial Specialised Hospitals	**1,865,964**	**2,152,109**	**1,904,271**	**-**	**2,266,743**	**2,316,383**	**2,375,343**	**-**

7.5.3 EXPENDITURE TRENDS

Although there is an increase in the expenditure trends over the past three years, funds have been moved to the more appropriate levels of service (District Health Services) in accordance with Departmental policy. However, this movement in monetary terms has been negated by the improvements to conditions of service, inflation and the poor performance of the Rand on international markets, especially in respect of medicines, medical equipment and plant, mainly used at this level of service.

An over expenditure in this Programme was projected for the current financial year, which will also have an effect on the future MTEF years:

- Increased pressure on specialised TB facilities as a result of HIV/AIDS.
- Performance of the Rand on international markets and its influence on the cost of medicine, medical equipment and general inflation.
- Supporting the policy of allocating contract to SMME's.

Additional funds have been provided in the revised estimates relieving the pressure on this programme.

Table:7.5.3 PROGRAMME 4: OBJECTIVES, OUTPUTS, MEASURES AND TARGETS

Programme Structure Measurable Objectives	Performance measures (quantitiy,quality, cost,timeliness)	2001/02 Actual	2002/03 Estimated	2003/04 Target	2004/05 Target	2005/06 Target
4.1 General Hospitals						
To provide hospital facilities for those	Number of admissions to be					
patients that require treatment at	maintained at present levels or					
specialist level.	reduced.		274,064	275,000		
4.2 **Tuberculosis hospitals**	Number of admissions to be					
To provide hospital facilities for those patients	increased resulting from HIV.AIDS		4,852	5,400		
that require treatment for tuberculosis.						
4.3 Psychiatric hospitals	Number of admissions					
To provide hospital facilities for those patients	to be increased in rural areas		4,362	4,800		
that require mental health care						
4.4 Chronic Medical Hospitals (Longterm)	Number of admissions to be					
To provide hospital facilities for those patients that	increased as a result of HIV/AIDS		1,198	1,220		
longterm care						
4.5 Dental training hospitals						
To render dental health services and	Number of cases to be increased		47,880	52,700		
to provide training for dental						

7.6 CENTRAL HOSPITAL SERVICES

AIM: The provision of highly specialised and quaternary health care services.

7.6.1 SUB-PROGRAMME: CENTRAL HOSPITALS

Objective: The rendering of a highly specialised and quaternary health care service.

Output : The provision of facilities and expertise for sophisticated medical procedures.

7.6.2. SUB-PROGRAMME: TERTIARY HOSPITALS

Objective: To provide referral services to general hospitals for patients who require more specialised care.

Output: The provision of referral hospital services for patients who require more specialised care.

Table 7.6.1: Evolution of expenditure by budget programme and sub-programme (Rmillion) Nominal Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3
	2000/01 (actual)	2001/02 (unaudited)	2002/03 Adj.Estimate	annual change (%)[2]	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF Yr 2+6%
5.1. Central Hospital Services	127,816	111,265	184,143		190,445	203,813	218,055
5.2 Provincial tertiary hospital services	511,265	445,058	736,570		564,938	604,593	646,840
Total programme	**639,081**	**556,323**	**920,713**	**-**	**755,383**	**808,406**	**864,895**

Table 7.6.2: Evolution of expenditure by budget programme and sub-programme (R million) Real Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	Average
	2000/01 (actual)	2001/02 (actual)	2002/03 Adj.Estimate	annual change (%)[2]	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	annual change (%)3
5.1. Central Hospital Services	137,786	118,497	184,143		180,005	183,947	188,629	
5.2 Provincial tertiary hospital services	551,144	473,987	736,570		533,968	545,662	559,550	
Total programme	**688,929**	**592,484**	**920,713**	**-**	**713,973**	**729,608**	**748,179**	**-**

7.6.3 EXPENDITURE TRENDS

The downward trend from 2000/01 to 2001/02 is due to the commencement of the commissioning of Inkosi Albert Luthuli Central Hospital and the systematic movement of the services/expenditure relevant to King Edward and Wentworth Hospitals to the lower levels of service. (District Health Services and Provincial Hospital Services). The funding is, however, below the target expenditure of 11% for tertiary services.

This programme will be affected by the performance of the Rand since September 2001 as this influenced the unitary fees of the PPP contract in respect of the Inkosi Albert Luthuli Central Hospital.

For the 2002/03 financial year, this programme was projecting an over-expenditure, mainly due to the commissioning of the Inkosi Albert Luthuli Central Hospital and the simultaneous running of the central and tertiary services at King Edward Hospital, Wentworth and Grey's Hospital. This service has been negatively influenced by the performance on the Rand on the Forex markets. The following expenditure pressures are being experienced by this programme:

- Pressure to unfreeze frozen posts due to work pressure.
- Performance of the Rand on international markets and the general inflation affecting the cost of medicine.
- Because of the weakening of the Rand, the unitary payment for the PPP contract has been affected and will place pressure on the budget.

Additional funds have been provided in the revised estimates relieving the pressure on this programme.

Table:7.6.3 PROGRAMME 5: OBJECTIVES, OUTPUTS, MEASURES AND TARGETS

Programme Structure Measurable Objectives	Performance measures (quantitiy,quality, cost,timeliness)	2001/02 Actual	2002/03 Estimated	2003/04 Target	2004/05 Target	2005/06 Target
5.1 Central Hospital Services						
To provide facilities and expertise for	Number of admissionsto be increased		64,556	71,000		
sophisticated medical procedures	in line with national guidelines					

7.7 PROGRAMME 6: HEALTH SCIENCES AND TRAINING

AIM: **To provide for the training of nursing and ambulance personnel, health workers and personnel in health management, administration and health promotion, as well as the granting of bursaries.**

7.7.1 SUB-PROGRAMME: NURSE TRAINING COLLEGES

Objective: The training of nursing personnel.

Outputs : The provision of trained nursing staff.

7.7.2. SUB-PROGRAMME: EMRS TRAINING COLLEGES

Objective: The training of ambulance personnel.

Output: The provisionof trained ambulance personnel.

7.7.3 SUB-PROGRAMME: BURSARIES

Objective: Granting of bursaries to students and other personnel studying in Health Sciences and Administration.

Output: To improve capacity in health services and to provide funding for the disadvantaged students.

7.7.4 SUB-PROGRAMME: PRIMARY HEALTH CARE TRAINING

Objective: To render training to improve clinical skills of nurses functioning in the Primary Health Care Services.
Output: The improved clinical skills of nurses functioning in Primary Health Care Services.

7.7.5 SUB-PROGRAMME: TRAINING OTHER

Objective: This service provides training for health workers and personnel in health management, administration and health promotion.

Output: Trained and capacitated health workers and personnel in health management, administration and health promotion.

Table 7.7.1: Evolution of expenditure by budget programme and sub-programme (R million) Nominal Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	Average
	2000/01 (actual)	2001/02 (unaudited)	2002/03 Adj. Estimate	annual change (%)[2]	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF Yr 2+5%	annual change (%)3
6.1. Nurse Training Colleges	101,827	108,027	122,057		128,210	137,085	146,530	
6.2. EMS Training Colleges	1,103	3,050	3,815		4,000	4,281	4,580	
6.3 Bursaries	6,827	22,701	26,810		24,400	26,113	27,937	
6.4 Primary Health Care Training	25,574	32,736	33,527		36,890	39,603	42,506	
6..5 Training Other	39,036	43,595	46,252		84,540	90,442	96,744	
Total programme	174,367	210,109	232,461	-	278,040	297,524	318,297	-

Table 7.7.2 : Evolution of expenditure by budget programme and sub-programme (R million) Real Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	Average
	2000/01 (actual)	2001/02 (actual)	2002/03 Adj.Estimate	annual change (%)[2]	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	annual change (%)3
6.1. Nurse Training Colleges	109,770	115,049	122,057		121,181	123,723	126,756	
6.2. EMS Training Colleges	1,189	3,248	3,815		3,781	3,864	3,962	
6.3 Bursaries	7,360	23,506	26,810		23,062	23,568	24,167	
6.4 Primary Health Care Training	27,569	34,864	33,527		34,868	35,743	36,770	
6..5 Training Other	42,081	46,429	46,252		79,905	81,654	83,733	
Total programme	187,968	223,095	232,461	-	262,797	268,551	275,388	-

7.7.3 EXPENDITURE TRENDS

The increasing expenditure trend over the past three years is mainly related to the consolidation of all training expenditure within one programme and includes, inter alia, provision for pharmacy interns, family planning trainers and the administrative training component. This programme is also affected by the improvements to conditions of service and personal profile expenditure.

