WESTERN CAPE
DEPARTMENT OF HEALTH

ANNUAL
PERFORMANCE PLANS
2005/2006

MARCH 2005

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MESSAGE FROM THE WESTERN CAPE MINISTER OF HEALTH, MR. PIERRE UYS

The Western Cape Government is committed to the principle of equal access to quality health care.

In support of this principle it is our belief that removing social and economic factors that contribute to inequities within and between communities is key to improving health. Although the Western Cape has some of the best indicators of health and socio-economic status in South Africa, there are nevertheless vast disparities between different communities.

An examination of one health indicator namely Infant Mortality Rate (IMR), illustrates the inequalities between both the Cape Town Metro District area and the rural areas of the province, and between the different health sub-districts within Cape Town itself. Khayelitsha has the highest IMR at 44/1000 live births, whilst South Peninsula has the lowest of 13/1000 live births

Supported by the Western Cape Cabinet our Healthcare 2010 strategy that is geared to reshape public health to focus on primary-level services, community based care and preventative care, will go some way in helping to ensure greater equity in health care. It will also bring health closer to the people by treating patients at the level of care most appropriate to their needs.

We have already made some progress on this front with a number of improvements made to the health infrastructure needed to accommodate Healthcare 2010. The Department is also close to finalising a new service delivery plan that would define how many hospital beds are required at each level of the service together with the levels of staffing in each case.

As mentioned the establishment of a well managed and responsive Primary Health Care Service is the foundation of Healthcare 2010. While services provided at a number of our Community Health Centers have already been improved, the coming years will see further improvements to management and staffing levels together with a greater emphasis on patient needs and satisfaction at our other facilities.

The long awaited and eagerly anticipated provincialisation of Personal Primary Health Care services in the non-metropolitan areas of the Western Cape will go ahead this year. Province will start funding PPHC services from the beginning of the financial year while matters related to financial, human resource and asset management will be finalised by Provincial and Local Government.

The revitalisation and expansion of our regional hospital service are progressing well, with communities on the West Coast, in the Southern Cape and Boland already starting to reap the benefits. We have also made good progress with the revision of the joint agreements with the universities.

While great strides have been made in improving Emergency Medical Services in the Western Cape there is still room for improvement. Additional funding will be provided to further strengthen this service with specific focus on improved communication systems, additional personnel, vehicles and equipment in order to improve response times and service delivery.

Another key area that will enjoy attention in the Department is employment equity with greater emphasis being placed on the achievement of the goals set out in the Department's Employment Equity Plan.

It is our responsibility as a Department to create the conditions where disadvantaged people are able to make healthier choices. We need to promote health and healthy living and help them choose health by demonstrating the many rewards this holds for individuals and families, and our communities.

Therefore the challenge in the Western Cape is to address inequity, to develop our communities and by doing so make the Western Cape a Home for All. Tackling the root causes of the diseases and ill health will promote health and build a healthy, vibrant and developing society.

Pierre Uys
WESTERN CAPE MINISTER OF HEALTH
March 2005

FOREWORD BY PROFESSOR CRAIG HOUSEHAM: HEAD OF HEALTH

Budgetary pressures experienced during 2004/5 and their consequences

In order to meet the initial budget allocations for 2004/05 the Department decided at that time that it would need to reduce expenditure by R100m or 2%. In the light of Healthcare 2010 it was decided that it would be most appropriate for the budget reductions to occur mainly in the central hospitals, with limited reductions in the secondary services. The central and regional hospitals were therefore given the targets of reducing expenditure in real terms by over 2% and 1% respectivey.

However, due to increasing need for health services, approximately 2% per year when measured in patient day equivalents, the Department was unable to downscale services in the absence of a significant change to the service platform. The complexity and inter-relatedness of secondary and tertiary services made it difficult for management to compartmentalise and prioritise these services. This process affirms the need to change the current service delivery platform.

The result is that the Department's expenditure has remained relatively constant in real terms. Due to the change to the BAS, problematic interventions between BAS and LOGIS, the slowness of the system, the new item classification which resulted in an accounting backlog, the Department was unable to make accurate financial projections throughout the current financial year. This was clearly an untenable situation taking into account the complexity of the organisation and the consequences of budgetary stringency. An over expenditure was projected after the second quarter and plans were drawn up to reduce expenditure. Following discussions with the Provincial Ministers of Health and Finance and additional funds were made available to the Department, which will carry through into the 2005/06 financial year. These steps prevented a further reduction in service delivery.

Budgetary process and construction of the budget allocations for 2005/6 and beyond

The Department has revised its budget process during the past year so that budget allocations have been made to meet the projected expenditure of the respective budget entities. The budget projections for the respective entities formed the basis of the Adjustment Budget on which the allocations for 2005/06 are based. As indicated above these projections have been problematic and allocations may have to be revised at the time of the Adjustment estimates in the coming financial year. This emphasises the critical need for credible and timeous financial management information to ensure both credible budgets and ensure ongoing service delivery.

In order to make the allocations for 2005/06 the Adjustment Budget was adapted with a factor for cost increases based on an appropriate baseline. The baseline was adjusted, for instance, for payments that would not recur in the next financial year.

Initially 192 policy options which required additional funding were proposed by the Department. These options were evaluated and reduced after significant input from the Provincial Minister to come within the affordable envelope. The most important options approved by the Minister are the following:

PRIMARY HEALTH CARE

- Non metro personal primary health care (for 9 months): R65,85m
- Strengthening the management of day hospitals: R5m

- Social Capital formation projects: R7m
- Community outreach: R8m
- Strengthening level 1 hospital services: R20m

EMERGENCY MEDICAL SERVICES

- Strengthening Emergency Medical Services: R31m

REGIONAL SERVICES

- Strengthening level 2 hospital services: R33m
- Strengthening psychiatric services: R11m

CENTRAL HOSPITALS

- Compared to the main budget of R1 743 million for 2004/05 the Central Hospitals received an increase of R193,3 million, which includes an additional R93,3 million in the National Tertriary Services Grant (NTSG).

TRANSVERSAL ISSUES

- The funding allocated to provide performance bonuses to staff has been increased from 0.5% of the personnel budget to 1%. (R5m).
- Funding has been allocated to fill posts in financial administration throughout the Department. This is deemed to be a priority as it will enable effective financial management promoting amongst others, the procurement process, effective billing and revenue generation. (R10m)
- Adjustment of clerical posts to level 4 across the Department in line with job evaluation results. (R4m)
- It is unfortunate reality that provision also has to be made for medico-legal claims against the Department which are estimated to R10m within the coming financial year.

Considerable progress has been made with the definition of the service platform which is the key to enabling the restructuring of staffing establishments to ensure that there are the correct numbers and skill mix of personnel at the respective health care facilities. It is anticipated that the service plan will be finalised by the June 2005 and that there will be significant progress with the restructuring of the staff establishments by the end of 2005/06.

PROFESSOR KC HOUSEHAM
HEAD: HEALTH, WESTERN CAPE
March 2005

STRATEGIC OVERVIEW

1. OVERVIEW OF STRATEGIC PLAN

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

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

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

2. SECTORAL SITUATION ANALYSIS

2.1 Summary of service delivery environment and challenges

2.1.1 Major demographic characteristics

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

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

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

	Total population										
District	**2 001**	**2 002**	**2 003**	**2 004**	**2 005**	**2 006**	**2 007**	**2 008**	**2 009**	**2 010**	**%Public Pop**
Cape Town	2 893 248	2 938 222	2 983 897	3 030 285	3 077 397	3 125 243	3 173 835	3 223 186	3 273 307	3 324 209	68.40
W Coast	282 672	287 057	291 510	296 032	300 625	305 289	310 026	314 836	319 722	324 683	81.00
Boland	629 490	639 265	649 192	659 273	669 512	679 911	690 471	701 196	712 088	723 150	80.00
Overberg	203 517	206 672	209 875	213 129	216 433	219 789	223 196	226 657	230 172	233 741	83.00
Garden R	454 924	461 989	469 164	476 451	483 851	491 366	498 999	506 751	514 623	522 619	81.00
Central Karoo	60 485	61 425	62 379	63 349	64 333	65 333	66 348	67 379	68 427	69 490	89.00
Western Cape	**4 524 336**	**4 594 629**	**4 666 017**	**4 738 519**	**4 812 150**	**4 886 930**	**4 962 876**	**5 040 005**	**5 118 338**	**5 197 892**	**0.730**

	Uninsured population									
District	**2 001**	**2 002**	**2 003**	**2 004**	**2 005**	**2 006**	**2 007**	**2 008**	**2 009**	**2 010**
Cape Town	1 978 982	2 009 744	2 040 986	2 072 715	2 104 939	2 137 666	2 170 903	2 204 659	2 238 942	2 273 759
W Coast	228 964	232 516	236 123	239 786	243 506	247 284	251 121	255 017	258 975	262 993
Boland	503 592	511 412	519 353	527 419	535 610	543 928	552 377	560 957	569 670	578 520
Overberg	168 919	171 537	174 197	176 897	179 639	182 424	185 253	188 125	191 042	194 005
Garden R	368 488	374 211	380 023	385 925	391 919	398 007	404 189	410 468	416 845	423 321
Central Karoo	53 832	54 668	55 517	56 380	57 256	58 146	59 050	59 968	60 900	61 846
Western Cape	**3 302 777**	**3 354 088**	**3 406 199**	**3 459 122**	**3 512 870**	**3 567 456**	**3 622 893**	**3 679 194**	**3 736 374**	**3 794 444**

Source: Census 2001

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

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

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

*Census 2001denomination

**Includes Flush toilets with septic tank and chemical toilets

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

Table 3: Socio-demographic characteristics of the population

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

Source: Census 2001

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

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

2.1.2 Epidemiological profile

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

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

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

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

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

Khayelitsha sub-district at 44/ 1 000 live births and the lowest is in the South Peninsula sub-district at 13/ 1 000 live births.

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

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

Source: Sanders: 2004

Table 6: Major causes of death in the Metropole

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

Source (Groenewald et al, 2003)

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

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

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

Group I: 19% infectious diseases, including 6% HIV/AIDS;
Group II: 54% non communicable diseases; and
Group III 19% injuries.

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

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

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

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

HIV and AIDS

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

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

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

2.1.3 Major health service challenges and progress

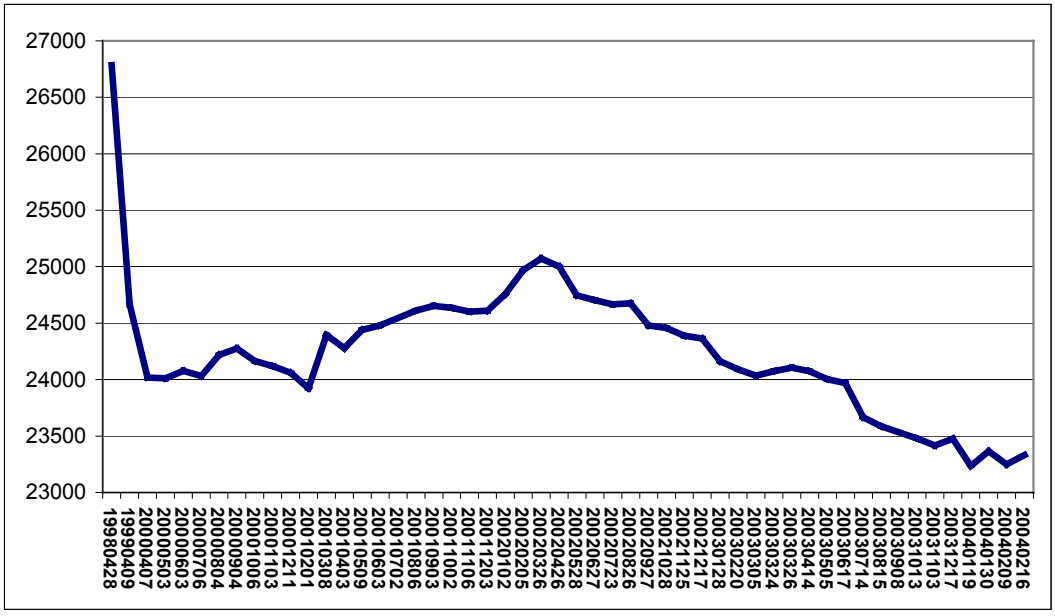
Having formulated the Department's long-term strategic framework, Healthcare 2010, the major challenge facing the Department is to develop effective implementation plans for the service platform and reshaping the staff establishments.

An important issue to be addressed is the fact that from 1 April 2005 the Province will be responsible for providing the Personal Primary Health Care (PPHC) services in the rural areas that were previously provided by the municipalities. Local government will continue to provide a service in the Metropole for the next three years during which time the issue of funding for these services must be resolved between provincial and national government.
From April 2005/06 the Works funding for Health will be transferred to the Health Department. It will be a significant challenge to manage this process effectively to ensure the funding is optimally utilized for the provision, maintenance and upgrading of the infrastructure.

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

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

Figure 1: Personnel numbers in Provincial Health Facilities from 1998 to 2004



2.1.4 Intra and inter provincial equity in the provision of services

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

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

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

2.1.5 Resource trends

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

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

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

Source: Western Cape Government Budget 2005

The sources of the Department's funding are:

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

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

Table 9: Funding sources of the Western Cape Health Department

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

Source: Western Cape Government Budget 2005

Table 10: Conditional grant allocation for 2005/06

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

Source: Western Cape Government Budget 2005

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

Table 11: Cost of medical inflation in comparison to CPIX

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

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

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

Table 12: Trends in provincial service volumes [A2]

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

Table 13 illustrates the trend in the distribution of funds between the respective programmes in the Department. Funding has been made available to implement the Language Policy. An amount of R2,3 million has been allocated for this purpose in 2005/06. A new sub-programme 2.10, the Global Fund has been established to effectively manage the donor funds for the comprehensive plan for the management, care and treatment of people living with HIV and AIDS.

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

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

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

2.1.6 Policy changes and trends

Mental Health Care Act, Act 17 of 2002

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

and is in the final stages of appointing the members of the Board which it is anticipated will be in place by 1 April 2005.

National Health Act, Act 61 of 2003

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

2.2 Summary of organisational environment and challenges

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

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

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

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

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

3. BROAD POLICIES, PRIORITIES AND STRATEGIC GOALS

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

3.2 National Department of Health

3.2.1 Free health services

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

1) Family planning services;
2) Health advisory services,
3) Immunizations to combat notifiable infectious diseases, excluding vaccination for foreign travel;
4) Treatment of infectious, formidable and/or notifiable diseases, e.g. pulmonary tuberculosis, Leprosy, Meningococcal meningitis;
5) The preparation of medical reports required in cases with legal implications such as rape, assault, drunken driving, post mortems, etc.
6) Oral health services: the screening, preventive and promotive services offered at schools and also scholars classified according to a means test and referred by the school nursing services or oral health services;
7) Patients are transported free of charge in certain instances;
8) Certified psychiatric patients and state patients;
9) School children classified (as H1 patients) according to a means test;
10) Children committed in terms of section 15 and 16 of the Child Care Act, Act 74 of 1983;
11) Children under the age of six years. This applies to children classified as H0, H1, H2 in terms of a means test;
12) Immigrants residing permanently in the country, visitors, foreigners with study permits, temporary work or visitors permits as well as persons from neighbouring countries who enter South Africa illegally;
13) Pregnant women classified as H0, H1 and H2 patients;
14) Termination of pregnancies is free to hospital patients (H0, H1, and H2 patients) as well as full paying and private patients. This includes free ambulance and patient transport services.
15) Primary health care services are rendered free to permanent residents and who are classified as H0, H1 or H2 patients.

3.2.2 The Uniform Patient Fee Schedule (UPFS)

The regulations relating to the UPFS in terms of which patient fees are determined are amended annually by the provincial Minister of Health and published in the Provincial Gazette. In terms of the regulations published in the Provincial Gazette 6198 on 28 December 2004, the provincial Health Department provides free health services to the following categories of patients [subject to conditions specified in the Gazette], in addition to the free services outlined

in Annexure C of Finance Instruction G50 of 2003, dated 23 December 2003, determined by the National Department of Health:

- Social pensioners
- Formally unemployed.

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

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

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

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

Table 14: Tariff categories

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

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

3.3 The Millennium Development Goals

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

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

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

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

Table 15: Millennium development goals

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
1. Eradicate extreme poverty and hunger.	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children under 5 years of age.
		Proportion of the population below minimum level of dietary energy consumption.
2. Achieve universal primary education.	Ensure that by 2015, children everywhere, boys and girls alike, will able to complete a full course of primary schooling.	Net enrolment ratio in primary education.
		Literacy rate of 15 – 24 year-olds.
3. Promote gender equality and empower women.	Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.	Ratio of girls to boys in primary, secondary and tertiary education.
		Ratio of literate females to males of 15 – 24 year-olds.
4. Reduce child mortality.	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.	Under-5 mortality rate (U5MR).
		Infant mortality rate.
		Proportion of one-year old children immunised against measles.
5. Improve maternal health.	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	Maternal mortality ratio.
		Proportion of births attended by skilled health personnel.
6. Combat HIV and AIDS, malaria and other diseases.	Have halted, by 2015, and begun to reverse the spread of HIV and AIDS, malaria and other diseases	HIV prevalence among 15 – 24 year old pregnant women.
		Condom use rate of the contraceptive prevalence rate.
		Number of children orphaned by HIV and AIDS.

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
		Proportion of the population in malaria risk areas using effective malaria prevention and treatment measures. (Prevention to measured by the % of under 5 year olds sleeping under insecticide treated bednets and treatment to be measured by % of under 5 year olds who are appropriately treated.
		Prevalence and death rates associated with TB.
		Proportion of TB cases detected and cured under DOTS.
7. Ensure environmental sustainability.	Halve, by 2015, the proportion of people without sustainable access to safe drinking water.	Proportion of people with sustainable access to an improved water source.
	By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers.	Proportion of urban population with access to improved sanitation.
8. Develop a global partnership for development.	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.	Official development assistance
		Proportion of exports admitted free of duties and quotas.
	In co-operation with pharmaceutical companies, provide access to affordable , essential drugs in developing countries.	Proportion of population with access to affordable essential drugs on an established basis.

3.4 National Department of Health five-year priorities

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

Table 16: National Department of Health five-year priorities

PIORITY	ACTIVITY
1. Improve governance and management of the NHS	• Review and strengthen communication within and between health departments. • Strengthen corporate identity, public relations and marketing of health policies and programmes. • Strengthen governance and maintenance structures and systems. • Strengthen oversight over public entities and other bodies. • Adopt Health Industry Charter

PIORITY	ACTIVITY
2. Promotes healthy lifestyles.	• Initiate and maintain healthy lifestyles campaign. • Strengthen health promoting schools initiative. • Initiate and maintain diabetes movement. • Develop and implement strategies to reduce chronic diseases of lifestyle. • Implement activities and interventions to improve key family practices that impact on child health.
3. Contribute towards human dignity by improving quality of care.	• Strengthen community participation at all levels. • Improve clinical management of care at all levels of the health care delivery system. • Strengthen hospital accreditation system in each province in line with national norms and standards.
4. Improve management of communicable diseases and non-communicable illnesses.	• Scale up epidemic preparedness and response. • Improve immunisation coverage. • Improve the management of all children under the age of 5 years presenting with illnesses such as pneumonia, diarrhoea, malaria and HIV. • Updated malaria guidelines, integrate malaria control into comprehensive communicable disease control programme and ensure reduction of cases. • Implement TB programme and review recommendations. • Accelerate implementation of the Comprehensive Plan for HIV/AIDS. • Strengthen free health care for people with disabilities. • Strengthen programmes on women and maternal health . • Strengthen programmes for survivors of sexual abuse and victim empowerment. • Improve risk assessment of non-communicable illnesses. • Improve mental health services
5. Strengthen primary health care, EMS and hospital service delivery systems.	• Strengthen primary health care. • Implement provincial EMS plans. • Strengthen hospital services.
6. Strengthen support services	• Strengthen NHLS. • Ensure availability of blood through South African National Blood Service • Transfer forensic labs including mortuaries to provinces. • Implement health technology management system. • Strengthen radiation control.
	• Quality and affordability of medicines. • Establish an integrated disease surveillance system. • Integrate non natural mortality surveillance into overall mortality surveillance system. • Establish an integrated food control system.
7. Human resource planning, development and management.	• Implement plan to fast-track filling of posts. • Strengthen human resource management. • Implement national human resource plan. • Strengthen implementation of the CHW programme and expand mid level worker programme. • Strengthen programme of action to mainstream gender.

PIORITY	ACTIVITY
8. Planning, budgeting, monitoring and evaluation.	• Implement SHI proposals as adopted by Cabinet. • Strengthen health system planning and budgeting. • Strengthen use of health information system.
9. Prepare and implement legislation.	• Implement Mental Health Care Act • Implement National Health Bill • Implement Provincial Health Acts • Traditional healers, Nursing & Risk Equalisation Fund Bills implemented.
10. Strengthen international relations.	• Strengthen implementation of bi and multi-lateral agreements • Strengthen donor co-ordination • Strengthen implementation of NEPAD strategy and SADC.

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

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

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

3) **Contribute towards human dignity by improving quality of care:**
- Community participation is facilitated by the Facilities Boards that have been appointed in all hospitals, in line with the Health Facility Boards Act.
- Effective public relations are facilitated by means of communication with the public and internal communication, for example face to face meetings and media coverage.
- A provincial policy on Quality Assurance has been developed and implemented within the framework of the national policy.
- A provincial policy for the monitoring of complaints and complimented has been implemented and is monitored quarterly.
- External Client Satisfaction Surveys have been conducted in accordance to a planned schedule
- Waiting time surveys and analysis of systems to reduce waiting times have been conducted at nine clinics. Plan for further roll out.
- A policy for structured morbidity and mortality monitoring has been implemented.

- Development of standards to monitor the quality of service delivery is in progress which will constitute a mechanism for both internal and external accreditation
- Specific aspects of the Clinic Supervision Manual have been implemented.
- A formal procedure for monitoring the progress of quality improvement initiatives has been implemented.
- Staff satisfaction surveys are being rolled out.
- Monitoring of the progress of the outputs required in terms of the Hospital Management and Quality Improvement Grant is ongoing.

4) **Improve management of communicable diseases and non-communicable illnesses:**
   - HIV and AIDS: The Western Cape has achieved significant increase in anti-retroviral treatment access and universal coverage for the PMTCT intervention, through successful partnerships and multi-sectoral efforts. The Province also introduced a dual therapy PMTCT regimen (AZT from 34 weeks plus single-dose Nevirapine to the mother, and AZT for 1 week and single-dose Nevirapine for the baby), universally across the province by May 2004.
   - The incidence of tuberculosis (TB) in the Western Cape continues to be amongst the highest in the world, exacerbated by the HIV/AIDS pandemic. The Department has made significant progress in the implementation of the WHO DOTS Strategy and is working towards the overall goal of achieving an 85% cure rate. This is reflected in the steady improvements in the TB cure rates from 65% in 1997 to 68% in 2002.

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

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

7) **Human resource planning, development and management**:
   - New staff establishments are being developed in the Generic Staffing Models. The aim of these models is to create establishments that linked to the projected patient activity and an appropriate skill mix.
   - An Employment Equity Plan has been developed and implemented.

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

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

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

3.5 iKapa elihlumayo

3.5.1 iKapa elihlumayo is the Xhosa term for a growing Cape. The goals of iKapa elihlumayo are:
- Higher economic growth;
- Higher levels of employment
- Lower levels of inequality; and
- A sustainable social safety net.

In order to achieve these goals the following lead strategies have been identified:
- Human resource development with an emphasis on youth;
- Social capital formation with an emphasis on youth;

- Strategic infrastructure plan;
- Spatial development framework; and
- Micro-economic strategy.

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

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

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

3.5.2 Strategic Infrastructure Plan

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

3.5.3 Social Capital Formation (SCF) in Health

Introduction and background

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

The concept of *bonding* social capital is further defined as *bridging* social capital that applies to the horizontal links between individuals or groups sharing similar demographic characteristics, and *linking* social capital refers to linkages that cross different communities/ individuals. An important aspect of linking social capital is that it spans different levels of power in society.

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

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

Situational analysis

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

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

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

It is of concern that research has shown that if smokers had the same death rate as non-smokers, 58% of lung cancer deaths would have been avoided and approximately 8% of all

adult deaths in South Africa are caused by smoking. Recent studies have also shown that the winery areas of the Western Cape have the highest prevalence of Foetal Alcohol Syndrome in the world. These facts clearly illustrate the importance of individual responsibility for their own health and therefore importance of facilitating the development of social capital in the quest to fight the burden of disease.

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

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

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

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

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

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

- Assist the communities to address the water and sanitation problems by engaging the relevant departments (linking social capital).
- Engage with community structures to educate and empower the people, particularly mothers regarding the importance of early presentation of children with diarrhoeal disease to the health services. The Department of Health does not seek to create new or additional community structures but rather to make use of existing structures and to strengthen these where necessary.

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

Immunisation

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

Management of chronic diseases

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

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

Trauma

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

The way forward for Health and social capital formation

The Department of Health has made a concerted effort to analyse social capital formation and its implications for the Department. It is clear that social capital plays a fundamental role in the prevention of disease and the promotion of health. As the successful functioning of the Department rests on an effective and efficient Primary Health Care service so does the development of social capital. The Department's Healthcare 2010 and social capital formation strategy are therefore closely aligned and both have a primary health care focus.

3.6 Healthcare 2010

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

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

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

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

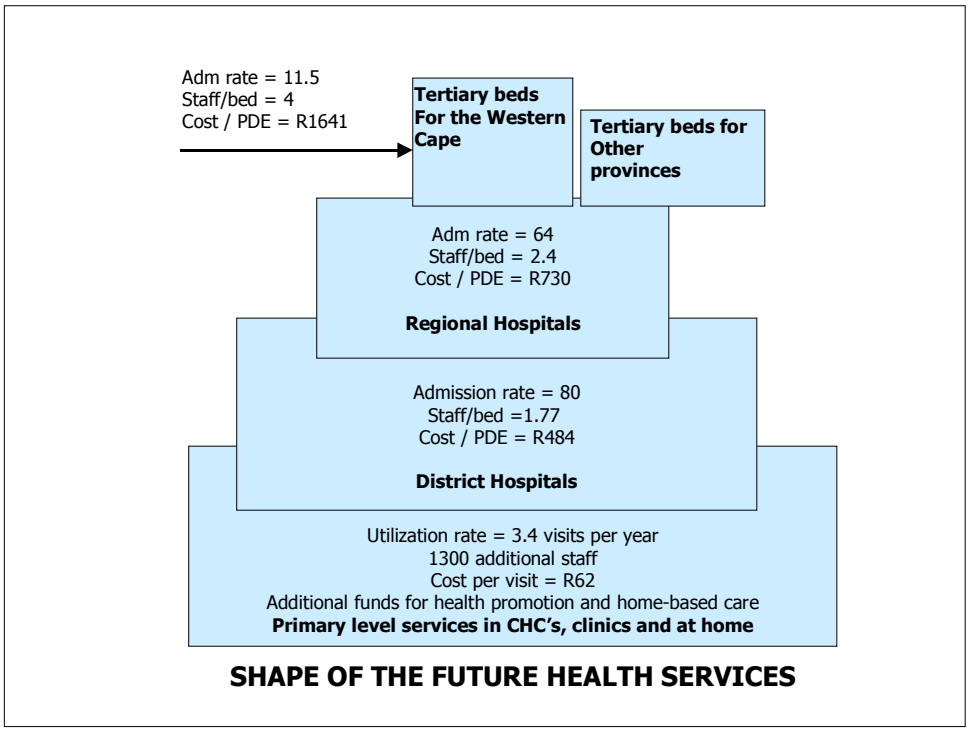
3.6.3 The underlying principles of Healthcare 2010 are:

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

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

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

Figure 2: The proposed shape of future health services



3.6.5 Implementation of Healthcare 2010

The strategic goals of the Department are:

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

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

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

The personnel plan

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

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

The service plan

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

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

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

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

The infrastructure plan

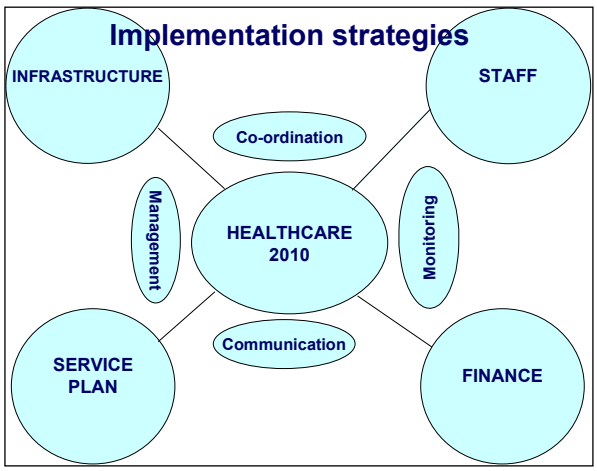
The infrastructure plan for hospitals has been compiled and similar plans for Primary Health Care and the Emergency Medical Services are being compiled. Planned patient transport is a key issue to facilitate the accessibility of services to patients and is being addressed.

Finances

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

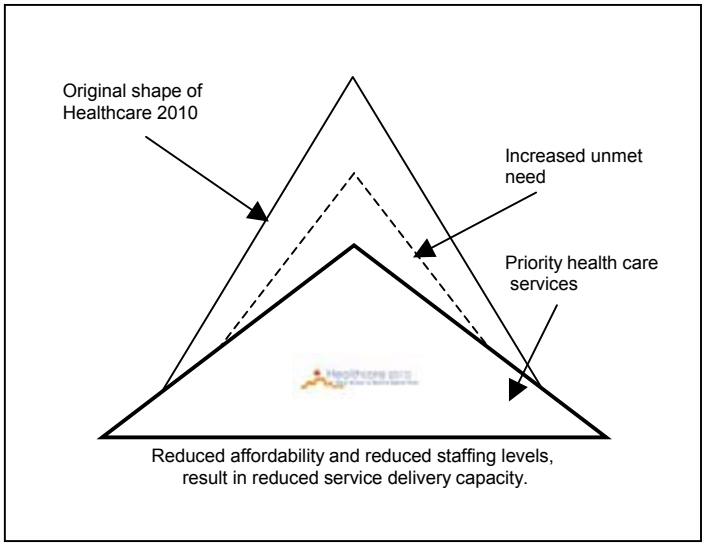
3.6.6 The framework of Healthcare 2010 was reviewed by the Department in June 2004 and found to still be valid. In the analogy that the Department of Health is a vehicle that provides essential health services, the four plans can be regarded as the wheels of the car, each playing a vital and related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

Figure 3: Healthcare 2010 implementation projects



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

Figure 4: Shape of the affordable service



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

4. DESCRIPTION OF THE STRATEGIC PLANNING PROCESS

4.1 The Healthcare 2010 conceptual framework was developed as a result of the Strategic Position Statement process initiated by the National Department of Health. In September

2002 the Provincial Cabinet requested that the conceptual framework be tested against a wide range of stakeholders.

4.2 The consultation process included the following:

- A media conference, addressed by top management explaining the concept and inviting engagement and comment;
- Over eighty engagements with representative stakeholder groups;
- Media interviews and response to media queries, i.e 21 articles and letters directly related to Healthcare 2010 occurred between October 2002 and February 2003;
- Advertisements were place in the English and Afrikaans media on 22 February 2004, to remind stakeholders that the closing date for comments was 28 February 2004.
- Representatives from senior and middle management considered all the inputs

4.3 A submission was made to the Provincial Cabinet who resolved that the Department of Health should proceed with the detailed planning and implementation of Healthcare 2010 on 26 March 2003.

4.4 Subsequently an information booklet titled: Healthcare 2010: Health Western Cape's plan for ensuring equal access to quality health care was published in English, Afrikaans and Xhosa.

4.5 In preparing the strategic plan for 2005/06 a Strategic Planning Review session was held at Ongegund on 27 and 28 June 2004. This meeting was attended by the MEC for Health, the Head of Department, the Department's top management, programme managers and representatives from the Directorates: Information Management, and Policy and Planning. In addition to this representatives from the Strategic Planning Cluster at the National Department of Health and the National and Provincial Treasury were invited.

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

4.6 On 10 November 2004 the group met again to discuss the First Draft of the Strategic Plan In addition to the above role-players, representatives from the three universities were invited. This was followed up by an in-house workshop on 23 November 2004 at which the respective policy options were discussed in a process of aligning the anticipated budget with proposed strategies.

4.7 The second draft of the Strategic plans were submitted in December 2004.

4.8 The Department revised its budget process during 2004/05 so that budget allocations were made to meet the projected expenditure of the respective budget entitites. The budget projections for the respective entities formed the bases of the Adjustment Budget on which the allocations for 2005/06 are based.

In making the allocations for 2005/06 the Adjustment Budget was adapted by a factor for cost increases based on an appropriate baseline. The baseline was adjusted for payments that would not recur in the following year.

4.9 Initially 192 policy options which required additional funding were proposed. These options were evaluated and reduced to an affordable envelope. Approximately R370 million has been made available to address these priorities. The criteria used to determine which of the options should be funded, over and above the projections based on current spending trends, include Healthcare 2010 and the Social Capital Formation strategies.

The Department continues to make a concerted effort to meet the challenge to provide a service in the face of the financial constraints described. This is clearly illustrated by the fact that each department is allowed to allocate 1.5% of its personnel budget to performance bonuses for its staff but due to financial predicament it was decided to provisionally only allocate 1% of the budget for this purpose in 2005.

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

Table 17: Trends in provincial public health expenditure (R million) [A3]

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	3 557 870	3 850 228	4 381 622	5 166 386	---	---	---
Total per person	786	838	939	1 090	---	---	---
Total per uninsured person	1 077	1 148	1 286	1 494	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	4 333 486	4 269 903	4 609 466	5 166 386	5 742 503	6 133 707	6 488 103
Total per person	958	929	988	1 090	1 193	1 255	1 307
Total per uninsured person	1 312	1 273	1 353	1 494	1 635	1 719	1 791
% of Total spent on:-							
DHS	21.4%	23.3%	25.5%	25.5%	28.1%	27.8%	27.6%
PHS	20.8%	22.8%	22.8%	22.8%	22.2%	22.1%	22.2%
CHS	31.1%	34.6%	34.9%	34.7%	33.7%	33.5%	33.6%
All personnel	62.2%	61.6%	55.8%	55.4%	54.6%	55.6%	55.6%
Capital				5.6%	5.2%	5.8%	5.9%
Health as % of total public expenditure	29.59%	27.25%	27.81%	27.98%	27.86%	27.48%	27.37%

PROGRAMME 1: ADMINISTRATION

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

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 1.1 OFFICE OF THE PROVINCIAL MINISTER

Rendering of advisory, secretarial and office support services.

2.2 SUB-PROGRAMME 1.2 MANAGEMENT

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

Sub-programme 1.2.1 Central Management

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

Sub-programme 1.2.2 Decentralised Management

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

3. SITUATION ANALYSIS

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

The central head office determines policy and ensures that the health service functions in harmony with both national and provincial policy and directives.

Human resource and financial management policies and procedures are determined and co-ordinated at the central head office. The central head office also provides overall policy determination, management and direction for Health Programmes.

Professional Support Services and Communication, with staff and public, are likewise co-ordinated and directed from the central head office. The organisational chart of the senior management of the Department is illustrated below.

From an epidemiological perspective, the migration into the Western Cape remains an issue of concern as whilst the province receives funding for patients from other provinces for tertiary services, albeit insufficient at present, no financial provision is made for these patients who require primary and secondary level care. This places an additional financial strain on the limited provincial resources.

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

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

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

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

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

Note: in order to retain the principle of compiling the strategic plan per financial programme, table HR3 Situational analysis and projected performance for human resources (excluding health sciences and training) is reported in Programme 1 rather than Programme 6.
Human Resource Management and Labour Relations resort financially and functionally within Programme 1, and whereas Health Sciences and Training is a separate financial programme it resorts managerially and functionally under Human Resources.

Table 1.1: Public health personnel in 2003/04 [HR1]

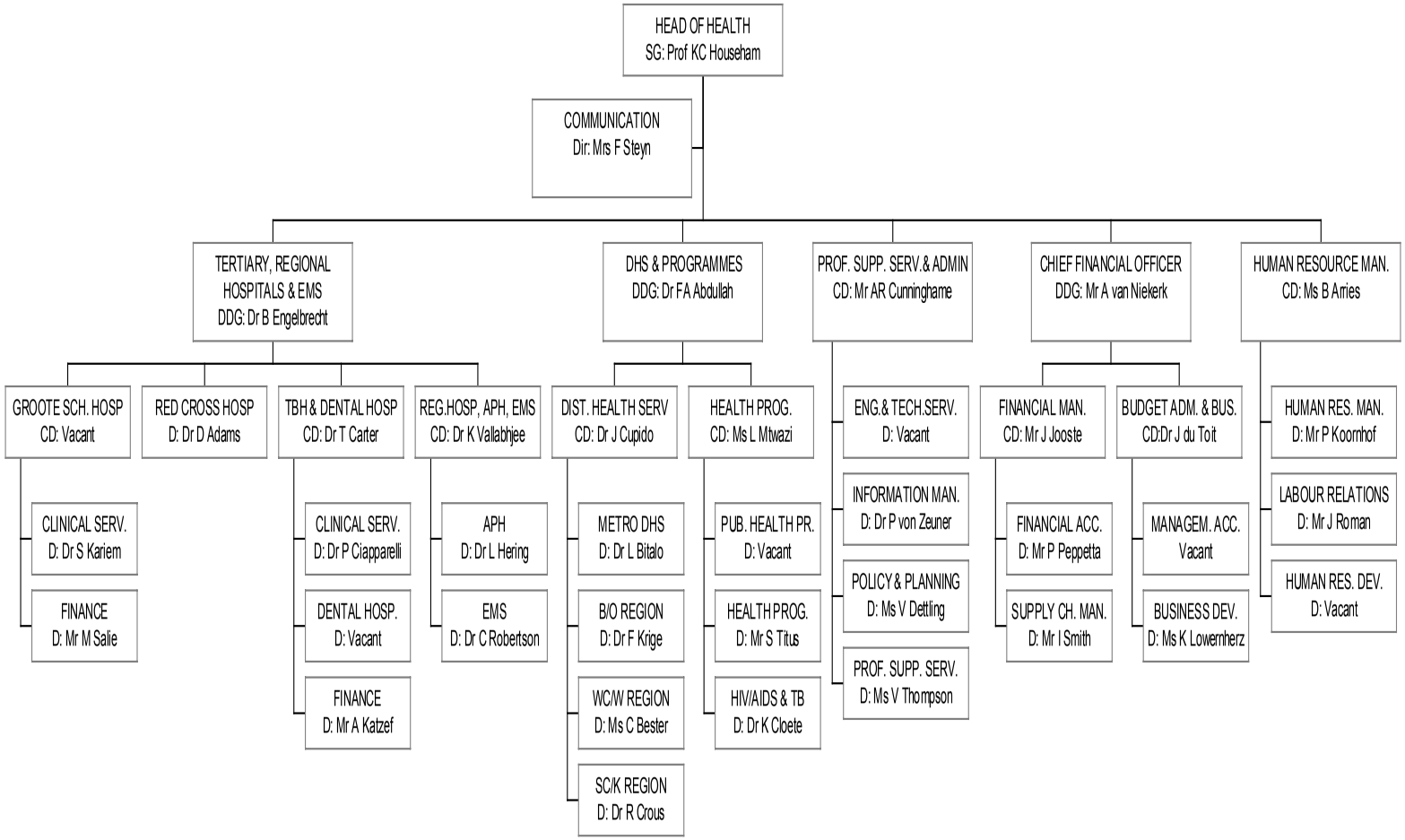
Categories	Number employed	% of total employed	Number per 1000 people	Number per 1000 uninsured people	Vacancy rate	% of total personnel budget	Annual cost per staff member	National average	
								% of total employed	Number per 1000 uninsured people
Medical officers	765	3.3%	0.16	0.22	21.5%	8.1%	261 369		
Registrars	571	2.4%	0.12	0.17	6.5%	7.2%	311 799		
Medical specialists	378	1.6%	0.08	0.11	23.0%	6.4%	419 244		
Dentists	61	0.3%	0.01	0.02	22.8%	0.6%	261 587		
Professional nurses	3 908	16.7%	0.82	1.13	22.2%	20.2%	127 707		
Staff nurses	1 732	7.4%	0.37	0.50	14.3%	6.3%	89 145		
Nursing assistants	3 868	16.6%	0.82	1.12	11.8%	10.9%	69 908		
Student nurses	332	1.4%	0.07	0.10	25.4%	0.7%	51 781		
Pharmacists	230	1.0%	0.05	0.07	34.7%	1.5%	164 854		
Nutritionists and dieticians	51	0.2%	0.01	0.01	21.5%	0.3%	129 041		
Other allied health professionals and technicians	908	3.9%	0.19	0.26	16.8%	4.9%	132 883		
Managers, administrators and all other support staff	10 542	45.2%	2.22	3.05	17.8%	32.8%	76 960		
Total	23 346	100.0%	4.93	6.75	17.7%	100.0%	105 627	100	

Table 1.2: Situational analysis and projected performance for human resources (excluding health sciences and training) [HR3]

Indicator	Type	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input									
1. Medical officers per 100,000 people	No	40	38	37	37	37	37	37	18.7
2. Medical officers per 100,000 people in rural districts	No	11	11	12	13	13	13	13	12.2
3. Professional nurses per 100,000 people	No	91	85	84	85	95	100	100	105
4. Professional nurses per 100,000 people in rural districts	No	59	57	55	55	60	70	80	92.5
5. Pharmacists per 100,000 people	No	5	4	5	5	8	10	15	34
6. Pharmacists per 100,000 people in rural districts	No	4	3	4	4	6	8	12	24
Process									
7. Vacancy rate for professional nurses	%	Not available	22%	19%	17%	15%	15%	15%	15
8. Attrition rate for doctors	%	31%	31%	37%	36%	30%	25%	25%	25
9. Attrition rate for professional nurses	%	10%	10%	12%	11%	12%	12%	12%	25
10. Absenteeism for professional nurses	%	3%	3%	3%	3%	3%	3%	3%	5
Output									
11. Doctors recruited against target	%								80
12. Pharmacists recruited against target	%								60
13. Professional nurses recruited against target	%								90
14. Community service doctors retained in the province	%								40
Quality									
15. Hospitals with employee satisfaction survey	%			15%	30%	45%	60%	65%	50
Efficiency									
16. Nurse clinical workload (PHC)	No		29,7	30,1	35	35	35	35	
17. Doctor clinical workload (PHC)	No		48,3	50,6	50	50	50	50	
Outcome									
18. Supernumerary staff as a percentage of establishment	%								

NOTES:
1. Excludes Local Government personnel.
2. Excludes sessions, periodical and extraordinary appointments.
3. Recruitments are Persal number and not per appointment.
4. Absenteeism is calculated: Persons*261 / days sick leave * 100
5. Doctors = medical officers, specialists, registrars and medical superintendents
6. Doctors as defined in Note 4 are used throughout the Table when reference is made to medical professionals, i.e. for Indicators 1, 2, 8 and 11
7. The unfunded posts within the Department of Health were abolished during July 2004 and the target for indicators 11, 12 and 13 will not be a true reflection of the real service need in terms various occupational classes. Furthermore the information is not obtainable from PERSAL. Once restructuring in terms of Healthcare 2010 has been finalised and proper HR planning has been done the information will be made available.
8. The job evaluation benchmark for medical officers with effect from 1/12/2003 have only been implemented during 2004. There was previously no specific job title for community service doctors to differentiate from medical officers on the PERSAL system. The information for indicator 14 will therefore only be available in the new financial year, 2005/06.

MANAGEMENT ORGANISATIONAL CHART



4. POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

4.1 National Department of Health's priorities for the next five years

In formulating the priorities for the next five years (2004 – 2009), in line with the new political term of office, the achievements of the past ten years were evaluated and the following focus areas were identified and approved by the Health MINMEC. These issues are being addressed by the Western Cape as follows:

4.1.1 Improve governance and management of the National Health System:

- Governance and management of the District Health System are being strengthened through the development of District offices in the Metropole and the appointment of facility managers at the major metropolitan community health centres. Following a long process of consultation, the Department will provincialise Personal Primary Health Care in rural and district municipalities with effect from 1st April 2005. The City of Cape Town will continue to partially fund and provide PHC services in the Cape Metropole.

4.1.2 **Promote healthy lifestyles**:

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

4.1.3 **Contribute towards human dignity by improving quality of care**:

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

4.1.4 **Improve management of communicable diseases and non-communicable illnesses**:

- HIV/AIDS: The Western Cape has achieved significant increase in anti-retroviral treatment access, expansion of the prevention strategy (including increased VCT coverage, condom distribution, STI management and universal access for PMTCT and post-exposure prophylaxis) and expansion of the care and support strategy (home-based care and palliative care), through successful partnerships and multi-sectoral efforts.
- The Province also introduced a dual therapy PMTCT regimen (AZT from 34 weeks plus single-dose Nevirapine to the mother, and AZT for 1 week and single-dose Nevirapine for the baby), universally across the province by May 2004.
- The incidence of tuberculosis (TB) in the Western Cape continues to be amongst the highest in the world, exacerbated by the HIV/AIDS pandemic. The Department has made significant progress in the implementation of the WHO DOTS Strategy and is working towards the overall goal of achieving an 85% cure rate. This is reflected in the steady improvements in the new smear positive (NSP) TB cure rates from 65% in 1997 to 72% in 2003.

4.1.5 **Strengthen primary health care, EMS and hospital delivery systems**:

- Initiatives planned to strengthen Primary Health Care include the provincialisation of the rural personal primary health care (PPHC) services currently provided by District and Local Government, to establish facility management, to computerise PHC services and to develop an infrastructure plan for PHC.
- Personal primary health care services will continue to be provided by the City of Cape Town in co-operation with the provincial Department for the next three years.
- Infrastructure plans for Emergency Medical Services are being developed.
- It is planned that hospital services, particularly regional hospital services providing level 2 services will be strengthened. The application of the Generic Staffing Models will assist in this process.

4.1.6 **Strengthen support services**

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

4.1.7 **Human resource planning, development and management**:

- New staff establishments are being developed in the Generic Staffing Models. The aim of these models is to create establishments that linked to the projected patient activity and an appropriate skill mix per level of care.
- An Employment Equity Plan has been developed and implemented.

