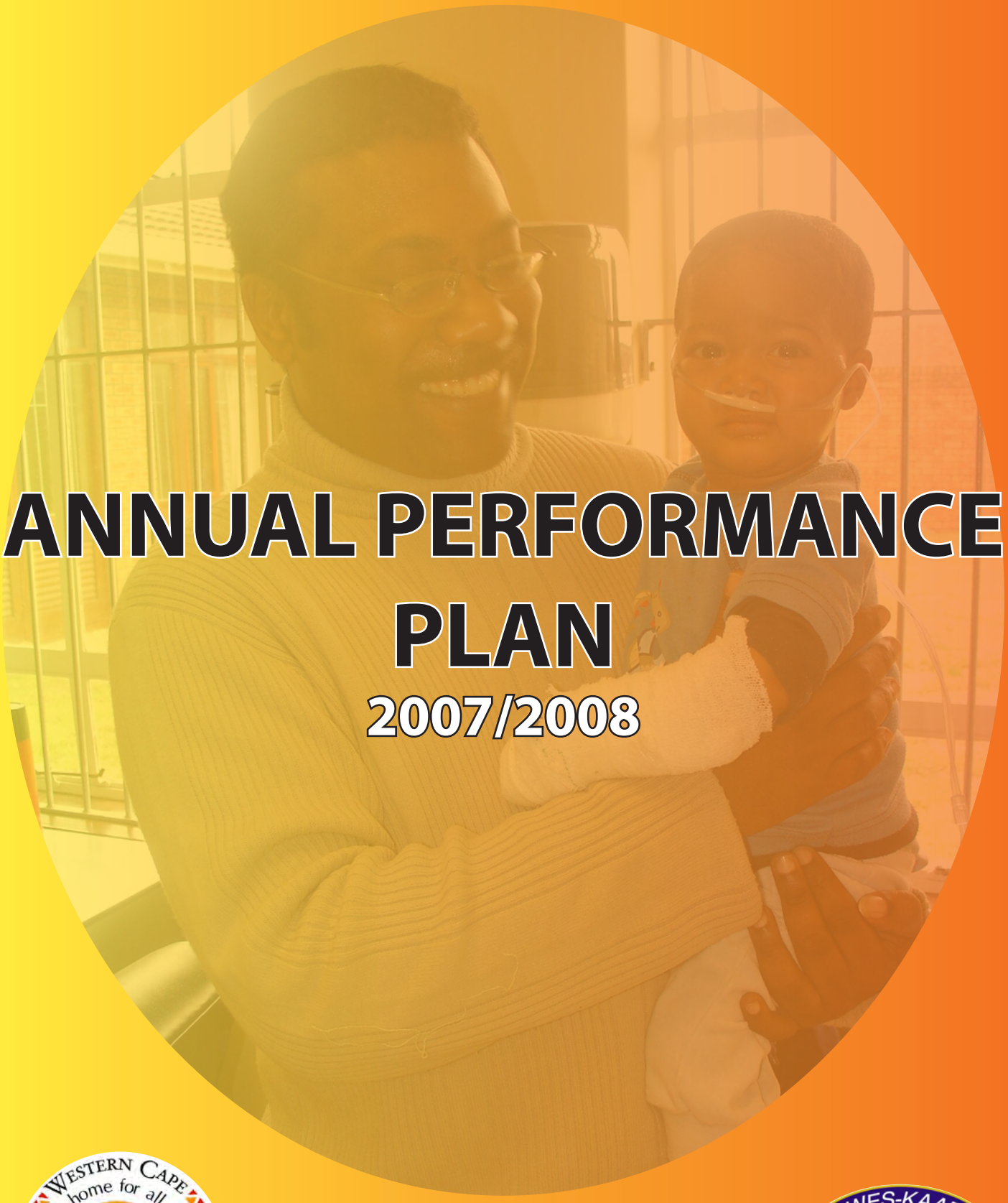


ANNUAL PERFORMANCE PLAN

2007/2008

Provincial Government of the Western Cape
Department of Health

TABLE OF CONTENTS

INDEX OF TABLES AND FIGURES

TABLE/FIGURE PAGE

PART A: STRATEGIC OVERVIEW

Programme 7

Programme 8

MESSAGE BY THE WESTERN CAPE HEALTH MINISTER: PIERRE UYS

NOW IS THE TIME FOR ACTION

There is a time for contemplation and a time for action. Our annual performance plan allowed time for contemplation during which we as a team grappled with the challenges facing healthcare in our province. Now is the time for action. Together we decided on the steps needed to overcome the challenges facing us and committed ourselves to this plan that will guide our actions in the year ahead.

As Health Minister in the Western Cape, I have pledged this department to give real and tangible effect to its mission namely to provide our people with "equal access to quality health care". This, we all know is only possible if the health service improves and does not discriminate but delivers on dependable, high quality care as close as possible to the people who use our services.

In the process of developing this plan we took onboard the demands made on our services by communities and made changes in the allocation of our resources. In this regard, our annual performance plan recognizes the following priorities;

- The primacy of primary health care (PHC) services as the gateway to health services for the majority who are dependent on our services. For this reason the finalisation of the process of assuming responsibility for Personal Primary Health Care (PPHC) in the rural areas and the upgrading of infrastructure to accommodate the service carries a high priority.
- The implementation of Healthcare 2010 Comprehensive Service Plan which will reshape the service by treating patients at the level of care that is most appropriate to their need and therefore improving quality of care and realising significant efficiency gains. In doing this we have had to make difficult choices on how resources are allocated, giving priority to PHC services over more highly specialized services.
- The strengthening of Emergency Medical Services by recruiting and training significant additional numbers of medical rescue staff.
- The upgrading of facilities following the transfer of forensic pathology services from the South African Police Service to the Department of Health.
- Improvement of salaries for health professionals with a particular focus on nursing salaries during 2007/08.
- Appointment of additional staff including two-year interns, community service nurses and other health professionals.

Once we have completed the process of the integration of health related services and the rollout of the Healthcare 2010 Comprehensive Service Plan, we will for the first time be in a position to ensure that high quality healthcare is equitablyprovided throughout the province. I also wish to reassure the people of the Western Cape that provincial standards of care closely linked to national standards will be guaranteed. There will be easier and swifter access to appropriate healthcare when and where our people need it.

While healthcare all over the world is undergoing change to adapt to the demands made on it by the public, it is good to know that the Western Cape is keeping pace. With the changes envisaged through this performance plan we will begin to provide new and better services to our people. There are many challenges ahead but I am confident that with the support of the community, the dedication of all our staff and the backing of the Western Cape Government, we will continue to provide high quality healthcare to all our people.

WESTERN CAPE HEALTH MINISTER:

PIERRE UYS

MESSAGE FROM THE HEAD OF HEALTH WESTERN CAPE: PROFESSOR CRAIG HOUSEHAM

The Department of Health in the Western Cape is tasked with the provision of a comprehensive package of health services to the people of the Western Cape. Included in this package of services are highly specialized tertiary health care services, which are provided to people from the Western Cape, neighbouring provinces and beyond. These services are funded from the National Tertiary Services Conditional Grant (NTSG). The remainder of the health services such as that provided in primary health clinics, community health centers, district and regional hospitals are funded largely from the provincial equitable share or "own" provincial funding.

The R7, 095 billion allocated to the Department of Health for the 2007/2008 financial years comprises 34% of the provincial budget and reflects a 9.6% nominal increase in the Health budget. This amount has been divided largely amongst district health services (DHS) R2, 44 billion (34%), which includes all health care provided from home-based care through clinics, community health centers to district hospitals; emergency medical services R345 million (4,8%); provincial hospital services, which includes regional, TB and psychiatric hospitals R1, 17 billion (16,5%) and central hospitals R2,175 billion (30,6%).

In the current year the District Health Service [DHS] will see around 13 million PHC contacts at an average cost per visit, which is one of the lowest cost per contact as reported in the provincial quarterly performance reports for health released by the National Treasury. In addition the utilization rate for district hospitals is 80%, which is the highest in the country. This is the level of care where most people access the service and where the pressure of numbers and the demand for services is the greatest. It is the level of care where communities complain about long queues and the quality of care received, and thus it was a priority for the budget.

The 192 ambulances of the emergency medical services (EMS) will cover nearly 13 million kilometers in the current financial year in response to around 100, 000 calls. The response time of 15 minutes for "code red" or urgent patients in urban areas is achieved in only 40% of cases. Funds allocated in the 2007/2008 budget will allow the appointment of additional staff to address the poor performance in terms of response times.

Provincial hospitals in the Western Cape are on average more than 100% full which exceeds all other provinces with the nearest being Gauteng which has a bed occupancy of 82% in the second quarter of the 2006/2007 financial year. The average length of stay in these facilities at 3,6 days is also amongst the lowest in the country. These hospitals struggle to cope with large patient numbers and overload of their emergency departments on many days in the year.

Finally in the central hospitals the bed occupancy was nearly 84% once again higher than in other provinces that have reported. From these figures it is clear the health services at all levels of care in the Western Cape are both busy and efficient and further that the pressure on the service is acute at all levels of care.

Budget projections in the 2006/2007 financial year show financial pressure in particularly the district health services, general hospitals such as George, GF Jooste, Hottentots Holland, Somerset and Karl Bremer hospitals as well as, although to a lesser degree proportionally, the central hospitals. The priority for the department must be the areas in the health service where the majority of patients are seen.

In compiling the budget the department considered many policy options and identified the need for over R400 million in addition to salary adjustments and funding earmarked for specific purposes.

These options were developed in the department, submitted to Treasury and subsequently discussed with the provincial Treasury in two formal engagements. These options were also weighed up against priorities of other departments in the social cluster and the province. In the end taking into account the available funds it was not possible to fund many of the priorities identified in health. Only by raising the revenue to be collected and reprioritizing within the existing health budget was it possible to allocate funds to certain key priorities.

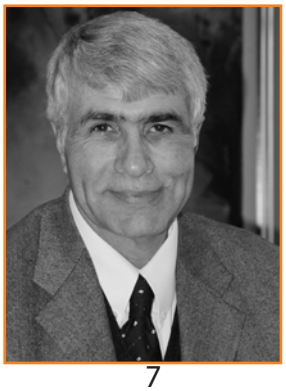
These include amongst others funding the strengthening of the management structures in the Metro to ensure cost effective and efficient utilization of the around R1 billion allocated to these services in this area; providing additional funding to district hospitals; providing funding for the provincialization of certain provincially aided and TB hospitals; relieving the funding pressures at GF Jooste Hospital; funding home-based care previously funded by the European Union and providing funds to offset the increased GMT tariffs. Additional funds have also been allocated for maternity and neonatal services and assist with the opening of the new wards at the George Regional Hospital.

To partially achieve but not fully address these modest but essential objectives it was necessary to allocate additional funds over and above earmarked and conditional grants funds to both district health services and regional hospitals. This was achieved by allocating projected increased revenue collection against these objectives and only increasing the funds to the central hospitals by 1,8%. The central hospitals nevertheless receive the entire R1, 335 billion NTSG, R210 million from the Health Professions Training and Development Grant (HPTDG) and R578 million from the provincial equitable share. It is important to note that the NTSG decreases in real terms by R12 million in the 2007/2008 financial year while the additional R51 million provided for modernization of tertiary services is earmarked for specialized medical equipment. If the NTSG was to be adjusted upward additional funds could be made available to the Central hospitals for the provision of further highly specialized services. Failing this the department had no option but to prioritize the allocation of funds toward district and regional levels of care.

It is clear from this that the department was faced with difficult choices in the compilation of this budget. Whilst the department could have reduced the expenditure on equipment and maintenance and maintained operational expenditure as has been done in the past, it was decided that this would be a short sighted approach and thus this expenditure has been maintained in the coming year.

Whilst the impact of the bed closures should not be minimized, it is important to note that in terms of the final comprehensive service plan (CSP) Groote Schuur Hospital will have 971 beds while Tygerberg Hospital will have 1195 beds. In both cases even after the envisaged bed reductions the total useable beds would be within the envisaged CSP 2010 targets. What will have to change is the distribution of beds between level 2 and 3 from the current configuration and this reinforces the need to restructure the services to achieve both an affordable and efficient service platform.

The Department is convinced after thorough evaluation of all possible options that despite the understandable concerns, the decisions taken in this budget places the Western Cape in the best possible position to deliver health care to the majority of the citizens that we serve.



HEAD OF HEALTH: WESTERN CAPE
PROFESSOR KC HOUSEHAM

PART A

STRATEGIC OVERVIEW

STRATEGIC OVERVIEW

1. OVERVIEW OF STRATEGIC PLAN

Healthcare 2010 sets out the strategic direction of the Western Cape Department of Health. This strategy 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 growth and development strategy giving effect to iKapa elihlumayo/the Provincial Growth and Development Strategy. The Health Department supports the Social Capital Formation strategy and the Provincial Strategic Infrastructure Plan. The Department of Health contributes significantly to growth and development through ensuring and promoting a healthy community and workforce.

Healthcare 2010:

Healthcare 2010 is about reshaping the 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 cost effective. 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 district 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 rural districts, i.e. Cape Winelands, Overberg, Eden, Central Karoo and Westcoast.

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

Previous 2001 population estimates with the adjusted 2005 mid-year statistics (reduced Western Cape population)

TOTAL POPULATION											
DISTRICT	**2000/01**	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**% Public Population**
Cape Town	2, 893,248	2,938,222	2,938,222	2,938,897	3,030,285	3,012,776	3,059,516	3,106,983	3,155,189	3,204,146	68.40
West Coast	282,672	287,057	287,057	291,510	296,032	295,503	300,087	304,743	309,471	314,273	81.00
Cape Winelands	629,490	639,265	639,265	649,192	659,273	656,455	666,639	676,982	687,485	698,153	80.00
Overberg	203,517	206,672	206,672	209,875	213,129	213,580	216,893	220,258	223,676	227,146	83.00
Eden	454,924	461,989	461,989	469,164	476,451	475,785	483,166	490,662	498,275	506,007	81.00
Central Karoo	60,485	61,425	61,425	62,379	63,349	63,569	64,555	65,557	66,574	67,607	89.00
Western Cape Province	4,524,336	4,594,629	4,594,629	4,666,017	4,738,519	4,717,668	4,790,857	4,865,186	4,940,671	5,017,332	73.00
Source: Information Management											
UNINSURED POPULATION											
DISTRICT	**2000/01**	**2001/02**	**2002/03**	**2003/04**	**2004/05**	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**% Public Population**
Cape Town	1,978,982	2,009,744	2,009,744	2,040,986	2,072,715	2,060,739	2,092,709	2,125,176	2,158,149	2,191,636	68.40
West Coast	228,964	232,516	232,516	236,123	239,786	239,357	243,071	246,842	250,672	254,561	81.00
Cape Winelands	503,592	511,412	511,412	519,353	527,419	525,164	533,311	541,585	549,988	558,522	80.00
Overberg	168,919	171,537	171,537	174,197	176,897	177,271	180,022	182,815	185,651	188,532	83.00
Eden	368,488	374,211	374,211	380,023	385,925	385,386	391,365	397,437	403,603	409,865	81.00
Central Karoo	53,832	54,668	54,668	55,517	56,380	56,576	57,454	58,346	59,251	60,170	89.00
Western Cape Province	3,302,777	3,354,088	3,354,088	3,406,199	3,459,122	3,444,494	3,497,931	3,552,200	3,607,314	3,663,286	73.00

Source: Western Cape Department of Health, Directorate: Information Management

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.

Table 3: Socio-demographic characteristics of the population

	% of total population	% < 15 yrs	% > 60 yrs	% Female	% Foreign born	% of population >20 years with no education	% of population 15-64 years 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 years who are unemployed.

Annual in-migration figures 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'. It is of note that the impressions from service related statistics is that the actual migration to the Western Cape is greater than reflected by the official statistics.

2.1.2 Epidemiological profile

The burden of disease within a community can measured using mortality and morbidity statistics. Mortality statistics are more readily available although they underestimate the burden of diseases with a higher morbidity component e.g. mental illness. Mortality statistics can be presented as follows:

1) By counting the causes of death and ranking them. The South African National Burden of Disease Study 2000: Estimates of Provincial Mortality (Bradshaw et al, 2004) reports that the top five causes of death in the Western Cape are:
   - Ischaemic heart disease:12,0%
   - Stroke: 8,4%
   - HIV and AIDS:8,8%
   - Homicide and violence:8,1% and
   - Tuberculosis: 6,8%.

Due to the fact that the Western Cape is at a relatively more advanced stage in the demographic and health transitions, the province reflects a different death profile to the rest of the country where at 29,8% HIV and AIDS is the number one cause of death and ischaemic heart disease at 5,6% is the number three cause of death.

2) Mortality statistics can be weighted for premature mortality (Years of Life Lost). This reflects the number of years a person lost when they died before the end of the their expected lifespan. Measuring premature mortality is important for identifying preventable deaths and ranking the most important causes that could in theory respond to preventive interventions aimed at reducing mortality. The The South African National Burden of Disease Study 2000: Estimates of Provincial Mortality (Bradshaw et al, 2006) reports that the Western Cape tope five causes of premature death are:
   - HIV and AIDS: 14,1%
   - Homicide and violence: 12,9%
   - Tuberculosis: 7,9%
   - Road traffic accidents: 6,9% and
   - Ischaemic heart disease: 5,9%.

Although not as many people die prematurely from HIV and AIDS in the Western Cape (14,1%) in comparison to the rest of the country (39%), HIV and AIDS is still the leading cause of premature death in this province. Tuberculosis is another significant cause of death in the Western Cape and together with HIV and AIDS accounts for 22% of premature mortality.

This is closely followed by premature deaths due to homicide/violence and road traffic accidents which account for 20% of premature deaths in the Western Cape.

The profile of causes of deaths differ according to gender and socio-economic class. As indicated in Table 4, in the Western Cape homicide is the leading cause of premature death for men, accounting for 18,5% of premature deaths, whereas the leading cause of premature deaths for women is HIV and AIDS, 18,8%. The reasons for these differences are complex but can be attributed to varying vulnerability to particular causes of death based on anatomical and physiological differences, gender roles and socio-economic disparities. Premature mortality due to causes related to poverty and under development such as diarrhoeal disease, infectious diseases, nutritional deficiencies and violence is more prevalent in poorer communities. However, non-communicable disease mortality affects both the developed and under developed communities alike.

Table 4: Leading 20 single causes of premature mortality burden (YLLs) by sex in the Western Cape 2000

	MALES		FEMALES		PERSONS	
Rank	**Cause of death**	**%**	**Cause of death**	**%**	**Cause of death**	**%**
1	Homicide/ violence	18.5	HIV and AIDS	18.8	HIV and AIDS	14.1
2	HIV and AIDS	10.8	Tuberculosis	7.7	Homicide /violence	12.9
3	Road traffic accidents	8.2	Ischeamic Heart disease	6.0	Tuberculosis	7.9
4	Tuberculosis	8.1	Stroke	5.8	Road traffic accidents	6.9
5	Ischaemic heart disease	5.7	Road traffic accident	5.0	Ischaemic heart disease	5.9
6	Stroke	3.7	Homicide/violence	4.9	Stroke	4.6
7	Trachea/bronchi/lung ca	3.1	Diabetes mellitus	3.2	Trachea/bronchi/lung ca	2.7
8	Suicide	3.0	Diarrhoeal disease	2.7	Lower respiratory infections	2.4
9	Chronic obstructive pulmonary disease	2.3	Breast ca	2.7	Suicide	2.3
10	Lower respiratory infections	2.1	Lower respiratory infections	2.7	Diarrhoeal disease	2.3
11	Diarrhoeal diseases	2.0	Septicaemia	2.2	Diabetes mellitus	2.1
12	Low birth weight	1.9	Trachea/bronchi/lung ca	2.1	Chronic obstructive pulmonary disease	2.1
13	Fires	1.7	Fires	1.8	Fires	1.8
14	Diabetes mellitus	1.3	Chronic obstructive pulmonary disease	1.8	Low birth weight	1.7
15	Epilepsy	1.2	Cervix ca	1.7	Septicaemia	1.5
16	Septicaemia	1.1	Hypertensive heart disease	1.6	Hypertensive heart disease	1.2
17	Asthma	0.9	Nephritis/nephrosis	1.6	Breast ca	1.1
18	Oesophogeal ca	0.9	Low birth weight	1.4	Nephritis/nephrosis	1.1
19	Hypertensive heart disease	0.9	Suicide	1.3	Asthma	1.0
20	Cirrhosis of the liver	0.9	Diabetes mellitus	1.2	Epilepsy	1.0

Source: South African National Burden of Disease Study 2000 (MRC: 133)

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.

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 and the preliminary report of the South African Demographic Health Survey (SADHS) 2003-2004.

Table 5: Trends in key provincial mortality indicators [A1]

Indicator	Source: ASSA 2000		SADHS 2003-2004	Target Health goals, objectives and indicators 2001 to 2005
	Western Cape	National	Western Cape	
Infant mortality (under 1)	30	59	43.5	45 per 1,000 live births by 2005
Child mortality (under 5)	46	100	56.5	59 per 1,000 live births by 2005
Maternal mortality	45		-	100 per 100,000 live births by 2005

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 6: Infant Mortality Rate (per 1 000 live births)

	2002	2003	2004	2005	Source
South Africa	59	-	-	-	South African Health Review 2005: 302
Western Cape	30	-	-	-	
Cape Town Metro district	-	25.16	23.74	22.28	City of Cape Town
Cape Town Metro Sub-districts	-				
Eastern	-	28.98	22.90	27.51	
Khayelitsha	-	42.11	36.61	34.72	
Klipfontein	-	28.65	28.79	27.41	
Mitchell's Plain	-	22.03	2418	22.85	
Northern	-	24.55	20.80	22.88	
Southern	-	16.98	20.97	5.23	
Tygerberg	-	18.61	19.58	16.20	
Western	-	17.58	16.41	15.22	

There are striking differences in the cause of death profile across the sub-districts in the Metro with injuries and pre-transitional causes, especially HIV and AIDS featuring prominently in poorer sub-districts such as Khayelitsha and Mitchells Plain in contrast to the non-communicable diseases that are responsible for the majority of deaths in the more affluent sub-districts.

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, albeit possibly at a slower rate.

According to the report of the National HIV and Syphilis antenatal sero-prevalence survey in South Africa, 2005 it is estimated that 30,2% of women attending antenatal clinics were HIV positive. This is a sharp increase from the 0.7% recorded in 1990. In the Western Cape the HIV prevalence rates amongst antenatal clinic attendees for 2003, 2004 and 2005 are 13.1%, 15.4% and 15.7% respectively. Although the prevalence rate for the province is less than the national prevalence, in some districts such as Khayelitsha the prevalence is estimated to be 33% which is higher than the national average.

Non-communicable diseases

As illustrated in Table 7 HIV and AIDS, homicide and TB are the top three causes of death in most sub-districts. Non-communicable diseases are shown to be more prominent in the relatively more affluent sub-districts. However, Table 7 illustrates that poorer communities are also affected by diseases of lifestyle. Sub-districts such as Athlone and Mitchell's Plain are not affluent but also have a significant burden of non-communicable diseases such as diabetes and cardiovascular diseases which could be attributed to the differential health transition involving a shift to diseases of lifestyle.

Table 7: Top 10 causes of premature mortality (YLLs) for Cape Town and sub-districts for persons, 2004

Source: Medical Research Council

Rank	Athlone	Blaawberg	Central	Helderberg	Khayelitsha	Mitchells Plain	Nyanga	Oostenberg	South Peninsula	Tygerberg East	Tygerberg West	Cape Town
1	Diabetes mellitus (8.7%)	HIV/AIDS (14.4%)	HIV/AIDS (16.2%)	HIV/AIDS (14.9%)	HIV/AIDS (27.3%)	Homicide (11.8%)	HIV/AIDS (28.5%)	HIV/AIDS (18.3%)	HIV/AIDS (9.7%)	HIV/AIDS (16.6%)	Tuberculosis (7.1%)	HIV/AIDS (17.6%)
2	Homicide (8.3%)	Homicide (11.8%)	Homicide (10.1%)	Homicide (11%)	Homicide (16.9%)	HIV/AIDS (10.3%)	Homicide (18.6%)	Homicide (12%)	Homicide (6.9%)	Homicide (10.2%)	Homicide (6.8%)	Homicide (12.4%)
3	Ischaemic heart disease (6.3%)	Tuberculosis (8.1%)	Tuberculosis (5.4%)	Tuberculosis (9.5%)	Tuberculosis (10.8%)	Diabetes mellitus (7.7%)	Tuberculosis (8.5%)	Tuberculosis (9.2%)	Ischaemic heart disease (6.0%)	Tuberculosis (9.0%)	Stroke (6.4%)	Tuberculosis (8.1%)
4	HIV/AIDS (5.9%)	Road traffic (7.4%)	Ischaemic heart disease (4.5%)	Ischaemic heart disease (6.9%)	Road traffic (5.6%)	Low birth weight and RDS (5.7%)	Road traffic (5.2%)	Road traffic (8.5%)	Tuberculosis (5.5%)	Road traffic (6.3%)	Road traffic (6.0%)	Road traffic (5.7%)
5	Tuberculosis (5.7%)	Ischaemic heart disease (5.3%)	Road traffic (4.5%)	Lower respiratory infections (5.4%)	Diarrhoeal Diseases (4.6%)	Tuberculosis (5.6%)	Lower respiratory infections (3.9%)	Suicide (4.1%)	Diabetes mellitus (5.3%)	Low birth weight and RDS (5.1%)	Diabetes Mellitus (5.9%)	Diabetes Mellitus (3.7%)
6	Road traffic (5.6%)	Low birth weight (3.5%)	Diabetes mellitus (4.4%)	Road traffic (5.2%)	Lower respiratory infections (3.5%)	Road traffic 4.8%)	Diarrhoeal diseases (3.4%)	Ischaemic heart disease (3.9%)	Stroke (4.5%)	Ischaemic heart disease (3.5%)	Ischaemic heart disease (5.6%)	Stroke (3.5%)
7	Stroke (5.4%)	Stroke (3.3%)	Stroke (4.1%)	Fires (4.3%)	Low birth weight and RDS (2.9%)	Stroke (4.7%)	Low birth weight and RDS (3.0%)	Lower Respiratory infections (3.6%)	Road traffic (4.1%)	Stroke (3.5%)	HIV/AIDS (5.3%)	Low birth weight (3.4%)
8	Hypertensive heart disease (5.3%)	COPD (2.9%)	Lower respiratory infections (3.7%)	Stroke (3.8%)	Fires (2.1%)	Ischaemic heart disease (4.2%)	Fires (2.4%)	Stroke (3.2%)	Lung cancer (3.8%)	Diabetes mellitus (3.2%)	Low birth weight and RDS (5.2%)	Ischaemic heart disease (3.4%)
9	COPD (4.6%)	Lower respiratory infections (2.6%)	Low birth weight and RDS (3.3%)	Suicide (2.5)	Stroke (1.7%)	Lung cancer (3.6 %)	Hypertensive heart disease (2.3%)	Diabetes mellitus (3.1%)	Low birth weight and RDS (3.1%)	Lower Respiratory infections (2.8%)	Lung cancer (5.0%)	Lower Respiratory infections (3.4%)
10	Lung cancer (4.3%)	Lung cancer (2.4%)	Hypertensive heart disease (3.1%)	Diarrhoeal diseases (2.4%)	Diabetes mellitus (1.7%)	Lower respiratory infections (2.9%)	Stroke (2.1%)	Low birth weight and RDS (2.7%)	Lower respiratory infections (3.1%)	Lung cancer (2.7%)	Hypertensive heart disease (4.5%)	Lung cancer (2.4%)

Alcohol

Alcohol abuse is a particular problem in Western Cape. The National Injuries Mortality Surveillance System (NIMSS) report of 2005 indicates that in Cape Town 58% of all homicides in 2004 tested positive for blood alcohol concentration which is significantly higher than Johannesburg and Durban. The rural areas of the Western Cape also have a significant alcohol problem. 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.

Substance abouse

The overwhelming increase in methamphetamine (TIK) abuse and addiction with all its consequences since its rise in popularity in 2003 presents an even greater challenge. TIK has had extremely negative consequences for the Province, not only the obvious social and legal consequences but also dire health and mental health consequences. TIK use is associated with anxiety, depression, as well as behavioural problems such as violence and high risk HIV behaviour. Furthermore, withdrawal can be protracted, often lasting several months, and is associated with dysphoria (restlessness and agitation) and anhedonia (total loss of feeling pleasure) that predispose to relapse and for which there is no specifically proven effective medication. According to the Western Cape SANCA 2005/2006 TIK has for the first time replaced alcohol as the number one substance used by people seeking their services (TIK 26% of users, alcohol 21% and dagga 11%).

2.1.3 Major health service challenges and progress

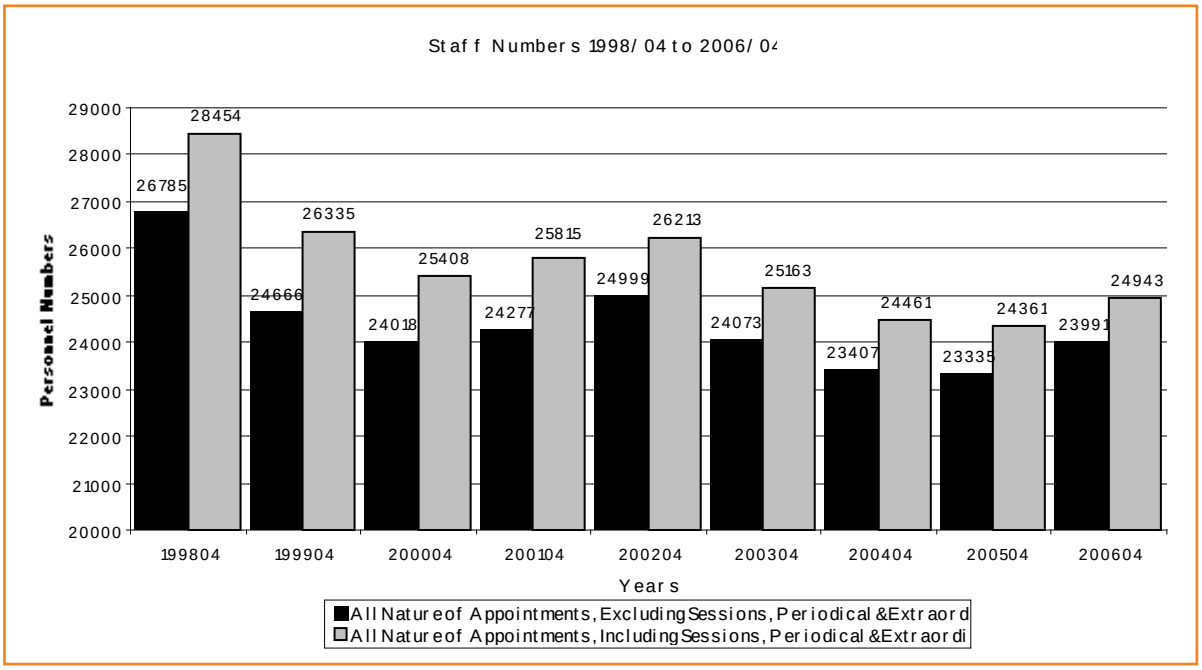
The key challenge of the Department is to finalise and implement the Comprehensive Service Plan. This will reshape the service platform and facilitate the implementation of the Department's long-term strategy, Healthcare 2010.

From 1 April 2005 the Province has been funding the Personal Primary Health Care (PPHC) services in the rural areas. Local government will continue to provide a service in the Metropole for the next two years during which time the issue of funding for these services must be resolved between provincial and national government.

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. Figure 1 illustrates that the number of personnel in the Department of Health has decreased by approximately 10% between 1998 and 2006. The attrition rate of nurses is of particular concern, for professional nurses it was approximately 10% and for some specialist areas of nursing it was 16% for the period 1 April 2005 to 31 March 2006.

Figure 1: Personnel numbers in Provincial Health Facilities from 1998 to 2006



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 8: 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 2007/08 is R7,095 billion and compared to the revised estimate of the budget there is a nominal increase of 8,78% or R622,825 million.
Table 8 below reflects the Department's budget for the MTEF period

Table 9: Health Department budget as a percentage of Provincial budget

	Audited 2003/04	Audited 2004/05	Audited 2005/06	Main appropriation 2006/07	Adjusted appropriation 2006/07	Revised estimate 2006/07	2007/08	2008/09	2009/10
Department of Health	4,547,304	5,169,199	5,733,567	6,323,493	6,476,348	6,472,360	7,095,173	7,942,423	8,411,769
Provincial Total	13,100,824	14,581,101	16,374,027	18,360,059	19,443,059	19,412,396	20,701,612	23,251,551	25,029,319
Health budget as a percentage of the Provincial Total	34.71%	35.45%	35.02%	34.44%	33.31%	34.34%	34.27%	34.16%	33.61%

Source: Western Cape Budget: 2007

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 64,20% of the Department's funding and the conditional grants for 30,68%. The projected revenue for 2005/06 will account for approximately 5,12% of the budget.

Table 10: Funding sources of the Western Cape Health Department

	Audited 2003/04	Audited 2004/05	Audited 2005/06	Main appropriation 2006/07	Adjusted appropriation 2006/07	Revised estimate 2006/07	2007/08	2008/09	2009/10
Treasury Funding									
Equitable share	2,364,128	2,826,872	3,663,110	4,034,688	4,041,688	4,035,225	4,555,076	5,067,124	5,495,081
Conditional grants	1,467,022	1,555,421	1,816,047	1,991,725	2,018,025	2,020,501	2,177,028	2,499,265	2,562,363
Financing					91,582	91,582			
Total Treasury Funding	**3,831,150**	**4,382,293**	**5,479,157**	**6,026,413**	**6,151,295**	**6,147,308**	**6,732,104**	**7,566,389**	**8,057,444**
Departmental Receipts	119,872	165,011	254,410	297,080	325,053	325,053	363,069	376,034	354,325
TOTAL RECEIPTS	**3,951,022**	**4,547,304**	**5,733,567**	**6,323,493**	**6,476,348**	**6,472,360**	**7,095,173**	**7,942,423**	**8,411,769**

Source: Budget Statement 2007.

Note: Provincial Funding R91,582,000 of which:
R26,432,000 is in respect of frontloading from the budget estimates 2007/08 for accelerating of capital expenditure.
R28,553,000 is in respect of roll-over funds for the Hospital Revitalisation Conditional Grant not uitlised in 2005/06.
R8,329,000 is in respect of roll-over funds of the Forensic Pathology Services Conditional Grant not utilized in 2005/06.
R28,268,000 is in respect of: R22,208,000 revenue retained from the 2005/06 financial year, R5,000,000 new allocation from provincial funds for unforeseeable and unavoidable expenditure and R1,060,000 roll-over of global funds from the 2005/06 financial year.

Table 11: Conditional grant allocation for 2007/08

CONDITIONAL GRANT	ALLOCATION 2007/08	% OF TOTAL HEALTH BUDGET FOR 2007/08
National Tertiary Services Grant (NTSG)	1,335,544	18.82%
Health Professions Training and Development (HPTDG)	339,442	4.78%
HIV and AIDS Grant	150,559	2.12%
Hospital Revitalisation Grant (HRP)	191,796	2.70%
Forensic Pathology Services	79,425	1.12%
Provincial Infrastructure Grant (PIG)	80,262	1.13%
TOTAL CONDITIONAL GRANT ALLOCATION	**2,177,028**	**30.68%**
TOTAL HEALTH BUDGET	**7,095,173**	

Source: Western Cape Budget 2007

The allocation to the Department of Health must also be seen in the context of the high level of medical inflation, illustrated in Table 11.

Table 12: Cost of medical inflation in comparison to CPIX

PERIOD	CPIX	MEDICAL INFLATION
APRIL 2001 – MARCH 2002	9.2%	11.5%
APRIL 2002 – MARCH 2003	7.4%	9.8%
APRIL 2003 – MARCH 2004	5.6%	10.2%
APRIL 2004 – MARCH 2005	4.1%	7.2%
APRIL 2005 – MARCH 2006	3.5%	4.9%

Source: Western Cape Health Department: Budget Review 2004/2005: 14
STATSSA: Consumer Price Index (CPI) Headline March 2006

The migration into the Province and the trends in the burden of disease and service demands place an increasing burden on the limited resource envelope.

Table 13: Trends in provincial service volumes [A2]

Indicator	2000/01 (actual)	2001/02 (actual)	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)
PHC headcount in PHC facilities	11 986 838	12 064 857	12 959 900	12 882 038	12 758 966	13 068 303
OPD headcounts	1 578 701	2 055 286	1 966 520	2 804 556	2 787 090	2 687 090
Hospital separations						
District hospitals	128 972	122 476	141 785	167 150	195 150	142 864
Regional hospitals	155 823	147 002	169 617	174 978	180 855	188 166
Central hospitals	126 163	125 001	133 691	116 093	119 250	122 649

Table 14: Division of budget between the respective financial programmes since 2002/03 and for the MTEF period

	2003/04		2004/05		2005/06		2006/07*		2007/08		2008/09		2009/2010	
	R'000	%	R'000	%	R'000	%	R'000	%	R'000	%	R'000	%	R'000	%
1. Administration	215,644	4.74%	213,316	4.13%	174,782	3.05%	167,699	2.59%	367,238	5.18%	399,038	5.02%	516,752	6.14%
2. District Health Services	1,144,699	25.17%	1,330,397	25.74%	1,649,725	28.77%	1,976,416	30.54%	2,440,654	34.40%	2,728,663	34.36%	2,866,811	34.08%
4. Emergency Medical Services	185,695	4.08%	198,170	3.83%	253,374	4.42%	286,357	4.42%	344,796	4.86%	374,651	4.72%	397,126	4.72%
4. Provincial Hospitals	1,053,048	23.16%	1,176,641	22.76%	1,288,031	22.46%	1,369,533	21.16%	1,170,380	16.50%	1,902,298	23.95%	2,036,620	24.21%
5. Central Hospitals	1,607,089	35.34%	1,805,918	34.94%	1,963,483	34.25%	2,137,767	33.03%	2,175,801	30.67%	1,701,985	21.43%	1,780,271	21.16%
6. Health Sciences and Training	71,116	1.56%	73,541	1.42%	81,533	1.42%	101,393	1.57%	142,214	2.00%	177,064	2.23%	187,459	2.23%
7. Health Care Support Services	73,837	1.62%	82,752	1.60%	92,075	1.61%	93,601	1.45%	85,401	1.20%	92,795	1.17%	98,361	1.17%
8. Health Facilities Management	196,176	4.31%	288,464	5.58%	230,564	4.02%	339,594	5.25%	368,689	5.20%	565,929	7.13%	528,369	6.28%
TOTAL	4,547,304	100.0%	5,169,199	100.0%	5,733,567	100.0%	6,472,360	100.0%	7,095,173	100.0%	7,942,423	100.0%	8,411,769	100.0%

Source: Budget Statement 2007.

Notes:

1. The funding for Programme 8 was transferred from the Department of Public Works from 1 April 2005
2. The funding for GF Jooste, Hottentots Holland, Karl Bremer and Nelspoort Hospitals will be transferred from Programme 4 to Programme 2 during 2007/08.
3. The funding for the level 2 beds in the Central Hospitals is transferred from Programme 5 to Programme 4 during 2008/09.
4. The revised estimate of the budget was used for 2007/08.

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 established a Mental Health Review Board during 2005.

National Health Act, Act 61 of 2003

The National Health Act has been developed to comply with the obligations imposed by the Constitution and establish a structured and uniform health system within the Republic.
This Act came into effect on 2 May 2005 with the exception of some sections and chapter 6 (health establishments and relating to the certificate of need) and chapter 8 (control of use of blood, blood products, tissue and gametes in humans). However, the regulations, which must accompany the Act, have not yet been finalised by the National Department. The provincial Departments are therefore developing and implementing new policies, which are in line with the regulations.

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 to some degree, assisted in retaining staff, but a key issue will be the appropriate remuneration of health professionals. This matter is due to be addressed in the MTEF period.

As a transitional arrangement an agency agreement was signed with the Cape Peninsula University of Technology (CPUT), which thus assists with management of the Western Cape College of Nursing

In order to optimise the utilisation of personnel generic staff establishments have been developed to ensure that there are the correct numbers and skill mix of personnel at the respective institutions in relation to the projected patient activities. This is linked to the development of the Comprehensive Service Plan, which sets out how services will be distributed across the various levels of care in the health service platform.

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 the Provincial Growth and Development Strategy 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) Involuntary (certified) mental health care users (MHCU);
9) School children referred by schools and classified (as H0 and 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) Pregnant women classified as H0, H1 and H2 patients;
13) Termination of pregnancies is free to hospital patients (H0, H1, and H2 patients) as well as full paying and patients treated by their private doctors. The free service includes free ambulance and patient transport services.
14) 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 6302 on 7 October 2005, 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 grantees
- Formally unemployed.

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

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

- Old age pension;
- Child support grant;;
- Veteran's pension;
- Care dependency grant;
- Foster care grant;
- Disability grant;

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

Table 15: 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 (Self-funded)	Equal to or more than R72 000	Equal to or more than R100 000	The full price of the UPFS
Private and externally funded	Not applicable	Not applicable	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 16: 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.
		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.