In the 2002/03 financial year and the Medium Term expenditure Framework period, this programme will be under pressure because of the policy of increasing the number of student nurses trained in order to provide sufficient staff to replace those who are leaving the services for more lucrative offers elsewhere, as well as deaths as a result of HIV/AIDS.

Table 7.7.3 PROGRAMME 6: OBJECTIVES, OUTPUTS, MEASURES AND TARGETS

Programme Structure Measurable Objectives	Performance measures (quantity, quality cost, timeliness)	2001/02 Actual	2202/03 Estimated	2003/04 Target	2004/05 Target	2005/06 Target
6.1 Nurse Training Colleges To provide training for nurses.	Number of nurses trained per annum	3,040	3,788	5,682		
6.3 Bursaries To improve capacity in health services and to provide funding for the disadvantaged.	Number of students funded per annum	435	605	670		
6.5 Other	Number of community health workers trained		2,000	2,200		
	Number of hospital managers trained		-	240		
	Number of employees trained in computer literacy		1,712	2,500		
	Number of interns		297	300		
	Number of persons in skills development programme		1,200	1,200		

7.8 PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

AIM: To provide funding for Health Care Support Services.

7.8.1 SUB-PROGRAMME: MEDICINE TRADING ACCOUNT

Objective: To provide for augmentation of the Medicine Trading Account.

Table 7.7. 1: Evolution of expenditure by budget programme and sub-programme (R million) NominaRl Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	Average
	2000/01 (actual)	2001/02 (actual)	2002/03 Adj. Estimate	annual change (%)²	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF Yr2+106%	annual change (%)3
1. Medicine Trading Account			5,000		1	1	1	
Total programme	-	-	5,000	-	1	1	1	-

Table 7.7. 2: Evolution of expenditure by budget programme and sub-programme (R million)Real Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	Average
	2000/01 (actual)	2001/02 (actual)	2002/03 Adj.Estimate	annual change (%)²	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF Yr2+106%	annual change (%)3
1. MEDVAS Trading Account			5,000		1	1	1	
Total programme	-	-	5,000	-	1	1	1	-

Programme7: Objectives, Outputs, Measures and Targets

- **Turnover of stock to be less than eight times per year.**

7.9 PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

AIM: To manage the physical facilities of the Department to provide new facilities, for example clinics and community health centres, as well as to maintain the existing structures

7.9.1 SUB-PROGRAMME: COMMUNITY HEALTH SERVICES

Objective: Physical management of Community Health Clinics and Community Health Centres.

Outputs:

1. **Maintenance and Facilities Audit:** Well maintained and improved Primary Health Care facilities.
2. **Clinic Building and Upgrading Programme:** The provision of new and replacement clinics to provide improve access to health services in the underserved areas of the Province.

7.9.2 SUB-PROGRAMME: DISTRICT HOSPITALS

Objective: Physical management of District Hospitals.

Output: **Maintenance and Facilities Audit:** Well maintained and improved District Hospitals.

7.9.3 SUB-PROGRAMME: EMERGENCY MEDICAL SERVICES

Objective: Physical management of Emergency Service facilities

Output Well maintained and improved of Emergency Service Facilities.

7.9.4 SUB-PROGRAMME: PROVINCIAL HOSPITAL SERVICES

Objective: Physical management of provincial hospitals.

Output: Well maintained and improved Provincial Hospitals.

7.9.5 SUB-PROGRAMME: CENTRAL HOSPITAL SERVICES

Objective: Physical management of Central and Tertiary Hospitals.

Outputs: Well maintained and improved Central and Tertiary Hospitals.

7.9.6 SUB-PROGRAMME: OTHER SERVICES

Objective: Physical management of all Departmental Buildings not falling into the above categories.

Outputs: Well maintained and improved non- medical building infrastructure.

Table 7.9. 1: Evolution of expenditure by budget programme and sub-programme (R million) Nominal Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	Average
	2000/01 (actual)	2001/02 (actual)	2002/03 Adj.Estimate	annual change (%)²	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF Yr2+106%	annual change (%)3
8.1 Community Health Services	12,288	27,895	93,761		86,032	73,966	75,858	
8.2 District Health Services	29,300	44,254	42,527		140,059	221,827	226,361	
8.3 Emergeny Medical Services	472	435	392		2,292	2,257	3,055	
8.4 Provincial Hospital Services	56,677	72,459	98,855		142,021	146,848	170,434	
8.5 Central Hospital Services	86,956	414,245	13,485		66,022	59,063	72,527	
8.6 Other Services.	49,078	64,783	69,578		27,962	33,062	27,094	
Total programme	234,771	624,071	318,598	-	464,388	537,023	575,329	-

Table7.9.2: Evolution of expenditure by budget programme and sub-programme (R million) Real Terms

Sub-Programme	Year -2	Year - 1	Base year	Average	Year 1	Year 2	Year 3	Average
	2000/01 (actual)	2001/02 (actual)	2002/03 Adj Estimate	annual change (%)²	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	annual change (%)3
2. Physical Facilities Management	13,246	29,708	93,761		81,316	66,756	65,621	
8.1 Community Health Servoces	31,585	47,131	42,527		132,381	200,205	195,814	
8.2 District Health Services	509	463	392		2,166	2,037	2,643	
8.3 Emergeny Medical Services	61,098	77,169	178,855		134,235	132,534	147,434	
8.4 Provincial Hospital Services	93,739	441,171	13,485		62,403	53,306	62,740	
8.5 Central Hospital Services	52,906	68,994	69,578		26,429	29,839	23,438	
Total programme	253,083	664,636	398,598	-	438,930	484,678	497,689	-

7.9.3 EXPENDITURE TRENDS

Expenditure trends over the past three years: When the funding for the Inkosi Albert Luthuli Central Hospital is excluded the expenditure for this Programme shows a gradual increase from 1.75% in 1999/2000 to 3.5%, which is in line with the policy of making an increasing provision for maintenance and the improvement of the general infrastructure of the Department in order to provide safe facilities.

This programme is subject to the following expenditure pressures:

- Performance of the Rand on international markets and its influence on the cost of medical equipment and general inflation.
- Supporting the policy of allocating contracts to SMME's.
- To maintain the buildings in a safe and acceptable condition.
- The enormous backlog and bad state of the infrastructure.

Table:7.9.3 PROGRAMME 3: OBJECTIVES, OUTPUTS, MEASURES AND TARGETS

Programme Structure Measurable Objectives	Performance measures (quantity,quality, cost,timeliness)	2001/02 Actual	2002/03 Estimated	2003/04 Target	2004/05 Target	2005/06 Target
Programme 8: Health Facilities Management	New facilities - number of projectects completed		62	45		
	Rehabilitation - number of projects completed		274	86		
	Replacement - number of projectes completed		64	19		
	Upgrading - number of projects completed		590	98		

8. MEDIUM TERM REVENUES

8.1 SUMMARY OF REVENUE

The following table illustrates the sources of funding for this Department.