4.1.8 **Planning, budgeting, monitoring and evaluation**:

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

4.1.9 **Prepare and implement legislation**:

- Mental Health Act: Considerable preparatory work has been done to prepare for the this legislation which was implemented in December 2004.
- National Health Act 61 of 2003: this has not yet been implemented but the implications of the Act on the functioning of the services has been assessed as far as possible at this stage.
- A Provincial Health Act for the Western Cape may be drafted once the National Health Act is implemented and the regulations published.
- The Medicines and Related Substances Act 101 of 1965 as amended and Pharmacy Act 53 of 1974 as amended: considerable preparatory work has been to prepare for the implementation of this legislation.

4.1.10 **Strengthen international relations**:

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

4.2 **Links to Healthcare 2010**

The Healthcare 2010 strategy of the Western Cape supports the above initiatives of the National Department and it is a priority that Healthcare 2010 be implemented as a matter of urgency in order to improve service delivery and to address the financial constraints.

A key priority is the reshaping of the services and improving the utilisation of human resources by striving to provide the correct numbers and skills mix of personnel at the various levels of care. Another important facet of Healthcare 2010 is to ensure that quality care is accessible to the people of the Western Cape. This process will be facilitated by the Infrastructure Plan, which is heavily dependent on the Hospital Revitalisation Programme.

Departmental policy is to keep the central head office as small as possible commensurate with its functions of policy-making, overall management and administration. The regional offices are required to ensure that the policies and procedures are implemented at institutional level. They are also responsible for co-ordinating activities to ensure effective and efficient delivery of quality health services. They provide decentralised management that is vital in keeping the Department in touch with the needs of communities – particularly in rural areas.

Currently a major strategic objective is to bring the Department into budget without the need to significantly curtail service delivery. Healthcare 2010 will lead to a major realignment of services over the next 7 years.

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

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

Better communication with staff at all levels, as well as with stakeholder such as the media, is also considered a key objective. The Communications Directorate is making progress in this regard.

4.3 **Funding priorities**

Funding has been allocated to the following priorities:

- R250 000 has been provided for additional personnel to manage the administrative burden, i.e. licensing and inspections that will be created by the implementation of the Mental Health Act.
- R2,5 million has been allocated for the appointment of a Transaction Advisor and consultants to perform study on the feasibility of making use of a PPP to build a new Forensic Unit at Valkenberg Hospital.
- R1,6 million has been made available for the appointment of personnel and equipment to improve the Supply Chain Management function of the Department.
- R10 million has been allocated for the appointment of financial staff at all institutions and offices to strengthen the financial management capacity of the Department.
- R800 000 has been allocated to the creation of Nursing and a Professions Allied to Medicine (PAMS) components to facilitate the co-ordination and management of issues related to these key personnel components.

- R800 000 for the appointment of 15 pharmacist interns to improve the efficiency and effectiveness of the Pharmacy service.
- R1 million for the provision of training and licensing of personnel as required in terms of the Medicines Act.
- R8,3 million has been allocated for the set-up and ongoing operational costs of contracting a chronic dispensing unit to facilitate the distribution of chronic medications to patients. It is anticipated that this will be time-saving for patients and will also reduce the congestion at PHC facilities.
- R877 000 for the appointment of 'Lead Clinicians' who will advise, manage and co-ordinate a particular discipline, from a clinical perspective, throughout the service, i.e. at all levels of care.
- R1 million for the provision of an Employee Assistance Programme (EAP).
- The pressure on accommodation in the Tower Block has necessitated that additional office accommodation be identified. Therefore R1,2 million has been allocated for the necessary refurbishments and moving costs.
- R800 000 has been allocated for the appointment of personnel and operational funding as required to the Directorate: Communications.
- In terms of the Language policy earmarked funds in the amount of R2,303 million have been allocated within the Communications Directorate to cover the cost of translations of official documents.
- R3,850 million has been allocated for the upgrading of clerical posts to salary level 4 and R10 million has been made available to improve the personnel performance incentives from 0.5% to 1% of the personnel cost. The latter remains below the indicative national norm of 1,5%.
- R1,5 million has been allocated for the establishment and R8 million for the operation of a Chronic Dispensing Unit to reduce the waiting times at Community Health Centres in the Metropole for patients receiving chronic medication.

5. CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The inability to meet the demand for services within the allocated financial resources remains the most significant constraint and challenge for the Department. Stringency measures implemented to curb over-expenditure have had a detrimental effect on service delivery, staff morale and efficiency. As personnel is the main cost driver, not filling vacant posts in non-critical areas and the more efficient use of human resources have the maximum impact on cost containment.

Recruitment of specific skills remains a problem. The financial, human resources and business management components are short staffed both at head office and institutional level. Recruitment of appropriate numbers of certain clinical personnel, e.g. pharmacists, theatre

nurses, etc, remains a problem. It is anticipated that the application of the Generic Models to the various establishments will determine the appropriate number and mix of staff for a particular level of service delivery, therefore optimising the use of human resources.

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

Legal compliance with the Pharmacy and Medicines legislation by July 2005 will be a challenge as it will demand upgrading of infrastructure, training and licensing of identified dispensers, additional human resource requirements, training and registration of Pharmacists Assistants as well a re-engineering of the drug supply chain,

6. PLANNED QUALITY IMPROVEMENT MEASURES

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

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

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

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

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

Specific quality improvement measures for 2005/2006 include:

- The determination of waiting times at clinics by conducting waiting time surveys and based on the results the implementation of strategies to reduce waiting times.
- Rollout of the external client satisfactions survey with the following targets for tertiary hospitals – 100%, secondary hospitals – 100% district hospitals – 100% and clinics – 30%.

- The establishment of Quality Assurance committees at all facilities and regions.
- The development of standards to monitor the quality of service delivery.
- Morbidity and mortality monitoring with quarterly reporting to the Department.
- Conducting of staff satisfaction surveys.
- Formalisation of an adverse event incident reporting system and centralised data capture in order to create a provincial database of adverse clinical events which guide the pro-active arm of the risk management programme.
- Continued training of Pharmacists Assistants to support improved Pharmaceutical care.
- Implementation of a Service Level Agreement with the NHLS.

7. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 1.3: Provincial objectives and performance indicators for Administration [ADMIN1]

7.1 Chief Directorate: Professional Support Services and Administration

Objective	Indicator	2002/2003 (Actual)[2]	2003/2004 (Actual)[2]	2004/2005 (Estimate)	2005/2006 (Target)	2006/2007 (Target)	2007/08 (Target)
POLICY AND PLANNING							
Facilitate the development of provincial health policy and draft legislation.	Requisite legislation and policies identified and drafted.	Uniform Patient Fee Regulations & Amendment 2003 Amendment: Private health establishment regulation (R187) Draft amendment to Hospitals Ordinance, 1946 Draft regulations: Western Cape Health Facilities Boards Act, 2001	70%	80%	80%	80%	80%
Provision of a legal advisory service to the Minister, Head of Department and other components of the Department.	Provision of effective legal advice to protect the interests of the Department.			100%	100%	100%	100%
Provision of Legal Administration support to prevent litigation and where unavoidable to ensure that the Department is appropriately defended.	Average number of litigation cases.	12	15	20	20	25	30
	Average number of litigation cases successfully defended.	3	6	8	8	10	15
Effective health service planning to ensure that plans are developed to ensure that health services are equitable, accessible, affordable and provide quality care.	A widely acceptable and realistic strategic plan that is based on the principles of Healthcare 2010.	Development of Healthcare 2010.	Healthcare 2010 approved by Cabinet and Strategic plan in place	Generic staffing models developed and applied to hospitals and PHC. Hospital infrastructure plan developed	Facilitate the implementation of Healthcare 2010 via the Strategic plan.	Facilitate the implementation of Healthcare 2010 via the Strategic plan.	Facilitate the implementation of Healthcare 2010 via the Strategic plan.
INFORMATION MANAGEMENT							
Provide health service and health status information to evaluate and monitor the effectiveness and efficiency of the services rendered by the department.	% of prescribed information collected, collated, published and disseminated.	80%	67%	85%	90%	90%	90%
Provide the necessary information technology, in accordance with Departmental and Provincial policy.	% of applications for information technology realised.	95%	98%	95%	95%	95%	95%

Objective	Indicator	2002/2003 (Actual)[2]	2003/2004 (Actual)[2]	2004/2005 (Estimate)	2005/2006 (Target)	2006/2007 (Target)	2007/08 (Target)
Manage the implementation and support of the Health Information System (HIS) in all hospitals of the department, as contracted.	% of hospitals where the HIS has been implemented.	0	10%	15%	30%	45%	60%
Manage and administer the Promotion of Access to Information Act, 2000 and National Archives Act to ensure accessibility, preservation of health records respectively.	% of requests for information addressed.	Component not established.	Component not established.	Component not established.	80%	80%	80%
PROFESSIONAL SUPPORT SERVICES							
Ensure that essential and quality drugs are available and dispensed as required.	% of indicator drugs immediately available and dispensed to patients.	Not known	100%	85%	90%	95%	98%
	% of alignment or PGWC code list with the National EDL	Not known	Not known	75%	85%	90%	95%
Ensure good pharmacy practice and efficient pharmaceutical care to patients.	% of pharmacists posts filled.	Not known	90%	80%	80%	90%	95%
	% of pharmacist's assistants trained / in training.	Not known	50%	50%	50%	90%	100%
	% of health facilities that comply with Medicines and Pharmacy Acts.				100%	100%	100%
Containment of financial losses resulting from the defence or settlement of claims resulting from personal injury an public liability claims.	Annual settlement costs.	R669 126	R600 000	R3,5 m	R3m	R4m	R4,5m
Provision of instructions to the State Attorney for purposes of defending the Department's interests in malpractice litigation.	Number of new medico-legal claims notified.	10	21	40	50	50	50
	Number of claims settled or defended.	9	11	15	20	25	25
Containment of negative publicity resulting from medico-legal queries.	Average number of medico-legal queries.	600	600	650	650	700	750
Ensure the effective co-ordination of quality of care improvements initiatives at facility and regional level.	% of regional offices and facilities with quality assurance committees.		0%	10%	70%	100%	100%
	% of regional offices and facilities with quality improvement plans.	20%	20%	50%	80%	90%	100%
	% of regional offices that submit 6-monthly reports	0	0	0	100%	100%	100%

Objective	Indicator	2002/2003 (Actual)[2]	2003/2004 (Actual)[2]	2004/2005 (Estimate)	2005/2006 (Target)	2006/2007 (Target)	2007/08 (Target)
To systematically evaluate the quality of service delivery.	% of facilities that have conducted an external client satisfaction survey, published the results and developed action plans for improvement.						100%
	Tertiary facilities	0	0	100%	100%	100%	100%
	Secondary facilities	0	Eben Donges Hospital	George Eben Donges Psychiatric Hospitals x 4	100%	100%	100%
	District facilities	0	0	Mossel Bay Hospital	40%	80%	100%
	Community Health Centres	0	0	0%	30%	60%	100%
	Complaints & compliments: % of facilities that submit quarterly returns on number of client complaints & compliments received.	0	0	75%	100%	100%	100%
	% of facilities with have included strategies to reduce complaints as reflected in the Quality Improvement Plans	0	0	0	50%	75%	100%
	Nature and extent of complaints reflect concomitant decrease in line with plans.	0	0	0	0	50%	75%
	Development of a set of standards against which to measure performance.	0	0	0	Develop 5 standards for each component of service delivery.	Evaluate the 5 standards set during 2004/05	Develop 10 additional standards
	% of facilities which conduct morbidity and mortality reviews in accordance with Provincial guidelines.	0	0	0	10%	45%	80%

Objective	Indicator	2002/2003 (Actual)[2]	2003/2004 (Actual)[2]	2004/2005 (Estimate)	2005/2006 (Target)	2006/2007 (Target)	2007/08 (Target)
Reduce client waiting times	The average time spent per clinic attendance. The average waiting time at each point of contact.	Not known	Not known	• Conduct a survey at 1 tertiary, 1 regional and 2 district hospitals and 5 clinics • Benchmark an acceptable Waiting time	• Conduct a survey at 1 tertiary, 1 regional and 2 district hospitals and 5 clinics • Benchmark an acceptable Waiting time	The Waiting Time is within the set standard.	Benchmark maintained

7.2 Chief Directorate: Human Resource Management

Objective	Indicator	2002/2003 (Actual)[2]	2003/2004 (Estimate)[2]	2004/2005 (Estimate)	2005/2006 (Target)	2006/07 (Target)	2007/08 (Target)
HUMAN RESOURCE MANAGEMENT							
Ensure the effective management of human resource management policies and practices.	Develop and implement policies and practices and audit the application of the policies and practices.	Not reported.	Develop policies as determined by legislation and collective agreements. Execute audits.	Develop policies as determined by legislation and collective agreements. Execute audits.	Develop policies as determined by legislation and collective agreements. Execute audits.	Develop policies as determined by legislation and collective agreements. Execute audits.	Develop policies as determined by legislation and collective agreements. Execute audits. Training of line managers and staff of HRM Offices.
The development and maintenance of an effective organisational structure for the Department.	Restructuring of departmental establishment to facilitate the achievement of Healthcare 2010.	Not reported	Develop Generic Models to be applied during the restructuring of the Department as a whole.	Restructure the organisational structure and staff establishment of the Department in terms of Healthcare 2010.	Partial implementation of the new approved organisational structure.	Implementation of the new approved organisational structure.	Emphasis on HR Planning by line managers w.r.t. their approved structures. Directorate HRM will facilitate the process.
	Update PERSAl accordingly.		100%	100%	100%	100%	100%

Objective	Indicator	2002/2003 (Actual)[2]	2003/2004 (Estimate)[2]	2004/2005 (Estimate)	2005/2006 (Target)	2006/07 (Target)	2007/08 (Target)
Provide an efficient personnel administration service to employees.	The execution of all personnel procedures with regard to recruitment, selection, appointments, conditions of service and the assessment of staff should be in terms of approved departmental standards.	Not recorded.	Execute all applicable policies and practices.	Execute all applicable policies and practices.	Execute all applicable policies and practices.	Execute all applicable policies and practices.	Execute all applicable policies and practices.
HUMAN RESOURCE DEVELOPMENT							
Ensure the effective management of human resource development policies and practices.	Develop and co-ordinate the implementation of HRD policies and practices. Monitor and evaluate the implementation of HRD policies and practices.	Not reported.	Develop policies as determined by legislation and Departmental strategies. Monitor and evaluate the implementation of HRD policies and practices.	Develop policies as determined by legislation and Departmental strategies. Monitor and evaluate the implementation of HRD policies and practices.	Develop policies as determined by legislation and Departmental strategies. Monitor and evaluate the implementation of HRD policies and practices.	Develop policies as determined by legislation and Departmental strategies. Monitor and evaluate the implementation of HRD policies and practices.	Develop policies as determined by legislation and Departmental strategies. Monitor and evaluate the implementation of HRD policies and practices.
LABOUR RELATIONS							
Ensure labour peace by providing and maintaining effective collective bargaining structures.	Number of incidents of labour unrest.	0	0	0	0	0	100%
Training of employees in labour relations issues, including practical training for supervisors in disciplinary matters, IMLC training, basic labour relations training for Xhosa speaking staff.	Number of employees trained	0	0.5%	2%	2.4%	3.5%	5%
Provide an efficient labour relations advisory service to employees and managers	% of disputes and grievances resolved	0	70%	70%	80%	85%	85%

Note: Information regarding Human Resource Development is reflected in Programme 6 and information regarding Engineering is reflected in Programme 7.

7.3 Finance

Objective	Indicator	2002/2003 (Actual)[2]	2003/2004 (Estimate)[2]	2004/05 (Estimate)	2005/2006 (Target)	2006/2007 (Target)	2007/08 (Target)
BUDGET ADMINISTRATION							
To appropriately allocate budgets to programmes in line with Healthcare 2010.	Consensus by management		Reasonable consensus	Consensus	Consensus	Consensus	Consensus
To spend the allocated budget without overspending	Unauthorised expenditure over budget.	(R3,926m)	R0	R0	R0	R0	R0
Facilitate the generation and collection of revenue.	Meeting of revenue target		Meet target	Meet target	Meet target	Meet target	Meet target
MANAGEMENT ACCOUNTING							
Timeous production of reliable financial statements.	Timeous submission of Annual Financial Statements	Financial statements to be produced by 30 April 2003.	Financial statements to be produced by 3 April 2004	Financial statements to be produced by 30 April 2005	Financial statements to be produced by 30 April 2006	Financial statements to be produced by 30 April 2007	Financial statements to be produced by 30 April 2008
SUPPLY CHAIN MANAGEMENT							
To minimize procurement related cost.	% decrease in expenditure of items procured.	Not applicable	Not applicable	2%	5%	10%	10%
To improve the management of contracts.	Number of contracts with service level agreements.	Not applicable	Not applicable	Not applicable	20%	50%	80%
To improve the level of asset management in the department.	% of institutions with credible asset registers.	Not applicable	Not applicable	30%	50%	80%	100%
	% of staff trained in asset management principles	Not applicable	Not applicable	30%	50%	80%	100%
To establish PPP's	% of identified projects registered.		80%	100%	100%	100%	100%
To increase own revenue	Number of case managers		10	16	16	16	16
	Number of designated service provider agreements		2	4	5	5	5

Objective	Indicator	2002/2003 (Actual)[2]	2003/2004 (Estimate)[2]	2004/05 (Estimate)	2005/2006 (Target)	2006/2007 (Target)	2007/08 (Target)
To license and inspect private health care establishments	Number of applications and adjudications outside prescribed timeframes.		0	0	0	Dependent on Health Act Regulations	Dependent on Health Act Regulations
	Number of inspections per year		256	350	430		
To increase own revenue	Number of hospitals billing audits per institution per year		1	2	2	2	2

7.4 Communications

Objective	Indicator	2002/2003 (Actual)[2]	2003/2004 (Actual)	2004/2005 (Estimate)	2005/2006 (Target)	2006/2007 (Target)	2007/2008 (Target)
COMMUNICATIONS							
Establish branding and visibility of the Western Cape Health Department.	Percentage of corporate items designed.	Not applicable	80%of items designed.	100% of items designed	Not yet determined	Not yet determined	
Maintain adequate communication with all stakeholders.	Number of publications per year.	Not applicable.	22	22	22	22	22
Assist with awareness campaigns and promotions for Programmes and other Health directorates.	Number of communications plans implemented and communicated in at least 2 of the mass media.		23	64	74	74	74
Implement 2005/06 internal communication plan.	Number of: • staff indabas • internal newsletters • team briefings	Not applicable	45 Not applicable Not applicable	45 12 58	45 12 67	45 12 67	45 12 67
Implement the national language policy	Number of awareness raising events and campaigns.	Not applicable	Not applicable	Awareness raising campaign x 1			
	Number of awareness raising workshops aimed at senior and line management.		Presentation to TMM x 1	Workshops for senior and line management x 5			
	Development of an implementation plan for the Western Cape Health Department. Development of capacity building programmes for Health. Establishment of a language unit for the provision of translation and interpretation services for the Western Cape Health Department.		Not applicable Not applicable Not applicable	Finalise implementation plan. Finalise capacity building programmes Appointment of 1 language practitioner.	Appoint 2 additional language practitioners	Appoint 3 additional language practitioners	

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

The allocation to Administration decreases to 3.4% of the vote in 2005/06 in comparison to 4.3% in 2004/05. This is due to the devolution of the earmarked equipment to the clinical programmes and the reallocation of regional management from Sub-programme 1.2.2 to Sub-programme 2.1.

The nominal increase of 77.82% in 2003/04 was due to the once-off payment of ± R51 million for deferred overspending and the earmarked allocation of R42 million for equipment. An amount of R51 million is the earmarked in the 2005/06 budget for medical equipment of which R11 million will resort in Programme 1 for use in other clinical programmes.

It is significant that the Department is permitted to allocate 1.5% of the personnel cost to performance incentives to personnel but in view of the financial and service pressures the Department has chosen to reduce this, in 2004/05 it was set at 0.5% but in 2005/06 it will increase to 1%. Depending on the financial projections this may be reviewed during the course of the financial year with a view to restoring the allocation to 1.5%.

Table 1.4: Trends in provincial public health expenditure for Administration (R' million) [ADMIN2]

Expenditure (R million)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	122 813	121 273	215 644	221 859	---	---	---
Total per person	27	26	46	47	---	---	---
Total per uninsured person	37	36	63	64	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	149 586	134 492	226 857	221 859	**195 618**	207 943	220 216
Total per person	33	29	49	47	**41**	43	44
Total per uninsured person	45	40	67	64	**56**	58	61
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

PROGRAMME 2: DISTRICT HEALTH SERVICES

1. INTRODUCTION

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

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

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

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

2. PROGRAMME DESCRIPTION

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

3. PROGRAMME STRUCTURE

Sub-programme 2.1 District Management

Planning and administration of services, managing personnel- and financial administration and the co-ordinating and management of the Day Hospital Organisation and Community Health Services rendered by Local Authorities and Non-Governmental Organisations within the Metro and determining working methods and procedures and exercising district control.

Sub-programme 2.2 Community health clinics

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

Sub-programme 2.3 Community health centres

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

Sub-programme 2.4 Community based services

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

Sub-programme 2.5 Other community services

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

Sub-programme 2.6 HIV/AIDS

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

Sub-programme 2.7 Nutrition

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

Sub-programme 2.8 Coroner services

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

Sub-programme 2.9 District hospitals

Rendering of a hospital service at district level.

Sub-programme 2.10 Global Fund

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

PRIMARY HEALTH CARE SERVICES

4. SITUATION ANALYSIS

4.1 Demographic profile

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

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

Table 2.1: Infant Mortality Rate (per 1000 live births) in 2002

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

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

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

4.2 Burden of Disease

HIV and TB:

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

Maternal, Child and Women's Health:

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

Chronic disease:

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

Violence and trauma:

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

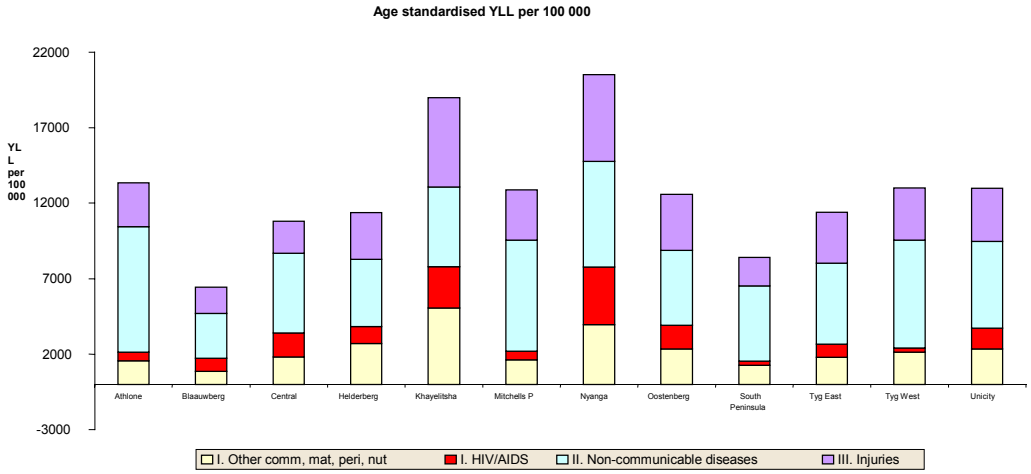


Figure 1: Age standardised YLLs per 100,000 by cause groups and HIV/AIDS for Cape Town and sub-districts, 2001 (Scott et al, 2003)

4.3 Health System

4.3.1 District Health Systems

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

Management systems in many districts are rudimentary, poorly coordinated between local and provincial government and incapable of improving service delivery to a significant degree, given the degree of fragmentation and overlap. The process of developing joint district health plans has improved this situation in some of the districts. The Department will focus on improving this situation during the next year. Processes are already under way in this regard.

[1] Data courtesy of Social Capital Formation in Health Concept Document (2004)

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

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

Table 2.2: Primary Health Care services expenditure per local authority in rand millions[2]

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

Source: Survey conducted 2000-2001

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

Existing provincial and local government services:

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

[2] Information is not supplied per district as requested as the Local Government information is being updated.

4.3.2 **Primary Health Care facilities**

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

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

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

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

In the past insufficient attention has been paid to the organisation and development of primary health care services and a severe lack of management capacity has arisen at the PHC level. Together with a lack of computerisation of these facilities and the neglect of physical infrastructure development, the primary health care service in the Province is comparable to similar services in other provinces.

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

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

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

Table 2.4: Personnel in district health services by health district [DHS2]

Health district	Personnel category	Posts filled	Posts approved	Vacancy rate (%)	Total Personnel (incl. LG)	Number in post per 1000 uninsured people
West Coast	**PHC facilities**					
	Medical officers	1	1	0%	3	0.01
	Professional nurses	6	6	0%	78	0.33
	Pharmacists	1	1	0%	N/A	N/A
	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	1	1	0%	1	0.004
	Professional nurses	79	93	15%	79	0.33
	Pharmacists	8	8	0%	8	0.03
Boland	**PHC facilities**					
	Medical officers	8	11	27%	20	0.04
	Professional nurses	60	75	20%	189	0.36

Health district	Personnel category	Posts filled	Posts approved	Vacancy rate (%)	Total Personnel (incl. LG)	Number in post per 1000 uninsured people
	Pharmacists	9	11	18%	7	0.01
	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	16	24	33%	16	0.03
	Professional nurses	95	122	22%	95	0.18
	Pharmacists	12	15	20%	12	0.02
	PHC facilities					
	Medical officers	6	10	40%	4	0.02
	Professional nurses	13	17	24%	70	0.39
	Pharmacists	N/A	N/A	N/A	N/A	N/A
Overberg	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	11	17	35%	11	0.06
	Professional nurses	53	70	24%	53	0.30
	Pharmacists	5	5	0%	5	0.03
	PHC facilities					
	Medical officers	14	14	0%	12	0.03
	Professional nurses	22	47	53%	133	0.34
	Pharmacists	2	4	50%	N/A	N/A
Eden	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	27	30	10%	27	0.07
	Professional nurses	139	163	15%	139	0.36
	Pharmacists	11	13	15%	11	0.03
	PHC facilities					
	Medical officers	3	3	0%	5	0.09
	Professional nurses	6	6	0%	31	0.55
	Pharmacists	1	2	50%	1	0.02
Central Karoo	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	3	2	0%	3	0.05
	Professional nurses	17	26	35%	17	0.30
	Pharmacists	3	3	0%	3	0.05
	PHC facilities					
	Medical officers	133	175	24%	96	0.12
	Professional nurses	479	578	17%	838	0.40
	Pharmacists	47	61	23%	45	0.02
Metropole	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	21	24	13%	21	0.01
	Professional nurses	82	90	9%	82	0.04
	Pharmacists	7	7	0%	7	0.003
	PHC facilities					
	Medical officers	165	214	23%	165	0.05
	Professional nurses	586	729	20%	586	0.17
	Pharmacists*	N/A	N/A	N/A	N/A	N/A
Province	Community health workers	Undetermined	Undetermined			
	District hospitals					
	Medical officers	79	98	19%	79	0.02
	Professional nurses	465	564	18%	465	0.13
	Pharmacists	46	51	10%	46	0.01

4.3.3 District hospitals

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

Table 2.5: Situation analysis indicators for district health services [DHS3]

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Boland 2003/04	Overberg 2003/04	Eden 2003/04	Central Karoo 2003/04	West Coast 2003/04	City of Cape Town 2003/04	National target
Input											
1 Uninsured population served per fixed public PHC facility	No		11184	12354	12558	7691	9896	5125	5212	17417	
2 Provincial PHC expenditure per uninsured person	R	203	212	241	212	247	216	284	254	251	N/A
3 Local government PHC expenditure per uninsured person	R	42	44	54	48	41	63	18	89	55	N/A
4 PHC expenditure (provincial plus local government) per uninsured person	R	245	256	295	260	288	279	302	343	306	227
5 Professional nurses in fixed PHC facilities per 100,000 uninsured person	No	N/A	N/A	40,34	40,98	46,35	43,23	75,8	37,17	39,01	107
6 Sub-districts offering full package of PHC services	%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	60
7 EHS expenditure (provincial plus local govt) per uninsured person	R	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	9
Process											
8 Health districts with appointed manager	%	0	0	0	0	0	0	0	0	0	
9 Health districts with plan as per DHP guidelines	%	N/A	50	83	100	100	Note 1	100	100	100	92
10 Fixed PHC facilities with functioning community participation structure	%	N/A	N/A	29%							69
11 Facility data timeliness rate for all PHC facilities	%										80
Output											
12 PHC total headcount	No	11,905,704	12,863,830	12,786,544	1,614,530	552,272	1,482,407	258,657	845,090	8,033,588	N/A
Population (Census 2001)		4,523,905	4,594,191	4,665,573	649,131	209,767	469,040	62,283	291,471	2,983,881	N/A
Uninsured Population (Census 2001)		3,257,212	3,307,818	3,359,213	467,374	151,032	337,709	44,844	209,859	2,148,394	N/A
13 Utilisation rate - PHC	No	3.7	3.9	3.8	3.5	3.7	4.4	5.8	4.0	3.7	2.3
PHC headcount under 5 years		2,509,598	2,925,777	2,487,273	313,049	104,920	309,797	43,866	154,852	1,560,789	
Population under 5 years (Census 2001)		405,542	411,828	418,212	60,992	19,064	43,203	6,673	27,556	260,723	
Uninsured Population under 5 years (Census 2001)		291,990	296,516	301,113	43,914	13,726	31,106	4,805	19,840	187,721	
14 Utilisation rate - PHC under 5 years	No	8.6	9.9	8.3	7.1	7.6	10.0	9.1	7.8	8.3	3.8
Quality											
15 Supervision rate	%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	78

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Boland 2003/04	Overberg 2003/04	Eden 2003/04	Central Karoo 2003/04	West Coast 2003/04	City of Cape Town 2003/04	National target
16 Fixed PHC facilities supported by a doctor at least once a week	%										31
Efficiency											
17 Provincial PHC expenditure per headcount at provincial PHC facilities	R	56	55	63	61	68	49	49	63	67	99
18 Expenditure (provincial plus LG) per headcount at public PHC facilities	R	68	66	78	75	68	64	52	85	82	99
Outcome											
19 Health districts with a single provider of PHC services	%	0	0	0	0	0	0	0	0	0	50

Note1: The district planning process has not been initiated in Eden as yet.

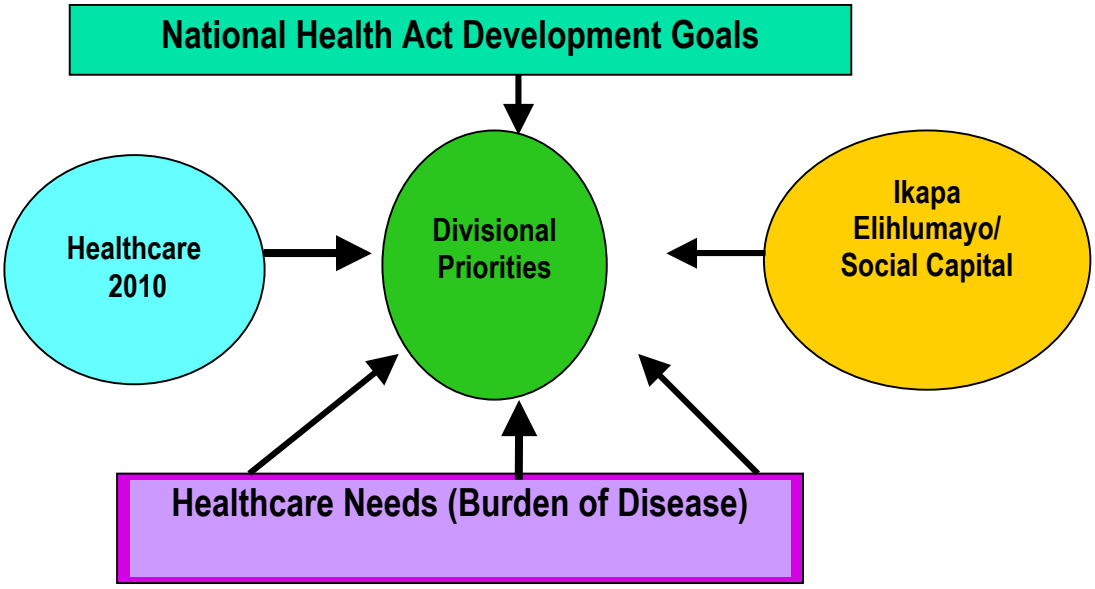
Table 2.6: Situation analysis indicators for district hospitals sub-programme [DHS4]

Indicator		Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	National target 2005
Input						
1	Expenditure on hospital staff as % of district hospital expenditure	%	75.5%	75.9%	73.0%	
2	Expenditure on drugs for hospital use as % of district hospital expenditure	%	5.4%	5.9%	6.3%	11
3	Expenditure by district hospitals per uninsured person	R	98.69	96.91	103.07	
Process						
4	District hospitals with operational hospital board	%	90%	90%	100%	76
5	District hospitals with appointed (not acting) CEO in post	%	82%	86%	86%	69
6	Facility data timeliness rate for district hospitals	%	90%	90%	90%	34
Output						
7	Caesarean section rate for district hospitals	%	13.42	13.9	14.43	12.5
Quality						
8	District hospitals with patient satisfactory survey using Department of Health template	%	0%	36%	50%	10
9	District hospitals with clinical audit (M & M) meetings every month	%	40%	50%	85%	36
Efficiency						
10	Average length of stay in district hospitals	Days	2.56	2.48	2.70	4.2
11	Bed utilisation rate (based on usable beds) in district hospitals	%	64.00%	65.00%	65.56%	68
12	Expenditure per patient day equivalent in district hospitals	R	528	557	596	814 in 2003/04 prices
Outcome						
13	Case facility rate in district hospitals for surgery separations	%	0.71	0.64	0.75	3.9

Table 2.7: Provincial objectives and performance indicators for District Hospitals [DHS5]

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	Expenditure 2001/02	Expenditure 2002/03	Expenditure Projected 2003/04	Budget Original 2004/05	Budget Estimate 2005/06	Budget Estimate 2006/07	Budget Estimate 2007/08
INPUT									
Provide sufficient funds for non-personnel expenditure in district hospitals	Expenditure on staff as % of total expenditure	68.45%	75.50%	75.90%	73.00%	71.70%	70.00%	68.00%	68.00%
	Expenditure on drugs as % of total expenditure	9.4%	5.4%	5.9%	6.3%	6.5%	6.5%	6.5%	6.3%
	Expenditure on maintenance as % total expenditure	3.98%	1.1%	1%	2.0%	3.0%	3.8%	3.8%	3.8%
Provide district hospitals infrastructure in line with SPS	Useable beds per 1000 total population	0.56	0.38	0.37	0.34	0.34	0.36	0.35	0.35
	Useable beds per 1000 uninsured population	0.76	0.53	0.51	0.47	0.46	0.49	0.48	0.48
Provide sufficient funding to ensure an efficient district hospitals service for the population	Hospital expenditure per capita (total population)	163	72	71	75	78	87	91	95
	Hospital expenditure per capita (uninsured population)	223	99	97	103	107	119	125	130
Provide services that adequately adress the needs of inpatients, outpatients and trauma cases.	Outpatients per inpatient day ratio	0.90	1.57	1.32	1.63	1.75	1.55	1.55	1.55
	Trauma as % of total outpatient headcounts	31%	39.8%	48.9%	39.9%	35.5%	32.7%	29.4%	27.2%
	Total number of inpatient days	896 635	405 296	405 697.50	381 674	379 363	441 760	467 003	479 625
	Total number of outpatient headcounts	808 865	635 295	533 944	621 261	663 885	684 727	723 854	743 418
PROCESS									
Facilitate representative management	Percentage of hospitals with operational hospital board	100%	90%	90%	100%	100%	100%	100%	100%
Facilitate decentralised management and accountability	Percentage of hospitals with appointed CEO in place (or Medical Superintendents)	100%	82%	86%	86%	100%	100%	100%	100%
	Percentage of hospitals with bussiness plan agreed with provincial health department	100%	100%	100%	100%	100%	100%	100%	100%
	Percentage of hospitals with up to date asset register	100%	75%	75%	80%	90%	100%	100%	100%
OUTPUT									
Ensure accessible district hospital services to the population of the western Cape	Separations per 1000 total population	59.4	35.0	35.6	30.3	29.7	34.0	35.4	35.8
	Separations per 1000 uninsured population	81.3	47.9	48.8	41.5	40.6	46.6	48.5	49.0
	Patient day equivalents per 1000 total population	224	136	127	126	127	139	145	147
	Patient day equivalents per 1000 uninsured population	307	187	174	173	174	191	199	201
QUALITY									
Ensure adequate infrastructure	Percentage of hospitals in facility audit condition 4 or 5								
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	100%	0%	36%	50%	100%	100%	100%	100%
	Percentage of hospitals with designated official responsible for coordinating quality management	100%	20%	30%	100%	100%	100%	100%	100%
	Percentage of hospitals with clinical audit (M&M) meetings at least once a month	100%	40%	50%	85%	100%	100%	100%	100%
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources	Average length of stay	2.91	2.56	2.48	2.70	2.70	2.70	2.70	2.70
	Bed utilisation rate based on useable beds	85%	64%	65%	66%	65%	70%	74%	76%
	Expenditure per patient day equivalent	726	528.23	556.87	596.29	618.17	624.09	627.55	647.09

5. POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES



5.1 Policy Context

Three broad policy developments inform the provision of primary health care and district hospital services. These are the National Health Act, assented to during 2004, the Healthcare 2010 strategy, adopted in 2002, and the provincial objective of social capital formation as described in iKapa Elihlumayo. The National Health Act will establish the district health system and with it new boundaries, governance structures, planning and reporting formats.

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

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

Programme 2 is a key role-player in the Department's Social Capital Formation initiatives. The Primary Health Care (PHC) focus on which Healthcare 2010 is based is the foundation for this initiative. In addition to this there are the four focus areas: prevention and management of diarrhoeal disease and immunization in children (IMCI) and the prevention and effective management of chronic diseases, including HIV and AIDS. In addition to this, the Department

will play an important role in providing data regarding the nature and incidence of Trauma to assist other departments focus their efforts appropriately in Trauma prevention.

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

To meet the healthcare needs of the people in the Western Cape, the Department's activities and programmes must be integrally linked to their needs, to their ability to access services and to their willingness to be involved and participate in managing their own health and the overall health of their community. This is central to the ideology of social capital, that is, building a community rich in social cohesiveness, together working towards (social action) improving health outcomes and in so doing, improving the community climate for success. Increased social cohesion provides the Department with an opportunity to strengthen and further grow the networks with the communities it has, and establish a platform for real dialogue with local communities. Linked to this notion is the focus on equity and the provision of and access to resources. Focusing on equitable delivery mechanisms should point clearly to a more broad-based, integrated health promotion and comprehensive health care approach.

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

System Priorities:

1) Strengthening the District Health System
2) Community-based services[3]
3) District Hospitals
4) Chronic disease management[4]

Programme Priorities:

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

[3] Home-based care is a priority programme that will drive community-based services
[4] the broader management of chronic diseases will be a priority programme within Health programmes

5.2 Key Strategies

5.2.1 Implementation of the District Health System

The structure of the Division: District Health Services and Programmes will be amended with a view to addressing the policy environment and to bring in necessary public health expertise. There will also be a review of the management structures and staff establishments of primary health care facilities particularly in the Metro. Significant funding has been made available for taking over the full financial responsibility of primary health care services in the five rural districts. An additional amount of R65,850 million has been allocated to funding the provision of the PHC function previously funded by Local Government. Funding has been allocated to promote community participation (in terms of the National Health Act) and the implementation of the governance and managerial arrangements as well as for direct community participation at the facility and district level. Further computerization of the community health centers will take place in the year with a view to networking all community health centers, patient administration and access to hospital information.

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

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

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

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

The process of appointing facility managers has already commenced, and posts in the major community health centres in the Metropole are currently being filled. Recommendations regarding the composition of the sub-district management structures have been developed as part of the broader Departmental restructuring process. The necessary information

technology infrastructure is being created in the major community health centres in order to allow managers access to the Provincial intranet. This will expedite the procurement process, human resource management process as well as improve the ability to collect service related data in facilities. As part of the Healthcare 2010 significant expansion and reconfiguration of the existing facilities is being considered because of greater demands caused by rapid migration into the Province.

5.3 **Community-based care:**

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

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

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

Key Strategies

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

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

5.4 District Hospitals

Policy context

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

Key Strategies

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

An amount of R20m has been made available in the next financial year for the commissioning of 120 additional district level beds. These beds will be in Tygerberg, Karl Bremmer and Lentegeur Hospitals. Some of these beds will be decanted into the new Khayelitsha Hospital when it is ready for commissioning.

The HealthCare 2010 strategy encourages the decanting of inpatient admissions from secondary and tertiary hospitals to the district level hospital. The additional 120 beds will make a substantial contribution to this strategy. No additional funds have been made available to the current district hospitals to increase the number of admissions and theatre cases but this situation is expected to improve over the outer two years of the MTEF period.

5.5 Chronic Disease Management

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

A first attempt will be made at the improvement of the management of chronic diseases at the primary care level including the setting up of primary and secondary prevention, health education and rehabilitation services. Additional doctors, nurses and pharmacists at community health centers, the introduction of family medicine and the operationalisation of chronic dispensing units are funded in 2005/06.

Key Strategies

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

6. ANALYSIS OF CONSTRAINTS AND MEASURES TO OVERCOME THEM

Table 2.8: Analysis of constraints and measures to overcome them

SYSTEM PRIORITIES	CONSTRAINTS	MEASURES TO OVERCOME THEM
STRENGTHEN THE DISTRICT HEALTH SYSTEM	• National Health Act regulations being promulgated.	• Creation of District Health Councils
	• Failure to reach consensus with partners re DHS governance.	• Intervention of political principals to resolve issues around DHS governance.
COMMUNITY BASED SERVICES	• Availability of physical infrastructure.	• Infrastructure planning in progress.
	• Programme for decanting mental health patients to be developed in conjunction with Programme 4 managers.	• Coherent strategy for decanting of mental health patients developed in conjunction with Programme 4 managers
	• Continued availability of donor funding for HBC.	• Training and capacitation of NPO's rendering HBC services
	• Complexity of procurement procedures.	• Training of home-based carers and technical assistants.
	• Availability of professional staff.	• Efforts being made to focus on recruitment of certain professional categories.
DISTRICT HOSPITALS	• Availability of Hospital Revitalisation Project funding.	• Development of feasible Business Plans; and • Secure HRP funding.
CHRONIC MEDICATION SUPPLY	• Recruitment and retention of pharmacy personnel. • Regulations relating to dispensing medications.	• Seed funding for business plan for CDU.

7. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.9: Provincial objectives and performance indicators for district health services [DHS5]

Measurable objective	Performance measure	Year –1 2003/04 (actual)	Base year 2004/05 (estimate)	Year 1 2005/06 (target)	Year 2 2006/07 (target)	Year 3 2007/08 (target)
Sub-programme 2.1: District management						
Implementation of the district health system.	Number of health district management structures created.	Not applicable	Not applicable	New macro-structure imple-mented for Division	Revised staff establish-ments	Functional District Manage-ment System
	% of districts with appointed managers.	Not applicable.	0%	80%	100%	100%
	% District Health Plans developed.	Not applicable.	69%	100%	100%	100%
Sub-programme 2.2: Community health clinics						
Provision of Primary Health Care (PHC) services to uninsured citizens of the Western Cape.	Number of PHC visits per annum	7 980 423	7 953 594	8 000 000	8 000 000	8 000 000
Provision of Immunisation coverage as per World Health Organisation (WHO) standard.	% of 1 yr olds immunised.	73%	80%	85%	90%	90%
Implement cervical screening programme in Clinics and Community Health Centre's (CHC's).	% of patients in target group reached.	41%	44%	75%	80%	85%
Effective clinical management of suspected TB cases.	% of smear positive TB cases cured	68%.	70%	73%	74%	75%
Sub-programme 2.3: Community health centres						
Provision of CHC services	Number of CHC visits per annum		4 483 318	4 954 226	4 500 000	4 500 000
Improve facility management	Number of facility managers appointed		15	40	64	64
Improve management information.	Number of facilities linked to the Provincial Internet	Not applicable	15	40	64	64
Sub-programme 2.4: Community based services						
Home based care services to be provided in all sub-districts.	Number of category 3 clients receiving home-based care			4 717	8 000	10 000
	Number of home-based carers appointed.	125	125	650	1 000	1 000

Table 2.10: Performance indicators for district health services [DHS6]

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input							
1. Uninsured population served per fixed public PHC facility	No	11 184	12 184	12 347	12 479	12 671	<10,000
2. Provincial PHC expenditure per uninsured person	R	231	230	253	277	286	
3. Local government PHC expenditure per uninsured person	R	44	54	53	52	51	N/A
4. PHC expenditure (provincial plus local government) per uninsured person	R	274	284	286	329	337	274
5. Professional nurses in fixed PHC facilities per 100,000 uninsured person	No	40,34	41	44,8	52	57	130
6. Sub-districts offering full package of PHC services	%	65%	80%	85%	90%	100%	100
7. EHS expenditure (provincial plus local govt) per uninsured person	R	N/A	10	10	12	15	13
Process							
8. Health districts with appointed manager	%	0	60	66	80	85	100
9. Health districts with plan as per DHP guidelines	%	66	100	100	100	100	100
10. Fixed PHC facilities with functioning community participation structure	%	28%	40%	60%	70%	75%	100
11. Facility data timeliness rate for all PHC facilities	%	N/A	70%	100%	100%	100%	100
Output							
12. PHC total headcount	No	12 499 678	13 741 705	14 436 450	15 638 176	15 881 120	17 370 066
13. Utilisation rate - PHC	No	2.7	2.9	3.0	3.2	3.3	3.5
14. Utilisation rate - PHC under 5 years	No	5.5	5.5	5.4	5.5	5.5	5.0
Quality							
15. Supervision rate	%	N/A	50%	60%	70%	85%	100
16. Fixed PHC facilities supported by a doctor at least once a week	%						100
Efficiency							
17. Provincial PHC expenditure per headcount at provincial PHC facilities	R	85	79	84	87	87	
18. Expenditure (provincial plus LG) per headcount at public PHC facilities	R	101	98	95	103	102	
Outcome							
19. Health districts with a single provider of PHC services	%	0	0	0	100	100	100

Table 2.11: Performance indicators for district hospitals sub-programme [DHS7]

Indicator		Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input								
1	Expenditure on hospital staff as % of district hospital expenditure	%	73.00%	71.70%	70.00%	68.00%	68.00%	62
2	Expenditure on drugs for hospital use as % of district hospital expenditure	%	6.25%	6.47%	6.50%	6.53%	6.34%	11
3	Expenditure by district hospitals per uninsured person	R	103.07	107.34	119.03	124.59	129.93	
Process								
4	District hospitals with hospital board	%	100%	100%	100%	100%	100%	100
5	District hospitals with appointed (not acting) CEO in post	%	86%	100%	100%	100%	100%	100
6	Facility data timeliness rate for district hospitals	%	90%	90%	90%	90%	100%	100
Output								
7	Caesarean section rate for district hospitals	%	14.43	14.43	14	12	12	11
Quality								
8	District hospitals with patient satisfaction survey using DoH template	%	50%	100%	100%	100%	100%	100
9	District hospitals with clinical audit (M and M) meetings every month	%	85%	100%	100%	100%	100%	100
Efficiency								
10	Average length of stay in district hospitals	Days	2.7	2.7	2.7	2.7	2.7	3.2
11	Bed utilisation rate (based on usable beds) in district hospitals	%	65.6%	65.0%	70.0%	74.0%	76.0%	72
12	Expenditure per patient day equivalent in district hospitals	R	596.29	618.17	624.09	627.55	647.09	814 in 2007/08 prices
Outcome								
13	Case fatality rate in district hospitals for surgery separations	%	0.22	0.21	0.20	0.20	0.20	3.5

8. TRANSFERS TO MUNICIPALITIES AND NON-GOVERNMENT ORGANISATIONS

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

Table 2.12: Transfers to municipalities and non-government organisations (R '000) [DHS8]

Municipalities R'000	Outcome						Medium term estimate			
	Audited 2001/02	Audited 2002/03	Audited 2003/04	Main appropriation 2004/05	Adjusted appropriation 2004/05	Revised estimate 2004/05	2005/06	2006/07	2007/08	% Change from Revised estimate 2004/05
Category A	127 240	114 072	132 304	92 730	133 181	133 181	**106 655**	110 438	116 411	(19.92)
City of Cape Town	127 240	114 072	132 304	92 730	133 181	133 181	**106 655**	110 438	116 411	(19.92)
Category B	35 826	28 540	33 449	33 149	39 044	39 044	**75 393**	1 594	1 685	93.10
Beaufort West	2 383	1 088	1 131	1 178	1 340	1 340	**879**	175	185	(34.40)
Bergrivier	263	348	33	35	35	35	**25**			(28.57)
Bitou	1 606	1 631	1 329	2 011	2 039	2 039	**4 363**	30	31	113.98
Breede River/ Winelands	1 106	801	808	857	857	857	**1 963**			129.05
Breede Valley	1 761	1 620	1 659	1 745	1 745	1 745	**6 016**			244.76
Cape Agulhas	479	63	67							
Cederberg	332	409	483	479	479	479	**556**			16.08
Drakenstein	2 959	2 777	3 313	3 544	6 215	6 215	**4 955**			(20.27)
George	6 655	4 650	6 411	5 660	6 115	6 115	**11 874**	483	512	94.18
Kannaland	297	17	24	5	5	5				(100.00)
Knysna	1 749	1 349	1 860	2 005	2 055	2 055	**4 313**	53	56	109.88
Laingsburg	24	19	32	5	5	5				(100.00)
Langeberg	3 101	1 999	1 881	1 420	1 823	1 823	**1 013**			(44.43)
Matzikama	467	470	738	748	748	748	**686**			(8.29)
Mossel Bay	2 854	2 281	2 231	2 545	2 635	2 635	**5 091**	95	101	93.21
Oudtshoorn	897	695	603	1 230	1 470	1 470	**1 823**	268	284	24.01
Overstrand	1 913	960	1 008	1 056	1 056	1 056	**1 921**			81.91
Prince Albert	212	244	342	255	285	285	**244**			(14.39)
Saldanha Bay	1 323	1 364	1 936	1 778	1 778	1 778	**3 303**			85.77
Stellenbosch	1 812	1 937	2 546	2 271	2 271	2 271	**3 797**	98	104	67.20
Swartland	1 928	1 458	1 935	1 842	3 608	3 608	**2 064**	391	410	(42.79)
Swellendam										
Theewaterskloof	1 164	1 719	2 487	1 855	1 855	1 855	**2 682**			44.58
Witzenberg	541	641	592	625	625	625	**757**			21.12
Unallocated							**17 068**			
Category C	38 931	32 143	36 603	41 586	52 186	52 186	**62 072**	4 536	3 581	18.94
Cape Winelands	5 297	8 448	8 619	12 641	17 043	17 043	**15 752**	451	228	(7.57)
Central Karoo	3 759	3 207	3 651	3 561	4 700	4 700	**3 861**	800	747	(17.85)
Eden	9 211	7 909	8 468	8 919	9 490	9 490	**11 018**	1 271	983	16.10
Overberg	7 845	6 237	7 084	7 278	8 549	8 549	**7 417**	312	158	(13.24)
West Coast	12 819	6 342	8 781	9 187	12 404	12 404	**11 092**	1 702	1 464	(10.58)
Unallocated							**12 932**	1	1	
Total transfers to local government	201 997	174 755	202 356	167 465	224 411	224 411	**244 120**	116 568	121 676	8.78

Source: Budget Statement 2, 2005: 449-450 Note: Excludes Regional services council levy

Note: The Department was allocated additional funding as from the 2005/6 financial year which allows the full funding of all rural municipal Personal Primary Health Care (PPHC) services as from 1st April 2005. The status quo for funding of PPHC services within the Cape Metro will be retained for the foreseeable future. The Department has indicated that it will to assume full control and responsibility for municipal PPHC services in rural municipalities, delivered largely in clinics, with effect from 1 April 2005. However, there are currently uncertainties regarding the amounts involved, including the actual current costs of those services funded by rural municipalities, which municipal staff should be linked to PPHC services, the extent to which municipalities have not filled vacancies and when the department will be able to assume full operational control of these services. Given these uncertainties it is not possible to determine the exact amounts that would need to be paid to municipalities as transfer payments in the 2005/6 financial year. For this reason amounts totalling R100 million has been allocated pro rata per municipality while a further R30 million remains unallocated and will be dealt with in the adjustment estimates in November 2005.

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

The funding for Programme 2 increases by R259,342 million in 2005/06 and constitutes 28,1 % of the vote. This is an increase of 19,2% in nominal terms and is the largest increase in primary health care funding in ten years and allows for real steps towards implementing the main policies of the Department in this arena.

Table 2.13: Trends in provincial public health expenditure for District Health Services (Programme 2) (R million) [DHS9]

Expenditure (R million)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	927 968	993 592	1 175 193	1 317 462	---	---	---
Total per person	205	216	252	278	---	---	---
Total per uninsured person	281	296	345	381	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	1 130 265	1 101 894	1 236 303	1 317 462	**1 611 684**	1 704 433	1 793 938
Total per person	250	240	265	278	**335**	349	361
Total per uninsured person	342	329	363	381	**459**	478	495
Total capital							

Note: Current price projections are not required for the MTEF period as these figures will be the same as the constant price projections for the same years.

Table 2.14: Trends in provincial public health expenditure for District Hospital Services (Sub-programme 2.9) (R'million) [DHS9]

Expenditure (R million)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	267 612	293 089	333 717	371 308	---	---	---
Total per person	59.15	63.79	71.52	78.36	---	---	---
Total per uninsured person	81.03	87.38	97.97	107.34	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	325 951	325 036	351 070	371 308	**418 143**	444 487	470 714
Total per person	72.04	70.74	75.24	78.36	**86.89**	90.95	94.85
Total per uninsured person	98.69	96.91	103.07	107.34	**119.03**	124.59	129.93
Total capital							

Note: Current price projections are not required for the MTEF period as these figures will be the same as the constant price projections for the same years.

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

10.1 SITUATION ANALYSIS

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

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

Table 2.15: Situation analysis indicators for HIV and AIDS, STI's and TB control [HIV1]

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Boland 2003/04	Overberg 2003/04	Eden 2003/04	Central Karoo 2003/04	West Coast 2003/04	City of Cape Town 2003/04
Input										
1. ARV treatment service points compared to plan [1]	%	0	0	106% (16/15)	100% (2/2)	0	100% (1/1)	0	0	108% (13/12)
2. Fixed PHC facilities with ANC offering PMTCT	%	100% (185/185)	100% (185/100)	%	100% (42/42)	100% (23/23)	100% (39/39)	100% (11/11)	100% (46/46)	100% (24/24)
3. Fixed PHC facilities offering VCT		60	90	100% (260/260)	100% (42/42)	100% (23/23)	100% (39/39)	100% (11/11)	100% (46/46)	100% (119/119)
4. Hospitals offering PEP for occupational HIV exposure	%	100% (53/53)	100% (53/53)	100% (53/53)	100% (8/8)	100% (4/4)	100% (8/8)	100% (5/5)	100% (8/8)	100% (20/20)
5. Hospitals offering PEP for sexual abuse	%	67.9% (36/53)	67.9% (36/53)	67.9% (36/53)	75% (6/8)	100% (4/4)	87.5% (7/8)	80% (4/5)	87.5% (7/8)	40% (8/20)
6 HTA Intervention sites compared to plan	%	0	0	0	0	0	0	0	0	0
Process										
7 TB cases with a DOT supporter	%	87	88	88.3	87	87	90	91	90	88
8. Male condom distribution rate from public sector health facilities	No	5.9	8.4	10.3	3.0	2.6	3.5	6.8	3.0	14.4
Male condom distributed		9,285,823	13,337,364	16,715,351	677,766	198,835	561,268	133,740	305,848	14,837,894
Male population >15 years		1,572,180	1,595,154	1,618,463	223,275	77,451	161,600	19,804	103,319	1,033,014
9. Male condom distribution rate from primary distribution sites	No	6.9	13.3	17.3	5.1	4.3	5.8	11.3	5.0	24.1
10. Fixed facilities with any ARV drug stock out	%	No data	No data	No data	No data	No data	No data	No data	No data	No data
11. Hospitals drawing blood for CD4 testing	%	No data	No data	No data	No data	No data	No data	No data	No data	No data
12. Fixed PHC facilities drawing blood for CD4 testing	%	No data	No data	No data	No data	No data	No data	No data	No data	No data
13. Fixed facilities referring patients to ARV treatment points assessment	%	No data	No data	No data	No data	No data	No data	No data	No data	No data
Output										
14. STI partner treatment rate	%	15.61%	15.41%	17.58%	17.53%	29.49%	18.03%	36.47%	15.15%	17.00%
Number of STI partners treated		18.986	18,964	19,541	1,714	984	1,441	329	711	14,362
Number of STI treated – new episode		121,634	123,064	111,169	9,777	3,337	7,994	902	4,692	84,467
15. Nevirapine dose to bay coverage rate	%	80*	85*	90*	90*	90*	90*	90*	90*	90*
16. Clients HIV pre-test counselled rate in fixed PHC facilities	%	0.01	1.2	1.6	0.86	0.98	2.2	2.3	2.4	1.6

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Boland 2003/04	Overberg 2003/04	Eden 2003/04	Central Karoo 2003/04	West Coast 2003/04	City of Cape Town 2003/04
Number of PHC clients pre-test counselled		1700	158,061	208,380	13,916	5,418	32,613	5,940	20,592	129,900
Total PHC headcount		11,905,704	12,863,830	12,786,544	1,614,530	552,272	1,482,407	285,657	845,090	8,033,588
17. Patients registered for ART compared to target	%	0	0	100	100	0	100	0	0	100
18. TB treatment interruption rate	%	16.4%	14.7%	pending	10.7%	4.6%	11.2%	14.2%	11.8%	13.6%
Number of TB clients who interrupt treatment		4,117	3,908	pending	355	13	602	69	374	1,538
Number of clients treated for TB		25,118	26,578	pending	3,311	282	5,362	486	3,181	11,321
Quality										
19. CD4 test at ARV treatment service points with turnaround time > 6 days	%	No data	No data	No data	No data	No data	No data	No data	No data	No data
20. TB sputa specimens with turnaround time > 48 hours	%	32	32	30	31	31	29	30	28	30
Efficiency										
21. Dedicated HIV/AIDS budget spent	%	68.0	57.5	70.3	76.5	76.5	82.2	82.2	81.1	46.9
Outcome										
22. New smear positive PTB cases cured at first attempt	%	74.0%	67.8%	Pending	66.7%	68.4%	69.1%	70.2%	72.7	67.0%
New smear positive PTB cases cured		11,200	12,366	Pending	2,438	711	1,530	153	1,196	6,338
New smear positive PTB cases treated		15,135	18,230	Pending	3,653	1,039	2,214	218	1,645	9,461
23. New MDR TB cases reported – annual % change	%	0	0	0	0	0	0	0	0	0
24. STI treated new episode amoung ART patients – annual % change	%	No data	No data	No data	No data	No data	No data	No data	No data	No data
25. ART monitoring visits measured at WHO performance scale 1 or 2	%	No data	No data	No data	No data	No data	No data	No data	No data	No data

*Approximate figures (have not been routinely collated from registers to date, as it was never a recommended indicator)

Note 1:The plan was to have 15 ARV sites in the Province by March 2005, but it was possible to establish 16, therefore 15/16 = 106%. The Metro had the additional site and there were therefore 13 instead of the planned 12 sites, 13/12 = 108%

10.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

10.2.1 Combat TB epidemic

Policy Context

Additional funding of R4,4 million has been allocated for additional staff and laboratories , as well as for improving the stock levels of TB medications. Funding has also been provided for the provincial takeover of two municipal TB hospitals and one TB hospital run by SANTA.

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

Key Strategies

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

10.2.2 Combat HIV pandemic

Policy Context

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

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

Key Strategies:

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

- As a preventive strategy, the expansion of the VCT programme, which aims to attain a coverage target of greater than 6% of the adult population over the age of 15 years remains the key strategy for the department. The provision of condoms, the management of STIs and the focus on PMTCT will continue into the next MTEF cycle.
- With its partners the Western Cape Education Department and the Department of Social Services and Poverty Alleviation, major investments in the roll-out of peer education (therefore linking closely to the focus on youth) and social mobilisation campaigns will contribute increasingly to higher awareness levels translating ultimately to more responsible sexual behaviour. These lifestyle interventions amongst the youth will contribute significantly to the development of social capital in this vulnerable population.
- Increasing the number of clients that have commenced ARV treatment, and delivering a comprehensive package of care at all PHC clinics for clients identified through the VCT programme are the two primary drivers of the Department's treatment strategy.
- Providing care and support to clients is integrated within the community-based strategy, and will focus on providing home-based care and hospice/step-down care for those clients.

10.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.16: Constraints and measures to overcome them

PROGRAMME PRIORITIES	CONSTRAINTS	MEASURES PLANNED TO OVERCOME THEM
TB new sputum positive (NSP) CURE RATE	• Inadequate funding for Programme. • Unresolved issues re DHS governance.	• Availability of funding for expansion of TB services. • Agreement with Local Government on PHC governance and funding.
HIV – ARV TREATMENT	• Inadequate physical facilities. • Insufficient Health personnel..	• Recruitment and training of medical and nursing personnel. • Viability of PHC platform. • Physical infrastructure requirements addressed.

10.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.17: Provincial objectives and performance indicators for HIV & AIDS, STI and TB control [HIV2]

Measurable objective	Performance measure	Year-1 2003/04 (actual)	Base year 2004/05 (estimate)	Year 1 2005/06 (target)	Year 2 2006/07 (target)	Year 3 2007/08 (target)
Sub-programme 2.6: HIV and AIDS						
Roll-out of Anti-retroviral (ARV) therapy.	Number of patients receiving ARV treatment.	2 000	6 000	9 305	12 000	13 000
Provision of preventive therapy to pregnant HIV positive mothers.	% of districts offering PMTCT.	<10%	100%	100%	100%	100%
Voluntary counseling and testing.	% VCT coverage of the population..	3%	5.5%	5%	6%	7%
Sub-programme 2.10: Global Fund HIV and AIDS Programme						
Roll-out of Anti-retroviral (ARV) therapy.	Number of patients receiving ARV treatment.		1 300	2 695	4 376	4 376
Expansion of peer education	Number of peer educators trained		1 000	1 470	4 070	4 070
Expansion of palliative in-patient service	Number of in-patient days		18 000	28 000	48 000	48 000
Provision of community-based response	Number of community-based projects		28	59	108	108

Table 2.18: Performance indicators for HIV & AIDS, STI and TB control [HIV3]

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2008
Input							
1. ARV treatment service points compared to plan	%	106	100	100	100	100	100
2. Fixed PHC facilities offering PMTCT	%	100	100	100	100	100	100
3. Fixed PHC facilities offering VCT	%	100	100	100	100	100	100
4. Hospitals offering PEP for occupational HIV exposure	%	100	100	100	100	100	100
5. Hospitals offering PEP for sexual abuse	%	73.6	73.6	75	80	85	100
6. HTA Intervention sites compared to plan	%	100	100	100	100	100	100
Process							
7. TB cases with a DOT supporter	%	88.3	90	95	98	98	100
8. Male condom distribution rate from public sector health facilities	No	10.3	11	12	12	12	11
9. Male condom distribution rate from primary distribution sites	No	17.3	18	22	25	30	32
10. Fixed facilities with any ARV drug stock out	%	No data	0	0	0	0	0
11. Hospitals drawing blood for CD4 testing	%	No data	100	100	100	100	100
12. Fixed PHC facilities drawing blood for CD4 testing	%	No data	25	50	75	100	20
13. Fixed facilities referring patients to ARV treatment points assessment	%	No data	25	50	100	100	10

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2008
Output							
14. STI partner treatment rate	%	17.58	20	25	30	35	40
15. Nevirapine dose to baby coverage rate	%	90	90	90	90	90	70
16. Clients HIV pre-test counselled rate in fixed PHC facilities	%	1.6	2.0	2.5	3.0	3.5	100
17. Patients registered for ART compared to target	%	100	100	100	100	100	100
18. TB treatment interruption rate	%	13	12	11	10	9	4
Quality							
19. CD4 test at ARV treatment service points with turnaround time >6 days	%	No data	20	15	10	5	0
20. TB sputa specimens with turnaround time > 48 hours	%	30	26	22	18	15	0
Efficiency							
21. Dedicated HIV/AIDS budget spent	%	70.3	100	100	100	100	100
Outcome							
22. New smear positive PTB cases cured at first attempt	%	67.8	73	77	80	82	85
23. New MDR TB cases reported - annual % change	%	0	0	-2	-4	-6	-30
24. STI treated new episode among ART patients - annual % change	%	No data	To be set	To be set	To be set	To be set	To be set
25. ART monitoring visits measured at WHO performance scale 1 or 2	%	No data	To be set	To be set	To be set	To be set	To be set

10.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 2.19: Trends in provincial public health expenditure for HIV and AIDS conditional grant (R' million) [HIV4]

Expenditure (R million)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	12 121	19 678	38 146	90 119	---	---	---
Total per person	2.68	4.28	8.18	19.02	---	---	---
Total per uninsured person	3.67	5.87	11.20	26.05	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	14 763	21 823	40 130	90 119	**116 023**	150 954	158 502
Total per person	3.26	4.75	8.60	19.02	**24.11**	30.89	31.94
Total per uninsured person	4.47	6.51	11.78	26.05	**33.03**	42.31	43.75
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

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

11.1 SITUATIONAL ANALYSIS

Nutrition

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

Although the Western Cape has the highest income per capita there are very poor areas, which have been set up as informal settlement areas. Amongst the economically active population, many of the workers are seasonal workers and amongst these there is a large percentage of substance abuse. Screening tools for detecting alcoholism suggest rates in excess of 60% amongst farm workers (London, 1995). A study in a typical rural town in the province found a Foetal Alcohol Syndrome (FAS) prevalence of 4,8% amongst Grade 1 school children (FARR, 1997). Current research (unpublished, 1998) indicates that this has increased to 8%. Twelve percent of the Western Cape is arable land; hence, not much land is available to the poor for food production. A high percentage of the people residing in the province live under the poverty line, mainly in rural areas and in informal settlements on the periphery of towns and cities.

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

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

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

Epidemiology:

Statistics: Maternal deaths reported in the Western Cape Province

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

Description of rates over last 5 years

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

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

The analysis of maternal deaths provides valuable information on the extent of the problem, what are the avoidable factors, missed opportunities and breakdowns in the health care system that could lead to a maternal death. This information allows health care providers to review their current provision of services, reassess clinical guidelines and plan facility audits. Areas needing more research are identified. The information is vital in creating awareness amongst families and communities about maternal mortality so that they can assist in the prevention of maternal deaths.

Table 2.20: Situation analysis indicators for MCWH and Nutrition [MCWH1]

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Boland 2003/04	Overberg 2003/04	Eden 2003/04	Central Karoo 2003/04	West Coast 2003/04	City of Cape Town 2003/04
Incidence										
Population under 5 years		405,542	411,828	418,212	60,992	19,064	43,203	6,673	27,556	260,723
1. Incidence of severe malnutrition under 5 years	1k	5.9	4.4	4.2	6.6	10.4	6.4	7.5	3.3	2.9
Number of severe malnutrition under 5 years		2,385	1,815	1,761	400	198	277	50	92	744
2. Incidence of pneumonia under 5 years	%									
Number of children under 5 years with Lower Respiratory Infection		66.194	62,321	66,859	7,936	2,072	5,330	2,337	3,119	46,065
Incidence of Lower Respiratory Infection under 5 years	%	16.3%	15.1%	16.0%	13.0%	10.9%	12.3%	35.0%	11.3%	17.7%
3. Incidence of diarrhoea with dehydration under 5 years	%									
Number of children under 5 years with diarrhoea		40,400	43,735	38,476	4,403	1,183	2,273	868	1,753	27,996
Incidence of diarrhoea under 5 years		10.0%	10.6%	9.2%	7.2%	6.2%	5.3%	13.0%	6.4%	10.7%
Input										
4. Hospitals offering TOP services	%	N/A	N/A	88%	75%	75%	83%	100%	88%	100%
5. CHCs offering TOP services	%	N/A	N/A	33%	0%	0%	0%	0%	0%	0%
Process										
6. Fixed PHC facilities with DTP-Hib vaccine stock out	%									
7. AFP detection rate	%	1.6	1.8	1.8						
8. AFP stool adequacy rate	%	64%	78%	92%						
Output										
9. Schools at which phase 1 health services are being rendered	%	Not measured	Not measured	20%						
10. (Full) Immunisation coverage under 1 year	%									
Measles at 9 months		70,784	75,256	79,500	10,115	3,391	7,200	1,055	4,471	53,268
Measles at 9 months coverage		81.8%	85.6%	89.1%	79.0%	83.8%	78.8%	80.1%	76.8%	94.9%
Population under 1 year		86.555	87,897	89,259	12,809	4,046	9,132	1,317	5.819	56,136
11. Antenatal coverage	%	91.5%	84.4%	83.9%	85.0%	84.1%	87.9%	94.6%	76.6%	83.6%
First antenatal visits		91,066	85.275	86,170	12,518	3,913	9,233	1,433	5,127	53,946

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Boland 2003/04	Overberg 2003/04	Eden 2003/04	Central Karoo 2003/04	West Coast 2003/04	City of Cape Town 2003/04
Population <1 year x 1.15		99,538	101,082	102,648	14,730	4,653	10,502	1,515	6,692	64,556
12. Vitamin A coverage under 1 year	%									
13. Measles coverage under 1 year	%	81.8%	85.6%	89,1%	79.0%	83.8%	78.8%	80.1%	76.8%	94.9%
Measles at 9 months		70,784	75,256	79,500	10.115	3,391	7,200	1,055	4,471	53,268
14. Cervical cancer screening coverage	%	32.9%	41.4%	39.1%	45.1%	43.1%	20.7%	39.4%	35.3%	40.8%
Number of cervical smears		27,868	35,683	34,256	5.358	1,632	1,808	438	1,889	23,131
Female population aged 30 - 59		847,909	861,819	875,957	118,674	37,901	87,530	11,121	53,490	567,242
Quality										
15. Facilities certified as baby friendly	%									
16. Fixed PHC facilities certified as youth friendly	%	18		2	0	0	0	0	16	0
17 Fixed PHC facilities implementing IMCI	%	N/A	N/A	50%	27%	59%	49%	62%	29%	72%
Efficiency										
17 Percentage of dedicated HIV/AIDS budget spent										
Outcome										
18. Institution delivery rate for women under 18 years	%	10.1%	10.7%	10.0%	9.0%	11.4%	10.0%	9.6%	10.7%	9.2%
Deliveries to women under 18 years		1,847	1,832	1,757	376	243	477	94	461	106
Total deliveries		18,344	17,046	17,514	4,155	2,136	4,785	978	4,302	1,158
19. Not gaining weight under 5 years incidence	%	2.3%	2.6%	2.9%	2.9%	3.7%	9.4%	10.7%	2.1%	1.7%
Growth faltering/failure under 5 years		9,457	10,845	12,243	1,759	709	4,081	715	580	4,399

11.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

11.2.1 Women's health

Policy Context

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

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

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

Key Strategies

- Increasing cervical cancer screening coverage is seen as a key element to reducing both morbidity and mortality in women. This indicator reflects a commitment to improve services at a number of levels, both at the community interface as well as within facilities. At a community level, surveillance will have to improve and this element combines with increasing awareness around the public's need to present for routine screening. This will in turn depend on the strength of both the Health Promotion programme as well as the strength of community structures and their level of community engagement. (Social capital).
- Increased facilities offering services for rape survivors and victims of sexual abuse: This key strategy forms part of a broader strategy to improve trauma and emergency services. The aim of creating a single consolidated platform for the management of trauma and emergency services per sub district has been discussed previously.
- By increasing antenatal booking rate below 20 weeks the Department aims to improve outcomes for both mother and infant. By reducing perinatal mortality, infant mortality can be reduced by 40%.

11.2.2 Child and youth health

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

Policy Context:

- The Millennium Development Goals seek to reduce the under five years mortality rates by two-thirds in 2015. It also seeks to halve the proportion of people who suffer from

hunger, which is measured by the prevalence of underweight children under five years of age.

- Strategic Priorities of the National Health System (2004-2009), aim at eliminating Polio by December 2005 and ensuring that no baby dies from measles. The immunisation average of 80% in every district is targeted as well as full implementation of the IMCI strategy within all PHC facilities.

Strategies:

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

11.2.3 Youth Health

Policy Context:

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

Strategies:

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

11.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.21: Analysis of constraints and measures planned to overcome them in MCWH

PROGRAMME PRIORITIES	CONSTRAINTS	MEASURES PLANNED TO OVERCOME THEM
WOMENS' HEALTH	• Inadequate and poorly trained personnel • Poor quality of laboratory assessments.	• Availability of additional funding for recruitment of personnel. • Quality of laboratory work being performed by NHLS.
CHILD HEALTH	• Availability of funds for training and replacement of personnel.	• Funding for IMCI and PHC training.

11.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.22 Provincial objectives and performance indicators for MCWH & N [MCWH2]

Measurable objective	Performance measure	Year-1 2003/04 (actual)	Base year 2004/05 (estimate)	Year 1 2005/06 (target)	Year 2 2006/07 (target)	Year 3 2007/08 (target)
Monitoring of growth in vulnerable children.	% of babies provided with a Road-to-Health Chart.	90%	100%	100%	100%	100%
Micro-nutrient supplementation to vulnerable children.	% of malnourished children provided with vitamin A supplementation.	100%	100%	100%	100%	100%

Table 2.23 Performance indicators for MCWH & Nutrition [MCWH3]

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National Target 2007/08
Incidence							
1. Incidence of severe malnutrition under 5 years	%	Awaiting SADHS[1]	Awaiting SADHS	Awaiting SADHS	Awaiting SADHS	Awaiting SADHS	Awaiting SADHS*
2. Incidence of pneumonia under 5 years	%	Not planned	Not planned	Not planned	Not planned	Not planned	Not planned
3. Incidence of diarrhoea with dehydration under 5 years	%	No target set	No target set	No target set	No target set	No target set	No target set
Input							
4. Hospitals offering TOP services	%	82%	85	88	90	90	100
5. CHCs offering TOP services	%	33%	45	48	52	60	80
Process							
6. Fixed PHC facilities with DTP-Hib vaccine stock out	%	No target set	No target set	No target set	No target set	No target set	
7. AFP detection rate	%	1.8	1.8	1.5	1.5	1.5	1
8. AFP stool adequacy rate	%	92%	90%	90%	90%	90%	80
Output							
9. Schools at which phase 1 health services are being rendered	%	20%					
10. (Full) Immunisation coverage under 1 year	%	New measure					
11. Antenatal coverage	%	68.00%	90	90	90	90	90
12. Vitamin A coverage under 1 year	%	86.21%	85	85	85	85	80%
13. Measles coverage under 1 year	%	87.53%	90	90	90	90	90
14. Cervical cancer screening coverage	%	44%	55	60	65	68	70
Quantity							
15. Facilities certified as baby friendly	%	5%	7.5	10	15	20	30
16. Fixed PHC facilities certified as youth friendly	%	10%	12	15	15	22	30
17. Fixed PHC facilities implementing IMCI	%	All sub-districts excluding West Coast					

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National Target 2007/08
Outcome							
18. Institutional delivery rate for women under 18 years	%	9.60%	11	11.5	12		13
19. Not gaining weight under 5 years	%	0.82%	No targets set	No targets set	No targets set	No targets set	

Note 1: *South African Demographic and Health Survey (SADHS) was last conducted in 2003 and the results have not yet been released.

11.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTION WITH PLAN

Table 2.24: Trends in provincial public health expenditure for INP Conditional Grant (R'million) [MCWH4]

Expenditure (R million)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	14 999	15 378	43 402	16 511	---	---	---
Total per person	3.32	3.35	9.30	3.48	---	---	---
Total per uninsured person	4.54	4.58	12.74	4.77	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	18 269	17 054	45 659	16 511	**14 811**	15 744	16 674
Total per person	4.04	3.71	9.79	3.48	**3.08**	3.22	3.36
Total per uninsured person	5.53	5.08	13.40	4.77	**4.22**	4.41	4.60
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

12. DISEASE PREVENTION AND CONTROL

12.1 SITUATION ANALYSIS

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

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

Key focus areas of this programme are:

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

12.1.1 Diarrhoeal disease and infectious diseases prevented by immunisation

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

12.1.2 Chronic disease prevention and treatment

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

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

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

In addition, a significant problem, most marked in some of the rural areas of the Western Cape is alcohol abuse. Recent studies reported that the winery areas of the Western Cape have the

highest prevalence of Foetal Alcohol Syndrome (FAS) worldwide (40.5-46.4 per 1,000 children). A critical issue in relation to FAS is the 'dop' system that was historically established by using alcohol as a medium of payment and social control over employees. This has aggravated widespread alcohol abuse, which has enormous impact on the social as well as the physical well being of farming communities (London, 1999).

The Province has made progress in gearing up services for chronic diseases and the elderly over the past year. As part of the 100 day deposits the provision of chronic medication was made more accessible and reliable. Strategies included linking all 15 of the big Community Health Centres in the Metropole to a chronic dispensing unit, thereby ensuring the continuous availability of medicine to users.

12.1.3 **Treatment of patients subjected to sexual abuse and rape victims**

Between April 2002 and March 2003 a total number of 6 502 cases of rape were reported in the Province. In addition 4 402 cases of child abuse were reported. This figure represents an increase of 62% over the figure for 2002. A number of dedicated centres for the management of clinical forensic services were initiate in 2003. These services are located in the district hospitals and 24-hour Community Health Centres. The programme has met with mixed success due to the difficulty in recruiting suitably trained personnel.

12.1.4 **Port health**

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

12.1.5 **Health promoting schools programme**

In view of the renewed focus on assessment of the current state of the Health Promoting Schools programme is currently being undertaken.

Developing the strategies for this programme is work in progress and will be further developed in the first quarter of 2005/06.

Table 2.25 Situation analysis indicators for disease prevention and control [PREV1]

	Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	Boland 2003/04	Overberg 2003/04	Eden 2003/04	Central Karoo 2003/04	West Coast 2003/04	City of Cape Town 2003/04	National target 2005
Input												
1	Trauma centres for victims of violence	No	N/A	N/A	24	N/A	N/A	N/A	N/A	N/A	N/A	
Process												
2	CHCs with fast queues for elder persons	%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Output												
3	Health districts with health care waste management plan implemented	No	N/A	N/A	83%	100%	100%	100%	100%	0	100%	
4	Hospitals providing occupational health programmes	%										
5	Schools implementing Health Promoting Schools Programme (HPSP)	%		20%								
6	Integrated epidemic preparedness and response plans implemented	Y/N										
7	Integrated communicable disease control plans implemented	Y/N										
Quality												
8	Schools complying with quality index requirements for HPSP	%										
9	Outbreak response time	Days										
10	Dental extraction to restoration rate	No	15.01	17.01	17.1	20.01	N/A	17.01	22.01	17.01	15.0	0.5
11	Malaria fatality rate	No	3.6%	0.0%	5.6%	0.0%	0.0%	0.0%	0.0%	0.0%	7.1%	
	Number of malaria cases who died		2	0	2	0	0	0	0	0	2	
	Number of malaria cases		55	29	36	4	1	2	0	1	28	
12	Cholera fatality rate	No	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	Number of cholera cases who died		0	0	0	0	0	0	0	0	0	
	Number of cholera cases		1	1	1	0	1	0	0	0	0	
13	Cataract surgery rate	No	998	1 253	1 163	770			1 840		1 001.5	
14	Trauma centres for victims of violence	No										

12.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

12.2.1 Building Healthy Communities

Policy Context

- Health care 2010 recognises the limitations of the medical model of health care in influencing the physical, social and economic environment in improving health holistically. It is for this reason that it advocates for collaboration and partnerships with all relevant stakeholders in building healthy communities and realising the true definition of health according to the World Health Organisation (health is the physical, social and mental well-being and not merely the absence of disease and infirmity).
- The strategic priorities for the National Health System (2004-2009) have included the promotion of healthy lifestyles as one of its indicators and targets. Intervention strategies are focused at nutrition, substance abuse, tobacco use, health promoting schools, and household and community component of IMCI.
- The Western Cape strategy of Ikapa Elihlumayo and Social Capital formation focuses on building healthy communities through intensive collaboration between the public sector and the civil society. This strategy aims at the development of the community through social and economic empowerment with special emphasis on women and youth.
- As a support department in the Social Capital Formation strategy, the foundation of the Department of Health's strategy is the promotion of an efficient and effective Primary Health Care service which will provide equal access to quality healthcare and is also the foundation of Healthcare 2010.
- The Department has also identified four key social capital formation issues, i.e.
    1) The Integrated Management of Childhood Illnesses (IMCI) with specific emphasis on the management of diarrhoeal disease.
    2) The strengthening of the immunisation campaign.
    3) The management of chronic diseases to ensure continuity of care.
    4) In view of the significance of the problem of trauma in the Province, Health will collaborate with other departments to assist in the formulation of strategies to reduce the levels of trauma.

General Strategies

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

12.2.2 **Strategies developed to address the identified 'social capital issues:**

12.2.2.1 **Diarrhoeal disease**

Activities and outputs

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

2) **Community awareness/ education**:
   The focus areas of the awareness/ education are:
   - The seasonal nature of the incidence of diarrhoeal disease;
   - The mixing and administration of the sugar-salt solution to all children with loose and watery stools;
   - The importance of early presentation of children with dangers signs to the health services;
   - The importance of hand washing in breaking the transmission of diarrhoeal disease.

3) **Improved PHC facility diarrhoeal disease case management**:
   Each PHC facility to have:
   - A functional oral rehydration (ORT) corner that is set-up and managed in accordance to standard WHO guidelines;
   - The capacity to stabilize severely dehydrated children, prior to referral to the next level of care

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

Proposed outcomes

- Improve access to basic services through collaboration with other government departments as well as local government;
- To provide support to community-based interventions by providing logistical support, supervision/monitoring and funding;
- Improved knowledge about hygiene and sanitation matters amongst learners and adults;

- Reduce the incidence of one of the commonest childhood killers by improving maternal knowledge base and community awareness;
- Improve patient care through improved human resources (both qualitative and quantitative) in health facilities;
- Improve efficiency and effectiveness of service delivery in PHC facilities as well as hospital based services;
- Improve access through more effective use of resources, better planning and better communication with healthcare providers and the public;
- The abovementioned contributions all contribute towards social capital formation by providing for human capital development in communities); by developing bridging social capital through improving the access of communities to authority structures (Woolcock/ Szreter model)
- Ultimately all of these contributions will improve health outcomes in the communities.

12.2.2.2 **Immunisation**

Activities/outputs

- Training of community IMCI (Integrated Management in Childhood Illnesses) workers. These workers are a 'subset' of workers currently engaged in community health activities within communities.
- Collaborate with Local Authorities regarding the need for immunization and the preparatory work for immunization campaigns.
- Work with the Department of Education to promote awareness and improve knowledge of immunization. Influence teachers and community leaders.
- Improve the outbreak response times during high-risk periods by means of improved communication.
- IMCI strategy to be implemented in all PHC facilities.

Proposed outcomes

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

12.3 SPECIFICAITON OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.26 Performance indicators for disease prevention and control [PREV3]

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input							
1. Trauma centres for victims of violence	No		At least 1/district	At least 1/district	At least 1/district	At least 1/district	1 per district
Process							
2. CHCs with fast queues for elder persons	%		**Note 1**	Not planned	Not planned	Not planned	20
Output							
3. Health districts with health care waste management plan implemented	No			6	6	6	All districts
4. Hospitals providing occupational health programmes	%			100	100	100	100
5. Schools implementing Health Promoting Schools Programme (HPSP)	%	No programme	Not yet planned	Not yet planned	Not yet planned	Not yet planned	
6. Integrated epidemic preparedness and response plans implemented	Y/N		Y	Y	Y	Y	Yes
7. Integrated communicable disease control plans implemented	Y/N		Y	Y	Y	Y	Yes
Quality							
8. Schools complying with quality index requirements for HPSP	%	New measure	No target set	No target set	No target set	No target set	
9. Outbreak response time	Days		Not measured	1	1	1	1
Outcome							
10. Dental extraction to restoration rate	No	17	15	15	12	11	0.4
11. Malaria fatality rate	No		**Note 2**				0.25
12. Cholera fatality rate	No		**Note 3**				0.5
13. Cataract surgery rate	No	1 163	1 616	2 069	2 522		1,000

Notes:

1. Management of chronic illness is described in section 6.5. As yet plans have not yet been developed for fast queues for the elderly.
2. Malaria is not endemic in the Western Cape.
3. During the 2000/01 cholera epidemic only one case was reported in the Western Cape.

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

1. AIM

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

2. PROGRAMME STRUCTURE

Sub-programme 3.1: Emergency Medical Services (EMS)

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

Sub-programme 3.2: Planned patient transport

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

3. SUB PROGRAMME 3.1: EMERGENCY MEDICAL SERVICES

3.1 SITUATIONAL ANALYSIS

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

3.1.1 Functions of EMS

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

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

3.1.2 **Existing services and performance:**

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

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

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

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

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

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

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

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

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

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

Note: Indicators required by the National Department of Health are shaded.

Indicator	Type	Province wide value 2001/02*	Province wide value 2002/03*	Province wide value 2003/04	National target 2003/4
Input					
1. Ambulance personnel per 1000 people	No			0.22	
2. Ambulances per 1000 people	No			0.045	
3. Hospitals with patient transporters	No			0	
4. Budget in Rands per 1000 people	R			39 093	
5. PTVs per 1000 people	No			0.01	
6. PTV Drivers per 1000 people	No			0.003	
7. Rescue Vehicles per 1000 people	No			0.006	
8. Jaws of Life per 1000 people	No			0.008	
Process					
9. Kilometers travelled per ambulance (per annum)	Kms			61 449	
10. Kilometres travelled by ambulance per 1000 people	Kms			4 222	
11. Km's travelled by fixed wing aircraft	Kms			171 533	
12. Km's travelled by rotor wing aircraft	Kms			112 867	
13. Km's travelled by PTV per 1000 people	Kms			1 111	
14. Km's travelled by Rescue Vehicle per 1000 people	Kms				
Quality					
15. % BLS personnel	%			44	
16. % ILS personnel	%			47	
17. % ALS personnel	%			9	
18. % Management & Admin personnel	%			17	
19. % Response time within 15 min (in town)	%			61	15min
20. % Response time within 40 min (out of town)	%			63	40min
21. Call outs serviced by a single person crew	No				
22. Ambulances with odometer less than 200,000 kms	Km			70	
Output					
23. Number of emergency patients transported per 1000 people	No			61	
24. IHT patients transported per 1000 population..	No			30	
25. Green code patients transported /1000 population.	No			49	
26. Cost per patient transported by ambulance.	No				
27. Ambulances with less than 500 000km on the clock.	No				
28. Cost per Emergency patient transported	R			593	
29. Red Code Patients Transported per 1000 population	No			4.5	
30. Yellow Code Patients Transported per 1000 population	No			38.3	
31. Green Code Patients Transported per 1000 population	No			49	
32. Km's travelled per Emergency patient transported	Kms			39.41	
33. Km's travelled per OPD patient transported	Kms			105.77	
34. Km's travelled by PTV per 1000 people	Kms			626.75	
35. Number of patients rescued per 1000 population	Kms			0.57	
36. Patients transported by PTS per 1 000 separations.	No				
37. Total number of patients transported	No			37 076	

Note: * Information not available for 2001/02 and 2002/03.

National targets for the indicators are not yet available, this is work in progress

3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Vision

Quality Emergency Care - Fast

Mission

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

3.2.1 Strategic priorities

EMS has two broad strategic priorities;

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

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

An additional amount of R32,07 million has been allocated to fund additional personnel, vehicles and equipment in order to improve response times and service delivery, with an emphasis on the Metropolitan Area.

It is anticipated that there will be an increase in the kilometre costs charged by the Government Motor Transport which could increase the cost to EMS by up to R6 million. Although the number of kilometres travelled will remain stable it is anticipated that the improvements to equipment, staffing and maintenance will facilitate improved response times.

The provision of a modern computerised communication system to manage Emergency Medical Services (EMS) resources is the top priority, central to the efficient deployment of resources in achieving appropriate response times. A new communications centre will be installed in the Metropolitan Area of Cape Town and will be phased in to the rural areas over the next two years. Electronic communications systems are essential to rapid response, efficient deployment and co-ordination with other emergency services. All of these matters contribute to improved patient care. Vehicle Tracking will be operational in all ambulances by the end of 2005.

An amount of R10 million, which will contribute to the building, furnishings and also to the operational Information Communication Technology (ICT) costs, has been allocated to

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

R5, 075 million is allocated on the EMS budget to procure new ambulances to increase fleet numbers in the Metropolitan Area.

R9 million is budgeted to recruit and place additional personnel in the Metropolitan Area and critical Rural Towns.

R2 million is budgeted to relocate a segment of the Air Mercy Service to cover the eastern Western Cape from Oudtshoorn which will service both the Central Karoo and Eden Districts with a helicopter EMS.

3.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

3.3.1 Finance

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

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

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

It is not within the resources of EMS or the Department to achieve National Response Time Targets in the Metropolitan Area of Cape Town during 2005.

During December 2004 an independent external review of the Western Cape Emergency Medical Services was performed by a consultant from the West Midlands Emergency Ambulance Service in the United Kingdom in order to quantify and qualify the gap between current performance and national requirements. Recommendations of the review report will be considered during 2005.

3.3.2 Human Resources

Human resourcing of EMS services is the major deficiency. International models determine that the personnel number required to crew an ambulance twenty-four hours a day is eleven (11 Liverpool Formula). Many of the services in the Western Cape consist of four personnel in small towns who are expected to provide a twenty-four hour service.

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

The additional finance provided for personnel in 2005 will provide key posts in small rural towns and augment the Metropolitan Staff complement by 73 personnel.

3.3.3 Support and Information Systems

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

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

4. SUB PROGRAMME 3.2: PLANNED PATIENT TRANSPORT

4.1 SITUATIONAL ANALYSIS

Function of Planned Patient Transport

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

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

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

Planned Patient Transport Services in the Western Cape transfers approximately 37 076 outpatients annually.

Patients need transport to health facilities in rural areas and between towns in order to reach referral centres. Public transport in rural areas is poorly developed resulting in poor access by

poor rural communities to health services. Patient transport infrastructure needs to be created in and around towns and between towns.