According to the Millennium Development Goals Country Report for South Africa, 'South Africa is well on course to meet all Millennium Development Goals and targets" (2005:3). Of particular interest are the following:

- **The focus of Goal 4 is to reduce the under-five mortality rate** by two thirds between 1990 and 2015. A comparison of the South African Demographic and Health Survey (SADHS) for 1998 and the preliminary report for 2003 suggests that the infant and under-five mortality rates have remained relatively constant since 1998, decreasing by 0.5% and 0.3% respectively. The Free Health Care policy has resulted in an increase in the number of outpatient visits, for paediatrics this has increased by 102% and for pregnant women by 29.8%
- **Goal 5: Improve maternal health by reducing the reduction in the maternal mortality rate**: According to the 1998 SADHS the estimated maternal mortality rate was 150/100,000 live births which was considered unacceptably high and as a result the Confidential inquiry into maternal deaths was instituted. This enquiry highlighted the major causes of maternal mortality, i.e. non-pregnancy related infections (31,4%), complications of hypertension in pregnancy (20,7%), obstetric haemorrhage (13,9%), pregnancy related sepsis (12,4%) and pre-existing medical conditions (7,0%).

The third report on confidential enquiries into maternal death in South Africa 2002-2004 (Department of Health, June 2006) shows that 3,406 maternal deaths were reported in the country. The Western Cape had the second lowest recorded maternal deaths (6,1%) after Northern Cape (3,1%). The top five causes of maternal death in the country were non-pregnancy related infections (37,8%), complications of hypertension (19,1%), obstetric haemorrhage (13,4%), pregnancy related sepsis (8,3%) and pre-existing maternal disease (5,6%).

The National Department of Health has developed a set of recommendations to address these issues.

- **Goal 6**: **Combat HIV and AIDS, malaria and other diseases** by having halted and begun to reverse the spread of HIV and AIDS; and having halted and begun to reverse the spread of malaria and other major diseases 2015. Dedicated expenditure on HIV and AIDS across the departments has increased significantly. In 1995 a revised National Tuberculosis Control Programme was established based on the Directly Observed Treatment Short Course (DOTS) strategy. Whilst the national target cure rate of 85% has not been met the cure rates in districts that have adopted the DOTS approach are consistently better than non-DOTS districts. The problem of TB is exacerbated by multi-drug resistance.

Table 17: The Western Cape progress on health related Millennium Development Goals 2000-2005

Millennium Development Goal	MDG objective	Indicator	2000	2001	2002	2003	2004	2005	2015 Target
Reduce Child Mortality:	Reduce <5 mortality by two thirds by 2015	IMR/100 000[1]	44 (1998)	-	-	43.5	-	-	15
		Child (<5y) Mortality Rate/ 100 000[1]	56.6 (1998)	-	-	56.3	-	-	19
		Measles coverage under 1 year	-	82.5	84.9	78.1	91.7	90.7	>90
Improve Maternal Health	Reduce maternal mortality ratio by 75% by 2015	Maternal Mortality Rate/100 000[2]	58.72	45.02	70.3	70.7	-	-	15
Combat HIV/ AIDS & other diseases	Halve new infections by 2015	HIV Incidence	-	-	0.7%/y[1]	-	0.9%/y[3]	-	<0.35
		HIV Prevalence in agegroup <20y[4]	4.9	6.3	7.3	8.7	8.1	7.2	2.45
		Condom distribution rate from public sector health facilities (per make >15y)	-	5.9	9.1	10.3	15.6	20.1	
		Number of maternal HIV and AIDS orphans under 15 y	1876	3097	4871	7325	10572	14682	
		New Smear Positive Cure Rate	-	72	68	72	68.3	70.2	
Ensure Environmental Sustainability:	Halve by 2015 proportion of people without access to safe drinking water	Proportion of the population with water on premise	-	-	-	92.2%	89.9%	98.5%	
		Proportion of the population with water Within 200m	-	-e	-	6.3%	8.6%	-	
	Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers	Proportion of the population with access to improved sanitation[5] Flush	-	-	-	89%	90%	-	
		Chemical	-	-	-	0.9%	0.5%	-	
		VIP	-	-	-	1.4%	1.7%	-	

Notes:

1. South African Demographic and Health Survey 1998 and 2003.
2. Status of maternal death notifications in the Western Cape Province 1998 – 2005. Internal report from the Department of Health, Western Cape, 2005.
3. South African Nation HIV prevalence, incidence behavioural and communication survey 2005 (Empirical data).
4. HIV prevalence in the Western Cape. Results of the Annual Provincial and District Antenatal HIV Surveys 2004. Western Cape Department of Health.
5. Acceptable sanitation is flush, chemical and VIP toilets.
6. Information obtained from surveys and not routinely collected.

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, which has subsequently been replaced by the National Health Council.

Table 18: 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
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.
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 and sub-district management structures in the province and facility managers have been appointed at the major community health centers in the Metro. Following a long process of consultation, the decision was made to assume responsibility for the provision of Personal Primary Health Care (PPHC) services that were previously provided by the rural municipalities with effect from 1 April 2005. The process to transfer staff and assets from local government to the provincial Department of Health is far advanced.
The management structure has been strengthened by the appointment of a Chief Director: Metro District and the planned appointment of a Director: Public Health.
The City of Cape Town will continue to provide and partially fund PPHC services in the Cape Town Metro District until the services are transferred to the Provincial Government. Closer co-operation between the City and the Department has been established via the participation of the City's Executive Director of Health in the Department's management structur.

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.
- Community participation is also facilitated by the newly appointed Provincial Health Council, in line with the National Health Act.
- Effective public relations are facilitated by means of communication with the public and internal communication, for example imbizo's/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 have been conducted in accordance with a planned schedule.
- Waiting time surveys and analysis of systems to reduce waiting times have been conducted at all community health centers and clinics in the Metro. 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) Improve management of communicable diseases and non-communicable illnesses:

- HIV and AIDS: The Western Cape has implemented the national comprehensive plan for the management, treatment and care of people living with HIV and AIDS. The province has achieved significant increase in anti-retroviral treatment access and universal coverage for the PMTCT intervention, through successful partnerships and multi-sectoral efforts.
- 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.

- The Department has implemented the Chronic Dispensing Unit (CDU) which dispenses pre-packed chronic medications to stable chronic patients in the Metro, which are then delivered to the respective facilities and therefore decreasing waiting times for patients at the dispensary. Similarly the rural districts have alternative dispensing methods for chronic stable patients whose medication is pre-packed by pharmacists at the community health centers.

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

- The strengthening of Personal Primary Health Care includes the assumption of responsibility for the provision of these services in the rural districts, the establishment of facility management, the computerization of PHC services and the development of an infrastructureplan for PHC.
- Emergency Medical Services have been strengthened with additional funding as well as restructuring of the service in line with the recommendations of an expert external review.
- Hospital services, particularly regional hospital services providing level 2 services are also being strengthened.

6) Strengthen support services

- The transfer of the Medico-Legal Mortuaries from South African Police Services to the Provincial Department of Health was accomplished largely without problems on 1 April 2006. A Directorate: Forensic Pathology has been established and newly created posts are being filled.
- Medicines and Pharmacy legislation is currently being implemented. Regional support is being provided to facilitate compliance.

7) Human resource planning, development and management:

- A Human Resource Plan that is aligned to the Comprehensive Service Plan is in the process of being developed and will be consulted with relevant stakeholders.
- Nurse training at various levels is being strengthened within the department.
- Training of additional categories of health workers will be extended through the Extended Public Works Programmes with learnerships in key areas.
- An Employment Equity Plan has been developed and implemented.
- An Affirmative Action Strategy has been developed and will be implemented in consultation with the relevant stakeholders.

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 has been 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 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 Annual Performance Plan. The Monitoring and Evaluation Committee is chaired by the Head of Department.
- 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 rolled out to several hospitals in the regions. Similarly the Primary Health Care Information System (PCIS) is being implemented in the province. These initiatives are constrained by lack of funding.

9) Prepare and implement legislation:

- Mental Health Act: A Mental Health Review Board has been established.
- National Health Act 61 of 2003: is being implemented and the governance requirements are being implemented with the Provincial Health Council which has been constituted in terms of teh Act.
- The Medicines and Related Substances Act 101 of 1965 as amended Pharmacy Act 53 of 1974 as amended: considerable prepatory work has been done to prepare for the implementation of this legislation.

10) Strengthen international relations:

- The Department has a number of co-operation agreements with various donor agencies, e.g. the European Union for community-based services and the Global Fund for TB/HIV and AIDS

3.5 Annual National Health Plan for 2006/07

It is a requirement of the National Health Act of 2003 that the National Department of Health develops and submits to the National Health Council an Annual National Health Plan that consolidates the Annual Performance Plans of the national and provincial departments of health. The Annual National Health Plan (ANHP) must indicate the national priorities and the anticipated outputs.

The ANHP for 2006/07 is the first such plan that has been developed since the promulgation of the Act and is based on the 5 priorities adopted by the National Health Council (NHC) for the health sector for the planning cycle 2006/07 to 2008/09. These priorities are:

1) The development of service transformation plans;
2) Strengthening of human resources;
3) Strengthening of physical infrastructure;
4) Improving quality of care; and
5) Strengthening strategic health programmes.

Table 19: Key priorities, activities, indicators, targets and progress: Annual National Health Plan: 2006/07

The indicators and targets for achieving these priorities as determined by the National Department of Health (Annexure 1: Annual National Health Plan) are outlined in the table below together with the provincial progress to date.

ACTIVITY	INDICATORS	2006/07 TARGET	PROGRESS 2006/07
PRIORITY 1: SERVICE TRANSFORMATION PLAN			
1. Application of the IHPF	Scenarios developed by all provinces.	100% of provinces with preferred option by May 2006	Comprehensive Service Plan using the Western Cape model approved by the Provincial Cabinet on 19 July 2006.
2. Provincial APP	Part A completed	Service Transformation Plan drafted by May 2006	
		EMS business plans completed by May 2006.	The business plan was completed and submitted. The Western Cape CSP model for EMS was presented to the National Committee for EMS.
		MTS (Tertiary hospitals) implementation plan agreed by all provinces by December 2006	The Western Cape is awaiting the MTS Plan as mentioned. LINAC equipment for radio-oncology services was acquired at Groote Schuur and Tygerberg Hospitals.
		Develop full transport systems plan for delivery of patients to hospitals and specialists to lower care levels.	The Healthnet patient transport system has been designed and implemented.
		Develop full plan for utilisation of telemedicine links to increase specialist availability.	A plan has not been developed to date.
		Develop risk assessment for each component of the plan.	
	Part B:	Operationalising of Part A strategies into Part B.	
3. Implementation management	Effective planning and implementation monitoring	All provinces to have developed strategic planning units closely linked to information and M&E units.	The Directorate: Policy and Planning is responsible for the collation of the Annual Performance Plan. The Directorate: Information Management is responsible for the collation of the quarterly and annual reports.Both these directorates are within the Chief Directorate: Professional Support Services.
	Fully implement delegations at all levels especially at hospital level.	Audit and strengthen existing delegations by September 2006.Fast track implementation of delegations.	All HR functions as listed have been delegated to hospital level. Financial delegations are in place to ensure the effective functioning of hospitals. The Supply Chain Management delegations have been revised and will be effective from 1/1/2007. These delegations will enable hospital managers to procure goods and services at institutional level.
	Health Information Systems	At least one province to be fully operational on DHIS 1.4 – including trained personnel to collect and use data at all levels. Appoint and train adequate personnel to deliver timely and accurate information.	Province is using SINJANI, a web-based DHIS
		RFP and assessment of patient information system service providerDevelop implementation plan.	The National adjudication process not completed.
		All tertiary, 33% of level 2 hospitals to be routinely reporting ICD 10 coding. Implement training programme and ensure adequate appointments to roll out coding.	It is Departmental policy that all hospitals use ICD10 diagnosis coding for all patients.Central hospitals (all tertiary and ±20% of level 2 services) routinely report ICD10 coding.
	Monitoring and Evaluation	Timely data reporting to Quarterly Reporting System. Ensure capacity to deliver accurate and timely information transfer.	Reports are submitted.

ACTIVITY	INDICATORS	2006/07 TARGET	PROGRESS 2006/07
PRIORITY 2: HUMAN RESOURCES			
1. Staff distribution	Proportion of establishment in each service point by level of care	Fully mapped distribution of all staff and agreement on appropriate base-line level of staffing by discipline for level 2 & 3 services. Map current and required staff against service delivery points, levels of care and outreach services.	The Department has a fully aligned structure that will change in line with the Comprehensive Service Plan that is in the process of being consulted and finalized.
		Fully mapped distribution of all PHC staff and agreement on appropriate baseline level of staffing for PHC and establishment of posts required to deliver a quality PHC service.	
	Human Resource Plan	Fully articulated HR Plan for the de-livery of the objective, i.e. to achieve 100% staffing in all disciplines (clinical specialities) in all facilities offering tertiary, secondary and PHC servic-esDevelop plan based on policy and provincial potential for private sector participation.	The Department has a fully consulted framework to do HR planning. Once the Comprehensive Service Plan is finalized the HR plan will be developed. However, the broad elements of the staffing requirements are inherent in the CSP.
2. Private sector partnerships	Private sector specialists in public facilities	Agree SLA with GPs and specialists for sessional work in public sector facilities.	Specialists are appointed in sessional posts in Central Hospitals and general practitioners in district hospitals par-ticularly in the rural areas.
	Recruitment and retention of all staff.	Agree on revised remuneration levels of all staff at National level. At provincial level implement agree-ment.	The Province participates in all discus-sions and workgroups with both the National Department of Health and the Department of Personnel Administra-tion to motivate and investigate all alternatives for revised remuneration levels for all health staff.
3. Increase training of nurses (re-opening of nursing schools)		Identify additional training resources (colleges, tutors, etc)Negotiate with provincial training colleges.	A concerted effort has been made to increase the number of students in training both at the Nursing College and at the Nursing Schools and is pleased to report a steady increase in these numbers.
4. Training of hospital CEOs	% of hospital CEOs trained.	Audit and strengthen existing programmes and enroll 25%Develop action plan and prioritization for CEO training.	
PRIORITY 3: PHYSICAL INFRASTRUCTURE			
1. Approved business cases including MTS hospitals.	New business cases completed and approved by May 2006.	Develop MTS hospital business plans and all business cases in line with service transformation plans.	Business cases have been approved for Khayelitsha, Mitchell's Plain and Valkenberg hospitals. Business cases have been submitted for Tygerberg, Brooklyn Chest, Hottentots Holland, Victoria and Mossel Bay hospitals – awaiting approval.
	Forensic Services transfers.	30% of forensic mortuaries rebuilt [National level] Develop and imple-ment transfer plan	Replacements are in progress for 6/18 facilities [33%]. An additional 4/18 facilities had emergency repairs and upgrades.The transfer plan is in the process of being implemented.Tenders have been awarded for new facilities at George, Hermanus, Paarl, Worcester and Malmesbury. Planning is in prog-ress for new facilities and upgrades for Salt River, Tygerberg, Beaufort West, Vredendal, Stellenbosch, Wolseley, Knysna, Mossel Bay, Oudtshoorn and Laignsburg.
Maintenance increased.	Worst 20% of non revitalization hospitals receiving essential upgrades.Develop implemena-tion plan for upgrades		Major capital upgrading projects in progress at Red Cross, Mowbray, Caledon and Riversdale Hospitals. The following hospitals have major renova-tion projects of R2 million or more: Alexandra, GF Jooste, Karl Bremer, Stikland, Tygerberg, Groote Schuur, Red Cross.

ACTIVITY	INDICATORS	2006/07 TARGET	PROGRESS 2006/07
2. Hospital revitalistation	Maintenance increased	Maintenance expenditure increased to 2,5% of provincial budget.Issue guidelines to managers for maintenance requirements and expenditure.	Projected maintenance expenditure is 2,2 % of budget. (1,04% on equipment and 1,16% on buildings)
	Provision of essential equipment.	Agreement on essential equipment packaged (EQL) for all levels of care. Implement audits and identify priorities for provision in line with EQL.	Equipment lists compiled for individual projects after an audit and gap analysis.
3. Primary Health Care	Designated staff accommodated.	Audit of required accommodation and business plan prepared by June 2006.	At present there are no plans to provide staff accommodation except where it already exists.
	Intersectoral infrastructure provision.	Agreement on gaps in intersectoral infrastructure and develop implementation plans for inclusion into IDPs.	New CHC's and clinics are planned in collaboration with municipalities
	Facilities audited	Audit size and conditions of all PHC facilities. Identify and develop implementation plans for essential upgrades.	183 rural clinics previously managed by municipalities are being taken over by the Provincial government. A survey is being done to determine condition, suitability and to prioritise upgrades.
	CHCs development	Service Transformation Plan CHC restructuring implemented.Map clinics, CHCs and hospitals and identify the service platform.	The service needs have been determined and mapped in the Comprehensive Service Plan. All new CHC's, clinics and upgrades will be in accordance with the service platform defined in the Comprehensive Service Plan. New CHC's are under construction in Swellendam, Montagu, Simondium, Stanford and Wellington. A new CHC have been constructed at Brown's Farm
PRIORITY 4: QUALITY OF CARE			
1. Hospital improvement plans	Clinical audits	Clinical audits routinely monitored in all tertiary and 25% of level 2 hospitals.Implement appropriate training to management teams and monitor outcomes.	The Provincial Department of Health currently monitors the percentage of services conducting clinical audits, not the detail. 100% of tertiary hospitals conduct clinical audits and no secondary hospitals according to the statistics.The Department has a structured system for monitoring morbidity and mortality (M&M) and receives quarterly M&M reports from all facilities.
	Complaints mechanisms	Complaints mechanisms routinely managed in all tertiary hospitals and 25% of level 2 hospitals.Develop or strengthen complaints mechanisms in line with best practice guidelines.	The Provincial Department of Health has a structured system for the monitoring and management of complaints. 100% of tertiary and secondary facilities have implemented this provincial policy. Quarterly returns are received from facilities reflecting the number and categories of complaints and compliments received per quarter.
	Infection control	Infection control management effected in all tertiary and level 2 hospitals and 25% of district hospitals and CHCs.Develop or strengthen infection control structures in line with best practice guidelines.	The Provincial Department of Health has an Infection and Prevention Control Policy which was approved on 12/11/2006. The tertiary hospitals have an Infection Control Practitioner.
2. Improving access to services	Transport systems	10% increase in planned patient transport fleet deployed. Develop implementation plans for deployment of transport and training of staff based on business plans	Ten additional patient transporters have been acquired for the Metro and 26 drivers have been appointed. A further 20 drivers will be appointed in January 2007.
		10% of increase in EMS road ambulance fleet deployed.	The shift system in the Metro has been changed to match the emergency rates improving the peak fleet deployment by more than 10%.
		Flying doctor services started or SLA effected.	Complete programme running.
		Air EMS services started or SLA effected.	Complete programme running.

ACTIVITY	INDICATORS	2006/07 TARGET	PROGRESS 2006/07
		Private sector agreements in place for patient referrals	Agreements concluded to include ER24 and Lifecare into the communication centers.Agreements on the funding of private sector dispatch not yet in place.
2. Improving access to services	Telemedicine	Hub and spoke systems developed in accordance with the Service Transformation Plan. Develop implementation plans for skills decentralization using telemedicine, flying doctors services and private sector practitioners.	Implementation plan not yet developed.
3. Supervision	Supervision rate for PHC	Supervision plan included in Part B of the APP. Develop and implement plans for increasing the supervision rate to target	
PRIORITY 5: PRIORITY HEALTH PROGRAMMES			
1. Accelerated HIV prevention.	National microbiological surveillance [NMS] system established.	Develop implementation plans for each of the key strategies with milestones and indicators for progress and funding allocations	Not addressed at provincial level.
	Improved management of genital herpes.	Increased health seeking behaviour and early presentation for ulcers through social mobilization campaigns reaching 30% of high risk communities.	1. The STI programme has achieved a partner treatment rate of 19,6% for the period April to September 2006. 2. The VCT rate for STI clients has increased during the April to September period.
2. Implementation of the TB crisis plan	Increase in smear conversion rate in selected provinces and districts.	10% above the baseline.Develop implementation plans for each of the key strategies with milestones and indicators for progress and funding allocations.	1. The 2-month smear conversion for April to June 2006 was 68% as compared to 59% for October to December 2005. 2. The 3-month smear conversion rate July to September 2006 was 80% as compared to 79% for October to December 2005.
	Increase in cure rate in selected provinces and districts.		The NSP cure rate for July to September 2005 was 71% as compared to 69% for April to September 2004. This is mainly due to an increase in NSP cure rate in the 5 prioritised sub-districts for the TB crisis plan in the Western Cape.
3. Accelerated promotion of healthy lifestyles.	Implementation of context specific (urban, rural, cultural) healthy lifestyle implementation plans.	Development of detailed implementation plans.	Provincial plan compiled for 2006-2008. The plan has been piloted in the Metro district and still to be finalized in the other districts.
	Number of community based Move for Health programmes.	1 per district.Develop context specific plans for community implementation.	Two of the 6 districts have developed programmes (Metro and Westcoast)
	Number of Health Promoting Schools.	Develop programme with Provincial Department of Education.3,500 schools nationally.	Programme with the Department of Education in 2 districts (Metro and Boland) 150 schools.
	Percentage of schools implementing Schools Health Policy.	60% Develop implementation with the Provincial Department of Education.	Metropole: 97%* Southern Cape/Karoo: 50%* Boland/Overberg: 21%* Westcoast /Winelands: 0 *= rural regions that have restarted implementing the Schools Health Policy.
4. Strengthen the follow-up of patients with priority chronic conditions treated in PHC facilities.	Number of workshops with provincial managers for chronic diseases, to ensure adherence to guidelines for the management of chronic conditions at PHC facilities.	Cascade training workshops to PHC workers in all districts to ensure adherence to guidelines for the management of chronic conditions at PHC facilities.	Workshops: • 3 implementation of support groups (Metro, Westcoast & Southern Cape) • 2 audit of diabetes care feedback in the Metro • 3 rapid appraisals on the management of chronic diseases (Metro, Southern Cape and Westcoast)· • 1 inter-regional conference where minimum package of service for chronic diseases was agreed upon.**Total : 9**

ACTIVITY	INDICATORS	2006/07 TARGET	PROGRESS 2006/07
	Number of provinces with formal referral systems for chronic care patients.	Formal referral systems in place. NdoH guidelines used to strengthen existing referral systems and to develop systems where they do not exist.	• Referral system in place in all six districts as guidelines and algorithms are used. • System of referral to and from tertiary, secondary and district hospitals to HBC programme and back in place.
5. Strengthen self-management of patients.	Number of provinces with therapeutic education programmes for patients.	Ensure that therapeutic education programmes are implemented in PHC facilities in all districts.	• Therapeutic education in place in all facilities dealing with chronic diseases.· • 124 support groups assist in complementing the therapeutic education.
6. Develop a comprehensive programme for the treatment and care of survivors of gender based violence.	Implementation plan for the National Policy on Sexual Assault Care Practice in place.	Development of an implementation plan for the National Policy on Sexual Assault Care Practice in consultation with the National Department of Health.	The Western Cape has implemented the comprehensive management of sexual assault since 2001.
	Audit report of all specialized services (forensic clinic services, one-stop centers and Victim Empowerment Centres) produced.	National Department of Health to commission and audit of specialized services and Provincial Departments to provide the required data.	A tool to audit sexual assault care services has been developed and is currently being tested in 2 health districts in the province.
	National policy and guidelines for the treatment and care of survivors of domestic violence developed.	National Department of Health in consultation with Provincial Departments to develop a comprehensive national policy and guidelines for the treatment and care of survivors of domestic violence.	Policy and guidelines for the treatment and care of sexual assault survivors are currently implemented at 42 centres in the province. There is no policy on domestic violence.
	Comprehensive plans for the provision of psychosocial support for survivors of gender-based violence developed.	Province to develop comprehensive plans to provide psychosocial support to survivors of gender-based violence.	NGOs and the Department of Social Services are currently rendering psychosocial support to a small number of survivors. Huge gap still to expand this service.
	Number of training workshops for professional nurses and medical practitioners focusing on sexual assault care practice.	National Department of Health to facilitate training workshops.Provincial Departments to identify health care providers to participate in the workshops and support the implementation of assault care practice guidelines.	The district HRDs in the province currently offer training workshops with support from the provincial office. To date 9 workshops have been offered in 3 districts.

3.6 The Provincial Growth and Development Stratetgy (PGDS)

3.6.1 The Provincial Growth and Development Strategy named iKapa elihlumayo, meaning the Growing the Cape and deepens and expands the original growth and development agenda by addressing local imperatives and realities, therefore reinforcing the shared to achieve the vision of the Western Cape as a "Home for All."

The following nine first and second generation iKapa Elihlumayo strategies constitute the provincial policy and situational base of the PGDS are described in the Provincial Growth and Development Strategy which serves as a green paper for the Western Cape, (Provincial Gazette Extraordinary: 6385: 4 October 2006):

First generation strategies:
Micro-economic Development Strategy (MEDS)
Strategic Infrastructure Plan (SIP)
Human Capital Development Strategy (HCDS)
Social Capital Formation Strategy (SCFS)
Provincial Spatial Development Strategy (PSDF)

Second generation strategies
Scarce Skills Strategy (SSS)
Human Settlement Strategy (HSS)I
Integrated Law Reform Project (ILRP)
Sustainable Development Implementation Plan (SDIP)

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.

3.6.2 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.

3.6.3 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 bridging social capital refers to linkages that cross different communities/ individuals and linking social capital refers to vertical linkages, e.g. between government and civil society, or between organizes labour and organized business, i.e. 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 resides 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 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, 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 3.7 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.

3.7 Burden of disease

The Provincial Government of the Western Cape (PGWC) Social Cluster identified the need to delineate the extent of the burden of disease (BoD) in the province along with its associated risks. The Department of Health commissioned the Schools of Public Health from the Universities of Cape Town, Stellenbosch and the Western Cape and other research agencies such as the Medical Research Council (MRC) to recommend how the burden of disease in the province could be reduced, not just through preventive health interventions such as health promotion, primary, secondary and tertiary promotion, but also through interventions that are of a more multi-sectoral and developmental nature.

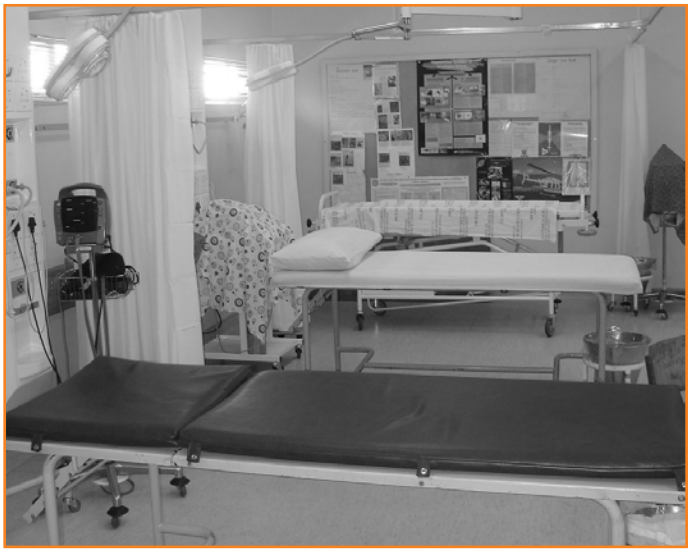
The rationale for doing this is that the greatest share of health problems discussed in paragraph 2.1.2 are attributable to broad social conditions such as poverty, poor housing, water and sanitation, gender inequality, etc. which are the so-called upstream factors. At the same time health problems have been largely addressed by health policies that have been dominated by disease focused solutions that largely ignore the social environment. As a result the burden of disease has persisted, inequalities have widened and health interventions have obtained less than optimal results. The incidences for TB, HIV and non-communicable diseases for example continue to increase.

There is, however, evidence that policy, action and leadership to address the social dimensions of health can improve health and access to health care. The attainment of health status must therefore be seen as an integral part of sustainable development and be approached in a comprehensive way using a multi-sectoral and transversal approach.

The burden of disease project will provide recommendations that span across the PGWC departments that could address the burden of major infectious diseases (HIV and AIDS and TB), violence and road traffic accidents, childhood illnesses, cardiovascular diseases and mental illness which is an underestimated burden.

The other critical part of the burden of disease project is the institutionalization of the burden of disease surveillance system within the province to enable monitoring and evaluation of the disease burden, the risk factors as well as responses over time. In the context of limited resources and disparity in health outcomes as explained in paragraph 2.2.1, the availability of timeous, accurate and spatial statistics that go to the level of at least the sub-district are an essential component required for planning and prioritization of interventions and services, monitoring and evaluation and further research. Furthermore, the transversal nature of the response to the burden of disease will necessitate that the challenge of very strong alignment in planning, monitoring and evaluation with other departments in the province be addressed.

The final burden of disease report will be submitted by 31 March and there will be a provincial conference on the subject on 31 May to 1 June 2007.



3.8 Healthcare 2010

3.8.1 Healthcare 2010 originates from 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.

3.8.2 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.

3.8.3 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.

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

1) The Service Plan

The Comprehensive Service Plan (CSP) has been developed and provides the framework for the reshaping of the service at all levels of care to give effect to Healthcare 2010.

The Provincial Cabinet approved the CSP on 19 July 2006. Following a period of consultation with external stakeholders the Department will begin with an implementation process during the 2007/08 financial year.

2) The Personnel Plan

The primary cost driver in health is 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 personnel plan is being developed to take further refine the broad staffing models indicated n the CSP.

3) The Infrastructure Plan

The infrastructure plan has been developed to provide health facilities ranging from clinics, community health centers and hospitals of the correct design and appropriate location.

4) The Financial Plan

The costing of the Comprehensive Service Plan and the appropriate allocation of resources across the service platform in an equitable manner will be set our in the financial plan for Healthcare 2010.

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

4.3 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.

4.4 The Comprehensive Service Plan has been developed to give effect to the implementation of Healthcare 2010. This process has required groundbreaking technical work and has been extensively internally consulted. Following this process of internal consultation the plan has been further refined and approved by the Provincial Cabinet for external consultation on 19 July 2006. Nevertheless the broad thrust of the Comprehensive Service Plan has been taken into account in the compilation of the Annual Performance Plan for 2007/08.

4.6 Strategic Planning workshops were held on 24-25 July and 6-7 November 2006, attended by the senior management and the Provincial Minister of Health to determine the strategic priorities of the Department for 2007/08.

4.7 **The information on the external activities and events relevant to the budget decisions for 2007/08:**

4.7.1 **The budgetary pressures experienced during 2006/07 and their consequences**

In the financial years prior to 2005/06 the Department had to scale down services due to shrinking budget allocations. However, in 2005/06 the challenge was to expand services in line with the strategic priorities as indicated by the designated policy options.

After the period of expansion in 2005/06 the 2006/07 financial year brought in a period of consolidation and the reality of limited funding and continued growth in patient numbers which increased by 3,5 per cent in 2005/06. It is anticipated that 2006/07 will not show an increase in patients, as measured by patient day equivalents, as the hospitals simply cannot accommodate more patients and are forced to be more selective. Clinical staff experience the emotional strain of refusing services to patients.

The Department assumed full responsibility for the **Personal Primary Health Care (PPHC**) in the rural regions from 1 April 2006, which entails the assumption of financial and operational responsibility for services previously provided by the relevant local authorities. However, with respect to PPHC, the Department has also faced increased expenditure for cleaning, maintenance and transport costs, which were previously included in the overhead expenditures of local authorities. The vehicles and buildings taken over from municipalities are generally in a poor condition, and require substantial maintenance and replacement costs. As a result and in order to remain within budget, the Department has to maintain tight control over these expenses, and is unable to expand these services.

District hospitals, hospitals that provide mainly level 1 services, experience significant pressure. Due to the declared policy direction of the Department, to shift funds from level 3 to level 1, management has been more receptive to the requirements for resources to address service pressures experienced by district hospitals.

Emergency Medical Services received additional funding in real terms in 2006/07 but the late notification of the sharp increase in vehicle tariffs resulted in an unexpected increase in expenditure of approximately 7 million. Ambulance response times remain below the target and significant additional funding will be required to reduce response times.

Both programmes 4, provincial hospital services, and 5, central hospitals, experienced funding pressures due to an increasing patient load. Much of the pressure arises from Goods and Services expenditure, which include items such as blood, laboratory services and pharmaceuticals and not from personnel costs. To manage these pressures each hospital prepared a plan outlining mechanisms to reduce expenditure in these areas. The Department also initiated a project under the management of the Chief Director Finance to analyse and manage this expenditure transversally for the Department.

Due to poor service delivery the Department took over the DP Marais TB Hospital from SANTA during 2006/07. This change and the increased service levels resulted in additional expenditure. In general, the treatment of TB patients presented a challenge and specific actions requiring additional resources were needed to address the falling cure rate.

The growth in patients requiring **anti-retroviral treatment (ART)** continues to escalate exponentially. The Department estimates it would need an additional R34 million in 2006/07. the meet the escalating demand for ART the National Treasury mad an additional R17,5 million available and the Department has to manage the balance within the existing budget.

The general inability of all programmes to attract nursing staff to hospitals places further pressure on the Department as agency staff, where available are used at additional cost.

The **Information Technology (IT)** budget for Health in the Department of the Premier has been drastically reduced from the previous levels of approximately R15 million per annum. In the past this budget paid for IT infrastructure, with the result that that the IT infrastructure in the Department of Health is deteriorating.

The **Forensic Pathology Service (FPS**) was transferred from the South African Police Service to Health with effect from 1 April 2006. This programme is funded by the Forensic Service Pathology Service conditional grant. Escalation in infrastructure costs will have a significant impact on the ability to upgrade the Forensic Pathology Laboratories (mortuaries) according to the agreed implementation plan.

4.7.2 Budgetary process and construction of the budget allocations for 2006/07 and beyond

The budget projections for the respective entities formed the basis for the allocations for 2005/06. However, the 2006/07 and 2007/08 allocations were based on the 2005/06 budgets adjusted by inflation and the Improvement in Conditions of Services (ICS). These baseline budgets were further adjusted for specific issues including:

- Shifts of funds between entities, limited to identified projects.
- As far as funds were available, budget entities were compensated for mandatory additional expenses.
- For 2007/08, Provincial Treasury allocated additional earmarked allocations to the Department in line with the national priorities. These funds were allocated according to the relevant conditions.

As was done in previous years the Department developed a list of policy options as part of the MTEC process, with significant funding implications, however, apart from the conditional grants and earmarked funds the Department received very little additional funding in real terms.

The Comprehensive Service Plan is in the process of being finalized and will be used in future as the basis for the allocation of funds.

4.8 The focus for 2007/08

The key issue for the Department in 2007/08 will be the finalisation of the Comprehensive Service Plan. The process will be managed by an Implementation Task Team chaired by the Head of Department and supported by the development of the related Personnel Plan, Infrastructure Plan and Financial Plan.

Other focus areas for 2007/08 include:

- The strengthening of Emergency Medical Services.
- Improvement of salaries for health professionals with a particular focus on nursing salaries during 2007/08.
- Appointment of additional staff including two-year interns, community service nurses and other health professionals.
- Purchase of key equipment including that required to strengthen highly specialized services.
- Establishment of the new Forensic Pathology Service.

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

Table 20: Trends in provincial public health expenditure (R million) [A3]

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	**4,547,303,825**	**5,169,200,000**	**5,718,813,000**	**6,472,360,000**	**7,095,173,000**	**7,942,423,000**	**8,411,769,000**
Total per person	975	1,091	1,212	1,351	1,458	1,608	1,677
Total per uninsured person	1,335	1,494	1,660	1,850	1,997	2,202	2,296
Constant 2006/07 prices							
Total	**5,138,452,547**	**5,634,428,000**	**6,004,752,600**	**6,472,360,000**	**6,733,319,177**	**7,195,835,238**	**7,250,968,903**
Total per person	1,101	1,189	1,273	1,351	1,384	1,456	1,445
Total per uninsured person	1,509	1,629	1,743	1,850	1,896	1,995	1,979
% of Total spent on:-							
DHS[4]	25.4%	26.1%	28.7%	31.0%	34.9%	34.8%	34.6%
PHS[5]	25.8%	26.1%	25.0%	23.8%	19.0%	27.1%	25.8%
CHS[6]	35.6%	35.2%	35.3%	33.6%	31.4%	22.3%	21.9%
Capital[2]	4.3%	5.6%	3.8%	5.2%	5.2%	7.1%	6.3%
Health as % of total public expenditure	34.71%	35.45%	35.02%	33.34%	34.27%	34.16%	33.61%

6. NOTE ON THE FORMAT OF THE ANNUAL PERFORMANCE PLAN AND THE BUDGET STATEMENT

A concerted effort is made to conform to the formats for the Annual Performance Plan and the Budget Statement documents as determined by the National Treasury and the National Department of Health.

However, currently the formats for the indicators in the two documents differ. Therefore the substance of the indicators in the Budget Statement is reflected in the Annual Performance Plan but the manner in which the indicators are defined may differ.

It is recognized that there are some indicators where information is not available for all the years but the processes of collecting data are improving. The National Department of Health is also engaged in a process of revisiting the mandatory indicators against which the Department is required to report.

PART B

BUDGET PROGRAMMES & SUB-PROGRAMMES

Programme 1: Administration

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 MEC

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

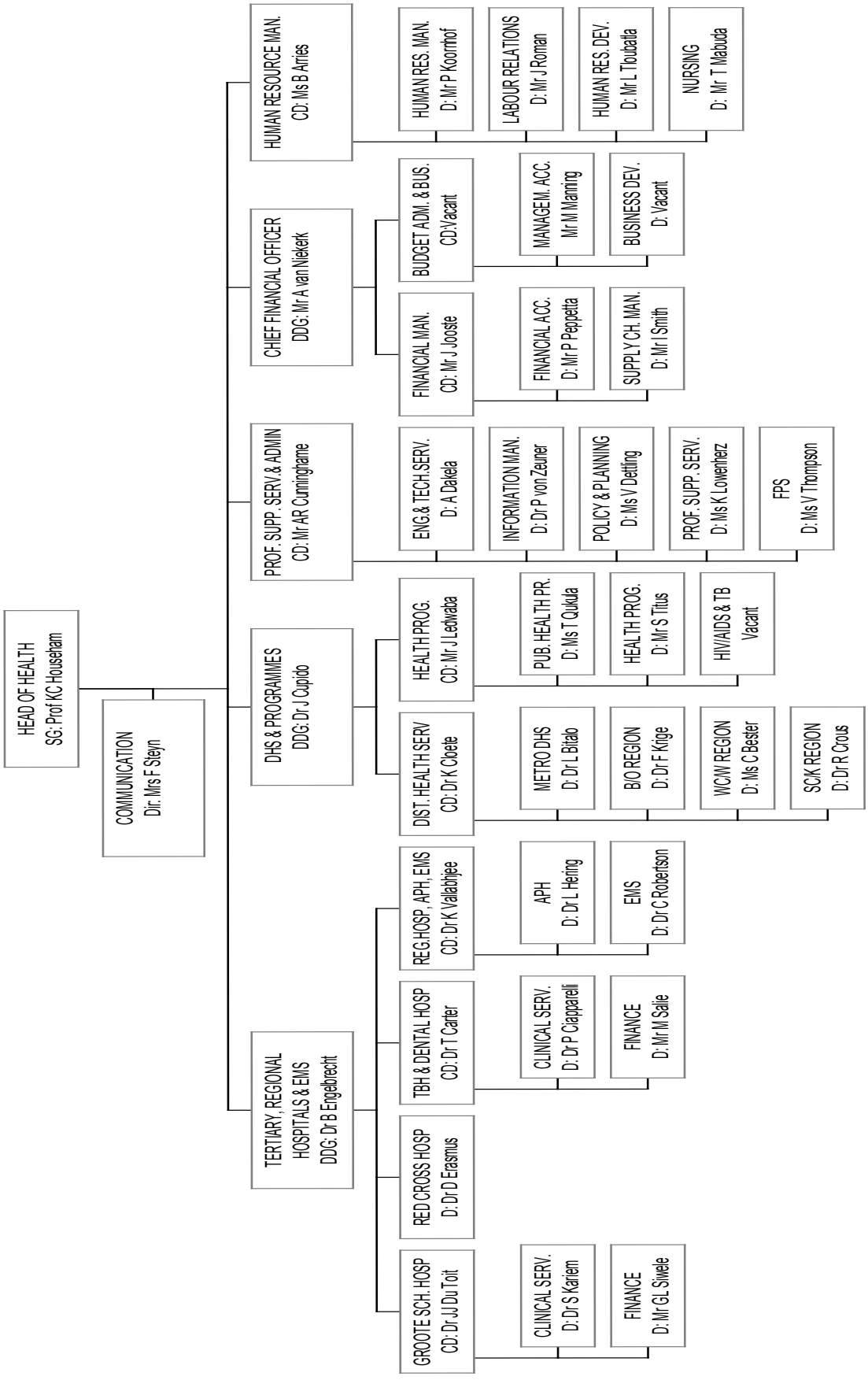
The Health Service is managed by a combination of a central management situated in the head office in Cape Town and currently decentralised offices in Bellville, George, Worcester and Malmesbury.

The central head office management together with the Provincial Minister determines policy and ensures that the Western Cape provincial health service functions in harmony with national, provincial and departmental 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 Administration, which includes Policy and Planning, Information Management, and Communication, are likewise co-ordinated and directed from the central head office. The current organisational chart of the senior management of the Department is reflected overleaf.