Table 8.1: Summary of Sources of Revenue

R 000	2000/01 Actual	2001/02 Adj. Budget	2002/03 MTEF	2003/04 MTEF	2004/05 MTEF	2005/06 MTEF
Vote by legislature	4,779,178	5,548,407	6,178,142	6,643,751	7,062,226	7,521,688
Conditional grants	1,100,830	942,970	1,018,521	1,197,899	1,414,604	1,535,877
Other (specify)						
Total revenue	5,880,008	6,491,377	7,196,663	7,841,650	8,476,830	9,057,565

8.2 DEPARTMENTAL REVENUE COLLECTION

It should be noted that the only meaningful revenue in this Department is that of patient fees. Most of the remaining revenue items are not uniform and are not received on a regular basis. It is therefore very difficult to assess these items accurately. Previous years' figures were mainly used to estimate the revenue trends. Of note are the following:

8.2.1 Property Income:

The income received under this item includes interest, housing rental and State Property rights. The increase in the interest collection during 2001/02 resulted mainly from a special effort being made by the Department to improve the management of the long outstanding debts. Considering the increasing trends of the previous financial years and the expected stabilisation of the interest collection, a 4% increase was viewed as being reasonable in estimating the revenue of the consecutive years.

8.2.2. Fees and Charges:

The main categories of revenue received under this item are the **patient fees, health services (**for example, deposits for oxygen cylinders and medical report costs, etc), and **board and lodging.** The other revenue items under this category are mostly received on an irregular basis and estimated at an average of between 5-6% based on previous years' trends.

Approximately 96% of the patients attending the department's health facilities are unable to make any meaningful contribution for the services provided. It however remains a challenge to the Department to maximise revenue collection.

The Department is also in the process of implementing new tariffs/charges negotiated between National Health and the Provinces, in terms of the Uniform Patient Fees Schedule. The implementation of this new system will be done on a phased basis which commence on 1 November 2002.

The main challenge facing the Department at this stage is therefore to develop a uniform system for Patient Revenue as well as to build capacity at all institutions to effectively collect the potential revenue due to the Department.

The revenue for patient fees, board and lodging, health services and the other items were estimated on an average of between 5 - 6% based on the trends from the previous years.

8.2.3 Capital Revenue

The two items of revenue collected under this category refer to the sale of redundant and damaged equipment and stock that have been written off during the Board of Survey process at institutions and sold mainly as scrap.

Revenue received for these items are once again inconsistent and an average increase of 6% was used based on the revenue trends since 2000/01.

8.2.4 **Table 8.2.4** below illustrates the revenue collected by this Department over the reporting period.

Table 8.2.4: Departmental Revenue

R 000	2000/01 Actual	2001/02 Unaudited	2002/03 Estimate	2003/04 MTEF	2004/05 MTEF	2005/06 MTEF
Current revenue	**109,775**	**117,964**	**116,854**	**124,284**	**131,870**	**139,751**
Tax revenue						
Non-tax Revenue	109,775	117,964	116,854	124,284	131,870	139,751
Interest	535	1,849	1,040	1,040	1,040	1,072
Health patient fees	89,444	97,701	95,918	100,713	105,749	112,094
Other revenue	19,796	18,414	19,896	22,531	25,081	26,585
Capital Revenue	**235**	**261**	**263**	**279**	**296**	**315**
Sale of Land and Buildings						
Sale of Stock and Livestock, etc	235	261	263	279	296	315
Other capital revenue						
Departmental revenue	**110,010**	**118,225**	**117,117**	**124,563**	**132,166**	**140,066**

9. CONDITIONAL GRANTS FOR THE 2003 MTEF PERIOD

NAME OF CONDITIONAL GRANT	PURPOSE OF CONDITIONAL GRANT	2002/03 Budget	2003/04 Estimate	2004/05 Estimate	2005/06 Estimate
		R'000	R'000	R'000	
1. NATIONAL TERTIARY SERVICES GRANT	Fund national tertiary services as identified and costed by the Department of Health; Ensure equitable access by all South Africant to basic tertiary health level care; and Ensure collective planning for tertiary services.	488,575	537,752	601,853	637,854
2. HEALTH PROFESSIONALS TRAINING AND DEVELOPMENT GRANT	Support the training of health professionals; Development and recruitment of medical specialists in under-served provinces; and Enableshifting of teaching activities from central hospitals to regional and district facilities.	164,755	156,178	179,303	190,061
3. HOSPITAL REVITALISATION GRANT	To transform and modernise hospitals in line with the national planning framework and to achieve sustain-ability.	111,000	94,050	99,693	105,675
4. INTEGRATED NUTRITION PROGRAMME	To improve the nutritional status of South Africans, specifically to enhance active learning capacity and improveschool attendance of primary school learners from poor households.	136,337	132,471	140,419	140,844
5. HIV/AIDS GRANT	To enable the social sector to develop an effective inte-grated response to the HIV/AIDS epidemic, focusing on children infected and affected by HIV/AIDS.	54,470	63,523	88,996	94,336

CONDITIONAL GRANTS CONTINUED

PURPOSE OF CONDITIONAL GRANT	2002/03 Budget	2003/04 Estimate	2004/05 Estimate	2005/06 Estimate	
	R '000	R '000	R '000	R '000	
To improve financial management in the health sector.	19,000	17,000	18,020	19,101	
To help accelerate construction maintenance and rehabilitation of new and existing infrastructure.	46,358	69,430	85,797	90,945	

10. CO-ORDINATION, CO-OPERATION AND OUTSOURCING PLANS

10.1 INTERDEPARTMENTAL LINKAGES

Although the Department of Health co-operates with the other Departments where services overlap, each Department funds its own core business functions and no joint funding for specific projects is provided.

The following projects are jointly administered and executed by:

1. The Departments of Health, Education and Agriculture:

Primary School Nutrition Programme: Funding is provided by the Department of Health in order to reduce hunger and malnutrition among primary school learners. School Governing Bodies have been established at the schools to administer the feeding scheme An agreement has been signed by the Department of Health and the Department of Education and Culture whereby the monitoring of the administration and financial control is shared by the two Departments.

2. The Departments of Health and Education:

School Health Services: Funding is provided by the Department of Health, which provides health education and renders a primary health service at the schools with the co-operation of the Department of Education and Culture.

3. All the Departments in the Province of KwaZulu-Natal.

HIV/AIDS: The Department of Health provides funding to the Provincial Aids Action Unit, which plays a co-ordinating role in initiating joint HIV/AIDS-related projects with the above Departments and Local Authorities.

4. The Departments of Health, Education, Water Affairs, Local Government and Traditional Affairs

Cholera Liaison: Liaison and co-operation between the above Departments enables improvement in the infrastructure giving the people of the Province better access to potable water and health facilities. Funding is provided within each Department to fulfil its own core functions in this respect.

5. Department of Health and Works

Physical Facilities Management: Co-ordination and co-operation is established whereby the Department of Health provides the funding and the Department of Works provides the expertise to manage the capital works projects of Health.

10.2 LOCAL GOVERNMENT LINKAGES

The Department provides three categories of funding to local government, namely for Primary Health Care Clinics, HIV/AIDS related projects and Environmental Health.

The transfers to Local Authorities are under review to ensure equity amongst the various Districts, and therefore the schedule below reflects the total amounts allocated for each category and not funding provided to the individual municipalities.