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

The limitations of the PPT system include:

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

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

4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

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

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

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

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

4.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

4.3.1 Finance:

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

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

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

4.3.2 Human resources:

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

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

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

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

4.3.3 Support systems:

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

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

4.3.4 Information systems:

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

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

Table 3.2: Performance indicators for the EMS and planned patient transport [EMS3]

Indicator	Type	2003/04	2004/05 Target	2005/06 Target	2006/07 Target	2007/08 Target	National target 2007/08
Input							
1. Ambulance personnel per 1000 people	No	0.22	0.22	0.28	0.3	0.32	
2. Ambulances per 1000 people	No	0.045	0.045	0.05	0.053	0.056	
3. Budget in Rands per 1000 people	R	39 093	45 555	48 666	51 585	56 164	
4. PTVs per 1000 people	No	0.01	0.01	0.013	0.016	0.02	
5. PTV Drivers per 1000 people	No	0.003	0.003	0.006	0.01	0.013	
6. Rescue Vehicles per 1000 people	No	0.006	0.006	0.006	0.006	0.006	
7. Jaws of Life per 1000 people	No	0.008	0.008	0.01	0.01	0.01	
Process							
8. Kilometers travelled per ambulance per annum	Kms	61 449	60000	50000	50000	50000	
9. Kilometres travelled by ambulance per 1000 people	Km's	4 222	4 222	4 100	4 000	3 900	
10. Km's travelled by fixed wing aircraft	Km's	171 533	171 533	185 000	190 000	200 000	
11. Km's travelled by rotor wing aircraft	Km's	112 867	112 867	120 000	125 000	130 000	
12. Km's travelled by PTV per 1000 people	Km's	1 111	1 111	1 200	1 300	1 400	
13. Km's travelled by Rescue Vehicle per 1000 people	Kms						
Quality							
14. % BLS personnel	%	44	54	52	48	44	
15. % ILS personnel	%	47	44	44	46	48	
16. % ALS personnel	%	9	2	4	6	8	
17. % Management & Admin personnel	%	17	17	17	17	17	
18. % Response time within 15 min (in town)	%	63	60	65	70	75	
19. % Response time within 40 min (out of town)	%	70	70	75	80	85	
20. Ambulances with odometer less than 200,000 kms	No	70	150	200	230	240	
Output							
21. Number of emergency patients transported per 1000 people	No	61	61	61	61	61	

Indicator	Type	2003/04	2004/05 Target	2005/06 Target	2006/07 Target	2007/08 Target	National target 2007/08
22. Cost per Emergency patient transported	R	593	500	450	400	350	
23. Red Code Patients Transported per 1000 population	No	4.5	4.5	4.5	4.5	4.5	
24. Yellow Code Patients Transported per 1000 population	No	38.3	38.3	38.3	38.3	38.3	
25. Green Code Patients Transported per 1000 population	No	49	42.5	42.5	42.5	42.5	
26. Km's travelled per Emergency patient transported	Kms	39.41	39.41	38	36	34	
27. Km's travelled per OPD patient transported	Kms	105.77	105.77	102	100	98	
28. Km's travelled by PTV per 1000 people	Kms	626.75	626.75	620	610	600	
29. Number of patients rescued per 1000 population	No	0.57	0.57	0.56	0.54	0.52	
30. Number of Inter-hospital Transfers per 1000 population	No	17	17	16	15	14	
31. Total number of OPD patients transported	No	37 076	40 000	42 000	45 000	50 000	

5. PAST EXPENDITURE TRENDS AND RECONCILIATON OF MTEF PROJECTIONS WITH PLAN

In 2005/06 Emergency Medical Services is allocated 4.4% of the vote in comparison to 4% in 2004/05 and has increased by 24.11% in nominal terms.

Table 3.3: Trends in provincial public health expenditure for EMS and patient transport (R million) [EMS4]

Expenditure (R million)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	131 673	152 910	185 695	205 041	---	---	---
Total per person	29.10	33.28	39.80	43.27	---	---	---
Total per uninsured person	39.87	45.59	54.52	59.28	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	160 378	169 577	195 351	205 041	254 470	270 501	286 461
Total per person	35.45	36.91	41.87	43.27	52.88	55.35	57.72
Total per uninsured person	48.56	50.56	57.35	59.28	72.44	75.82	79.07
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projectiosns for the same years.

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

1. AIM:

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

2. PROGRAMME STRUCTURE

Sub-programme 4.1 General (Regional) hospitals
Rendering of hospital services at a general specialist level and a platform for training of health workers and research.

Sub-programme 4.2 Tuberculosis hospitals
To convert present Tuberculosis hospitals into strategically placed centers of excellence in which a small percentage of patients may undergo hospitalization under conditions, which allow for isolation during the intensive phase of the treatment, as well as the application of the standardized multi-drug resistant (MDR) protocols.

Sub-programme 4.3 Psychiatric hospitals
Rendering a specialist psychiatric hospital service for people with mental illness and intellectual disability and providing a platform for the training of health workers and research.

Sub-programme 4.4 Chronic medical hospitals
These hospitals provide medium to long-term care to patients who require rehabilitation and/or a minimum degree of active medical care but cannot be sent home. These patients are often unable to access ambulatory care at our services or their socio-economic or family circumstances do not allow for them to be cared for at home.

Sub-programme 4.5 Dental training hospitals
Rendering an affordable and comprehensive oral health service, supporting the primary health care approach and training.

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

3. SUB-PROGRAMME 4.1: GENERAL (REGIONAL) HOSPITALS

3.1 SITUATION ANALYSIS:

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

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

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

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

The HIV/AIDS pandemic is a chief contributor to the load on the services both in terms of patient numbers and acuity of illness. The impact is being felt at acute hospitals, TB and chronic medical hospitals. Of all medical admissions who die at GF Jooste Hospital, 32% are HIV positive and a further 10% (not tested) die of AIDS related diseases e.g. Kaposi's sarcoma (Birch 2003). Tuberculosis rates remain high and co-infection of TB and HIV has resulted in uncommon forms of presentation and late diagnosis of the disease. Thirty one percent of patients who die at GF Jooste Hospital are TB positive.

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

Table 4.1: Public hospitals by hospital type [PHS1:]

Hospital type	Number of hospitals	Number of beds	Provincial average number of beds per 1 000 uninsured
District	28	1 595	0.47
Regional	9	1 870	0.55
Central	3	2 469	0.72
Sub-total acute hospitals	**40**	**5 934**	**1.74**
Tuberculosis	6	1 073	0.32
Psychiatric	4	2 205	0.65
Other Special	7	729	0.21
Total public hospitals	**57**	**9 942**	**1.18**

Table 4.2: Public hospitals by level of care [PHS2]

Level of care	Number of Hospitals providing level of care*	Number of Beds	Provincial average number of beds per 1 000 uninsured
L1 Beds	28	1 987	0.58
L2 Beds	9	2 397	0.70
L3 Beds	3	1 550	0.46
All acute levels	**40**	**5 934**	**1.74**

Bed configuration in acute hospitals*

	District	Regional	Central	**Total**
L1 Beds	1 351	636	-	**1 987**
L2 Beds	160	1 187	1 050	**2 397**
L3 Beds	-	-	1 550	**1 550**
Total Acute	1 511	1 823	2 600	**5 934**
No of Hospitals	28	9	3	**40**

Table 4.3: Situation analysis indicators for general (regional) hospitals [PHS3]

Indicator		Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	National target 2003/04
Input						
1	Expenditure on hospital staff as % of regional hospital expenditure	%	73%	73%	71%	
2	Expenditure on drugs for hospital use as % of regional hospital expenditure	%	4.5%	4.8%	6.6%	12
3	Expenditure by regional hospitals per uninsured person	R	206.01	202.78	205.50	
Process						
4	Regional hospitals with operational hospital board	%	90%	90%	90%	80
5	Regional hospitals with appointed (not acting) CEO in post	%	82%	82%	86%	75
6	Facility data timeliness rate for regional hospitals	%	80%	80%	90%	43
Output						
7	Caesarean section rate for regional hospitals	%	25.4	26.7	28.5	22
Quality						
8	Regional hospitals with patient satisfaction survey using DoH template	%	0%	0%	0%	20
9	Regional hospitals with clinical audit (M and M) meetings every month	%	40%	40%	50%	90
Efficiency						
10	Average length of stay in regional hospitals	Days	4.45	4.40	3.47	4.8
11	Bed utilisation rate (based on usable beds) in regional hospitals	%	85%	85%	80%	72
12	Expenditure per patient day equivalent in regional hospitals	R	804	811	900	1 128
Outcome						
13	Case fatality rate in regional hospitals for surgery separations	%	1.8	1.9	1.7	2.5

Note: The above table does not reflect referral routes or access of district population to regional hospitals as the drainage areas of regional hospitals do not correspond with district boundaries.

3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

- In line with Healthcare 2010, Level 1 and 2 services in the Metro and rural regions must be strengthened as soon as possible to avoid inappropriate referrals to tertiary level.
- The upgrading of George and Worcester Hospitals in terms of the Revitalisation Programme will continue.
- An additional R3 million is allocated in 2005/06 towards the opening of an additional 100 level 2 beds at Eben Donges Hospital over the next three years.
- R5 million has been provided to open 6 high care beds and between 5 and 10 additional general ward beds at George Hospital to address service pressures.

- R5 million has been allocated to open 30 new level 1 beds at Lentegeur Hospital as an extension of GF Jooste Hospital service.
- R1 million has been allocated to roll-out the specialist Ear, Nose and Throat (ENT) service in the Metro and R1,2 million to create 14 acute paediatric beds at Somerset Hospital to accommodate the increased admissions during the 'diarrhoea season'.
- R12 million has been allocated to the filling of critical posts in these hospitals and also R5 million to facilitate the appointment of additional specialists to provide a sustainable specialist service at George, Paarl and Worcester Hospitals.
- In addition an amount of R840 000 has been allocated to relieve the pressure on the service and to improve service delivery.
- In line with the Healthcare 2010 Infrastructure Plan, planning will commence in 2005/06 on the building of a new district hospital in the Metro Region to serve the Khayelitsha community.
- Financial strategies include:
    - Increase revenue generation at facilities including the attraction of private patients and improved billing systems
    - Other cost containment strategies will be implemented to alleviate financial pressure, (e.g. referral, treatment, and drug protocols)'
    - Facilities management of non-core activities where appropriate and affordable.
- Continuous improvement in quality of care.
- Significant progress was achieved in expansion of ENT and Ophthalmology services to L2 facilities
- The national policy of free care to disabled persons will have cost and reduced revenue implications for hospitals.
- Implementation of the new medicine legislation on 1 July 2005
- Implementation of the new Mental Health Act
- Implementation of community service for nurses
- Forge a closer working relationship and support PHC Facilities within each sub-district area.

3.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

3.3.1 Human Resource constraints

Re-shaping of the Service in line with Healthcare 2010

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

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

- There was a reduction in the number of community service doctors for the Western Cape during 2004. The number will be augmented for 2005. Medical Officers have therefore become a critical resource that needs to be retained, possibly through improved career-pathing and/or by appointment at appropriate level.

- Retention and recruitment of nursing staff remains a major challenge and lack of skilled staff e.g. theatre nurses, has resulted in the discontinuation of some services i.e. a reduced number of theatres being used in affected hospitals.

Measures to overcome the problem:

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

3.3.2 **Goods and Services**

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

It is of concern that certain tender items are more expensive than alternative items. Drug costs will increase as a result of inflation as well as the increased number of Stage 3 and 4 AIDS patients attending our facilities. The envisaged roll-out of ARV treatment will further increase the costs and the conditional grants and donor funding must be appropriately utilized.

Revitalisation of selected current Regional Hospitals in the Metro is in the process of being confirmed. It is envisaged that in time replacement hospitals will be constructed for Victoria and Hottentots Holland Hospitals. New hospitals are envisaged for the Khayelitsha and Mitchells Plain areas, as well as a comprehensive upgrade of Tygerberg Hospital. A comprehensive upgrade of Somerset Hospital should be funded from the disposal of a portion of the hospital site.

The upgrading of George and Worcester Hospitals in terms of the Revitalisation Programme will continue. The Paarl Hospital upgrade was delayed as a result of limitations to additional Hospital Revitalisation funding in 2004/05, but the project is expected to begin in 2005/06.

Currently hospitals still depend significantly on agency staff, however, this will be addressed during 2004/05, by the filling of posts, especially for nursing. The costs of security and catering tenders have escalated.

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

3.4 PLANNED QUALITY IMPROVEMENT MEASURES

- Provision of adequately trained clinical personnel

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

3.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.4: Provincial objectives and performance indicators for general (regional) hospitals [PHS4]

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2001/02 Actual	2002/03 Actual	2003/04 Actual	2004/05 Estimate	2005/06 Target	2006/07 Target	2007/08 Target
INPUT									
Provide sufficient funds for personnel in regional hospitals	Expenditure on staff as % of total expenditure	65.31%	72.8%	72.6%	71.0%	67.8%	67.0%	66.0%	65.0%
Provide sufficient funds for non-personnel in regional hospitals	Expenditure on drugs as % of total expenditure	8.3%	4.5%	4.76%	6.60%	4.6%	5.2%	6.0%	6.5%
	Expenditure on maintenance as % total expenditure	6.70%	1.9%	0.9%	1%	0.9%	2.0%	3.0%	3.0%
Provide regional hospital infrastructure in line with Healthcare 2010	Useable beds per 1000 total population	0.41	0.47	0.46	0.40	0.40	0.41	0.41	0.41
	Useable beds per 1000 uninsured population	0.57	0.65	0.64	0.55	0.55	0.56	0.56	0.55
Provide sufficient funding to ensure an efficient regional hospital service for the population of the W Cape	Hospital expenditure per capita (total population)	171	150	148	150	160	161	169	176
	Hospital expenditure per capita (uninsured population)	234	206	203	206	219	221	231	241
Provide regional hospital services that adequately address the needs of in patients and out patients	Outpatients per inpatient day ratio	1.00	0.83	0.80	1.30	1.17	0.99	0.98	0.98
	Total number of inpatient days	668 579	662 694	662 694	542 941	631 085	672 111	682 295	682 295
	Total number of outpatient headcounts (incl trauma)	668 580	549 336	528 545	704 932	740 263	665 390	668 649	668 649
PROCESS									
Facilitate representative management	Percentage of hospitals with operational hospital board	100%	90%	90%	90%	100%	100%	100%	100%
Facilitate decentralised management and	Percentage of hospitals with appointed CEO in place (or Medical Superintendents)	100%	82%	82%	86%	86%	100%	100%	100%
OUTPUT									
Ensure accessible regional hospital services to the population of the western Cape	Separations per 1000 total population	29.7	32.9	32.8	33.6	39.9	41.8	41.8	41.2
	Separations per 1000 uninsured population	40.7	45.1	44.9	46.0	54.6	57.3	57.3	56.4
	Patient day equivalents per 1000 total population	172	187	183	167	185	186	185	182
	Patient day equivalents per 1000 uninsured population	235	256	250	228	254	254	254	250
QUALITY									
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	100%	0%	0%	0%	36%	100%	100%	100%
	Percentage of hospitals with clinical audit (M&M) meetings at least once a month	100% 0	40% 0	40% 0	50% 0	85% 0	100% 0	100% 0	100% 0
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources	Average length of stay	4.3	4.45	4.40	3.47	3.34	3.34	3.34	3.34
	Bed utilisation rate based on useable beds	85%	85%	85%	80%	91%	93%	93%	93%
	Expenditure per patient day equivalent	995	804	811	900	862	869	912	966
OUTCOME									
Ensure desired clinical outcomes	Case fatality rate for surgery separations	0	1.8	1.9	1.7	0	0	0	0

Table 4.5: Performance indicators for general (regional) hospitals [PHS5]

	Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input								
1	Expenditure on hospital staff as % of regional hospital expenditure	%	71.0%	67.8%	67.0%	66.0%	65.0%	66
2	Expenditure on drugs for hospital use as % of regional hospital expenditure	%	6.6%	4.6%	5.2%	6.0%	6.5%	12
3	Expenditure by regional hospitals per uninsured person	R	206	219	221	231	241	
Process								
4	Regional hospitals with operational hospital board	%	90%	100%	100%	100%	100%	100
5	Regional hospitals with appointed (not acting) CEO in post	%	100%	82%	82%	86%	86%	100
6	Facility data timeliness rate for regional hospitals	%	90%	90%	100%	100%	100%	100%
Output								
7	Caesarean section rate for regional hospitals	%	28.5%	25.0%	22.0%	20.0%	18.0%	18.0%
Quality								
8	Regional hospitals with patient satisfaction survey using Department of Health template	%	0%	36%	100%	100%	100%	100
9	Regional hospitals with clinical audit (M and M) meetings every month	%	50%	85%	100%	100%	100%	100
Efficiency								
10	Average length of stay in regional hospitals	Days	3.5	3.3	3.3	3.3	3.3	4.1
11	Bed utilisation rate (based on usable beds) in regional hospitals	%	80%	91%	93%	93%	93%	75
12	Expenditure per patient day equivalent in regional hospitals	R	900	862	869	912	966	1 128
Outcome								
13	Case fatality rate in regional hospitals for surgery separations	%	1.70	1.80	-	-	-	2.0

3.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Programme 4 is allocated 22.2% of the vote in 2005/06 in comparison to the 22.8% that was allocated in 2004/05. The allocation increases by 8.55% in nominal terms in 2005/06.

Table 4.6: Trends in provincial public health expenditure for general (regional) hospitals (R million) [PHS6]

Expenditure: Sub-programme 4.1	**2001/02 (actual)**	**2002/03 (actual)**	**2003/04 (actual)**	**2004/05 (estimate)**	**2005/06 (MTEF projection)**	**2006/07 (MTEF projection)**	**2007/08 (MTEF projection)**
Current prices							
Total	558 626	613 307	665 389	757 042	---	---	---
Total per person	123.47	133.48	142.60	159.76	---	---	---
Total per uninsured person	169.14	182.85	195.35	218.85	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	680 406	680 157	699 990	757 042	**776 762**	825 698	874 412
Total per person	150.39	148.03	150.02	159.76	**161.42**	168.96	176.19
Total per uninsured person	206.01	202.78	205.50	218.85	**221.12**	231.45	241.36
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

4. SUB - PROGRAMME 4. 2 TUBERCULOSIS HOSPITALS

4.1 SITUATIONAL ANALYSIS:

In 2003 a total of 22 999 TB cases were reported in the Metropole Region. This is an increase of 66% in seven years, reflecting a growing population, migration, improved case detection and an increased burden of disease. However, when population growth is accounted for, the TB case detection rate has only increased by 30% over the same period, with a high of 678/100,000 population in 2003
TB/HIV co-infection has adversely affected morbidity and mortality of patients and resulted in an increase in the average length of stay (ALOS) of patients.

An amount of R2,23 million has been allocated in 2005/06 to facilitate the provincialisation of the SANTA and Local Government TB hospitals.

4.1.1 DP Marais Hospital

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

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

4.1.2 Brooklyn Chest Hospital (BCH)

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

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

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

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

4.1.3 **Brewelskloof Hospital**

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

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

Tuberculosis and HIV co-infected patients average at 16%. Currently approximately 19% of TB patients are MDR, with no isolation wards or germicidal ultraviolet lights available to protect staff. The installation of germicidal ultraviolet lights has been placed on the maintenance budget for 2005/6. Bed occupancy rates average at 82% and has been largely affected by staff shortages, both medical and nursing.

The hospital has experienced difficulty with planned patient transport, resulting in patients not turning up for admission or for respiratory clinics.

Brewelskloof Hospital accommodates a school (average 10 pupils) next to the Paediatric ward. There is a definite need for the building of a school on the premises. The school will be moved to a house on the premises in 2005.

An amount of R500 000 has been allocated to Brewelskloof Hospital in 2005/06 for the filling of critical posts.

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

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

4.1.6 **The Infectious Diseases Hospital in Malmesbury** is managed by the Swartland Municipality. It has 52 beds and a personnel component totalling 19. The budget for the financial year 2004/05 was R 1 766 000. Obstacles to the implementation of the District Health System have meant that the service at this hospital could not be provincialised, even though studies have shown that the discrepancies between the salaries of municipal and

provincial employees are responsible for a much higher cost per PDE at this institution. It is envisaged that this hospital will be provincialised during 2005.

4.1.7 Multi-Drug Resistant TB

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

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

Table 4.7: Situation analysis indicators for TB hospitals [PHS3]

Indicator		Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04
Input					
1	Expenditure on hospital staff as % of TB hospital expenditure	%	81%	80%	79%
2	Expenditure on drugs for hospital use as % of TB hospital expenditure	%	9%	10%	10%
3	Expenditure by TB hospitals per uninsured person	R	18.09	16.91	16.76
Process					
4	TB hospitals with operational hospital board	%	80%	80%	100%
5	TB hospitals with appointed (not acting) CEO in post	%	100%	100%	100%
6	Facility data timeliness rate for TB hospitals	%	80%	80%	90%
Quality					
8	TB hospitals with patient satisfaction survey using DoH template	%	20%	20%	30%
9	TB hospitals with clinical audit (M and M) meetings every month	%	40%	40%	50%
Efficiency					
10	Average length of stay in TB hospitals	Days	80.20	69.00	72.05
11	Bed utilisation rate (based on usable beds) in TB hospitals	%	90%	86%	86%
12	Expenditure per patient day equivalent in TB hospitals	R	153	172	169

4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES:

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

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

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

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

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

4.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM:

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

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

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

4.4 PLANNED QUALITY IMPROVEMENT MEASURES:

The major challenge will be the protection of health workers against occupational exposure of TB, especially MDR TB. The Metro policy on this issue was finalised and implemented during the 2004/2005 financial year. Brooklyn Chest Hospital and D.P. Marais will be high risk settings, that will need significant protective measure to safe guard their staff.
Client satisfaction surveys will be implemented and norms around patient care and discharge plans (especially for MDR clients) are in the process of being finalised.

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

4.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.8: Performance indicators for TB hospitals [PHS4]

		2004/05 REAL TERMS							
OBJECTIVE	**INDICATOR**	**HEALTHCARE 2010 TARGET**	**2001/02 Actual**	**2002/03 Actual**	**2003/04 Actual**	**2004/05 Estimate**	**2005/06 Target**	**2006/07 Target**	**2007/08 Target**
INPUT									
Provide sufficient funds for personnel in TB hospitals	Expenditure on staff as % of total expenditure	80.00%	81.18%	80.41%	79.00%	78.00%	76.00%	75.00%	75.00%
Provide sufficient funds for non-personnel in TB hospitals	Expenditure on drugs as % of total expenditure	27.3%	8.9%	9.90%	9.80%	9.8%	11.0%	12.0%	12.0%
	Expenditure on maintenance as % total expenditure	5.86%	1.9%	0.9%	1%	0.9%	1.5%	2.0%	2.0%
Provide regional hospital	Useable beds per 1000 total population	0.22	0.26	0.23	0.23	0.23	0.24	0.24	0.24
infrastructure in line with Healthcare 2010	Useable beds per 1000 uninsured population	0.31	0.35	0.31	0.32	0.31	0.32	0.33	0.32
Provide sufficient funding to ensure	Hospital expenditure per capita (total population)	22	13	12	12	13	13	14	15
an efficient TB hospital service for the population of the W Cape	Hospital expenditure per capita (uninsured population)	31	18	17	17	17	18	19	20
Provide TB hospital services	Outpatients per inpatient day ratio	-	0.06	0.05	0.01	0.01	0.01	0.01	0.01
that adequately address the needs	Total number of inpatient days	383 998	383 998	324 887	337 263	336 815	352 134	361 441	362 993
of in patients and out patients	Total number of outpatient headcounts (incl trauma)	-	23 040	16 244	4 472	3 368	3 521	3 614	3 630
PROCESS									
Facilitate representative management	Percentage of hospitals with operational hospital board	100%	80%	80%	100%	100%	100%	100%	100%
Facilitate decentralised management and	Percentage of hospitals with appointed CEO in place (or Medical Superintendents)	100%	100%	100%	100%	100%	100%	100%	100%
OUTPUT									
Ensure accessible TB	Separations per 1000 total population	0.9	1.1	1.0	1.0	1.0	1.0	0.9	0.9
hospital services to the	Separations per 1000 uninsured population	1.3	1.4	1.4	1.4	1.4	1.4	1.3	1.3
population of the western Cape	Patient day equivalents per 1000 total population	74	87	72	73	71	73	74	73
	Patient day equivalents per 1000 uninsured population	101	119	98	99	98	101	102	101
QUALITY									
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	100%	20%	20%	30%	100%	100%	100%	100%
	Percentage of hospitals with clinical audit (M&M) meetings at least once a month	100%	40%	40%	50%	100%	100%	100%	100%
EFFICIENCY									
Ensure efficient and cost effective	Average length of stay	80.2	80.20	69.00	72.05	70.00	70.00	80.00	80.00
utilisation of resources	Bed utilisation rate based on useable beds	90%	90%	86%	86%	86%	85%	85%	85%
	Expenditure per patient day equivalent	304.24	152.58	171.75	168.53	177.26	181.50	187.96	198.19

Table 4.9: Performance indicators for TB hospitals [PHS5]

Indicator		Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input								
1	Expenditure on hospital staff as % of TB hospital expenditure	%	79.0%	78.0%	76.0%	75.0%	75.0%	
2	Expenditure on drugs for hospital use as % of TB hospital expenditure	%	9.8%	9.8%	11.0%	12.0%	12.0%	
3	Expenditure by TB hospitals per uninsured person	R	16.76	17.32	18.25	19.11	19.92	
Process								
4	TB hospitals with operational hospital board	%	100%	100%	100%	100%	100%	
5	TB hospitals with appointed (not acting) CEO in post	%	100%	100%	100%	100%	100%	
6	Facility data timeliness rate for TB hospitals	%	90%	90%	90%	90%	100%	
Quality								
8	TB hospitals with patient satisfaction survey using DoH template	%	30%	100%	100%	100%	100%	
9	TB hospitals with clinical audit (M and M) meetings every month	%	50%	100%	100%	100%	100%	
Efficiency								
10	Average length of stay in TB hospitals	Days	72.0	70.0	70.0	80.0	80.0	
11	Bed utilisation rate (based on usable beds) in TB hospitals	%	86%	86%	85%	85%	85%	
12	Expenditure per patient day equivalent in TB hospitals	R	169	177	181	188	198	

4.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 4.10: Trends in provincial public health expenditure for TB hospitals(R million) [PHS6]

Expenditure Sub-programme 4.2	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	49 065	51 154	54 269	59 902	---	---	---
Total per person	10.84	11.13	11.63	12.64	---	---	---
Total per uninsured person	14.86	15.25	15.93	17.32	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	59 761	56 730	57 091	59 902	**64 124**	68 163	72 182
Total per person	13.21	12.35	12.24	12.64	**13.33**	13.95	14.54
Total per uninsured person	18.09	16.91	16.76	17.32	**18.25**	19.11	19.92
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant rice projections for the same years

5. SUB-PROGRAMME 4.3 PSYCHIATRIC HOSPITALS

5.1 SITUATIONAL ANALYSIS

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

Table 4.11: Situation analysis indicators for psychiatric hospitals [PHS3]

Indicator		Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04
Input					
1	Expenditure on hospital staff as % of Psychiatric hospital expenditure	%	82%	83%	81%
2	Expenditure on drugs for hospital use as % of Psychiatric hospital expenditure	%			
3	Expenditure by Psychiatric hospitals per uninsured person	R	79.04	74.46	71.90
Process					
4	Psychiatric hospitals with operational hospital board	%	100	100	100
5	Psychiatric hospitals with appointed (not acting) CEO in post	%	100	100	100
6	Facility data timeliness rate for Psychiatric hospitals	%	70%	80%	90%
Quality					
8	Psychiatric hospitals with patient satisfaction survey using Department of Health template	%	0	20	40
9	Psychiatric hospitals with clinical audit (M and M) meetings every month	%	25	50	70
Efficiency					
10	Average length of stay in Psychiatric hospitals	Days	120.00	120.00	117.80
11	Bed utilisation rate (based on usable beds) in Psychiatric hospitals	%	84%	84%	83%
12	Expenditure per patient day equivalent in Psychiatric hospitals	R	335	362	362

5.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

5.2.1 Policy

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

Regulations promulgated in terms of the Mental Health Care Act 18 of 2002 have resulted in the need to adjust many of the mental health policies to ensure compliance with obligations imposed by the Act. An important provision of the Act is the establishment of the Mental

Health Review Boards which play an integral role in ensuring that the rights of the mental health care users are protected. The Department is in the process of establishing a single Review Board for the Province which should be in place by mid-April 2005. The Review Board will consist of five people appointed by the Provincial Minister and will be supported by an administrative component. An amount of R4,9 million has been allocated for the implementation of the Act and included the funding of the Review Board, licensing capacity and inspectorate and the increased cost of administrative services resulting from the implementation of the Act.

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

R2 million has been made available for the filling of critical posts within the psychiatric hospitals.

R1 million has been allocated for the increased costs of security contracts at mental health facilities.

An amount of R672 000 has been allocated for transfer to a group home, run by a non-profit organisation caring for people discharged from Alexandra and Lentegeur Hospitals.

In addition to this, an amount of R7,608 million has been allocated to the psychiatric hospitals to improve service delivery.

5.2.2 Service Priorities and Broad Strategic Objectives.

Bed plan

- The number of beds in the specialist hospitals are expected to decline from the 2003 platform of 2 235 to a revised platform of approximately 1 457 in 2010, the reductions will lead to the closure of chronic care beds predominantly in services for people with intellectual disability.
- The 2004 platform is 2 142, ninety-three beds were closed and further efficiency gains made by consolidating services.
- Whilst bed closures are expected in the specialist hospitals the number of district and regional beds for the province is expected to increase from the current 12 in the Southern Cape to a total of 300 for the province, 50 in each of the rural regions and 150 in the Metro as part of the Healthcare 2010 strategy. .
- Similarly a range of alternative community based support services, including alternative residential options is expected to develop making it possible for people and their families to obtain the necessary safe, alternative care. These include:
    - Care for the aged with mental illness and intellectual disability in old age homes.

  - Care for adolescents particularly those who no longer attend school.
  - Placement for people with severe mental illness in supervised group homes.
  - Placement for people with intellectual disability in-group homes with varying levels of supervision.
  - Supervised community residences for state patients in the forensic service who do not have stable families to which they can be discharged under supervision.
  - Frail care for the multiply disabled.
- It will be essential for Health and Social Services to implement formal agreement regarding the primary responsibility for providing financial assistance to the above groups of people to purchase these services

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

Service priorities for 2005/2006

- The focus remains on the continued consolidation, broadening and strengthening of adolescent services across the service platform.
- In the Red Cross/Groote Schuur/ William Slater service there is scope for further consolidation and the APH plays a facilitation role as the principal specialist for the Child and Adolescent service platform for the Province is located within the APH.
- At Lentegeur Hospital, the subacute unit for adolescents with psychotic illness opened on 2 August 2004. This service will be closely monitored and supported as it is envisaged that the pressures on the current tertiary hospital services at Tygerberg and Groote Schuur should be significantly relieved by this unit. The priority now will be to ensure that the multidisciplinary team skills are built up, that the services are more efficiently used. The unit will require increased staffing to run at full capacity.
- The development of general level 2 services for this group are a priority and the Tertiary Hospitals/ APH sub-specialist group will provide the necessary training, support and outreach to generalists who provide these services.
- The two areas that need further development are services for adolescents with substance abuse and mental illness and juvenile offenders with mental illness dual diagnoses. This will require collaboration between the relevant Departments including Social Services, Education and Correctional / Justice Departments.
- Definition of the regional hospital service package with distinction between those services, which will be rendered in general hospitals as opposed to specialist hospitals, remains important for service planning.
- Stabilisation of acute services, which continue to struggle with wards with bed occupancy rates of 90 to 100% is also a priority. This pressure would be significantly alleviated with the opening of regional and district beds to which more stable patients could be transferred. Current infrastructure and staffing are key rate limiting factors. The vacancy rate for professional nurse posts remains a challenge particularly at Valkenberg Hospital where critical mass is now below 50%.

Infrastructure

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

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

Alexandra Hospital

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

Lentegeur Hospital

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

Stikland Hospital

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

Valkenberg Hospital

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

The forensic services require the urgent replacement of Ward 20, which is far from the remaining services on the Pinelands Estate (Valkenberg East) remains a key goal. Currently this building houses 15 people referred in terms of the Criminal procedures Act for Observation Services by the Department of Justice from the Western and Northern Cape Provinces as well as 35 State patients admitted in terms of the Mental Health Act after being found unfit to stand trial for alleged serious crimes due to mental illness. There is a year-long waiting list of awaiting-trial prisoners in prison requiring observation services. The service is running at maximum efficiency, for 2003/2004 average of 93% occupancy of the 15 beds and 99% of the 35 beds, the average length of stay for observation is 34 days (minimum of 30 days required for serious offences). During the 2003/2004 financial year 166 people were admitted to the observation beds, the current waiting list stands at over 140 people. Interim upgrades to the physical structure have been made as a short-term option to make the facility more acceptable, pending the long-term redevelopment.

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

The building of the replacement admission suite is in progress, but has been significantly delayed due to the appointed contractor being unable to deliver on time. Originally the wards were due for delivery in February 2004 and again delivery due in February 2005 did not occur. In the interim the personnel and patients struggle to make the best of the 110 year old facilities in which all essential services are failing, any further delays will require funding to be allocated to urgent measures to allow further extension of the use of these wards. This is against a background of fully occupied beds. A tender has been awarded for the renovation of Ward 4 in the Riverside group of wards to convert it from a low secure unit to a sub-acute secure ward, this ward should be completed at the end of the month.

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

5.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.3.1 Finance and financial management

Financial administrative capacity at hospital level remains limited and the Department does not have the critical mass of staff required with the correct skills, this means that often the system depends on one person. The acquisition of financial skills is part of the identified priorities for skills development and wherever possible the appropriate officials are afforded the opportunity to attend training and when posts are filled every attempt is made to recruit skilled people. Supply chain management is a particular focus area. Skilled people in other regions are identified and requested to assist in giving practical training. Funding has been allocated centrally in Programme 1 to address this shortcoming.

5.3.2 Human resources

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

Mental health services, by their very nature, are provided within a stressful environment. Staff are supported by an outsourced Employee Assistance Programme. The utilisation statistics,

which far exceed the market benchmark, bear testimony to the value that this service brings in supporting staff.

5.3.3 Support systems

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

5.3.4 Information

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

5.4 QUALITY IMPROVEMENT MEASURES

5.4.1 Management of Organisation

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

5.4.2 Patient Care

During 2003 a client satisfaction survey was conducted at all four of the hospitals using the Department of Health Client Satisfaction instrument. These surveys will be repeated annually. The UCT Department of Social Work has provided students to conduct the surveys during their August and November vacations. This has been a mutually beneficial experience. A similar survey is in progress currently.

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

Morbidity and mortality committees are in place at all hospitals and during 2004/2005 trends will be identified which will inform the development of indicators. Meetings are held regularly at all hospitals.

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

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

The target for 2004/2005 is to develop a regular monitoring report, which clearly reflects the outputs and to evaluate these outputs accurately to begin to measure outcomes and set realistic, incremental improvement targets. A key measurable objective (KMO) report has been instituted from July 2003.The KMO report is refined incrementally with measurable indicators and targets.

5.4.3 **Human Resource Management**

The Associated Psychiatric Hospitals (APH) became the first region to contract an outsourced Employee Assistance Programme (EAP) in July 2002; the tender was awarded to the Centre for Human Development (CHD) until 31 August 2003. Subsequently a new 2-year contract has been awarded to ICAS from 1 September 2003. The EAP provider conducted a staff climate survey at the end of 2003 and recommendations made in this survey are being addressed at each hospital.

5.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.12: Provincial objectives and performance indicators for psychiatric hospitals [PHS4]

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2001/02 Actual	2002/03 Actual	2003/04 Actual	2004/05 Estimate	2005/06 Target	2006/07 Target
INPUT								
Provide sufficient funds for personnel in Psychiatric hospitals	Expenditure on staff as % of total expenditure	75.00%	82.00%	82.75%	81.49%	81.28%	80.00%	80.00%
Provide psychiatric hospital infrastructure in line with Healthcare 2010	Useable beds per 1000 total population	0.26	0.51	0.48	0.47	0.46	0.46	0.45
	Useable beds per 1000 uninsured population	0.35	0.70	0.66	0.65	0.64	0.63	0.62
Provide sufficient funding to ensure an efficient psychiatric hospital service for the population	Hospital expenditure per capita (total population)	41	58	54	52	54	59	62
	Hospital expenditure per capita (uninsured population)	56	79	74	72	75	81	85
		0	0	0	0	0	0	0
Provide services that adequately adress the needs of inpatients and outpatients	Outpatients per inpatient day ratio	0.03	0.05	0.03	0.03	0.03	0.03	0.03
	Total number of inpatient days	437 568	702 737	681 968	668 741.00	682 550	682 550.00	682 550
	Total number of outpatient headcounts	14 221	35 137	22 388	21 820	20 476.50	19 794	19 111
PROCESS		0	0	0	0	0	0	0
Facilitate representative management	Percentage of hospitals with operational hospital board	100%	90%	90%	90%	100%	100%	100%
		0	0	0	0	0	0	0
Facilitate decentralised management and accountability	Percentage of hospitals with appointed CEO in place (or Medical Superintendents)	100%	82%	82%	86%	86%	100%	100%
		0	0	0	0	0	0	0
	Percentage of hospitals with bussiness plan agreed with provincial health department	100%	100%	100%	100%	100%	100%	100%
		0	0	0	0	0	0	0
OUTPUT		0	0	0	0	0	0	0
Ensure accessible psychiatric hospital services to the population of the Western Cape	Separations per 1000 total population	0.8	1.3	1.2	1.2	1.3	1.3	1.3
	Separations per 1000 uninsured population	1.1	1.8	1.7	1.7	1.7	1.8	1.8
	Patient day equivalents per 1000 total population	85	172	150	145	145	143	141
	Patient day equivalents per 1000 uninsured population	117	236	206	198	199	196	193
QUALITY		0	0	0	0	0	0	0
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	100%	0%	0%	0%	25%	100%	100%
		0	0	0	0	0	0	0
	Percentage of hospitals with clinical audit (M&M) meetings at least once a month	100%	40%	40%	50%	85%	100%	100%
		0	0	0	0	0	0	0
EFFICIENCY		0	0	0	0	0	0	0
Ensure efficient and cost effective utilisation of resources	Average length of stay	106.0	120.00	120.00	117.80	115.00	110.00	106.00
	Bed utilisation rate based on useable beds	90%	84%	84%	83%	85%	85%	85%
	Expenditure per patient day equivalent	478.66	335.00	362.27	362.26	374.44	413.95	440.17

Table 4.13: Performance indicators for psychiatric hospitals [PHS5]

	Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input								
1	Expenditure on hospital staff as % of psychiatric hospital expenditure	%	81.5%	81.3%	80.0%	80.0%	80.0%	
3	Expenditure by psychiatric hospitals per uninsured person	R	71.90	74.62	81.21	85.00	88.64	
Process								
4	Psychiatric hospitals with operational hospital board	%	75%	75%	100%	100%	100%	
5	Psychiatric hospitals with appointed (not acting) CEO in post	%	100%	100%	100%	100%	100%	
6	Facility data timeliness rate for psychiatric hospitals	%	90%	100%	100%	100%	100%	
Quality								
8	Psychiatric hospitals with patient satisfaction survey using DoH template	%	0%	25%	100%	100%	100%	
9	Psychiatric hospitals with clinical audit (M and M) meetings every month	%	50%	85%	100%	100%	100%	
Efficiency								
10	Average length of stay in psychiatric hospitals	Days	117.8	115.0	110.0	106.0	106.0	
11	Bed utilisation rate (based on usable beds) in psychiatric hospitals	%	83%	85%	85%	85%	90%	
12	Expenditure per patient day equivalent in psychiatric hospitals	R	362.26	374.44	413.95	440.17	441.41	

5.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 4.14: Trends in provincial public health expenditure for psychiatric hospitals (R million) [PHS6]

Expenditure Sub-programme 4.3	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	214 322	225 209	232 790	258 131	---	---	---
Total per person	47.37	49.02	49.89	54.48	---	---	---
Total per uninsured person	64.89	67.14	68.34	74.62	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	261 044	249 757	244 895	258 131	**285 273**	303 244	321 136
Total per person	57.70	54.36	52.48	54.48	**59.28**	62.05	64.71
Total per uninsured person	79.04	74.46	71.90	74.62	**81.21**	85.00	88.64
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

6. SUB-PROGRAMME 4.4: CHRONIC MEDICAL HOSPITALS

6.1 SITUATIONAL ANALYSIS

The following hospitals are classified as chronic medical hospitals: Maitland Cottage Hospital, Booth Memorial Hospital, Western Cape Rehabilitation Centre, Sarah Fox Hospital, St Joseph's Home, Malmesbury Infectious Diseases Hospital and Nelspoort Hospital.

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

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

Table 4.15 Situation analysis indicators for chronic medical hospitals [PHS3]

Indicator		Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04
Input					
1	Expenditure on hospital staff as % of Chronic hospital expenditure	%	82%	83%	81%
3	Expenditure by Chronic hospitals per uninsured person	R	24.64	14.36	13.91
Process					
4	Chronic hospitals with operational hospital board	%	90%	90%	90%
5	Chronic hospitals with appointed (not acting) CEO in post	%	82%	82%	86%
6	Facility data timeliness rate for Chronic hospitals	%	60%	60%	70%
Quality					
8	Chronic hospitals with patient satisfaction survey using DoH template	%	0%	0%	0%
9	Chronic hospitals with clinical audit (M and M) meetings every month	%	40%	40%	50%
Efficiency					
10	Average length of stay in Chronic hospitals	Days	71.00	68.00	50.86
11	Bed utilisation rate (based on usable beds) in Chronic hospitals	%	85%	96%	80%
12	Expenditure per patient day equivalent in Chronic hospitals	R	200.45	182.14	262.04

6.2 POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES

No major changes are envisaged for the chronic medical hospitals during 2005/06. They will play an important role as cost effective step-down facilities in terms of Healthcare 2010. The size of the service platform is to be maintained in the short term and reviewed in the medium to long term in keeping with the direction of Healthcare 2010.

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

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

The Karl Bremer and Conradie Rehabilitation services have been consolidated into a single modernized center of excellence at the Western Cape Rehabilitation Centre (WCRC) at Lentegeur Hospital. The activities of the Rehabilitation Centre were downscaled in order to facilitate the move from Conradie Hospital to the Lentegeur site. An amount of R4 million has been allocated to provide for the upscaling of patient services at the new WCRC during 2005/06. The WCRC plans to employ a facility manager and outsource non-core activities at the new facility.

6.3 CONSTRAINTS

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

6.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.16: Performance indicators for Chronic hospitals [PHS4]

2004/05 REAL TERMS

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2001/02 Actual	2002/03 Actual	2003/04 Actual	2004/05 Estimate	2005/06 Target	2006/07 Target	2007/08 Target
INPUT									
Provide sufficient funds for personnel in chronic hospitals	Expenditure on staff as % of total expenditure	75.00%	82.0%	82.8%	81.5%	81.3%	80.0%	80.0%	80.0%
Provide chronic hospital infrastructure in line with Healthcare 2010	Useable beds per 1000 total population	0.13	0.17	0.16	0.16	0.15	0.20	0.20	0.20
	Useable beds per 1000 uninsured population	0.18	0.23	0.22	0.21	0.21	0.28	0.27	0.27
Provide sufficient funding to ensure an efficient chronic hospital service for the population	Hospital expenditure per capita (total population)	18	10	10	12	10	20	21	22
	Hospital expenditure per capita (uninsured populatio	25	14	14	16	14	28	29	30
Provide services that adequately adress the needs of inpatients and outpatients.	Outpatients per inpatient day ratio	0.02	0.01	0.01	0.01	0.01	0.01	0.01	0.01
	Total number of inpatient days	230 055	235 790	255 560	212 710.00	212 868	290 021.70	300 632	300 632
	Total number of outpatient headcounts	4 599	2 358	1 917	2 935	2 128.68	2 900	3 006	3 006
PROCESS									
Facilitate representative management	Percentage of hospitals with operational hospital board	100%	90%	90%	90%	100%	100%	100%	100%
Facilitate decentralised management and accountability	Percentage of hospitals with appointed CEO in place (or Medical Superintendents)	100%	82%	82%	86%	86%	100%	100%	100%
	Percentage of hospitals with bussiness plan agreed with provincial health department	100%	100%	100%	100%	100%	100%	100%	100%
OUTPUT									
Ensure accessible chronic hospital services to the population of the western Cape	Separations per 1000 total population	1.3	0.7	0.8	0.9	0.9	1.3	1.4	1.4
	Separations per 1000 uninsured population	1.7	1.0	1.1	1.2	1.2	1.8	1.9	2.0
	Patient day equivalents per 1000 total population	45	52	56	46	45	60	62	61
	Patient day equivalents per 1000 uninsured populat	61	72	76	63	62	83	85	83
QUALITY									
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	100%	0%	0%	0%	36%	100%	100%	100%
	Percentage of hospitals with clinical audit (M&M) meetings at least once a month	100%	40%	40%	50%	85%	100%	100%	100%
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources	Average length of stay	35.0	71.00	68.00	50.86	50.00	45.00	45.00	42.00
	Bed utilisation rate based on useable beds	90%	85%	96%	80%	80%	82%	85%	85%
	Expenditure per patient day equivalent	403.76	200.45	182.14	262.04	232.14	332.86	341.34	361.49

Table 4.17: Performance indicators for chronic medical hospitals [PHS5]

Indicator		Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input								
1	Expenditure on hospital staff as % of chronic hospital expenditure	%	81.5%	81.3%	80.0%	80.0%	80.0%	
3	Expenditure by chronic hospitals per uninsured person	R	16.44	14.33	27.57	28.86	30.10	
Process								
4	Chronic hospitals with operational hospital board	%	90%	100%	100%	100%	100%	
5	Chronic hospitals with appointed (not acting) CEO in post	%	86%	86%	100%	100%	100%	
6	Facility data timeliness rate for chronic hospitals	%	70%	90%	100%	100%	100%	
Quality								
8	Chronic hospitals with patient satisfaction survey using DoH template	%	0%	36%	100%	100%	100%	
9	Chronic hospitals with clinical audit (M and M) meetings every month	%	50%	85%	100%	100%	100%	
Efficiency								
10	Average length of stay in chronic hospitals	Days	50.9	50.0	45.0	45.0	42.0	
11	Bed utilisation rate (based on usable beds) in chronic hospitals	%	80%	80%	82%	85%	85%	
12	Expenditure per patient day equivalent in chronic hospitals	R	262.04	232.14	332.86	341.34	361.49	

6.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 4.18: Trends in provincial public health expenditure for chronic hospitals (R million) [PHS6]

Expenditure Sub-programme 4.4	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	38 934	42 078	53 228	49 579	---	---	---
Total per person	8.61	9.16	11.41	10.46	---	---	---
Total per uninsured person	11.79	12.55	15.63	14.33	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	47 422	46 665	55 996	49 579	**96 859**	102 961	109 038
Total per person	10.48	10.16	12.00	10.46	**20.13**	21.07	21.97
Total per uninsured person	14.36	13.91	16.44	14.33	**27.57**	28.86	30.10
Total capital							

Note: Current prices projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.
The increase in 2005/06 is due to the transfer of the funds from Sub-programme 4.1 for the Western Cape Rehabilitation Centre

7. SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

7.1 SITUATIONAL ANALYSIS

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

7.1.1 Policy and political environment

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

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

7.1.2 Population characteristics and equity

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

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

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

7.1.3 Service facilities, utilization and gaps

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

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

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

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

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

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

7.1.4 **Resources**

- It is unlikely that there will be short-term growth in resources for OHC.
- Dental inflation is substantially greater than medical inflation.
- There are gaps in current and projected personnel
- The infrastructure from which service are delivered are owned by the universities. Both buildings at Tygerberg hospital and Mitchell's Plain are old and functionally not optimal in terms of space or high maintenance cost.