ORGANISATIONAL CHART OF SENIOR MANAGEMENT



The migration into the Western Cape remains an issue of concern from the perspective that whilst the province receives funding for patients from other provinces for tertiary services, no financial provision is made in terms of the provincial equitable share for these patients who require primary and secondary level care. Indeed in terms of a new allocation formula the provincial baseline equitable share has been decreased. This places a significant and increasing additional financial strain as on the limited provincial resources.

The demand for services exceeds the quantum provided for by the available resources. The challenge to the Department is therefore to ensure that available resources are optimally utilised as outlined in the Healthcare 2010 strategic plan. A concerted effort will be made to improve revenue generation and collection in order to bolster these resources.

Extensive groundwork has been undertaken during the past two years on the implementation of Healthcare 2010. The departmental Comprehensive Service Plan, which outlines the way in which the services should be reshaped, has been be finalised and approved by the Provincial Cabinet for final consultation with all relevant stakeholders. Following an analysis of the feedback from stakeholders the Department will move to the implementation of restructuring the staff establishments in line with the broad direction of the Comprehensive Service Plan.

An infrastructure plan for hospitals has been developed in support of Healthcare 2010, which will be implemented using all available funding for hospital upgrading and construction. A similar plan is being developed for the Primary Health Care facilities but the Department faces a major challenge to fund the necessary upgrading and construction of those facilities. It is envisaged, for instance, that funds obtained from the disposal of the Conradie Hospital site will be used for this purpose.

As indicated in Part A the Faculties of Health Sciences of the Universities of Cape Town, Stellenbosch and the Western Cape have been requested to assist the Department in determining the burden of disease and the formulation of a strategy for the reduction of the burden of disease.

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 2005/06 [HR1]

Categories	Number-employed	% of total employed	Number per1000 people	Number per 1000 uninsured people	Va-cancy rate1	% of total personnel budget	Annual cost per staff member
Medical Officers	1638	6.79	0.35	0.48	13.29	16.35	292,588
Medical Specialists	426	1.77	0.09	0.12	24.60	6.80	467,665
Dentists	66	0.27	0.01	0.02	20.48	0.64	283,606
Professional Nurse	4030	16.71	0.85	1.17	28.55	19.72	143,392
Staff Nurses	1781	7.38	0.38	0.52	18.27	6.15	101,285
Nursing Assistants	3818	15.83	0.81	1.11	17.52	10.52	80,761
Student Nurses	71	0.29	0.02	0.02	84.57	0.20	84,131
Pharmacists	280	1.16	0.06	0.08	33.49	1.63	170,446
Physiotherapists	105	0.44	0.02	0.03	19.23	0.43	121,344
Occupational Therapists	94	0.39	0.02	0.03	27.13	0.42	129,452
Clinical Psychologists	62	0.26	0.01	0.02	12.68	0.35	163,472
Radiographers	391	1.62	0.08	0.11	16.63	1.91	143,221
Emergency Medical Staff	1164	4.83	0.25	0.34	7.84	4.73	119,059
Dieticians	56	0.23	0.01	0.02	23.29	0.26	134,374
Other allied health professionals & technicians	745	3.09	0.16	0.22	27.03	3.66	143,988
Managers, Administrators & all other staff	9390	38.94	1.99	0.23	24.74	26.24	81,889
Grand Total	**24117**	**100.00**			**23.43**	**100.00**	**121,527**

Note 1: These vacancy rates are expressed as a percentage vacancy determined by the existing approved staff establishment. This is materially different from the envisaged staff establishment that will be derived from the Comprehensive Service Plan.

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

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2007/08
Input									
1. Medical officers per 100,000 people	No	37	37	37	37	37	37	37	18.7
2. Medical officers per 100,000 people in rural districts	No	12	13	13	13	13	13	13	12.2
3. Professional nurses per 100,000 people	No	84	85	95	100	100	100	100	105
4. Professional nurses per 100,000 people in rural districts	No	55	55	60	70	80	80	80	92.5
5. Pharmacists per 100,000 people	No	5	5	8	10	15	15	15	34
6. Pharmacists per 100,000 people in rural districts	No	4	4	6	8	12	12	12	24
Process									
7. Vacancy rate for professional nurses	%	19%	23%	15%	15%	15%	15%	15%	15
8. Attrition rate for doctors	%	37%	42%	30%	25%	25%	25%	25%	25
9. Attrition rate for professional nurses	%	12%	15%	12%	12%	12%	12%	12%	25
10. Absenteeism for professional nurses	%	3.24%	3.56%	3%	3%	3%	3%	3%	5
Output									
11. Doctors recruited against target	%	Refer to Note 7 below							80
12. Pharmacists recruited against target	%	Refer to Note 7 below							60
13. Professional nurses recruited against target	%	Refer to Note 7 below							90
14. Community service doctors retained in the province	%	NA	NA	NA	50	50	50	50	40
Quality									
15. Hospitals with employee satisfaction survey	%	15%	30%	45%	60%	65%	65%	65%	50
Efficiency									
16. Nurse clinical workload (PHC)	No	30,1	35	35	35	35	35	35	
17. Doctor clinical workload (PHC)	No	50,6	50	50	50	50	50	50	
Outcome									
18. Supernumerary staff as a percentage of establishment	%	0	0	0	0	0	0	0	

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 or frozen since July 2004 and the information for indicators 11, 12 and 13 would not be a true reflection of the real service need in terms various occupational classes. Furthermore the information is not obtainable from PERSAL.
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 is only be available from the 2006/07 financial year.
9. Although the current indicator for medical officers exceeds the national target, in the Western Cape's view there is not an over provision of personnel.
10. The indicators regarding pharmacists confirm the shortage of this category of personnel in the Province.

4. POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

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

The detail regaring the Western Cape Department of Health's response to these priorities is outlined in **Part A: Strategic Overview in paragraph 3.4.**

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. It is planned to restructure the current regional offices into district offices in the rural districts which will then report to a Chief Director: Rural Districts. A Chief Directorate will manage the Cape Town Metro district and will be supported by four substructure offices. These components will be responsible for co-ordinating and integrating health services to ensure effective and efficient delivery of quality District Health Services.

Another significant 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 will be 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. 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 stakeholders such as the media, is also considered a key objective. The Communications Directorate has made significant progress in this regard with the distribution of regular newsletters and communication newsflashes, as well as facilitating staff indabas where the Head of Department and management interact face to face with staff.

4.3 Funding Priorities

Funding has been allocated to the following priorities during 2007/08

- R 946,000 for the appointment of staff to establish a risk management unit
- R1 million for the appointment of critical human resources management staff.
- An earmarked allocation of R97,094 million for the improvement of health professionals' remuneration.
- An earmarked allocation R21,105 million for the appointment of additional health staff, in particular interns and community service staff.

Both the earmarked allocations will be distributed to the respective programmes once the details of salaries and staff to be appointed become available.

5. CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The Department has implemented a Financial Personnel Management Instrument (FPMI) which consists of a contractual arrangement between the Chief Financial Officer (CFO) and the respective institutional managers. The purpose of this instrument is the more effective and effective control over the filling of posts. Through the FPMI management is empowered by determining how many posts can be filled in line with available funds.

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 challenge and will only be addressed when the salary packages become competitive.

Reshaping the service entails the shift of patients to the most appropriate level of care as well as the related reallocation of resources. To ensure that the reshaping is appropriately managed a comprehensive service plan has been developed to guide the implementation of the restructuring process.

The Comprehensive Service Plan addresses the movement of patient activities as well as the reallocation of resources over the respective levels of care over the MTEF period.

In an effort to address the shortage of staff and capacity within the Human Resource components at both central and regional levels the Department will create and fill additional posts over the MTEF period.

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 has created a Directorate: Nursing and appointed a director in order to provide a driver for an enabling and co-ordinating service to nursing and therefore contributing to improving the quality of care.

The Directorate: Supply Chain Management deals with procurement and provisioning functions including the Cape Medical Depot. The Department has implemented LOGIS, Delta 9 and the Basic Accounting System (BAS). These procurement, billing and accounting systems enable better financial control that will benefit patient care and hospital management.

The Department has set up a Hospital Revitalisation Programme (HRP) Unit. The post of Provincial Project Manager, at director level has been created to manage this programme Project Office. Appropriate staff will be recruited and appointed to run this programme.

The revitalisation of George Hospital is completed and the hospital was opened by the Minister of Health on 30 June 2006. Construction work is in progress at Worcester, Paarl and Vredenburg Hospitals. Business cases have been approved for Khayelitsha, Mitchell's Plain and Valkenberg Hospitals and planning on these projects is in progress, although the funding of these projects have not been approved to date.

Business cases have been submitted for Tygerberg, Hottentots Holland, Victoria, Mossel Bay and Brooklyn Chest Hospitals. It is intended that Somerset Hospital will be rebuilt as part of the FIFA World Cup 2010 project.

Specific quality improvement measures for 2007/2008 include:

- The determination of waiting times at clinics by conducting waiting time surveys to monitor the effect of 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 –70% 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.
- Continued training of Nursing Assistants to support improved nursing care.
- Implementation of a Service Level Agreement with the NHLS.
- Controlled management of the relationship between the Department of Transport and Public Works and Health through the Service Level Agreement agreed between departments.

7. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

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

Indicator	2003/04 Actual	2004/05 Actual	2005/06 Target	2006/07 Target	2007/08 Target	2008/09 Target	2009/10 Target
Timeous submission of strategic planning documents as prescribed by Treasury.	Complied	Complied	Complied	Compliance	Compliance	Compliance	Compliance
Timeous submission of quarterly and annual reports as prescribed by Treasury.	Complied	Complied	Complied	Compliance	Compliance	Compliance	Compliance
% of hospitals where the HIS has been implemented.	10%	15%	25%	35%	50%	65%	80%
Financial statements submitted in accordance with National Treasury prescripts.	Financial statements produced.	Financial statements produced.	Financial statements produced.	Financial statements produced by 31 May 2006.	Financial statements produced by 31 May 2007	Financial statements produced by 31 May 2008	Financial statements produced by 31 May 2009
Hospitals with up to date asset register.	0%	0%	33%	100%	100%	100%	100%
Number of items on dues out at the CMD	<60	<60	<60	<50	<50	<50	<50
% of facilities that have conducted an external client satisfaction survey, published the results and developed action plans for improvement.							
Tertiary facilities	100%	100%	100%	100%	100%	100%	100%
Secondary facilities	George Eben Donges Psychiatric Hospitals x 4	50%	100%	100%	100%	100%	100%
District Hospitals	Mossel Bay Hospital	18%	40%	70%	90%	100%	100%
Community Health Centres	0	30%	30%	30%	50%	70%	100%
% of facilities that submit quarterly returns on number of client complaints & compliments received.	75%	95%	100%	100%	100%	100%	100%
Consult the draft Macro HR Restructuring plan with organised labour in the Provincial Health and Welfare Bargaining Council. Finalise the HR Restructuring Plan and communicate it with line managers.	-	-	-	-	Draft document finalised. Plan consulted with Organised Labour	Micro restructuring plans to be developed for implementation at institutional level.	
Determine the final human resources gap in terms of a shortage/over supply of staff per occupational group in accordance with the HC 2010 organisation and post structures.	-	Generic Models developed	Generic models developed. Groundwork with regard to restructuring completed	A draft Comprehensive Service Plan was developed	Groundwork for the drafting of a HR Plan to be finalised by the Chief Directorate	Emphasis on HR Planning by line managers w.r.t. their approved structures. Directorates will facilitate the process.	

Note 1: Extracted from Table 8.7 [HFM5] as this function is managed from Programme 1 and not Programme 8

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

The allocation to Administration increases to 5.18 percent in 2007/08 in comparison to the 2,59 percent allocated in the revised estimate of the 2006/07 Budget. There is a nominal increase of 118.99 percent or R199,539 million from the revised appropriation for 2006/07 to 2007/08. This is as a result of the funding which is allocated in Programme 1 pending clarity on the conditions regarding the allocation of the Health Professionals Remuneration Review and the funding for additional health posts. Further, due to the ambitious revenue target set, it was decided not to disburse R21 million and allocate this amount against Programme 1. Once the revenue trends for 2007 have been determined these funds will be utilized to address funding pressures for the vote. Allocations earmarked for medical equipment have been allocated to Programme 1 where they will be centrally managed.

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

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	215,643,730	213,316,000	167,291,000	167,699,000	367,238,000	399,038,000	516,752,000
Total per person	46.22	45.02	35.46	35.00	75.48	80.77	102.99
Total per uninsured person	63.31	61.67	48.57	47.94	103.38	110.62	141.06
Constant 2006/07 prices							
Total	243,677,414	232,514,440	175,655,550	167,699,000	348,508,862	361,528,428	444,923,472
Total per person	52.22	49.07	37.23	35.00	71.63	73.17	88.68
Total per uninsured person	71.54	67.22	51.00	47.94	98.11	100.22	121.45

Programme 2: District Health Services

PROGRAMME 2: DISTRICT HEALTH SERVICES

1. PROGRAMME DESCRIPTION

To render Primary Health Care Services and District Hospital Services including preventive, promotive and curative services. The foundation for the effective and efficient provision of these services is based on the integration of facility based services; community based and support services.

2. 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 excercising 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 based care, abuse victims, mental- and chronic care, school health, etc.

Sub-programme 2.5 Other community services
Rendering environmental and port health etc.

Sub-programme 2.6 HIV and AIDS
Rendering a primary health care service in respect of HIV and 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.

3. DISTRICT HEALTH SERVICES

3.1 SITUATION ANALYSIS

3.1.1 Demographic profile

According to the adjusted mid-year population estimates from Statistics South Africa: 2005 the population of the Western Cape estimated to be 4,7 million constitutes approximately 9.9% of the national population. The Western Cape has six districts namely, Cape Town Metro District, Cape Winelands, Westcoast, Overberg, Eden and Central Karoo. It is estimated that 64% of the people living in the Western Cape, live within the Cape Town Metro District, which is only 2% of the province's surface area. Table 2.1 below shows the population distribution in the province. About 73% of the population of the province are uninsured and thus dependent on the Public Health Sector.

Table 2.1: Population distribution in the Western Cape:

District	Population	% of population
Cape Town Metro	3,012,776	64%
Cape Winelands	656,455	14%
Westcoast	295,503	6%
Overberg	213,580	5%
Eden	475,785	10%
Central Karoo	63,569	1%
Province	4,717,668	100%

Source: Departmental projections for 2006 from Census 2001. Directorate: Information Management, Western Cape Department of Health

3.1.2 Epidemiological profile

The burden of disease (BoD) is defined as the total number of healthy life years lost to all causes whether from premature mortality or from a degree of physical or mental disability over a period of time. Therefore the burden of disease implies both the burden of mortality and morbidity.

In the Western Cape there is a fairly good understanding of the cause of premature mortality but not morbidity. The top five causes of premature mortality (i.e. taking into account the number of years a person lost when he/she died before the end of their expected lifespan) in the Western Cape are[1]:

1) HIV and AIDS: 14.1%
2) Homicide/violence: 12.9%
3) TB 7.9%
4) Road traffic accidents: 6.9%
5) Ischaemic heart disease: 5.9%

The measure of mortality is important for identifying preventable death and ranking the most important causes that could theoretically respond to preventive interventions aimed at reducing mortality.
The implications of these statistics are[2]:

1) Although the mortality rate from HIV and AIDS in the Western Cape (14.1%) is lower than the national rate of 39.0%, HIV and AIDS is still the leading cause of premature death in the Western Cape.
2) Tuberculosis is a significant cause of premature death. The Western Cape and Northern Cape have the highest proportion of premature deaths from TB.
3) Infectious causes of premature mortality, i.e. HIV and AIDS and TB are collectively 22%.
4) Premature death due to intentional or unintentional violence, i.e. homicide/violence and road traffic accidents are collectively 20% in the Western Cape.
5) According to the national burden of disease study, premature mortality due to chronic/ non-communicable diseases is similar across all provinces although the profile in the Western Cape is different where there is a relatively higher incidence of premature deaths due to ischaemic heart disease.

1 Bradshaw et al. South African National Burden of disease Study 2000. Estimates of Provincial Mortality summary Report, March 2006.
2 Bradshaw et al. South African National Burden of disease Study 2000. Estimates of Provincial Mortality summary Report, March 2006

3.1.3 Existing provincial and local government services

3.1.3.1 Management and governance structures

The implementation of the District Health System (DHS) as set out in the National Health Act (Act 61 of 2003) is progressing.

One of the key activities that the province has been engaged in is the assumption of responsibility for Personal Primary Health Care (PPHC) services in the rural regions. As of 1 March 2006, the provincial Department of Health assumed operational responsibility for PPHC services in the rural districts. The process of transferring staff, moveable and immoveable assets from municipalities is currently being negotiated. As at September 2006, the Province had employed 1,242 people for services previously rendered by municipalities. These people belonged to one of four categories of staff:

1) Permanent municipal staff who resigned from municipalities and joined provincial services;
2) Temporary contract municipal staff who did not renew their contracts with municipalities but were appointed by the Province;
3) Municipal posts that had been vacant for some time and needed filling; and
4) Urgent posts that had to be filled as the result of the assumption of responsibility process, e.g. drivers and workshop staff.

In the Cape Town Metro district, both the provincial Department of Health and the City of Cape Town provide PPHC services. Of the 152 service points in the Metro, both spheres of government jointly managed 22 service points. However service delivery has been negatively affected by the separate managerial and administrative structures of the two spheres of government and therefore the Department of Health and the City of Cape Town agreed to consolidate the eight most problematic facilities. To date all staff have been consolidated into as single provider in the eight facilities:

- Durbanville CHC, Ikwezi CHC, Ocean View CHC consolidated as City-staffed facilities; and
- Vanguard, Site B, Delft, Gustrow and Hout Bay CHCs consolidated into the provincially-staffed facilities.

Governance structures are mandated by the National Health Act and are the Department's interface with the community to hold the Department accountable for the services that it has been mandated to deliver and also to use the social capital embedded in communities to advance service delivery. The provincial Minister of Health has established the Provincial Health Council.

Community participation structures have been established at facility level. As at September 2006, nearly 40% of all PHC facilities in the province had functioning structures. This includes the health facilities recently taken over from the municipalities.

The Healthcare 2010 Comprehensive Service Plan that details the service platform and the management and support structures required at district and sub-district level has been finalised and externally consulted. The finalisation of this process will result in the formal establishment of district and sub-district management structures that are critical to the effective and efficient delivery of comprehensive primary health care and acute level one hospital services.

3.1.3.2 Primary Health Care (PHC) services

It should be noted that although there was a 24% increase in the total Programme 2 budget from 2004/05, approximately 51% of the increase was as a result in the shift of functions, i.e. district management, assumption on non-Metro PPHC service responsibilities and coroner services, and an additional 17% of the increase was in the HIV and AIDS conditional grant and the Global Fund.

The performance of the province in the provision of PHC services and thus the quality of the service provided with the decreased expenditure appears to be varied with good performance in some indicators, e.g. maternal and child health, but poorer performance in TB cure rates and HIV prevention.

In the face of the nursing crisis, an encouraging indicator for PHC services is the number of professional nurses in fixed PHC facilities per 100,000 uninsured people, which has increased from 41 in the previous year to 50 in this year, which is higher than the target of 44.

In terms of the Department's Healthcare 2010 strategy, PHC services will be strengthened and will move towards a nurse-driven PHC service. There will therefore be an increased demand for Clinical Nurse Practitioners. It is important to ensure that there is not a shift of specialised nurses e.g. trauma and theatre professional nurses who can only advance to salary level 7 to Clinical Nurse Practitioner posts, where they could advance to salary level 8, at the expense of hospital services.

3.1.3.3 Improving service delivery on the PHC platform

The areas of development in PHC services are firstly the improvement of access to services which will be achieved by the implementation of the Comprehensive Service Plan, and secondly the improvement of the quality of services by improving the documentation of supervision visits and ensuring that information obtained during these visits is used to improve service delivery.

Another key strategy in the provision of efficient services at CHC's is the computerisation and networking project. This phased project, funded by a policy option of R9 million in 2005/06 has provided 33 CHC's with Information Communication Technology (ICT) infrastructure. A patient registration system, called the Patient Master Index (PMI) has been installed at 22 facilities in the province largely in the metro as part of the first phase roll out of the system. The long-term goal for this project is to have a comprehensive Primary Health Care Information System with an individual electronic patient record for all patients on the PHC platform.

The implementation of the Healthcare 2010 Comprehensive Service Plan and the establishment of the district and sub-district management structures is eagerly anticipated and is perceived to be a key enabler in the provision of effective and efficient services. The process of consolidating the provision of PPHC to a single service provider, the mainstreaming of service provision and performance reporting will facilitate a better understanding and planning of resources used to provide effective and efficient PPHC services.

3.1.3.4 District hospital services

One of the key challenges has been the availability of Level 1 beds in the Metro where there are only 433 Level 1 beds compared to 1,165 Level 2 beds and 2,474 Level 3 beds. This situation results in Level 1 services being provided on a Level 2 platform, which is not cost effective. Thus to increase the availability of level 1 beds in the Cape Town Metro district the Department is planning to convert some of the level 2 beds to Level 1 and build new 210 bed district hospitals in Khayelitsha and in Mitchell's Plain using Hospital Revitalisation Programme (HRP) funding. In the interim there are 90 level 1 beds at Tygerberg Hospital and 30 beds at Karl Bremer Hospital and 100 beds at Lentegeur Hospital that will form the nucleus of the new Khayelitsha Hospital and Mitchell's Plain Hospital. Note that 30 of the beds at Lentegeur Hospital are temporary while wards at GF Jooste Hospital are refurbished.

One of the key priorities for the Department has been to ensure effective and efficient utilisation of level 1 hospitals as acute hospitals. As a result the caesarean section rate has increased from 8,2% in 2003/04 to 14,3% in 2005/06, an increase of 70%. This implies that the types of services being provided at district hospitals are more complex and are therefore likely to be more expensive. The fatality rate for surgery separations has increased only slightly from 0,62% in 2004/05 to 0,7% in 2005/06. Although this is higher than the provincial target of 0,2% it is lower than the National average of 1.3% which implies that the quality of services have not been significantly affected.

The average length of stay in the Level 1 hospitals has increased from 2.5 in 2004/05 to 2.8 in 2005/06 and the bed utilisation has decreased from 76% to 71% but this was above the target of 70%.

3.1.3.5 Improving service delivery at district hospitals

Providing high quality services at all provincial facilities including district hospitals is one of the Department's goals. One of the ways to ensure such quality in hospitals is through mortality and morbidity meetings, which should be happening at all hospitals. Currently only 45% of district hospitals have morbidity and mortality meetings on monthly basis to ensure the maintenance of high standards of care.

The Department has collaborated with the Universities of Stellenbosch and Cape Town on a project called the Improvement and Maintenance of Competence Project (iMOCOMP) which aims to improve and maintain knowledge, appropriate skills and overall levels of competence of health professionals working in district hospitals. This project has been funded via the Hospital Management Quality Improvement Grant (HMQIG). The Department is also committed to ensuring that Morbidity and Mortality (M&M) meetings are held regularly and that clinical governance is strengthened.

The implementation of the Comprehensive Service Plan will have a positive effect on service delivery and clinical governance in the District Health Services as the number of level 1 beds will increase and the district hospital will play a more supportive role to the PHC platform in a "hub and spoke" type of configuration to facilitate the delivery of a seamless quality service.

The hub and spoke model is being partly implemented in the rural districts with the assumption of responsibility process. This is proving to be a challenge, as the district hospitals are not yet fully capacitated to fulfil such responsibilities.

3.1.3.6 Rural development nodes

The rural development node in the Western Cape is the Central Karoo district. The health budget to the Central Karoo increased by 21% from R42 million in 2004/05 to R51 million. A wide range of PPHC services are provided in each sub-district and preventive and curative services are well integrated. All sub-districts have a district hospital with a ratio of beds per 1,000 population higher than the national target of 0,5 beds per 1,000 population. The reason for this being that the area is sparsely populated.

3.1.3.7 Urban renewal nodes

The urban renewal nodes in the Western Cape are the Khayelitsha and Mitchell's Plain sub-districts. A wide range of PPHC services are provided in the sub-districts. Local and provincial government provide preventive and curative services respectively. As previously indicated the Khayelitsha Site B CHC was one of the facilities that benefited from the consolidation of services in Metro.

During 2006/07 these two sub-districts benefited from a programme to combat diarrhoeal disease and increased immunisation coverage that involved the employment of 70 community-based workers to implement a set of household and community based interventions aimed at addressing the key causes of childhood morbidity and mortality.

These sub-districts currently do not have district hospitals but the Department intends to address this as a matter of urgency using Hospital Revitalisation Programme (HRP) funding to build and commission the hospitals. As indicated above, there are 220 beds at Tygerberg, Karl Bremer and Lentegeur Hospitals in the interim. It is anticipated that the new hospitals could be completed by 2010, although funding for the construction of these hospitals has not been approved by the commencement of the 2007/08 financial year.

Table 2.2 District health service facilities by health district [DHS1]

Health district	Facility type	No.	Population (Uninsured) 2005/06	Uninsured Population per fixed PHC facility	Per capita utilisation
WEST COAST	Non fixed clinics	43	239,357	9,574	3.1
	Fixed Clinics	25			
	CHCs	0			
	Sub-total clinics + CHCs	68			
	District hospitals	7			
CAPE WINELANDS	Non fixed clinics	24	525,164	8,901	4.9
	Fixed Clinics	55			
	CHCs	4			
	Sub-total clinics + CHCs	83			
	District hospitals	4			
OVERBERG	Non fixed clinics	13	177,271	7,707	2.9
	Fixed Clinics	21			
	CHCs	2			
	Sub-total clinics + CHCs	36			
	District hospitals	4			
EDEN	Non fixed clinics	25	385,386	7,557	3.5
	Fixed Clinics	46			
	CHCs	5			
	Sub-total clinics + CHCs	76			
	District hospitals	6			
CENTRAL KAROO (Rural development node)	Non fixed clinics	6	56,576	5,143	4.4
	Fixed Clinics[4]	10			
	CHCs	1			
	Sub-total clinics + CHCs	17			
	District hospitals	4			
METROPOLE	Non fixed clinics	24	2,092,709	17,317	3.7
	Fixed Clinics	71			
	CHCs	48			
	Sub-total clinics + CHCs	143			
	District hospitals	3			
Province	Non fixed clinics	135	3,444,494	11,960	3.7
	Fixed Clinics	228			
	CHCs	60			
	Sub-total clinics + CHCs	423			
	District hospitals	28			

Table 2.3: 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%	1	0.0041
	Professional nurses	6	6	0%	93	0.3826
	Pharmacists	1	1	0%	2	0.0082
	Community health workers	No posts on PERSAL. Service provided by NPOs				
	District hospitals					
	Medical officers	8	10	20%	8	0.0329
	Professional nurses	79	93	15%	79	0.3250
	Pharmacists	8	8	0%	8	0.0329
Cape Winelands	**PHC facilities**					
	Medical officers	8	11	27%	23	0.04
	Professional nurses	60	75	20%	279	0.52
	Pharmacists	9	11	18%	18	0.03
	Community health workers	No posts on PERSAL. Service provided by NPOs				
	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
Overberg	**PHC facilities**					
	Medical officers	6	10	40%	24	0.13
	Professional nurses	13	17	24%	108	0.60
	Pharmacists	N/A	N/A	N/A	11	0.06
	Community health workers	No posts on PERSAL. Service provided by NPOs				
	District hospitals					
	Medical officers	11	17	35%	11	0.06
	Professional nurses	53	70	24%	53	0.29
	Pharmacists	5	5	0%	5	0.03
Eden	**PHC facilities**					
	Medical officers	14	14	0%	19	0.05
	Professional nurses	22	47	53%	178	0.45
	Pharmacists	2	4	50%	13	0.03
	Community health workers	No posts on PERSAL. Service provided by NPOs				
	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
Central Karoo	**PHC facilities**					
	Medical officers	3	3	0%	6	0.10
	Professional nurses	6	6	0%	40	0.70
	Pharmacists	1	2	50%	3	0.05
	Community health workers	No posts on PERSAL. Service provided by NPOs				
	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
Metropole	**PHC facilities**					
	Medical officers	133	175	24%	117	0.06
	Professional nurses	479	578	17%	819	0.39
	Pharmacists	47	61	23%	46	0.02
	Community health workers	No posts on PERSAL. Service provided by NPOs				
	District hospitals					
	Medical officers	21	24	13%	21	0.01
	Professional nurses	82	90	9%	82	0.04
	Pharmacists	7	7	0%	7	0.00
Province	**PHC facilities**					
	Medical officers	165	214	23%	190	0.05
	Professional nurses	586	729	20%	1517	0.43
	Pharmacists*	60	N/A	N/A	93	0.03
	Community health workers	No posts on PERSAL. Service provided by NPOs				
	District hospitals					
	Medical officers	86	107	19%	86	0.02
	Professional nurses	465	564	18%	465	0.13
	Pharmacists	46	51	10%	46	0.01

Table 2.4: Situation analysis indicators for district health services [DHS3]

DHS=Sub programmes 2.1+2.2+2.3+2.4+2.5

	Indicator	Type	Province wide value 2003/04	Province wide value 2004/05	Province wide value 2005/06	Metro District 2005/06	Cape Winelands District 2005/06	Overberg District 2005/06	Eden District 2005/06	Central Karoo District 2005/06	West Coast District 2005/06	National target 2005/06
Input												
1	Uninsured population served per fixed public DHS facility (excl district Hosp)	No	12,354	12,184	11,960	17,317	8,901	7,707	7,557	5,143	9,574	
2	Provincial DHS expenditure per uninsured person	R	252	258	306	Budget currently allocated per region and not per district						
3	Local government DHS expenditure per uninsured person	R	54	54	33	Not available						N/A
4	DHS expenditure (provincial plus local government) per uninsured person	R	306	312	339	Not available						227
5	Professional nurses in PHC facilities per 100,000 uninsured person	No	40	41	44	39	52	60	45	70	38	107
6	Sub-districts offering full package of DHS services	%	65	80	80	100	100	40	100	40	100	60
7	EHS expenditure (provincial plus local govt) per uninsured person	R				Not available						9
Process												
8	Health districts with appointed manager	No	-	-	4.00	1.00		1.00	1.00		1.00	
9	Health districts with plan as per DHP guidelines	%			100	100	100	100	100	100	100	92
10	Fixed PHC facilities with functioning community participation structure	%	29	40	66.3	82	0	75	61.5	66.7	38.7	69
11	Facility data timeliness rate for all PHC facilities	%	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	80
Output												
12	PHC total headcount	No	12,882,038	12,758,966	13,068,303	7,588,031	2,594,310	521,178	1,364,266	248,936	751,582	N/A
13	Utilisation rate - PHC (uninsured population)	No	3.9	3.8	3.79	3.7	4.9	2.9	3.5	4.4	3.1	3.87
14	Utilisation rate - PHC under 5 years	No	5.9	6.4	6.2	5	6	7.3	7	7.3	5.4	3.80
Quality												
15	Supervision rate	%	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	78
16	Fixed PHC facilities supported by a doctor at least once a week	%	Not available	Not available								31
Efficiency												
17	Provincial PHC expenditure per headcount at provincial PHC facilities Sub-programme 2.2 and 2.3	R	57	60	67	Budget currently allocated per region and not per district.						
18	Expenditure (provincial plus LG) per headcount at public PHC facilities	R	78	98	91	Budget currently allocated per region and not per district.						
Outcome												
19	Health districts with a single provider of PHC services	No	0	0	5	0	1	1	1	1	1	

Notes:
Indicator 7: Data not provided by municipalities
Indicators 11, 15 and 16: Data only collected from April 2006 in the new minimum data set.

Table 2. 5: Situation analysis indicators for district hospitals sub-programme [DHS4]

Indicator	Type	Province wide value 2003/04	Province wide value 2004/05	Province wide value 2005/06	Metro District 2005/06	Cape Winelands District 2005/06	Overberg District 2005/06	Eden District 2005/06	Central Karoo District 2005/06	West Coast District 2005/06	National target 2005/06
Input											
1 Expenditure on hospital staff as % of district hospital expenditure	%	73.0	71.7	65.40	65.35	62.20	68.80	61.13	64.29	66.18	
2 Expenditure on drugs for hospital use as % of district hospital expenditure	%	6.3	6.5	3.4	4.1	3.8	3	3.9	3.7	3.2	11
3 Expenditure by district hospitals per uninsured person	R	111	119	137	58	136	241	306	576	364	
Process											
4 District hospitals with operational hospital board	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	76
5 District hospitals with appointed (not acting) CEO in post	%	86.0	100%	100%	100%	100%	100%	100%	100%	100%	69
6 Facility data timeliness rate for district hospitals	%	90.0	90.0	90.0	100	100	100	60	40	100	34
Output											
7 Caesarean section rate for district hospitals	%	8.2	10.7	14.3	0.3	11.7	19.5	18.5	14.9	10.9	12.5
Quality											
8 District hospitals with patient satisfactory survey using DoH template	%	50	100	46	66	100	100	0	0	46	10
9 District hospitals with clinical audit (M & M) meetings every month	%	85	100	45	0	50	0	2	0	100	36
Efficiency											
10 Average length of stay in district hospitals	Days	2.60	2.50	2.80	3.90	2.80	2.40	2.90	3.40	2.50	4.20
11 Bed utilisation rate (based on usable beds) in district hospitals	%	66%	76%	71%	70%	75%	59%	76%	82%	68%	68%
12 Expenditure per patient day equivalent in district hospitals	R	565	566	684	697	602	616	670	705	725	814 in 2003/04 prices
Outcome											
13 Case fatality rate in district hospitals for surgery separations	%	0.62	0.63	0.7	1.12	0.79	0.59	0.8	0	0.27	3.9

3.2. POLICIES, PRIORITIES AND STRATEGIC GOALS

3.2..1 Programme 2 functions within a national, provincial and divisional strategic framework as illustrated in Table 2.5 below.

Table 2.6: Policy and strategic framework

National	National Health Act Public Finance Management Act Medium Term Strategic Framework National Spatial Development Framework Accelerated Shared Growth Initiative of South Africa Strategic Priorities for the National Health System (2004 –09)
Provincial	IKapa elihlumayo (PGDS) Healthcare 2010
Divisional	**EIGHT DIVISIONAL PRIORITIES:** **Implementation of the DHS:** 1) Strengthening the District Health System 2) Community-based services 3) District Hospitals 4) Chronic disease management **Priority Health Programmes** 5) TB 6) HIV and AIDS 7) Women's Health 8) Child Health

The National Health Act (No 61 of 2003) that establishes the District Health System (DHS) with its district boundaries, governance structures, planning and reporting formats. The National Health Act (No 61 of 2003) also mandates the provincial Ministers of Health to enact provincial legislation to inform the establishment of sub-district boundaries, District Health Councils, sub-district community participation structures, etc. This process is currently in progress.

Healthcare 2010 determines the strategic goal of the DHS to ensure that 90% of patient contacts with the provincial Department of Health should occur in level 1 services and that approximately 8% should occur in level 2 services and only approximately 2% of patient contacts should occur in level 3 services.

The Healthcare 2010 Comprehensive Service Plan (CSP) is based on the provision of the full package of Primary Health Care services at all facilities by the correct number and skill mix of staff to promote effectiveness and efficiency. The Community Health Centres (CHCs) and district hospitals play pivotal roles in the referral pathway for patients and where the district hospitals play an important role in terms of clinical governance and outreach and support for clinical and management functions.

In order to provide services to the majority of clients within the DHS, infrastructure, rehabilitation, rationalisation and appropriate expansion will have to be addressed. This process will be driven by the Infrastructure Plan that is being developed as one of the four pillars of Healthcare 2010 and in line with the CSP.

The CSP describes the structure and functions of the district and sub-district management structures and strengthened facility management. These district, sub-district and facility management structures will strengthen district-based planning, monitoring and evaluation and improved functional integration within the Integrated Development Planning Framework particularly within the rural development and urban renewal nodes where intersectoral planning, monitoring and evaluation is critical towards the realisation of the set of developmental goals and objectives.

The National Health Act (No 61 of 2003) also designates the responsibility for Personal Primary Health Care (PPHC) to the Provincial Department of Health. The provincial Department of Health has therefore assumed managerial responsibility for all PPHC services in the rural districts. The transfer of staff, moveable and immoveable assets is in progress.

Although the Department of Health will not take responsibility for the provision of PPHC services in the Cape Town Metro district in the current financial year, increasing the number of single authority facilities and the number of CHCs offering extended hours of service will improve efficiencies in the Metro. These will also be enhanced by the computerisation project.

The CSP details the bed plan for all district hospitals in all of the districts. There will be a significant increase in the number of level 1 and 2 beds in the Cape Town Metro district and a decrease in the number of level 3 beds. In the rural districts there will be a decrease in the number of level 1 beds but an increase in level 2 beds.

Improving clinical governance together with capacity development of clinical staff through the Improvement and Maintenance of Competencies Programme (iMOCOMP) at district hospitals and at the PHC platform will facilitate the improvement of the quality health services in the DHS.

3.2.2 Strategic objectives for District Health Services

1) Establishment of district management structures.
2) Computerization of PHC facilities
3) Extended Hours service
4) Assumption of responsibility of all Personal Primary Health Care services (PPHC) in the non-metro districts.
5) Improve clinical governance in the DHS
6) Improve the availability and optimal utilisation of acute hospital services within the DHS

3.2.3 Strategic objectives for District Hospitals

1) Improved clinical governance.
2) Increase the number of level 1 beds in the Province.

G.F. Jooste, Karl Bremmer and Hottentots Holland Hospitals will be moved from Programme 4 to Programme 2 in 2007/08. This shift is in line with the Comprehensive Service Plan where these hospitals will predominantly be Level 1 hospitals with some level 2 capabilities. The move from Programme 4 to Programme 2 will ensure that this transition is managed systematically.

3.4 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2. 7: Analysis of constraints and measures to overcome them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
PHC	• Non competitive nursing salary packages	• Additional funding received through Health professionals remuneration review
	• Poorly maintained infrastructure particularly infrastructure that will be taken over from municipalities	• The department is part of a national process to undertake an audit current PHC infrastructure and submit bid to national Treasury
	• The size of the Metro district exceeds the capacity of the current management structure	• Four management structures will be created in the metro
	• Information Management	• The PHC Information System has been developed and is currently being rolled out in the Province
DISTRICT HOSPITALS	• Non competitive nursing salary packages	• Additional funding received through Health professionals remuneration review
	• Level 2 services currently provided on a level 1 platform in the rural areas and driving the costs at level 1 hospitals	• Assessment of the cost drivers on level 1 platform currently being undertaken with a view to inform the implementation of the CSP and ensuring that Level 1 hospitals are funded appropriately • Implementing the departmental Outreach and Support policy particularly with regards to appropriate funding of activities per level of care.

3.5. MEASUREABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.8 Provincial objectives and performance indicators for District Health Services [DHS5]

Objective	Indicator	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)
Establishment of district management structures.	Number of district management structures created.	0	0	0	0	5	5	6
	Number of sub district management structures created in the Metro	0	0	0	0	4	4	4
Computerization of PHC facilities	Number of PHC facilities computerized and with access to PHCIS	0	0	13	26	33	46	60
Extended Hours service	Number of CHC's with functional extended hours service	0	0	0	10	10	20	25
Assumption of responsibility of all Personal Primary Health Care services (PPHC) in the non-metro districts.	Number of municipal PPHC staff remaining with rural municipalities	0	0	N/A	565	0	0	0
Improve clinical governance and competence in the DHS	Number of Family Physicians registrars employed at CHC's	N/A	N/A	N/A	N/A	6	9	12
	Number of District Hospitals/CHCs with a functioning MOCOMP program	N/A	N/A	N/A	11	20	30	35
Provide sub-acute step-down and chronic beds to patients discharged from hospital beds but still in need of care other than in a hospital bed.	Number of beds managed by non-government organisations	Included in sub programme 4.4	Included in sub programme 4.4	Included in sub programme 4.4	575	575	575	575
Ensure efficient and cost effective service delivery at Nelspoort hospital	Provincial beds: Nelspoort hospital	Included in sub programme 4.4	Included in sub programme 4.4	Included in sub programme 4.4	Included in sub programme 4.4	90	90	90
	In patient days per annum					28,632	28,632	28,632
	Bed occupancy rate					0.87	0.87	0.87
Ensure the availability and optimal utilization of district hospital services in the DHS.	Number of District hospital 1 beds (mainly L1)	1,750	1,763	1,544	1,541	2,113	2,113	2,276
	Number of in patient days per annum	421,650	489,061	400,019	404,981	578,434	578,434	623,055
	Number of out patients treated per annum	738,283	709,895	729,674	763,436	780,450	780,451	747,666
	Number patient day equivalents per annum	667,744	725,693	643,244	659,460	838,584	838,584	872,277
	Number of separations per annum	167,150	195,150	142,864	143,013	199,460	199,460	214,847
	Average length of stay	2.6	2.5	2.8	2.9	2.9	2.9	2.9
	Bed utilisationrate	66.0%	76.0%	71.0%	72.0%	75.0%	75.0%	75.0%
Provision of outreach and support to PHC platform.	Percentage of district hospitals providing administrative support and clinical outreach and support to the PHC platform.	N/A	N/A	N/A	N/A	51%	75%	100%

Notes:

1. The establishment of the district management structures is dependent on the promulgation of the district health council act expected in 2007/08 Currently the four regional directors manage the six health districts.
2. The following hospitals moved from Sub-programme 4.1 to Sub-programme 2.9 in 2007/08: Hottentots Holland, GF Jooste, Karl Bremer Hospitals: Total 572 beds
3. Nelspoort Hospital is reallocated from Sub-programme 4.4 to Sub-programme 2.4 in 2007/08.
4. The useable beds in Nelspoort are reduced from 185 to 90 from 2007/08 in order to facilitate efficient utilisation of the infrastructure.