LOCAL AUTHORITY GRANTS	2001/02 Unaudited Actual	2002/03 Estimate	2003/04 Estimate	2004/05 Estimate	2005/06 Estimate
	R'000	R'000	R'000	R'000	R'000
1. Primary Health Care Services	39,680	44,156			
2. Environmental Health	2,073	2,007			
3. HIV/AIDS grant	2,019	1,000			
TOTAL GRANT	**43,772**	**47,163**			

10.3 PUBLIC, PRIVATE PARTNERSHIPS AND OUTSOURCING

10.3.1 PUBLIC PRIVATE PARTNERSHIPS

The final agreement for the Public Private partnership for the Inkosi Albert Luthuli Central Hospital, between the Department has been signed and the financial close was reached on 2 February 2002.

10.3.2 OUTSOURCING OF SERVICES

As far as outsourcing of services is concerned, in general terms it is the policy of the Department to outsource all the non-core functions as far as possible. These include catering, garden and grounds, security and cleaning, and, in some instances, laundry services. This is an ongoing process, which requires close liaison with labour and the relevant personnel.

10.4 FINANCIAL MANAGEMENT

10.4.1 STRATEGIES TO ADDRESS AUDIT QUERIES

The audit queries for the 2001/02 financial year, which were addressed to the Department have been systematically dealt with, details of which are contained in the Financial Report for the 2001/02 financial year.

Detailed documentation is available on request from the Department.

10.4.2 IMPLEMENTATION OF PUBLIC FINANCE MANAGEMENT ACT

The Department has made good progress towards the implementation the above Act. Please refer to the attached document, which was submitted to Provincial Treasury in February 2002 for details.

10.5 TRAINING AND LEARNING

The Department sets aside approximately 2.6 per cent of its budget (Programme 5: Health Sciences) to provide for its training needs. It is also making a concerted effort to double the intake of student nurses as well as increase the number of other medical professionals over the 2003 Medium Term Expenditure Framework period in order to provide sufficient personnel to compensate for those emigrating, and retiring and also those exiting the service as a result of HIV/AIDS related diseases.

11. COMMENT

Part C of this Strategic plan, which is appended hereto contains additional information which is mostly required by the National Department of Health.

PART C

APPENDICES WITH ADDITIONAL INFORMATION

APPENDIX 1: ANALYSIS OF SERVICE DELIVERY ENVIRONMENT

1. The following resume is a broad analysis of the service delivery environment in which the Department operates, taking into consideration the external factors that have/may impact on the demand for its services, as well as those factors that have/may affect its ability to provide services.

2. From information made available in the Provincial Budget Statements for the 2002/03 financial year KwaZulu-Natal is the most populous province in South Africa, with the second largest poverty gap in the country. This indicates grossly insufficient resources and an inability to provide adequate services of a reasonable quality, resulting in, inter alia, more expenditure for health care. In addition, from a health point of view the following information is of relevance:

a. Demographic profile

- KwaZulu-Natal is the most highly populated province in South Africa; and has approximately 20.5% of the total population of South Africa
- 53% of the population is urbanised.
- Currently, approximately 2 million of the KwaZulu-Natal population does not have adequate access to health care.
- The Health Department of KwaZulu-Natal provides central services to 50% of the population of Eastern Cape.
- The Cross border flow of patients from the Eastern Cape into the Districts of Sisonke and Ugu of KwaZulu-Natal is estimated on a population of 101 661, which represents 1.67% of the total Eastern Cape population.
- The Mozambique and Swaziland population served by KwaZulu-Natal is estimated to be 30 000.

b. Socio-economic profile

According to available figures 39% of the economically active population is unemployed, and estimated third of the population survives on subsistence farming.

- Poverty levels in this Province are still amongst the highest in South Africa. According to the S.A.

indicator, 47% of females and 36% of males in KwaZulu Natal were unemployed in January 2000.

- Topography and the lack of infrastructure in rural areas, make access to health facilities particularly difficult.

c. Epidemics

KwaZulu-Natal recently, has the highest incidence of epidemics in the country:

- Cholera epidemic in 2000
- Malaria Pandemic
- TB incidence rate of 3/1000
  HIV/AIDS where the ante-natal survey showed a prevalence of 35% in 2000.

d. Violence

KwaZulu-Natal has one of the highest murder and rape rates in South Africa, as well as one of the highest motor vehicle accident rates. This places additional pressure on the provision of Medical Rescue Emergency services. The following statistics give an indication of the seriousness of the problem.

- Rape - 99,6 per 100 000 of the population reported in 1999.
- Murder - 70.2 per 100 000 of the population reported in 1999. (S.A. average 55.

The tables below give an overall summary of the population characteristics and social conditions relevant to service delivery by this Department.

5.2 SELECTED POPULATION CHARACTERISTICS AND SOCIAL CONDITIONS RELEVANT TO HEALTH

5.2.1 Overall comment on the Population figures of KwaZulu-Natal

- The figures quoted are obtained from Statistics South Africa and the KwaZulu Natal GIS unit (March 2002)

- The mid-year estimates for 2002 estimate the population as being 8 857 615 or 20% of the total population. It is estimated that the population would have been 8 986 857 without the increased deaths due to HIV/AIDS.

5.2.2 The following table gives an overview of the main Demographic and Socio-Economic Indictors for the Province of KwaZulu-Natal. The population figure is based on the 1996 Census:

KEY DEMOGRAPHIC AND SOCIO-ECONOMIC INDICATORS FOR KWAZULU-NATAL

Area (km²)	92,100
Population density	91.4
Population	8,417,021
% Population	20.7
Rural as % population	56.9
% Population < 5 years	11.5
Poverty rates	53.0
% Population > 20 yrs with no schooling	22.9
% Population > 20 yrs with matric or high qualification	20.7
% Women > 20 years with no schooling	25.2
% economically active population unemployed	39.1
% households living in 2 or less rooms	29.6
% households living in 1 or less rooms	15.6
% Using electricity for cooking	46.1
% with tap in house	39.8
% with tap in house or yard	48.7
% with flush or chemical toilet	42.0
Disabled as % of population	6.0

5.2.2 As a result of the lack of housing, water and sanitation in the rural areas, the demand for health care increases.

- In 2000 25 % of people living in KwaZulu-Natal did not have immediate or easy access to water on tap.
- 98 % of people in rural areas and 25 % in urban areas had no formal rubbish disposal system.

The following table gives an indication of access to water within the Province.

MAIN SOURCE OF WATER FOR HOUSEHOLD USE

SOURCE	KWAZULU-NATAL
Tap inside dwelling	55%
Tap on premises	19%
Tap in area	9%
Borehole / well	3%
River	10%
Tank	3%
Other	1%

5.2.4 The following table illustrates the distribution of the population per district and shows a predominance of urbanisation in the more industrialised Districts namely eThekwini (Durban), Umgungundlovo (Pietermaritzburg) and Amajuba (Newcastle).

Statistics from 1999 indicate that at that stage 53.7% of the total population lived in rural areas.

URBAN AND RURAL DISTRIBUTION OF POPULATION PER DISTRICT – ESTIMATED PERCENTAGES

DISTRICT	URBAN %	RURAL %	INFORMAL %
eThekwini District	67,6	17,4	15
District 21 : Ugu	14	86	not evaluated
District 22 : Umgungundlovo	53,3	46,7	not evaluated
District 23 : Uthukela	25,6	74,4	not evaluated
District 24 : Umzinyathi	12,9	87,1	not evaluated
District 25 : Amajuba	56,5	43,5	not evaluated
District 26 : Zululand	14,1	85,9	not evaluated
District 27 : Umkhnyakude	3,3	96,7	not evaluated
District 28 : Uthungulu	16,1	83,9	not evaluated
District 29 : Ilembe	18,5	81,5	not evaluated

5.2.5 The following table illustrates the distribution of males and females per district with an overall dominance of females, which is attributable to the longer life expectancy of females as well as males gravitating to Gauteng for employment.