7.1.5 **Health needs**

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

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

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

7.1.6 **Cost efficiency**

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

7.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

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

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

7.2.1 Improve accessibility to oral health services

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

7.2.2 Improve efficiency

- Establishment of cost centres .
- Involve clinicians in management decisions though regular meetings.
- Identify efficiency and beneficial gains in the merger and incorporation process.
  1) Procurement
  2) Administration
  3) Equipment
  4) Human resources.
  5) Management / organisational structure

- Use process-mapping techniques to improve priority areas where bottlenecks occur.
- Reducing theatre utility demand by creating conscious sedation clinics for minor oral surgery and children. Maximize theatre efficiency by employing session anaesthetist.
- Maintain high throughput and low attrition of students. Students trained to implement the primary health care approach. Incorporate more clinical exposure in the latter years of undergraduate training.
- Fill administration posts to improve revenue collection.

7.2.3 Improve cost-effectiveness

- Together with provincial business unit do feasibility study regarding preferred provider status with medical aids.

- To expand training of dentists and extended duties of oral hygienists in the Metropole clinics so that services other than just primary health care are taken away from the OHC and the specialized children's clinic.

7.2.4 **Primary care approach**

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

7.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

7.3.1 An assessment of water fluoridation levels in the province conducted in 2000/1, revealed that the water quality in the urban areas of the Province was adequate in most instances. However, it was noted that the level of water fluoridation on many of the farms in the Province was inadequate. A lack of resources has, however, precluded an in-depth investigation to quantify the extent of the problem and resource constraints have similarly curtailed attempts to rectify the problem. The persistent drought in the province has also complicated matters. The finalization of the process of reorganization of environmental health services will create an opportunity to address this problem once resources are made available. It has been proposed that a project management team be created to drive the process in the Province.

7.3.2 Develop an integrated provincial service platform to meet demand based on the principles of equity and affordability. Turnkey requirement is to develop referral sites at George and Paarl with a minimum of six dental chairs per site. Rationale is to deliver services that are accessible and affordable for non-Metro areas. Allocation of activity based budget to these centres.

7.3.3 Reduce the theatre demand by using conscious sedation for children and minor oral surgery procedures. This is a more cost-effective manner in delivering the same services. Initially the sedation clinics would only be at COHC but roll-out to other facilities when training dentists in this regard has been completed. Presently there is only one conscious sedation unit at COHC. It is envisaged that three more units be established.

7.3.4 An increase of dentures for the population between 18 to 35 years would serve them well in regards to suitability for employment and their quality of life. It would be advantageous to increase the production of dentures by 15% and reduce the cost per denture though collaboration with Technicons and private entities.

7.4 PLANNED QUALITY IMPROVEMENT MEASURES

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

7.4.1 Patient Satisfaction

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

7.4.2 Care for the Carer

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

7.4.3 Clinical Quality

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

7.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.19: Measurable objectives and performance indicators: Academic Dental Services [PHS4]

Objective	Performance measure/ indicator	2010 Target	2001/02 Actual	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)	2006/07 (Target)	2007/08 (Target)
Optimise Student training as agreed to by Committee of Dental Deans	Graduating students	80	69	64	129 *	97 *	90	80	
Evaluate service rendering	The number of patient visits	120 000	±150 000	150 000	160 000	160 000	150 000	130 000	
Reduce time patients spend on waiting lists for dentures	Number of patients on waiting lists for dentures	500	1000	1000	1000	900	800	700	
Increase patient revenue	Percentage of accrued accounts received	75%	50%	60%	70%	75%	75%	75%	
Establish revenue generation initiatives	Number of projects implemented	4	0	0	0	1	2	3	
Improved efficiency	Theatre stats.	1500 (80% operating time)	1137	1293	1300 (70% operating time)	1400	1500	1500	

7.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 4.20: Trends in provincial public health expenditure for academic dental services (R million) [PHS6]

Expenditure (R million)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	40 654	42 525	47 371	51 546	---	---	---
Total per person	8.99	9.26	10.15	10.88	---	---	---
Total per uninsured person	12.31	12.68	13.91	14.90	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	49 517	47 160	49 835	51 546	53 747	57 133	60 500
Total per person	10.94	10.26	10.68	10.88	11.17	11.69	12.19
Total per uninsured person	14.99	14.06	14.63	14.90	15.30	16.02	16.70
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

PROGRAMME 5: CENTRAL HOSPITAL SERVICES

1. AIM:

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

2. PROGRAMME STRUCTURE:

Sub-programme 5.1 Central hospital services

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

3. SITUATIONAL ANALYSIS:

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

Table 5.1: Situation analysis indicators for central/tertiary hospitals [CHS2]

Indicator		Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	National target 2003/04
Input						
1	Expenditure on hospital staff as % of hospital expenditure	%	73.6%	70.4%	65.0%	
2	Expenditure on drugs for hospital use as % of hospital expenditure	%	5.7%	6.8%	6.9%	13
Process		R				
3	Operational hospital board	%	100%	100%	100%	100
4	Appointed (not acting) CEO in post	%	75%	100%	100%	100
5	Individual hospital data timeliness rate	%	67%	67%	67%	100
Output						
6	Caesarean section rate	%	37.49	34.67	28.57	32
Quality						
7	Patient satisfaction survey using DoH template	%	0%	25%	100%	100
8	Clinical audit (M and M) meetings at least once a month	%	75%	75%	100%	100
Efficiency		%				
9	Average length of stay	Days	6.02	6.18	6.19	6.8
10	Bed utilisation rate (based on usable beds)	%	84.3%	84.4%	86.2%	75
11	Expenditure per patient day equivalent	R	1 461	1 668	1 478	1 877
Outcome						
12	Case fatality rate for surgery separations	%	3.3	3.72	3.67	3.6

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

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

Table 5.2: Numbers of beds in hospitals by level of care [CHS1]

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

3.1 **Financial issues**:

The central hospitals are funded by the National Tertiary Services Grant (NTSG), the Health Professions Training and Development Grant (HPTDG) and also a 25% contribution from the Equitable Share for secondary level care that they provide. The allocation of the NTSG increased by R111million for 2005/06 in relation to the 2004/05 allocation. In 2005/06 the Central Hospitals are allocated 33.7% of the vote in comparison to the 34.7% allocated in 2004/05. The allocation to the Programme increases by 8.05% in nominal terms.

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

Table 5.3: The sources of funding for the Central Hospitals during 2005/06

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

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

The Health Professions Training and Development Grant (HPTDG) funds the service costs related to teaching and training across all services in the province, and for all health sciences study courses. Tygerberg Hospital is currently linked to the University of Stellenbosch and Groote Schuur and Red Cross Children's Hospitals are currently linked to the University of Cape Town. This situation will change in future whereby universities and other higher education institutions will have equal access to health institutions and will no longer be linked primarily to specific institutes of higher education. The HPTDG funds allocated to the Western Cape have not increased in accordance with inflation or increased student requirements. In fact the allocation for 2005/06 decreases by R3,9 million in comparison to 2004/05, i.e. a nominal decrease of 1%. The funding in 2006/07 remains constant which translates into a 5% decrease in real terms.

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

However, the central hospitals are not sustainable in their present configuration. Many of the service units are below the critical mass of sustainability, diminishing the capacity to provide the full package of care, and to effectively train students. This is further exacerbated by the backlogs in equipment and health technology. The poor condition and extent of the physical infrastructure, particularly at Tygerberg Hospital, contributes significantly to making the current level of activities unsustainable.

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

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

3.2 Disease burden

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

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

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

3.3 Consumables

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

3.4 Estate and Equipment

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

3.5 The service platform

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

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

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

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

Universities are major players in the Western Cape health service delivery and their role in supporting the province towards implementing Healthcare 2010 is important. The process of Joint Operational Planning is at an advanced stage, supporting the national Modernisation of Tertiary Services (MTS), thereby enhancing the co-operation between the Health department and the universities. The national policy decisions regarding the implementation and funding of the MTS proposals are awaited.

The Health Information Systems have been rolled out to the Central Hospitals. The systems require adequate capacity to manage and obtain maximum benefits from this investment. The capacity is currently not in place and the recruitment of suitably qualified staff is a significant challenge. The implementation of a Cost Centre Accounting system is deemed critical in terms of decentralized management. A Cost Centre Accounting system was implemented as a pilot at Groote Schuur Hospital in 2004/5, and will roll out to Tygerberg and Red Cross Hospitals at the beginning of 2005/6. The process of decentralizing the management of cost centers in the Central Hospitals is well advanced.

There is a need to develop decentralized decision-making in the institutions, and to have budgets and service information at that level. Whilst the structural developments of a cost center management system have progressed, there is a lack of support towards decentralized

decision-making. It is planned to establish the necessary financial and information support so as to establish "mini-hospitals" or responsibility centers within the larger hospital organisations However, due to financial constraints this may only be realized within the next two years.

The central hospitals face a significant challenge in meeting the employment equity targets. This is particularly true for the medical professional categories, and more so in Tygerberg Hospital, where language has been a historical challenge. Focused, joint strategies with the respective universities will be required to address this situation.

Table 5.4 Analysis of the Central Hospitals staffing profile: 2003/04 and 2004/05

Functional Category	2003/4 Filled Posts	2003/4 % of Total Staff	2004/5 Filled Posts	2004/5 % of Total Staff
ADMIN	1183	13.0%	1305	15.0%
DOMESTIC SERVICES	1946	21.4%	1506	17.4%
HEALTH MANAGERS	51	0.6%	68	0.8%
HEALTH TECHNICIANS	119	1.3%	159	1.8%
LIFE SCIENCES	45	0.5%	45	0.5%
MAINTENANCE WORKERS	31	0.3%	120	1.4%
MEDICAL PROFESSIONALS	**1015**	**11.2%**	**1011**	**11.6%**
Junior MO	115	1.3%	122	1.4%
MO	240	2.6%	145	1.7%
Registrars	275	3.0%	481	5.5%
Specialists	384	4.2%	263	3.0%
NATURAL SCIENCES	3	0.0%	13	0.2%
NURSING	**3739**	**41.2%**	**3542**	**40.8%**
Professional Nurse	1450	16.0%	1409	16.2%
Staff Nurse	714	7.9%	654	7.6%
Assistants	1575	17.4%	1479	17.0%
OPERATORS	24	0.3%	65	0.8%
PHARMACISTS	59	0.7%	56	0.6%
SEN MANAGERS	4	0.0%	7	0.1%
SOCIAL SCIENCES	60	0.7%	62	0.7%
THERAPISTS	731	8.1%	493	5.8%
TRADE WORKERS	63	0.7%	236	2.7%
TOTAL	**9073**	**100.0%**	**8688**	**100.0%**

Note: Groupings to be revisited

4. POLICIES, STRATEGIES AND BROAD STRATEGIC OBJECTIVES

The policy regarding tertiary health care is contained in Healthcare 2010. However, the detail of this plan must be defined in terms of the range, quantum and location of the various services across the central hospitals platform. The focus of the MTEF period will be on integrating the detailed and refined tertiary services plan with the other levels of the health

care system in support of the implementation of Healthcare 2010. The revision of the staffing structure will evolve from the service plan. Effective communication with stakeholders and the development of an implementation strategy is essential.

The re-negotiation of agreements with the universities and the rationalization and the consolidation of tertiary and quarternary services are major policy directives. These must be viewed in the light of the national initiative aimed at the Modernisation of Tertiary Services.

4.1 Central Hospitals: Organisational Development

The management structure has been designed to devolve operational management to the level of cost centres. The Clinical Responsibility Centres that are being planned for implementation will consist of a Clinical Manager, Nurse Manager, Clinical Departmental Head and administrative support. The funding for the necessary administrative and information support could not be made available and therefore some centralization will still be required.

The Clinical Responsibility Centre will eventually function as a mini-hospital in a big hospital with its own budget, personnel establishment, procurement mechanisms and appropriate delegations. The resources and output targets will be progressively aligned towards the Health Care 2010 expectations. Information management capacity and dedicated administrative support will be required.

The institutions aim to modernise management and establish bed management, theatre management and quality management capacity. Unfortunately it is not possible to fund this in the 2005/2006 budget and therefore the implementation of these management tools will take longer than anticipated. The Quality Assurance Manager is a particularly important post and it may be possible to provide bridging funds from the Hospital Management and Quality Improvement Grant.

Once the service packages for each institution have been finalized, the organizational design will be refined and finalized towards an appropriate skills mix.

4.2 Individual Central Hospitals

4.2.1 Red Cross Children's Hospital (RCCH)

Red Cross Children's Hospital is a national asset and has been established as a separate entity with its own support structure. Key financial, human resource management and information management capacity is still lacking.

- Identified sub-specialist paediatrc services across Red Cross and Tygerberg Hospitals will be consolidated into single discipline departments. Implementation has already commenced in the Cardiology and Cardiothoracic services; Nephrologoy and Renal Transplant services; Neurology and Child Development services; and paediatric services. Other areas will follow.

- **Estate Management**:
  The community support for Red Cross War Memorial Children's Hospital has been phenomenal and the fundraising arm of the hospital, The Children's Hospital Trust has raised over R90 million since 1995 for redevelopment projects, such as:
  - a new specialist outpatients and emergency services wing – R43 million
  - a new integrated paediatric intensive care unit – R3.8 million
  - specialized medical equipment – R15 million
  - a new trauma and diagnostic radiology unit R16 million
  - a new oncology unit – R16 million .

4.2.2 Tygerberg Hospital

- During 2003, continued through 2004 Tygerberg Hospital commenced with consolidating regional services into separate wards as the first step towards strengthening capacity for regional metro hospital services. This process will continue during the MTEF period. Funding for a quantum of Level 2 services will be transferred to Sub-programme 4.1 (Regional/General hospitals) during 2006/07.
- Once the service plan for the Metro has been finalized, the future service and infrastructure configuration of Tygerberg Hospital will be clarified and it will be possible conduct feasibility studies and prepare a motivation for funding from the Hospital Revitalisation Fund.
- In order to ensure sustainable service delivery it is necessary for Tygerberg Hospital to expand and develop already well functioning revenue generation initiatives, e.g. the further roll-out of differentiated amenities, maximization of revenue collection and increased revenue through the Road Accident Fund.
- The principles of Healthcare 2010 include improving the quality and access to appropriate health services by strengthening level 2 services and restructuring level 3 services.
- **Revenue generation** has been identified as a key strategic objective for the Department in addressing the budgetary constraints. Tygerberg Hospital has been very successful in generating additional revenue over the revenue target and has successfully rolled out differentiated amenity beds in the Wards D4 and D3. This has been expanded by the creation of private ICU beds. The hospital, however, has not have a case manager to manage these services which has to be addressed.
- Tygerberg hospital is experiencing an increasing load on trauma and emergency services. Therefore the creation of additional management and infrastructure capacity has been prioritised. Trauma headcounts have consistently increased over the past three years and the average for the first 4 months in the 2004/05 financial year shows an increase of 400 – 500 patients per month. The nature of trauma trauma requires very expensive interventions and orthopedic trauma is placing a major burden on medical surgical consumables. The projections of orthopedic implants on current trends indicate an increase in this expenditure in excess of R1,5 million

4.2.3 Groote Schuur Hospital

The key strategies of GSH are as follows:

- Re-engineering the institutional framework – this will include restructuring management, the interface between the hospital and higher education institutions, clinical departmental and divisional structures, and the separation of tertiary and secondary services within the institution. The consolidation of the Intensive Care Units, Wards and Trauma and Emergency Units will be completed. This will result improved theatre management and day surgery utilization.
- Strengthen de-centralised management through five clinical centers, supported by Cost Centre Accounting.
- Strengthen revenue flows by expanding on the bed capacity and aggressive following up of road accident fund and other hospital fees.
- Establishing a step down / hospice care facility.
- Consolidate secondary services and ensure appropriate outpatient attendances.

4.2.4 Other strategies:

- The Department has established a dedicated team to address prioritization and central procurement to systematically address the equipment backlogs.
- A high-level intervention in terms of the joint agreements is underway in order to update the current agreements.

5. CONSTRAINTS AND MEASURES TO OVERCOME THEM

5.1 Main Challenges facing the Central Hospitals

- Additional funding has been allocated to Programme 5 to address the following:
  - R9 million to increase capacity in theatres and ICU's;
  - R12 million for the maternity and neonatal services;
  - R4 million for the modernsation of management, particularly theatre management;
  - R4 million to improve nursing care by ensuring post-basic nursing training; and
  - Improve patient access to the service.
- Personnel structure with incorrect staff mix and shortages of scarce resources especially Nursing staff, Clinical Technologists, Pharmacists, Radiographers, Physicists and Perfusionists. Post-basic qualifications in nursing, particularly theatre and intensive care are severely lacking, causing a high dependency on agency services, which cannot always provide in the need.
- Realignment of personnel within the budget.
- Equipment shortages and problems with maintenance.
- Inadequate capacity at primary and secondary levels of care to accommodate referrals and prevent patients from moving up in the referral chain. The lack of chronic medication and professions allied to medicine personnel has a significant impact. There is a significant increase (17%) in the demand for obstetric care, and the provision of gyanecology services is very limited at less specialized facilities and Primary health Care.
- Shortages of funded beds particularly ICU and General Ward Beds.
- Long waiting times and waiting lists, especially in cardiac surgery, vascular surgery, urology cancers, and head and neck cancer surgery.

5.2 The current service platform in the Metropole region results in an inappropriately large number of outpatients being seen at the Central Hospitals. This will be addressed with Programme 4, regional general hospitals, whilst taking the financial constraints of this programme into consideration. The relocation of general specialists to regional hospitals will strengthen the capacity at the appropriate levels.

5.3 The operational and maintenance costs of the extensive and rapidly deteriorating physical infrastructure of the Central Hospitals are a significant constraint. A concerted effort is being made to enhance the capacity of the province to address the infrastructure backlogs, in line with Healthcare 2010.

5.4 Policy options identified to develop/enhance the services in the Central Hospitals:

- Implementation of managed Clinical Responsibility Centres (cost center) management to enhance financial management.
- Local, in-house post basic training of nurses in specialties such as ICU, theatre. This would require the investment of two staff members in both GSH and TBH.
- Address the bottlenecks in the system, especially day surgery, theatre efficiency, theatre time, ICU bed capacity, and radiation therapy
- Appoint full time nursing staff to reduce the use of agency personnel.
- Filling of key posts that would unlock efficiencies, including a Quality Manager, Bed Manager, and Theatre manager
- 'start-up' funds to facilitate revenue generation, such as renal dialysis
- Improve the safety of the institutions (especially GSH and TBH) regarding Fire detection and protection system
- Refresh slow and outdated information technology hardware - IT refresh
- Funding for assistive devices.
- Have direct access to Level 1 beds that would assist in appropriateness of care management.
- Advanced management training for staff

Funding will not be available for the above priorities in the 2005/06 financial year, however, they will be addressed if funding capacity is created during the year. The greatest need is the establishment of the responsibility centers to enable clinicians and managers to effectively manage services and resources

6. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 5.5: Provincial objectives and performance indicators for Central Hospitals 2004/05 Real Terms [CHS3]

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2001/02 Actual	2002/03 Actual	2003/04 Actual	2004/05 Estimate	2005/06 Target	2006/07 Target	2007/08 Target
INPUT									
Provide sufficient funds for personnel in central hospitals	Expenditure on staff as % of total expenditure	63.80%	73.6%	70.4%	65.0%	66.2%	65.0%	65.0%	68.0%
Provide sufficient funds for non-personnel in central hospitals	Expenditure on drugs as % of total expenditure	11.0%	5.7%	6.75%	6.95%	5.7%	5.7%	5.7%	5.7%
	Expenditure on maintenance as % total expenditure	6.81%	1.7%	1.9%	0.9%	1.6%	3.0%	3.5%	3.5%
Provide central hospital infrastructure in line with Healthcare 2010	Useable beds per 1000 total population	0.25	0.57	0.57	0.53	0.52	0.51	0.50	0.49
	Useable beds per 1000 uninsured population	0.34	0.78	0.78	0.72	0.71	0.70	0.69	0.68
Provide sufficient funding to ensure an efficient central hospital service for the population	Hospital expenditure per capita (total population)	214	363	356	362	378	402	421	439
	Hospital expenditure per capita (uninsured population)	293	497	488	496	518	551	577	601
Provide services that adequately adress the needs of inpatients, outpatients and trauma cases.	Outpatients per inpatient day ratio	1.00	1.24	1.22	1.42	1.70	1.50	1.40	1.50
	Total number of inpatient days	400 223	795 850	809 800	776 896.00	750 250	750 250.20	759 182	759 182
	Total number of outpatient headcounts (incl trauma)	400 223	984 173	986 809	1 100 714	1 275 425.34	1 125 375	1 062 854	1 138 773
PROCESS									
Facilitate representative management	Percentage of hospitals with operational hospital board	100%	100%	100%	100%	100%	100%	100%	100%
Facilitate decentralised management and accountability	Percentage of hospitals with appointed CEO in place (or Medical Superintendents)	100%	75%	100%	100%	100%	100%	100%	100%
	Percentage of hospitals with bussiness plan agreed with provincial health department	100%	100%	100%	100%	100%	100%	100%	100%
OUTPUT									
Ensure accessible central hospital services to the population of the western Cape and the rest of the country	Separations per 1000 total population	12.7	29.2	28.5	26.9	26.7	26.0	25.9	25.5
	Separations per 1000 uninsured population	17.4	40.0	39.1	36.8	36.6	35.6	35.5	34.9
	Patient day equivalents per 1000 total population	103	248	214	245	248	234	228	229
	Patient day equivalents per 1000 uninsured population	141	340	293	336	340	320	312	314
QUALITY									
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	100%	0%	0%	0%	50%	100%	100%	100%
	Percentage of hospitals with designated official responsible for coordinating quality management	100%	20%	20%	30%	100%	100%	100%	100%
	Percentage of hospitals with clinical audit (M&M) meetings at least once a month	100%	50%	50%	75%	100%	100%	100%	100%
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources	Average length of stay	6.0	6.02	6.18	6.19	5.92	6.00	6.00	6.00
	Bed utilisation rate based on useable beds	85%	84%	84%	86%	84%	84%	85%	85%
	Expenditure per patient day equivalent	2 086	1 461	1 668	1 478	1 524	1 720	1 847	1 912
OUTCOME									
Ensure desired clinical outcomes	Case fatility rate for surgery separations	0	3.30%	3.72%	3.67%	0%	0%	0%	0%

Table 5.6: Performance indicators for central hospitals [CSH4]

Indicator		Type	2003/04	2004/05	2005/06	2006/07	2007/08	National target 2007/08
Input								
1	Expenditure on hospital staff as % of central hospital expenditure	%	65.0%	66.2%	65.0%	65.0%	68.0%	70
2	Expenditure on drugs for hospital use as % of central hospital expenditure	%	6.9%	5.7%	5.7%	5.7%	5.7%	13
3	Expenditure by central hospitals per uninsured person	R	496	518	551	577	601	
Process								
4	Central hospitals with operational hospital board	%	90%	100%	100%	100%	100%	100
5	Central hospitals with appointed (not acting) CEO in post	%	86%	86%	100%	100%	100%	100
6	Facility data timeliness rate for central hospitals	%	67%	67%	67%	100%	100%	100)
Output								
7	Caesarean section rate for central hospitals	%	28.6%	25.0%	25.0%	25.0%	25.0%	25.0%
Quality								
8	Central hospitals with patient satisfaction survey using DoH template	%	25%	50%	100%	100%	100%	100
9	Central hospitals with clinical audit (M and M) meetings every month	%	50%	75%	100%	100%	100%	100
Efficiency								
10	Average length of stay in central hospitals	Days	6.2	5.9	6.0	6.0	6.0	5.3
11	Bed utilisation rate (based on usable beds) in central hospitals	%	86.2%	84.0%	84.0%	85.0%	85.0%	75
12	Expenditure per patient day equivalent in central hospitals	R	1 478	1 524	1 720	1 847	1 912	1 877
Outcome								
13	Case fatality rate in central hospitals for surgery separations	%	3.7	3.0	3.0	3.0	3.0	3.0

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

The allocation of the NTSG has increased by R111 million for 2005/06 in comparison to the allocation for 2004/05. In 2005/06 the Central Hospitals are allocated 33.7% of the vote in comparison to the 34.7% allocated in 2004//05. The allocation to the programme increases by 8.05% in nominal terms in 2005/06

Table 5.7: Trends in provincial public health expenditure for central hospitals (R million) [CHS5]

Expenditure Sub-Programme 5.1	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	1 348 157	1 476 202	1 607 089	1 791 789	---	---	---
Total per person	297.98	321.29	344.42	378.13	---	---	---
Total per uninsured person	408.19	440.12	471.81	517.99	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	1 642 055	1 637 108	1 690 657	1 791 789	**1 936 056**	2 057 004	2 177 830
Total per person	362.94	356.31	362.33	378.13	**402.33**	420.92	438.82
Total per uninsured person	497.17	488.09	496.35	517.99	**551.13**	576.60	601.13
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

1. AIM:

Rendering of training and development opportunities for actual and potential employees of the Department of Health.

2. PROGRAMME STRUCTURE

Sub Programme 6.1: Nurse Training College (WCCN)

Training of nurses primarily at undergraduate level with limited post-basic training for nurses. Target group includes actual and potential employees.

Sub Programme 6.2: Emergency Medical Services (EMS) Training College

Training of rescue and ambulance personnel. Target group includes actual and potential employees.

Sub Programme 6.3: Bursaries

Provision of bursaries for health science training programmes at undergraduate and postgraduate levels. Target group includes actual and potential employees.

Sub Programme 6.4: Primary Health Care (PHC) Training

Provision of PHC related training for personnel, provided by the regions.

Sub Programme 6. 5: Training (Other)

Provision of skills development interventions for all occupational categories of personnel in the Department. Target group includes actual and potential employees.

3. SITUATION ANALYSIS

3.1 **Appraisal of existing services and performance during the past year**

Legislative mandate

The provision of HRD services is mandated by several key legislation and policy prescriptions such as example: Skills Development Act, Skills Development Levies Act, HRD Strategy for South Africa, White Paper on Transformation of the Health System, Employment Equity Act, etc.

Assessing training needs

The analysis of training need and scarce skills is informed by information gleaned from Persal reports which indicates valuable information including attrition trends, vacancy trends per occupational category per institution and regions, labour market trends and forces, supply and demand issues, including HRD priorities for the health sector at national, provincial and Departmental level.

Planning

HRD planning includes supporting the development of all employees and potential employees. This includes incorporating student interns, learnerships, functional training, life skills development, and development of a critical mass of health professionals as one of several HR strategies to sustain the health service staffing, recruitment and retention levels.

Training strategy

The training strategy for the Department is addressed through the annual Departmental Workplace Skills Plan (WSP). This is developed through a consultative process with inputs from the Regional and Institutional Workplace Skills Plans and reflects the prioritisation of skills needs throughout the Department.

Prospective health professionals and in particular prospective nursing professionals as well other professional categories in scarce supply are recruited each year through the allocation of bursaries by the Department, for South African citizens and permanent residents. The allocation of bursaries to support health science education, training and development is aligned to the planning within the Medium Term Expenditure Framework (MTEF) cycles, and in support of the Health Care 2010 plan of the Department.

iKapa Elihlumayo

The budget is aligned to iKapa Elihlumayo in the provision of training opportunities for the unemployed and more particularly for youth to have an opportunity to gain skills in the health service sector. This is achieved through the implementation of 18.2 Learnerships (for unemployed persons) for the training of Enrolled Nurse Assistants and Pharmacist Assistants: (Basic) at training sites in the Department. This strategy addresses identified gaps and is utilised as a ladder-approach recruitment mechanism for nurses and pharmacists.

Social Capital

Formal relationships and networks have been established with key social partners to inform the delivery of a responsive HRD agenda, and these include internal and external clients and partners. Formal relationships with the Higher Education Institutions i.e. University of Cape Town, University of Stellenbosch, and University of the Western Cape have been entered into by way of a Memorandum of Agreement for the provision of academic support to the Western Cape College of Nursing (Budget Sub-programme 6.1).

In addition a partnership has been entered into to promote a regional platform for undergraduate training of nurses with the Cape Higher Education Consortium (CHEC) comprised of the University of Cape Town, University of Stellenbosch, University of the Western Cape, Cape Technikon, and the Peninsula Technikon. At the Departmental Training Committee meeting, internal partners and organized labour address matters related to skills development and broader HRD issues that impact on the delivery of health services through provision of education, training, and development interventions.

The Department has also established a partnership with HWSETA, to support the sustainability of its learnership programmes and other key skills development priorities.

The training strategy provided interventions in the following key areas:

- Health science training to ensure a critical mass of health professionals
- Functional / generic training to ensure competency on the job
- Technical skills training to support specialist / dedicated areas of skills
- Management training to support effective management of all public resources and policy implementation
- Computer-based training to increase and enhance efficacy and efficiency levels
- Learnerships to alleviate unemployment and increase employability
- In-service training to ensure continuous professional development.

Surveys are undertaken to inform Adult Basic Education and Training (ABET), management training, financial management training, skills development facilitator training, computer and generic training.

All education, training and development interventions through formal education programmes, accredited training courses and short course programmes based on need are aligned to budget, service delivery and programme objectives.

Interventions are monitored on a quarterly and annual basis through formal processes such as the Quarterly Monitoring Reports, the Quarterly Training Reports and Annual Training Reports.

Quantitative information is reflected in Table HR 2

3.2 **Key challenges over the strategic plan period**

- Alignment of HRD strategies with Health Care 2010 plan, key legislation and policies
- Increase the critical mass of all categories of nurses at basic level
- Budget availability for the provision of an adequate number of bursaries, for health science and support service students to meet training targets based on service needs
- Accommodation of increasing number of all health science students
- Strengthen Human Resource Development Information system
- Quality assurance of education training and development interventions
- Relocation of the Western Cape College of Nursing to the proposed Cape Peninsula University of Technology

3.3 **Policy and Priority perspectives**

The policy on iKapa Elihlumayo and the Health Care 2010 plan frames and supports the mandate to meet the HRD needs of the Department through appropriate education, training and development interventions for health workers to enable them to render health services.

The priority is to ensure a multi-year rolling plan that supports the development and provision of a critical mass of health worked fro the Department to enable it to render its core business of health service delivery.

Over a period of four years the Department embarked on a process of rationalising its four former nursing colleges through consolidation of all resources and academic functions. Consequently the consolidation outcome resulted in the closure of the four former colleges in December 1999, and the relocation of all resources and academic functions to the Western Cape College of Nursing, (WCCN), which was established in January 2000.

The final phase of the transformation agenda will see the relocation of the Western Cape College of Nursing to the Cape Peninsula University of Technology as supported by the provisions of the Higher Education Act.

At present the WCCN has both employee student nurses and bursar students, and it is expected that they conclude their training in 2005 and 2006 respectively. Further admissions will be under the auspices of the Cape Peninsula University of technology and / or the Western Cape College of Nursing

The Department remains a committed partner in ensuring that sustainable levels of competent health practitioners are educated to meet the regional health service needs, and to this end the Department has been a key supporter in contributing towards the advancement of nursing education at various levels.

The establishment of learnerships in partnership with the Health and Welfare Sector Education Training Authority (HWSETA) will be further strengthened to alleviate unemployment and poverty by providing skills development and employment access opportunities.

The following table highlights the number of nurses that are expected to qualify over the MTEF period.

Table 6.1: Number of expected nursing graduates

4th Year Students	**2004/05 (Target)**	**2005/06 (Target)**	**2006/07 (Target)**	**2007/08 (Target)**
R 425 Diploma (Bursary students)	0	0	152	6
R 425 Diploma (Salaried students)	121	142	14	0
B Cur (Bursary students)	3	93	140	434
B Cur (Salaried students)	84	21	2	0
Total number of qualified nurses	**208**	**256**	**308**	**440**

Note: Salaried students will be phased out by the 2007 academic year

Key learnerships have already been implemented in nursing for unemployed persons and as pharmacist assistants for existing employees (SASO category). These and other learnerships will be further explored in 2004/05 year for possible expansion, dependent upon funding support.

Human resource development at a Departmental level can promote transformation through education, training and development interventions for all personnel as well as potential employees to the health sector.

However, this requires sustained commitment. As part of a coherent human resource development strategy, the gap between existing skills deficits and the desired competency levels of workers and practitioners for all occupational categories must address historical backlogs and the urgent needs of health service delivery towards narrowing and eventually eliminating skills and proper placements in workplace.

Programmes such as ABET (Adult Basic Education and Training), learnerships and management development programmes all contribute towards bridging the skills gap, while providing higher portability of skills and wider opportunities for career paths and employability.

The achievement of Health Care 2010 is reliant upon the provision of constant supply of health science professionals and support staff at sustainable levels to ensure effective service delivery. Training interventions need to be informed by health service needs and priorities and must be designed in such a way as to ensure that learners are empowered to assume the responsibilities and challenges of realities in the workplace.

4. POLICIES, STRATEGIC PRIORITIES AND OBJECTIVES

4.1 POLICIES

A summary list of some of the key mandating legislation and policies that govern the execution of Programme 6 is provided. It is accepted that relevant accompanying prevailing Regulations and Amendments apply.

Acts of Parliament of South Africa

- Constitution of the Republic of South Africa, 1998 (Act No. 108 of 1996)
- Skills Development Act, 1998 (Act No. 97 of 1998)
- Skills Development Levies Act, 1999 (No. 97 of 1998)
- South African Qualifications Act, 1995
- National Education Policy Act (Act No. 27 of 1996)
- Further Education and Training Act (Act No. 98 of 1998)
- Higher Education and Training Act (Act No. 101 of 1997)
- Adult Basic Education and Training Act (Act No. 52 of 2000)
- Public Finance Management Act, 1999 (Act No. 1 of 1999)
- Labour Relations Act, 1995 (Act No. 66 of 1995)
- Public Administrative Justice Act
- Employment Equity Act, 1998 (Act No. 55 of 1998)
- Public Service Act, 1994 (Act No. 103 of 1994)
- Basic Conditions of Employment Act, (Act No. 75 of 1997)
- Occupational Health and Safety Act, 1993 (Act No. 63 of 1993)
- Health Act, 1977 (Act No. 63 of 1977)
- Nursing Act, 1978 (Act No. 50 of 1978)

Western Cape Province

- Training of Nurses and Midwives Ordinance, 1994 (Ordinance No. 4 of 1984)
- Constitution of the Western Cape, 1997 (Act No. 1 of 1998)
- Western Cape Provincial Languages Act, 1998

White Papers

- White Paper on Reconstruction and Development, 1994
- White Paper on Transformation of the Public Service, 1995
- White Paper on Human Resource Management, 1997
- White Paper on Transformation of the Health System of South Africa, 1997

Policies and Plans

- Human Resource Development Strategy for South Africa, 2001
- Human Resource Development Strategy of the Public Service, 2002
- Integrated Human Resource Planning, 2002
- Western Cape Provincial Health Plan, 1995
- Health Care 2010, 2002 (WC)
- ikapa Elihlumayo, 2003 (WC)
- Departmental Policy for Full Time Higher Education Bursaries (WC)
- Bursary Contract for Full Time Bursar Students

Collective Agreements

- Public Service Co-ordinating Bargaining Council (PSCBC) Collective Agreements
- Provincial Service Bargaining Council Agreements

4.2 STRATEGIC PRIORITIES

The key strategic priorities to be addressed within the Health Care 2010 plan context includes the following:

Plans to address shortfall in the number of professionals being trained in order to meet future service requirements are:

- Increase critical mass of nurses based on health service needs and priorities
- Increase critical mass of health science professionals and support staff in scarce skills, based on health service needs and priorities (pharmacists, radiographers, medical / clinical technologists, medical physicists, industrial technicians)
- Support the broadening of clinical teaching/ learning platform to widen access to health science students in support of recruitment and retention
- Secure the budget for fulltime and part-time bursaries to attain the targets for delivery in terms of Health Care 2010
- Increase the critical mass of pharmacist assistants, enrolled nurse assistants and enrolled nurses through the learnership programme

Plans to ensure the relevance and quality of training programmes are:

- Alignment of HRD strategies with policy directives of the skills development legislation, the HRD transformation agenda, and the Departmental Health Care 2010 plan for service delivery.
- A review of decentralised Primary Health Care training to assess alignment of departmental training to Health Care 2010 priorities
- Strengthen partnerships with Higher Education Institutions.

Plans to address the training skills and competencies gap, both in-service and pre-service are:

- Training programmes for clinical nurse practitioners
- Reorientation programmes for primary health care
- Training programmes for mid-level workers through short courses, learnerships, mentoring
- Enhance capacity of health science professionals through encouraging appropriate CPD training
- Programmes such as integrated management of childhood illnesses and home based care are programmes coordinated under the Chief Directorate: Programmes
- ABET programmes for staff all contribute towards bridging the skills gap, while providing higher portability of skills and wider opportunities for career paths and employability.
- The establishment of learnerships in partnership with the Health and Welfare Sector Education Training Authority (HWSETA) some of which will be intended to alleviate unemployment and poverty by providing skills development and employment access opportunities.

The training strategy should include interventions in the following key areas:

- Functional / generic training to ensure competency on the job
- Technical skills training to support specialist / dedicated areas of skills
- Management training to support effective management of all public resources and policy implementation
- Computer-based training to increase and enhance efficacy and efficiency levels
- Learnerships to alleviate unemployment and increase employability
- In-service training to ensure continuous professional development

The Western Cape College of Nursing is being transferred to the Cape Peninsula University of Technology (CPUT).

5. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.1 Budget Constraint

Limitations to the training budget will mean that not all the training objectives and targets will not be met with a subsequent negative impact on service delivery. The financial management and control of training budgets in alignment with the provisions and prescripts of the Public Finance Management Act and Treasury Regulations will ensure the effective, efficient, economic and appropriate utilisation of resources.

Measures to overcome constraint

Secure adequate funding to meet HRD objectives and targets, which have been aligned to service delivery needs.

Extension of a bursary scheme to support the development of a critical mass of health professionals.

5.2 **HR constraint**

New policy demands for programme managers. New appointments in HRD posts.

Measure to overcome constraint

Ensure continuous professional development, support and mentorship of programme managers to address skills development needs.

5.3. **HRD Information System**

Inadequate fragmented systems

Measure to overcome constraints

Ensure development of an effective and efficient information system as a planning and monitoring instrument.

6. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 6.2: Provincial objectives and performance indicators for human resource development [HR2]

Programme 6.1: Nurse Training College

Objective		Indicator	2001/02 (actual	2002/03 (actual)	2003/04 (estimate)	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08 (target)
6.1.1	**Nurse Training: R425 Nursing Diploma Programme and B Cur Nursing Science Programme**	**Input:** 4-year R425 Diploma / Degree Programme: **Number of student nurses** on the staff establishment (i.e. Employee Students) of the Western Cape College of Nursing (WCCN) trained per year							
		1st Year	273	159	177 [1] [2]	0 [2]	202 [2]	205 [2]	230 [2]
		2nd Year	212	273	174	177	0	202	205
		3rd Year	184	212	208	174	177	0	202
		4th Year	100	184	196	208	174	177	0
		Sub-Total: Basic Nurse Training	**769**	**828**	**755**	**559**	**553**	**584**	**637**
		Output: Progression of successfully trained nurses based on year 1 to year 4 per financial year **Target**: 85% graduates per programme	690	755	645	475	450	475	520
6.1.2	**Post basic nurse Training** Post basic Nurse Training: • Critical Care: General • Critical care: Trauma • Operating Theatre	Input: Number of Professional nurses admitted to the post-basic nurse-training programme. (Employees)							
		1. Critical Care: General	8	10	13	12	15	16	18
		2. Critical care: Trauma	9	14	9	11	12	15	18
		3. Operating Theatre	2	2	0	3	3	4	4
		Sub-Total: Post Basic Nurse Training	**19**	**26**	**22**	**26**	**30**	**35**	**40**
		Output: Progression of successfully trained Professional nurses **Target**: 99% graduates per programme	18	25	21	25	29	34	39
		GRAND TOTAL: Nurse Training	**788**	**854**	**777**	**585**	**583**	**619**	**677**

Notes

1 Bursary system introduced at WCCN: Of 177 students, 165 are bursars and 12 are employee students (8 repeat 1ST year and 4 are on the establishment of Groote Schuur Hospital).

2 This projection is reflected under sub-programme 6.1 and sub-programme 6.3.

Sub Programme 6.2: EMS Training College

Objective	Indicator	2001/02 (actual) [1]	2002/03 (actual)	2003/04 (estimate)	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08 (target)
	Number of intake of students for training per year.							
	1. BAA		294	200	12 [2]	12 [2]	12 [2]	12 [2]
	2. AEA		75	75	24 [3]	24 [3]	24 [3]	24 [3]
	3. Paramedic		15	14	16 [4]	16 [4]	16 [4]	16 [4]
	4. MBR		99	16	24 [5]	24 [5]	24 [5]	24 [5]
	5. IMR		16	12	0 [6]	0 [6]	0 [6]	0 [6]
	6. Flight Medical		17	15	14	14	14	14
	7. CPD Training		60	100	150	150	150	150
	8. National Diploma BMC		60	60	60	60	60	60
	9. Level 3		362	100	0 [7]	0 [7]	0 [7]	0 [7]
6.2 EMS Training Monitor and evaluate the EMS training programmes	**TOTAL: Number of new intake**		**836**	**592**	**300**	**300**	**300**	**300**
	Number of graduates per programme							
	1. BAA		250	170	10	10	10	10
	2. AEA		65	65	20	20	20	20
	3. Paramedic		12	12	14	14	14	14
	4. MBR		85	14	20	20	20	20
	5. IMR		13	10	0	0	0	0
	6. Flight Medical		14	123	12	12	12	12
	7. CPD Training		50	85	150	150	150	150
	8. National Diploma BMC		50	50	50	50	50	50
	9. Level 3		305	85	0	0	0	0
	TOTAL: Number of learners to complete programmes per year.		**844**	**503**	**276**	**276**	**276**	**276**

Notes
1. No data available for the 2001/2002 financial year.
2. Number of candidates reduced due to less need in service for this qualification, i.e. percentage targets for this qualification have been reached.
3. Training capacity limited due to availability of only one instructor
4. The number of candidates has been increased as there is a greater need for paramedics specifically in the rural areas.
5. Training capacity limited due to availability of only one instructor
6. Course redesigned for compliance with HPCSA accreditation standards
7. Entrance level course for BAA ([2]) course. No longer required as limited capacity on BAA.

Sub Programme 6.3 Bursaries

Objective	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
6.3.1 Nursing Bursaries Identify nurse training needs based on service delivery priorities for all categories of nursing: • Bridging Nurse Training • Basic Nurse Training • Post basic / post registration Nurse Training	Input: 1. Number of new bursary students admitted to nurse training (basic and post-basic nursing) [1] 1.1. Bridging Nurse Training – Mid Level (ENA To EN and EN To RN)							
	ENA	3	10	27	150	40	40	40
	EN	19	75	35	100	40	40	40
	Sub-Total: Bridging Nurse Training	**22**	**85**	**62**	**250**	**80**	**80**	**80**
	1.2. Basic Nurse Training							
	R425 Nursing Diploma	0	0 [1]	169 [2]	0 [2]	202 [2]	205 [2]	230 [2]
	B Cur Nursing Science	0	119	188	407	300	345	370
	Sub –Total: Basic Nurse Training	**0**	**119**	**357**	**407**	**502**	**550**	**600**
	1.3. Post basic Nurse Training							
	(Clinical specialty/ non clinical for RN)	**36**	**73**	**118**	**120**	**42**	**50**	**50**
	TOTAL: Number of new students admitted to nurse training	**58**	**277**	**537**	**777**	**624**	**680**	**730**
	Throughput 2. Maintenance of existing nursing bursaries 2.1. Bridging Nurse Training Mid Level (ENA To EN and EN To RN)							
	2.1.1 EN	**0**	**0**	**35**	**26**	**50**	**50**	**50**
	2.2. Basic Nurse Training							
	R425 Nursing Diploma	0	0	0	169	161	568	618
	B Cur Nursing Science	0	0	119	297	667	915	1126
	Sub –Total: Basic Nurse Training	**0**	**0**	**119**	**466**	**828**	**1483**	**1744**
	2.3. Post basic Nurse Training	0	0	**50**	**61**	**40**	**40**	**40**
	TOTAL: Maintenance of existing nursing bursaries	**0**	**0**	**204**	**553**	**918**	**1573**	**1834**
	GRAND TOTAL: Nursing Bursaries	**58**	**277**	**741**	**1330**	**1542**	**2253**	**2564**

Notes
1 Employee students at WCCN. Bursary introduced at WCCN during 2003/04.
2 This projection is reflected under sub-programme 6.1 and sub-programme 6.3.

Objective	Indicator	2001/04 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
6.3.2 Bursaries for Health Science, excluding nursing Identify training needs based on service delivery priorities for all categories of health science students.	**1. New bursaries for:**							
	1.1. Full-time studies.							
	1.1.1 Health Science	55	110	115	117	96	100	136
	1.1.2 Support Services	0	3	0	0	0	0	0
	Sub –Total:	**55**	**113**	**115**	**117**	**96**	**89**	**136**
	1.2 Part-time studies	79	89	71	31	262	291	400
	TOTAL: Number of new students admitted to health science training	**134**	**202**	**186**	**148**	**358**	**391**	**536**
	2. Maintenance of existing bursaries							
	2.1. Full-time studies.							
	2.1.1 Health Science	59	91	133	182	199	170	191
	2.1.2 Support Services	0		2	0	0	0	0
	Sub –Total:	**59**	**91**	**135**	**182**	**199**	**170**	**191**
	2.2 Part-time studies	55	119	95	77	59	189	222
	TOTAL: Maintenance of existing health science bursaries	**114**	**210**	**230**	**259**	**258**	**359**	**413**
	GRAND TOTAL: Bursaries for Health Science, excl. Nursing	**248**	**412**	**416**	**360**	**616**	**750**	**949**

Sub Programme 6.4: Primary Health Care Training

Objective	Indicator	2001/02 (actual	2002/03 (actual)	2003/04 (estimate)	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08 (target)
6.4.1. Primary Health Care Training [1] Provision of PHC related training interventions for personnel, provided by the regions	Number of training interventions provided to PHC personnel	N/A [2]	2013	5467	6000	6500	6800	7100
Notes 1. This budget is decentralised to and accounted for by the regions. This is not in a separate envelope It is recommended that Primary Health Care-related Training is costed and funded by the regions and a separate funding envelope is identified within the regional budgets 2. No data collected.								