Table 2.9: Performance indicators for District Health Services [DHS6]

Indicator	Type	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)	National target 2007/08
Input									
1. Uninsured population served per PHC facility	No	12,354	12,184	11,960	11,687	9,526	9,072	8,640	<10,000
2. Provincial PHC expenditure per uninsured person	R	260	266	306	339	373	431	450	N/A
3. Local government PHC expenditure per uninsured person	R	54	54	33	Not available	Not available	Not available	Not available	N/A
4. PHC expenditure (provincial plus local government) per uninsured person	R	306	312	339	Not available	Not available	Not available	Not available	274
5. Professional nurses in fixed PHC facilities per 100,000 uninsured person	No	40	41	44	45	48	50	50	130
6. Sub-districts offering full package of PHC services	%	65	80	80	80	90	95	100	100
7. EHS expenditure (provincial plus local govt) per uninsured person	R	Not available	Not available	Not available	Not available	Not available	Not available	Not available	13
Process									
8. Health districts with appointed manager	%	0	0	0	66.6	66.6	80	100	100
9. Health districts with plan as per DHP guidelines	%	0	0	0	100	100	100	100	100
10. Fixed PHC facilities with functioning community participation structure	%	29	40	66	55	60	70	80	100
11. Facility data timeliness rate for all PHC facilities	%	Not available	Not available	Not available	50	70	80	95	100
Output									
12. PHC total headcount	No	12,882,038	12,758,966	13,068,303	12,907,061	13,143,141	13,419,209	13,737,324	N/A
13. Utilisation rate – PHC	No	3.9	3.8	3.79	3.2	3.4	3.7	3.8	3.87
14. Utilisation rate - PHC under 5 years	No	5.9	6.4	6.2	5.5	5.5	5.5	5.5	5
Quality									
15. Supervision rate	%	N/A	N/A	N/A	40%	60%	80%	100%	100
16. Fixed PHC facilities supported by a doctor at least once a week	%	N/A	N/A	N/A	40%	60%	80%	100%	100
Efficiency									
17. Provincial PHC expenditure* per headcount at provincial PHC facilities	R	57	60	67	73	71	80	78	78
18. Expenditure (provincial plus LG) per headcount at public PHC facilities	R	78	98	72	Not available	Not available	Not available	Not available	78
Outcome									
19. Health districts with a single provider of PHC services	%	0%	0%	83%	83%	83%	100%	100%	100%

Notes:
Indicator 10: This data for 2005/06 did not include clinics, it was only for CHCs. Many of the clinics taken over from municipalities did not have health committees thus the decrease in targets.

Table 2.10: Performance indicators for district hospitals sub-programme [DHS7]

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2007/08
Input									
1. Expenditure on hospital staff as % of district hospital expenditure	%	73	71.7	65.4	65	65	64	63	62
2. Expenditure on drugs for hospital use as % of district hospital expenditure	%	6.3	6.5	3.4	4	4	5	6	11
3. Expenditure by district hospitals per uninsured person	R	110.71	118.69	136.69	131.01	214.39	229.40	139.00	0
Process									
4. District hospitals with operational hospital board	%	100	100	100	100	100	100	100	100
5. District hospitals with appointed (not acting) CEO in post	%	86	100	100	100	100	100	100	100
6. Facility data timeliness rate for district hospitals	%	90	90	90	60%	70%	80%	95%	100
Output									
7. Caesarean section rate for district hospitals	%	8.2	10.7	14.3	15.0	15.0	15.0	15.0	11.0
Quality									
8. District hospitals with patient satisfaction survey using DoH template	%	50	100	46	70	70	80	90	100
9. District hospitals with clinical audit (M and M) meetings every month	%	85	100	45	50	60	60	60	100
Efficiency									
10. Average length of stay in district hospitals	Days	2.6	2.5	2.8	2.9	2.9	2.9	2.9	3.2
11. Bed utilisation rate (based on usable beds) in district hospitals	%	66	76	71	72	75	75	75	72
12. Expenditure per patient day equivalent in district hospitals	R	565	566	684	695	862	894	866	814 in 2007/08 prices
Outcome									
13. Case fatality rate in district hospitals for surgery separations	%	0.62%	0.63%	0.70%	0.70%	0.70%	0.70%	0.70%	3.5

Note:
Indicator 9: M&M meetings will only occur monthly in district hospitals with 50 beds or more the other district hospitals will do M&Ms quarterly.

3.6 SERVICE LEVEL AGREEMENTS AND TRANSFERS TO MUNICIPALITIES AND NON-GOVERNMENT ORGANISATIONS

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

Table 2.11: Transfers to municipalities and non-government organisations (R'000) [DHS8]
Transfers to local government by transfers/grant type, category and municipality

	Outcome						Medium term estimate			
Municipalities R'000	**Audited**	**Audited**	**Audited**	**Main appropriation**	**Adjusted appropriation**	**Revised estimate**				**% change from revised estimate**
	2003/04	**2004/05**	**2005/06**	**2006/07**	**2006/07**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2006/07**
Category A	132 304	131 074	104 662	127 075	131 256	131 256	**139 133**	151 427	159 134	6.00
City of Cape Town	132 304	131 074	104 662	127 075	131 256	131 256	**139 133**	151 427	159 134	6.00
Category B	33 449	40 241	58 284							
Beaufort West	1 131	1 073	1 463							
Bergrivier	33	3								
Bitou	1 329	2 313	3 510							
Breede River/Winelands	808	805	850							
Breede Valley	1 659	1 745	3 997							
Cape Agulhas	67									
Cederberg	483	588	707							
Drakenstein	3 313	6 648	7 699							
George	6 411	5 949	11 981							
Kannaland	24	1								
Knysna	1 860	2 004	3 738							
Laingsburg	32	7								
Hessequa	1 881	1 871	1 040							
Matzikama	738	828	749							
Mossel Bay	2 231	2 482	3 766							
Oudtshoorn	603	1 139	1 362							
Overstrand	1 008	1 056	1 230							
Prince Albert	342	248	335							
Saldanha Bay	1 936	2 284	4 000							
Stellenbosch	2 546	2 727	6 570							
Swartland	1 935	3 990	2 829							
Swellendam										
Theewaterskloof	2 487	1 855	2 112							
Witzenberg	592	625	346							
Unallocated										
Category C	36 603	49 372	54 481	9 394	11 121	11 121	**7 683**	8 172	2 495	(30.91)
Cape Winelands	8 619	16 570	17 140	2 074	2 540	2 540				(100.00)
Central Karoo	3 651	3 356	4 910	1 164	1 850	1 850	**1 676**	1 805	924	(9.41)
Eden	8 468	9 044	13 641	2 538	2 752	2 752	**2 464**	2 612	645	(10.47)
Overberg	7 084	8 640	7 921	1 565	1 565	1 565	**1 592**	1 687	416	1.73
West Coast	8 781	11 762	10 869	2 053	2 414	2 414	**1 951**	2 068	510	(19.18)
Unallocated										
Total transfers to local government	202 356	220 687	217 427	136 469	142 377	142 377	**146 816**	159 599	161 629	3.12

Note: Excludes regional services council levy.

Table 2.12: Transfers to municipalities and non-government organisations (R'000) for Personal Primary Health Care Services [DHS8]

	Outcome						Medium-term estimate			
Municipalities R'000	**Audited**	**Audited**	**Audited**	**Main Appropriation**	**Adjusted Appropriation**	**Revised estimate**				**% Change from Revised estimate**
	2003/04	**2004/05**	**2005/06**	**2006/07**	**2006/07**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2006/07**
Personal Primary Health care services	202 356	209 752	206 214	113 608	115 108	115 108	119 288	129 616	137 392	3.63
Category A	132 304	125 041	97 589	113 608	115 108	115 108	**119 288**	129 616	137 392	3.63
City of Cape Town	132 304	125 041	97 589	113 608	115 108	115 108	**119 288**	129 616	137 392	3.63
Category B	33 449	38 253	57 863							
Beaufort West	1 131	923	1 463							
Bergrivier	33	3								
Bitou	1 329	2 303	3 510							
Breede River/Winelands	808	805	850							
Breede Valley	1 659	1 745	3 997							
Cape Agulhas	67									
Cederberg	483	557	707							
Drakenstein	3 313	6 431	7 699							
George	6 411	5 537	11 981							
Kannaland	24	1								
Knysna	1 860	1 950	3 738							
Laingsburg	32	7								
Hessequa	1 881	1 871	1 040							
Matzikama	738	808	749							
Mossel Bay	2 231	2 403	3 766							
Oudtshoorn	603	972	1 362							
Overstrand	1 008	1 056	1 230							
Prince Albert	342	248	335							
Saldanha Bay	1 936	1 915	3 839							
Stellenbosch	2 546	2 453	6 355							
Swartland	1 935	3 785	2 784							
Swellendam										
Theewaterskloof	2 487	1 855	2 112							
Witzenberg	592	625	346							
Unallocated										
Category C	36 603	46 458	50 762							
Cape Winelands	8 619	16 438	16 545							
Central Karoo	3 651	3 099	4 465							
Eden	8 468	8 433	12 538							
Overberg	7 084	8 549	7 165							
West Coast	8 781	9 939	10 049							
Unallocated										

Note: Excludes regional services council levy.

Table 2.13: Transfers to municipalities and non-government organisations (R'000) for Integrated Nutrition [DHS8]

	Outcome						Medium-term estimate			
	Audited	Audited	Audited	Main Appropriation	Adjusted Appropriation	Revised estimate				% Change from Revised estimate
	2003/04	2004/05	2005/06	2006/07	2006/07	2006/07	2007/08	2008/09	2009/10	2006/07
Integrated Nutrition		4 983	2 997	3 000	3 000	3 000	3 150	3 375	3 573	5
Category A		2 882	2 997	3 000	3 000	3 000	**3 150**	3 375	3 573	5.00
City of Cape Town		2 882	2 997	3 000	3 000	3 000	**3 150**	3 375	3 573	5.00
Category B		1 081								
Beaufort West		150								
Bergrivier										
Bitou		10								
Breede River/Winelands										
Breede Valley										
Cape Agulhas										
Cederberg		31								
Drakenstein		75								
George		412								
Kannaland										
Knysna		54								
Laingsburg										
Hessequa										
Matzikama		20								
Mossel Bay		79								
Oudtshoorn		167								
Overstrand										
Prince Albert										
Saldanha Bay		42								
Stellenbosch		18								
Swartland		23								
Swellendam										
Theewaterskloof										
Witzenberg										
Unallocated										
Category C		1 020								
Cape Winelands		62								
Central Karoo		141								
Eden		398								
Overberg										
West Coast		419								
Unallocated										

Note: Excludes regional services council levy. Due to structural changes comparative figures cannot be submitted.

Table 2.14: Transfers to municipalities and non-government organisations (R'000) for the Global Fund [DHS8]

Municipalities R'000	Audited	Audited	Audited	Main Appropriation	Adjusted Appropriation	Revised estimate				% Change from Revised estimate
	2003/04	2004/05	2005/06	2006/07	2006/07	2006/07	2007/08	2008/09	2009/10	2006/07
Global Fund		2 905	7 296	12 910	14 218	14 218	**11 042**	11 705	2 894	(22.34)
Category A		2 117	3 773	3 516	3 516	3 516	**3 803**	**4 032**	**1 000**	8.16
City of Cape Town		2 117	3 773	3 516	3 516	3 516	**3 803**	4 032	1 000	8.16
Category B										
Beaufort West										
Bergrivier										
Bitou										
Breede River/ Winelands										
Breede Valley										
Cape Agulhas										
Cederberg										
Drakenstein										
George										
Kannaland										
Knysna										
Laingsburg										
Hessequa										
Matzikama										
Mossel Bay										
Oudtshoorn										
Overstrand										
Prince Albert										
Saldanha Bay										
Stellenbosch										
Swartland										
Swellendam										
Theewaterskloof										
Witzenberg										
Unallocated										
Category C		788	3 523	9 394	10 702	10 702	**7 239**	7 673	1 894	(32.36)
Cape Winelands		70	595	2 074	2 540	2 540				(100.00)
Central Karoo		116	363	1 164	1 431	1 431	**1 232**	1 306	323	(13.91)
Eden		213	1 103	2 538	2 752	2 752	**2 464**	2 612	645	(10.47)
Overberg		91	756	1 565	1 565	1 565	**1 592**	1 687	416	1.73
West Coast		298	706	2 053	2 414	2 414	**1 951**	2 068	510	(19.18)
Unallocated										

Note: Excludes regional services council levy. Due to structural changes comparative figures cannot be submitted.

Table 2.15: Transfers to municipalities and non-government organisations (R'000) for the HIV and AIDS [DHS8]

Municipalities R'000	Audited	Audited	Audited	Main Appropriation	Adjusted Appropriation	Revised estimate				%Change from Revised estimate
	2003/04	2004/05	2005/06	2006/07	2006/07	2006/07	2007/08	2008/09	2009/10	2006/07
		3 047	920	6 951	10 051	10 051	**13 336**	14 903	17 770	32.68
Category A		1 034	303	6 951	9 632	9 632	**12 892**	14 404	17 169	33.85
City of Cape Town		1 034	303	6 951	9 632	9 632	**12 892**	14 404	17 169	33.85
Category B		907	421							
Beaufort West										
Bergrivier										
Bitou										
Breede River/Winelands										
Breede Valley										
Cape Agulhas										
Cederberg										
Drakenstein		142								
George										
Kannaland										
Knysna										
Laingsburg										
Hessequa										
Matzikama										
Mossel Bay										
Oudtshoorn										
Overstrand										
Prince Albert										
Saldanha Bay		327	161							
Stellenbosch		256	215							
Swartland		182	45							
Swellendam										
Theewaterskloof										
Witzenberg										
Unallocated										
Category C		1 106	196		419	419	**444**	499	601	5.97
Cape Winelands										
Central Karoo			82		419	419	**444**	499	601	5.97
Eden										
Overberg										
West Coast		1 106	114							
Unallocated										

Note: Excludes regional services council levy. Due to structural changes comparative figures cannot be submitted.

3.7 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH THE PLAN

Programme 2 is allocated 34,40 percent of the total vote in 2007/08 in comparison to the 30,54 percent that was allocated in the revised estimate for 2006/07. This translates into an increase of R464,238 million or 23,49 percent in nominal terms.

Contributing factors to this increase are the allocation of funds for the creation of the District Health Service structures and the allocation of GF Jooste, Hottentots Holland and Karl Bremer Hospitals from Sub-programme 4.1 to Sub-programme 2.9 and Nelspoort Hospital from Sub-programme 4.4 to Sub-programme 2.4.

Additional funding has been allocated to Programme 2 for the following:

- R17,036 million earmarked human resource development funding for district management,
- R6,198 million earmarked human resource development funding allocated to Sub-programme 2.9, district hospitals.
- R9 million equitable share has been allocated to sub-programme 2.4 to fund community based services following the phasing out of the European Union donor funding.
- R11 million equitable share has been allocated to GF Jooste Hospital to address service pressures.
- R2 million equitable share has been allocated to the provincially aided hospitals, Prince Albert and Clanwilliam for provincialisation.
- R1 million has been allocated to Laingsburg Hospital to address the shortfall as a result of the provincialisation in 2006/07.
- An amount of R2,5 million has been allocated for the rent of PPHC facilities owned by local government.
- An amount of R2,716 million has been allocated to address the increases in Government Motor Transport tariffs.

Table 2.16: Trends in provincial public health expenditure for District Health Services (R million) [DHS9]

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	1,204,896,180	1,418,912,000	1,670,716,000	2,081,543,000	2,547,125,000	2,950,959,000	3,148,849,000
Total per person	258.23	299.44	354.14	434.48	523.54	597.28	627.59
Total per uninsured person	353.74	410.19	485.04	595.08	717.06	818.05	859.57
Total capital	60,197,000	88,515,000	40,765,000	105,127,000	106,471,000	222,296,000	282,038,000
Constant 2006/07 prices							
Total	1,361,532,684	1,546,614,080	1,754,251,800	2,081,543,000	2,417,221,625	2,673,568,854	2,711,158,989
Total per person	292	326	372	434	497	541	540
Total per uninsured person	400	447	509	595	680	741	740
Total capital	68,022,610	96,481,350	42,803,250	105,127,000	101,040,979	201,400,176	242,834,718

Table 2.17: Trends in provincial public health expenditure for District Hospitals (R million) [DHS9]

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	381,341,795	446,679,000	446,723,000	531,972,000	832,527,000	1,012,721,000	1,114,388,000
Total per person	81.73	94.27	94.69	111.04	171.12	204.98	222.11
Total per uninsured person	111.96	129.13	129.69	152.08	234.37	280.74	304.20
Total capital	47,625,000	70,030,000	27,639,000	73,708,000	70,963,000	185,218,000	237,240,000
Constant 2006/07 prices							
Total	430,916,228	486,880,110	469,059,150	531,972,000	790,068,123	917,525,226	959,488,068
Total per person	92.35	102.75	99.43	111.04	162.39	185.71	191.23
Total per uninsured person	126.51	140.75	136.18	152.08	222.42	254.35	261.92
Total capital	53,816,250	76,332,700	29,020,950	73,708,000	67,343,887	167,807,508	204,263,640

4. HIV & AIDS, STI AND TB CONTROL

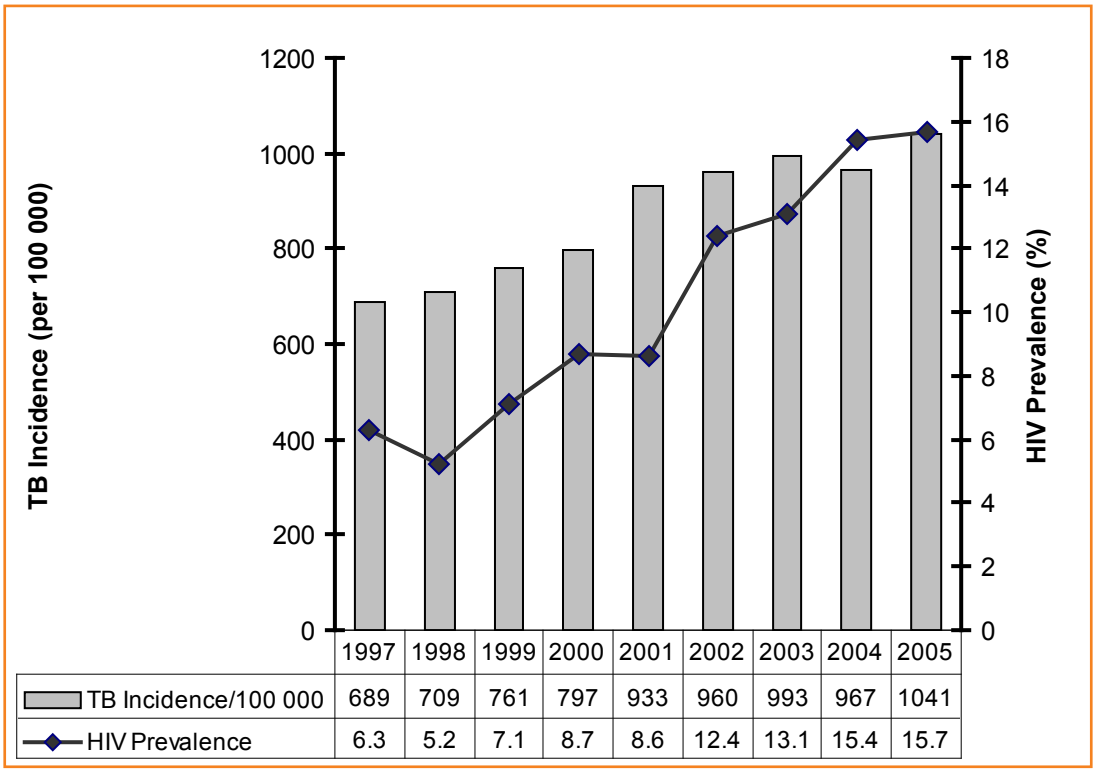
4.1 SITUATION ANALYSIS

4.1.1 Overview

As shown in Figure 2 below, the annual antenatal HIV prevalence and TB incidence has steadily increased. In 2005 the HIV prevalence was 15,7% and TB incidence was 1,041/100,000 population. Even although the 2005 HIV prevalence in the province is lower than the national prevalence, in some districts such as Khayelitsha the prevalence is estimated to be 32.5%, which is higher than the average national HIV prevalence rate.

The HIV epidemic has also fuelled the TB epidemic as illustrated in Figure 2 below. The incidence of TB in the Western Cape has increased from 689/100,000 in 1997 to 1,041/100,000 in 2005. This incidence is almost double the national TB incidence. In 2003 the national TB incidence was 550/100,000.

Figure 2: TB incidence and HIV prevalence for the Western Cape Province 1997 – 2005



	1997	1998	1999	2000	2001	2002	2003	2004	2005
TB Incidence/100 000	689	709	761	797	933	960	993	967	1041
HIV Prevalence	6.3	5.2	7.1	8.7	8.6	12.4	13.1	15.4	15.7

In response to the HIV and AIDS epidemic the province has implemented the Comprehensive HIV and AIDS Care, Management and Treatment Plan adopted by the National Cabinet in November 2003. The Department has committed itself to integrating the HIV and AIDS programme into the general health services in such a way that the additional resources lead to strengthening the general health system rather than creating a vertical HIV and AIDS service delivery model.

4.1.2 HIV Prevention programmes

4.1.2.1 Community mobilisation:
There are 32 multi-sectoral action teams that bring relevant role-players [government departments, local government and non-governmental organisations and civil society organisations] together at sub-district level to initiate local responses to the epidemic. Three hundred and fifty three projects are funded through community-based organisations. Targeted work is undertaken in high transmission areas, e.g. sex workers and truckers, women and youth. Research was undertaken in 2006 with men aged 29 – 40 in high HIV prevalence sub-districts and specific interventions with this age group will be undertaken in 2007.

4.1.2.2 Life skills and peer education:
There is a peer education programme in 95 secondary schools. LoveLife programmes are aimed at selected secondary schools (14,780 groundbreakers at 139 schools).

4.1.2.3 Voluntary Counselling and Testing (VCT):
VCT is offered at 441 health facilities: 43 hospitals, 12 MOUs, 64 CHCs, 288 clinics, 34 mobile clinics and 30 non-medical sites. There are 23 NGOs who employ 373 lay counsellors who provide the bulk of the pre and post test counselling services. The annualised VCT coverage in those 15 years and older was 9.0% as at 31 December 2006.

4.1.2.4 Prevention of mother-to-child transmission (PMTCT):

There were 64,111 new antenatal bookings from April 2006 to December 2006 of which 63,551 (99.1%) were counselled. Of those counselled, 62,902 accepted testing resulting in a 98.1% acceptance rate. Of those tested 8,495 were found to be HIV positive. The 13.5% HIV prevalence during this period compares well with the Antenatal Surveillance survey data.

There is currently a 2-drug regimen policy that has been implemented throughout the province. CD4 counts were done on all HIV positive mothers and PCR was done at 14 weeks on all babies born to HIV positive mothers. Transmission rates are being measured as part of monthly cohorts and reported at 6 months. The transmission rate for 2005/06 was 6.1%. . The transmission rate is currently 5.3% for the province.

4.1.2.5 Sexually transmitted infections (STIs):
The STI program remains a challenge for the department. The STI partner treatment rate for April to December 2006 is 19.5% (Target for 2006/07 is 25%). Since a significant proportion of clients have their STI's treated in the private sector, the Department has a partnership programme with 12 General Practitioners to jointly treat STI's. This programmes has, however, not been expanded due to the amendments to the pharmacy legislation.

4.1.2.6 Condoms:
The province has an extensive condom distribution network that includes traditional public sector and non-traditional non public sector sites such as the airport, *shebeens* and *spaza* shops. From 1 April 2005 to 31 March 2006 there were 37,262,600 male condoms distributed, which translates to 20 condoms per adult male over the age of 15 years. In the same time period 131,987 female condoms were distributed from 35 sites. From April to December 2006 39,038,694 male condoms were distributed, thus 23 condoms per adult male over the age of 15 years were distributed. In the same time period 168,149 female condoms were distributed.

4.1.2.7 Post Exposure Prophylaxis (PEP):

PEP for occupational exposure to HIV is offered in all hospitals. The department also has a PEP programme for victims of sexual assault where PEP is available at designated sites.

4.1.3 Treatment programme:

4.1.3.1 Care of HIV infected persons

All the Department's CHCs and clinics provide first contact ambulatory care for HIV positive patients including and up to conducting CD4 counts with a view to referral to an ARV centre. Treatment for opportunistic infections and nutritional support is also available at primary health care facilities

4.1.3.2 Anti retroviral treatment (ARV)

At the end of December 2006, there were 23,452 patients on treatment at 47 treatment sites, which exceeded the target of 20,780 patients. The target for 2006/07 has been revised from 22,489 to 25,697. This translates to approximately 61% of all those requiring treatment being on treatment.

4.1.3.2 Diflucan partnership

A donor partnership programme was started in 2001 for the treatment of oesphogeal candidiasis and cryptococcal meningitis. From January to December 2005, there were 150,326 Diflucan tablets used to treat 6,428 patients [2,530 oesophogeal candidiasis and 3,898 cryptococcal meningitis]. From April – December 2006 74, 375 Diflucan tablets were used to treat 2,873 patients (1,963 for oesophogeal candidiasis and 910 for cryptococcal meningitis). In the same period, 924 bottles of Diflucan syrup were used to treat 39 patients (35 for oesophageal candidiasis and 4 for cryptococcal meningitis).

4.1.4 Care and support programme

4.1.4.1 Home-based care:

In 2005/06 this service grew to 81 NGOs employing 1,288 home-based carers. There are currently 20,189 patients in care and an average of 285,316 visits are done per quarter.

4.1.4.2 In-patient palliative care:

There are 16 hospices/respite centres funded to provide 254 beds for in patient palliative care. The bed occupancy rate is 80% and the average length of stay is 24 days.

4.1.4 Tuberculosis

Tuberculosis persists as a public health problem of serious magnitude in the Western Cape Province. The incidence of TB in the Western Cape is 1,006 cases/100 000 population for all TB cases and 534/1000 population for new TB cases. This is almost double that of the national average and the highest in South Africa. There has been a significant rise in the number of TB cases in the Western Cape over the past few years. The increase has been disproportionately higher in geographic areas with higher HIV prevalence. In 2006 the province had a caseload of 47,441 TB cases. This caseload consisted of 72,1% newly diagnosed TB cases and 27,9 % of the cases had previously been treated for TB. Pulmonary TB cases made up 88,2% of the caseload and extra pulmonary TB cases made up 11,8% of the caseload. Of all the pulmonary TB cases 60,2% were smear positive infectious cases. Children under the age of seven years made up 14, 2% of cases. Over 95% of pulmonary TB cases in the Western Cape were bacteriological confirmed by the NHLS laboratory services.

The TB burden is not equally distributed throughout the Province. The Metro carries 55% of the overall TB burden. 12 Sub-Districts (8 in the Metro) register more than 1000 TB patients per annum and 22 health facilities in these sub-districts register more than 400 TB patients per annum. Ten clinics, all in the Metro (Site B, Nolungile, Guguletu, Delft, Ikwezi, Nyanga, Langa, Mzamomhle, Wallacedene, Kuyasa and Vuyani) carried 21.5% of the provincial TB burden. All these facilities also have a high HIV burden.

In response to the epidemic, the Department developed and implemented a strategy to accelerate and enhance the response (TB Crisis Plan) in controlling TB. The policy option amount of R12,5 million received was utilised to strengthen TB control in 5 Sub-Districts (Khayelitsha, Klipfontein, Eastern, Drakenstein and Breede Valley) as well as to improve TB in-patient care. Additional staff was appointed and NGOs were funded to support community outreach services community TB DOT.

The TB cure rate for new smear positive cases in 2005 for the Western Cape Province was 71,3 % and the treatment success rate was 79%. The cure rate improved by 1,1% from 2004. Cure rates in the high burden health facilities were however significantly lower than the provincial average. This reflects the need for continued and additional support for these facilities. The interruption rate of 11,1% is still high and needs to be addressed. The death rate of 3,7% is very low and may be due to the fact that TB patients die in hospitals before they have been registered as a confirmed TB case on the TB register as well as that many cases who defaulted actually died.

Tuberculosis in the Western Cape has reached epidemic proportions. Health services are being overburdened by a continuous increase of cases of tuberculosis many of whom are also HIV positive. It is estimated that the number of TB cases will continue to increase in the next decade. To reverse the epidemic and ensure that the Millennium Development Goal targets are achieved effective TB control strategies that are adequately funded are required.

Table 2.18: Situation analysis for HIV & AIDS, STIs and TB control [HIV1]

Indicator	Type	Province wide value 2003/04	Province wide value 2004/05	Province wide value 2005/06	Metro District 2005/06	Cape Winelands District 2005/06	Overberg District 2005/06	Eden District 2005/06	Central Karoo District 2005/06	West Coast District 2005/06	National target 2005/06
Input											
1. ARV treatment service points compared to plan	%	106%	100%	98%	98%	100%	100%	100%	100%	100	100
2. Fixed PHC facilities offering PMTCT	%	74%	74%	74%	-	-	-	-	-	-	50
3. Fixed PHC facilities offering VCT	%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90
4. Hospitals offering PEP for occupational HIV exposure	%	100%	100%	100%	100%	100%	100%	100%	100%	100	100
5. Hospitals offering PEP for sexual abuse	%	67.90%	77.30%	89.7%	72.7%	100%	100%	100%	100%	85.7	100
6. HTA Intervention sites compared to plan	No	0	3	12	6	2	2	0	2	N/A	N/A
Process											
7. TB cases with a DOT supporter	%	88.3%	90.0%	86%	91%	72%	91%	88%	83%	83%	100.0%
8. Male condom distribution rate from public sector health facilities	No	10.3	15.6	20	12.2	7.3	5.6	7.1	5.5	5.8	7
9. Male condom distribution rate from primary distribution sites	No	27,319,	27,270	37,262		-	-				21
10. Fixed facilities with any ARV drug stock out	%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
11. Hospitals drawing blood for CD4 testing	%	No data	No data	100%	100%	100%	100%	100%	100%	100%	N/A
12. Fixed PHC facilities drawing blood for CD4 testing	%	No data	56	62	No data	No data	No data	No data	No data	No data	N/A
13. Fixed facilities referring patients to ARV treatment points assessment	%	No data	No data	100	100	100	100	100	100	100	N/A
Output											
14. STI partner treatment rate	%	17.58%	21.0%	18.5%	17.9%	21.7%	26.7%	17.3%	24.1%	13.5%	27.0%
15. Nevirapine dose to baby coverage rate	%	90.0%	97.0%	97.1%	96.5%	98.9%	99.2%	99.2%	98.2%	98.9%	20.0%
16. Clients HIV pre-test counselled rate in fixed PHC facilities	%	1.6%	1.5%	1.5%	1.4%	1.4%	2.1%	1.8%	1.6%	1.5%	
17. Patients registered for ART compared to target	%	100.0%	100.0%	119.0%		100.0%	100.0%	112.6%	120.0%		N/A
18. TB treatment interruption rate	%	12.0%	11.5%	11.9%	12.4%	15.3%	8.0%	7.3%	9.3%	11.0%	5.00%
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	N/A
20. TB sputa specimens with turnaround time > 48 hours	%	30.0%	26.0%	28.0%	25.O%	34%	30.0%	31.0%	48%	21.0%	
Efficiency											
21. Dedicated HIV/AIDS budget spent	%	100%	100%	105%	106%	100%	100%	98%	98%	100%	
Outcome											
22. New smear positive PTB cases cured at first attempt	%	72.0%	68.3%	70.2%	66.9%	65.6%	84.6%	81.8%	72.5%	74.7%	65.0%
23. New MDR TB cases reported - annual % change	%	0.00%	0.00%	No data	No data	No data	No data	No data	No data	No data	No data
24. STI treated new episode among ART patients - annual % change	%	No data	No data	No data	No data	No data	No data	No data	No data	No data	N/A
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	N/A

Notes:

Indicator 23: There is no MDR TB information system to monitor this indicator. The national TB programme is in the process of developing a system which should be ready in 2007.

Indicator 24: This was not routinely collected before but data collection started in July 2006.

Indicator 25: The tools to undertake these visits have not been provided by national.

2.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

The provincial Department of Health has committed itself to a comprehensive HIV & AIDS/STI & TB programme that addresses, via all relevant departments of the provincial government and all sectors of society, all aspects of the HIV and AIDS and TB dual epidemics. The broad goals of the provincial programme are:

1) To prevent the further spread of the diseases;
2) To ensure treatment and care for those individuals infected with HIV & TB; and
3) To ensure care and support for those individuals, families and communities whose own support systems have been affected by AIDS and TB.

The provincial strategy draws from the 'National HIV/AIDS and STD Strategic Plan for South Africa, 2000 – 2005' which provides a broad framework for a comprehensive response to the HIV and AIDS pandemic in South Africa, pending the official release of the HIV & AIDS and STI Strategic Plan for South Africa, 2007 – 2011 (expected during the course of 2007). The adoption of the 'Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa' by the National Cabinet in 2003 launched a national commitment to provide anti-retroviral treatment (ART) for HIV infected individuals. The advent of this large-scale treatment programme has had major implications for the health care delivery system in the country and this province. The impact of HIV and AIDS on levels of care has been increasing steadily as the prevalence of HIV has increased in the Western Cape over the past eight years.

The Provincial HIV & AIDS/STI & TB Programme is co-ordinated by the Provincial AIDS Council, which has representation from all relevant stakeholders in the province and is chaired by the Provincial Minister of Health. The Provincial Inter-Departmental AIDS Committee (PIDAC), co-ordinates the government sector response, and is convened by the Provincial Department of Health.

In addition to its co-ordinating and leadership role in the Province's HIV & AIDS/STI & TB programme, the Department of Health is responsible for the development and implementation of policies, strategies and activities within the Department to curb and manage the HIV & TB epidemics. The provincial Department of Health's HIV & AIDS/STI & TB programme relates to all three broad goals.

Table 2.19: The three broad goals of the HIV & AIDS/STI programme

Prevention	Treatment	Care & support
Community mobilisation	Anti-retroviral treatment (ART)	Home-based care/ community ARV adherence support.
Lifeskills and peer education (Education Department)	Ongoing management of HIV positive clients not on ARVs.	Palliative hospice care
Voluntary counselling and testing (VCT)	In-patient management of HIV and AIDS disease.	Social support (Department of Social Services)
Sexually transmitted infections (STI) management		Orphans/ vulnerable children (Department of Social Services)
Condom/barrier method		
Post exposure prophylaxis (PEP)		
Prevention of mother-to-child transmission (PMTCT)		

The implementation of the various strategies has been incremental over the last 5 years. The Provincial AIDS Council has officially endorsed the Accelerated HIV Prevention Strategy: A Multi-sectoral framework for action in the Western Cape 2006 – 2011. The strategy provides a roadmap for increased effort and commitment to contain the spread of HIV, with ambitious targets.

In response to the TB epidemic, the Department has developed a strategy to accelerate an enhanced response in controlling TB in the province, during the 2005/06 and 2006/07 financial years. The strategy will be refined in 2007/08 financial year as follows:

1) An improved community-based TB control service: a new model of TB & HIV adherence support (drawing from the success of the ART adherence programme) will be formally piloted and evaluated, and increased coverage for community TB DOT will be achieved in the 22 highest burden clinic drainage areas.

2) **An improved PHC service for TB:** additional resources will be deployed in the 22 highest burden TB clinics, to achieve better patient care and follow-up and basic administrative system improvements.

3) **An improved in-patient TB service:** The provincialisation of all TB hospitals will be completed. Additional resources will be deployed to implement the initial steps towards the CSP Healthcare 2010 TB bedplan.

4.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.20: Analysis of constraints and measures to overcome them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
HIV/AIDS/TB	• Demand for services far exceeds the capacity of the government to provide services in prevention, care and support and treatment	• The department has developed a comprehensive prevention strategy, which will help decrease new infections. This will see such interventions as VCT being provided at many more non-medical sites to alleviate the strain on the public sector. Non-government organisations (NGO's) working with women, children and vulnerable groups will be further engaged to assist with targeted prevention interventions • The department will implement a strategy for the Provincial Interdepartmental AIDS Committee (PIDAC), which will commit other government departments to implement appropriate targeted actions aimed at the downstream and upstream factors associated with the HIV & TB epidemics
	• Recruiting and retaining the appropriate Human Resources	• Human resources employed through the HIV/AIDS program will be integrated into health services to strengthen services generally
	• Adequate infrastructure	• The department will employ a project manager through Global Funding to assist the departments of Health and Public Works to improve the planning and implementation of PHC infrastructure projects. This will significantly improve PHC infrastructure challenges globally
	• The department's ability to take over the activities currently funded by Global Fund into the equitable share in a phased manner thus not overburdening the state.	• The department has a structured exit strategy from Global fund to slowly take over the Global Fund financial commitments over a four-year period from 2006 to 2010.

4.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.21: Provincial objectives and performance indicators for HIV & AIDS, STI and TB control [HIV2]

Indicator	Type	2003/04	2004/05	2005/06	2006/07 (Target)	2007/08 (Target)	2008/09 (Target)	2009/10 (Target)
Input								
1. Number of active hospice beds	No.	-	-	287	304	304	304	304
1.1 Number of hospice beds via equitable share	No.	-	-	133	136	214	242	256
1.2 Number of hospice beds via the Global Fund	No.	-	-	154	168	90	62	48
2. Number of badged peer educators via Global Fund	No.	-	-	4,410	7,967	11,501	15,035	15,035
3. Number of MSAT projects funded via Global Fund	No.	-	-	160	274	343	412	412
Process								
4. Female condom distribution from primary distribution sites	No.	No Data	71,010	120,617	180,000	200,000	220,000	230,000
Output								
5. Cumulative number of clients on ART	No.	2,319	7,670	16,300	25,697	35,863	46,029	56,195
5.1 Cumulative number of clients on ART via the Conditional Grant	No.	0	4,979	10,905	17,536	28,962	41,706	56,195
5.2 Cumulative number of clients on ART via the Global Fund	No.	0	2,691	5,395	8,161	6,901	4,323	
6. Total number of persons tested for HIV		-	-	-	415,000	484,000	554,000	626,445
6.1 Number of persons tested for HIV, excluding antenatal	No.		-	262,000	320,000	380,000	440,000	500,000
6.2 Number of persons tested for HIV during antenatal care		-	-	-	95,000	104,500	114,950	126,445
Outcome								
7. PMTCT transmission rate	%	12%	10%	6.10%	5.50%	5.00%	4.50%	4.00%
8. Smear conversion rate at 2 months for new smear positive PTB cases	%	57.3%	59,1%	61,9%	64%	66%	68%	70%

Table 2.22: Performance indicators for HIV & AIDS, STI and TB control [HIV3]

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2008
Input									
1. ARV treatment service points compared to plan	%	106%	100%	98%	100%	100%	100%	100%	100
2. Fixed PHC facilities offering PMTCT	%	74%	74%	74%	74%	74%	74%	74%	100
3. Fixed PHC facilities offering VCT	%	100%	100%	100%	100%	100%	100%	100%	100
4. Hospitals offering PEP for occupational HIV exposure	%	100%	100%	100%	100%	100%	100%	100%	100
5. Hospitals offering PEP for sexual abuse	%	67.90%	77.30%	89.7%%	89.7%	100%	100%	100%	100
6. HTA Intervention sites compared to plan	No	0	3	12	18	25	30	35	100
Process									
7. TB cases with a DOT supporter	%	88.30%	90%	86%	90%	95%	95%	95%	100
8. Male condom distribution rate from public sector health facilities	No per 15 yr male	10.3	15.6	20	22	25	28	30	11
9. Male condom distribution from primary distribution sites	No	27,319,	27,270	37,262	40,000	42,000	45,000	48,000	32
10. Fixed facilities with any ARV drug stock out	%	0	0	0	0	0	0	0	0
11. Hospitals drawing blood for CD4 testing	%	0	0	0	0	0	0	0	0
12. Fixed PHC facilities drawing blood for CD4 testing	%	No data	56%	62%	74.4%	82.6%	93%	100%	20
13. Fixed facilities referring patients to ARV treatment points assessment	%	No data	No data	100%	100%	100%	100%	100%	10
Output									
14. STI partner treatment rate	%	17.50%	21%	18.50%	20%	21%	22%	23%	40
15. Nevirapine dose to baby coverage rate	%	90%	97%	97.1%	98%	98%	98%	98%	70
16. Clients HIV pre-test counselled rate in fixed PHC facilities	%	1.6	1.5%	1.5%	2%	2.5%	3%	3.5%	100
17. Patients registered for ART compared to target	%	100%	100%	119%	100%	100%	100%	100%	100
18. TB treatment interruption rate	%	12.00%	11.50%	11.90%	10.00%	9.00%	8.00%	7.00%	5.00%
Quality									
19. CD4 test at ARV treatment service points with turnaround time >6 days	%	No data	No data	0	0	0	0	0	0
20. TB sputa specimens with turnaround time > 48 hours	%	30	26	28	18	15	10	5	0
Efficiency									
21. Dedicated HIV/AIDS budget spent	%	100	100	105	100	100	100	100	100
Outcome									
22. New smear positive PTB cases cured at first attempt	%	72%	68.30%	70,2%	71,3%	73%	75%	77%	85%
23. New MDR TB cases reported - annual % change	%	No data	No data						
24. STI treated new episode among ART patients - annual % change	%	No data	No data						
25. ART monitoring visits measured at WHO performance scale 1 or 2	%	No data	No data						

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

An earmarked allocation of R37,048 million has been made to Sub-programme 2.6 for HIV and AIDS in 2007/08.