POPULATION OF KWAZULU-NATAL BY DISTRICT AND GENDER

Health District		Female	% Female	Male	% Male	Total	Total per cent
Durban Metro	Ethekwini	1,519,624	51.26%	1,444,653	48.74%	2,964,277	32.68%
DC 21	Ugu	379,407	54.68%	314,520	45.32%	693,927	7.65%
DC22	UMgungundlovo	500,277	52.77%	447,792	47.23%	948,069	10.45%
DC 23	Uthukela	324,033	54.24%	273,411	45.76%	597,444	6.59%
DC 24	Umzinyathi	257,041	55.83%	203,360	44.17%	460,401	5.08%
DC 25	Amajuba	231,717	52.34%	210,959	47.66%	442,676	4.88%
DC 26	Zululand	417,616	54.32%	351,175	45.68%	768,791	8.48%
DC 27	Umkhanyakude	295,286	54.39%	247,668	45.61%	542,954	5.99%
DC28	Uthungulu	444,719	54.13%	376,832	45.87%	821,551	9.06%
DC 29	Ilembe	305,837	53.00%	271,237	47.00%	577,074	6.36%
DC 43	Sisonke	137,303	54.35%	115,304	45.65%	252,607	2.79%
TOTAL		**4,812,860**	**53.06%**	**4,256,911**	**46.94%**	**9,069,771**	**100.00%**

Source: GIS Unit: KwaZulu-Natal March 2002.

5.2.6 The following table gives a better indication of the poverty levels per district. 29% of employed people in KwaZulu-Natal have an income level of less than R800 per month with 15% earning less than R200 per month:

POPULATION OF KWAZULU-NATAL BY DISTRICT, EMPLOYMENT AND INCOME
KWAZULU-NATAL GIS UNIT MARCH 2002

Health District		Employed	%	Unemployed	%	Not Working *	%	Unspecified	%	Total	Total %	Annual income per capita
Durban Metro	EThekwini	852,940	28.77%	409,906	13.83%	814,051	27.46%	887,377	29.94%	2,964,274	32.68%	8,725.59
DC 21	Ugu	92,116	13.27%	67,414	9.71%	252,844	36.44%	281,561	40.57%	693,935	7.65%	3,331.43
DC22	Umgungundlovo	216,110	22.80%	133,390	14.07%	274,791	28.99%	323,750	34.15%	948,041	10.45%	5,334.70
DC 23	Uthukela	75,348	12.61%	70,749	11.84%	207,092	34.66%	244,244	40.88%	597,433	6.59%	3,046.21
DC 24	Umzinyathi	38,953	8.46%	49,480	10.75%	173,194	37.62%	198,809	43.18%	460,436	5.08%	1,968.91
DC 25	Amajuba	83,074	18.77%	57,154	12.91%	133,590	30.18%	168,861	38.15%	442,679	4.88%	4,023.34
DC 26	Zululand	69,711	9.07%	86,410	11.24%	264,853	34.45%	347,807	45.24%	768,781	8.48%	2,156.32
DC 27	Umkhanyakude	40,116	7.39%	46,920	8.64%	205,744	37.89%	250,174	46.08%	542,954	5.99%	1,694.13
DC28	Uthungulu	106,910	13.01%	86,969	10.59%	282,691	34.41%	344,975	41.99%	821,545	9.06%	3,501.41
DC 29	Ilembe	97,277	16.86%	63,452	11.00%	200,390	34.72%	215,967	37.42%	577,086	6.36%	3,013.96
DC 43	Sisonke	34,990	13.85%	25,375	10.05%	82,049	32.48%	110,179	43.62%	252,593	2.79%	2,311.78
TOTAL		**1,707,545**	**18.83%**	**1,097,219**	**12.10%**	**2,891,289**	**31.88%**	**3,373,704**	**37.20%**	**9,069,757**	**100.00%**	**5,018.80**

* Not working includes housewives, home keepers, scholars, students, children below school going age, pensioners, retired people and those not wishing to work.

Source: KwaZulu Natal GIS Unit March 2002.

APPENDIX 2

5.3 BROAD STRUCTURE OF PUBLIC HEALTH SERVICE AND EXTENT OF PRIVATE HEALTH SECTOR ACTIVITY

5.3.1 The following table provides the statistics for the **number of Clinics and Community Health Centres per District as at 2001:**

Table: Fixed public primary health care facilities (Clinics and Community health centres)[1]

PHC facilities[1]	Number	Average population[2] per facility	Consulting rooms	Consulting rooms per population
Province wide	**466**			
Ethekwini District	103	29,693		
DC 21 : Ugu	44	16,272		
DC 22 : Umgungundlovo	33	29,641		
DC 23 : Uthukela	37	16,660		
DC 24 : Umzinyathi	36	13,195		
DC 25 : Amajuba	17	26,866		
DC 26 : Zululand	60	13,220		
DC 27 : Umkhanyakude	49	11,432		
DC28 : Uthungulu-Empangeni	49	17,298		
DC 29 : Ilembe	19	31,336		
DC 43 : Sisonke	19	13,717		

COMMENTS

1. To use the number of Clinics and Community Health Centres to gauge the level of service in a particular District is regarded as incorrect as in the more urbanized areas the facilities are normally much bigger than in the rural areas. The Department prefers to use the number of consultation rooms as a basis of comparison.

2. Influence of cross border patients coming from the Eastern Cape and Mozambique has a much lower influence on the clinics and community health centres than on hospitals in Ugu (District 21), Sisonke (District 43) and Umkhanyakude. (District 27).

5.3.2 The following table provides the statistics for the **number of Public Hospitals and the number of beds as at 2000/01:**

Table: Public hospitals

Hospital type	**Number**	**Number of beds[1] Authorised**	**Number of beds Used**		**Beds per 1000 people[2,3]**	**Beds per 1000 uninsured people[2]**
District[3]		11,191				
General (regional)		5,556				
Central		2,355				
Sub-total acute hospitals[4, 5]						
Tuberculosis[5]		3117			---	---
Psychiatric[5]		3617			---	---
Chronic medical and other specialised[5]		237			---	---
Total		26,073			---	---

Comment

1. The schedule reflects authorised beds and not usable beds based on 2000/2001 information.

2. For calculation purposes the Department is using beds in use. Because of financial constraints some of the authorised beds cannot be staffed and therefore some wards have been closed.

3. It is important to note that the categorization of the beds mentioned above will be rectified in terms of the Strategic Positioning Statement and will be corrected once the services have been rationalized.

5.3.3 NUMBERS OF PUBLIC HEALTH PERSONNEL AND VACANCY RATES BY MAIN CATEGORY ANY SIGNIFICANT TRENDS IN STAFF NUMBERS, RATES OF RESIGNATION AND OTHER ASPECTS OF HUMAN RESOURCE DEVELOPMENT

Table: Public health personnel[1]

Categories	Number employed	% of total number employed	Number per 1000 people[2]	Number per 1000 uninsured people[2]	Vacancy rate	% of total personnel budget	Average annual cost per staff member
Medical officers[3]	1533						
Medical specialists	205						
Dentists	45						
Dental specialists	2						
Professional nurses	9164						
Staff nurses	6416						
Nursing assistants	6394						
Student nurses	1393						
Pharmacists[3]	291						
Allied health professionals and technical staff[4]	2861						
Managers, administrators and logistical support staff	395		---	---			---
Total	28699	100				100	