Sub Programme 6.5: Training (Other)

Objective	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (estimate)	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08 (target)
6.5.1 Levy payment to HWSETA [1]			R 1 440	R 1 654	R 1 873	R 1 966 [2]	R 2 065	R 2 170
Notes 1. Administrative levy payable to HWSETA in terms of skills development legislation. 2. Increase of 5% per annum in HWSETA levy to allow for increase in personnel budget								
6.5.2 Workplace Skills Plan Coordinate the implementation of the Departmental Workplace Skills Plan through the provision of training and development of personnel within the Department	Number of training interventions provided to personnel	14125 [1]	8338 [2]	15286	15500	15800	16300	16600
6.5.3 Management and Leadership Development Skills [3] Ensure appropriate development of human resources to support health service delivery through the development of management and leadership development skills	Number of management and leadership development training opportunities	153	838	663	750	900 [4]	860	860
6.5.4 ABET [5] Ensure appropriate development of human resources to support health delivery through the provision of ABET training [6]	Number of ABET learners registered for courses.	1841	160	545	1000	1100	1400	1600
6.5.5 Learnerships [7] Ensure appropriate development of human resources to support health delivery through the provision of learnerships for personnel	Number of learnerships provided to employed personnel	N/A	N/A	0	382	420	440	465
Contribute to the goals of iKapa Elihlumayo through provision of learnerships for unemployed people	Number of learnerships provided to unemployed persons			19	142	160	170	190
	TOTAL			19	524	580 [8]	610 [8]	655 [8]

Objective	Indicator	2001/02 (actual)	2002/03 (actual)	2003/04 (estimate)	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08 (target)
6.5.6 Internships [9] Partner Higher Education Institutions to contribute to the growth and development of the province through the provision of internships	Number of interns placed	N/A	N/A	21	36	50	60	70

Notes
1. Data collected manually.
2. Variance due to new system of data collection. Data reporting error due to non-receipt of reports from some components. Had reports been received, variance would have been reflected in same reporting statistical band
3. Target group is Senior Officials, Deputy Directors, and Assistant Directors. In addition personnel, in other categories who have financial / management responsibilities
4. Additional finance training due to critical need
5. Figures reflect ABET learners : interventions from ABET level 1 to NQF level 4.
6. Delivery of ABET programme will be operationalised in partnership with Western Cape Education Department (WCED)
7. Learnerships : Enrolled Nurse Assistants, Enrolled Nurses, Pharmacist Assistants : Funded by HWSETA
8 Increase of 5% per annum.
9. Internships : workplace learning opportunities for students (excludes Health Professional interns)

End-note: HRD perspectives

Training is in alignment with iKapa Elihlumayo, HealthCare 2010 and the Social Cluster set up by the Provincial Cabinet in March 2003.

HealthCare 2010

- Train, retrain and retain staff in health facilities, with increased emphasis on primary health care clinics, district level services and staff at community level.

iKapa Elihlumayo

- Broadening base of skills amongst personnel toward an economically viable and valued workforce in increasing and sustaining growth and development

Social Cluster

- Social cluster with Social Services & Poverty Alleviation, Education, Cultural Affairs and Sport, Community safety and Housing.
- Establish strategic partnerships (Delivery of ABET with WCED the service provider: Establish Memorandum of Understanding)
- Broaden base of skills; personnel remain employable thereby maintaining a sustainable social net

Table 6.3: Situational analysis and projected performance for health sciences and training [HR4]

Indicator	Type	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	National target for 2007/08
Input									
1. Intake of medical students	No								
2. Intake of nurse students	No								
3. Students with bursaries from the province	No	284	689	1 157	1 700	2 670	3 282	3 823	
Process									
4. Attrition rates in first year of medical school	%								10
5. Attrition rates in first year of nursing school	%	19	10	10	15	15	15	15	10
Output									
6. Basic medical students graduating	No								
7. Basic nurse students graduating	No	155	179	196	211	211	298	445	
8. Medical registrars graduating	No								
9. Advanced nurse students graduating	No	55	99	140	146	150	150	150	
Efficiency									
10. Average training cost per basic nursing graduate	R	40,576	32,709	34,663	37,674	39,214	26,000	26,000	
11. Development component of HPT & D grant spent	%								100

Notes:
I

Indicators 1 & 6: Information regarding medical students is not available at present.

ndicator 2: It is assumed that this information relates to 1st year intake only. The data available are only for bursaries and / or posts funded by Western Cape Dept. of Health, which does not include self funded nurse students.
Actual data: 2001/02 = 273; 2002/03 = 278; 2003/04 = 365; 2004/05 = 407
Projected data: 2005/06 = 500; 2006/07 = 550; 2007/08 = 600

Indicator 5 & 9: This data is only for the Western Cape College of Nursing.

Indicator 7: It is assumed that this information relates to 4th year graduates only. The data available are only for bursaries and / or posts funded by Western Cape Dept. of Health, which does not include self funded nurse students.

Indicator 10: For the 2001/02 financial year nurse students were in salaried posts. The bursary system for nurse training was introduced during the 2002/03 financial year.
From the 2006/07 financial year the variance in the average training cost is due to the phasing out of salaries students and the funding of bursary students only.

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

Health Sciences and Training is allocated 1,5% of the budget in 2005/06 as was the case in 2004/05. There is a nominal increase of 11.44% in 2005/06 to Programme 6.

Table 6.4: Trends in provincial public health expenditure for Health Sciences and Training (R million) [HR5]

Expenditure (R million)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	58 132	65 381	71 117	75 058	---	---	---
Total per person	12.85	14.23	15.24	15.84	---	---	---
Total per uninsured person	17.60	19.49	20.88	21.70	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	70 805	72 508	74 815	75 058	**83 648**	88 917	94 163
Total per person	15.65	15.78	16.03	15.84	**17.38**	18.19	18.97
Total per uninsured person	21.44	21.62	21.96	21.70	**23.81**	24.92	25.99
Total capital							

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

1. AIM: To render support services required by the Department to realise its aims

2. PROGRAMME STRUCTURE

Programme 7.1: Laundry Services:
Rendering a laundry service to hospitals, care and rehabilitation centres and certain local authorities.

Programme 7.2: Engineering Services
Rendering a maintenance service to equipment and engineering installations, and minor maintenance to buildings.

Programme 7.3: Forensic Services
Rendering specialised forensic and medico-legal services in order to establish the circumstances and causes surrounding unnatural death.

Programme 7.4: Orthotic and Prosthetic Services
Rendering specialised orthotic and prosthetic services.

Programme 7.5: Medicine Trading Account
Managing the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities.

3. SUB-PROGRAMME 7.1 LAUNDRY SERVICES

3.1 SITUATION ANALYSIS

Laundry services are provided by large central laundries at Tygerberg, Lentegeur and George Hospitals. Several rural hospitals have small in-house laundries. Over the past seven years much of the laundry service has been successfully outsourced resulting in significantly reduced costs. The outsourcing has not only had a direct cost benefit in that the outsourced service is less expensive, but has resulted in a substantial reduction in overtime worked at in-house laundries. However, due to the limited two-year contract periods being awarded to the private sector laundries a number of the larger operations that had the capacity to process the Department's linen have shut down. There is only one large private laundry able to process the work from the larger institutions. This is of great concern and impacts negatively on the cost of providing laundry services.

Maintaining the operational status of the Department's in-house laundries is of the utmost strategic importance as a number of private sector laundries have failed over recent years.

Fortunately the in-house laundries have been able to meet the service requirements at the affected hospitals and institutions.

No major equipment has been replaced for more than 10 years, which is of concern as the in-house laundry services are not sustainable without equipment replacements. It is envisaged that approximately R20 million will be required to replace ageing equipment and to conform to the South African National Standard (SANS) over the next 5 years. Unfortunately no funding is available for the replacement of this equipment in the coming year.

3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

In order to provide a cost effective service with minimum risk, a combination of in-house and outsourced laundry services has been instituted. The immediate priority is to increase the efficiency of in-house services. Large volumes of work are imperative for the strategic laundries to make them cost-competitive with the private sector. Recent productivity gains have led to a shift of work from the private sector to the in-house laundries. This was necessary to ensure that personnel resources were fully utilised.

A funding priority that has been identified is the allocation of R1,1 million for the laundry contract at Red Cross Children's Hospital.

3.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The relatively high salaries of in-house laundry personnel coupled with low productivity are a significant constraint to making these laundries cost competitive. A gradual reduction in staff coupled with morale building and training is improving the situation. At Tygerberg Laundry this has shown a measure of success and additional work has been brought into the plant to improve cost effectiveness.

The lack of capacity in the private sector has a negative effect on laundry service costs. A plan to build capacity has been developed. Period contracts have been extended from 2 years to 5 years to make contracts financially viable for private contractors.

3.4 PLANNED QUALITY IMPROVEMENT MEASURES

A plan to replace ageing equipment over the next 5 years is being developed.

3.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.1

Table 7.1: Provincial objectives and performance indicators for Laundry services

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Provide a laundry service to all provincial hospitals	A combination of strategic in-house and out-sourced services	Clean and disinfected linen	Number of pieces laundered **Target:** 22 million pieces per annum	Production records	Number of pieces laundered	Number of pieces laundered	1 (year)	DD: Laundry Services	Yes
Provide cost effective in-house laundry service	Personnel productivity, production cost control and increased volumes	Average cost per item processed competitive with out-sourced service	Average cost per item **Target:** R1-50 per item	Production records and financial statements	Average cost per item	Total cost of in-house laundries	Total number of items laundered in-house	DD: Laundry Services and Institutions	Yes
Provide cost effective out-sourced laundry service	Competitive tendering process	Lowest average cost per item processed	Average cost per item **Target:** R1-10 per item	Production records and financial statements	Average cost per item	Total cost of out-sourced laundry service	Total number of items laundered by out-sourced laundry service	DD: Laundry Services and contractors	Yes

Objective	Indicator[1]	2002/03 (actual)[2]	2003/04 (estimate)[2]	2004/05 (target)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Provide a laundry service to all provincial hospitals	Total number of pieces laundered:	21m	21m	22m	23m	23m	23m
	Number of pieces laundered: in-house laundries	14.4m	17m	17m	17.5m	17.5m	17.5m
	Number of pieces laundered: outsourced services	7.6m	5m	5m	5.5m	5.5m	5.5m
Provide cost effective in-house laundry service	Average cost per item	R1.50	R1.68	R1.74	R1.74	R1.74	R1.74
Provide cost effective out-sourced laundry service	Average cost per item	R1.10	R1.15	R1.37	R1.48	R1.60	R1.73

Note: In-house laundry costs **exclude** cost of capital for buildings and equipment
Outsourced costs **include** cost of capital, profit and VAT (all of which are **not** included in the in-house cost).

4. SUB-PROGRAMME 7.2 ENGINEERING SERVICES

4.1 SITUATIONAL ANALYSIS

The policy is that each hospital has its own engineering workshop to provide routine day-to-day maintenance for which a minimal staff complement is provided. However, at some institutions there are no staff, or staff with limited capabilities. Two general engineering workshops (at Zwaanswyk and Bellville) and one clinical engineering workshop (at Vrijzee) provide support to the hospitals. The Bellville, Vrijzee and Zwaanswyk workshops employ engineers, technicians and artisans that are able to assist hospitals with larger and more complex maintenance and repair work. These three workshops are part of the Directorate: Engineering and Technical Support.

4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

All hospital equipment maintenance and repair work is done by the hospital workshop personnel and the Directorate: Engineering and Technical Support.

Maintenance of buildings is a joint venture with Public Works. The latter undertake all major construction, repair and maintenance work at hospitals. The Directorate: Engineering and Technical Support is responsible for prioritising and defining the work to be done by Public Works.

The most urgent priority is to address the backlog of maintenance and rehabilitation of hospital infrastructure. The backlog is currently estimated at over R750 million. A Healthcare 2010 Hospital Infrastructure Plan aimed at addressing the backlog and future infrastructure needs has been compiled. Work is in progress on schemes that will lead to the realisation of Healthcare 2010, the strategic plan of the Department. As part of this plan some of the most dilapidated infrastructure will be disposed of and as this is surplus to the needs of the service, the backlog will be reduced without additional recurrent expenditure

4.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Inadequate funding for maintenance and rehabilitation has been a problem for many years. Coupled to this is inadequate funding for new or replacement medical equipment with the result that the hospital engineering personnel have to resort to innovative measures to keep outdated and obsolete equipment operational. In respect of buildings the focus is largely on safety and minimum functionality rather than rehabilitation and upgrading.

The following funding priorities have been identified:
R500 000 for the filling of critical engineering posts, mainly in clinical engineering; and
R1,2 million for building costs to set up the Chronic Dispensing Unit.

4.4 PLANNED QUALITY IMPROVEMENT MEASURES

The Hospital Revitalisation Programme and the increased availability of funds for new equipment will reduce the maintenance backlog by replacing obsolete buildings, infrastructure and equipment.

Table 7.2: Physical condition of hospital network

Hospitals by type	Average 1996 NHFA condition grading[1]	Any later provincial audit grading (with date)	Outline of major rehabilitation projects since last audit
DISTRICT HOSPITALS			
Beaufort West	4		The construction of a new pharmacy and administration wing.
Caledon	4		Routine maintenance only.
Ceres	5		Routine maintenance only.
Citrusdal	4		Internal and external renovations and painting.
False Bay	4		Internal and external renovations and upgrading in progress.
Hermanus	4		Routine maintenance only.
Knysna	4		Internal and external renovations and painting.
Ladismith	4		Routine maintenance only.
LAPA Munnik	4		Routine maintenance only.
Montagu	2/3		Internal and external renovations and painting.
Mossel Bay	4		Partial internal and external renovations and painting.
Otto du Plessis	3/4		Routine maintenance only.
Oudtshoorn	4		Routine maintenance only.
Riversdale	4		External renovations and painting.
Robertson	4		Routine maintenance only.
Stellenbosch	4		Roof replaced.
Swartland	4		Roof replaced and kitchen upgraded.
Swellendam	4		Routine maintenance only.
Vredenburg	3		Comprehensive revitalisation in progress.
Vredendal	4		Casualty upgraded. Entrance upgrade in progress.
Wesfleur	2		Extensive internal and external repairs and renovations
PROVINCIALLY AIDED DISTRICT HOSPITALS			
Clanwilliam			Ward upgraded for “private” patients.
Laignsburg			One wing converted for use as a clinic.
Murraysburg			OPD added.
Prnce Albert			OPD added.
Radie Kotze			Ward upgraded for “private” patients.
Uniondale			Routine maintenance only.
GENERAL HOSPITALS			
Conradie	1		None – hospital has closed.
Eben Donges	4		New CHC to replace general OPD New 90 bed ward block added. Pharmacy upgraded Comprehensive revitalisation in progress.
GF Jooste	4		Casualty upgraded OPD and staff amenities block added
George	4		New Administration block and nurses home added. New patient reception and specialist OPD added. Several wards upgraded. Comprehensive revitalisation in progress.
Hottentots Holland	3		Maternity wing upgraded.
Karl Bremer	4		Central steam installation converted to point of use electrical heating. Wards and reception upgraded for “private” and hospital patients.
Paarl	3		Casualty upgraded. Central steam installation converted to point of use electrical heating. Hospital identified for priority Revitalisation.
Somerset	4		Central steam installation converted to point of use electrical heating.
Victoria	2		Substantial external renovation of buildings. Central steam installation converted to point of use electrical heating.
CENTRAL HOSPITALS			
Groote Schuur	5		Major renovations and improvements to maternity block and OPD.
Red Cross	4		New specialist OPD added. Prefab buildings replaced with permanent structures. Day theatre extensively upgraded. External renovation of main hospital building. Renovation of nurses home. Central steam installation converted to point of use electrical heating.
Tygerberg	3		Pharmacy upgraded.

Hospitals by type	Average 1996 NHFA condition grading[1]	Any later provincial audit grading (with date)	Outline of major rehabilitation projects since last audit
TUBERCULOSIS HOSPITALS			
Brewelskloof	4		Extensive internal and external repairs and renovations
Brooklyn Chest	4		Ongoing internal and external renovation of wards. Installation of UV lights in progress.
PROVINCIALLY AIDED TB HOSPITALS			
DP Marais SANTA	4		Ablutions upgraded.
Harry Comay SANTA	1		Minor renovations and painting.
PSYCHIATRIC HOSPITALS			
Alexandra	3		Administration and teaching/clinic blocks upgraded. Standby generator replaced.
Lentegeur	4		Renovation of ward blocks in progress.
Nelspoort	3		Central steam installation converted to point of use electrical heating.
Stikland	4		Several ward blocks renovated.
Valkenberg	3		Hospital being scaled down from 1039 to 320 beds. New admissions ward under construction.
CHRONIC MEDICAL AND OTHER SPECIALISED HOSPITALS			
KBH Rehabilitation			None – has been relocated to Lentegeur
Mowbray Maternity	3		Portion of nurses home converted to active birthing unit and ward for “private” patients. Comprehensive renovations and upgrading in progress.
PROVINCIALLY AIDED CHRONIC MEDICAL AND OTHER SPECIALISED			
Booth Memorial			One wing renovated. Standby generator installed.
Die Wieg			Internal and external renovations and painting.
Maitland Cottage Home			Routine maintenance only.
Sarah Fox			
St Josephs Home			Routine maintenance only.
Conradie - Lifecare			Wards upgraded for use by Lifecare

4.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.2

Table 7.3: Provincial objectives and performance indicators for Engineering services

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Effective maintenance of buildings and engineering installations	A combination of in-house and out-sourced maintenance in co-operation with Works	Health facilities that are maintained safe, presentable and fit for purpose	Maintenance backlog as % of replacement value **Target:** <4%	Routine inspections and cost estimates	Maintenance backlog as % of replacement value	Estimated maintenance backlog	Total replacement cost of buildings and engineering installations	Hospital Engineering Services and Works	Yes
Efficient engineering installations	Monitoring of plant efficiency and modification or renewal as necessary	Minimised cost of utilities and operation	Cost of utilities per bed **Target:** R3600 p.a.	Inspections, measurements and bench-marking	Cost of utilities per bed	Cost of utilities	Number of beds	Institutions and Information Management	Not immediately & Yes
Cost effective maintenance of medical equipment	A combination of in-house and out-sourced maintenance	Extended economic life of equipment and increased safety	Number of requisitions completed- in-house/outsourced	Routine inspections and records kept by Technicians	Number of tasks completed-in-house/outsourced.	Number of tasks completed- in-house/outsourced	Number of tasks received	Clinical Engineering Departments	Yes

Objective	Indicator[1]	2002/03 (actual)[2]	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Effective maintenance of buildings and engineering installations	Maintenance backlog as % of replacement value	10%	9%	8%	8%	7%	7%
Efficient engineering installations	Cost of utilities per bed	R3650	R3600	R4 300	R4 200	R4 000	R4 000
Cost effective maintenance of medical equipment	Number of jobs completed – in-house/outsourced	10 050	11 200	12 000	12 800	13 800	13 800

5. SUB-PROGRAMME 7.3 FORENSIC SERVICES

5.1 SITUATIONAL ANALYSIS

Forensic Services are delivered from two components – one at the University of Cape Town Medical School and the other at the University of Stellenbosch.

5.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

To provide a forensic pathology service to the Metropole Region and forensic pathology support service to the other regions in accordance with the provisions of the following Acts: Inquest Act, National Health Act, Human Tissue Act, Births & Death Registration Act, Prisons Act, and the Medical, Dental, & Supplementary Health Services Professions Act.

The Forensic Pathology Service (FPS) aims to render a standardised, objective, impartial and scientifically accurate service, following national protocols and procedures, for the medico-legal investigation of death that serves the judicial process in the Provincial Government of the Western Cape. The priority is to retain the necessary medical expertise to ensure a uniform, high standard of medico-legal autopsy in cases of unnatural death or unattended/ non-ascertained natural deaths.

A strategic objective is to provide training of medical and non-professional staff that is sufficient to ensure that forensic pathology services in the province, and beyond, are adequately resourced. The Division's main function is service delivery to the community in rendering a service in providing medico-legal evidence from the performance of post-mortem examinations in terms of the above mentioned Acts. The components further provide training and consultation on clinical forensic cases for the Province.

Currently, 10 000 medico-legal post-mortems (PM) are performed annually in the Western Cape in order to establish the cause of death in cases as defined in The Inquest Act. Of these 5 600 Medico-Legal post-mortems are performed in the Metropole region, and 4 400 in the rural regions.

Post-mortem statistics have decreased slightly over the past 5 years due to a decrease in the number of cases of natural causes of death being referred to the mortuaries. There is still concern that a substantial number of medico-legal cases are under-reported. The Provincial Department of Health may become aware of unsatisfactory medico-legal post-mortems or complete failure to perform such post-mortems, via complaints voiced by the SA Police Services, the Independent Complaints Directorate, or the Department of Justice. However, few such cases are reported, and those that are, most likely under-represent the scope of the problem, with significant and negative implications for the criminal justice system in South Africa. As a result of this the Provincial Department of Health has identified the need to improve the Forensic Pathology Support in the rural regions. It is anticipated that the

proposed organisational structure for the Forensic Pathology Service, in terms of which the Medico-legal service will be transferred from SAPS to Health will make provision for specialist forensic pathologist support in the regions.

An amount of R779 000 has been allocated to fund two posts.

5.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The high workload and related stress of performing approximately 5 600 medico-legal autopsies per annum results in a high turnover of medical specialists. This could be addressed by providing additional specialist posts of suitable grading.

A present constraint is lack of employment opportunities for the specialists who are trained, in spite of a need for these specialists in rural areas. This is addressed in the proposed organisational structures for the Forensic Pathology Service (transfer of Medico-legal Service from SAPS to Health) with the creation of additional specialised capacity.

The proposed amendment of section 56 of Act 56 of 1974, will have a significant impact on the practice of Forensic Medicine and Pathology nationally. The primary aim of amending section 56 is to change the definition of unnatural deaths. The proposed amendment reads as follows:

Section 56: “The death of a person whilst under the influence of a general anaesthetic or local anaesthetic, or *of* which the administration of an anaesthetic undergoing or as a result of a procedure *of* a therapeutic, diagnostic or palliative nature or of which any aspect of such a procedure has been a contributory cause, shall not be deemed to be a death from natural causes as contemplated in the Inquest Act, 1959 (Act No. 58 *of* 1959), or the Births, Marriages and Deaths Registration Act, 1963 (Act No. 81 of 1963)."

The scope of what will be considered to be an unnatural death will be extended. Therefore the number of autopsies and inquest hearings to be performed will increase significantly which will in turn impact on the financial and human resources required.

5.4 PLANNED QUALITY IMPROVEMENT MEASURES

The proposed transfer of medico-legal mortuaries from SAPS to Health will provide a model for establishing and building a comprehensive Forensic Pathology Service in the Western Cape.

The Forensic Pathology Services in the province are designed to contribute positively to:

1) Ensure the development of a just South African society;
2) Assist in the fight against crime;
3) Assist in the prevention of crime;

4) Assist in the prevention of unnatural death;
5) Endeavour to protect the rights of all persons;
6) Establish the independence of medical and related scientists;
7) Ensure that the service is rendered within a uniform system;
8) Ensure participation of society in the service;
9) Ensure that the service is equitable;
10) Ensure that the service is efficient and cost effective;
11) Ensure the promotion of relevant education, training and research;
12) Rectify the deprived state of the service;
13) Provide for the specific needs of those persons rendering the service; and
14) Establish adequate data collection and processing.

5.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.3

Table 7.4: Provincial objectives and indicators for Forensic services

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Render a forensic pathology service to the Metropole region in accordance with the prevailing statutory requirements	Provision of medico-legal services to Salt River- and Tygerberg, South African Police Services mortuaries	Post-mortem examinations, submission of medico-legal reports and attendance at inquests	Number of post-mortem examinations performed and documented **Target:** 6000	Annual Reports to The Head of Forensic Services, and (National) Department of Health	Number of post mortem examinations	Number of post mortem examinations	1 (year)	Forensic services at GSH and TBH	Yes
Render a cost effective forensic service in the Metropole	Productivity and cost control	Cost effective service	Average cost per examination **Target:** R960-00	FMS and annual reports	Average cost per examination	Total budget	Number of examinations	Forensic services at GSH and TBH	Yes

Objective	Indicator[1]	2002/03 (actual)[2]	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Render a forensic pathology service to the Metropole region in accordance with the prevailing statutory requirements	Number of post mortem examinations	5273	6500	5 650	5600	6 000	6 000
Render a cost effective forensic service in the Metropole	Average cost per examination	R1 037	R1 150	R1 140	R1 390	R1 529	R1 682

6. SUB-PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

6.1 SITUATION ANALYSIS

The Orthotic and Prosthetic (O&P) Service is rendered from a provincial centre situated on the Conradie Hospital site. Orthotist/Prosthetists attend orthopaedic clinics throughout the province. The service in the Southern Cape/Karoo has been successfully outsourced.

6.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The policy is to render an effective, efficient and sustainable service through a combination of in-house and outsourced services. The immediate priority is to recruit, train and retain personnel to sustain the in-house service. The broader strategic objective is to ensure continuity of service delivery through an optimum mix of in-house and outsourced services.

6.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

A major constraint is the inability to attract and retain suitably skilled and experienced personnel. This can be attributed to a shortage of qualified Orthotist/Prosthetists and surgical boot-makers, coupled with uncompetitive salaries. The shortage is being addressed by in-house training programmes. The uncompetitive salaries are part of a larger problem of uncompetitive salaries of registered health support personnel. The outsourcing of more Orthotic services is currently under consideration – purely as a result of inability to attract and retain qualified personnel.

6.4 PLANNED QUALITY IMPROVEMENT MEASURES

Quality improvement focuses on two areas:

- The reduction of waiting times which is being addressed by recruiting additional personnel and outsourcing selected services.
- Working with other professionals in the rehabilitation field to improve the quality of appliances. The relocation of the O&P Centre to the new Provincial Rehabilitation Centre at Lentegeur is under investigation.

6.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

Table 7.5: Provincial objectives and indicators for orthotics and prosthetics

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Render an Orthotic and Prosthetic service for the Province	A combination of in-house and out-sourced services	Orthotic and Prosthetic devices	Number of patients registered and number of devices manufactured **Targets:** 4500 patient registrations. 3500 completed devices	Patient data-base	Number of devices manufactured	Number of devices manufactured	1 (year)	O&P patient data base	Yes
Provide quality devices	Training and liaison with Physiotherapists and Occupational Therapists	Devices that meet patient needs first time	% of devices requiring remanufacture **Target:** <5%	Production records	% of devices requiring remanufacture	Number of devices requiring remanufacture	Total devices manufactured	O&P production data base	Yes
Provide a responsive service	Increase productivity and outsourcing where cost effective	More devices for same cost. Reduced waiting time	Number of patients waiting over 6months **Target:** <600	Patient data-base	Number of patients waiting over 6 months	Number of patients waiting over 6 months	1 (year)	O&P patient data base	Yes

Objective	Indicator[1]	2002/03 (actual)[2]	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Render an Orthotic and Prosthetic service for the Province	Number of devices manufactured	4 500	5 884	4 800	5 000	5 000	5 000
Provide quality Orthotic and Prosthetic devices	% of devices requiring remanufacture	5%	3%	3%	3%	2%	2%
Provide a responsive Orthotic and Prosthetic service	Number of patients on waiting list waiting over 6 months	600	15.0	600	800	800	700

7. SUB-PROGRAMME 7.5 MEDICINE TRADING ACCOUNT

7.1 SITUATION ANALYSIS

The Cape Medical Depot (CMD), operating on a trading account, is responsible for the purchasing, warehousing and distribution of pharmaceuticals and medical sundries. Orders are supplied in bulk to larger hospitals or as smaller one-off items to smaller institutions. The academic hospitals generally buy directly from manufacturers and tend to use the CMD as a top-up service, which adversely affects other institutions.

The CMD is also responsible for pharmaceutical quality control. This is achieved by means of a Quality Control Laboratory (QCL) situated at the Cape Technikon. The Pre-pack Unit currently situated at the Metro Regional Office is responsible for preparing patient ready packs.

7.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

In order to render an effective service, the CMD needs sufficient working capital to maintain adequate stock levels in the face of poor supplier performance, erratic deliveries and erratic demands. The Capital Account was therefore augmented by R4,103 million during the 2004/05 financial year. However, this amount is still insufficient as an additional R13 million is required.

The immediate priority is to obtain Cabinet approval for the abolition of the interest levied on working capital employed which impedes efficient performance. This will enable the CMD to adequately fund the Capital Account to meet demands.

7.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Inadequate working capital is an on-going problem. Motivations have been made annually to augment the working capital in line with the inflationary price increase percentage for pharmaceuticals, taking into account the annual turnover of the CMD. As indicated in paragraph 7.2 the Capital Account was augmented by R4, 103 million during 2004/05 and it is anticipated that the R13 million shortfall will be addressed in due course.

7.4 PLANNED QUALITY IMPROVEMENT MEASURES

The upgrading of the CMD to comply with the Pharmacy Act is a priority and although essential is not funded in the 2005/6 year.

7.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.5

Table 7.6: Provincial objectives and performance indicators for the MEDPAS trading account

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Ensure availability of essential drugs	Monitor stock levels in terms of demand and supplier performance	Dues out below 60	Dues out below 60 items **Target:** <60	Dues out reports	No of items on dues	No of items with Nil balance	1	Medsas	Yes
Efficient utilisation of working capital	Monitor low turnover items and put on DDV's	Stock turnover 8 or more times per year	Stock turnover **Target:** >8	Medsas report	Stock turnover	Stock issued	Working capital	Medsas	Yes
Adequate working capital to support adequate stockholding	Increase working capital in line with projected inflator	Adequate working capital	Sufficient working capital to keep stock turnover below 12	Increased Working capital	Stock turnover	Stock issued	Working capital	Medsas	Yes
Sufficient stock available at end-user level	Number of demands to be satisfies within 48 Hours	Service level above 85%	Service level Target: >85%	Medsas reports	Service level	No of demands satisfied	Total no of demands	Medsas	Yes

Objective	Indicator	2002/03 (actual)[2]	2003/04 (actual)	2004/05 (estimate)	2005/06 (target)	2006/07 (target)	2007/08 (target)
Ensure availability of essential drugs	No of items on dues	61	60	60	60	60	60
Efficient utilisation of working capital	Stock turnover	8.7	9	9	9	9	9
Adequate working capital to support adequate stockholding	Stock turnover	32 million	46 million	46 million	53 million	59 million	59 million
Sufficient stock available at end-user level	Service level	81,5%	> 85%	> 85%	> 85%	> 95%	> 95%

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

Health Care Support Services is allocated 1.5% of the vote in 2005/06 in comparison to 1.8% allocated in 2004/05. It is noted that in 2004/05 an amount of R12 million was allocated for various items of once-off expenditure, i.e. R5 million for the purchase of linen for the laundries, R5 million of fire detection systems at Tygerberg and Groote Schuur Hospitals and R2 million to augment the capital of the CMD. The allocation to Programme 7 therefore decreases by 3.82% in nominal terms in 2005/06.

Table 7.7: Trends in Health Care Support Services expenditure (R million)

Expenditure (R million)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	67 526	66 597	73 837	90 934	---	---	---
Total per person	14.93	14.49	15.82	19.19	---	---	---
Total per uninsured person	20.45	19.86	21.68	26.29	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	82 247	73 856	77 677	90 934	**87 457**	92 965	98 457
Total per person	18.18	16.07	16.65	19.19	**18.17**	19.02	19.84
Total per uninsured person	24.90	22.02	22.80	26.29	**24.90**	26.06	27.18
Total capital							

Note: Current price projections for the MTEF period are not required as these figures will be the same as the constant price projections for the same years.

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

1. AIM:

To provide for new health facilities, upgrading and maintenance of existing facilities, including the Hospital Revitalisation Programme and the Hospital Infrastructure Grant.

2. PROGRAMME STRUCTURE

Sub-programme 8.1: Community health facilities

Sub-programme 8.2: Emergency medical rescue

Sub-programme 8.3: District hospital services

Sub-programme 8.4: Provincial hospital services

Sub-programme 8.5: Central hospital services

Sub-programme 8.6: Other facilities

Programme 8 includes: the management of capital assets, i.e. health facilities and equipment (medical equipment and furniture) in all programmes.

ACCURACY OF INFORMATION

Where possible, audited or verified information has been used to calculate the values in the tables in this section. However, in many instances the calculations are based on estimates based on experience or trends. Further this programme was transferred form the Department of Transport and Public Works after a decision taken late in 2004. For this reason the strategic plan reflected here is to an extent provisional and will be reviewed in detail during the 2005/6 financial year.

3. SITUATION ANALYSIS

The existing hospital infrastructure is not affordable. The original design capacity of the existing infrastructure is over 15,000 beds and the requirement for Healthcare 2010 is approximately 9,600 beds. Much of the theoretical excess of over 5,000 beds is located in dilapidated buildings or in institutions that are poorly located in terms of the population they serve and thus do not meet the accessibility and equity criteria for Healthcare 2010. A number of hospitals are on excessively large sites where the cost of securing and maintaining the sites is unaffordable.

In 1999, a Public Works survey estimated the backlog of maintenance and rehabilitation work at hospitals to be in the order of R500 million. The replacement value of the buildings was then estimated at R5 billion. Based on a maintenance budget of 4% of replacement cost, expenditure on maintenance should have been R200 million per annum (R300 million in 2004 rands). The fact that maintenance expenditure has been less than R200 million means that

the backlog has grown since 1999. The growth is considerable if inflation is taken into account and the backlog is now considered to be in the order of R750 million – this excludes any upgrading. An important feature of the Healthcare 2010 Infrastructure Plan is that some of the worst infrastructure will be disposed of, thereby reducing the backlog and simultaneously releasing available funding to upgrade the rest.

Rural hospital infrastructure

The rural hospital infrastructure is in relatively good condition. Much of the unsatisfactory infrastructure will be upgraded in the near future:

- The revitalisation of George, Worcester and Vredenburg Hospitals is proceeding well.
- The revitalisation of Paarl hospital is scheduled to commence in 2005/6.
- The major downscaling of Nelspoort Hospital and the renovation of the small remaining portion is in progress.

Metropole hospital infrastructure

In contrast to the rural hospital infrastructure, the Metropole hospitals are in poor condition and many are no longer fit for purpose in respect of condition, design and locality. During 2004 Conradie Hospital was finally closed with the transfer of services to Groote Schuur Hospital and the newly constructed Western Cape Rehabilitation Centre. The Healthcare 2010 Infrastructure Plan proposes the upgrading and/or replacement of many Metropole hospitals.

Equipment

There is an urgent need for the replacement of much of the hospital equipment. In the 2003/4 year a programme to replace defective and obsolete equipment was commenced. The programme has been assisted by donor funding (Red Cross hospital) and equipment supplied in terms of the Hospital Revitalisation Programme at the hospitals mentioned above. The need for new and replacement equipment is such that this programme will be on-going for many years.

4. POLICIES, PRIORITIES AND STRATEGIC GOALS

It was decided at provincial level that the funding for the Works function for Health be transferred from the Department of Public Works to the Department of Health from 1 April 2005. The funding for the Property Management function (purchase, sale, rental and leasing of property) remains with Works. A Memorandum of Understanding will be entered into between the Department of Transport and Public Works and the Department of Health in order to clarify the process according to which the reciprocal responsibilities of these departments will be defined.

The Department has prioritised the development of infrastructure in line with Healthcare 2010 and this is reflected in the Hospital Revitalisation Projects at George, Worcester and Vredenburg. It is envisaged that the next project will be Paarl Hospital which will commence during 2005/06.

Planning is in progress to begin construction for a district hospital to serve the community of Khayelitsha. Other major projects include Mowbray Maternity Hospital, Caledon and Riversdale Hospitals and the improvements to ambulance stations.

The development of a service plan in line with Healthcare 2010 will give further direction to the prioritisation of facilities that need to be upgraded.

The forensic mortuaries are in the process of being transferred from the South African Police Services to the Department of Health. The physical infrastructure needs to be upgraded to meet the requirements of the Occupational Health and Safety Act, for which conditional grant funding is being made available.

There are terms in the Pharmacy and Medicines Acts that relate to the infrastructure requirements. These requirements will become binding on the State as of 1 July 2005. These statutory requirements have significant financial implications and are presently unfunded.

The Department of Health has embarked upon a process to establish a Chronic Dispensing Unit to improve the provision of chronic medication. The infrastructure must be upgraded to accommodate this.

The Healthcare 2010 Hospital Infrastructure Plan (July 2004) outlines the way forward for the upgrading and replacement of hospitals. Similar infrastructure plans are being compiled for Primary Health Care facilities and Emergency Medical Services ambulance stations.

5. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The improvement of physical facilities is heavily dependent on the success of the Hospital Revitalisation Programme. This programme got off to a slow start in all provinces but is now proceeding rapidly in the Western Cape. Every effort will be made to ensure the success of the present projects to ensure that the programme is eventually extended to include all hospitals.

Equipment maintenance is also a problem and steps have already been taken to strengthen Clinical Engineering. This includes improved salaries in an attempt to recruit and retain highly specialised personnel.

Table 8.1: Historic and planned capital expenditure by type [HFM1]

R 000's	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/7 (MTEF projection)	2007/08 (MTEF projection)
Major capital (Health)	10 979	8 282	17 350	33 747	18 000	18 000	18 000
Major capital (HRP)	35 293	36 954	81 939	127 427	172 038	202 000	198 000
Major capital (PIG)	4 880	25 483	36 324	51 878	55 229	61 829	80 262
Major capital (Donor RCCH)	6 904	5 575	9 147	11 400	16 000	0	0
Maintenance & minor capital	18 108	30 210	71 677	70 169	69 262	76 462	85 000
Equipment	61 319	61 277	92 679	108 745	112 000	116 000	120 000
Equipment (Donor RCCH)	6 702	2 882	9 734	3 737	0	0	0
Equip maintenance	45 429	48 025	50 426	49 766	52 254	54 867	57 610
Total capital	**189 614**	**218 688**	**369 276**	**456 869**	**494 783**	**529 158**	**558 872**

Notes on table HFM 1
1. "Maintenance & minor capital" is the "maintenance" expenditure by Public Works.
2. "Equipment maintenance" excludes the personnel costs of Hospital and Clinical Engineering workshop personnel.

Table 8.2: Summary of sources of funding for capital expenditure [HFM2]

R 000's	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/7 (MTEF projection)	2007/08 (MTEF projection)
Equitable share	10 979	8 282	17 350	33 747	18 000	18 000	18 000
Revitalisation grant[1]	35 293	36 954	81 939	127 427	172 038	202 000	198 000
Infrastructure grant	4 880	25 483	36 324	44 869	51 878	61 829	80 262
Donor funding (RCCH)	6 904	5 575	9 147	11 400	16 000	0	0
Other	18 108	30 210	71 677	45 963	69 262	76 462	85 000
Total capital	**61 319**	**61 277**	**92 679**	**263409**	**327 178**	**358 291**	**381 262**

Notes on table HFM 2
1. Hospital rehabilitation and reconstruction grant (HR&R) expenditure prior to 2003/4 is recorded under revitalisation grant

Table 8.3: Historic and planned major project completions by type [HFM3]

	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/7 (MTEF projection)	2007/08 (MTEF projection)
New hospitals	0	0	1	1	0	0	0
New clinics / CHC's	0	0	0	0	4	3	4
Upgraded hospitals				1	3	4	2
Upgraded clinics / CHC's	1	0	0	0	3	0	1

Table 8.4: Total projected long-term capital demand for health facilities management (R'000) [HFM4]

Programme	Province wide total R1 000's	Planning horizon (years)	Province total annualised[4] R1 000's	Annualised		
				District	District	District
Programme 1				**Information not available by District**		
MECs office and Administration[1]	2 000	2	1 000	-	-	-
Programme 2						
Clinics and CHC's	270 000	18	15 000			
Mortuaries	75 300	3	25 100			
District hospitals	864 000	6	144 000			
Programme 3						
EMS infrastructure[1]	40 000	5	8 000	-	-	-
Programme 4						
Regional Hospitals	390 000	5	78 000			
Psychiatric hospitals[1]	227 000	6	37 833	-	-	-
TB hospitals[1]	85 000	6	14 166	-	-	-
Other specialised hospitals[1]	33,000	3	11 000	-	-	-
Programme 5						
Provincial tertiary and national tertiary hospitals[1]	945 000	10	94 500	-	-	-
Other programmes[1,3]						
Compliance with Pharmacy Act.	96 000	3	32 000	-	-	-
Total all programmes	**2 907 300**		**460 599**			

Note on table 8.4 [HFM 4]

1. The above figures are for building work only and specifically exclude equipment, furniture and maintenance
2. The planning horizon is based on expected available cash flows. The horizon could shorten substantially if additional funding is available from conditional grants, donors or the sale of surplus property.
3. The above estimates are based on the 2004 Hospital Infrastructure Plan and will be revised during 2005.
4. The budget for clinic's and CHC's is largely based on existing provincial services. The projection could vary substantially as the full implication of the provincialisation of personal primary health care is determined. Work on an integrated primary health care infrastructure plan is in progress.

Table 8.5: Situation analysis indicators for health facilities management [HFM5]

Indicator	Type	Province wide value 2001/02	Province wide value 2002/03	Province wide value 2003/04	National target 2003/4
Input					
1. Equitable share capital programme as % of total health expenditure	%	0.31	0.22	0.40	1.5
2. Hospitals funded on revitalisation programme	%	3	3	5	17
3. Expenditure on facility (building) maintenance as % of total health expenditure	%	0.51	0.78	1.64	2.5
4. Expenditure on equipment maintenance as % of total health expenditure	%	1.28	1.25	1.15	2
Process					
5. Hospitals with up to date asset register	%				100
6. Health districts with up to date PHC asset register (excl hospitals)	No				All
Quality					
7. Fixed PHC facilities with access to piped water	%	100	100	100	100
8. Fixed PHC facilities with access to mains electricity	%	100	100	100	100
9. Fixed PHC facilities with access to fixed line telephone	%	100	100	100	100
10. Average backlog of service platform in fixed PHC facilities	R	270 000 000	270 000 000	270 000 000	30
11. Average backlog of service platform in district hospitals	R	23 361 284	23 361 284	23 601 284	30
12. Average backlog of service platform in regional hospitals	R	124 723 006	120 437291	120 437 291	30
13. Average backlog of service platform in specialised hospitals	R	54 626 937	54 626936	54 293 641	30
14. Average backlog of service platform in tertiary and central hospitals	R	359 849 408	357 921 375	356 254 708	30
15. Average backlog of service platform in provincially aided hospitals	R	13 066 667	13 066 667	13 066 667	30
Efficiency					
16. Projects completed on time	%	10	10	10	
17. Project budget over run	%	0	5	5	
Outcome					
18. Level 1 beds per 1000 uninsured population	No	0,45	0,45	0,45	100
19. Level 2 beds per 1000 uninsured population	No	0,45	0,45	0,56	65
20. Population within 5km of fixed PHC facility	%	93	93	93	85

Notes on table HFM 5

1. Average backlog of service platform is for building work only and specifically excludes equipment and furniture.

6. SPECIFICATION OF MEASURABLE OBJECTIVEWS AND PERFORMANCE INDICATORS

Table 8.6: Performance indicators for health facilities management [HFM7]

Indicator	Type	2003/04	2004/05	2005/06 Projection	2006/07 Projection	2007/08 Projection	National target 2007/08
Input							
1. Equitable share capital programme as % of total health expenditure	%	0.40	0.71	0.36	0.34	0.33	2.5
2. Hospitals funded on revitalisation programme	%	3	3	4	5	6	25
3. Expenditure on facility maintenance as % of total health expenditure	%	1.64	1.48	1.40	1.46	1.55	4
4. Expenditure on equipment maintenance as % of total health expenditure	%	1.15	1.05	1.05	1.05	1.05	4
Process							
5. Hospitals with up to date asset register	%						100
6. Health districts with up to date PHC asset register (excl hospitals)	No						All
Quality							
7. Fixed PHC facilities with access to piped water	%	100	100	100	100	100	100
8. Fixed PHC facilities with access to mains electricity	%	100	100	100	100	100	100
9. Fixed PHC facilities with access to fixed line telephone	%	100	100	100	100	100	100
10. Average backlog of service platform in fixed PHC facilities	R	270 000 000	270 000 000	270 000 000	265 000 000	260 000 000	15
11. Average backlog of service platform in district hospitals	R	23 601 284	22 341 281	31951484	31468739	26187230	15
12. Average backlog of service platform in regional hospitals	R	120 437 291	116 151 577	97 000 000	53 333 333	26 666 667	15
13. Average backlog of service platform in specialised hospitals	R	54 293 641	43 071 419	42 738 086	39 071 405	34 626 939	15
14. Average backlog of service platform in tertiary and central hospitals	R	356 254 708	352 921 375	349 588 042	346 254 708	336 254 667	15
15. Average backlog of service platform in provincially aided hospitals	R	13 066 667	13 066 667	13 066 667	13 066 667	13 066 667	15
Efficiency							
16. Projects completed on time	%	10	10	25	50	50	
17. Project budget over run	%	**5**	**5**	**0**	**0**	**0**	
18. Level 1 beds per 1000 uninsured population	No	0,45	0,45	0,45	0,75	0,75	90
19. Level 2 beds per 1000 uninsured population	No	0,56	0,55	0,55	0,61	0,60	60
20. Population within 5km of fixed PHC facility	%	93	93	94	94	95	95

Notes on Table H8.6

1. Average backlog of service platform is for building work only and specifically excludes equipment and furniture
2. All hospitals have asset registers but cannot be considered comprehensive at this stage. This is work in progress..

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

Programme 8 is allocated 5.2% of the vote's budget. Expenditure on district hospitals will increase significantly in 2007/08 when the new district hospitals in the Metro are built. Approximately 60% of the funds will be used for facilities management in the provincial hospitals, i.e. Programme 4. Expenditure on the central hospitals will increase as the intensity of planning increases in preparation for major work beyond the MTEF period.