Table 2.23: Trends in provincial public health expenditure for HIV and AIDS conditional grant (R million) [HIV4]

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	38,146,399	94,394,000	122,655,000	168,454,000	187,607,000	207,078,000	241,188,000
Total per person	8.18	19.92	26.00	35.16	38.56	41.91	48.07
Total per uninsured person	11.20	27.29	35.61	48.16	52.81	57.41	65.84
Constant 2006/07 prices							
Total	43,105,430	102,889,460	128,787,750	168,454,000	178,039,043	187,612,668	207,662,868
Total per person	9.24	21.71	27.30	35.16	36.59	37.97	41.39
Total per uninsured person	12.65	29.74	37.39	48.16	50.12	52.01	56.69

5. MATERNAL CHILD AND WOMEN'S HEALTH, AND NUTRITION

5.1. SITUATION ANALYSIS

5.1.1 Maternal & Woman's Health

The number of termination of pregnancies (TOPs) performed per annum continues to increase significantly each year while the number of contraceptive users continues to decline. The emergency contraceptive utilisation rate remains poor despite awareness programmes. Therefore it seems that contraceptive delivery needs to be improved and aggressively promoted. The department is currently undertaking a study to understand contributory factors to this situation the results of which will assist in improving programme design.

Antenatal coverage has remained above 80% in the last three financial years. As at December 2006, the antenatal coverage was projected to be 81,9% by the end of the 2006/07 financial year which is a slight decrease from 83.9% in 2005/06 and is less than the target of 85%. Ensuring high antenatal coverage and antenatal coverage for women less than 20 weeks gestation is a key priority for 2007/08.

Cervical cancer screening has been a priority in the department since 2004 and this is evidenced by the significant increase in the number of women screened. In 2005/06, 5.5% of all women aged 30 –59 years were screened translating to 75% of the target of 8%. In the two previous financial years only about 40% of the target was reached.

The institutional delivery rate for women < 18years is hovering around 10% in the last three years. This may be an indication that teenage deliveries have remained relatively constant over time.

5.1.2 Child Health

Full Immunisation and measles coverage for under one's has remained above 90% in the last three financial years. As a result of the immunization survey done in 2004 which showed full immunisation coverage of 75.8% key districts and sub districts are implementing the WHO Reach Every District (RED) strategy, which entails the following:

1) Outreach to areas with poor access
2) Supervision and training
3) Community links with staff
4) Monitoring & use information for action (coverage, completeness, timeliness, QA)
5) Planning and Management of resources

The National School Health policy was completed during 2003 and implemented during 2004. In the Western Cape school health services were previously rendered in all regions in the province, however, this service integrated into general PHC services. The coverage of schools within the province thus only reflects the Cape Town Metro district. The province is currently extending school health services to the rest of the province in line with National Policy. Currently the phase one school health programme is available in 100% of primary schools in the Metro, 20% of primary schools in the Central Karoo, 83% of primary schools in Eden, 33% of primary schools in the Cape Winelands and 50% of primary schools in the Overberg.

The vitamin A supplementation policy was changed in all public health facilities from medically targeted for malnourished children to a blanket cover to all children under 1year as of 1 April 2004. However, Vitamin A data elements were only incorporated into the Routine Monthly Report (RMR) from 1 April 2005 in three of the four regions thus the low coverage of 26.5% under 1 year for 2005/06 is not a true reflection of programme performance. As at December 2006 there was an annualised Vitamin A coverage of 75,2%.

The number of facilities declared baby friendly have increased from 5% in 2005/06 to 11,5% in December 2006.

The availability of the Integrated Management of Childhood Illness (IMCI) programme in fixed PHC facilities is progressing well although due to the high staff turnover training needs to be intensified. As at December 2006, there were 86,8% fixed PHC facilities implementing IMCI.

Table 2.24 Situation analysis indicators for MCWH & Nutrition [MCWH1]

Indicator	Type	Province wide value 2003/04	Province wide value 2004/05	Province wide value 2005/06	Metro District 2005/06	Cape Winelands District 2005/06	Overberg District 2005/06	Eden District 2005/06	Central Karoo District 2005/06	West Coast District 2005/06	National target 2005/06
Incidence											
1. Hospitals offering TOP services	%	83	86	92	100	100	100%	67%	25%	100	100
2. CHCs offering TOP services	%	33	45	80	100	0	100%	0	0	0	50
Process											
3. Fixed PHC facilities with DTP-Hib vaccine stock out	%	Not measured	Not measured	Not measured	Not measured	Not measured	Not measured	Not measured	Not measured	Not measured	
4. AFP detection rate	%	1.8	1.93	1.9	Collected provincially	Collected provincially	Collected provincially	Collected provincially	Collected provincially	Collected provincially	1
5. AFP stool adequacy rate	%	78	96	84	Collected provincially	Collected provincially	Collected provincially	Collected provincially	Collected provincially	Collected provincially	80
Output											
6. Schools at which phase 1 health services are being rendered	%	20	20	29	29	Not available	Not available	Not available	Not available	Not available	
7. (Full) Immunisation coverage under 1 year	%	91.6	91.3	91.5	92	80	89%	92.6	92.8	84.3	90
8. Antenatal coverage	%	87.9	82.2	85	91.4	94	84%	92.6	92.8	83.9	80%
Vitamin A coverage under 1 year	%	Not available	Not available	26.5	8	70	64.3%	73.7	84.5	75.1	80%
9. Measles coverage under 1 year	%	78.1	91.7	90.7	92	78	89%	92.4	92.6	84.5	90
10. Cervical cancer screening coverage	%	4	4.49	5.6	4.94	7.1	5.2%	6		4.3	15
Quality											
11. Facilities certified as baby friendly	%	8	12	15		0%	0%	0	0	14.3	20
12. Fixed PHC facilities certified as youth friendly	%	2	2			0%	0%	0	0	0	20
13. Fixed PHC facilities implementing IMCI	%	50	79	81	99.2	71	68%	54		60	
Outcome											
14. Institutional delivery rate for women under 18 years	%	9.6	11.1	12	14.0	10.1	10%	8.9	8.2	13	13
15. Not gaining weight under 5 years	%	2.9	2.6	0.8	0.45	0.5	0.9%	2.6	1.2	0.4	

Notes:
Indicator 3: This indicator has not been collected before but will be collected in 2007/08.
Indicators 4 and 5 are measured provincially.

5.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

The strategic objectives are:

- Improve contraceptive service provision;
- Fast-track IMCI health workers training;
- Training and introduction of IMCI household and community component in all districts.
- Implement the recommendations from the saving mothers and saving babies report.
- Implement and strengthen the nutrition supplementation programme including micronutrient supplementation in:
  - Health facilities
  - ARV sites
  - PMTCT
  - Community-based services.
- Implementation of phase 1 of the National School Health policy throughout the province.

5.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.25: Analysis of constraints and measures to over come them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
Finance	Financial management of priority programmes e.g. women's health have no specific budget items within the region's budget. This makes monitoring and evaluation of expenditure on priority programmes difficult.	Create budget items for priority programmes.

5.4 SPECIFICATION OF MEASUREABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.26: Provincial objectives and performance indicators for MCWH & Nutrition [MCWH2]

Objective	Indicator	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)
Improve immunisation status.	Number of sub-districts with <1year immunisation coverage of >80%	-	-	New indicator	New indicator	32	32	32
To provide access to Post Exposure Prophylaxis for survivors of sexual assault	Percentage of survivors of sexual assault reporting to health facilities who received full course of PEP	30%	32%	35%	38%	40%	42%	45%
Improve antenatal coverage	Antenatal booking rate below 20 weeks	N/A	37.30%	37.3	45%	50%	60%	65%
	Percentage of fixed PHC facilities providing basic antenatal care (BANC) programme to improve the quality of antenatal care.	N/A	N/A	N/A	3%	10%	12%	15%
Improve the management of childhood illnesses.	The proportion of district hospitals with the paediatric problem identification programme. (PPIP)	N/A	N/A	34%	40%	50%	55%	60%

Table 2.27: Performance indicators for MCWH & Nutrition [MCWH3]

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2007/08
Incidence									
1. Incidence of severe malnutrition under 5 years	%		0.2	0.2	0.2	0.2	0.2	0.2	
2. Incidence of pneumonia under 5 years	%	Not measured	Not measured	Not measured	0.3	0.3	0.3	0.3	
3. Incidence of diarrhoea with dehydration under 5 years	%	Not measured	Not measured	Not measured	1.0	1.0	1.0	1.0	
Input									
4. Hospitals offering TOP services	%	83	86	92	92	95	100	100	100
5. CHCs offering TOP services	%	33	45	80	80	7.5	7.5	7.5	
Process									
6. Fixed PHC facilities with DTP-Hib vaccine stock out	%	Not measured	Not measured	Not measured	<2%	<2%	<2%	<2%	
7. AFP detection rate	%	1.8	1.93	1.9	1.9	1.9	1.9	1.9	1
8. AFP stool adequacy rate	%	78	96	84	84	84	84	84	80
Output									
9. Schools at which phase 1 health services are being rendered	%	20	20	29%	30%	50%	70%	90%	100%
10. (Full) Immunisation coverage under 1 year	%	91.6	91.3	91.5	90	90	90	90	90
11. Antenatal coverage	%	87.9	82.2	85	87	88	89	90	80%
12. Vitamin A coverage under 1 year	%	Not available	Not available	26.5	60	65	90	90	80%
13. Measles coverage under 1 year	%	78.1	91.7	90.7	91.2	91.2	91.2	91.2	90
14. Cervical cancer screening coverage	%	4	4.49	5.6	6.5	7.5	8.5	9.5	15
Quality									
15. Facilities certified as baby friendly	%	8	12	15	19	23	30	34	30
16. Fixed PHC facilities certified as youth friendly	%	2	2	0					30
17. Fixed PHC facilities implementing IMCI	%	50	79	81	82	90	95	95	
Outcome									
18. Institutional delivery rate for women under 18 years	%	9.6	11.1	12	11.8	9	8.7	8.5	
19. Not gaining weight under 5 years	%	2.9	2.6	0.8	0.8	0.8	0.8	0.8	

Notes:
Indicators 2 and 3: Only part of the RMR from April 2006.
Indicator 4: The denominator is the number of hospitals designated to offer the services up to 2006/07. From 2007/08 the denominator is all the CHCs.
Indicator 5: The denominator is the number of CHCs designated to offer the services.

5.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 2.28: Trends in provincial public health expenditure for INP conditional grant (R million) [MCWH4]

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	12,908,000	15,442,000	13,700,000	15,155,000	16,599,000	17,788,000	18,827,000
Total per person	2.77	3.26	2.90	3.16	3.41	3.60	3.75
Total per uninsured person	3.79	4.46	3.98	4.33	4.67	4.93	5.14
Constant 2006/07 prices							
Total	14,586,040	16,831,780	14,385,000	15,155,000	15,752,451	16,115,928	16,210,047
Total per person	3.13	3.55	3.05	3.16	3.24	3.26	3.23
Total per uninsured person	4.28	4.87	4.18	4.33	4.43	4.47	4.43

6. DISEASE PREVENTION AND CONTROL

6.1 SITUATION ANALYSIS

6.1.1 Programmes within the Public Health Directorate

In the Public Health Directorate, disease prevention and control includes chronic diseases, geriatrics and disabilities, mental health, environmental health, occupational health, oral health and health promotion. This directorate also addresses home-based care, palliative and sub-acute care. The key focus areas of these programmes are:

- Prevention of infectious diseases such as those prevented by immunisation and those promoted by poor hygiene such as infantile diarrhoeal disease.
- Provision of service for chronic care and the elderly.
- Preparations for dealing with epidemics and environmental disasters.
- The implementation of the provisions of the National Health Act dealing with the provision of Port health and Environmental health services.
- The implementation of the provisions of the Mental Health Care Act (No 17 of 2002) dealing with the assessment and certification of mental health patients and the role of SAPS in assistance with transportation.
- The implementation of the provision of free health for disabled persons.
- The health promoting schools programme.
- The implementation of the provisions of the National Health Act (No 61 of 2003) dealing with the provision of occupational health services.

6.1.2 Burden of disease as affecting the Directorate: Programmes

6.1.2.1 HIV and TB

The HIV prevalence rate continues to rise and has been recorded at 15.7% in the 2005 antenatal survey. The incidence of TB in the Western Cape has increased from 689/100,000 in 1997 to 1,041/100,000 in 2005. This incidence is almost double the national TB incidence. In 2003 the national TB incidence was 550/100,000. There is therefore a need to integrate community TB Directly Observed Treatment Strategy (DOTS) and community AIDS care/ARV community treatment support as part of the home-based care programme and ensure that existing home-carers are trained as generalists.

6.1.2.2 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, i.e. diarrhoeal disease, parasitic infections, respiratory diseases as well as non-communicable diseases, i.e.under/malnutrition and trauma being the main causes. The Department has expanded the Integrated Management of Childhood Illnesses (IMCI) project as a Social Capital project to include a community based IMCI element. The Health Promotion programme is thus concentrating on prevention programmes pertaining to these aspects of community IMCI.

6.1.3 Achievements and gaps

6.1.3.1 Community based services

Rapid expansion and improvement of community-based services has been undertaken through the implementation of a new integrated model for home-based and stepdown care, including palliative care, and improved management of NPO partners. This service has been funded mainly from the European Union for home-based care, and from the Global Fund for palliative care. The implementation of this structured community-based programme has offered exciting opportunities to the Division with regard to improving quality of services, providing an additional interface with communities and consumers and supporting social capital imperatives of iKapa Elihlumayo. There is a need to finalise the community-based service plan and packages of services for non-health services, i.e. services rendered at crèches, old age homes, schools and prisons which would be an outreach from the facility based services and which would be rendered by the community-based service co-ordinators.

The palliative care inpatient service is run by NPOs and currently there are 16 palliative facilities in the province with 269 beds. The Global Fund funds 8 of these facilities. As an exit strategy from Global Funding, 3 palliative organisations will no longer be funded and are being taken over by provincial funding. The directorate has also taken over the management of 3 sub-acute care facilities and 1 chronic care facility transferred from Programme 4 to Programme 2. These are:

1) St Josephs Home for children: 114 sub-acute care beds and 25 hospice beds;
2) Sarah Fox Convalescent Home for children: 36 beds and 24 cots;
3) Booth Memorial Hospital for adults: 84 sub-acute care beds and 22 hospice beds;
4) Lifecare Centre in Conradie Hospital: 280 chronic beds

The Department's definition of palliative and sub-acute services is different to the National Department of Health's generic name of step-downs and this causes difficulty in reporting to the National Department of Heatlh. These definitions will be reviewed together with national Department of Health.

Another focus area is the training of community-based rehabilitation workers. Unit standards have been drawn up and submitted to the HWSETA for accreditation as a skills course and then be part of the EPWP training.

6.1.3.2 Chronic diseases

Amongst the causes of death in the Province chronic diseases, e.g. cardiovascular conditions and diabetes mellitus are amongst the highest. Non-communicable diseases, traditionally associated with increasing wealth and also known as the chronic diseases of lifestyle, in South Africa and in the Cape Town Metro in particular affect the poorest communities the greatest (Bradshaw et al: 2002). The highest burden of chronic 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) (Bradshaw et al: 2002). This data indicates that high levels of chronic conditions particularly cardiovascular diseases and diabetes also afflict poorer communities.

During the past year an alternative dispensing mechanism has been put in place in each of the six districts and strenuous efforts were made to improve the functionality of the Cape Medical Depot. However, one of the key shortcomings with regard to the provision of chronic medicines has been the interruption in supplies. With non-communicable diseases having such an impact on the health status of communities, health promotion, disease prevention, treatment and rehabilitation have to be integrated.

The province will develop an overarching policy for the management of chronic diseases in line with the WHO definition as well as a minimum package of care for each facility that provides these services.

6.1.3.2 Environmental and port health:

Surveillance at the three major harbours in the Western Cape, i.e. Cape Town, Saldanha and Mossel Bay and at the Cape Town International Airport has reverted to the provincial Department of Health in terms of the National Health Act (No 61 of 2003). In terms of this mandate on average 65 ships are assessed for a clearance certificate monthly.

In terms of the National Health Act (No 61 of 2003),the coordination of environmental services is now a provincial function. This has meant that the province has had to centralise all the regional environmental health practitioners who now render a provincial function and work across districts.

In planning for the 2010 World Cup the province is compiling an Environmental Health Plan and a Port Health Plan.

6.1.3.4 Oral health:

The Department is developing an Oral Health policy and plan in line with Healthcare 2010 and which will include the Dental Schools. The monitoring and evaluation of both the Department and the Dental Schools is being standardised and integrated.

Table 2.29: Situation analysis indicators for disease prevention and control [PREV1]

Indicator	Type	Province wide value 2003/04	Province wide value 2004/05	Province wide value 2005/06	Metro District 2005/06	Cape Winelands District 2005/06	Overberg District 2005/06	Eden District 2005/06	Central Karoo District 2005/06	West Coast District 2005/06	National target 2005/06
Input											
1. Trauma centres for victims of violence	No	At least1 / district	At least1 / district	At least1 / district		2	0	7	4	7	N/A
Process											
2. CHCs with fast queues for elder persons	%	0	0	0	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	10
Output											
3. Health districts with health care waste management plan implemented	No	N/A	N/A	6	1	1	1	1	1	1	N/A
4. Hospitals providing occupational health programmes	%	100	100	100	100	100	100%	0	0	100	80
5. Schools implementing Health Promoting Schools Programme (HPSP)	%	0	0	Not planned	Not planned	Not planned	Not planned	Not planned	Not planned	Not planned	
6. Integrated epidemic preparedness and response plans implemented	Y/N	Y	Y	Y	Y	Y	Y	Y	y	Y	Yes
7. Integrated communicable disease control plans implemented	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Yes
Quality											
8. Schools complying with quality index requirements for HPSP	%	New measure	No target set	No target set	Not planned	Not planned	-	Not planned	Not planned	Not planned	
9. Outbreak response time	Days	0	1	1	1	1	-	1day	1day	1	2
Outcome											
10. Dental extraction to restoration rate	No	17	15	18		-	-	Not Collected	Not Collected		13:1
11. Malaria fatality rate	No	N/A	N/A	N/A	N/A	N/A	-	N/A	0	N/A	0.4
12. Cholera fatality rate	No	N/A	N/A	N/A	N/A	N/A	-	0	0	N/A	1
13. Cataract surgery rate	No	1163	1133	1276		-	-	N/A	N/a		950

Notes:

Indicator 2: Approximately 70% of patients with chronic diseases are elderly and are therefore catered for in the system for patients fetching chronic medication.

Indicator 5: School health services are being revived and will only address Phase 1 of the School Health Services which is screening of Grade 1 children.

Indicator 8: No national quality index requirements developed yet.

6.2. PRIORITIES AND BROAD STRATEGIC OBJECTIVES

6.2.1 The policy context

One of the key strategies of Healthcare 2010 is to reshape public health services to focus on primary level services, community-based and preventative care. This strategy will see the expansion of community-based services, increased funding and improved management and efficiency of clinics and community health centres. The foundation for implementing this change in strategy will be an integrated approach of community-based services, facility-based services and support services.

The Western Cape strategy of iKapa Elihlumayo and Social Capital Formation focus on building healthy communities through intensive collaboration between the public sector and civil society. The ideology of social capital is building a community rich in social cohesiveness, working towards (social action) improving health outcomes and in so doing improving the community climate for success. The social capital link to the Chronic Disease Sub-directorate is the therapeutic groups, community-based workers, i.e. adherence supporters/ health promoters and to the CBS the employment of community-based workers via NPOs and sub-district co-ordinating structures.

6.2.2 Other applicable policies

- Mental Health Care Act 17 of 2002
- Implementation of national programmes for the control and management of chronic diseases, e.g. diabetes and hypertension
- Development and implementation of home-based care
- National free health services for disabled persons

6.2.3 Divisional priorities

6.2.3.1 Community-based services

6.2.3.1.2 Strategic goals

1) Strengthen the community-based platform and implement a comprehensive community-based service package in all sub-districts;
2) Improve the decanting of patients from acute hospital beds into community-based institutional care;
3) Provide inpatient palliative/sub-acute/stepdown care to all clients in need of this care.

6.2.3.1.2 Strategic objectives

1) Provide home-based care for all category 3 clients;
2) Provide community-based support for all categories of clients wit a health care need;
3) Implement appropriate package of service at all non-health institutions and
4) Provide inpatient palliative/sub-acute/stepdown care to all clients in need of this care;
5) Training of community-based workers through the South African Qualifications Authority (SAQA) accredited EPWP programme;
6) Establishment of district and sub-district liaison structures;
7) Improve community-based adherence support;
8) Improve decanting of intellectually disabled clients from mental health hospitals; and
9) Develop unit standards for a community rehabilitation worker and advocate with Health and Welfare sector Education and Training (HWSATE) Authority for the inclusion of a rehabilitation skills programme as part of the Community Health Worker qualification.

6.2.3.2 Chronic disease management

6.2.3.2.1 Strategic goal:

Improve chronic disease management and implement a comprehensive package of care to all clients with a long-term need.

6.2.3.2.2 Strategic objectives:

1) Provide alternative methods of medicine supply to clients on chronic medication;
2) Implement a minimum standard practice;
3) Develop a chronic disease management strategy and implementation plan;
4) Implement appropriate prevention strategies to decrease the incidence of chronic illnesses.
5) Improve community-based adherence support.

6.2.3.3 Oral Health

6.2.3.3.1 Strategic goals:

To improve the oral health status especially of children in the Western Cape.

6.2.3.3.2 Strategic objectives:

1) Implementation of a fissure sealant programme to at least 10% of Grade 1 pupils;
2) Monitor the dental restoration rate.

6.2.3.4 Health Promotion

6.2.3.4.1 Strategic goals:

Promote healthy lifestyles and improve community-based prevention and health promotion.

6.2.3.4.2 Strategic objectives

1) Implementation of health prevention programmes for the Divisional priorities;
2) Implementation of activities for prioritised calendar health days

6.2.3.5 Environmental Health

6.2.3.5.1 Strategic goals:

To improve the co-ordination and monitoring of municipal port and environmental health services.

6.2.3.5.2 Strategic objectives:

1) Finalise the Environmental Health Plan;
2) Refine the monitoring and evaluation for the municipality Environmental Health Services;
3) Monitor the services of local authorities;
4) Monitor port health services;
5) Monitor international flights.

6.2.3.6 Occupational Health

6.2.3.6.1 Strategic goals:

To maintain employee well-being and improve the quality of service delivery and productivity of all employees.
To render an occupational health service to the public who access the public health facilities.

6.2.3.6.2 Strategic objectives:

1) To prevent and reduce injuries and acquired diseases of employees;
2) To ensure the rehabilitation of injured and sick employees.

6.2.3.7 Expanded Public Works Programme (EPWP)

The EPWP is a national programme designed to provide productive employment opportunities for a significant number of the unemployed, not only to earn an income but to skill them to increase their employability.

The Department has, as one of the Social Sector Departments, identified projects which include Community-based Ancillary Health Workers, i.e. community-based care workers, IMCI workers, TB DOTS workers, ARV counsellors and VCT counsellors. These workers will be upskilled through the programme to become ancillary health workers in the first phase leading to a community health worker. The training is co-ordinated by Programme 6, Health Sciences and Training but the operational issues are dealt with by the Community-based Services.

In 2006/07 an amount of R20,7 million was made available for the training of Community Health Workers as part of the EPWP training.

Table 2.30: Outputs: Number of learners to be trained through EPWP

	Financial year				
	2004/05	**2005/06**	**2006/07**	**2007/08**	**2008/09**
Community Home-based carers			1430	2720	3165
ARV /Lay Counsellors	N/A	N/A	220	270	700
Total	**N/A**	**N/A**	**1630**	**2990**	**3865**

6.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.31: Analysis of constraints and measures to overcome them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
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.	• Departmental exit strategy and training and capacitation of NPO's rendering HBC services to be able to fundraise
	• Service fragmentation according to vertical health programmes, resulting in fragmented line management	• Implementation of the Community Based Directorate will result in an integrated service.
	• Inadequate capacity to implement the integrated CBS approach	• Implementation of the DHS and the Comprehensive Service Plan
CHRONIC DISEASES	• Regulations relating to dispensing medications. • Continued availability of funding for eye care	• Development of guidelines for the management of Chronic Diseases • Dedicated funding
ORAL HEALTH	• Service fragmentation between the Provincial programme and the Dental Health Schools	• Development of a joint Oral Health Plan and standardised integrated M&E
HEALTH PROMOTION	• Inadequate staffing	• Implementation of the Comprehensive Service Plan
ENVIRONMENTAL HEALTH	• Grey areas in National Health Act, 2003 • Incorrect placement of EHPs • No line function over LAs who render municipal health services • Lack of proper information system for Port health Services • Minimum guidance from National Dept regarding municpal health services excluding food control	• Clarity to be sought from National Department • Correct the placement of EHPs • Constant liaison with EH and Municipal managers • Consultants have been appointed to address this matter • Attend National meetings

6.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.32: Provincial objectives and performance indicators for disease prevention and control [PREV 2]

Objective	Indicator	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)
Implement exit strategy for EU Partnership funding	Number of PGWC funded posts in districts & sub-districts previously funded by EU	N/A	N/A	**0**	0	4 Regional & 29 Sub district TA's& 4 clerks	4 Regional & 29 Sub district TA' & 4 clerks	6 District TA's 29 Sub-Districts TA' & 6 clerkss
	Number of NPO's funded by PGWC	N/A	24	**55**	**85**	90	90	
Increase the number of clients receiving Home-based care service	Total number of NPO appointed Home carers	N/A	125	933	1100	1300	1400	1500
	Total number of clients seen	N/A	N/A	10222	11000	13000	14000	15000
	Number of Hospital referrals	N/A	N/A	N/A	New	7200	8200	9200
Provide in-patient palliative step-down care to all medical clients in need of care	Number of usable beds	N/A	N/A	269	269	269	269	269
	Number of Inpatient days	N/A	N/A	16226	16226	16226	16226	16226
	Bed Occupancy rate	N/A	N/A	78%	80%	85%	85%	85%
Provide in-patient sub-acute/ step-down care to all medical clients in need of care	Number of usable beds	258	258	258	258	258	288	318
Improve chronic disease management	Number of patients with prescriptions issued for chronic medication through an alternative supply system	New indicator	New indicator	688,222	700,000	720,000	730,000	740,000
Implementation of fissure sealant programmes for Grade 1s	% Grade 1 pupils with fissure sealants done	N/A	5%	10%	15%	20%	25%	30%
Monitor municipal envirnmental health services	% Water samples conforming to standards	N/A	84.10%	85%	88%	90%	90%	90%
	% Sewage effluent samples complying to requirements	N/A	53.90%	55%	60%	65%	70%	75%
	% Food samples conforming to Act 54/72	N/A	72.70%	75%	78%	80%	85%	85%
	% Households with effective refuse removal service (minimum of one refuse removal per week)	N/A	88.60%	88.59%	89%	90%	90%	90%

Table 2.33: 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	At least 1/ district	1 per district
Process							
2. CHCs with fast queues for elder persons	%	N/A	N/A	N/A	40	50	20
Output							
3. Health districts with health care waste management plan implemented	No	N/A	N/A	6	6	6	All districts
4. Hospitals providing occupational health programmes	%	100	100	100	100	100	100
5. Schools implementing Health Promoting Schools Programme (HPSP)	%	N/A	N/A	10	15	30	50
6. Integrated epidemic preparedness and response plans implemented	Y/N	Y	Y	Y	Y	Y	Yes
7. Integrated communicable disease control plans implemented	Y/N	Y	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	No National tool
9. Outbreak response time	Days	-	1	1	1	1	1
Outcome							
10. Dental extraction to restoration rate	No	17	15	18	16	16	13
11. Malaria fatality rate	No	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	0.25
12. Cholera fatality rate	No	0	0	0	0	0	0.5
13. Cataract surgery rate	No	1,163	1,133	1,276	1,400	1,600	1,400

Notes:
Indicator 2: There is a fast queue for chronic disease patients most of whom are elderly patients.
Indicator 8: This index is not been made available by National.

7. FORENSIC PATHOLOGY SERVICES (SUB-PROGRAMME 2.8)

7.1 SITUATIONAL ANALYSIS

The transfer of the "Medico-legal Mortuaries"' from the South African Police Service to Provincial Departments of Health was effected 1 April 2006. The Department of Health, Provincial Government Western Cape established a new Forensic Pathology Service (FPS) in the Province. This service is rendered via two M6 Academic Forensic Pathology Laboratories in the Metro, three Referral FPS Laboratories and smaller FPS Laboratories and Holding Centres in the West Coast, Cape Winelands, Overberg, Eden and Central Karoo Districts

The Western Cape FPS is managed through a central unit that is responsible for the management and coordination of the service. The post of the Director: Forensic Pathology Service was created and filled in the 2006/07 financial year. The FPS is as a new service facing the challenge of providing sufficient Human Resource and Infrastructure capacity to improve the service delivery.

2.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

In terms of section 27(2) of the Health Act 2003, the provincial Departments of Health is responsible for implementation of the entire Forensic Pathology Service, excluding Forensic Laboratories (which is a national responsibility), in compliance with national policies and law. This is a culmination of a cabinet decision on 29th April 1998 to transfer the medico-legal mortuaries from SAPS to Health.

Strategic objectives for Forensic Pathology Services

To provide a Forensic Pathology Service in the Province 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, Health Professions Act.

The Forensic Pathology Service (FPS) renders 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 Forensic Pathology Service provides medico-legal evidence from the performance of post-mortem examinations in terms of the above mentioned Acts. The component further provides training and consultation on clinical forensic cases for the Province. The academic components are also responsible for undergraduate and postgraduate training as well as research in the pursuit of service excellence.

Currently, approximately 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, 542 Medico-Legal post-mortems were performed in the Metropolitan area and 4, 358 in the rural districts during the 2005/06 financial year.

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. As a result of this the Provincial Department of Health has identified the need to improve the Forensic Pathology Support in the rural regions, thus the proposed organisational structure for the Forensic Pathology Service make provision for specialist forensic pathologist support in the rural districts.

7.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM :

The high workload and related stress of performing approximately 10 000 medico-legal autopsies per annum results in a high turnover of medical specialists. This is being addressed by providing additional specialist posts of suitable grading as provided in the proposed human resource plan for the FPS. The National Strategic Plan for FPS, (linked to that the Healthcare 2010 Plan) proposes 123 Forensic Pathologists (FP's) for South Africa (SA). There are approximately 30 registered and practising Forensic Pathologists in SA at present. There are 8 University training centres in South Africa, of which only 6 train post-graduate students. The average output of these centres is not even 1 qualified student (Forensic Pathologist) per year. To achieve full implementation as expeditiously as possible, the Forensic Pathology academic training centres must be resourced and supported in the short to medium term, to enable the training of Registrars; whilst continuing optimum, competent service delivery.

A high percentage of staff in the new Forensic Pathology Service are new to the Department of Health and the Forensic Pathology Service and orientation of these staff as well as comprehensive basic training is required in order to ensure continued service delivery to the community.

The Human Resource plan for the service will be implemented with an increase in personnel to 233 filled posts in 2007/2008 financial year. Building and infrastructure will be upgraded as per the Infrastructure plan with 5 new facilities being built during 2007/8. Incident response time will be increased by ensuring 52 vehicles in active service on the road.

7.4 SPECIFICATION OF MEASUREABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table2.34: Provincial objectives and performance indicators for Forensic Pathology Services

Sub-programme 2.8:	**Forensic pathology services**	2004/5	2005/6	2006/7	2007/8	2008/9	2009/10
Provision of an effective and efficient forensic pathology service in accordance with the statutory requirements.	Number of post mortem examinations performed and documented.	5 016 Metro only	5 239 Metro only	9822	10 000	10 000	10000
	Number of post mortem examinations performed by Specialist Forensic Pathologists.	5 016 Metro only	5 600 Metro only	6 500	7 500	8 500	9000
	Turnaround time from receipt to dispatch of the corpses	Not recorded	Not recorded	7 days	7 days	7 days	7 days
	Waiting period for Forensic Pathology Services documentation.	Not recorded	Not recorded	20 working days	20 working days	20 working days	20 working days
	Average cost per examination.	R1 284 (Only Health expenditure in Metro)	R1 390 (Only Health expenditure in Metro)	R4 100	R4 500	R4 600	R4,700

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

Table 2.35: Forensic Pathology Services: Indicative allocations for 2006/07 – 2009/10

Expenditure	**2003/04 (actual)**	**2004/05 (actual)**	**2005/06 (actual)**	**2006/7 (estimate)**	**2007/08 (MTEF projection)**	**2008/09 (MTEF projection)**	**2009/10 (MTEF projection)**
Current prices							
Total	304,042	843,000	2,004,000	65,145,000	88,301,000	65,179,000	60,359,000
Total per person	0.07	0.18	0.42	13.60	18.15	13.19	12.03
Total per uninsured person	0.09	0.24	0.58	18.62	24.86	18.07	16.48
Constant 2006/07 prices							
Total	343,568	918,870	2,104,200	65,145,000	83,797,649	59,052,174	51,969,099
Total per person	0.07	0.19	0.45	13.60	17.22	11.95	10.36
Total per uninsured person	0.10	0.27	0.61	18.62	23.59	16.37	14.19

Programme 3: Emergency Medical Services

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 (PPT)

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 district, sector and station.

3.1.1 Functions of EMS

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

- Emergency communications 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:

The performance of the service is measured by response times on a district basis. Response times are measured from the time an emergency call is received in a Communication Centre until the time the ambulance arrives on scene. The National Department of Health norms for response times are 15 minutes in built up or urban areas and 40 minutes in rural or out of town areas.

These targets are being achieved in the 5 rural districts 30% of the time in built up areas, and 75% of the time in out of town areas. In the Metropolitan area of Cape Town in 2006 the target is achieved 12% of the time and average response times are 40 minutes for Priority 1 (Life threatening) emergencies and 150 minutes for Priority 2 and 3 (Limb threatening) emergencies. The apparent decrease in relation to the previously reported figure of 31% does not reflect a deterioration in performance but is due to the refinement of the definition. However, the performance reflects the resource gap in Metropolitan EMS where the personnel establishment is significantly under-resourced.

Improvements in computer aided dispatch and tracking systems have resulted in improved information on performance, which underlines the resources gap. Radical changes to shift systems to align staff with emergency call load have contributed to improved response times.

Table 3.1: Distribution of the operational staff during 2006 and the projected model staff numbers required to meet performance targets.

DISTRICT	NUMBER OF PERSONNEL	MODEL
Central Karoo	48	80
Eden	139	209
West Coast	126	154
Winelands	142	225
Overberg	115	121
Total rural areas:	**570**	**789**
Metro	369	669
TOTAL PERSONNEL	**939**	**1,458**

Note: The model excludes the 232 Rescue Personnel Required. This table excludes supervisors or managers.

3.1.3 The transfer of the City of Cape Town operational personnel to the Province has been completed.

Table 3.2: Situational analysis indicators for EMS and Patient Transport [EMS1] 2006/7

Indicator	Type	Province wide value 2004/05	Province wide value 2005/06	Province wide Estimate 2006/7	Metro 2006/7	West Coast 2006/7	Overberg 2006/7	Cape Winelands 2006/7	Eden 2006/7	Central Karoo 2006/7	National target 2007/8
Input											
1. Ambulances per 1000 people	No	0.041	0.04	0.040	0.026	0.08	0.09	0.06	0.05	0.17	.
2. Hospitals with patient transporters	%	5	5	**0**	0	0	0	0	0	0	
Process											
3. Kilometres travelled per ambulance (per annum)	Kms	57,258	50,793	57,244	42,092	67,083	88,718	43,238	86,285	76,741	
4. Locally based staff with training in BLS	%	33	41	46	43	55	32	46	51	61	
5. Locally based staff with training in ILS	%	60	38	44	45	35	58	46	38	31	
6. Locally based staff with training in ALS	%	7	7	10	12	10	10	8	11	8	
Quality											
7. Response times within national urban target (15 mins)	%	NA	30	46	40	76	67	37	59	85	
8. Response times within national rural target (40 mins)	%	NA	73	65	-	43	45	38	49	55	
9. Call outs serviced by a single person crew	%	0	0	0	0	0	0	0	0	0	
Efficiency											
10. Ambulance journeys used for hospital transfers	%	14	20	29	45	13	9	13	5	5	
11. Green code patients transported by ambulance	%	37	29	36	20	51	62	47	57	70	
12. Cost per patient transported by ambulance	R	502	557.11	758	451	713	634	464	495	623	
13. Ambulances with less than 500,000 kms on the clock	%	100%	100%	100	100	100	100	100	100	100	
Output											
14. Patients transported (by PTS) per 1,000 separations	No	34	22	-	-	92	153	100	40	52	

Notes:

Indicator 2: Patient transporters are centrally managed and not allocated to specific hospitals.

Indicator 9: Single person ambulance crews were abolished a few years ago in the Western Cape.

The national targets are being reviewed and are therefore omitted from the table above.

3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Vision

Equal Access to 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.

3.2.1 Strategic priorities

The main goal of EMS is to improve response times and provide quality care to emergency patients. This is linked to the number and skills of the staff, adequately equipped vehicles and the functionality of the communication system.

EMS has three strategic priorities for 2007/08:

1) **Training**

Training of EMS personnel supercedes Communications as the number one priority in EMS. In order to deliver the required number of personnel with the composite skills necessary to provide quality care both initial and continuous training will have to be accelerated towards 2010.

2) **Communications**:

To consolidate the electronic computer aided communications systems including automatic vehicle location to support the call taking and dispatch needs of the service and ensure efficient dispatch within all districts.

The provision of a modern computerised communication system to manage Emergency Medical Services (EMS) resources is a top priority, central to the efficient deployment of resources in achieving appropriate response times. The 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 access.

In a joint initiative with the Departments of Local Government, Housing and Community Safety, EMS established Disaster Management and Emergency Medical Services Communication Centres in Bredasdorp, Worcester, Cape Town, Beaufort West, George and Mooreesburg in 2006/7.

EMS is pursuing discussion with the South African Police Services to explore combined call taking services to mutually improve the efficiency of dispatched resources.

1) **Personnel:**

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

The personnel gap in EMS is 1,086 personnel of which 751 are operational personnel (not supervisors or administrative personnel).

3.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

1.1.1 Finance

Funding for EMS has improved over the last three years and this commitment continues over the MTEF period. These funds will enable EMS to move progressively closer to the targets and service levels outlined in the National EMS Framework. The additional funding provided will continue to improve response times in the Metropolitan area.

Funding for additional personnel has been committed to EMS to address Metropolitan response times but this will be committed to appointing interns who will be in training on the mid-level worker program as Emergency Care Technicians. The response times in the Metropolitan Area should be achieved at least 50% of responses by the end of the 2007/08 year.

Funds for additional medical equipment have been provided to begin to address the major shortages in defibrillators and other electronic EMS equipment.

Additional ambulances will be procured for the Metropolitan area in order to meet the peak shift requirements for ambulances (target 75).

Government Motor Transport tariff increases (due amongst other reasons to the increases in fuel costs) have eroded augmentation by R20 million to the EMS Budget for 2007.

Funds will continue to flow for the Red Cross Air Mercy Service in order to continue the excellent support for the transfer of acute emergencies from rural areas to referral hospitals.

3.3.2 Human Resources

The calculated personnel gap in EMS is 1,086 personnel based on an activity and population based model (Africon and Van Rooyen 2006) to meet response time targets. The model assumes 100% efficiency which places a very significant management challenge to the EMS.

Funding to address the service plan human resource gap will be committed to EMS over the next three years to 2010.

Interns will be recruited in 2007 to facilitate training and selection of the best EMS candidates for the service.

EMS will re-establish intermediate life support training through the Emergency Care Technician program over eighteen months and deliver this program through a School of Emergency Care at Tygerberg. Six instructors will be employed to teach within this structure.

Additional Paramedics and ILS personnel will be appointed in the Metropolitan area.

The service plan makes provision for the appointment of 232 medical rescue personnel to ensure that the function of medical rescue is adequately staffed and that Medical Rescue response time targets are met. A limited number of rescue personnel will be appointed in 2007.

1.1.1 Support and Information Systems

The institution of computer aided dispatch and automatic vehicle location systems (vehicle tracking) has improved the management of the mobile EMS resources and improved efficiencies both in financial management and service delivery. Provincial Treasury has committed funding to this function for two years to initiate essential systems.

Information Management has been improved and information on performance and service volumes will soon be available real-time via a web portal. The next phase of the computer aided dispatch project the mobile data terminals will be installed with electronic patient record software on the Metropolitan ambulances in 2007.

4. SUB PROGRAMME 3.2: PLANNED PATIENT TRANSPORT (PPT)

4.1 SITUATIONAL ANALYSIS

Function of Planned Patient Transport

Planned Patient Transport includes the provision of local out-patient transport (within the boundaries of a town or local area) and inter-city/town out-patient transport, i.e. into referral centres. Currently Planned Patient Transport is provided by the Emergency Medical Services funded from Sub-programme 3.2.