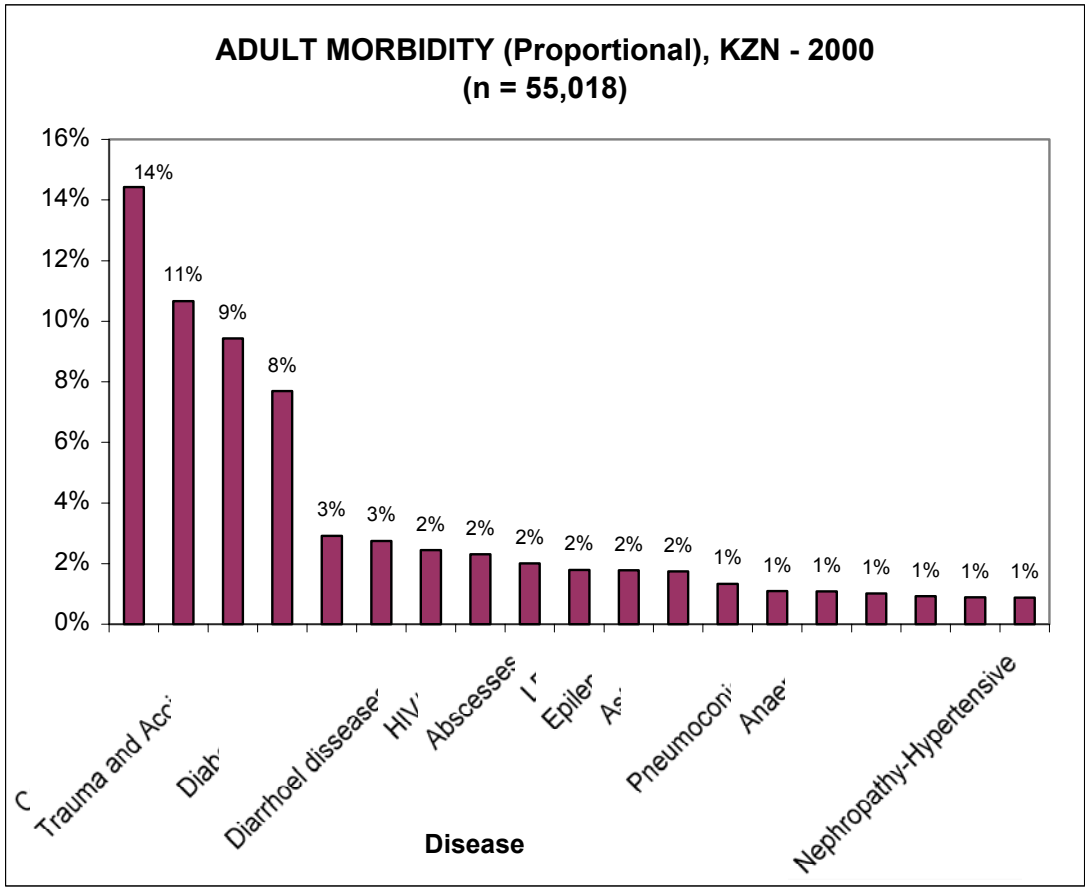
1. This table should be for provincial health personnel. If data are available, another table for local government personnel should be added, as well as a third table showing public health personnel in total (provincial plus local government).
2. Populations should be those of resident people.
3. Interns should be included.
4. This group comprises 'health therapists' (e.g. physiotherapists, speech therapists, occupational therapists, clinical psychologists, radiographers, environmental health officers) and specialised auxiliary staff.

APPENDIX 3

EPIDEMIOLOGICAL PROFILE

1. Health Status information of the inhabitants in KwaZulu-Natal has been obtained by aggregating the routine data collected from public health facilities and information from the Demographic and Household survey (DHS) conducted in 1998.

   Inherent in the data sources are biases that are carried through to the health indicators. The most important of these is that of an Access to Health care bias, which assumes those who attend health facilities are representative of the general population. Further, the data source reflects the throughput of the health facility and not the morbidity and mortality in the general population. However, in the absence of more reliable data from the vital registration process it is a proxy measure to inform resource allocation within the health services. To obtain a community perspective information from the DHS has been used. This is an annual survey conducted by the Medical Research Council. Health information and demographic information is collected through household interviews.



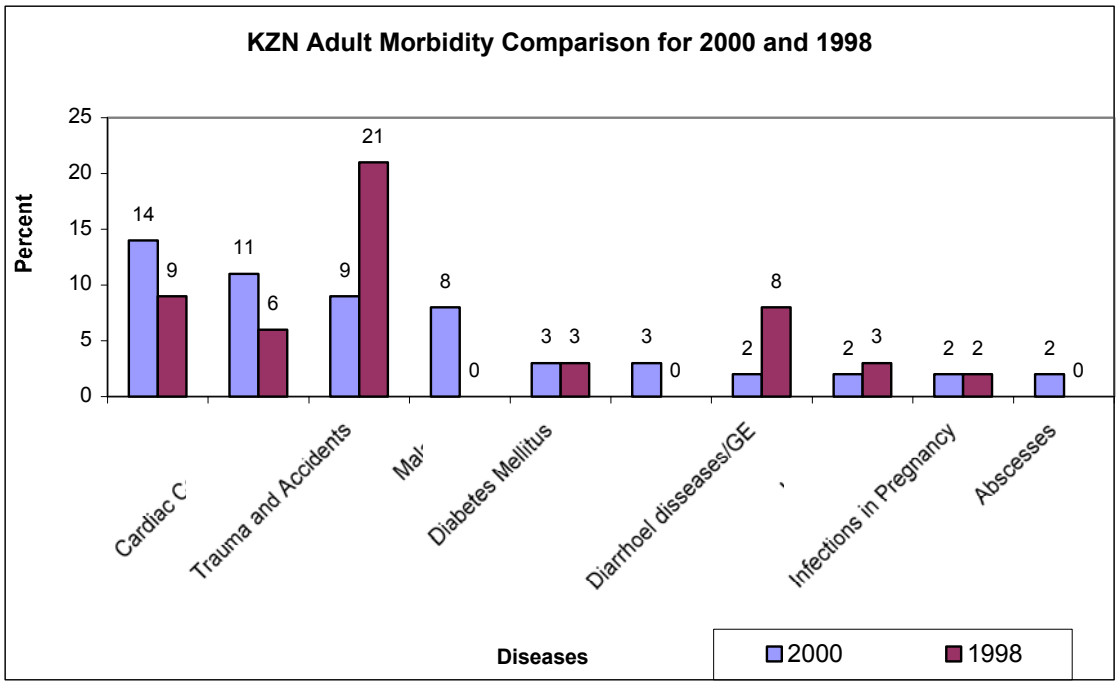
1 Double Burden of Disease

The above graph displays the juxtaposition of Tuberculosis and Malaria, with that of Cardiac Disease and Diabetes. This is referred to as the double of burden of disease. It is often seen in

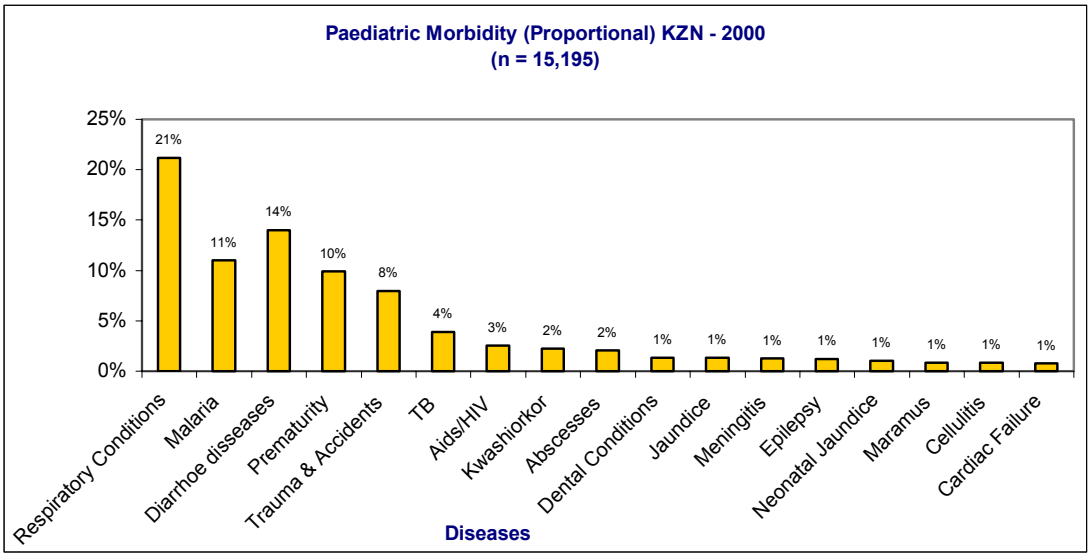
developing countries where populations are undergoing an Epidemiological Transition, which reflects the burden of Infectious Diseases and the Chronic Diseases of Lifestyle indicating the differential levels of development within a population.