Table 8.7: Trends in provincial public health expenditure for health facilities management (R' million) [HFM8]

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/7 (MTEF projection)	2007/08 (MTEF projection)
Current prices	189,614	218,688	369,276	456,869	494,783	529,158	558,872
Total	189,614	218,688	369,276	456,869	494,783	529,158	456,869
Total per person	41.91	47.82	80.04	98.10	105.32	111.76	117.13
Total per uninsured person	58.21	66.41	111.17	136.25	146.27	155.19	132.93
Constant (2004/05) prices							
Total	221,549	241,708	388,712	456,869	479,159	490,167	403,968
Total per person	48.97	52.85	84.25	98.10	101.99	103.52	84.66
Total per uninsured person	68.01	73.41	117.02	136.25	141.65	143.75	117.54

Table 8.8: Trends in provincial public health expenditure on health facilities management funded from Programme 8 (R' million) [HFM8]

Expenditure	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (estimate)	2005/06 (MTEF projection)	2006/07 (MTEF projection)	2007/08 (MTEF projection)
Current prices							
Total	143 375	100 794	196 176	288 043	---	---	---
Total per person	31.69	21.94	42.04	60.79	---	---	---
Total per uninsured person	43.41	30.05	57.59	83.27	---	---	---
Total capital					---	---	---
Constant (2004/05) prices							
Total	174 631	111 781	206 377	288 043	**296 805**	354 745	379 770
Total per person	38.60	24.33	44.23	60.79	**61.68**	72.59	76.52
Total per uninsured person	52.87	33.33	60.59	83.27	**84.49**	99.44	104.83
Total capital							

Table 8.9: Provisional priorities for hospital revitalisation

Priority	HOSPITAL	2010 Classification	2004 BEDS	2010 beds	Building ESTIMATE R'million	Start	End
1	George	Provincial	202	265	100		2006
2	Eben Donges	Provincial	213	315	160		2007
3	Vredenburg	District	56	80	60		2005
4	Paarl	Provincial	250	326	140	2005/6	2009
5	Khayelitsha	District	0	230	140	2006/7	2009
6	Mitchells Plain	District	0	230	120	2006/7	2009
7	Victoria	District	159	230	140	2007/8	2010
8	Hottentots Holland	District	121	230	140	2007/8	2010
9	Tygerberg	Central	1273	1081	400	2008/9	2014
10	Valkenberg	Psychiatric	385	315	100	2008/9	2012

Notes on the above provisional priorities:

1. The above priorities have been extracted from the 2004 Hospital Infrastructure Plan. This plan will be updated in 2005.
2. Estimates are for building costs only and exclude equipment
3. The estimate of R400 million for Tygerberg is the minimum necessary to upgrade the engineering services and renovate the building. Public Works have proposed a more extensive upgrading that could cost over R800 million. An audit of the hospital infrastructure will be done in 2005 to determine the condition and suitability of the hospital. The scope of work and a more accurate estimate of cost will be possible when the results of the audit are available.

WORKING DRAFT

DEPARTMENT OF HEALTH

SOCIAL CAPITAL FORMATION

1. INTRODUCTION AND BACKGROUND

The focus on social capital in the Western Cape comes at an exciting and challenging time. Within the health sector globally, there is a growing interest in developing mechanisms that link the social and economic aspects of our lives and their impact on our health. This can be seen by the expansion in the amount of research, accompanied by policies and interventions that are adopting a primary health care/health promotion approach to health and disease. Significant within the shift is the level of commitment to strengthening the collaboration between the public sector and civil society organizations, as a means of enhancing local health development (Kahssay et al, in press).

It is commonly acknowledged that living in an inequitable society results in ill health (Wilkinson, 1996; Braveman & Tarimo, 2002). An approach that focuses on social and economic factors that contribute to inequities within and between communities is key to reducing inequities and therefore improving health. Programmes such as the Global Equity Gauge Alliance (GEGA, 2003), being implemented locally Cape Town, provide a framework for achieving this. Giving consideration to equity is particularly important in South Africa, given the vast, and increasing disparities between the rich and poor, and it therefore has significant implications for the way that social capital is addressed in the Western Cape. The approaches and examples cited in the document reflect the importance of such an approach.

The Department of Health's Healthcare 2010 plan outlines a radical shift in health care provision in the Western Cape with a focus on primary-level services, community-based care and preventative care (Healthcare 2010). However the Department is being further challenged to focus on the "social dimension" of health provision.

Premier Ebrahim Rasool in his State of the Province Address in May 2004 stated that: "The holistic strategy of developing our people and solidifying community resilience (social capital) in combination with a well considered economic development path represents a new innovative approach to our philosophy of making the Cape 'A Home for All'" (Rasool, 2004a). This strategy is consistent with the *Ikapa elihlumayo* framework which defines the Social Capital Formation Strategy (SCFS) as one of the lead strategies (Ikapa elihlumayo, 2003).

In June 2004, in his budget vote speech, the Premier introduced the concept of Holistic Governance as a strategy for all departments to realise the government's mandate of 'creating work and fighting poverty' (Rasool, 2004b). The four pillars for Holistic Governance are Integrated Governance, Co-operative Governance, Responsive Governance and Globally Connected Governance. The Premier stated that transformation of personnel management to build internal social capital among its own staff members would form a component of Integrated Governance.

This approach corresponds with the recognition at national level of the need to integrate government departments. In the Western Cape the departments of Health, Education Community Safety, Cultural Affairs and Sport, Social Sciences and Poverty Alleviation, and Local Government and Housing are grouped together in the Social Sector Cluster with the latter department filling the role of lead department in the strategy: Social Capital Formation.

In order to achieve holistic governance, strategies developed by individual departments, need to be consulted with other departments, civil society organizations and academia, and refined as a component of the broader strategies of the social cluster. This inclusive process

of joint planning and implementation needs to filter throughout all spheres of government to facilitate effective service delivery. Strategies which are jointly decided upon at central level will need to be implemented in a coordinated manner at the service delivery interface. This will require a new mindset on the part of managers as well as service providers. Mechanisms will have to be created for joint accountability and reporting to take place.

Concepts of social capital

The extent to which people *participate* in social and civil activities, *volunteer* or donate their time and effort to the community, are considered important dimensions of social capital. These include the experience of a sense of *trust* and *reciprocity* in relationships (be these in terms of individual, social or institutional relationships) and the experience of 'belonging' to a social network. In other words, it assumes a sense of *social inclusion* as opposed to social exclusion or isolation.

Simply put, in this interpretation social capital suggests a *social cohesion* and of having *a sense 'of community'*. It refers to the social (and mutual trusting) relationships and networks that exist between people and that link people together in a community.

However, as with many issues in the social sciences, there are numerous definitions of social capital, with the concept being strongly contested at times. Baum & Ziersch (2003), in their glossary outlining some of the key terms used in considering the field of social capital for health, suggest that there are currently two main schools of thought. The first school, influenced by the work of Robert Putnam conceives social capital as *a community or collective level* resource. Putnam defines it as the 'features of social organisation such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit' (1995, p. 67, quoted in Baum & Ziersch). This school of thought sees social capital as a distinctively social feature reflected in the structure of social relationships.

The second main school of thought, drawing on the work of Bourdieu, focuses on the resources that accrue to *individuals* as a result of their membership of social networks, and suggests that social capital is 'the aggregate of the actual or potential resources which are linked to the possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition (Bourdieu, 1986, p. 79, quoted in Gilbert & Walker, 2002). Bourdieu argues that social capital is inextricably linked to economic capital, with access to economic and cultural resources accruing through social contacts. This implies the reinforcement of economic capital through social capital, and conversely, the reinforcement of material inequities when there are social inequities (Baum 2000).

This latter definition suggests that in addition to the *bonding* social capital, that applies to horizontal links between individuals or groups sharing similar demographic characteristics, *bridging* and *linking* social capital, referring to linkages that cross different communities/individuals is more important (Narayan 1999). This distinction is important, with the former referring to links which may be exclusive, without producing society-wide benefits, whilst the latter, which refers to vertical connections, spans different levels of power. Szreter (2002) suggests that this type of social capital is particularly important in terms of reducing inequities because it encourages people to feel a sense of responsibility for people beyond their bonded group.

One of the core tenets of developmental governance is that communities have to be consulted and informed about decisions affecting service delivery. Only meaningful participation within forums which incorporate the key role-players can lead to true participatory democracy. Although attempts have been made to create clinic committees and health forums in the past, these efforts have often faltered. Reasons for this include a lack of enthusiasm and support from facility managers and staff, "transformation fatigue" on the part of the communities, a lack of funding and support from higher authority structures and role confusion between a multitude of structures within communities. Furthermore, the

lack of clear guidelines around the role of these structures has caused confusion and conflict.

However the Department of Health has made significant progress in the implementation of hospital boards which adhere to the requirements of the Provincial Health Facilities Act (of 2001). It is the Department's intention to use the experience gained from this process to develop structures which give expression to the ideal of participatory governance. The implementation of the Health Act will also give impetus to this process as it makes the creation of District Health Committees compulsory. The functioning of these committees will be overseen by both provincial and local government and are ideal vehicles to improve cooperative governance, as well as accountability.

2. SITUATIONAL ANALYSIS

Although the Western Cape has some of the best indicators of health and socio-economic status in South Africa, there are nevertheless vast disparities between different communities. Whilst the wealthiest communities live in comfortable first world conditions and have good health indicators, the poorest live in conditions comparable with some of the worst found in developing countries and have very poor health indicators.

An examination of one health indicator, Infant Mortality Rate (IMR), illustrates that although the IMR for the Western Cape Province (31/1000 live births) is good compared to South Africa as a whole (56/1000 live births), there are considerable inequities between both the urban Cape Town Metro District area and the rural areas of the province, and between the different health sub-districts within Cape Town. For example, in the Cape Town Metro District, Khayelitsha sub-district has the highest IMR of 44/1000 live births, whilst South Peninsula has the lowest of 13/1000 live births (See Table 1). These figures clearly highlight inequities which are not apparent if one looks at the overall figures for Cape Town or the Western Cape Province (Cape Town Equity Gauge, 2003).

Table 1: Infant Mortality Rate (per 1000 live births) in 2002

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

2.1 Demography

The total population of the Western Cape is estimated to be 4.5 million, of which approximately 64% reside in the Cape Town Metro Region covering just 2% of the surface area of the province. The remainder of the population is distributed, more sparsely, in approximately equal proportions between the other three regions namely, Boland/Overberg, South Cape/Karoo and West Coast Winelands.

2.2 Specific socio-economic variables

Whilst the immediate causes of disease are biological, such as HIV, hypertension and infectious diseases like pneumonia and diarrhoea, there is increasing evidence that underlying socio-economic and environmental determinants impact significantly on morbidity and mortality.

Table 2: Socio-economic data across the 8 sub-districts using Census 1996 data (Scott et al 2003)

New Health Sub-District	%						
	Unemployed of the employable	Households below poverty line	No electricity	Not completed grade 7	Not on Medical Aid	No piped water in dwelling	Informal Housing
Central	16%	19%	7%	8%	45%	4	6%
Eastern	20%	18%	9%	16%	70%	8	14%
Khayelitsha	47%	55%	32%	26%	99%	26	80%
Klipfontein	36%	37%	20%	20%	84%	15	23%
Mitchell's Plain	33%	30%	23%	20%	88%	21	31%
Northern Panorama	18%	20%	10%	16%	41%	9	12%
Southern	19%	17%	7%	15%	58%	5	10%
Tygerberg	22%	17%	2%	15%	69%	0	4%
Cape Town TOTAL	**26%**	**25%**	**13%**	**17%**	**69%**	**10**	**20%**

Some of the gross inequities between different health districts across the Cape Town are illustrated in a range of socio-economic indicators shown in Table 2. Khayelitsha sub-district is consistently worse in all the indicators presented, followed by Klipfontein and Mitchell's Plain. For example, 80% of the population in Khayelitsha live in informal housing compared to 10% in Southern sub-district; 55% live below the poverty line compared to just 17% in Southern and 26% do not have piped water in their dwelling compared to 5% in the Southern sub-district.

Other contributory factors are the housing backlog, estimated to be about 220,00 houses in Cape Town and increasing by 30-50,000 per annum (Cape Metropolitan Housing Task Team, 1999); poor infrastructure in the city in which a recent study found that the poor in Cape Town travel longer distances and incur higher transport costs than the more affluent (CMC, 1999); and a study by PLAAS and the School of Public Health in townships in Cape Town which found that 67% wage earners do not earn enough to push their household income above the poverty line (de Swardt, 2004).

The mortality profile was compiled for the eleven health sub-districts, whereas the socio-economic data presented in Table 3 are for the eight new sub-districts. It is salutary to note that whereas the socio-economic data single out Khayelitsha as the sub-district with the worst indicators, previous work using the eleven sub-districts pointed to Khayelitsha and Nyanga as having similar socio-economic and mortality profiles. The allocation of the population of Nyanga to Central and Mitchell's Plain sub-districts means that the situation in Nyanga has been masked within the overall sub-district profiles. This indicates that even within sub-districts it is possible for there to be considerable disparities between areas, and an accurate picture of the local conditions is crucial.

Various scholars, amongst others Omran (quoted in Chopra and Sanders) have described an epidemiological transition, which illustrates a transition of disease profiles as communities transform their social, economic and demographic structures that are almost patterned.
A "… sequence of events starting with a preponderance of infectious diseases, followed by an era when chronic diseases predominate," (Chopra and Sanders) is described. In the context of Cape Town this is demonstrated clearly in the disease profile prevalent in communities on the Cape Flats. In the informal settlements around Khayelitsha and Nyanga where inadequate provision of water, lack of sanitation and poverty caused by very low-income levels and unemployment, infectious diseases such as diarrhoea are common. Where communities consume a typical westernised diet and adopt other unhealthy lifestyles such as alcohol consumption, smoking tobacco products and being physically inactive they are more prone to

chronic diseases such as heart disease, hypertension and obesity. In 1998 the question "Was the deceased a smoker five years ago?" was introduced into the newly revised South African death notification form in order to estimate the impact of tobacco related mortality.[1]

For a variety of reasons social dislocation and breakdown of social capital is prevalent in these communities. In the informal settlements this is the result of in-migration of mainly young people attempting to escape the even more dire poverty in surrounding provinces and rural areas. Areas like Mitchell's Plain, whose inception was based on forced removal, have experienced sustained disruption, which has resulted in high levels of crime, homicide and trauma. It is under these conditions of rapid urbanisation, unemployment and disruption of family units that social capital significantly disintegrates, resulting in high levels of crime, homicide and trauma.

2.3 Drivers/determinants

Morbidity and mortality profile

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

The disease and death profile in Cape Town reflects a quadruple burden of disease namely, infectious diseases and HIV/AIDS, non-communicable diseases and injuries (trauma and violence). An adapted version of the 1990 Global Burden of Disease (GBD) list of causes of death was used for the classification (Groenewald et al, 2003). In Cape Town in 2001 deaths were categorized as follows:

Group I 19% (Infectious diseases -includes 6% HIV/AIDS)
Group II 54% (Non-communicable)
Group III 19% (Injuries)

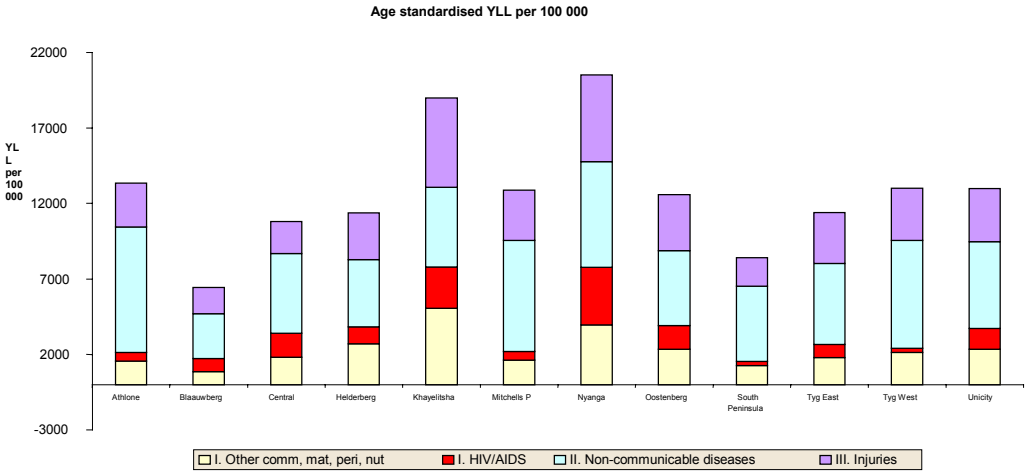
The top single causes of death in Cape Town in 2001 are ranked in Table 3.
In males the top cause of death was homicide (16.4%) followed by IHD (7.8%), TB (6.6%) and HIV/AIDS (5.8%). In females the top causes were HIV/AIDS (9.3), hypertensive heart disease (8.8%), IHD (8.6%) and diabetes mellitus (7.3%).

Table 3: Comparison of the estimate of deaths and YLLs for all persons in Cape Town in 2001 (Groenewald et al, 2003)[2]

Causes of deaths			Years of Life Lost (YLL)		
Rank	**Disease**	**%**	**Rank**	**Disease**	**%**
1	Homicide	10.6	1	Homicide	18.4
2	Ischaemic Heart Disease	8.1	2	HIV/AIDS	12.2
3	HIV/AIDS	7.4	3	TB	7.7
4	Hypertensive heart disease	6.4	4	Road Traffic	5.7
5	TB	5.9	5	Ischaemic heart disease	3.9
6	Diabetes Mellitus	5.3	6	Lower Respiratory Infections	3.6
7	Stroke	4.7	7	Hypertensive heart disease	3.3
8	Lower Respiratory Infections	3.9	8	Diabetes Mellitus	2.9
9	Road Traffic	3.7	9	Low birth weight and RDS	2.6
10	Trachea/bronchi/lung cancer	3.6	10	Stroke	2.5

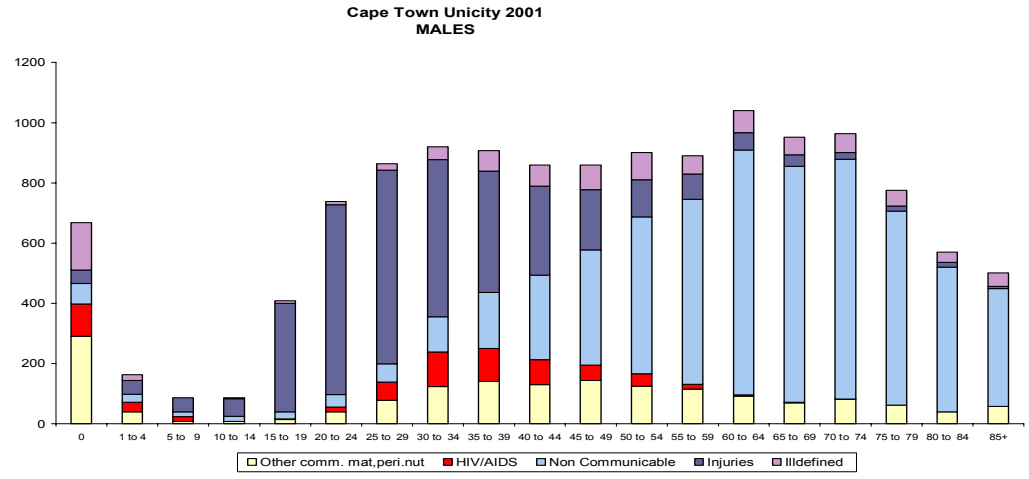
[1] Sitas, F., Urban, M., Bradshaw, D., Kielkowski, D., Bah, S., Peto, R. "Tobacco attributable deaths in South Africa." Tobacco Control 2004; **13**: 396 – 399.
[2] Note: Years of Life Lost (YLL) is a measure of premature mortality and has been estimated using age weightings, discounting and standard life expectancies. It is a particularly useful measure of deaths that occur prematurely or are preventable.

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



Total mortality varies across the city and while mortality was greatest in Khayelitsha and Nyanga sub-districts, when we look at premature mortality (years of life lost or YLLs) it is clear that premature mortality is disproportionately higher in these sub-districts (See Figure 1). In 2001, premature mortality (YLLs per 100,000) in Khayelitsha (18, 932) and Nyanga (19 619) was approximately 1.5 times higher than Cape Town overall (12 140) (Scott et al 2003).

Figure 2: Age distribution of male deaths by cause group, Cape Town 2001 (Groenewald et al, 2003)



A disturbing finding was the extremely high rate of injuries (mainly homicide) in Cape Town in young males between the ages of 15-40 years illustrated in Figure 2. Homicide was the top cause of mortality overall in Cape Town representing 10.6% of all deaths with an age standardised rate of 70 per 100,000. Khayelitsha and Nyanga had the highest rates of injuries (120/100,000 and 133/100.000 respectively) and Blaauwberg and South Peninsula (33/100.000 and 35/100.000 respectively) the lowest rates. These figures need to be put into perspective. It is estimated that the average rate of injuries for middle-income countries such as South Africa is around 32.1 per 100 000 which, in turn, is more than twice that of high-income countries (14.4 per 100 000) (Krug et al (eds), 2002). One-fifth of all homicides across

South Africa occur in only 23 police station precincts, which accounts for 2.1% of all the stations. Six of the 23 police station precincts were from Cape Town, namely Khayelitsha, Nyanga, Guguletu, Kuilsriver, Kraaifontein and Mitchell's Plain. These areas and police stations were also among those with the highest reported incidence of attempted murder and assault with grievous bodily harm (Prinsloo et al. 2003).

In 2002 alone more than 300 boys, between the ages of 15-24, in Cape Town alone suffered a violent death.

Infectious diseases and other pre-transitional causes lead to significant mortality in infants and young children particularly in Nyanga and Khayelitsha sub-districts with age standardised mortality rates of 366/100,000 and 363/100,00. This compares to figures of 86/100,000 and 94/100,000 in Blaauwberg and South Peninsula.

HIV/AIDS

Despite the consistent provision of health education, increasing condom distribution and utilisation, expansion of HIV services and the almost universal awareness of HIV/AIDS and its routes of transmission the latest antenatal surveillance data shows that the epidemic continues to spread in the Province. Furthermore, the extremely rapid growth in HIV sero-prevalence from 0.7% in pregnant women in 1990 to 27.9% in 2003 (Department of Health, 2003) and the large variations in HIV prevalence between different health sub-districts in the Western Cape province - ranging from 1% to 27% (Western Cape Department of Health, 2004) - clearly suggests that it is more than individual choices and knowledge that is driving this epidemic

It is widely recognised that there are numerous factors and forces that contribute towards making people vulnerable – both in terms of exposure to HIV infection and in terms of defining the experience of living with HIV/AIDS – and that these factors are not so much to do with *individual choices*, but determined by the social and economic context of people's daily lives. This context has been shaped by sharp and rising social inequalities in income and employment status, the mass resettlements of populations and labour migrations which have given rise to high levels of mobility, and the high levels of sexual violence – all partly the legacy of our colonial and apartheid past (Fassin & Schneider 2003).

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

According to research published by Sitas, et al, if smokers had the same death rate as non-smokers, 58% of lung cancer deaths, 37% of deaths resulting from chronic obstructive airways disease (COPD), 20% of tuberculosis deaths, and 23% of vascular deaths would have been avoided. About 8% of all adult deaths in South Africa, i.e. more than 20 000 per year) were caused by smoking.[3]

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

[3] Sitas, F., Urban, M., Bradshaw, D., Kielkowski, D., Bah, S., Peto, R. "Tobacco attributable deaths in South Africa." Tobacco Control 2004; **13**: 396 – 399.

2.4 Current policies and delivery patterns and their impact on specific socio-economic variables and determinants

Health inequities & resource allocation

The Cape Town Equity Gauge[4] has examined the level of inequities across the city, using a range of socio-economic and health indicators, and compared this with the level of primary health care expenditure in the districts.[5] The findings revealed a stark manifestation of the inverse care law[6] with the districts suffering the highest burden of disease (in particular Nyanga and Khayelitsha) receiving far less health care resources than the better off districts. The relationship between need and resource allocation is illustrated in the following graphs:

Figure 3

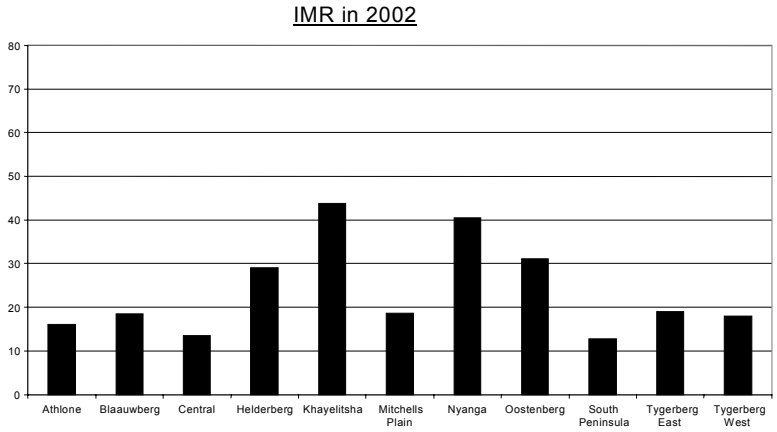
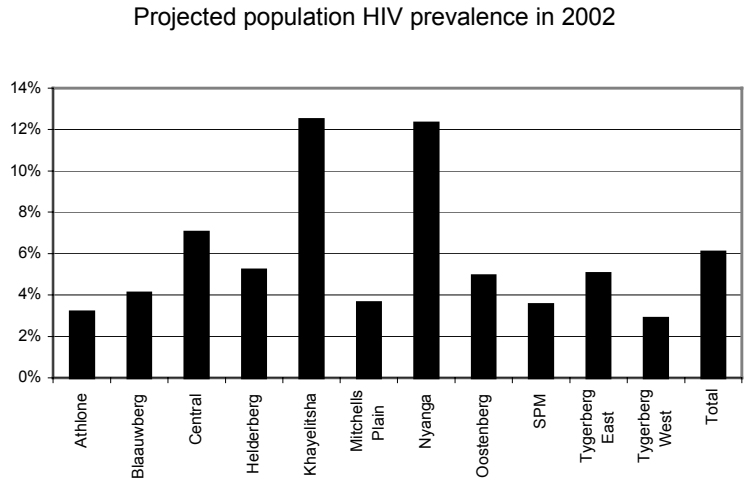


Figure 4



[4] The Equity Gauge is a collaboration between the School of Public Health, UWC, the PGWC, the City of Cape Town and relevant NGOs and CBO's. The study described included managers and information officials from the Health Department of PGWC and the City of Cape Town.

[5] The data used in this study relate to the 11 old health districts.

[6] Tudor Hart, J. 2000.'Commentary: Three decades of the inverse care law', *British Medical Journal*, 320 (7226): 18–19.

Figure 5

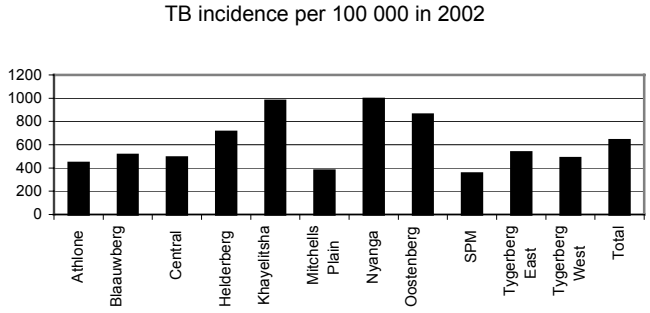
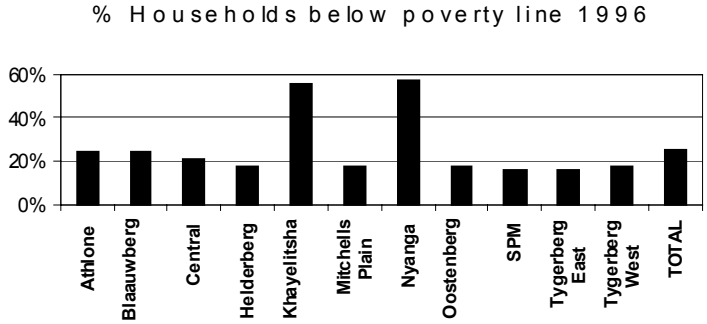
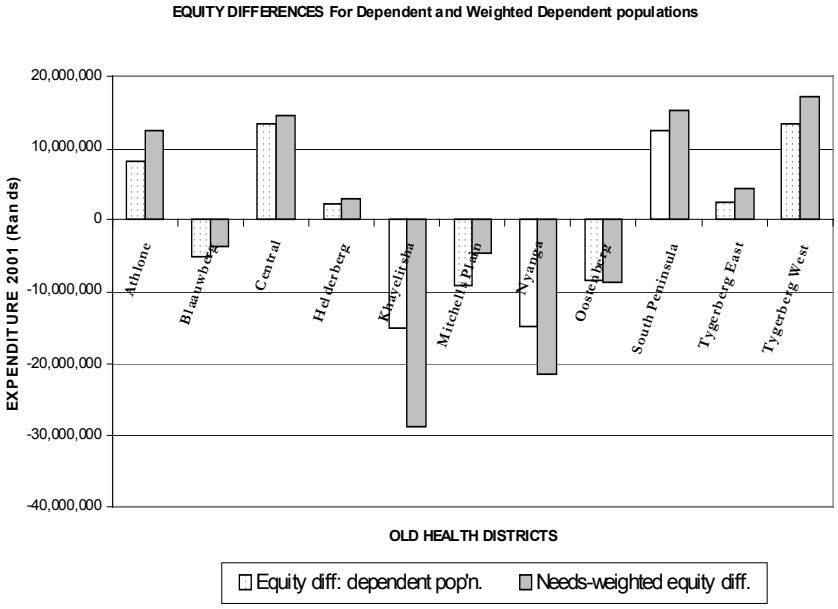


Figure 6





From these graphs it is clear that until a substantial reallocation is undertaken, the work stress on staff in the poorer areas will remain, and the facilities and treatment offered to patients with the greatest need will remain inferior.

Healthcare 2010 and its effect on Social Capital and Equity

Healthcare 2010 (HC 2010) is the Health Department's strategic plan. Healthcare 2010 was developed in response to a situation where there is a significant need for primary care services; where high levels of inequity in health service provision exist; where primary level services are inappropriately (and at an unaffordable high cost) being provided at secondary and tertiary level, thereby preventing them from focussing on secondary and tertiary services, as well as preventing them from providing support to primary level services. Healthcare 2010 intends that the focus of health service delivery be shifted to community and primary level care, with appropriate referral mechanisms to secondary and tertiary levels of care. This will relieve the current inappropriately high primary level care utilisation at secondary and tertiary levels of care and will expand coverage of primary level services. The effect of this is that health services will become more appropriate to the needs of the population, will become more efficient, and will become more equitable. Inequity is decreased because the expanded primary care services will be preferentially extended to areas where they are currently lacking. Since health services will better match the health needs of the population and will be provided more efficiently, it is anticipated that the effect will be a significant improvement in the health of the population.

Healthcare 2010 affects social capital in two ways. Firstly it conserves the currently existing social capital and secondly it creates more social capital. Conservation of social capital occurs because improved health services mean that the social capital previously being "squandered" by providing support to those with poor health because of a lack of health services, will no longer be "squandered". In addition social capital currently being utilised to advocate for provision of basic health services where they are absent, can now be conserved since the services will be provided thus obviating the need to demand them. Thus social capital can now be more effectively utilised by engaging with local health service providers, to ensure that high quality health services are provided in a manner acceptable to the community.

Building of social capital will occur as a result of the expansion of appropriate health services, since these will translate into improved levels of health in the community, which in turn facilitates the building of social capital by freeing up peoples time and increasing their ability to engage in the social interaction required to build social capital. Increased availability and improved quality of health services will encourage community ownership of the health facilities with resultant increased community motivation to have a say in the provision of services, both of which will substantially increase the levels of social capital.

2.5 Existing delivery structures

Existing structures and their functioning, both internal and external to the Health Department, that either facilitate or act as constraints or barriers to the development of social capital, are considered in this section.

2.5.1 Factors internal to the Health Department

2.5.5.1 Structures and resources

It is a general perception that the Western Cape Provincial Health Department operates in a well functioning manner and, in particular, its hospital services are well recognized nationally as providing excellent tertiary care.

However, given the changing health demography, the focus of Healthcare 2010 on the delivery of primary-level services, community-based care and preventive care, and the demands of the social capital formation strategy[7], Health has to grapple with a range of structural and functional elements that require a different configuration.

[7] As articulated in *Ikapa elihlumayo: Framework for Development of the Western Cape Province*. (undated) PAWC, Cape Town.

1) **Reshaping of service delivery platform and restructuring of staff establishments**

A key Healthcare 2010 initiative is the reshaping of the service delivery platform in order to ensure that the appropriate numbers and levels of service are provided to accommodate patients at the appropriate level of care. The plan for hospital beds highlights the following shifts per level in the Metro and the rural regions:

- The Metro acquires more level 1 district beds and 2 regional beds;
- Level 2 services are strengthened in the rural areas, by the commissioning of new level 2 beds in Eben Donges and George Hospitals;
- There is a modest increase in the total number of beds.

A related issue is that out patients must also be treated at the appropriate level. It is anticipated that 448 662 patients currently treated in hospital OPD's could be treated effectively in PHC facilities. The results of the proposed shifts are:

- An increase in the capacity to render out patient services at certain hospitals, i.e. Eersterivier, GF Jooste, Karl Bremer, Somerset, Victoria and Mowbray Maternity Hospitals.
- Whereas out patient activity should decrease at academic hospitals in particular, but also at False Bay Hospital, Hottentots Holland Hospital and Wesfleur hospital.
- Increased capacity will be created in both existing and new PHC facilities.

The process of relocating services will be carefully co-ordinated in order to synchronise the cascade of changes required. It has been decided that the services will be reshaped and will conform to the 'Healthcare 2010 shape' by 2007/08 within the existing facilities. Thereafter with building of new facilities, such as the Khayelitsha Hospital, services will be relocated to more appropriate areas.

Associated with this is the restructuring of staff establishments in order to ensure the provision of the correct numbers and skill mix of personnel in the respective healthcare facilities. Considerable progress has been made with this process and it is anticipated that service platform will be finalised during 2005.

2) **The separation between and within Health's service and support functions**

Structurally, bureaucracies require logical and well-organized structures, varying levels of authority and efficient communication channels to make them work effectively. Given the size of the Health Department, there is a need for the division and demarcation of different functions and responsibilities.

Currently the management of Health is structured into:

- Two key service provision divisions, namely: the Tertiary, Regional Hospitals & Emergency Medical Services; and the District Health Services & Programmes; and
- Three support divisions, namely: Finance, Human Resources and Professional Support Services & Administration.

There is thus a separation between the two service provision divisions, which are in turn separated from the three support divisions. This has the potential for to a lack of integration in the implementation of key departmental policies and programmes.

It is also evident that the **various health programmes** whilst tending to work closely and collaboratively with partner non-governmental organisations (NGOs), often have limited internal collaboration and integration across their various programme areas.

This was evident in a rapid situational analysis for home and community based care (HCBC) in the Metropolitan region, where key informants said that they thought that a more integrated approach to HCBC was needed (School of Public Health, UWC, 2004)[8], and at a recent health promotion workshop (20th September 2004) where programme managers highlighted the lack of horizontal integration between programmes.

[8] School of Public Health, University of the Western Cape.2004 Qualitative Assessment of Home and Community Based care Needs and Services. Research Report.

The separation of health programmes, in terms of their provision of community-based services, was also made evident in a recent audit conducted by the Metro District Health Services. The audit documented the availability and distribution of community-based services across the Metro region in 2003/4.[9]

The audit noted that:

- One of the current challenges facing community-based services in the Metro region is the vertical manner in which each programme element renders its service at a local level, i.e. through its own particular cadre of community-based workers or through out-sourcing this activity to relevant NGOS. This vertical approach is likely to be resulting in considerable duplication of work, and missed opportunities;
- That the funding of NGOs between the programmes within Health is not synchronized, which results in varying levels of funding being given for the equivalent work output, and inconsistent mechanisms being used for tendering, monitoring and evaluation processes;

A transversal link will be required for the strengthening of internal social capital (or as it is often termed - human capital), which is considered a critical step in the process of developing social capital. Amongst other things, it is urgent to assist staff to develop more trusting and co-operative relationships with patients. The strengthening of this transversal link will also assist in addressing some of the human resource issues that are evident at primary level health facilities: such as a perceived lack of management support, high levels of reported stress, disillusionment, and burn out (Lehmann & Sanders, 2004)[10]

Two other significant structural issues that ought to be borne in mind in relation to the social capital formation strategy are decentralization and the issue of resource allocation.

3) **The decentralisation of the District Health Service (DHS)**

A crucial way in which the Health Department can contribute to strengthening social capital is to allow local people to have a greater involvement in the organization and provision of health services. To promote this, Primary Health Care in South Africa will be based on a decentralized district health system.

Although facilities may be implementing many activities they have limited decision-making power. Local communities are even more limited in their influence on the implementation of services.

International experience has shown that decentralization of health services is a complex and fragile process. Care is needed to prevent increasing inequity, increased administrative costs, fragmentation, and avoid any weakening in strategic direction, provincial coordination and cohesion. The health system in the Western Cape is in a crucial and complex stage in the establishment of a DHS. It is likely that it will still take time for the governance and managerial structures of the DHS to be addressed. The DHS being a necessary component in any social capital formation strategy, consideration will need to be given as to how best to lay the foundations of a social capital formation strategy given that such an essential feature of the national health system is still not in place on the ground.

4) **Health inequities & resource allocation**

The relationship between equity and social capital has been highlighted in the introductory section of paragraph 2 and also paragraph 2.2, as has the existence of significant inequities in the City of Cape Town.

[9] Metro District Health Services. *Input paper on community-based services*. Draft 2, 22 November 2004.
[10] Lehmann, U. & Sanders, D. (2004). Human Resources for Health in South Africa: Background and Overview Paper. JLI National Consultation, 3-4 September 2004, Cape Town, South Africa.

It is clear that until a substantial reallocation is undertaken, staff in under-resourced areas will continue to experience difficulties in meeting the service demands.

2.5.5.2 Functioning and quality of care

Ultimately, an expression of good functioning is quality of care. The provision of quality of care is in turn dependent on a variety of factors being in place: such as the availability of sufficient numbers of health personnel to be able to manage the patient load; appropriately skilled staff who are able, and provided with the necessary resources and management support to deliver a sound and accessible PHC service; the existence of a seamless referral mechanism to secondary and tertiary levels of care which allow for the continuum of care; the ability at facility level to be able to interpret and integrate the demands of a range of vertically-driven health programmes and policies, and the development of an organisational culture within a facility which is characterized by respect, integrity and a client-centred approach to service delivery.

These factors, act, as a foundation to support the delivery of a quality health service, are often inconsistently present or unavailable at all levels of health care, and thus reduce the potential for social capital formation. For example:

1) **Patient waiting times and service times**

In some instances and although there has been progress in this regard, considerable waiting times are still experienced by patients at health facilities – which in itself is an expression of insufficient access to care.

A waiting and service times profiles conducted in the Cape Town Metropole for 2003/2004[11] illustrated the following:
That 47% of clinics had an acceptable[12] median waiting time for the overall visit. In terms of the individual sections, median waiting times (i.e. times waiting for the doctor, professional nurse, pharmacy, reception, and HIV counselling service), were all within the acceptable time period[13] apart from the waiting time for the doctor (where 36% of the clinics had a waiting time of between 30 – 60 minutes, and 28% of clinics had a waiting time between 60 – 120 minutes).

In terms of the large community health clinics (CHC's), the majority did not have an acceptable median waiting time for the overall visit, with 70% of clinics having a median waiting time of between 120 – 240 minutes, and 20% of clinics having a median waiting time greater than 240 minutes. The median waiting times for four out of the five individual services profiled were longer than the acceptable waiting period.

In terms of individual section median service times, both the clinics and CHC's had in the majority of cases, acceptable service times.[14]

The median service times for the overall visit for the majority of the clinics (57%) was from 5 - 10 minutes, and for the CHC's (60%) from 10 – 15 minutes. The difference in service time is appropriately reflective of the different types of services that the two facilities offer (see provider/client interactions below).

Whilst it is commonly acknowledged that the long waiting times are due to logistical problems (such as the logjams that occur at particular work stations/service sections and the uneven flow of patients throughout the course of a day in a facility), lengthy waiting times, such as those experienced at the CHC's, and, the consequence of this: not being

[11] Data for summary table obtained from L Solomon (MDHIS, Health Department, Metro Region, PGWC) and J Daniels (Health Department, City of Cape Town).
[12] An overall acceptable waiting times is less than 30 minutes for clinics and less than 60 minutes for CHC's.
[13] Individual section acceptable waiting times are less than 30 minutes.
[14] Individual section acceptable service times are between 5 – 15 minutes, and in the case of reception and HIV counselling between 1 and 5 minutes, and 15 and 30 minutes respectively.

provided with sufficient time to engage with a service provider, such as appears to be the case in relation to HIV counselling, can lead to a patient feeling frustrated, discouraged and in many cases, reluctant to return to the facility because of the inconvenience they experienced the first time. Lengthy waiting times and opportunity costs and belligerence that results diminishes existing social capital and reduces the potential of creating linking social capital between health professionals and their clients.

2) **Communication barriers**

In many areas, particularly in the Metro region, significant language barriers exist in the delivery of service due to the fact that many of the health care workers are English or Afrikaans speaking and the patients Xhosa speaking. This results in a communication barrier, which has not been remedied by, for example, the employment of trained interpreters, although the evaluation of a pilot NGO/sponsored programme at Red Cross and Mowbray Maternity Hospitals revealed the indispensable value of such personnel.[15]. The consequence of this is that it reduces the possibility of a more trusting and co-operative relationship to be established between the health care workers and their patients – something that is fundamental to social capital formation.

3) **Human resource issues**

Two recent studies, conducted by the School of Public Health, University of the Western Cape, in the Cape Town Metropole[16] identified a number of human resource issues that were having a negative impact on the delivery of services. The first study explored the experiences and challenges faced by staff working at the frontline – specifically in relation to HIV/AIDS, and the second investigated the challenges of translating the Integrated Nutrition Programme policy into practice.

In relation to the former study, staff felt overwhelmed, 'swamped' and in a sense, hopeless – not only by the sheer size of the challenge confronting them in relation to the HIV/AIDS epidemic, but, following the introduction of the comprehensive 'supermarket' approach to service delivery, by the increasing demand for curative services. Constantly reduced to a role of 'fire fighting' and of clearing the backlog of patients in the waiting room, staff felt that they were unable to provide their clients with an acceptable level of quality care and with the necessary preventive and promotive health input. This often meant that the nurses felt frustrated, demotivated and burnt out, and in some instances admitted to having been rude to their clients because of the stresses of their working environment. Nurses also experienced a sense of isolation at the coalface - of feeling that they lacked sufficient moral and practical support from their managers. They also felt that their constant engagement with HIV/AIDS at the workplace was impacting negatively on their family life, and that they lacked the appropriate skills to deal effectively - with their HIV/AIDS clients in particular.

A practical example that illustrates the human resource concerns raised in the above study is the implementation of the **Integrated Nutrition Programme (INP**). For example, the delayed and incomplete integration of PHC services between local authority and provincial structures has resulted in staff who are meant to work together at a facility level having different structures of management and accountability, different levels of hierarchy and at a very basic level - different salary structures and conditions of employment. These differences not only reduce the potential for collaboration and teamwork between the staff employed by different authorities at facility level, but also increase the chances of policy, such as the INP, being implemented in a fractured and duplicative manner.

[15] Petros, G. An evaluation of a pilot health interpreter programme in the Cape Metropolitan Region. Unpublished MPH Thesis, School of Public Health, University of the Western Cape.
[16] Lehmann, U. & Zulu, J. "You feel like you are fighting a losing battle": How nurses in Cape Town clinics experience the HIV epidemic. School of Public Health, University of the Western Cape. (in press). Lehmann, U. et al. Implementing the Integrated Nutrition Programme in the Cape Town Metropole: investigating challenges of translating policy into practice. Unpublished research report.

4) **Provider-client interactions**

In a resource-constrained setting personnel inevitably have to see a large number of clients per day, are likely to have to manage a number of interruptions and requests for information whilst consulting a client, and are likely to feel unsupported by a manager: this has a significant impact on the nature of the rapport they are able to establish with a client.

Lewin (2004)[17], in a recent study which investigated the organization of nursing work in primary health care clinics in Cape Town, suggested that the organisation of nursing care in primary care facilities does not generally allow nurses to engage very actively in 'caring' for patients, but rather confines their function to completing tasks as rapidly as possible. As a result, client-provider interactions in these settings are rather rigid and provider-oriented with priority being placed on maintaining order in the clinics.

The problem of poor nurse - patient relationships is clearly a complex one and multiple solutions are required (Jewkes, 1998: 1793). However, in order to foster 'bridging' and 'linking' social capital (in other words, to develop vertical connections or links which span different levels of power, and encourage a sense of responsibility beyond one's 'bonded' group) the nurturing of open, engaging and non-judgemental interactions between the providers of the service and clients of the service are essential.

The above factors (local organization of health care and provider attitudes) impact on poor health service performance in respect of, despite the Western Cape's relatively well-resourced situation. This is illustrated by two key 'markers' of service provision and quality, namely immunisation coverage rates and TB treatment completion rates.

It is striking that the percentage of PHC facilities providing immunisation services in the Western Cape in 2003 (47%) was found to be the third lowest in the country, after the Northern Cape and Gauteng.[18] Immunization dramatically reduces childhood morbidity and mortality, and is an essential service that all PHC facilities should provide. The lack of sufficient coverage "…means that many opportunities for immunisation of children are lost as every visit of a child to a health facility provides an opportunity for the child to be immunized." (Health Systems Trust, 2004, p 9). Amongst other reasons the continuing failure to establish integrated PHC through well functioning district health systems provides an explanation for this apparent anomaly.

2.5.2 Factors external to the Health Department

Given the many challenging and interrelated social problems in the Western Cape (such as unemployment, violence and gangsterism, and substance and alcohol abuse), all of which impact on health, building social capital requires commitment and action at all levels and across different sectors. Inter-sectoral collaboration (ISC) is thus an important pathway or strategic approach to utilize in the development of health and social capital.

In the next section, key factors in relation to Health's association and involvement with other provincial departments, local health authorities and community-based structures will be considered in order to broadly outline the current level of inter-sectoral engagement.

[17] Lewin, S. (2004) The organisation of TB nursing work in primary health clinics in Cape Town, South Africa. Unpublished PhD thesis, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine. [Chapter 4, p119-167].
[18] Health Systems Trust. 2004. The National Primary Health Care Facilities Survey 2003. Durban: Health Systems Trust and Department of Health.