As of April 2005 Planned Transport Services were separated from Emergency Ambulance Services. 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. Limited public transport and 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 47,000 outpatients annually.

4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The PPT (HealthNET, i.e. Health Non Emergency Transport) will undergo significant changes over the next three years as outlined below.

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 what transfer times that can be expected in rural and urban areas.

The Department has made a decision to centralise the management of PPT within EMS. This means that individual hospitals will terminate existing transport contracts and the function with funds will move to EMS. This will result in a better co-ordinated and more efficient service.

Planned initiatives to improve patient transport in the Province include:

- Separation from Emergency Services;
- Creation of a Transport Hub at Tygerberg Hospital;
- Focussed management of the function;
- Introduction of electronic booking systems; and
- Procurement of multi-load (wheelchairs, stretchers, seats) patient transporters.

It is important to note 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.

The policy options for additional vehicles and drivers will significantly contribute to the development of the service. An incremental increase in funding will result in a gradual improvement in performance targets.

4.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

4.3.1 Finance:

The 2006/07 financial year is the second year that the budget for PPT is separated from the Emergency Services. Significant steps have been made in improved funding of EMS in the last two years and the commitment continues over the MTEF period. A portion of these funds will go towards improving PPT. Ten new patient transporters were delivered in 2006 to service the Metropolitan Area six more will be delivered during 2007.

The expansion of the PPT System in rural areas will continue in cooperation with District Health Services.

4.3.2 Human resources:

The personnel deployed in the function of PPT were separated from Emergency Ambulance personnel from 1st April 2005. An evaluation of PPT driver posts needs to be conducted during 2007 as part of a broader organizational development exercise.

A contract manager has been appointed to manage the function of PPT and develop systems necessary to the function. The organizational structure for PPT is currently under review to create an appropriate platform from which to deliver PPT. Additional Drivers will be appointed in 2007.

4.3.3 Support systems:

A PPT hub has been created at Tygerberg Hospital to focus and structure the movement of PPT vehicles within and outside the Metropolitan Area. A second hub, purely to address Metropolitan PPT, has been established at Heideveld Day Hospital.

Planned Patient Transport vehicle design has been reviewed and multipurpose PPT Vehicles that accommodate the range of wheelchair, sitting or stretcher patients likely to use the service have been delivered.

4.3.4 Information systems:

The TRANSMETRO computer software which records the movement of patients relative to vehicles has been upgraded to a WINDOWS based system. A web-based hospital booking system for outpatients has been designed and developed to facilitate the parallel booking of outpatient visits and PPT. The system has been implemented in Tygerberg, Groote Schuur and Red Cross Children's Hospitals.

Table 3.3: Performance indicators for the EMS and planned patient transport [EMS3]

Indicator	Type	2003/04 Actual	2004/05 Actual	2005/06 Actual	2006/07 Estimate	2007/08 Target	2008/09 Target	2009/10 Target	National target 2007/08
Input									
1. Ambulances per 1000 population	No	0.045	0.141	0.04	0.040	0.042	0.044	0.043	
2. Hospitals with patient transporters	%	0	0	0	0	0	0	0	
Process									
3. Kilometres travelled per ambulance (per annum)	Kms	61,449	57,258	50,793	57,244	60,000	60,000	60,000	
4. Proportion of non-supervisory, uniformed staff with BLS qualification	%	20	33	41	46	50	42	40	
5. Proportion of non-supervisory, uniformed staff with ILS qualification	%	71	60	38	44	40	46	44	
6. Proportion of non-supervisory, uniformed staff with ALS qualification	%	9	7	7	10	10	12	16	
Quality									
7. Proportion of Priority 1 Urban Calls within 15 minutes	%	NA	NA	30	46	50	70	80	
8. Proportion of Priority 1 Rural Calls within 40 minutes	%	NA	NA	73	65	70	75	80	
9. Call outs by a single person crew.	%	0	0	0	0	0	0	0	
Efficiency									
10. Ambulance journeys used for hospital transfers.	%	30	14	20	29	20	20	20	
11. Green code patients transported by ambulance.	%	49	37	29	36	30	30	30	
12. Cost per emergency patient transported by ambulance.	R	593	502	557	758	800	800	800	
13. Ambulances with less than 500 000 kms on the clock	%	100	100	100	100	100	100	100	
Output									
14 Number of patients transported by PPT per 1,000 uninsured population.	No	NA	34	22	119	120	120	120	

Notes:

Indicator 2: Patient transporters are centrally managed and not allocated to specific hospitals.

Indicator 9: Single person ambulance crews were abolished a few years ago in the Western Cape.

The national targets are being reviewed and are therefore omitted from the table above.

5. PAST EXPENDITURE TRENDES AND RECONCILATION OF MTEF PROJECTIONS WITH PLAN

It is planned that an earmarked amount of R58,216 million will be allocated to this programme during 2007/08 to provide for the expansion of emergency medical services, in part to prepare for the 2010 FIFA World Cup. An amount of R46,021million will be allocated to Sub-programme 3.1 for emergency transport, R10,143 million will be allocated to Sup-programme 7.2 for planned patient transport and the balance of R2,052 million will be allocated to Programme 6.2 for emergency medical services training.

Note that the amount of R58,216 million includes the carry-through effect of the EMS earmarked allocation of R10,957 made in 2006/07.

In 2007/08 Emergency Medical Services is allocated 4,86 percent of the vote in comparison to the 4,42 percent allocated in the revised estimate of the budget for 2006/07. This amounts to a nominal increase of 20,41 percent or R58,439.

An amount of R4,948 million has been allocated to address the increase in Government Motor Transport tariffs.

Table 3.4: Trends in provincial public health expenditure for EMS and patient transport (R million) [EMS4]

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection	2008/09 (MTEF projection	2009/10 (MTEF projection)
Current prices							
Total	190,473,687	205,198,000	256,064,000	303,199,000	367,266,000	390,174,000	428,736,000
Total per person	40.82	43.30	54.28	63.29	75.49	78.97	85.45
Total per uninsured person	55.92	59.32	74.34	86.68	103.39	108.16	117.04
Total capital	4,779,000	7,027,000	213,000	16,842,000	22,470,000	15,523,000	31,610,000
Constant 2006/07 prices							
Total[2]	215,235,267	223,665,820	268,867,200	303,199,000	348,535,434	353,497,644	369,141,696
Total per person	46.13	47.20	56.99	63.29	71.64	71.55	73.57
Total per uninsured person	63.19	64.66	78.06	86.68	98.12	97.99	100.77
Total capital	5,400,270	7,659,430	223,650	16,842,000	21,324,030	14,063,838	27,216,210

Programme 4: Provincial Hospital Services

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:

The acute services provided by regional hospitals in this programme continue to operate under tremendous pressure as evidenced by their hospital performance statistics.

Trauma and Emergency services in particular continue to be under severe strain with high volumes of attendances and a high acuity of illness amongst patients at presentation. GF Jooste Hospital has the highest trauma patient activity within the Metro with approximately 7 000 cases per month. 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. There has been increased pressure on the need for access to ICU services and ventilation of patients. The increased need for emergency trauma surgery has also caused the waiting time for elective surgery to increase.

The HIV and AIDS pandemic contributes significantly to the load on the services both in terms of patient numbers and acuity of illness. The impact is being felt at all the acute hospitals, TB and chronic medical hospitals. Tuberculosis rates remain high and co-infection of TB and HIV has resulted in uncommon forms of presentation and late diagnosis of the disease.

The provision of anti retroviral drugs to an increasing number of patients has reduced the concomitant sequelae of other AIDS related diseases. However, the increased number of patients on ARV treatment at these hospitals has significantly impacted on their workload.

Many of these hospitals are over full, with occupancy rates often exceeding 100%. The bed occupancy for Somerset, Mowbray Maternity and GF Jooste Hospitals maintained an average of 100%, 112% and 124% respectively. The opening of 220 additional level 1 beds in the Metro since 2005 has alleviated the situation to some extent. Opening of more level 1 beds are planned to relieve the service pressures within the Khayelitsha and Mitchells Plain drainage areas.

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

Hospital type	Number of hospitals	Number of beds 2006/07	Provincial average number of beds per 1 000 uninsured
District	28	1,541	0.441
Regional	9	1,933	0.553
Central	3	2,562	0.732
Sub-total acute hospitals	**40**	**6,036**	**0.725**
Tuberculosis	6	1,008	0.288
Psychiatric	4	2,059	0.589
Other Special	2	336	0.096
Sub-total chronic hospitals	**12**	**3,403**	**0.973**
Total public hospitals	**52**	**9,439**	**2.698**

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	1,631	0.466
L2 Beds	9	1,933	0.553
L3 Beds	3	2,472	0.706
All acute levels	**40**	**6,036**	**1.725**

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

Indicator	Type	Province wide value 2003/04	Province wide value 2004/05	Province wide value 2005/06	National target 2005/06
Input					
1. Expenditure on hospital staff as % of regional hospital expenditure	%	67.7	67.3	61.4	
2. Expenditure on drugs for hospital use as % of regional hospital expend	%	4.4	4.5	4.6	12
3. Expenditure by regional hospitals per uninsured person	R	221	237	242	
Process					
4. Regional hospitals with operational hospital board	%	90	100	100	80
5. Regional hospitals with appointed (not acting) CEO in post	%	86	100	100	75
6. Facility data timeliness rate for regional hospitals	%	Not available	Not available	84	43
Output					
7. Caesarean section rate for regional hospitals	%	29.4	27.5	32	22
Quality					
8. Regional hospitals with patient satisfaction survey using DoH template	%	36	80	80	20
9. Regional hospitals with clinical audit (M&M) meetings every month	%	85	100	80	90
Efficiency					
10. Average length of stay in regional hospitals	Days	3.5	3.6	3.6	4.8
11. Bed utilisation rate (based on usable beds) in regional hospitals	%	88	90	98	72
12. Expenditure per patient day equivalent in regional hospitals	R	812	824	903	1,128
Outcome					
13. Case fatality rate in regional hospitals for surgery separations	%	1.7	1.7	1.74	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, the major objectives in this sub-programme include the reconfiguration of services within these hospitals and the expansion and strengthening of rural regional hospitals.

A major challenge within this sub programme is the reconfiguration of services. According to Healthcare 2010, the largest provision of level 2 services will occur within the central hospitals. This will require the reclassification of existing beds and their reconfiguration of the package of care provided.

Historically different hospitals have not provided the full range of services. For Example, Karl Bremer does not provide trauma and orthopedics, Victoria does not provide obstetrics, GF Jooste does not provide pediatrics and obstetrics. Further steps have to be taken to enable these hospitals to provide the full package of level 1 care.

The rural regional hospitals are being upgraded through a systematic national infrastructure initiative of hospital revitalization. Resources would need to be allocated to commission additional services in a phased manner over the MTEF period. The salaries of specialists working at these hospitals are being incrementally improved to retain their services in rural regions. They play a vital role in reducing inappropriate referrals to central hospitals as well as building capacity through outreach and support at the district hospitals in rural regions.

The policy priorities for 2007/2008 include the following main areas:

1) Service issues:
   - On completing the building project at Eben Donges hospital, 80 beds will be moved from Brewelskloof hospital as an interim arrangement to Eben Donges in January 2008.
   - A temporary 20-bed short stay ward is to be constructed at Hottentots Holland Hospital (HHH) to relieve the pressure from the overflow of patients coming from the Grabouw area. This is to accommodate patients on trolleys who currently crowd the emergency section within HHH.
   - A project to physically distinguish L2 from L3 beds within the central hospitals will be systematically implemented. The largest concentration of level 2 beds will be within the central hospitals.
   - Karl Bremer, G F Jooste and Hottentots Holland Hospital will be reallocated to Sub- Programme 2.9 in the 2007/08 financial year to be developed as primarily district hospitals in line with the CSP.
   - A project will be initiated to manage the process of transition of MOUs currently managed from Mowbray Maternity Hospital being transferred to management by the Metro DHS by the 1 April 2008.
2) Strengthening Human Resources:
   - Strengthening existing obstetric services within the Metro and rural regional hospitals. A team approach across programs 4 and 5 will be developed to address the increased workload. This will allow a co-ordinated approach across the obstetric platform in line with the Comprehensive Service Plan. The total package of obstetric beds must be reviewed and in so doing the funding provided for strengthening obstetric beds will be utilized across programmes.
   - Employ ward clerks to relieve pressures on nursing staff
   - The salaries of professional nurses will be improved in this year as part of a national dispensation to retain them within the public service.
   - Create a virtual establishment for the Mitchells Plain hospital and a separate staff establishment for the 100 beds on Lentegeur site. Part of this capacity to be placed at GF Jooste Hospital to help alleviate the pressures from the hospital which is carrying the workload in the current context until the new hospitals are built and commissioned.

3.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

3.3.1 Human Resource constraints

1) **Difficulty in attracting and retaining staff especially nurses and medical officers**:
   The lack of key staff has become the limitation to the provision of services within the current platform and to any further expansion. The range of strategies adopted by the Department will to some extent improve the ability to recruit and retain staff, especially professional nurses and doctors.

2) **Re-shaping of the Service in line with Healthcare 2010**
The Comprehensive Service Plan envisages significant reconfiguration of services and a consequent redeployment of staff. This will require an effective communication and change management strategy as well as due labour processes.

2.2.2 Cost Drivers

1) The increased patient load at the regional hospitals results in a significant escalation in the cost of goods and services (consumables, blood products, medication and laboratory tests).
2) The failure to recruit and retain staff results in a significant dependency on agencies. This drives up the cost of providing essential services. A detailed analysis of agency costs has been undertaken within the programme, to enable improved control of agency utilization.
3) Cost containment measures are applied in all hospitals to improve efficiencies.

3.3.3 Information management systems

1) Strengthen the monitoring and evaluation processes within the programme to improve planning and implementation of objectives.
2) Better information systems and data must ultimately be linked to the budget process to ensure equitable budget allocation based on measurable deliverables.

3.4 PLANNED QUALITY IMPROVEMENT MEASURES

- The greater demand for quality assurance at frontline services remains a challenge and specific improvements are targeted to address quality assurance effectively.
- 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. New boards have been appointed.
- General improvements in Hospital infrastructure have resulted from the Revitalization Programme at, Eben Donges and George Hospitals and will occur in the future at Paarl Hospital.
- 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 of 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.

OBJECTIVE	INDICATOR	SERVICE PLAN 2010 TARGET	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)
INPUT									
Provide regional hospitals infrastructure in line with Healthcare 2010.	Useable beds	2,539	1,904	2,076	1,856	1,933	1,361	2,316	2539
	Useable beds per 1000 uninsured population	0.66	0.56	0.60	0.54	0.55	0.38	0.64	0.69
	Hospital expenditure per uninsured person	0	221	237	242	256	173	335	337
OUTPUT									
Provide services that adequately address the needs of inpatients, outpatients and trauma cases.	Outpatients per inpatient day ratio	1.02	1.61	1.44	1.17	1.18	1.18	1.18	1.02
	Total number of inpatient days	787,725	600,659	669,107	663,461	693,043	488,320	760,806	787,725
	Total number of outpatient headcounts (incl trauma)	803,479	967,406	963,697	774,026	819,213	577,220	899,312	803,479
Ensure accessible regional hospital services to the population of the Western Cape.	Separations per annum	207,296	174,978	180,855	188,166	191,470	128,505	200,212	207,296
	Separations per 1000 uninsured population	52	51.37	52.3	54.6	54.74	36.18	55.50	56.59
	Patient day equivalents per annum	1,055,551	926,031	993,273	924,692	966,114	680,727	1,060,577	1,055,551
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources	Average length of stay	3.8	3.50	3.60	3.60	3.70	3.80	3.80	3.80
	Bed utilisation rate based on useable beds	85%	88.0%	90.0%	98.0%	98.2%	98.3%	90.0%	85.0%
	Expenditure per patient day equivalent (constant 2006/7 prices)		812	824	903	927	901	1,139	1,169

Notes:
1. The following hospitals move to Sub Programme 2.9 in 2007/08: Hottentots Holland (150), GF Jooste (184) and Karl Bremer (238) = a total of 572 beds.
2. The regional (L2) beds in the Central hospitals are to be moved to Sub Programme 4.1 in 2008/09

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

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2007/08
Input									
1. Expenditure on hospital staff as % of regional hospital expenditure	%	67.7	67.3	61.4	63	65	65	65	66
2. Expenditure on drugs for hospital use as % of regional hospital expend	%	4.4	4.5	4.6	6	6	6	7	12
3. Expenditure by regional hospitals per uninsured person	R	220.74	236.57	242.47	256.09	172.73	334.82	336.87	
Process									
4. Regional hospitals with operational hospital board	%	90	100	100	100	100	100	100	100
5. Regional hospitals with appointed (not acting) CEO in post	%	86	100	100	100	100	100	100	100
6. Facility data timeliness rate for regional hospitals	%	Not available	Not available	84	100	100	100	100	100
Output									
7. Caesarean section rate for regional hospitals	%	29.4	27.5	32	25	25	25	24	18
Quality									
8. Regional hospitals with patient satisfaction survey using DoH template	%	36	80	80	100	100	100	100	100
9. Regional hospitals with clinical audit (M&M) meetings every month	%	85	100	80	100	100	100	100	100
Efficiency									
10. Average length of stay in regional hospitals	Days	3.5	3.6	3.6	3.7	3.8	3.8	3.8	4.1
11. Bed utilisation rate (based on usable beds) in regional hospitals	%	88	90	98	98.22	98.3	90	85	75
12. Expenditure per patient day equivalent in regional hospitals	R	811.95	823.85	903.22	927.20	901.34	1,138.81	1,169.11	1128
Outcome									
13. Case fatality rate in regional hospitals for surgery separations	%	1.7	1.7	1.74	1.74	1.4	1.4	1.4	2

3.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

An earmarked amount of R12,641 million has been allocated to Sub-programme 4.1 for Human Resource Development

Programme 4 is allocated 16,50 percent of the vote during 2007/08 in comparison to the 21.16 percent that was allocated in the revised estimate of the 2006/07 budget. This translates into a nominal decrease of 14.54 percent or R199,153 million. This is the result of the reallocation of GF Jooste, Hottentots Holland, Karl Bremer and Nelspoort Hospitals to Programme 2. From 2008/09 the equitable share funding for level 2 services in Programme 5 is shifted to Sub-programme 4.1.

Additional equitable share funding has been allocated as follos:
- R2 million for maternal and neonatal services
- R3 million for the commissioning of new wards at George Hospital
- R2,232 million to address the increase in Government Motor Transport tariffs.

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

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	783,281,477	924,095,000	929,462,000	1,067,973,000	821,106,000	1,581,152,000	1,569,666,000
Total per person	167.87	195.02	197.02	222.92	168.77	320.03	312.85
Total per uninsured person	229.96	267.15	269.84	305.32	231.15	438.32	428.49
Total capital[2]	117,892,000	173,353,000	134,037,000	172,195,000	174,563,000	248,047,000	136,385,000
Constant 2006/07 prices							
Total	885,108,069	1,007,263,550	975,935,100	1,067,973,000	779,229,594	1,432,523,712	1,351,482,426
Total per person	189.69	212.57	206.87	222.92	160.16	289.95	269.36
Total per uninsured person	259.85	291.19	283.33	305.32	219.37	397.12	368.93
Total capital	133,217,960	188,954,770	140,738,850	172,195,000	165,660,287	224,730,582	117,427,485

4. SUB - PROGRAMME 4. 2 TUBERCULOSIS HOSPITALS

4.1 SITUATIONAL ANALYSIS:

Despite efforts to strengthen TB control in the Western Cape, the burden of disease from TB continues to rise. A significant growth in the proportion of MDR patients has been detected, fostered by the increase in HIV and AIDS. A further development has been the identification of cases of extremely drug resistant Tuberculosis (XDR TB) in the Western Cape. The collaboration between the HIV and AIDS and TB programmes will be strengthened to address effective treatment.

Pulmonary TB in the Western Cape dramatically increased over the past 7 years. The incidence of TB in the Western Cape has increased from 689/100,000 in 1997 to 1,041/100,000 in 2005. The incidence of TB in the Western Cape is almost double that of the national incidence which was 550/100,000 in 2003. This is a cumulative reflection of a growing population, migration, improved case detection and an increased burden of disease. Thirty percent of TB patients in the Western Cape are co-infected with HIV resulting in high morbidity and mortality rates in this group and an increase in the average length of stay (ALOS) of patients.

An amount of R2,23 million was allocated in 2005/06 to facilitate the provincialisation of the SANTA and Local Government TB hospitals. Harry Comay Hospital was provincialised during 2005 and the provincialization of DP Marais was concluded on 1 September 2006. The Local Government TB hospitals will be provincialiased by the 1st April 2007.

The line function responsibility of TB hospitals will resort to this Programme as well. In the rural regions, the TB Hospitals will be managed by the Rural Regional Hospital Management.

1.1.1 DP Marais Hospital

DP Marais Hospital which was provincialized on 1 September 2006 has 260 available beds and bed occupancy rates have remained stable over the past few years at approximately 85%.

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.

As experienced with Harry Comay Hospital, the provincialization process includes challenges relating to labour issues, the standardisation of services in line with the norms and standards of the Department of Health and the implementation of new systems and technical support. The staffing of D P Marais will be reviewed and strengthened.

A single service platform will be developed to maximise the utilisation of TB beds within DP Marais and Brooklyn Chest hospitals. Ultimately it is intended to consolidate the service on the site of the Brooklyn Chest Hospital.

4.1.2 Brooklyn Chest Hospital (BCH)

Brooklyn Chest Hospital caters for complicated TB cases requiring admission and specialised care. Brooklyn Chest Hospital 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), which is in all likelihood a reflection of the impact of the HIV epidemic.

Due to the high TB and 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 Brooklyn Chest Hospital have been converted to isolation facilities for MDR patients. These wards are equipped with germicidal ultraviolet lights. The opening of these isolation wards has not been sufficient to deal with the demand for beds for MDR patients especially females. A further challenge is the management of patients with XDR TB with has now been identified in a number of Western Cape patients. Additional beds for MDR and XDR TB patients have been opened. The hospital also increasingly has to manage patients with chronic or terminal MDR TB and the option of building a step-down/palliative care facility for these patients is being considered. It is planned to rebuild a large 721 bedded hospital for TB in the Metro that will incorporate DP Marais and Brooklyn Chest Hospitals. A business case has been submitted to the National Department of Health in terms of the Hospital Revitalisation Programme.

An increasing number of dually infected patients also qualify for ARV treatment and there is a need to provide either ARV out-reach services to the hospital or accredit the hospital as an ARV site.

The exact prevalence of XDR TB within the Western Cape is being currently investigated following the identification of several patients with this strain of TB. This report will provide a basis to plan the Department's response to this threat and may require additional and separate facilities at Brooklyn Chest.

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. The Hospital is also the designated multi-drug resistant (MDR) specialist centre and is responsible for the management of all MDR patients in the Boland Overberg Region.
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 current pharmacy is very small and inadequate and plans are in progress to move the pharmacy to larger premises and refurbish a new pharmacy that will meet the requirements.

The average co-infection of Tuberculosis and HIV is 16%. Currently approximately 21.5% of TB patients are multi-drug resistant. Germicidal ultraviolet lights have been installed but there are no separate wards for female patients as yet. The average bed occupancy rates is 82% and has been affected by shortage of both medical and nursing staff.

The hospital has entered into a partnership with Eben Donges Hospital in Worcester to provide anti-retroviral services to patients who qualify for treatment.

The hospital has experienced difficulty with planned patient transport, resulting in patients not attending respiratory clinics or failing to be admitted as arranged.

Brewelskloof Hospital accommodates a school with an average of 10 pupils, which has moved from the hospital to an old staff house on the premises where it is functioning well.

4.1.4 Harry Comay (TB Hospital) in George has reduced the number of beds from 125 to 100 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. The hospital was provincialised as from 1 June 2005. The current hospital infrastructure is generally of poor quality and inadequate for the type of services that needs to be delivered. Consideration will be given to replace the hospital with improved facilities in the medium term. The hospital also manages MDR TB cases for the Southern Cape Region and currently makes provision for 18 patients.

4.1.5 Sonstraal Hospital in Paarl is in the process of being provincialised. It currently has 90 beds and patients are referred to the hospital from PHC clinics and 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.

4.1.6 The Infectious Diseases Hospital in Malmesbury is in the process of being provincialised. It has 52 beds and a personnel component of 19. The hospital facility is in a poor state and not adequately staffed at present.

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. It is important that the Department take steps on an ongoing basis to keep the rates for MDR TB low.

However, the most recent threat of drug resistance to second line drugs (XDR TB) is still being investigated to better understand the nature of the problem, size and scope of the challenge and the most appropriate interventions.

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

	Indicator	Type	Province wide value 2003/04	Province wide value 2004/05	Province wide value 2005/06	National target 2005/06
	Input					
1	Expenditure on hospital staff as % of TB hospital expenditure	%	79	68.8	59.79	
2	Expenditure on drugs for hospital use as % of TB hospital expenditure	%	9.8	2.9	2.9	
3	Expenditure by TB hospitals per uninsured person	R	18.01	19.55	19.76	
	Process					
4	TB hospitals with operational hospital board	%	Not measured	Not measured	80	
5	TB hospitals with appointed (not acting) CEO in post	%	100	100	100	
6	Facility data timeliness rate for TB hospitals	%	Not measured	Not measured	93	
	Quality					
7	TB hospitals with completed annual patient satisfaction survey in the last 12 months using DoH template	%	Not measured	Not measured	100	
8	TB hospitals with clinical audit (M and M) meetings every month	%	Not measured	Not measured	100	
	Efficiency					
9	Average length of stay in TB hospitals	Days	71.9	72.4	75.5	
10	Bed utilisation rate (based on usable beds) in TB hospitals	%	88	77	79	
11	Expenditure per patient day equivalent in TB hospitals	R	190.94	239.48	236.89	

4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES:

Service Priorities 2007/2008:

The dual TB and 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 treatment 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 provides for the upgrading of Brooklyn Chest Hospital and the possible move of D.P. Marais from the current Princess Alice Orthopaedic Hospital site to the Brooklyn Chest Hospital site.

According to the Healthcare 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 an increase in the current number of beds at present.

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, XDR and complicated TB. The D.P. Marais facility will accommodate the more ambulant TB cases, but will benefit from the proximity to the centre of excellence on the same premises. Two isolation wards for MDR patients were opened at Brooklyn Chest Hospital during 2004. The acuity of patients to be accommodated within DP Marais may also need to be changed given the pressure for acute TB beds. This will require additional resourcing not currently available.

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 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. Provision has been made for an increase of 300 beds over time in the plan.

The provincialisation of Harry Comay, Paarl Tuberculosis (TB) Hospital (Sonstraal), Malmesbury TB Hospital (Infectious Diseases) and DP Marais Hospital requires the Department to upgrade the services and facilities of these hospitals and increase their capacity to care for more acutely ill patients. The capacity of all the TB hospitals to collect and manage information must be addressed. Increased measures to protect staff and patients from contracting TB and MDR TB must be put in place. This is going to require significant additional resources which are not available in the 2007/08 year.

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 at all levels of care will need to be upgraded.

The acuity of patients being managed in TB hospitals has increased. This has required more intensive hospitalisation, an increase in the drug budget and an increase in staffing levels.

The infrastructure within certain TB hospitals is old and requires renovation, maintenance and upgrading. The clinical capacity and management of Brooklyn Chest Hospital and the other TB hospitals needs to be strengthened to address the increasing service pressures.

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 and D.P. Marais Hospitals are high-risk settings, that need significant protective measures 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: General Hospitals, will also apply to TB Hospitals.

Improving the clinical skills at PHC level to diagnose TB in a HIV positive patient, who is sputum negative, needs to be addressed. These missed opportunities result in patients being diagnosed at a later and more acute stage of the disease with a poorer prognosis.

5.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.8: Provincial performance indicators for TB hospitals [PHS4]

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)
INPUT									
Provide TB hospitals infrastructure in line with Healthcare 2010	Number of useable beds	1287	998	998	998	1,008	1,008	1,008	1,008
	Useable beds per 1000 uninsured population	0.31	0.29	0.29	0.29	0.29	0.28	0.28	0.29
Provide sufficient funding to ensure a efficient TB hospital service for the population.	Hospital expenditure per capita (uninsured population)		18.01	19.55	19.76	20.60	20.43	22.71	20.1
OUTPUT									
Ensure accessible TB hospital services to the population of the Western Cape.	Number of separations per annum	7438	4,443	3,867	3,340	4,140	4,140	4,140	4,140
	Separations per 1000 uninsured population		1.30	1.12	0.97	1.18	1.17	1.15	1.13
	In patient days per annum	446267	319,622	281,034	291,784	310427	310427	310427	310427
	Out patients per annum	8925	4,472	4,091	3,784	3,848	3,848	3,848	3,848
	Patient day equivalents per annum	448747	321,161	282,413	293,059	311,710	311,710	311,710	311,710
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources.	Average length of stay	60	71.9	72.4	75.5	75	95	100	100
	Bed utilisation rate	90%	88	77	79	84	80	85	85
	Expenditure per patient day equivalent (constant 2006/7 prices)	0	190.94	239.48	236.89	223.50	249.43	258.75	260.65

Table 4.9: Performance indicators for TB hospitals [PHS5]

	Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2007/08
Input										
1	Expenditure on hospital staff as % of TB hospital expenditure	%	79	68.8	59.79	60	63	65	70	
2	Expenditure on drugs for hospital use as % of TB hospital expenditure	%	9.8	2.9	2.9	4	4	4	6	
3	Expenditure by TB hospitals per uninsured person	R	18.01	19.55	19.76	20.60	20.43	22.71	20.10	
	Process									
4	TB hospitals with operational hospital board	%	Not measured	Not measured	80	100	100	100	100	100
5	TB hospitals with appointed (not acting) CEO in post	%	100	100	100	100	100	100	100	100
6	Facility data timeliness rate for TB hospitals	%	Not measured	Not measured	93	90	100	100	100	100
	Quality									
7	TB hospitals with patient satisfaction survey using DoH template	%	Not measured	Not measured	100	100	100	100	100	100
8	TB hospitals with clinical audit (M and M) meetings every month	%	Not measured	Not measured	100	100	100	100	100	100
	Efficiency									
9	Average length of stay in TB hospitals	Days	71.9	72.4	75.5	75.0	95	100	100	
10	Bed utilisation rate (based on usable beds) in TB hospitals	%	88	77	79	84.37351	80	85	85	
11	Expenditure per patient day equivalent in TB hospitals	R	190.94	239.48	236.89	223.50	249.43	258.75	260.65	

4.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

An additional R6,5 million equitable share funding has been allocated to address the shortfall as a result of the provincialisation of Harry Comay, Paarl Tuberculosis Hospital (Sonstraal), Malmesbury TB Hospital (Infectious Diseases) and DP Marais Hospital.

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

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	54,268,611	62,049,000	66,116,000	69,666,000	81,928,000	89,023,000	94,363,000
Total per person	11.63	13.09	14.01	14.54	16.84	18.02	18.81
Total per uninsured person	15.93	17.94	19.19	19.92	23.06	24.68	25.76
Constant 2006/07 prices							
Total	61,323,531	67,633,410	69,421,800	69,666,000	77,749,672	80,654,838	81,246,543
Total per person	13.14	14.27	14.72	14.54	15.98	16.32	16.19
Total per uninsured person	18.00	19.55	20.15	19.92	21.89	22.36	22.18

5. SUB-PROGRAMME 4.3: PSYCHIATRIC HOSPITALS

5.1 SITUATIONAL ANALYSIS

In keeping with global trends the burden of mental health disease is increasing. This is also evidenced by the high bed occupancies experienced by the acute services within psychiatric hospitals and the increased number of psychiatric emergencies attending acute general hospitals.

5.1.1 The Mental Health Act

The introduction of the new Mental Health Care Act obliges the Department to improve access to 72-hour services within the general acute hospitals. The development of these services in general hospitals continues to be slow and the expected increase in general hospital beds and community residential alternatives to take up increased patient numbers due to dehospitalisation of chronic mental health patients has not materialised. The Act also makes provision for Mental Health Review Boards, which play a key role in ensuring appropriate standards of care and the protection of the rights of mental health care users. A licensing and inspectorate capacity must be created within the Department to ensure good quality of care even amongst community based facilities providing mental health services. This is particularly important given the need to de-institutionalise and re-integrate chronic patients into communities. The Mental Health Review Board of the Western Cape is established and fully functional.

5.1.2 Substance abuse services

The rapidly escalating substance abuse epidemic with a changing substance abuse profile requires a concerted inter-sectoral review of services that should be provided, health has a growing role in providing a specialist service supporting early treatment and sustainable rehabilitation programmes for addicts.

The opening of the opiate detoxification unit at Stikland Hospital in June 2006 is a significant milestone. The unit assists those addicted to heroin and other opiates to safely withdraw from these substances before entering a recognised rehabilitation programme.

The overwhelming increase in methamphetamine (TIK) abuse and addiction with all its consequences since its rise in popularity in 2003 presents an even greater challenge. TIK has had extremely negative consequences for the Province, not only the obvious social and legal consequences but also dire health and mental health consequences. TIK use is associated with anxiety, depression, as well as behavioural problems such as violence and high risk HIV behaviour. Furthermore, withdrawal can be protracted, often lasting several months, with a predisposition to relapse. According to the Western Cape SANCA 2005/2006 TIK has for the first time replaced alcohol as the number one substance used by people seeking their services (TIK 26% of users, alcohol 21% and dagga 11%).

5.1.3 Child and adolescent services

At Lentegeur Hospital the sub-acute unit for adolescents with psychotic illness now operates the planned 18 beds, the next challenge will be to provide suitable training and career pathways to retain skilled professional staff in the child and adolescent services. While this unit does provide some relief to the Tygerberg acute service, the waiting list for admission to these services remains at 12 to 15 people at any given time.

The development of general specialist services for children and adolescents at regional hospital level remains a priority.

Future development includes services for adolescents with substance abuse and mental illness and juvenile offenders with mental illness. This will require collaboration between the relevant Departments including Social Services, Education and Correctional/Justice Departments. An observation service capacity is planned for juveniles within the new forensic unit at Valkenberg Hospital as part of the Hospital Revitalisation Project. Twenty secure places at Lentegeur for those juveniles that are mentally ill and behaviourally disturbed are being considered.

5.1.4 Acute adult servcies

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.

The adult acute services remain oversubscribed and less ill patients have to make way for more acutely ill patients without sufficient time for adequate recovery, this is largely due to the lack of the range of rehabilitation and community based services required to support people who suffer from severe mental illnesses and intellectual disabilities on their path to support recovery.

5.1.5 The new long-stay group of patients

Only 41 chronic beds remain in the psychiatric services. The bulk of the remaining chronic beds i.e. 455 are in the two intellectual disability services at Alexandra and Lentegeur Hospitals.

The acute service is placed under further pressure as the new long stay patients emerge who cannot be discharged. The vigorous dehospitalisation process of the past decade has not been matched by growth of a range of adequately resourced alternative community based services. This is not a unique Western Cape experience as in "the dehospitalisation of patients and the closure of chronic beds a group of people are entering the service who are becoming "new long stay" or "new chronic" patients. This was first observed in deinstitutionalisation programmes in England and Wales during the late 1960s and early 1970s (Magnus, 1967; Wing, 1971). These patients have remained in institutions because: (a) the handicap of psychiatric illness and associated physical illness and disability require 24 hour nursing and medical care; (b) their behaviour cannot be managed in community settings; (c) there is no alternative care available in the community (Clifford et al., 1991" from Norms and Standards for Psychiatric Care in South Africa, a report submitted to the Department of Health). This will necessitate a review of provision of services for these people within the services provided for mental health patients.

5.1.6 Forensic psychiatric services

The waiting list for places in the male observation services has decreased over 2006/07 and is now approximately 60 –70 to compared to the 120 it was last year. Further improvement will only be possible when the new expanded capacity is available as envisaged in the HRP.

A 20 bed step down forensic pathology facility at Lentegeur Hospital for state patients in rehabilitation preparing for community supervised placement opened in October 2006.

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

	Indicator	Type	Province wide value 2003/04	Province wide value 2004/05	Province wide value 2005/06	National target 2006/07
Input						
1	Expenditure on hospital staff as % of Psychiatric hospital expenditure	%	81.5	79.5	76	
2	Expenditure on drugs for hospital use as % of Psychiatric hospital expenditure	%	1.9	2.2	3	
3	Expenditure by Psychiatric hospitals per uninsured person	R	77	81	85	
Process						
4	Psychiatric hospitals with operational hospital board	%	90	100	100	
5	Psychiatric hospitals with appointed (not acting) CEO in post	%	86	100	100	
6	Facility data timeliness rate for Psychiatric hospitals	%	90	90	90	
Quality						
7	Psychiatric hospitals with patient satisfaction survey using DoH template	%	100	100	100	
8	Psychiatric hospitals with clinical audit (M and M) meetings every month		50	100	100	
Efficiency						
9	Average length of stay in Psychiatric hospitals	%	114.7	118	125.8	
10	Bed utilisation rate (based on usable beds) in Psychiatric hospitals		0.82	0.83	0.828	
11	Expenditure per patient day equivalent in Psychiatric hospitals	R	388	428	451	

5.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

5.2.1 Policy

Healthcare 2010 envisages the provision of psychiatric beds at regional and district hospitals and the development of community based services. The number of specialist psychiatric hospitals will remain unchanged, however, the number of acute beds in these hospitals will increase and the chronic beds decrease.

Regulations promulgated on 15 December 2004, in terms of the Mental Health Care Act 17 of 2002 have resulted in the need to adjust many of the mental health policies to ensure compliance with obligations imposed by the Act. The Mental Health Review Board plays an integral role in ensuring compliance with the provisions of the Mental Health Care Act 17 of 2002, particularly relating to the protection of the rights of mental health care users in the broader service context. The licensing capacity and inspectorate aspects of the Act have been established at provincial level.

In terms of the Act the Provincial Minister of Health has designated 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 expect to receive treatment at all levels of care in the least restrictive manner, and only if required be referred to a designated facility. This results in a significant challenge particularly within busy emergency units.

Funds will be allocated to strengthen mental health services outside of the specialist hospitals in supporting community based and primary health care services as well as capacitating district and regional hospitals to provide acute services.

The Associated Psychiatric Hospitals continues to support INCLUDID to provide step down care to patients discharged from Alexandra and Lentegeur's Intellectual Disability Services. The number of residents funded has increased from 70 to 90.

5.2.2 Service Priorities and Broad Strategic Objectives for 2007/2008:

5.2.2.1 Strategies outside the programme 4.3 brief

5.2.2.1.1 Mental Health Act:

The two priorities this year will be:

1) Strengthening the capacity in general hospitals to manage mentally ill people which includes infrastructure and human resource measures. A policy framework is in place which is in line with the Mental Health Care Act.
2) Establishing a licensing and inspectorate capacity for community based residential and day care programmes.

5.2.2.1.2 Increase level 2/3 mental health beds in general health facilities:

- The number of beds in the specialist psychiatric hospitals is now 2,064. Any further reduction in the number of beds at the psychiatric hospitals is dependant on an increase in district and regional hospital beds and the provision of additional capacity within community based services.
- A critical priority is the development of 72-hour services in district and regional hospitals. This will require a combination of infrastructure changes, additional staff, training and capacity building within these institutions. This is in keeping with the statutory obligation of the Mental Health Care Act. However, it has not been possible to allocate additional resources in this financial year to give effect to this objective.
- Community psychiatric teams which include a psychiatrist and medical officer will be appointed in the metro to support the development of 72-hour services within regional and district hospitals.

5.2.2.1.3 Substance abuse services

Consider ways to improve service support to the largely NPO based rehabilitation services in managing the consequences of the TIK epidemic.

5.2.2.1.4 Dehospitalization:

A systematic plan to address this challenge including service delivery models, standards of care, appropriate staffing and financial implications is being developed. The pace of de-hospitalisation for these patients is being revised within the Comprehensive Service Plan (CSP) as they are unlikely to be in alternative care by 2010.

There is an agreement with the Department of Social Development and Poverty Alleviation relating to intellectually disabled persons who need access to services. An assessment tool has been developed to assess the functionality of these patients, in order to determine the Department responsible for their care. It is agreed that Health is responsible for profound and severely intellectually disabled and Social Development and Poverty Alleviation is responsible for clients categorised as mild and moderately disabled. The planning for 2007/08 is to phase in the assumption of responsibility for these two departments according to the agreements. In 2007/08 the financial allocation to the NPOs providing services to these clients will be increased by 50%.

5.2.2.1.5 Seclusion Rooms and Psychiatric OPD:

Safe observation rooms and low secure wards for patients with confusion due to psychiatric or medical conditions need to be established and psychiatric nurses appointed at regional and district hospitals. Safe observation rooms have already been established at GF Jooste and Karl Bremer Hospitals as well as a low secure ward at GF Jooste Hospital. These facilities have made a significant impact increasing safety for staff and patients allowing patients to be managed in a humane and dignified manner. The co-ordinating clinician is guiding the process supported by Emergency Medicine. These measures contribute towards general hospitals' compliance with the specifics within the Mental Health Care Act.

5.2.2.1.6 Perinatal Mental Health:

Mental health services at Mowbray Maternity Hospital are to be expanded.