This trend is perpetuated in the Morbidity patterns seen at health facilities.

Adult Morbidity



Paediatric Morbidity



The trend in morbidity trends reflects an excessive burden of infectious preventable diseases, which in turn impacts on the Infant Mortality Rate.

HEALTH PROFILE FOR KZN

INDICATORS	KZN	
Life expectancy at birth[1]	53 years	
Crude death rate[2]	11.5%	
Stunting[3] Age < 1-9 years	18.5%	
Under-weight[4] Age 1-9 years	6%	
Disability Prevalence of	6.7%	
Reproductive Health Indicators[1]:	1.1 MALE	1.2 FEMALE
%		6.7%
women aged 15-49		58.3%
Use contraceptive:	1.2%	1.2%

Immunization Coverage	82.6%
Children<1 year[7]	49.5%
12-23 months[6]	
Childhood mortality[6]:	
Infant Mortality Rate	52.1 per 1000 live births
Under 5 Mortality Rate	74.5 per 1000 live births
Infectious Diseases (per 100,000 population	471
Malaria 2000	1.6
Measles	316.6
Tuberculosis	0.4
Typhoid	2.3
Viral Hepatitis	96.7
STD	17.8%
Prevalence of Diarrhoea Under 5 years	34.2%
HIV Prevalence:	60%
Antenatal	
General Population	

Reference:

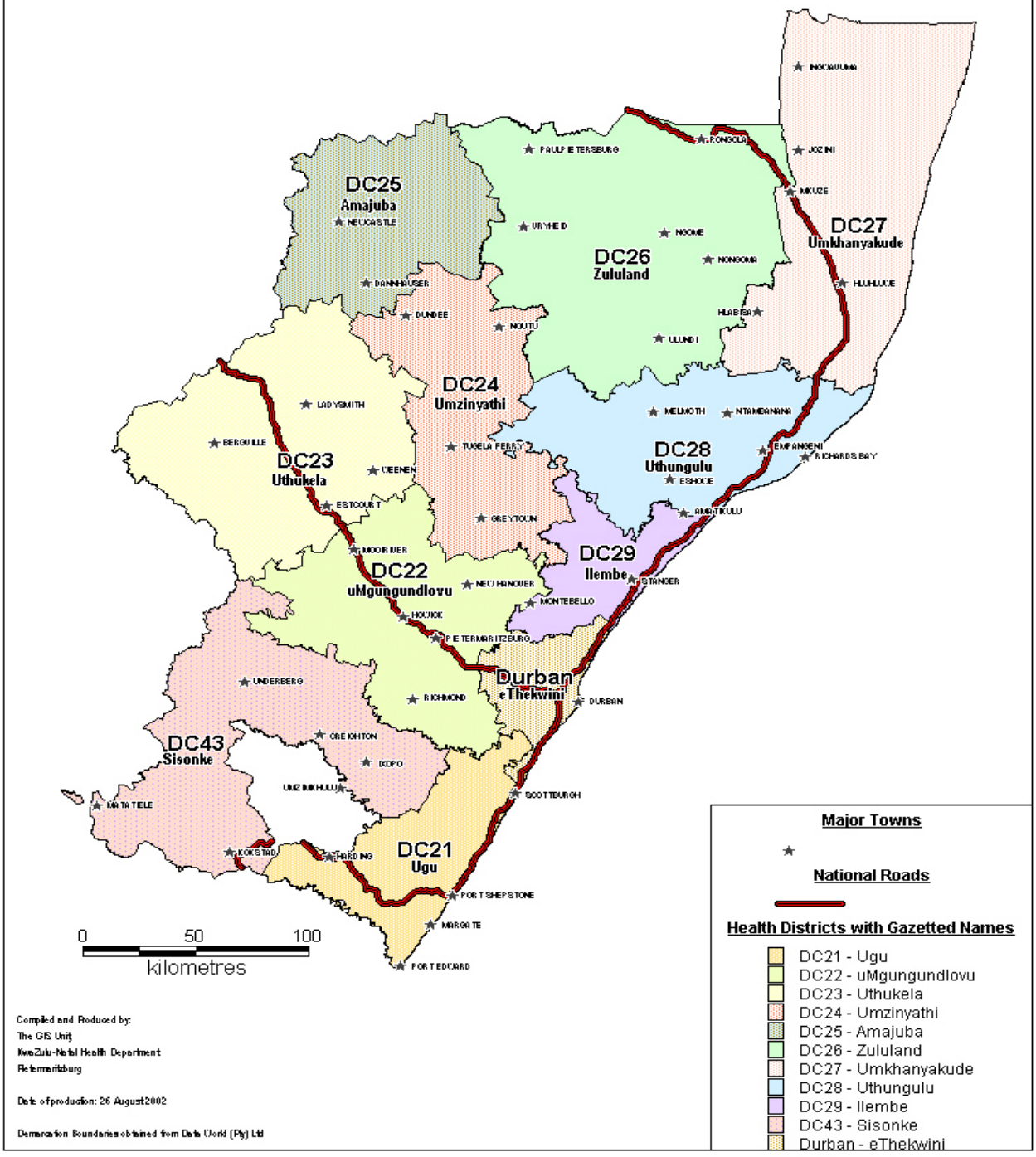
1. Stats SA HHI 2001
2. IFR Projections 1999
3. SAVACG Survey
4. Food Consumption Survey

5. CASE Disability Survey for the Dept. of Health 1998.
6. South African Demographic Health Survey 1998.
7. National Report on DHIS Data: Gathering, Analysing and Using Information to Accelerate PHC Delivery 2002.
8. DOH, Pretoria. Malaria Report 2001
9. DHIS 2001, DOH Pretoria, Page 17
10. National HIV and Syphilis sero-prevalence survey in South Africa 2001.
11. October Household Survey for the Dept. of Health 1995.
12. PERSAL 2001.
13. Provincial Health Informatics

APPENDIX 4

5.6 SEE ATTACHED MAP

KWAZULU-NATAL HEALTH DISTRICTS
Illustrating Gazetted Names



Major Towns

National Roads

Health Districts with Gazetted Names

- DC21 - Ugu
- DC22 - uMgungundlovu
- DC23 - Uthukela
- DC24 - Umzinyathi
- DC25 - Amajuba
- DC26 - Zululand
- DC27 - Umkhanyakude
- DC28 - Uthungulu
- DC29 - Ilembe
- DC43 - Sisonke
- Durban - eThekwini