1) **Relationship with other provincial departments**

The Department does participate in various interdepartmental structures, however, there are limited formal and systematic mechanisms that ensure that potential relationships with other departments are identified and pursued collectively. Stringent financial constraints also contribute to departments' caution in addressing issues that may not be within their identified priorities and budget.

Where inter-sectoral initiatives do exist, they are either in the form of large formal structures that focus on coordination, or small, often time-limited projects. However, neither of these has been able to exert significant influence on mainstream policy and programme development, as there is generally neither the commitment nor the infrastructure to support the initiatives.

Examples of broad coordinating initiatives that are in place include the Provincial AIDS Council and the Western Cape Health Promoting Schools Network.[19] Both of these have the potential to initiate local inter-sectoral projects and to influence policy, yet, because of the constraints, they focus more on networking, partnership building and oversight. An example of a locally based inter-sectoral project is the Khayelitsha Task Team (KTT) schools initiative that has worked closely with Health and the Western Cape Education Department (WCED)[20]. It is only because of the success on the ground and the effective advocacy by the KTT team that this collaboration has continued and strengthened.

2) **Relationship with local government**

Any PGWC social capital formation strategy would have to be underpinned by a strong co-operative working relationship with local government to ensure consistency in approach, to harness their complementary strengths, and to build on the existing opportunities created by the local authorities in building social capital.

The current responsibility of local government, in terms of health, is to deliver preventive and promotive health care (along with curative care for children less than 13 years of age), and environmental services. The responsibility of the Department of Health is that of delivering curative and rehabilitative services. It is thus essential that current points of collaboration and communication between the two authorities be used optimally to ensure an integrated approach to health care, and in this particular case to explore the foundations of joint social capital formation strategies.

Good examples of co-operative relationships do already exist. One example is the development of *The Cape Town Metro District Health Plan (2004 – 2006).* In April 2004, in the absence of a full DHS being established, the City of Cape Town, the Metro District Health Services, and the Department of Health, Provincial Government Western Cape finalised the Plan as an integrated medium term plan for improving Primary Health Care within the Metro district. The district health plan (DHP) is a three-year plan that integrates the needs and priorities of the various role-players in the Cape Metro district, and is informed by the objectives of Healthcare 2010, governmental growth and development strategies (such as those contained in the Urban Renewal programme and *iKapa Elihlumayo)*, as well as the Integrated Development Plan (IDP) of the City of Cape Town. Similar initiatives have been completed in the three rural regions.

Importantly, the principles of equity, co-operative governance and stakeholder partnerships have been identified as critical considerations in guiding the priority interventions within the district health plans. Such a planning initiative illustrates the potential that exists for co-operative arrangements between the province and local authorities and can be used as a model for the planning of joint social capital formation strategies.

[19] These include local government and communities as well.
[20] This is, in fact, a community led initiative, with partners from PGWC and the local government.

In addition, co-ordinating structures between the provincial and local authorities do presently exist in the Metro and rural regions. In the Metro these include the co-operative interim management structures that have been developed between the City of Cape Town and the Metro District Health Services (MDHS) at district and sub-district level.[21] These platforms provide an ideal opportunity through which dialogue and action about social capital can begin. Similar structures can be found in the rural regions and function with varying degrees of success, with the greatest impact being made in the Boland and Southern Cape.

3) **Relationship with communities**

The National Primary Health Care Facilities Survey (2003) commissioned by the Department of Health and conducted by Health Systems Trust, noted that approximately 30% of facilities in the Western Cape have functioning community health committees and that only 28% of them had met recently.

This is not surprising given that, in the Metro region for example, there appears to be limited up to date information available on the current role, responsibilities and level of authority of community-based health committees; the proposed or actual terms of reference for the individual members of these committees, and – in some cases - any substantive documentation on the proceedings of local meetings.

These observations are verified by an evaluation of community health committees in the Metro, which demonstrated that, despite extensive training and capacity building of community health committees, they were not functioning optimally. It was suggested that this was due to a high turn over of committee members, which was in turn related to their sense of frustration of not having clarity on their roles and responsibilities.[22]

In addition it appears that there is a general lack of clarity about the specific role of, and relationship between the various community-based stakeholder structures that currently exist – be they those created by the provincial government or those created by local government.[23] It is not unexpected therefore that staff, given their workloads and their initial training, often feel ill-equipped and have limited time to facilitate such community-based initiatives, and in some instances, to deal with instances of conflict within and between the local committees that arises. [24]

The lack of a uniform understanding amongst stakeholders about the particular role, authority and power that community-based health committees have – or ought to have - is perhaps also a reflection on the fact that the decentralization policy has not been formalized/ is still in process and the fact that the National Health Act, 2003 (No. 61 of 2003), which makes provision for the establishment of clinic and community health centre committees within provincial legislation, has been assented to, but not yet commenced.

[21] These include the Metropolitan District Executive Management Committee, the Interim District Management Team, and the Integrated Sub-district Management Team.

[22] Levendal, E. 2000. A study to explore perceptions of the current and future role do community health committees and the consequences of the roles for capacity development programmes for community health committee members, in the Cape Metropolitan Health region of the Western Cape Province. Unpublished MPH thesis. School of Public Health, University of the Western Cape.

[23] For example, in the Metro region, the City of Cape Town has facilitated the development of Ward Committees, and in some instances Neighbourhood Development Forums, and the Sub-District HIV/AIDS-focused MSATS. The Health Department, in collaboration with the City has facilitated the ongoing meeting of the Cape Metropolitan Health Forum (which is equivalent to a District Health Forum), and the associated Sub-District Health Forums, which appear to operate currently at varying levels of efficiency. In some instances, such as the in Khayelitsha sub-district, there appears to be a lack of clarity amongst the various stakeholders about how best the different committees ought to relate to one another – and particularly how the local government ward committees in the Khayelitsha MSAT ought to link to the Khayelitsha Development Forum and its associated Health Forum. In addition a variety of names are being used to refer to the most local of health committees (such as, a Community Health Committee, a Health Forum, a Facility Board, a Facility Health Committee), which tends to add further to the confusion around their particular functions.

[24] These observations are drawn from preliminary data obtained from a study currently being conducted by the School of Public Health, University of the Western Cape, an aspect of which is exploring the relationship between primary health care facilities and community based committees in the Khayelitsha sub-district, Cape Town Metropole.

The Provincial AIDS Council, which is convened and chaired by Health, and the HIV/AIDS-focused multi-sectoral action teams (MSATS) which in turn were initiated in the Metro region by the City of Cape Town, and are now in the process of being replicated in the other three health regions. Many of the other health and/or facility committees are also multi-sectoral in nature, and are engaged in key local activities and collaboration. However, these activities are often not documented and not part of a systematic and integrated process.

It appears that there is currently limited infrastructure within Health to support the development, maintenance and coordination of community based structures and initiatives.

Although the existing health structures and forums are perceived to be somewhat under-developed at present, it has been suggested that if linked to health facilities they could provide a valuable asset for building social capital in communities.[25] The Provincial Social Cluster recommended that an audit be undertaken documenting the existing and beneficial networks within communities. This could identify areas, which require further development, multi-sectoral linkages and/or capacity-building needs, and it would complement the findings and recommendations of the community-based services audit referred to above.

3. SOCIAL CAPITAL AND ITS RELATIONSHIP TO HEALTH

3.1 Social capital inequities and health

The association between social and economic conditions and ill health is well established. Whether socio-economic status is measured in terms of income, education, employment or housing, people living in poor conditions suffer the worst health (Black et al 1982, Whitehead 1988). This correlation is clearly illustrated locally by the Equity Gauge graphs of Cape Town shown above.

Wilkinson (1992) has taken this further, describing the adverse impact on health where there is a wide disparity in income within a country. Wilkinson's general thesis is that social inequality - not just income inequality but also inequality in power and status - has a fundamental influence on the content of social relationships and interactions, and consequently on health. The impact of powerlessness on health have also been shown to be a risk factor for disease by Wallerstein (1992) in her seminal study on empowerment, and on one's position in social and economic hierarchy by the study on civil servants in Britain by Marmot and Feeney (1997).

A disturbing aspect of the link between inequality and social cohesion is illustrated by the work of Kennedy et al (1998a, quoted in Emmet, 2003) showing their relationship to violent crime. Specifically, Wilkinson (1999a) suggested that when income differences are greater, people are less likely to trust one another, and rates of violence are likely to be higher. Kennedy et al (1998), in the study in the United States, found high correlations between violent crimes on the one hand and low social capital and income inequality on the other hand, even after the variables for poverty and access to firearms were controlled. The accumulating evidence suggests that as inequalities increase, the quality of social relations deteriorates, violence increases and the population's health suffers (Emmett, 2003, p 13).

More locally, in South Africa, it is suggested that in poorer and more crime-ridden communities, there is an increasing sense of withdrawal, passivity and powerlessness in the face of crime, and that crime is further eroding communities' limited resources (Emmett, 2003). As Kawachi et al (1999, quoted in Emmett, 2003) suggest:
'If people shun their neighbourhoods due to fear of crime, fewer opportunities exist for local networks and associations to take hold. The resulting disorganisation of community structure

[25] Minutes of Provincial Social Cluster meeting, 20th July 2004

in turn fuels further crime, producing a vicious cycle of declining social capital, followed by rising crime, followed by further disinvestments in social capital' (p. 727)

The South African situation is not unprecedented because there are striking similarities provided by history. Studies carried out in industrialising Sweden and Britain in the early nineteenth century provide useful insights for South Africa in terms of high mortality in young men. Sundin and Willner (2002, quoted in Chopra & Sanders, in press) attributed the high male mortality in Sweden to a number of factors including rapid, disorganised urbanisation and a lack of social networks leading to high alcohol consumption and increased accidents and violent trauma.

Szreter (1999) suggests that in the British context the main contributory factors included the disruption to established social relations and structures of authority that accompanied the rapid urban growth: inequality of incomes and the resulting residential segregation. He further notes the lack of an effective political and administrative response at national and local government level.

Using these examples, Putnam's view of social capital, referred to in Hawe and Shiell (2000) as a romantic, middle class view, evaporates, and Bourdieu's analysis sits more comfortably. As Hawe and Shiell argue, supportive relational ties are not a sufficient antidote to material deprivation and learned helplessness.

3.2 **Increasing Social Capital is cost effective.**

There is an increasing body of evidence that links lower levels of social capital to poorer health and development outcomes. For example, the relationship between aspects of social trust and deaths from stroke, accidents and suicides, and to survival from heart disease in the US has all been demonstrated (Kawachi et al., 1996, cited in Gillies 1998; Kawachi et al 1997 cited in Hawe & Shiell, 2000).

This poses significant and long-term economic and human costs. Economic costs resulting from ill health may accrue to the state or individual, as direct or indirect costs. Examples of direct costs include out-of-pocket or health insurance payments for health services, as well as a range of other financial payments related to illness (e.g. purchase of special foods) and treatment seeking (e.g. transport costs). Indirect costs relate primarily to income losses from time away from work. Even in situations where healthcare services are free, some of these costs are still incurred and may result in further entrenching poverty (McIntyre & Thiede 2003). Long-term illness or disability, in particular, may result in an inability to continue with gainful employment. It also results in the inability for individuals to participate in social and community activities, with the subsequent loss of human and social capital.

By contrast, Baum (1998) notes that societies that provide social support for their citizens are likely to be healthy ones. For example, Putnam's work in Italy (1993, quoted in Baum, 1998, p 95) provides some evidence that societies with high levels of civic engagement are more economically successful than those without them. In addition, historical evidence and international comparison indicate that economic growth, especially when combined with state intervention to direct and redistribute its benefits, is beneficial to health (World Bank, 1993; Szreter, 1995, quoted in Baum, 1998, p 95).

There is growing evidence on the importance of social networks in assisting households to cope with the potentially considerable economic and social consequences of illness and health care seeking. For example, being able to access money from family and friends, and to draw on their labour inputs to minimise lost income during illness, can protect a household from falling into poverty (McIntyre & Thiede, 2003). Reciprocal arrangements, whether informal such as 'stokvels' or more formalised mechanisms such as community-based pre-payment health schemes, contribute to the promotion of social capital as well as offering economic protection to households in time of need. By supporting such schemes, which are

frequently initiated by communities themselves, health services can play an important role in social capital development.

Kawachi, Kennedy et al. (1997, quoted in Baum, 1998) have outlined three possible mechanisms that might link social capital to health:

- Firstly, health related behaviours may be influenced in neighbourhoods with high social capital, by allowing a more rapid diffusion of health information or by increasing the likelihood that more healthy norms are adapted (e.g. physical activity), and by exerting social control over deviant behaviour (such as drug use);
- Secondly, socially cohesive neighbourhoods are more successful in protecting local services from the effects of budget cuts, or for advocating for additional services and amenities; and
- Thirdly, more cohesive communities could lead to greater levels of trust in each other, and hence increases in self-esteem and mutual respect, which in turn are beneficial for one's health.[26]

Social capital, however, is not without its downside. As Hawe & Shiell (2000) note, it can be used to exclude or constrain opportunities to non-network members, to place excessive demands on network members, and to reinforce anti-social delinquent behaviour where that is the defining characteristic of the group. They cite Bourdieu's acknowledgement of the repressive side of social capital, which can be used by those with power to maintain their position in the hierarchy. Baum (2000) describes the way it can be used by the state as a means of working to reduce social exclusion and link social and economic programmes, or to withdraw state support from communities in the name of community responsibility and self-reliance.

Notwithstanding the significant body of research that supports the importance of social capital for achieving health, aspects of the above critiques need to be considered as part of any implementation programme.

3.3 Building social capital by investing in human capital

A key component of Health's response and its contribution to the implementation of the Social Capital Formation Strategy (SCFS) will be its commitment to strengthening its existing human capital resources.

In relation to this, it must be noted that good support and able management are crucially important to health personnel performance in that they are able to significantly improve a sense of work satisfaction and the ability to function productively (Lehmann & Sanders, 2004). Along with strong leadership, good management and support contribute greatly to well-functioning service delivery, as has been shown by numerous studies conducted within the public health service (by, amongst others, Couper and Hugo (2002); Jewkes et al., (2000); Zondo et al. (no date); and Puoane et al. (2001): quoted in Lehmann & Sanders, (2004)).

It is proposed that in order to strengthen internal social capital or human capital, Health implement a series of human resource development interventions, which, for example:

- Increase the level of technical and moral support that is provided to staff in the context of their practice and in the face of considerable low morale. For example, Health needs to ensure that it provides the necessary training and on-going supervision support so as to strengthen the capacity of health care workers and managers to be able to implement health policy in the fullest sense;
- Assist in the development of more trusting relationships between health care workers and patients to be established so as to provide a more favourable context '…in which providers and patients can work co-operatively to establish care objectives and seek

[26] The above summary has been quoted from Chopra, M & Sundin, J. 2004. Health and Social Change Module Guide, Postgraduate Diploma in Public Health, School of Public Health, University of the Western Cape.

reasonable ways of achieving them' (Gilson, 2003: 1459). An innovative training intervention developed by the Women's Health Project and called *Health Workers for Change*, could be an example of how one could implement capacity building in this regard. The intervention not only focuses on the factors that influence health worker-client relations, but also on identifying ways and means to improve health services and job satisfaction for health care providers, which can lead to better health worker-client relationships (Women's Health Project et al., no date).

- Orientate facility, area and district managers to be able to identify, initiate and maintain appropriate community-based and health development partnerships between different stakeholders. In this regard, the use of such guidelines as '*Tapping into civil society: guidelines for linking Health Systems with civil society',* piloted by the WHO locally as part of a multi-country research study, provide health workers with a framework to assess the current performance and capacity of the local district health service to work in partnership with communities; to identify, make contact and analyse the work of local civil society organizations, and to consider the principles of working in partnership (WHO et al 2001).[27] In this regard the process of facilitating leadership and management at district and facility level has already been initiated
- Lend support to professional health workers by developing and/or strengthening additional layers of health workers, in particular community-based health workers and mid-level workers. The Community Home Based Care Partnership, funded in part by the European Union, is an example of such an initiative. The success of this project will depend upon its integration into the formal health services and how well other health workers support it. This initiative forms part of a broader thrust to establish networks of community health workers in areas where the populations are vulnerable. Significant progress has been made in the appointment of project coordinators (technical assistants) at a district level. The coordination of these projects will be undertaken by non-governmental organizations, which will raise the profile of these organizations and improve the linkages between government and civil society organizations. This in turn will promote the development of social capital in those districts and communities. (Strenuous efforts will have to be made not to disrupt existing structures run and developed by volunteers, which by definition is already contributing towards the formation of social capital.)
- Several inter-related initiatives to improve community-based services have also been initiated under the rubric of Healthcare 2010. At present the whole issue of community based respite centres, frail care institutions, group homes (for long-term mentally ill patients) is being investigated. If managed correctly these initiatives have the potential to build social capital, through community involvement, joint decision-making, intersectoral collaboration, increasing volunteerism, etc. Conversely if these projects are managed incorrectly they have the potential to do untold harm. Some of the negative consequences include shifting the cost and responsibility for the management of long-term patients back onto the families that can least afford it, creating divisions around resource allocation in communities, disruption of relationships NGO's and other partners. Stifling of community initiative through bureaucratic measures and co-modification of services previously undertaken in the spirit of communatarianism and neighbourliness.
- Restructure the training of health professionals to ensure that location and content of training reflects new priorities. Human resource planning has lagged behind the large-scale changes to the service platform that have occurred since 1994. Although there have been substantial changes in the curricula of the health sciences they have not brought about the change in skills and attitudes required to embed the transformation of the health services. Further restructuring of the training of health professionals is needed to ensure that the location and context of training reflects the new priorities. In order to facilitate the building of social capital students of the health care professions need to be socialised to the culture of health care, which is based on respect, empathy, caring and understanding the social context of ill health.

[27] The Provincial Social Cluster meeting, held on 20 July 2004, highlighted the need for an audit to be undertaken that would document the existing and beneficial networks within communities. The meeting noted that whilst the existing health structures and forums are perceived to be somewhat disorganized, it was felt that if linked to health facilities they could provide a valuable asset in communities in building social capital.

4. **GAP ANALYSIS: Between current delivery patterns and desired socio-economic and social capital outcomes**

4.1 There is a significant gap in health promotion and disease prevention relating to the burden of some of the chronic diseases, e.g. diabetes mellitus, obesity, hypertension, cerebro-vascular accidents, cardiovascular disease. If health promotion and disease prevention were more effective the incidence and severity of these diseases could be minimised. This would not only take more effective health promotion and disease prevention on behalf of the Department but also that people take ownership of the role that they play in determining their own health or ill-health.

4.2 There is a lack of community involvement and community structures to facilitate the development of the sense of reciprocal responsibility for the health of communities.

There is a lack of integrated planning between the respective departments, e.g. the Department of Housing and the Department of Water Affairs affects the provision of housing, potable water and sewage which contributes significantly to the burden of disease. A lack of an over-arching provincial development plan has frustrated efforts at joint planning. This is exacerbated by the "silo" approach of departments and therefore there is insufficient co-ordination in addressing inter-sectoral issues, i.e. joint planning, budgeting and evaluation.

Outstanding issues regarding the integration of the PHC platform with Local Government are the lack of progress in integrating the management structures and delivery structures within the PHC facilities has hampered service delivery and has led to the inequitable distribution of human and other resources.

4.3 The impasse, which has been reached regarding the governance of the District Health System, is having a negative effect on service delivery, staff morale and the ability to deliver good quality PHC services. This has a knock-on effect of undermining the transformation of secondary and tertiary services, which are swamped by patients who could effectively be treated at PHC level, creating undue pressure on their capacity to deliver the secondary and tertiary services for which they are responsible.

4.4 The above factors contribute to the inability to recruit and retain qualified and experienced personnel, particularly nurses. The reduced numbers of staff are thus left to manage the large numbers of patients, creating increasing stress which contributes to the breakdown of social capital at all levels of the service. It is intended that the implementation of Healthcare 2010 will address the issue of treating patients at the appropriate level of care.

4.7 Quality of care issues, for example,

- Patient waiting times and service times are still too long as the result of physical infrastructure that does not meet the current requirements of the service and lack of integration of services. Facility managers are being appointed to manage the PHC effectively.
- Language barriers persist in many areas due to lack of funding to appoint translators.
- There have been deficiencies in human resource management (recruitment and retention) and development with the result that the provision of an effective and caring service has suffered.

5. **LINKAGES WITH OTHER ROLE PLAYERS AND THEIR IMPACT**

The Department will in conjunction with the other Departments in the Social Cluster conduct an audit of community structures. The provincial Department of Local Government is in the process of appointing community development workers in all districts who, together with the community health workers, will be responsible for co-ordinating an audit of community based structures.

The success of the projects, which have been chosen by the Department, will hinge on close collaboration between Health and other government departments, local authorities, non-profit organizations as well as communities.

In the case of the Integrated Management of Childhood Illnesses (IMCI) project, the Department will have to work closely with the City of Cape Town, the Provincial Department of Local Government, the Department of Water Affairs, the Department of Education and a range of NGO's including the Khayelitsha Water and Sanitation Forum, organizations employing community health worker (IMCI workers), faith based organizations, health forums and clinic committees, etc.

The chronic diseases (inclusive of HIV and AIDS) intervention will require collaboration with the Dept. of Education, the Dept. of Social Services, the Provincial Department of Local Government, the Dept. of Cultural Affairs& Sports and the Department of Transport & Public Works. Linkages with NGO's and community-based organizations are crucial in this instance.

Case Study 1: Khayelitsha Task Team

KTT was launched in 1998 after a medical officer working at Nolungile Clinic (Site C, Khayelitsha) discovered a high level of worm infestation in children attending the clinic. The Medical Research Council found that worms affected 96% of learners in one of the schools in the area, resulting in high levels of diarrhoea. This not only affected their health but also their ability to concentrate in the classroom.

In order to address the problem, a collaborative initiative was established involving representatives from the local community (such as teachers, members of the school governing body, parents and NGO representatives), government representatives (such as nurses, environmental health offices, engineers and community sanitation officers) and researchers from the MRC and School of Public Health, UWC.

To make an impact on both the causes and effects of the worm infestation, KTT is currently implementing an intervention at two levels: a schools-based programme and a community-based programme.

The school-based programme involves the following:

- Regular de-worming programme
- Curriculum development and production of teaching materials
- Improvement of water and sanitation facilities in schools

The community-based programme, which focuses on improving sanitation facilities in Khayelitsha involves the following activities:

- Identifying appropriate and sustainable dry sanitation options for informal areas in Site B and C Khayelitsha
- Establishing pilot sites to construct and demonstrate three different options
- Engaging in health promotion activities within the community.
- Building a ward based Water and Sanitation Forum that will take the lead in directing a 'demand-led' initiative in collaboration with the City of Cape Town and the Department of Water Affairs and Forestry (DWAF)

Results of the first stage of this project have indicated that there is a high degree of acceptance of dry sanitation by users, community representatives and professionals. The emphasis is now on keeping up the momentum within the community through the Water and Sanitation Forum, so that they remain active in the 'roll out' of the toilets within the informal settlements

As well as being a local initiative in its own right, KTT is one of the Tracer Conditions of the Cape Town Equity Gauge Project. Its value as an Equity Gauge initiative is in the way that it is finding innovative solutions to deal with the impacts of inequity (Khayelitsha has amongst the worst conditions in Cape Town, regardless of the indicators used) (Stern & Mokgatle, 2004).

6. LINES OF RESPONSE: A new service delivery model

6.1 Putting the principles of the *primary health care approach* into practice

Many of the insights generated by debates and research around social capital were recognised in the formulation of the primary health care approach as detailed in the Alma-Ata Declaration**.**

The concept of primary health care (PHC), and that of the primary health care approach explicitly outlines a strategy that aims to respond more equitably, appropriately and effectively to basic health care needs, whist also addressing the underlying social, economic and political causes of poor health.

In essence, key principles underlying the PHC approach include:

- Universal accessibility and coverage on the basis of need;
- Comprehensive care with the emphasis on disease prevention and health promotion;
- Community and individual involvement and self-reliance;
- Intersectoral action for health; and
- Appropriate technology and cost-effectiveness in relation to available resources (adapted from Tarimo & Webster, 1994, p 3, in: Sanders, 2001).

Sanders (2001, p 63) notes that 'the primary healthcare approach is based on understanding that health improvements result from a reduction in the effects of the disease (morbidity and mortality) and its incidence, as well as from a general increase in social well being. The effects of disease may be modified by successful treatment and rehabilitation and its incidence by preventive measures. Well-being may be promoted by improved social environments created by harnessing popular and political will and effective intersectoral action'.

- Sander's analysis is supported by experience in four low-income countries: Kerala State in India; Sri Lanka; China and Costa Rica (Halstead et al., 1985). The authors, in their publication, Good Health at Low Cost, demonstrate that the provision of basic health care, along with the promotion of social action, have resulted in the achievement of low levels of child mortality, despite them being low income countries. This provides evidence of the importance of factors other than levels of income in determining health status outcomes. The authors attribute improvements in these countries specifically to four factors:
- Political and social commitment to equity;
- Education for all;
- Equitable distribution of public health services and primary health care; and
- Adequate calorific intake in a manner that does not inhibit indigenous agricultural activity.

These achievements were made following a basic needs approach to development that focused on equitable forms of service. A community-based approach with a "spirit of sharing and working together for the common good" was also embraced (Werner and Sanders 1997).

In the process of formulating Healthcare 2010 the Department of Health put forward a vision of a reconfigured service delivery platform, which would allow for greater accessibility of services and more effective service delivery. The theme running throughout Healthcare 2010 is the devolution/diversion of services to the appropriate level, principally to level one or the primary level. Much of the focus of Healthcare 2010 has been on the reconfiguration of hospital services, but the time has arrived to focus more keenly on level one or Primary Health Care services.

The new Health Act 61 (of 2003) gives primacy to the development of a health system built on the Primary Health Care approach. It enunciates twelve principles upon which the primary health care approach is anchored, namely *equity, access, quality, overcoming fragmentation, comprehensive services, effectiveness, efficiency, local accountability, community participation, developmental and intersectoral approach and sustainability.*

These core precepts of PHC delivery can easily be identified with many of the main tenets of *Ikapa elihlumayo*, the Provincial Government's formulation of developmental governance. It is therefore worth re-stating that by emphasizing the PHC approach in Healthcare 2010, the Department of Health is *de facto* committing itself to *Ikapa elihlumayo* and by extension to a social capital formation strategy.

One of the key areas which has to be systematically 'unpacked' in Healthcare 2010 is the provision of primary health services and how the delivery of these services will not only contribute to the delivery of better healthcare for the citizens of the Western Cape, but will also contribute towards developmental governance. Until now, interventions in the PHC arena, although substantial, have been fragmented, e.g. the 100-day deposits, the human resources restructuring plan for the District Health System, the formulation of District Health planning process, the home-based care initiative, the division of roles and functions between local and provincial government. All of these have contributed to a greater or lesser extent towards the strengthening of the PHC approach, the implementation of Healthcare 2010 and indirectly to social capital formation.

Any discussion on health care delivery and social capital formation has to be premised on the understanding that when healthcare delivery occurs in a manner which caring, sensitive, transparent and respects the dignity of the client/ patient it can contribute to the formation of social capital. However, it is beyond the confines of the caregiver-patient relationship that the healthcare system is able to make a far greater contribution to the development of social capital.

6.2 Specifically identified projects

Ten broad priorities have been identified for the strengthening of Primary Health Care.

1) District Health system Strengthening
2) Community Based Services
3) District Hospitals
4) Chronic Disease Management
5) Tuberculosis
6) HIV/AIDS
7) Women's Health
8) Child Health
9) Youth Health
10) Building Healthy Communities

Of these interventions, two relating to child health, one relating to the management of chronic diseases and one relating to trauma have been selected as specific pilot interventions in the coming year to focus on of social capital, particularly in the Metropole, namely:

1) The Integrated management of Childhood Illnesses with a specific emphasis on the management of diarrhoeal disease.
2) The strengthening of the immunisation campaign
3) The management of chronic diseases to ensure continuity of care.
4) In view of the significance of Trauma problem in the Province, Health will collaborate with other departments in order to assist in the formulation of strategies to reduce the levels of trauma.

6.3 Diarrhoeal disease

6.3.1 Activities and outputs

1) **Improve water and sanitation**:
   - Support local intersectoral initiatives around provision of potable water and sanitation, like the Khayelitsha Water And Sanitation Forum.
   - Engage Local Government and other government departments around provision of potable water in at risk communities. Advocate with other relevant departments that resources (e.g. water resources and latrines) are urgently deployed in relation to need (i.e. to those areas where diarrhoea mortality and morbidity are highest).
   - Raise community awareness around sanitation issues and support advocacy initiatives related to sanitation issues through health committees, health forums and other community structures.
   - Strengthen support other government Departments e.g. Education Department by the development of teaching materials and inclusion of health and hygiene in the school curriculum.
   - Eliminate inequitable distribution of Environmental Health Officers through recruitment and redeployment.
   - Encouraging hand washing at household level as a short-term emphasis.
   - Advocate that relevant government departments and NGO's involved in adult literacy programmes take action to improve maternal education which studies have shown to substantively reduce the incidence of childhood diarrhoea.

2) **Community awareness/ education**:
   The focus areas of the awareness/ education are:
   - The seasonal nature of the incidence of diarrhoeal disease;
   - The mixing and administration of the sugar-salt solution to all children with loose and watery stools to prevent dehydration and its consequences;
   - The importance of early presentation of children with dangers signs to the health services;
   - The importance of hand washing in breaking the transmission of diarrhoeal disease.

3) **Improved PHC facility diarrhoeal disease case management**:
   Each PHC facility to have:
   - A functional oral rehydration (ORT) corner that is set-up and managed in accordance to standard WHO guidelines;
   - The capacity to stabilize severely dehydrated children, prior to referral to the next level of care

4) **Extended hours child health services in selected CHC's**:
   The hours of child health services will be extended from 16h30 to 20h00 on weekdays and 10h00 to 14h00 on weekend days, from 1 February to 31 May 2005 at Khayelitsha Site B and Vanguard CHC's.

6.3.2 Timelines

- A task team to implement the diarrhoeal disease programme has already been established with experts for the Tertiary hospital/ Academic complexes working with programme managers within the Department of Health to implement this programme by February 2005. This team has also developed a detailed implementation plan for service providers at all levels of the service platform.
- As part of the Healthcare 2010 restructuring process a number of staffing models have already been developed for the different types of facilities rendering PHC services. These models will be presented to Top Management for endorsement early in 2005.
- Health Promotion Policy and School Health policies are currently being developed and will form part of the Healthcare 2010 implementation process

6.3.3 Resource Changes

Additional resources will also be made available for strengthening community-based initiatives and to improve communication with the communities being targeted for this intervention. The provision of extended hours of service will have human resource implications and attendant costs for the Department; but will promote access and foster a better image of the health services in communities.

6.3.4 Restructuring

This project does falls within the ambit of a broader attempt to improve community-based initiatives, the Integrated Management of Childhood Illnesses (IMCI).

6.3.5 Proposed outcomes

- The Household and Community component of the IMCI aims to enable community responsibility for the health and well being of children. The programme recruits and trains community volunteers to provide household and neighbourhood education, to identify health problems and refer children as necessary and to give overall support to caregivers in the management of the health and safety of pre-school children.
- Increased community participation through interacting with organised community structures such as clinic committees. These structures can mobilise and lobby for the provision of adequate water and sanitation, assist in environmental monitoring activities, provide support to community health workers whose responsibility it will be to encourage hand washing and other promotion activities. Interact with other community structures, local authority forums and other development workers in order to mount an integrated response at community level.
- Improve access to basic services through collaboration with other government departments as well as local government;
- To provide support to community-based interventions by providing logistical support, supervision/monitoring and funding;
- Improved knowledge about hygiene and sanitation matters amongst learners and adults;
- Reduce the incidence of one of the commonest childhood killers by improving maternal knowledge base and community awareness;
- Improve patient care through improved human resources (both qualitative and quantitative) in health facilities;
- Improve efficiency and effectiveness of service delivery in PHC facilities as well as hospital based services;
- Improve access through more effective use of resources, better planning and better communication with healthcare providers and the public;
- The abovementioned contributions all contribute towards social capital formation by providing for human capital development in communities); by developing bridging social capital through improving the access of communities to authority structures (Woolcock/ Szreter model)
- Ultimately all of these contributions will improve health outcomes in the communities.

6.4 **Immunisation**

The community IMCI (Integrated Management in Childhood Illnesses) workers provide an additional interface between the “formal” health delivery structures and the community, which enables the health workers to provide valuable information regarding preventive health, e.g. the need for immunization in a particular area. They provide a framework for closer co-operation between community structures and the service delivery entities, i.e. the CHC’s and clinics, and foster the closer and more trusting relationships. This is illustrated by the initiative in December 2004/January 2005 to immunise children in Fish Hoek in response to the outbreak of measles. Apparently the community was resistant to immunizing their children but

by effectively involving the schools and community leaders and informing the communities, parents co-operated and approximately 4 000 children were immunised.

6.4.1 Activities/outputs

- Training of community IMCI workers. These workers are a 'subset' of workers currently engaged in community health activities within communities.
- Collaborate with Local Authorities regarding the need for immunization and the preparatory work for immunization campaigns.
- Work with the Department of Education to promote awareness and improve knowledge of immunization. Influence teachers and community leaders.
- Improve the outbreak response times during high-risk periods by means of improved communication.
- IMCI strategy to be implemented in all PHC facilities.

6.4.2 Timelines

- Full implementation of IMCI at all PHC facilities in 2005.

6.4.3 Resource changes

- Strengthening community IMCI workers to cover all the high-risk areas
- Additional nurses at the clinics to manage the increased number of children to be immunised and mini campaigns.
- Additional stock of vaccines
- Additional vaccines to deploy to non-Health facilities, e.g. private pharmacies.
- Increased budget for information and educational communication.
- Budget for small EPI surveys.

6.4.5 Proposed outcomes

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

6.5 Management of chronic diseases to ensure continuity of care

Chronic diseases are for example: hypertension, cardiovascular disease, diabetes, mellitus, obesity, cerebro-vascular accidents, mental illness, HIV and AIDS.

6.5.1 Activities and outputs

- Community issues:
  - The home-based care programme facilitates the provision of care and support for people living with HIV and AIDs, chronic diseases, disabilities and the frail and elderly in the home environment.
  - Improve communities' knowledge around diabetes, hypertension and risks factors of other chronic diseases through health promotion and prevention
  - Support community health workers who will be employed by non-profit organizations. This will form part of the department's contribution towards economic growth and development through investment in human capital.
  - Support and develop non-profit and community-based organizations and through this contribute directly towards social capital formation.
  - By encouraging participation and developing the health committees and health forums the Department is able to contribute towards "people-centred governance" thereby strengthening social capital formation.

- Service issues
  - Provision of home-based care for all category three clients (requiring frail care) by trained home-based care workers, 20% of whom fulfil a specialised role, while 80% perform a generalised role.
  - Community based care at household level for non-category 3 clients – TB DOTS, ARV adherence support, child and women's health support, rehabilitation service;
  - Expansion of group homes, step-down facilities, hospice care, day care centres (institutions within communities including residential care institutions)
  - Establishment of service delivery mechanisms at formal institutions/provincially-aided/non-departmental health facilities (step-down facilities/palliative care);
  - Reduce numbers of patients having to attend health facilities to collect medicines through the creation of a Chronic Dispensing Unit at which stabilised patients will be able to receive chronic medication;
  - Ensure uninterrupted supply of medicines at health facilities;
  - Development of an alternative platform for service delivery in non-health facilities (prisons, old-age homes, schools).
  - Intersectoral / transversal issues
  - Encourage development of fitness clubs in at risk populations in conjunction with other departments
  - Facilitate through advocacy that relevant departments invest resources in recreational amenities, facilities and activities in disadvantaged communities.

6.5.2 Timelines

- An intradepartmental team is developing a blueprint for a chronic dispensing facility as one of the identified healthcare 2010 projects
- As part of the 100-day deposits the nine largest community health centres have had dedicated managers appointed to improve facility management with specific emphasis on waiting times which will be extended to fifteen centres by April 2005;
- A waiting time survey has been completed at a number of the Community health centres and a task team has been appointed to make specific recommendations around reducing waiting times which will be implemented;
- A detailed programme for reducing waiting times will be implemented by April 2005
- Significant progress has been made in the appointment of project coordinators (technical assistants) at a district level. The coordination of these projects will be undertaken by non-governmental organizations, which will raise the profile of these organizations and improve the linkages between government and civil society organizations. Adjudication around the appointment of these NGO's is currently being finalised. This in turn will promote the development of social capital in those districts and communities.

6.5.3 Resource changes

Additional resources will be allocated to implement the following changes in Departmental Functioning

- Appointment of facility managers
- Chronic dispensing unit
- Signage and alteration of flow in Community Health Centres
- Much of the funding for community-based projects is derived from sources outside of the provincial equitable share. The community home-based care initiative is funded from the European Union partnership programme and from HIV/ AIDS programmes Conditional Grant Funding. TB DOTS and funding for anti-retroviral therapy is likewise drawn from the funding provided by Global Fund grant.
- Departmental funding will require to be allocated to programmes currently funded by donor funding in order to sustain the programmes in the longer term.

6.5.4 Restructuring

- The creation of posts with facilities and the planned restructuring of PHC functioning as per Healthcare 2010 and described above will have a significant bearing on the DHS structure as well as the size and scope of the secondary and tertiary services.
- The expansion of the community based service delivery platform has given considerable impetus to the Department's attempts to strengthen community based interventions. Not only does the added presence of trained community health workers improve the Department's ability to render services within the community, it also provides a much-improved platform for preventive and promotive interventions. One example of this has been described in the Diarrhoea Prevention strategy, where community based IMCI workers can motivate and educate (around hygiene and the use of oral rehydration solution respectively at household level). At the same time these workers can create linkages with other Departments e.g. DWAF and Local Authorities, around water provision and refuse removal.
- The altered District Management structures described above will also allow for better support to these health workers, as the management and oversight of these workers will ultimately reside with the District Managers.

6.5.5 Proposed outcomes

Ultimately all of these contributions will improve health outcomes in the communities.

- Improve access through more effective use of resources,
- Improve healthcare provision and improve caregiver training;
- To provide support to community-based interventions and building social capital through building human resources as well as improving community resilience
- Improve access to basic services through collaboration with other government departments as well as local government;
- Community health workers will be supported and employed by non-profit organizations. This will form part of the department's contribution towards economic growth and development through investment in human capital.
- By supporting and developing non-profit and community-based organizations the Department will contribute directly towards social capital formation.
- In collaboration with other departments including the Western Cape Education Department, the Department of Social Services and Poverty Alleviation and the Department of Correctional Services, these strategies will realise the objectives of building social capital within these non-health institutions.
- By encouraging participation and developing the health committees and health forums the Department is able to contribute towards "people-centred governance" thereby strengthening social capital formation.
- Ultimately to improve health outcomes and move closer to the Millennium Development Goals by improving children's health in particular, thereby reducing infant and childhood morbidity and mortality.

6.6 **Trauma**

As indicated in paragraph 2.3 homicide is the top cause of death in Cape Town and motor vehicle accidents ranked ninth in the top causes of death. Young males between the ages of 15 – 40 years are particularly at risk. This is characteristic of societies in which there is migration, informal housing and unemployment all of which are detrimental to social capital formation.

The role of the Department of Health in relation to Trauma currently is as a recipient of the heavy disease burden in that Health treats patients who are the victims of Trauma but is not able to influence the incidence of Trauma, which is an outcome of the breakdown of Social Capital. However, Health is a vital link in the chain of Trauma management and prevention in

that it can provide useful information that could assist other departments, e.g. Community Safety, Local Government and Housing, Transport and Public Works and the South African Police Services in formulating strategies to prevent Trauma.

6.6.1 Activities /outputs

- Consult with Community Safety regarding their specific data requirements to facilitate their preventive strategies.
- Monitor incidence of trauma patients presenting at State health facilities.
- Identify risk areas and communities that should be targeted for interventions by other departments.
- Participate with other departments in the formulation of prevention strategies.
- Training of health workers in the care of trauma/emergency patients.

6.6.2 Timelines

Research into the various causes for admission to Emergency/Trauma units will be the initial step. The exact nature and extent of the studies will be determined in consultation with other stakeholders in the Social Cluster.

6.6.3 Resource changes

This will be determined by the nature and scope of research required. In the event of significant reduction in the incidence of trauma, resources would become available for re-allocation.

6.6.4 Restructuring

No significant changes in current structures other than those already outlined with the Healthcare 2010 framework.
There would be some implication for the personnel in the Trauma units.

6.6.5 Proposed outcomes

- Improved information, which would enable the other departments, as outlined above to plan meaningful prevention strategies.
- Improved education programmes in schools through the Health Promoting Schools Programme.

7. MONITORING AND EVALUATION

7.1 Finalising the service delivery platform and restructuring personnel establishments is key the implementation of Healthcare 2010. Once the service platform is approved this will enable the restructuring of the staff establishments and the finalisation of the Infrastructure Plan.

7.2 Diarrhoeal disease intervention

7.2.1 Number of infants and young children affected by diarrhoea during 2005 in comparison to the number affected during 2004.
7.2.2 The number of children referred to a secondary level hospital due to inadequate management at the primary health care level.
7.2.3 Determine the place of abode of children presenting with diarrhoea in order to improve sanitation in conjunction with Local Government and the Department of Water Affairs.
7.2.4 Monitor and evaluate the quality of the interventions of IMCI workers.
7.2.5 Mortality data to be collected in a disaggregated manner to measure the impact of the project.

7.3 **Immunization**

7.3.1 Measles coverage under one year of age to be increased to 90%.
7.3.2 Complete eradication of Poliomyelitis by the end of 2005.
7.3.3 Improved overall immunization coverage in the province as a whole.

7.4 **Chronic diseases**

7.4.1 Waiting time surveys have been conducted at all the major Community Health Centres and will be repeated during 2005 to ascertain whether there has been an improvement in the waiting times.
7.4.2 Appointment of community based home care workers as well as the designated non-governmental partners to be monitored.
7.4.3 Quality of care initiatives to be monitored by the technical assistants and independent quality monitoring to be conducted.
7.4.4 Indicators are being developed to monitor the functioning of health committees and health forums.
7.4.5 Monitoring of patients receiving medicines through the Chronic Diseases unit
- Timeliness of receiving the medications;
- Monitoring of e.g. blood pressures and blood glucose levels of patients receiving medications via this unit in comparison to those of patients managed through the clinic/CHC.

7.5 **Measuring social capital formation in the broader context**

7.5.1 It is difficult to attribute a change in health indicators or health status to specific projects as thee are numerous factors outside of the project that simultaneously influence this change. These include housing, poverty levels, nutrition and lifestyle etc. It is therefore difficult to ascertain the extent to which social capital projects initiated or supported by Health, have had in reducing Health problems.

However the following types of indicators could be considered:
- The number of community based health development projects in which Health has worked in collaboration with other Departments;
- The number of projects that Health has initiated and /or initiated that address the priority areas identified by Health and the Social Cluster and that contribute to the development of social capital, e.g. prevention of substance abuse and youth development projects.
- The amount of resources that Health has contributed annually to support community based projects or interventions which have a specific emphasis on building social capital within their framework.
- The percentage of the total budget that Health contributes annually to support community-based projects or interventions which have a specific emphasis on building social capital within their framework.
- The percentage of the total budget that Health contributes annually to support community-based projects or interventions, which have a specific emphasis on equity within their framework.
- The level of support for communities to build their own activities in the community through provision of resources for community based workers and other expenses such as meeting halls, transport, costs of social activities or sporting events
- The percentage of health facilities that have established operational health committees, or the number of health facilities that are regularly represented at an appropriate local level health forum (e.g. the sub-district health forum).

- The percentage of primary care facilities that have conducted an audit of local community-based organisations and networks, and can illustrate examples of how the facility has worked in partnership with these organisations to consolidate local health development and health promotion activities. It is understood that at sub-district level Technical Assistants (employed as part of the Community and Home-based Care initiative) are

currently collecting this type of information – an initiative that can be built on as part of Health's contribution to SCFS.

- The number of awareness raising programmes that support health care workers to provide a sensitive service to their clients at the point of delivery.
- The extent to which the attitudes and behaviour of health care staff towards patients have contributed to the establishment of a trusting relationship between the staff and patients.
- The level of client satisfaction on the quality of services received and the nature of the health worker-client relationship, as recorded by exit interviews.
- In addition, more in-depth consideration could be given to investigating whether any routinely collected information, such as the RMR, could be used as indicators of Health's contribution to the building of social capital.

Some measures of social capital that have been used to date in research, and could potentially also be considered for use by the Provincial Social Cluster, include the following:

- The level of civic engagement or the extent to which community members involve themselves in their communities (which has been measured at a 'neighbourhood level' by the per capita number of voluntary groups and associations to which community members belong, and could also include voting levels, reported trust in government leaders, and interest in neighbourhood problems);
- The level of social cohesion (measured by divorce rate, per capita crime rate, and the extent to which people in a neighbourhood are perceived to hold the same values, or get along with each other);
- The level of social trust experienced by community members (which has been gauged at an individual level by the proportion of informants that believed people were fair in their interactions with them, could be trusted, and were helpful);
- The characteristics of neighbourhoods, such as the level of physical and social disorder that in turn influences the patterns of social-network development, co-operation, collective efficacy, and social deviance - (and could potentially be measured by such things as the perceived 'helpfulness' of people; the likelihood that neighbours could be counted on to intervene in problems such as a fight, truancy or vandalism; and the rate of violent crime).[28]

8. CONCLUSIONS

The Department of Health has made a concerted effort to analyse social capital formation and its implications for the Department. It is clear that social capital plays a fundamental role in the prevention of disease and the promotion of health. As the successful functioning of the Department rests on an effective and efficient Primary Health Care service so does the development of social capital. The Department's Healthcare 2010 and social capital formation strategy are therefore closely aligned and both have a primary health care focus.

In addition to implementing Healthcare 2010, initial steps the Department has identified four issues with which to link the progress in social capital formation, i.e. diarrhoeal disease in children, immunisation, the management of chronic diseases, including HIV and AIDS; and trauma.

It is believed that by fostering social capital formation, communities will assume responsibility for their own health and the manner in which they utilise health facilities. The aim is to develop a reciprocal relationship between the Department and the communities that it serves.

[28] Drawn from Macinko & Starfield (2001).

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