5.2.2.2 Strategies within the sub-programme 4.3 brief

5.2.2.2.1 Acute adult services

1) Post acute support teams:

From January 2007 post acute support teams have been established for a two-year period. They are attached to each of the acute adult services at Lentegeur, Stikland and Valkenberg Hospitals. These teams will follow high frequency service users requiring additional intensive support who are discharged form the acute wards. Initially these teams will not be able to follow up all of these patients; they will conduct prospective research to evaluate the effect of this intervention when compared to the normal referral back to primary care clinics on discharge. If the intervention proves to significantly improve outcomes then expanding this service will be considered.

2) New long stay patients:

Hospitals will review those patients who remain in hospital for longer than sixty days within the acute services and if they cannot be discharged even with the support of the teams as described in paragraph 1) above, an assessment will be made regarding other alternatives within the hospital grounds and proposals will be developed for the possible establishment of "halfway house" or "stepdown" services that are more closely linked to the hospital service. Any places created in this way would not form part of the core specialist psychiatric hospitals beds as described in the CSP therefore proposals in this regard would need to be either for a transitional step or become part of the comprehensive community based alternatives that will be developed to replace chronic custodial care. The APH group will initiate this in order to free the acute beds for the patients that require more intensive treatment.

5.2.2.2.2 Continue to consolidate and re-align hospital services in line with the Comprehensive Service Plan.

5.2.2.2.3 Train registered nurses without basic psychiatry qualification. Obtain South African Nursing Council (SANC) accreditation to offer a diploma in psychiatric nursing science in terms of R880. The college staff are appointed and the process of preparing a curriculum and memorandum of agreement with a tertiary higher education institution in compliance with SANC requirements is close to conclusion which will allow submission to SANC in the first half of 2007.

5.2.2.2.4 Provide appropriate continuing professional development for mental health care practitioners.

5.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.3.1 Financial management

Financial management remains a challenge at institutional level. All such posts allocated to the APH have been filled. The acquisition of financial skills is part of the identified priorities for skills development. Supply chain management is a particular focus area. Whilst posts have been filled, the continued turnover and transfers within the Department continue to make capacity a challenge.

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.

At the beginning of 2007 the psychiatric hospitals have been successful in filling many of the professional nurse posts improving skills mix but still far short of the minimum optimal levels. Of particular note, Valkenberg Hospital has for several years not been able to fill more than 55 of its 132 professional nurse posts. The number has now increased to 85. The challenge is to provide sufficient mentoring and support of the new recruits to retain their services.

A strategy that is expected to address some of the retention and skills development challenges is the launch of the Associated Psychiatric Hospitals Training College to be located at Stikland Hospital. An amount of R640 000 has been set aside for the nurse training project within APH. The Head of College post and two of the four tutor's posts have been filled; the remaining two tutor posts were advertised for a third time and it is expected that the appointments could be made by April 2007.

The College is in the process of obtaining accreditation of the South African Nursing Council for the course leading to a diploma in psychiatric nursing science in accordance with regulation R880. This will enable the college to train generally qualified professional nurses who have qualified via the bridging course, to fulfil the requirements of the Mental Health Care Act and enable them to perform the duties of a mental health care practitioner.

Under the auspices of the college the APH is also providing regular continuing professional development (CPD) updates that are accredited by the South African College of medicine for CPD points for those health professionals maintaining CPD portfolios. The first successful update was presented on 10 November 2006.

Mental health services, by their very nature, are provided within a stressful environment. Staff is 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 within a difficult environment.

5.3.3 Infrastructure

- The single greatest challenge and risk to the service lies within the arena of managing ageing physical infrastructure on large estates with poor perimeter security. These further impacts on the daily stressful work experience of staff, which has negative implications for the retention of staff.
- The estate management of all four Psychiatric hospitals remains an ongoing challenge.
- Valkenberg hospital has been accepted as a hospital revitalization project. The business plan has been submitted and the operational narrative is being currently concluded. Confirmation of funding for the project is awaited.

5.4 QUALITY IMPROVEMENT MEASURES

1.4.1 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. The hospitals have all identified senior staff members to be their quality of care representatives.

2.2.2 Patient Care

Standards for the acute services are the current area of focus. A seclusion policy for the APH platform was adopted in April 2006. This policy is now being adapted to be applied at all provincial hospitals.

The fourth client satisfaction survey was conducted at all four of the hospitals during November 2006.

Complaints and compliments are monitored in accordance with departmental policy. Hospital and regional level trends are monitored and each complaint used to improve services and identify risks.

Morbidity and mortality committees are in place at all hospitals and quarterly reporting in accordance with provincial policy has been established, more importantly these reviews are used at hospital level to improve service delivery by identifying areas for improvement within a multidisciplinary team context. Meetings are held regularly at all hospitals.

Morbidity and safety and security monitoring systems are in place providing managers with regular monitoring reports and enabling the region to submit quarterly Provincial reports to the Provincial Quality Assurance co-ordinator as required.

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. This group has successfully motivated for the inclusion of second-generation antipsychotic as well as newer antidepressants onto provincial code. They have also provided the clinical guidelines for their use. Regular reports in accordance with the Mental Health Care Act of 2002 are also submitted to Mental Health Review Board.

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

OBJECTIVE	INDICATOR	Service Plan 2010	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)
INPUT									
Provide Psychiatric hospitals infrastructure in line with Healthcare 2010.	Number of useable beds	1,568	2,245	2,127	2,096	2,059	2,059	2,059	2,059
	Useable beds per 1000 uninsured population		0.66	0.61	0.60	0.60	0.59	0.56	0.56
OUTPUT									
Provide services that adequately address the needs of inpatients and outpatients.	Outpatients per inpatient day ratio	0.02	0.03	0.04	0.03	0.03	0.02	0.02	0.02
	Total number of inpatient days	515,088	668,741	645,245	643,405	643,314	646,320	653,835	661,351
	Total number of outpatient headcounts	20,604	29,752	22,121	19,238	16,726	14,865	14,384	13,227
	Patient day equivalents per annum	521,956	678,658	652,693	649,818	648,889	651,275	658,630	665,760
Ensure accessible Psychiatric hospital services to the population of the Western Cape.	Separations per annum	4,859	5,839	5,648	5,146	4,926	5,635	5,700	5,766
	Separations per 1000 uninsured population	1.1	1.71	1.63	1.47	1.58	1.60	1.54	1.53
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources.	Average length of stay	106	114.7	118	125.8	130.6	115	115	115
	Bed utilisation rate	90%	82	83	82.8	85.6	86	87	88
	Expenditure per patient day equivalent (constant 2006/7 prices)		387.61	427.87	450.92	454.83	467.89	479.94	478.29

Table 4.13: Performance indicators for psychiatric hospitals [PHS5]

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Input								
1. Expenditure on hospital staff as % of psychiatric hospital expenditure	%	81.5	79.5	76	77.7	78	80	80
2. Expenditure on drugs for hospital use as % of psychiatric hospital expend	%	1.9	2.2	3	2.9	4	4	4
3. Expenditure by psychiatric hospitals per uninsured person	R	77	81	85	84	86	88	87
Process								
4. Psychiatric hospitals with operational hospital board	%	90	100	100	100	100	100	100
5. Psychiatric hospitals with appointed (not acting) CEO in post	%	86	100	100	100	100	100	100
6. Facility data timeliness rate for psychiatric hospitals	%	90	90	90	100	100	100	100
Quality								
8. Psychiatric hospitals with patient satisfaction survey using DoH template	%	100	100	100	100	100	100	100
9. Psychiatric hospitals with clinical audit (M&M) meetings every month	%	50	100	100	100	100	100	100
Efficiency								
10. Average length of stay in psychiatric hospitals	Days	114.7	118	125.8	130.6	114.7	114.7	114.7
11. Bed utilisation rate (based on usable beds) in psychiatric hospitals	%	82.0%	83.0%	82.8%	85.6%	86.0%	87.0%	88.0%
12. Expenditure per patient day equivalent in psychiatric hospitals	R	387.61	427.87	450.92	454.83	467.89	479.94	478.29

4.4 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

An earmarked allocation of R598,000 has been made to Sub-programme 4.4 for 2007/08 for Human Resource Development.

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

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total[2]	232,790,236	256,210,000	279,060,000	295,137,000	321,098,000	348,899,000	369,830,000
Total per person	49.89	54.07	59.15	61.60	66.00	70.62	73.71
Total per uninsured person	68.34	74.07	81.02	84.37	90.39	96.72	100.96
Constant 2006/07 prices							
Total[2]	263,052,967	279,268,900	293,013,000	295,137,000	304,722,002	316,102,494	318,423,630
Total per person	56.38	58.94	62.11	61.60	62.63	63.98	63.46
Total per uninsured person	77.23	80.73	85.07	84.37	85.78	87.63	86.92

6. SUB-PROGRAMME 4.4: CHRONIC MEDICAL HOSPITALS

6.1 SITUATIONAL ANALYSIS

The following hospitals were previously 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. In 2006/07, Maitland Cottage Hospital, which is closely linked to Red Cross Children's Hospital, was shifted to Programme 5, while the Booth Memorial Hospital, Sarah Fox Hospital and St Joseph's Home were shifted to Programme 2. In this year, Nelspoort has also been moved to Programme 2. Only the Western Cape Rehabilitation Centre will remain part of this sub-programme.

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

	Indicator	Type	Province wide value 2003/04	Province wide value 2004/05	Province wide value 2005/06	National target 2005/06
Input						
1	Expenditure on hospital staff as % of chronic hospital expenditure	%	82	71	72	
2	Expenditure on drugs for hospital use as % of chronic hospital expenditure	%	1.9	2.2	3	
3	Expenditure by chronic hospitals per uninsured person	R	13	13	22	
Process						
4	Chronic hospitals with operational hospital board	%	90	100	100	
5	Chronic hospitals with appointed (not acting) CEO in post	%	86	100	100	
6	Facility data timeliness rate for chronic hospitals	%	90	90	90	
Quality						
7	Chronic hospitals with patient satisfaction survey using DoH template	%	100	100	100	
8	Chronic hospitals with clinical audit (M and M) meetings every month		50	100	100	
Efficiency		%				
9	Average length of stay in chronic hospitals	%	63.7	57.6	54.6	
10	Bed utilisation rate (based on usable beds) in chronic hospitals	%	90	58	73	
11	Expenditure per patient day equivalent in chronic hospitals	R	256	365	499	

6.2 THE WESTERN CAPE REHABILITATION CENTRE (WCRC)

The Western Cape Rehabilitation Centre is a 156-bed provincial specialized facility providing high intensity spinal cord injury and general rehabilitation services for persons with physical disabilities.

The in- and out-patient services of the WCRC continue to grow. Average bed occupancy has been increased through the introduction of specific client flow management structures and systems and supported by an allocation of R4m to facilitate normalization of services following the relocation from Conradie Hospital to new state-of the-art premises in Lentegeur, Mitchells Plain in 2004.

Policy option funding (R1,9 million) allocated in 2005/6 and 2006/7 for the development of the WCRC Nursing School has been beneficial in that the first group of students completed their bridging from Enrolled Nursing AssistantA to Staff nurse in September 2006. The first graduates of the 2-year bridging course (staff nurse to professional nurse) will be qualifying in February 2008. Nurses from various hospitals are trained at this facility therefore improving the capacity across the service platform. Nursing agencies have been utilized to fill the service gaps and this expenditure has been funded from the policy priority allocations.

6.2.1 Service priorities 2007/2008:

- The status of the current priorities is to remain in line with the existing plan for rehabilitation services across the health platform and the established modus operandi implementation plan will be maintained.
- On the 1 March 2007 a Public Private Partnership/Facility Management will be implemented at the WCRC and greater Lentegeur sites, in which all non-core services (and in the case of WCRC the provision of medical and therapeutic equipment) will be outsourced
- HMQIG funding provided in 2005/6 supported development of a rehabilitation-specific information-management system to allow for monitoring and evaluation, and the development of realistic performance targets unique to this specialized referral rehabilitation facility. This performance targets will be developed in 2007/08 as sufficient.
- Amongst other specialist services offered, the WCRC also offers specialised wheelchair/ buggy seating clinics for high-risk patients (children in particular). An amount of R3m in the form of a policy option was allocated in 2006/07 to be utilised for the provision of specialised mobility assistive devices and outreach seating clinics in the rural regions and outlying areas of the Metro. Services include training of rehabilitation staff to build capacity in the regions. The status of this priority will remain within 2007/08 as it is in line with the existing planned expansion of rehabilitation services.

Table 4.16: Provincial performance indicators for Chronic hospitals [PHS4]

OBJECTIVE	INDICATOR	HEALTHCARE 2010 TARGET	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)
INPUT									
Provide chronic hospitals infrastructure in line with Healthcare 2010.	Number of useable beds	156	710	752	911	336	156	156	156
	Useable beds per 1000 uninsured population		0.21	0.22	0.26	0.21	0.21	0.21	0.20
OUTPUT									
Provide services that adequately address the needs of inpatients and, outpatients services.	Outpatients per inpatient day ratio	0.10	0.01	0.01	0.02	0.05	0.10	0.10	0.10
	Total number of inpatient days	51,246	234,195	233,858	276,144	104,244	51,246	51,246	51,246
	Total number of outpatient headcounts	5200	1,502	2,944	4,740	5,119	5,119	5,119	5,119
	Patient day equivalents per annum	52,979	234,872	235,002	277,907	105,950	52,952	52,952	52,952
Ensure accessible chronic hospital services to the population of the Western Cape.	Number of separations per annum	1,090	3,678	4,111	5,059	1,135	1,090	1,090	1,090
	Separations per 1000 uninsured population	1.1	1.08	1.19	1.44	1.60	1.45	1.45	1.45
EFFICIENCY			-	-	-	-	-	-	-
Ensure efficient and cost effective utilisation of resources.	Average length of stay	47	64	58	55	92	47	47	47
	Bed utilisation rate based on useable beds	90%	90.0%	85.0%	73.0%	85.0%	90.0%	90.0%	90.0%
	Expenditure per patient day equivalent (constant 2006/07 prices)		256	256	365	499	1,074	1,114	1,123

Note:
1. In 2006/07 the following provincially aided hospitals were moved to Sub-programme 2.4: Booth Memorial, Sarah Fox and St Josephs.
2. In 2007/08 Nelspoort Hospital moves to Sub-programme 2.4.
3. From 2007/08 the Western Cape Rehabilitation Centre is the only hospital in Sub-programme 4.4.

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

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2007/08
Input									
1. Expenditure on hospital staff as % of chronic hospital expenditure	%	82	71	72	75	75	75	75	
2. Expenditure on drugs for hospital use as % of chronic hospital expend	%	1.9	2.2	3	2	3	3	4	
3. Expenditure by chronic hospitals per uninsured person	R	18	17	29	15	16	16	16	
Process									
4. Chronic hospitals with operational hospital board	%	90	100	100	100	100	100	100	
5. Chronic hospitals with appointed (not acting) CEO in post	%	86	100	100	100	100	100	100	
6. Facility data timeliness rate for chronic hospitals	%	90	90	90	100	100	100	100	
Quality									
8. Chronic hospitals with patient satisfaction survey using DoH template	%	100	100	100	100	100	100	100	
9. Chronic hospitals with clinical audit (M&M) meetings every month	%	50	100	100	100	100	100	100	
Efficiency									
10. Average length of stay in chronic hospitals	Days	63.7	57.6	54.6	91.84	47	47	47	
11. Bed utilisation rate (based on usable beds) in chronic hospitals	%	90%	85%	73%	85%	90%	90%	90%	
12. Expenditure per patient day equivalent in chronic hospitals	R	256	256	365	499	1074	1114	1123	

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	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	53,228,009	55,265,000	96,569,000	52,867,000	59,937,000	65,127,000	69,035,000
Total per person	11.41	11.66	20.47	11.03	12.32	13.18	13.76
Total per uninsured person	15.63	15.98	28.04	15.11	16.87	18.05	18.85
Constant 2006/07 prices							
Total	60,147,650	60,238,850	101,397,450	52,867,000	56,880,213	59,005,062	59,439,135
Total per person	12.89	12.71	21.49	11.03	11.69	11.94	11.85
Total per uninsured person	17.66	17.41	29.44	15.11	16.01	16.36	16.23

7. SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

1.1 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 1 April 2004, created a single platform for the training of oral health practitioners and facilitated integrated tertiary and health services. The service plan for oral health is at an advanced stage of development by the Department together with the dental schools and other role players.

7.1.1 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.

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

7.1.2 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 15 000 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.

7.1.3 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: 82% of children < 6 years have tooth decay.
2) Dentures: 50% of adults are edentulous
3) 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.

7.1.4 Cost efficiency

Cost of personnel is high due to the fact that there is 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

A Comprehensive Oral Health Service Plan (COHSP) has been developed and approved in principle by management of the Department. The plan is being finalised, will need to be costed and implemented in phases over time within the available resources. While most of the elements will rightly fall under Programme 2, the plan has been described in this section for completeness and easier reading.

7.2.1 Fluoridating the oral environment

1) Water fluoridation

Support and assist national efforts to facilitate the promulgation of regulations, in the current Health Act, for the implementation of water fluoridation.

2) School fluoride rinsing or brushing

In view of the anticipated time constraint in affecting and implementing water fluoridation the abovementioned programmes are proposed. The rinsing programme would be the cheaper programme, however, due to the need to establish a sound oral hygiene practice at an early age the brushing programme would be more appropriate.

7.2.2 Selective pit and fissure sealant programme

Firstly target grade one learners [6-7 year olds] permanent molars and secondly grade 3 and 4 learners [8-10 year olds] permanent molars.

7.2.3 Primary oral care treatment package

1) Early diagnosis and treatment first primary school years includes:
   - Annual screening for first primary school learners
   - Basic conservative care for permanent dentition and emergency care (extractions and ART) for primary dentition.
2) Contingency care: second to sixth primary school years:
   - Basic conservative care on demand for permanent dentition and emergency care (extractions and ART) for primary dentition.
3) Screening and conservative care for permanent dentition in final primary school year.
4) High school and adults includes:
   - Contingency care: emergency care (extractions) and basic conservative care on demand.

7.2.4 Oral health promotion

The above should be supported with an aggressive oral health education and promotion programme which should focus on mother and child care in order to address the profound problem of ECC.

7.2.5 Service priorities

Table 4.19: Service priorities for the oral health programme

PRIORITY	SERVICE	STAFF CATEGORY
1. Primary prevention	Water fluoridation Dental health education Fluoride rinsing/brushing programmes	Oral hygienists Dental assistants Dental therapists Dentists Speech therapists Dieticians, etc
2. Basic treatment package [clinical procedures]	Examination Intra-oral X-rays Simple fillings Emergency pain relief and treatment of sepsis Dentures	Oral hygienists Dental therapists Dentists Dental technicians

7.2.6 The service platform

The proposed service platform deviates from the national model. Primary oral health services in the Western Cape are only rendered in district hospitals where no suitable accommodation is available within a clinic or community health centre. Theatre facilities and anaesthetists should be made available at district hospitals for treatments requiring general anaesthesia.

Secondary level services are to be rendered within district hospitals. Referrals will therefore be directly from primary to tertiary levels of care.

7.2.7 Service package

The package of care to be provided at primary health care facilities will be in line with the national policy. The package of care must therefore consist of promotive and primary preventative services as well as basic treatment services. School children and pre-school children will be the priority patient groups.

The distribution of workload across the levels of care will be as follows:
- 90% primary care
- 8% secondary care
- 2-3 tertiary care
- 0.1% quaternary care

7.2.8 Human Resources required by region

The norms used to calculate staff are as follows:
- Oral hygienists: 1:100,000 population
- Dentists and therapists: 1:60,000 population
    - o It is assumed that the Dentist: Dental Therapist ratio will be 1:3 in the Metro and 1:1 in other districts.

Consideration should be given to adjust the recommended norm for oral hygienists in order to create more oral hygienist posts. In terms of national norms and standards for primary oral health care the ratio was adjusted from 1:50,000 to 1:100,000 due to financial constraints.

Oral hygienists who have completed the course on expanded functions should be retrained. In terms of their scope of practice this category of worker may do temporary fillings and this may assist in reducing the backlog in caries treatment. The curriculum for oral hygiene training could also be expanded to make provision for the extraction of deciduous teeth.

7.2.9 Cost of proposed oral health plan

The funding of the plan still requires to be more carefully determined but at this stage it appears that additional funding requirements could be relatively modest.

Denture provision:
The unabated provision of dentures is in conflict with the underlying principle of the National Oral Health Strategy as well as the proposed Oral Health Plan which advocates the prevention of oral disease, conservation of dentition and ultimately the prevention of edentulousness, i.e. dental disability.

The provision of dentures is a low priority and should only be supplied within resource limits. In the Metropole dental laboratory services should be centralised (Hope Street Clinic) and outsourced in the rural regions. The possibility of a tender for laboratory services needs to be investigated. Strict clinical criteria for denture provision need to be developed.

7.2.10. Support systems

Role of the oral health centre (OHC)

It is envisaged that the OHC can be engaged at the following levels:

1) Referral for the following:
   - Maxillo-facial surgery
   - Oncology
   - Oral pathology
   - Orthodontics
2) Human resource development

Improving the skills of oral health professionals as follows:

- Extended function skills of oral hygienists – in service training
- Dentist:
  - Interceptive orthodontics, e.g. ortho skills development of clinicians at designated clinics in the province in order to facilitate interceptive treatment and concomitant prevention of severe malocclusions.
  - Minor oral surgery, e.g. fracture immobilisation under local anaesthetic, impacted molars
- Dental assistants: in service training in terms of requirements for registration with the Health Professions Council.

3) Support to the regions
   - Registrar (maxillo-facial surgeon) rotation e.g. Paarl Hospital
   - Orthodontic expertise can be established in various regions. More advanced cases can be managed in consultation with a full-time service rendering orthodontist at the OCH which is available to the Provincial Oral Health Services.
   - Development of minor oral surgery skills of clinicians at designated clinics and regions to facilitate local treatment of simple fractures, impacted 3rd molars.
   - General specialist consultation service to the regions as required from time to time.

7.2.11 Infrastructure

1) Facilities

Dental equipment is expensive and it is recommended that upgrading of oral health facilities should be included in the Hospital Revitalisation Programme.

2) Supply chain management
   - Streamline procurement of non-contract items.
   - Streamline procedure of smaller capital equipment items.
   - Dental consumables to be standardised.

3) Transport

Availability of transport designated for the oral health programme is of crucial importance.

4) Oral Health Information

Due to the costly exercise of a national/provincial oral health survey to have an annual sentinel collection of key indicators to have up to date information for management decisions and monitoring performance.

7.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The following measures are planned to address the constraints highlighted above

1.1.1 That the Western Cape Comprehensive Oral Health Service Plan be implemented.

7.3.2 Oral health infrastructure requirements be addressed in the departmental infrastructure planning processes.

7.3.3 That the Oral Health HR requirements be considered within the broad Departmental HR Plan initiatives.

7.3.5 That measures be considered for the purpose of creating an exit strategy for oral health services delivered at Correctional Service facilities.

7.4 PLANNED QUALITY IMPROVEMENT MEASURES

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

7.4.1 Patient Satisfaction

- The development of a client based survey to assess the satisfaction with services rendered at the OHC.
- Complaints mechanism in place (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 4.20: Measurable objectives and performance indicators: Academic Dental Services [PHS4]

Objective	Performance measure/ indicator	HC 2010 Target	2002/03 (actual)	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (target)	2008/09 (target)	2009/10 (target)
Optimise Student training as agreed to by Committee of Dental Deans	Graduating students	80	64	129 *	97 *	174	90	100	110	120
Evaluate service rendering	The number of patient visits	120,000	150,000	160,000	160,000	181,141	180,000	182,000	185,000	188,000
Reduce waiting lists for dentures	Number of patients that have received dentures	500	1,000	1,000	900	2,282	1,335	1,385	1,410	1,450
Improved efficiency	Theatre cases.	1,500	1,293	1,300	1,400	1,363	1,500	1,700	1,900	2,000

7.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

An amount of R481,000 additional earmarked funding was allocated to Sub-programme 4.5 in 2007/08 for Human Resource Development.

Table 4.21: Trends in provincial public health expenditure for academic dental services (R million) [PHS6]

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)
Current prices						
Total	47,371,448	52,375,000	58,735,000	56,085,000	60,874,000	66,144,000
Total per person	10.15	11.05	12.45	11.71	12.51	13.39
Total per uninsured person	13.91	15.14	17.05	16.03	17.14	18.34
Constant 2006/07 prices						
Total	53,529,737	57,088,750	61,671,750	56,085,000	57,769,426	59,926,464
Total per person	11.47	12.05	13.07	11.71	11.87	12.13
Total per uninsured person	15.72	16.50	17.90	16.03	16.26	16.61

Programme 5: Central Hospital Services

PROGRAMME 5: CENTRAL HOSPITAL SERVICES

1. AIM:

To provide tertiary and quaternary health services to the Western Cape and beyond, and to provide a platform for the training of health science students and workers.

2. PROGRAMME STRUCTURE:

Sub-programme 5.1 Central hospital services
Rendering of highly specialized tertiary and quaternary health services on a national basis and a platform for the training of health science students and workers, as well as research.

3. CONTEXT OF CENTRAL HOSPITALS SERVICES:

The Central Hospitals in the Western Cape are:

1) Red Cross War Memorial Children's Hospital, established in 1956 and celebrated its 50th anniversary in 2006.
2) Tygerberg Hospital, established in 1976 and celebrated its 30th anniversary in 2006.
3) Groote Schuur Hospital, established in 1938, will celebrate its 70th anniversary during 2008.

The three Central Hospitals provide tertiary and quaternary services as well as regional services to the immediate drainage area. They therefore operate at the top end of the referral chain and are crucial for the coherence of the health delivery system. Health services across the referral chain at the various levels of care are interdependent. The central hospital tertiary component provides the only intensive care services in the province. Regional hospitals provide only high care and the close co-operation across these services is crucial. Adherence to clear referral guidelines is required for a seamless experience of services.

Central Hospitals furthermore contain highly specialized services appropriate to the disease burden of the province and the country. Highly specialized services include cardiology, cardiothoracic surgery, neurology, neurosurgery, and radiation therapy for cancer patients. A full list of services is provided in the situation analysis section. The Central Hospitals therefore play a key role to support the whole health care delivery system with expert knowledge necessary to enhance clinical governance across levels of care and to define clinical guidelines for the management of patients in the province.

Clinicians in Central Hospitals therefore have a major responsibility to reach out and support the health system and to monitor patterns on disease at the top of the referral chain.
These hospitals provide health services to those patients referred to it from the Western Cape Province, surrounding provinces, the rest of the country and from African countries.

IKAPA ELIHLUMAYO, SOCIAL, HUMAN AND INTELLECTUAL CAPITAL

A key strategic imperative of the Provincial Growth and Development Strategy is the focus on integrated development and the deepening of social capital, especially amongst the poor, women and children. The role of the Central Hospitals in this context is listed below:

- The central hospitals provide a range of unique services to patients from neighboring provinces and although quantifying the number of patients from other provinces is not easy, the 228% increase in Xhosa speaking patients is evidence of the change in the community served by the Central Hospitals. (January 2002: 1,356 admissions of Xhosa speaking patients and 4,442 in December 2006). These hospitals also provide services to patients from the rest of the country and African countries.
- The Western Cape Health Services provided a platform for 3,8 million health science student hours during 2006, of which 2,9 million were in the Central Hospitals. This is a significant contribution towards human and intellectual capital and provides doctors, nurses and pharmacists amongst others for the country as a whole.
- The services platform provides access for research by Institutions of Higher Education (HEI). This contributes to the intellectual development, human capital and continuous improvement of our services at all levels of care. Relevant research in communicable diseases such as Tuberculosis and HIV and AIDS has resulted in many International publications, portraying the Western Cape as an intellectual and significant province. Cutting edge research assists with service prioritization and service streamlining, e.g. statins, kangaroo mother care, new models of neonatal care delivery.
- The clinicians involved in service delivery actively enhance the capacity at referring institutions through a system of outreach and support, in-service training of health workers and advocacy. They form a key link in terms of Clincal Governance across all levels of care.
- The Child Injury Prevention Programme is housed and run from the Red Cross Children's Hospital, producing educational material in conjunction with the Department of Education. Internationally it has the largest database regarding child injuries in the world.
- Both Tygerberg and Red Cross Children's Hospitals have poison centres advising families and general practitioners across the country.

4. SITUATION ANALYSIS

4.1 Packages of services

The table below lists the range of services being provided at the three Central Hospitals. It also indicates the number of beds funded during the 2006/7 financial year[1].

Table 5.1: Range of services and funded beds during 2006/07

Specialty	Sub-specialty	Funded operational beds in 2006
Critical Care (General Intensive Care)	Adult critical care	90
	Paediatric critical care	32
Total Critical Care		**122**
Obstetrics	Obstetrics	202
Gynaecology	Oncology	6
	General Gynaecology	74
Total Obstetrics & Gynaecology		**282**
Medicine	Allergology	0
	Cardiology	37
	Clinical haematology/oncology	22
	Dermatology	24
	Emergency Medicine	51
	Endocrinology	10
	Gastro-enterology	4
	General Medicine	175
	Geriatrics	2
	Hepatology	5
	Infectious diseases	0
	Nephrology	15
	Neurology	26
	Pulomology	22
	Rheumatology	4
Total Medicine		**397**
Total Neonatology	**Neonatology**	**182**
Orthopaedics	Arthroplasty	6
	Hand Surgery	10
	Orthopaedics	198
	Spinal Unit	19
Total Orthopaedics		**233**
Paediatric Orthopaedics	Paediatric Hand Surgery	1
	Paediatric Orthopaedic Trauma	17
	Paediatric Orthopaedics	31
Total Paediatric Orthopaedics		**49**
Child Psychiatry	**Child Psychiatry**	**16**
Paediatric Surgery	Neonatal Surgery	1
	Paediatric Burns	18
	Paediatric Cardiothoracic Surgery	7
	Paediatric Neurosurgery	21
	Paediatric Ophthalmology	6
	Paediatric Otolaryngology	10
	Paediatric Plastic and Reconstructive Surgery	10
	Paediatric Surgery	45
	Paediatric Trauma	7
	Paediatric Urology	4
Total Paediatric Surgery		**129**
Paediatrics	General Paediatrics	59
	Paediatric Cardiology	13
	Paediatric Clinical Heamatology/Oncology	27
	Paediatric Dermatology	3
	Paediatric Emergency Medicine	45
	Paediatric Endocrinology	13
	Paediatric Gastro-enterology	34
	Paediatric Infectious Diseases	19
	Paediatric Nephrology	18
	Paediatric Neurology	16
	Paediatric Pulmonology	38
Total Paediatrics		**285**

1 A large outpatient service is not indicated in this table

Specialty	Sub-specialty	Funded operational beds in 2006
Psychiatry		**43**
Radiation Medicine		**84**
Surgery	Burns	21
	Cardiothoracic Surgery	53
	General Surgery	217
	Neurosurgery	80
	Ophthalmology	41
	Plastic and reconstructiv surgery	29
	Trauma Surgery	103
	Urology	51
	ENT	28
Total Sugery		**623**
Grand Total		**2445**

Note: The level 1 beds in TBH form the nucleus of the future Khayelitsha Hospital and will be moved to that hospital once it is established.

Table 5.2: Numbers of beds in central hospitals by level of care [2006] [CHS1]

Central /tertiary hospital (or complex)	Level 3 and 4 beds	Level 2 beds	Level 1 beds	Total beds
Groote Schuur Hospital	810	100		910
Red Cross Children's Hospital	227	61		288
Tygerberg Hospital	1124	150	90	1364
Total	**2161**	**311**	**90**	**2562**

Note: The level 1 beds in TBH form the nucleus of the future Khayelitsha Hospital and will be moved to that hospital once it is established.

4.2 Service trends over time

4.2.1 An analysis of service trends over time demonstrates the changes in services over the past 5 year period:

1) The total number of separations (admissions) has increased over the years, despite a reduction of beds. It is particularly evident at Tygerberg Hospital. (See graph below.)
2) The average length that patients stay in hospital has decreased, evidence of increased efficiency.
3) Trauma separations have increased dramatically in the Tygerberg services. This is largely due to interpersonal violence. (See graph below).
4) The total number of deliveries (babies born) in the Tygerberg Hospital area shows a dramatic increase of nearly 50% over the 5 year period. (See graph below).
5) The mortality rate in the hospitals has remained relatively stable, despite major trauma cases and an increase in the acuity of patients due to the commitment of both clinicians and managers.

Figure 3: Central Hospital Separations: 2002 to 2006

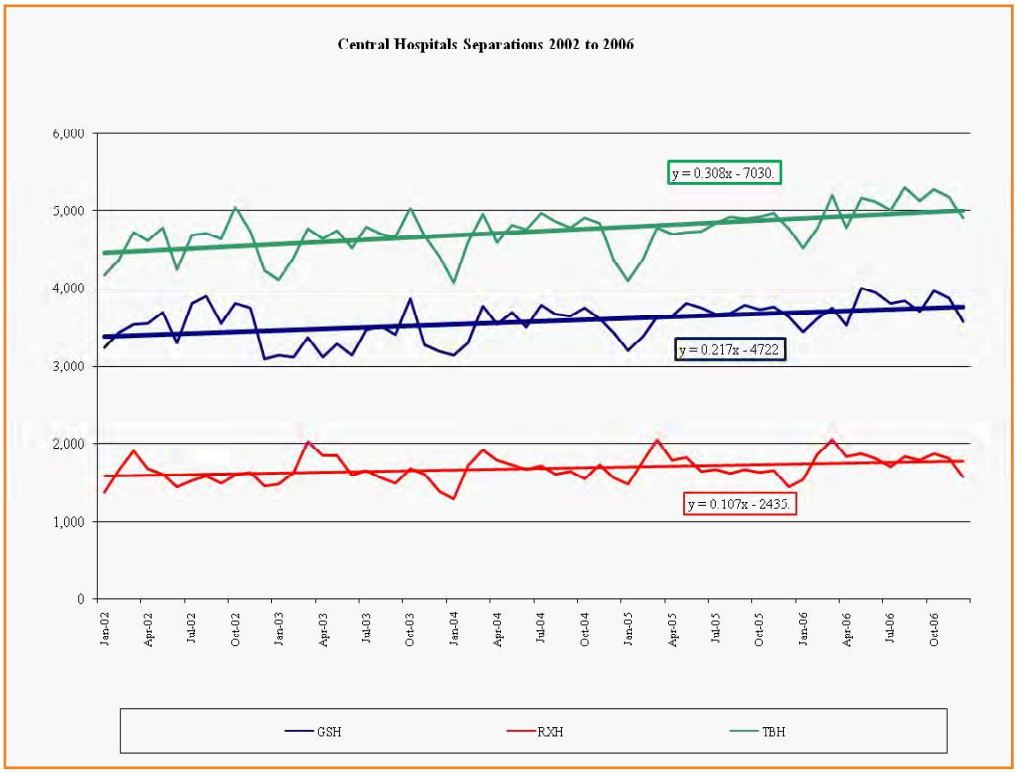


Figure 4: Separations: Trauma

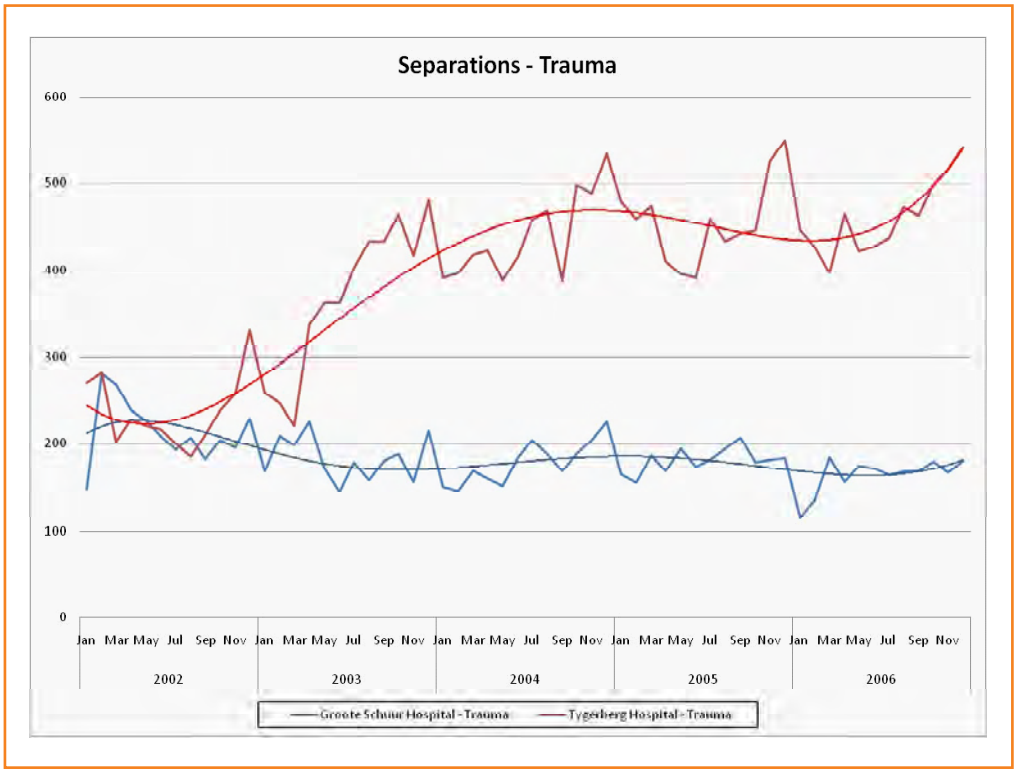
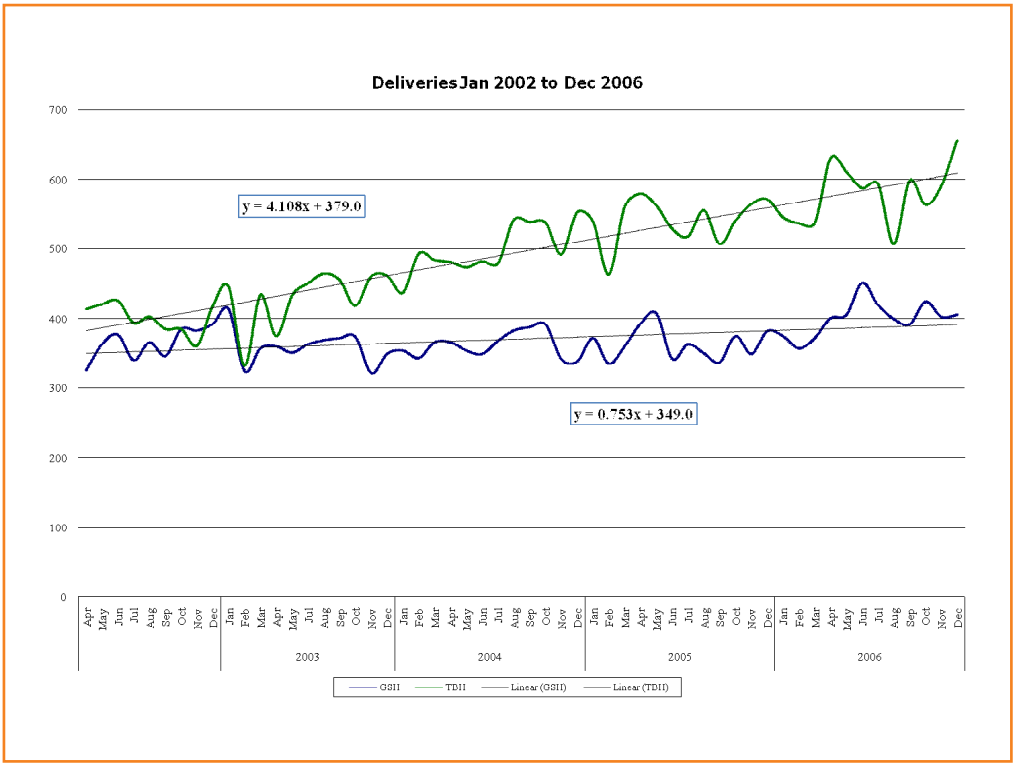


Figure 5: Deliveries from January 2002 to December 2006



4.2.2 Red Cross Children's Hospital

- Forty-seven percent of all medical and 14% of all surgical admissions to Red Cross Children's Hospital are for children less than 1 year. Thirty-two percent of all hospital admissions are for children less than 1 year. These patients are referred and require specialised skills to manage them. It is also important to note that the National Policy is that children younger than 6 years of age have their health services free of charge.
- The service pressures experienced in the financial year 2005/2006 can be attributed to two key factors, namely seasonal factors and nurse supply factors.
- The seasonal effect of diarrhoeal disease was markedly felt in February and March with bed occupancy rates in the general medical (short stay) wards exceeding 100%. A Top ten analysis of ICD10 coding revealed that diarrhoeal disease contributed significantly to the burden of disease profile for medicine.
- The inability to recruit skilled nursing staff, especially critical care nurses through all supply channels, had a direct impact on the capacity in the Intensive Care Unit (ICU). The capacity problems in ICU had a spill over effect into the wards resulting in an increased number of patients requiring "high care" having to be managed in general wards.
- Despite the negative nurse supply factors surgical outputs increased - an increase of 7% in operations than in the previous year was achieved. More than a third of all operations that were performed were longer than one hour. The fact that children weighing less than 10kgs are mostly operated upon in more specialized hospitals underpins this feature.
- Of great significance is that in 2005/2006, there has been an increase in cardiac operations with average of thirty-two operations per month. This output was achieved despite nurse supply pressures and capacity pressures in ICU. An increase in the number of emergency surgical cases also occurred (2004/2005 =243 vs 2005/2006 = 288). Emergency operations accounted for 38% of total operations performed in 2005/2006.
- Key managerial vacancies presented as a major challenge to the institution. These have all been filled during 2006/07.