Compiled and Produced by:
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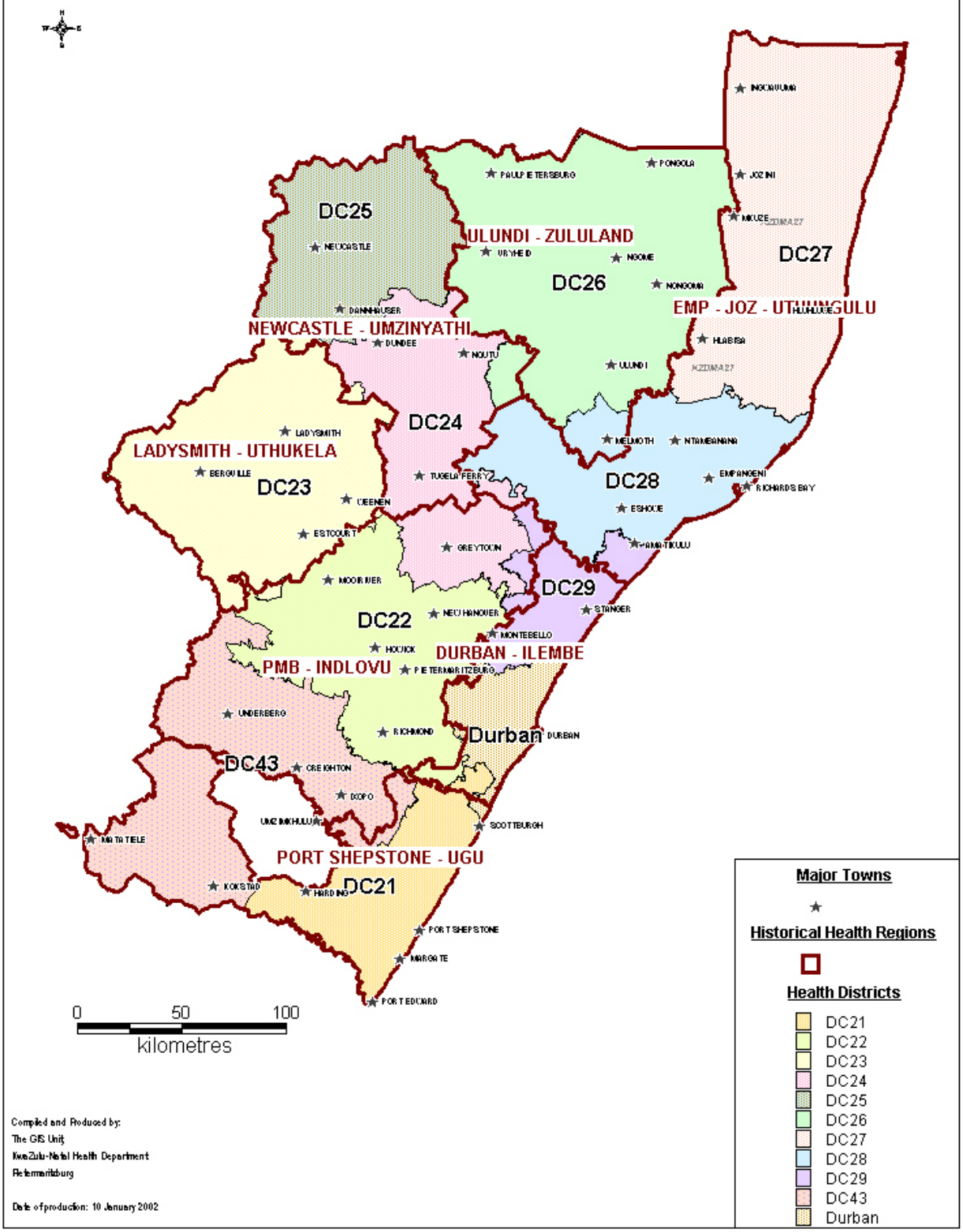
Pietermaritzburg

Date of production: 26 August 2002

Demarcation Boundaries obtained from Data World (Pty) Ltd

KWAZULU-NATAL HISTORICAL HEALTH REGIONS



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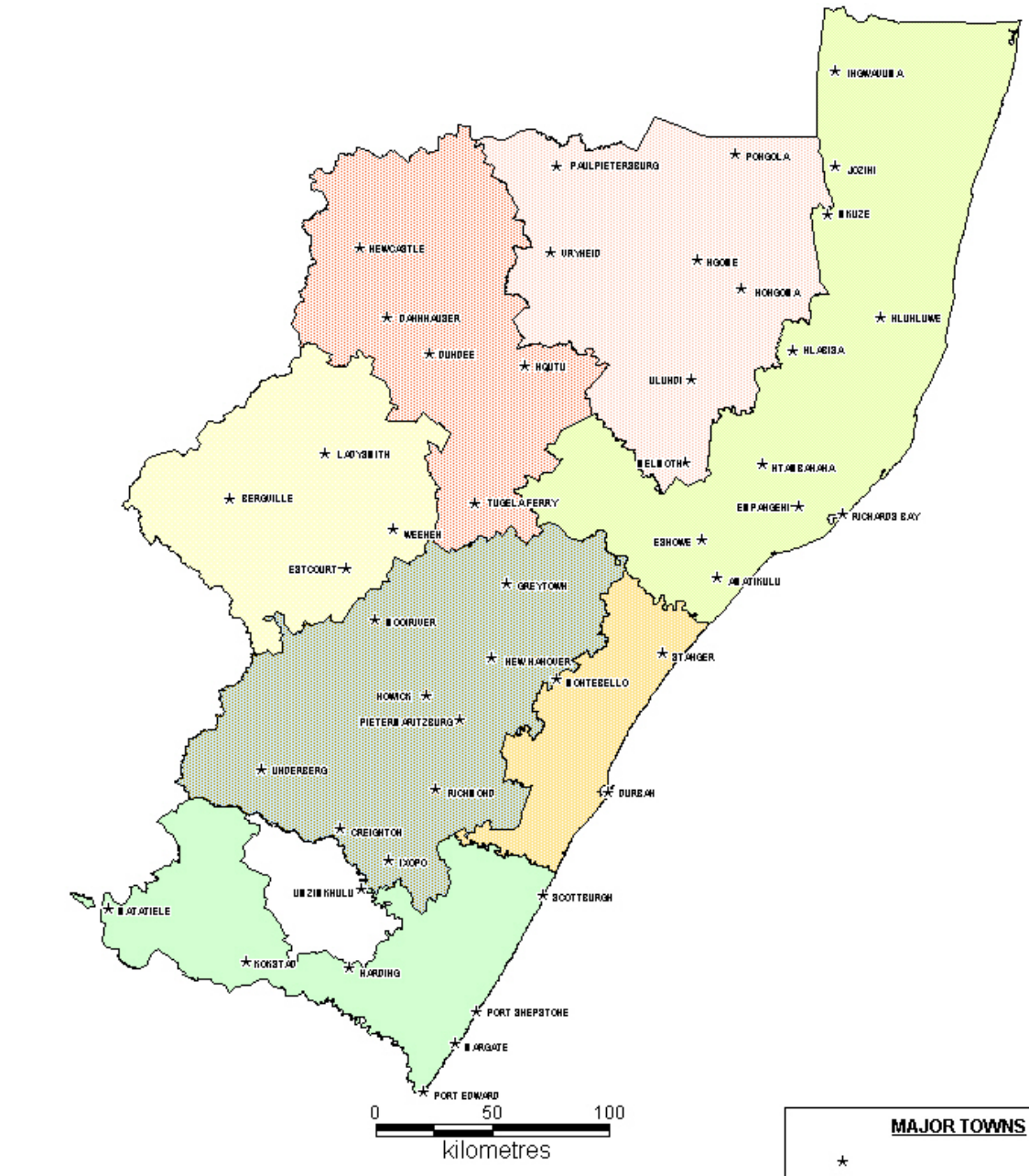
HISTORICAL HEALTH REGIONS



MAJOR TOWNS

★

Historical Health Regions by NAME

- DURBAN - ILEMBE
- EMP - JOZ - UTHUNGULU
- LADYSMITH - UTHUKELA
- NEWCASTLE - UMZINYATHI
- PMB - INDLOVU
- PORT SHEPSTONE - UGU
- ULUNDI - ZULULAND

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