4.2.3 Maitland Cottage Home

Maitland Cottage Home renders specialist orthopaedic surgery and treatment, as well as medical and nursing care to children in need of hospitalization.

The Maitland Cottage Home has been moved from Programme 4 (Chronic Hospitals) to Programme 5 during 2006/07. Whilst the level of nursing in this hospital is relatively low (at a District Hospital level), the specialist inputs are of a sub-specialist nature and therefore falls within the activities of these specialists. The Home is managed as a satellite of Red Cross Children's Hospital.

The hospital has 80 beds and performs between 300-400 orthopaedic operations per annum and has approximately 900 admissions per annum.

The hospital only offers an inpatient service for post-operative care and convalescence and operates as a key step down facility for trauma and orthopaedic patients from Red Cross Children's Hospital (RCCH). Children are also admitted from other hospitals in the Western Cape and from Eros Cerebral Palsy School, Astra School, Agape, Filia Training College and Tembaletu Day Centre.

The hospital is the main responsibility of the Maitland Cottage Home Society and is managed by a Management Committee which also manages the affairs of the Society. The hospital is a Provincially Aided Hospital and receives a subsidy of approximately 90% of agreed expenditure. The subsidy is disbursed and overseen by RCCH.

The service provided by the Maitland Cottage Home is largely of a step down nature and the future this facility must be finalized. At the moment this facility provides extremely cost effective services as a satellite of Red Cross Children's Hospital.

Table 5.3: Situation analysis indicators for central hospitals [CHS2]

Indicator	Type	Province wide value 2003/04	Province wide value 2004/05	Province wide value 2005/06
Input				
1. Expenditure on hospital staff as % of hospital expenditure	%	65	65.0	58
2. Expenditure on drugs for hospital use as % of hospital expenditure	%	6.9	5.7	5.6
Process				
3. Operational hospital board	Y/N	Y	Y	Y
4. Appointed (not acting) CEO in place	Y/N	N	N	Y
5. Individual hospital data timeliness rate	Y/N	Y	Y	Y
Output				
6. Caesarean section rate	%	28.6	35	37.0
Quality				
7. Patient satisfaction survey using DoH template	%	100	100	100
8. Clinical audit (M&M) meetings at least once a month	%	100	100	100
Efficiency				
9. Average length of stay	Days	6.2	6	5.6
10. Bed utilisation rate (based on usable beds)	%	79.9	82.1	81.8
11. Expenditure per patient day equivalent	R	1,637	1,763	1,904
Outcome				
12. Case fatality rate for surgery separations	%	3.7	3	3.1

Table 5.4: Situational analysis indicators for each central hospital [CHS2]

Indicator	Type	GSH 2004/05	TBH 2004/05	RCCH 2004/05	GSH 2005/06	TBH 2005/06	RCCH 2005/06
Input							
1. Expenditure on hospital staff as % of hospital expenditure	%	64,0	63,0	63,0	59,1	57,2	60,9
2. Expenditure on drugs for hospital use as % of hospital expenditure	%				6,1	4,4	8,6
Process							
3. Operational hospital board	Y/N	Y	Y	Y	Y	Y	Y
4. Appointed (not acting) CEO in place	Y/N	N	Y	Y	Y	Y	Y
5. Individual hospital data timeliness rate	Months	12	12	12	12	12	12
Output							
6. Caesarean section rate	%	46	26	0	48	26	0
Quality							
7. Patient satisfaction survey using DoH template	Y/N	Y	Y	Y	Y	Y	Y
8. Clinical audit (M&M) meetings at least once a month	Y/N	Y	Y	Y	Y	Y	Y
Efficiency							
9. Average length of stay	Days	6,7	6,5	4,3	6,2	6,5	4,1
10. Bed utilisation rate (based on usable beds)	%	80,2	80.4	84,0	82,9	80,6	81,9
11. Expenditure per patient day equivalent	R				1,940	2,007	2,174
Outcome							
12. Case fatality rate for surgery separations	%	4,0	4,9	2,0	3,8	4,6	3,0

Note: Indicator 5: The timeous returns of the NTSG review data as per the DORA and Service Level Agreement is being used as a proxy.

4.3 Resource planning 2006/07 and 2007/08

4.3.1 Each Central Hospital is headed by a Chief Executive Officer, with financial and human resource delegations to take the necessary decisions for the operation of these facilities. A personnel-finance instrument has been developed supporting the CEO with information for decision-making.

4.3.2 **Allocation of Funds**:
Due to overall financial pressures on the Department and the need to prioritise primary and secondary levels of care the decision has been made to reduce resource allocation to Programme 5. Consequently Central Hospitals will experience a real reduction of 2,7% and will effect the closure of 90 beds; 60 at GSH and 30 at TBH. No adjustment to bed numbers will be made at RCCH.

The sources of funding for Prorgramme 5 are shown in the table below. There is a nominal increase of 1,78% to Programme 5 in 2007/08 in comparison to the allocation in 2006/07.

Table 5.5 Funding sources for Programme 5

Fund	2006/07 Adjustment Estimate R'000	2007/08 R'000
National tertiary Services Grant	R1,272,640	R1,335,544
Health Professions Training and Development Grant	R199,677	R210,144
Modernisation of Tertiary Services Grant (MTS)	R13,173	R51,206
Equitable Share	R637,277	R578,907
TOTAL	**R2,122,767**	**R2,175,801**
Share of Departmental budget	33,03%	30,67%

Notes: MTS funds are earmarked for health technology.
Funding reflected as Equitable Share includes retained revenue.
Funding for 2007/08 includes earmarked allocations for additional posts for health professionals [R6,305 million] and R37,809 million for the Health Professionals Remuneration review.

4.3.3 Personnel trends 2006/07

Table 5.6: Personnel trends in 2006/07

	GSH	TBH	RCCH
Total staff full time equivalents (FTEs)	3,931	4,115	1,044
Change in staff numbers during 2006	-8	+16	-48
% medical	13,6%	13,1%	13,5%
Total nurse to bed ratio	1.52	1.69	1.78
Average nurse agency FTEs/month	250	211	87

Note: Staff working hourly shifts or sessions are converted to full time equivalents (FTEs) for comparison and monitoring purposes.

The dependency on nursing agencies for the highly specialized areas (largely intensive care, theatre, midwifery, emergency) is a concern. Several strategies have been embarked to address this issue.

4.3.4 Financial indicators 2006/07

The differences in these indicators are largely due to the different packages of care provided by these hospitals. Figures are for 2006/07 financial year.

Table 5.7: Financial indicators for 2006/07

	GSH R'000	TBH R'000	RCCH R'000
Budget allocation Programme 5 Adjustment Estimate	R908,645	R941,564	R264,645
Cost / PDE	R2,111	R1,793	R1,948
Revenue Budget Adjustment Estimate	R63,462	R67,875	R14,941
Revenue per PDE	R143	R104	R107
Annualised cost per bed (000)	R1,019	R749	R993

Notes:

Patient day equivalent (PDE) is equivalent to one inpatient day plus one third of outpatient visits and is an international measurement unit.

Revenue budget: A large amount is due to this programme from the Road Accident Fund from services already rendered. The Department is actively pursuing the payment of this outstanding debt.

5. ANALYSIS OF CHALLENGES AND CONSTRAINTS, AND MEASURES PLANNED TO OVERCOME THOSE

5.1 **The main challenges for 2007/8 are as follows**:

1) Demand for services;
2) Implementation of the Comprehensive Service plan;
3) Finalisation of Joint Agreements between the department and the 4 Institutes of Higher Education;
4) Quality of care which is adversely affected by the difficulty to recruit and retain well qualified and experienced health professionals, especially nurses;
5) Attaining employment equity targets in highly specialized fields where training alone extends beyond 12 years; and
6) Managing the 2,7% resource reduction.

5.2 Key Strategies to overcome these challenges:

5.2.1 Increased demand for services

- Identify high case-load conditions and together with Co-ordinating Clinicians and referring levels of care aim to strengthen prevention strategies, as well as to ensure enhanced capacity at referring levels of care.
- Obstetrics and neonatal services in the Metropole are particularly challenging and a summit is being planned to analyse supply and demand factors so as to enhance the ability to respond to this challenge across levels of care.
- An acute case load management policy was developed focusing largely on dealing with emergency cases, but has allowed improved bed management. The setting up of a bed bureau to increase information support for emergency case load distribution across emergency centers will assist further. This policy will be implemented from March 2007.
- Full implementation of the Cape Triage Score system in all emergency centres aiming at streamlining and prioritizing patients requiring emergency care.
- Discharge management will be strengthened with discharge lounges (already implemented at GSH), and HealthNET (non emergency transport).
- The lack of theatre and intensive care nurses to adequately staff operating theatres and intensive care units results in increased waiting times and waiting lists. As described above there is a dependency on agency staff for nurses who often do not have the required experience or commitment.
  Several strategies started, which will continue to be strengthened during 2007/8:
  - The Cape Peninsula University of Technology has been approached to assist with the training of theatre technicians, a midlevel category or worker to support theatre nurses.
  - Improving the nursing environment to ensure functional basic equipment and hospital beds.
  - Theatre managers have been appointed at Tygerberg and Groote Schuur Hospitals at executive level in order to improve efficiencies and the throughput of theatres. This system requires further strengthening.
  - Nursing mentors are being appointed in theatres and intensive care units to provide support for sub-professional, professional and student categories of nurses.
  - A co-ordinating clinician has been appointed for each of surgical services and anaesthetic services to ensure provincial wide safety, but also to identify areas where streamlining of systems could happen.
  - An investigation into critical care services (intensive and high care) commenced in 2006/07 and will conclude its work in 2007/08, aiming at getting a clear picture of the current situation and practices and to develop uniform admission and exit criteria/guidelines, as well as to propose a provincial approach to managing these scarce resources.
- Working with the Eastern Cape to enhance capacity in that province and reduce the need for people to seek health care in the Western Cape.

5.2.2 Implementation of the Comprehensive Service plan

- A technical team across the three Central Hospitals is planning the systematic implementation of the split of level 2 and level 3 services. This will entail clearly defining the level 2 and level 3 packages of care, clearly identify referral guidelines and diagnostic packages which are appropriate.
- Aligning the hospital information systems to support a level of care split within one hospital.
- Regionalise identified highly specialized services towards single services for the province across the platform. This includes Nuclear Medicine, Paediatric Cardiac care, transplant services.
- Enhance co-operation across the institutions towards collective planning and response.

5.2.3 Finalisation of Joint Agreements between the department and the four Institutes of Higher Education

- The final drafts for the bilateral and multilateral agreements have been concluded. This will replace outdated Joint Agreements dating back to 1966 and will cover the four Institutes of Higher Education: University of Stellenbosch, University of Cape Town, University of the Western Cape, and the Cape Peninsula University of technology.
- Key policy decisions will take this long overdue process towards conclusion. Technical work will be concluded early in 2007/8 in support of these policy decisions.

5.2.4 Quality of care which is adversely affected by the difficulty to recruit and retain well qualified and experienced health professionals, especially nurses.

- Whilst 2006 the total number of nurses was held relatively steady during 2006, the services are continuously losing experienced staff, largely in the specialised service areas such as intensive care, theatres, midwifery and emergency services. The service therefore remains dependent on agency staff and overtime payment and purchases on average the services of 610 full-time equivalents per month.
- Several strategies have been embarked upon within the Department to address this significant challenge.
  - Bursaries have been allocated for formal training (see section on programme 6) and the capacity for sub-professional training in certain hospitals (Tygerberg and Groote Schuur Hospitals and the Western Cape Rehabilitation Centre) has been increased, allowing for bridging towards a professional qualification.
  - A postgraduate training programme for midwifery, in conjunction with the University of the Western Cape, has been established at Mowbray Maternity Hospital, and a similar training programme for mental health nurses will start in 2007, based at Stikland Hospital.
  - Non-nursing tasks have been identified and appropriate other categories of staff to handle these tasks, largely clinical technologists, administration clerks.
  - Mentors in specialized areas have demonstrated the impact on recruitment and retention, and improved quality of care. This would be further strengthened during the year to come.

5.2.5 Attaining employment equity targets

Whilst attaining the targets has been achieved largely in nursing and administration, the main challenge remains medical specialists in highly specialized fields where training alone extends beyond 12 years. The co-operation of the universities is crucial towards training a representative group of medical students which is the source of applicants for registrar posts (specialists in training) and ultimately specialists. Both health science faculties (US and UCT) with medical schools have committed their institutions to this priority. It will, however, take time to move towards having a specialist cadre that is more representative. Despite this challenge the central hospitals seek applicants to posts who will address greater employment equity.

5.2.6 Managing the 2,7% resource reduction.

- A clear plan of action will be developed prior to the commencement of the financial year.
- Operational efficiencies will be further increased.
- A technical team will analyse services to identify potential areas where patient care could be adapted to accommodate patients waiting for diagnostic procedures or those who require limited input from medical specialists.
- A reduction of 30 beds at Tygerberg Hospital and 60 beds at Groote Schuur Hospital will occur and both service and staffing implications will be addressed

6. POLICIES, PRIORITIES, STRATEGIC GOALS

6.1 The Central Hospitals management falls within the Division of Secondary, Tertiary and Emergency Care Divisional team of the Department. The key strategic goals of the Division are as follows:

- Well-functioning health facilities
- Well-functioning health system
- Good governance
- Restructuring in line with the Comprehensive Service Plan

6.2 Priorities within Programme 5 for 2007/8:

6.2.1 Well-functioning health facilities

- Each hospital will have a business plan focusing on services, resources and performance targets within the priorities of the Department.
- Regular performance monitoring.
- Finances
  - Implement cost centre management
  - Enhance contract management
- Human Resources
  - Performance management of staff.
  - Enhance the working environment
- Quality Improvement strategies, with particular reference to:
  - Staff and patient satisfaction surveys
  - Morbidity and mortality meetings in all departments according to provincial guidelines
  - Patient liaison services/help desk.
  - Implementing infection prevention and control policy
  - Waiting times survey
  - Implementation of Service standards in line with Batho Pele

6.2.2 Well-functioning health system

- Co-ordinating clinicians in key disciplines counter the fragmentation of the health system in the Western Cape. This system, implemented during 2005 and 2006, has improved service delivery, enhanced clinical governance and facilitated both the treatment of patients at the level of care appropriate to their needs and the clinical outcomes. The positive effect has already been felt in Paediatrics and Child Health, Mental Health, Anaesthetic Services, Internal Medicine, Surgical services, and Obstetrics and Gynaecology, where Co-ordinating Clinicians have been appointed.
- The co-ordinating clinicians will be funded from this programme as from 2007/08.
- Each of the more specialised levels of care has the responsibility for outreach and support to peripheral services. The implementation of this policy will be more structured and monitored during 2007/08.
- Measures are being developed monitor the effectiveness of this system.
- A system to monitor waiting lists will be established.

6.2.3 Good governance

- The hospitals are committed to enhance managerial governance, clinical governance and community involvement in governance.
- Each Central Hospital has a facility board, supported by the CEO and the hospital.
- The respective roles of managers and clinicians as partners to Clinical Governance will be unpacked in a provincial framework for clinical governance. This framework will be concluded and implemented during 2007/08.
- Managerial competencies are enhanced through several strategies. The Hospital leadership programme by UCT business school provides an important basis for managers and clinicians alike. Sixty people participate in this training every year.

6.2.4 Restructuring in line with the Comprehensive Service Plan

- This is an important priority and was outlined in the section above.

6.2.5 Modernisation of Tertiary Services

- An amount of R51m will largely be spent on the following:
  - Complete the strategic plan towards digitizing medical imaging for the services and commence with the first steps towards implementing a PACS system (Picture Archiving and Communication System).
  - Strengthen radio oncology services.
  - Acquire equipment to enhance diagnostic imaging.
  - Implement the Western Cape Nuclear Medicine Services imaging communication system.
  - Acquire equipment that will enhance efficiency or where there is an urgent need.
  - Clinical engineering staff to support the maintenance of equipment.
  - The plan will be concluded and specifications developed before the start of the 2007/08 financial year.

6.3 Strategic priorities by hospital

This section outlines the range of services provided by the hospitals.

6.3.1 Tygerberg Hospital

- A key strategic objective for 2007/08 is infrastructure development. Whilst an analysis of the CSIR was submitted to the National Department of Health, TBH has not yet been accommodated on the Hospital Revitalisation Programme.
- Tygerberg Hospital has seen a significant acquisition of equipment during 2006. This will enable the hospital to perform 8,000 Nuclear Medicine studies in 4,000 patients. The SPECT CT technology will also improve diagnostic capability. It is anticipated that 2,124 cancer patients will be treated with the latest Radiotherapy equipment, including the Linear Accelerator.
- More than 28,000 operations will be performed of which 650 will be open heart surgery. At least 8 cochlear implants are envisaged, a service provided only at TBH in the province. The craniofacial unit will continue to provide a national service for the correction of severe deformities of the face and head. 250 hip and knee replacements will be undertaken.
- The hospital will handle 550,000 outpatient visits and to admit 61,000 patients who will stay on average 6 days each. Of these admissions, some 7,400 will require intensive care.
- Over 1,000,000 blood tests will be done and there will be 100,000 visits to the radiology department. Specialised investigations by Radiologists will include 10,000 ultrasound investigations, 4,000 invasive investigations such as arteriography, 12,000 CT scans and 2,500 MRI studies.
- The Trauma Unit will manage some 20,000 injured patients of whom 8,500 will require admission. Some 360 severely burnt patients will be admitted to the provincially unique Adults Burns Unit, of whom one third will require intensive care.
- Over 10,000 paediatric emergencies will be managed and over 6,000 adults with medical emergencies will be admitted.
- In terms of Obstetric services the total number of deliveries at TBH is expected to increase to 7,550. In 2007/08, the expansion of level 2 high care services at TBH will address the 25% increase in demand for high care services from 255 patients to 319. The peri-natal mortality will be maintained at below 18 per 1,000 deliveries.
- 9,700 neonates will be admitted to the Neonatal wards, with 450 of these requiring intensive care and 3,100 requiring high care treatment.
- A total of 6,500 chronic dialysis procedures will be done as well as 510 acutre dialysis procedures.
- The Cardiac Catherisation Unit will perform 1,300 catherisation procedures including the insertion of over 350 coronary artery stents.

6.3.2 Groote Schuur Hospital

- Forty-five thousand three hundred and seventeen patients will be admitted to Groote Schuur Hospital. In addition 11,541 will be managed in the Trauma Unit and 32,035 to the Medical Emergency Unit. Of the Trauma admissions more than 800 will be for gunshot wounds and more than 4,000 will be for assault or stab wounds. More than 250 patients will require the services of a neurosurgeon to operate for brain injuries. Eight thousand babies will be delivered of which 500 will be admitted to the neonatal intensive care unit. More than 450 pregnancies will be terminated on request.
- More than 24,00 operations will be performed of which approximately 250 will be heart valve replacements, 150 joint replacements, 1,000 eye cataract removals, 300 amputations and 140 to keep open the blood vessels of the brain by inserting a stent in order to prevent a stroke.

- Three hundred and seventy thousand outpatients will visit Groote Schuur hospital of whom 300,000 will be seen by specialists. One hundred and seventy thousand patients will attend medical clinics, 90,000 surgical and orthopaedic clinics and 40,000 to maternity and gynaecology clinics. Two thousand six hundred patients diagnosed with cancer will receive treatment at the cancer unit.
- Out of 3,000 patients who require renal dialysis 1,400 patients will receive dialysis at Groote Schuur Hospital. Only patients who qualify for kidney transplant, will receive dialysis. At least 50 kidney transplants will be performed.

6.3.3 Red Cross Children's Hospital

Red Cross War Memorial Children's Hospital will continue to provide comprehensive dedicated tertiary paediatric services with a wide range of sub-specialities.

The key focus areas for 2007/2008 are:

- Strengthening the consolidation of cardiac care services into single discipline tertiary services across the Red Cross Children's and Tygerberg Hospitals platform. Paediatric cardiac surgery has been regionalized at RCCH and it is aimed to perform a minimum of 300 cardiac operations in 2007/2008.
- Commencement of the consolidation of Nephrology and Paediatric surgery into single discipline tertiary services across the Red Cross Children's and Tygerberg Hospitals platform will be implemented in 2007/2008.
- The consolidation of paediatric tertiary services in line with the goals of the Comprehensive Service Plan.
- Ensuring quality surgical output will be a key priority for 2007/2008 and it is intended that an average of 750 operations per month in total inclusive of all the surgical disciplines, will be performed. A strong focus will placed on laparoscopic surgery.
- The paediatric transplantation programme is established at RCCH and the hospital is a national centre for the paediatric liver transplants. Fifty percent of the current waiting list of patients for renal transplants are from other provinces. Approximately 15 transplants (renal and liver) will be performed in 2007/2008.
- The management of diarrhoeal disease in collaboration with the Metro District Health Services will be strengthened and expanded and will include initiatives such as rapid transfer of dehydrated children by EMS, a rapid rehydration protocol and accelerated transfer of patients from RCCH to other level 1 and 2 units.
- Focus on nurse staffing with an emphasis on retention, mentoring and training and skills development. The key focus area will be on critical care nursing aiming to bolster staffing in ICU so that a minimum of 18 ICU beds can be supported at all times.
- Outreach and support by clinical staff in the areas of general paediatrics, cardiology, nephrology, paediatric surgery, neurology, neurosurgery and otorhinolaryngology will be expanded.
- Re-organisation of outpatient services with appropriate devolution of level 1 activities. This devolution of services will be supported by outreach and support from general paediatrics.
- Key quality of care objectives for 2007/2008 will include improvements in infection control, client satisfaction and monitoring and evaluation of morbidity and mortality.
- The key capital works programmes are the upgrading of the theatre complex through donor funding and the upgrade of wards.

7. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 5.8: Provincial objectives and performance indicators [CHS3]

OBJECTIVE	INDICATOR	HEALTH CARE 2010 TARGET	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)
INPUT									
Provide Central hospitals infrastructure in line with Healthcare 2010	Useable beds	1,460	2,474	2,405	2,472	2,470	2,380	1,460	1,460
	Useable beds per 1000 uninsured population	0.66	0.77	0.74	0.69	0.73	0.72	0.74	0.73
OUTPUT									
Provide services that adequately address the needs of inpatients, outpatients and trauma cases.	Number of inpatient days		741,380	743,310	695,990	740,820	720,152	452,965	452,965
	Number of outpatients treated (incl trauma)		1,098,867	1,114,363	1,183,390	1,234,028	1,202,654	611,503	597,914
	Number of patient day equivalents		1,109,509	1,116,712	1,092,450	1,152,163	1,121,037	656,799	652,270
Ensure accessible Central hospital services to the population of the Western Cape and other provinces.	Number of separations per annum		116,093	119,250	122,649	128,351	124,164	75,494	75,494
	Separations per 1000 uninsured population	52	34.1	34.5	34.9	53.5	53	51	50
EFFICIENCY									
Ensure efficient and cost effective utilisation of resources	Average length of stay	6	6.21	6.04	5.6	5.8	5.8	6	6
	Bed utilisation rate based on useable beds	85%	79.9%	82.1%	81.8%	82.0%	82.9%	85.0%	85.0%
	Expenditure per patient day equivalent		1,637	1,763	1,904	1,855	1,842	2,348	2,350
OUTCOME									
Ensure desired clinical outcomes	Case fatality rate for surgery-separations		3.67	3	3.1	3.0	3	3	3

Notes:
1. Due to a projected over expenditure in 2006/07 the beds in central hospitals have been reduced by 90 in 2007/08
2 Regional beds in central hospitals move to sub programe 4.1 in 2008/09

Table 5.9: Performance indicators for central hospitals [CHS4]

Indicator	Type	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	National target 2007/08
Input									
1. Expenditure on hospital staff as % of hospital expenditure	%	65	65.0	58	64.5	64	63	63	
2. Expenditure on drugs for hospital use as % of hospital expenditure	%	6.9	5.7	5.6	5.3	6	7	8	13
Process									
3. Operational hospital board	Y/N	Y	Y	Y	Y	Y	Y	Y	Yes
4. Appointed (not acting) CEO in place	Y/N	N	N	Y	Y	Y	Y	Y	Yes
5. Individual hospital data timeliness rate	Months	Y	Y	Y	Y	Y	Y	Y	Yes
Output									
6. Caesarean section rate	%	28.6	35	37.0	35	30	30	30	25
Quality									
7. Patient satisfaction survey using DoH template	%	100	100	100	100	100	100	100	Yes
8. Clinical audit (M&M) meetings at least once a month	%	100	100	100	100	100	100	100	Yes
Efficiency									
9. Average length of stay	Days	6.2	6.0	5.6	5.8	5.8	6.0	6.0	5.3
10. Bed utilisation rate (based on usable beds)	%	79.9%	82.1%	81.8%	82.0%	82.9%	85.0%	85.0%	75
11. Expenditure per patient day equivalent	R	1,637	1,763	1,904	1,855	1,842	2,348	2,350	1,877
Outcome									
12. Case fatality rate for surgery separations	%	3.67	3	3.1	3	3	3	3	3

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

The Central Hospital Services is allocated 30,67% of the vote in 2007 in comparison to the 33,03% allocated in the revised estimate of the budget for 2006/07. This amounts to a nominal increase of 1,78% or R38,034 million. From 2008/09 the equitable share funding of the level 2 beds in Central Hospitals is allocated to sub-programme 4.1.

An earmarked allocation of R51,206 million is made to Programme 5 in 2007/08 for the modernization of tertiary services.

Table 5.10: Trends in provincial public health expenditure for central hospitals (R million) [CHS5]

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	1,825,924,424	1,983,028,620	2,115,871,250	2,171,952,000	2,115,504,149	1,610,850,410	1,600,149,331
Total per person	391.32	418.49	448.50	453.35	434.82	326.04	318.92
Total per uninsured person	536.06	573.28	614.28	620.92	595.55	446.55	436.81
Total capital	9,914,000	14,578,000	36,131,000	34,185,000	50,669,000	68,852,000	67,336,000
Constant 2006/07 prices							
Total	1,827,213,244	1,984,340,640	2,117,677,800	2,171,952,000	2,112,920,030	1,604,378,322	1,590,789,627
Total per person	391.60	418.77	448.88	453.35	434.29	324.73	317.06
Total per uninsured person	536.44	573.65	614.80	620.92	594.82	444.76	434.25
Total capital	11,202,820	15,890,020	37,937,550	34,185,000	48,084,881	62,379,912	57,976,296

Programme 6: Health Sciences & Training

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

1. AIM:

Rendering of education, training and development opportunities for serving and potential employees of the Department of Health.

2. PROGRAMME STRUCTURE

Sub Programme 6.1: Nurse Training College (WCCN)

Training of nurses at undergraduate, post registration and post basic level. Target group includes actual and potential employees.

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

Education, training and development of rescue and ambulance personnel. Target group includes actual and potential employees.

Sub Programme 6.3: Bursaries

Provision of funding for health science and support 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 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

3.1.2 Legislative mandate

The provision of human resource development (HRD) services is mandated by key legislation and policy prescriptions such as example: Health Act, Nursing Strategy for South Africa, Skills Development Act, Skills Development Levies Act, HRD Strategy for South Africa, National Skills Development Strategy 2005 – 2010, etc.

3.1.2 Assessing training needs

A skills audit will be conducted in a phased approach to address the human resource development (HRD) requirements arising from the Comprehensive Service Plan (CSP). In 2007/2008, the initial focus of the skills audit will be:

- Nurses
- Pharmacists
- Emergency medical service personnel
- Administration components at service delivery sites.

The analysis of training needs and scarce skills is informed by the annual Workplace Skills Plan. In addition, the HWSETA and the PSETA produce the Sector Skills Plans which addresses HRD priorities for the public health sector.

This is supported by information from Persal reports including attrition trends, vacancy trends per occupational category per institution and regions, labour market trends and forces, supply and demand issues.

3.1.3 Planning

Planning for Human Resource Development addresses the educational needs of future employees based on the skills shortages in occupational groups within the Department. In addition, it addresses the developmental needs of serving personnel through assessing skills gaps against competencies required. Areas included are student intern and community service placements, 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.

3.1.4 Training strategy

The achievement of the goals of Healthcare 2010 is reliant upon the provision of constant supply of health science professionals and support staff at sustainable levels to ensure effective service delivery.

The dictates of service delivery as reflected in the Comprehensive Service Plan will impact on the Workplace Skills Plan and the prioritisation of training strategies.

3.1.5 Monitoring and Evaluation

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.

3.1.6 Partnerships

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 have been established with all the Higher Education Institutions in the Province.

A partnership has been entered into the Cape Higher Education Consortium (CHEC), which consists of the Universities of Cape Town, Stellenbosch and the Western Cape and also the Cape Peninsula University of Technology, to promote a regional platform for undergraduate training of nurses.

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.

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

The training strategy provided interventions for employees 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;
- Learnerships in a number of prescribed areas;

3.1.7 iKapa Elihlumayo Strategy (Provincial Growth & Development Strategy)

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 Nurses, Diagnostic Radiography 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, diagnostic radiographers and pharmacists. In addition, funding is offered to school leavers to pursue careers within the Department.

3.1.8 Social Capital: Expanded Public Works Programme

The Expanded Public Works Programme (EPWP) is a national programme designed to provide productive employment opportunities for a significant number of the unemployed, not only to earn an income but to facilitate their development of skills to improve their potential to gain employment.

To ensure a culture of service delivery with work creation as well as building mutually beneficial networks and relationships, the Department as part of the Social Sector Departments, has identified projects which include Community Based Ancillary Health Workers, i.e. community home-based care workers, integrated management of childhood illness (IMCI) community worker and TB DOTS community workers, Anti Retroviral Counselors (ARV) and Voluntary Counseling Testing (VCT) Counselors. These workers have been and continue to be up-skilled through the programme to become ancillary health workers in the first phase leading to a community health worker. In addition key learnerships will be extended in areas such as nursing and pharmacy assistants.

In line with the social and human capital strategies of the Western Cape Province, the Social Sector departments must create the long-term work opportunities in under-resourced communities and opportunities that trained personnel can then exit into, thereby bridging the gap between first and second economies.

Table 6.1: Outputs: Number of learners trained through Expanded Public Works Programme

	Financial year					
	2004/05	**2005/06**	**2006/07 Target**	**2007/08 Target**	**2008/09 Target**	**2009/10 Target**
General Education and Training Certificate in Ancillary Health Care: NQF Level 1	Not applicable	Not applicable	1,063	1,440	500	
National Certificate : Fundamental Ancillary Health Care : NQF Level 2	Not applicable	Not applicable		390	916	460
National Certificate : Community Health Work : NQF Level 3	Not applicable	Not applicable			360	843
Further Education and Training Certificate: Community Health NQF Level 4						332
Total	**Not applicable**	**Not applicable**	**1,063**	**1,830**	**1,776**	**1,635**

Notes:

[1] First year programme is based on part qualification of General Education and Training : Ancillary Health Care : 20 unit standards

[2] Training programme based on unit standards drawn from four levels of Community-Based Worker Qualifications

Note that the training for the 2009/10 year is dependent upon either funding received via Departmental policy options, alternatively from additional funding from the National Treasury

3.2 Key challenges over the strategic plan period

- Implementation of the centralisation of the 1% skills development levy.
- Improvement and maintenance of competencies of health professionals at district level (MOCOMP).
- Development of a placement framework for all graduating bursars.
- Development of a framework for clinical placement of learners.
- Development of Training and Development strategies for priority categories of personnel as per the Comprehensive Service Plan
- Development of a comprehensive nurse training and development strategy.

3.3 Policy and Priority perspectives

The policy on iKapa Elihlumayo and the Healthcare 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-out plan that supports the development and provision of a critical mass of health workers from the Department to enable it to render its core business of health service delivery.

The development of the HRD aspect of the Human Resources Plan. Ensuring synergy between the HRD Plan and Workplace Skills Plan through the development of the competencies of the skills development facilitators.

The Department remains a committed partner in meeting health service needs through the education and training of health practitioners.

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 6.2: Outputs: Number of expected nursing graduates

4th year students	Academic year					
	2004	2005	2006	2007	2008	2009
	Financial year					
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
R 425 Diploma (Bursary students)	0	0	146	55	150	195
R 425 Diploma (Salaried students)	121	147	5	4	0	0
B Cur (Bursary students)	3	90	146	359	160	198
B Cur (Salaried students)	84	21	2	0	0	0
Total number of qualified nurses	**208**	**258**	**299**	**418**	**310**	**393**

Notes:

1 Salaried students will be phased out by the 2006 and 2007 academic year respectively

2 Bursary system introduced at WCCN during the 2003 academic year. Due to 4-year lead-time of training, the first intake of **R 425 Diploma (Bursary students)** will graduate for the earliest at the end of the 2006 academic year.

3 20 Salaried Students will complete their studies in quarter 3 of 2006/07: 16 Bursary and 4 salary students will complete in 2007/08: Lead-time of training is 4 years.

4 No intake at WCCN for the 2004 academic year. This will reduce the number of potential **R 425 Diploma (Bursary students)** graduates for the 2007/08 financial year.

Table 6.3: Outputs: Number of expected General Nurses: Enrolled Nurses (EN) to Registered Nurses (RN)

4th year students	Academic year					
	2004	2005	2006	2007	2008	2009
	Financial year					
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
Part-time Bursaries: EN to RN	25	19	20	50	50	50
Learnerships (18.1): EN to RN	0	0	22	7	45	40
Part-time self study: EN to RN	19	63	25	[3]	[3]	[3]
Total number of general nurses	44	82	67	57	95	90
Total: Graduates: RN Total qualified nurses (Table 6.2) + number of general nurse	**252**	**340**	**366**	**475**	**405**	**483**

Notes:

1 Learnerships for this category commenced in the 2005/2006 Financial Year (FY)

2 Students will complete their studies in quarter 4 of the respective FY: Lead-time of training is 2 years

2 Information currently not available

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 for possible expansion, funding being provided within the Extended Public Works Programme for the Social Sector.

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 Healthcare 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

- 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)
- Health Act, 1977 (Act No. 63 of 1977)
- Nursing Act, 1978 (Act No. 50 of 1978)

Policies and Plans

- Human Resource Development Strategy for South Africa, 2001
- Human Resource Development Strategy of the Public Service, 2002
- National Skills Development Strategy II
- National Human Resource for Health Plan
- Nursing Strategy for South Africa
- Western Cape Provincial Health Plan, 1995
- Health Care 2010, 2002 (WC)
- ikapa Elihlumayo, 2003 (WC)
- Departmental Human Resource Development Policies

4.2 STRATEGIC PRIORITIES

The key strategic priorities to be addressed within the Healthcare 2010 plan context includes the following:

4.2.1 Addressing the shortfall in the number of professionals being trained in order to meet future service requirements by:

1) Alignment of HRD strategies with the Comprehensive Service Plan, key legislation and policies;
2) Implementation of Skills Audit;
3) Continued delivery on the Expanded Public Works Programme;
4) Increasing the critical mass of nurses based on health service needs and priorities;
5) Increasing the 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, emergency medical service practitioners);
6) Effective placement of medical interns and community service: Health professionals;
7) Supporting the broadening of clinical teaching / learning platform to widen access to health science students in support of recruitment and retention;
8) Increasing the critical mass of pharmacist assistants, enrolled nurse assistants and enrolled nurses through the learnership programme;
9) Implementation of management leadership programmes.

4.2.2 Ensuring the relevance and quality of training programmes by:

1) Incorporating the Comprehensive Service Plan Training priorities into the Workplace Skills Plan
2) Strengthening partnerships with Higher Education Institutions.

4.2.3 Addressing the training skills and competencies gap, both in-service and pre-service are:

1) Training programmes for clinical nurse practitioners;
2) Re-orientation programmes for primary health care;
3) Training programmes for mid-level workers through short courses, learnerships, mentoring;
4) Enhancing capacity of health science professionals through encouraging appropriate CPD training;
5) 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; and
6) 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.
7) Development of a framework to ensure professionalisation of Human Resource Development practitioners.
8) Development of a comprehensive management leadership programme.

4.4.4 The training strategy will include interventions in the following key areas:

1) Functional/generic training to ensure competency on the job;
2) Technical skills training to support specialist / dedicated areas of skills;
3) Management training to support effective management of all public resources and policy implementation;
4) Computer-based training to increase and enhance efficacy and efficiency levels;
5) Learnerships to alleviate unemployment and increase employability;
6) In-service training to ensure continuous professional development; and
7) Strengthen Provincial Web based Human Resource Development Information system.
8) Quality assurance of education training and development interventions.

5. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.1 Budget Constraints

Some of the prioritized Training may not be implemented due to Budget constrains.

Measures to overcome constraint

Alternative funding sources for education, training and development will be explored.

5.2 HRD Information System

Inadequate fragmented systems

Measure to overcome constraints

Ensure development of an effective and efficient decentralised information system as a planning and monitoring instrument.

5.3 Human Resource Constraints

Insufficient staff within the Directorate.

Measure to overcome constraints

Capacity Audit to assess the required number of staff as per the HRD objectives.

Table 6.4: Provincial objectives and performance indicators for human resource development [HR2]

Programme 6.1: Nurse Training College

Objective	Indicator	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (target)	2008/09 (target)	2009/10 (target)
6.1.1 Basic Nurse Training: 1. R425 Nursing Diploma Programme and B Cur Nursing Science Programme 2. Post Registration ProgrammeR254 – 1 year MidwiferyR880 – 1 year PsychiatryR276 – 1 year CNS	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	177 [1&2]	0 [2&4]	188 [2]	197 [2&3]	270 [2&3]	222 [2&3]	222 [2&3]
	2nd Year	174	172	17 [4]	178 [3]	195 [3]	218 [3]	222 [3]
	3rd Year	208	163	139	48 [3&4]	165 [3]	181 [3]	214 [3]
	4th Year	196	205	158	154	58 [3&4]	155 [3]	178 [3]
	Sub-Total: Basic Nurse Training							
	Output: Progression of successfully trained nurses based on year 1 to year 4 per financial year Target: 85% graduates per programme							
	R425 Nursing Diploma Programme and B Cur Nursing Science Programme	645	404	474	491	542	660	711
	Post Registration - Midwifery				23	30	35	40
	Post Registration - Psychiatry					25	30	35
	Post Registration – CNS						25	30
6.1.2 Post basic nurse Training	Input: Number of Professional nurses admitted to the post-basic & post-registration nurse-training programme. (Employees)							
	1. Critical Care: General	13	12	19	16	18	22	25
	2. Critical care: Trauma	0	3	2	2	4	6	6
	3. Operating Theatre	9	11	10	11	18	22	25
	Sub-Total: Post Basic Nurse Training	22	26	31	29	40	50	56
	Output: Progression of successfully trained Professional nurses							
	Target: 99% graduates per programme	21	25	29	29	40	50	55
	GRAND TOTAL: Nurse Training	777	566	533	606	728	826	892

Notes:
1 Bursary system introduced at WCCN.
2 This projection is reflected under sub-programme 6.1 and sub-programme 6.3.
3 This includes failures of the previous academic years, which is based on a 15% attrition (failure) rate per year of study.
4 No intake at WCCN for the 2004 academic year. This will reduce the bursary numbers for the subsequent 3 financial years.

Sub Programme 6.2: EMS Training College

Objective	Indicator	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (target)	2008/09 (target)	2009/10 (target)
6.2 EMS Training Monitor and evaluate the EMS training programmes	Number of intake of students for training per year.							
	1. National Diploma EMC (3-Yr Course)	60	60	123	141	161	181	201
	2. Paramedic (1-Yr Course)	14	12	14	0	24	24	24
	3. AEA (5- Months Course) (Being phased out)	75	24	83	0	0	0	0
	4. BAA (5- Week Course)	200	24	36	0	24	24	24
	5. BMR (5- Week Course)	16	30	12	24	24	24	24
	6. Flight Medical (2- Weeks Course)	15	0	0	14	14	14	14
	7. CPD Training (1 to 2 Days Course)	100	262	359	350	400	450	500
	8. IMR (Being phased out)	12	0	0	0	0	0	0
	9. Level 3 (Being phased out)	100	46	0	0	0	0	0
	10. National Cerificate: EMC (1-YR Course)	0	0	0	35	0	0	0
	GRAND TOTAL: Number of new intake	**592**	**300**	**647**	**564**	**647**	**717**	**787**
	Number of graduates per programme							
	1. National Diploma EMC (3-Yr Course)	50	37	13	15	15	15	15
	2. Paramedic (1-Yr Course)	12	9	11	0	20	20	20
	3. ~~AEA (5- Months Course)~~ (Being phased out)	65	21	32	0	0	0	0
	4. BAA (5- Week Course)	170	22	29	0	20	20	20
	5. BMR (5- Week Course)	14	28	11	22	22	22	22
	6. Flight Medical (2- Weeks Course)	12	0	0	12	12	12	12
	7. CPD Training (1 to 2 Days Course)	85	262	359	340	380	430	467
	8. IMR (Being phased out)	10	0	0	0	0	0	0
	9. Level 3 (Being phased out)	0	43	0	0	0	0	0
	10. National Cerificate: EMC (1-YR Course)	0	0	0	21	0	0	0
	GRAND TOTAL: Number of learners to complete programmes per year.	**418**	**276**	**475**	**410**	**469**	**519**	**556**

Notes

1. 1-year Paramedic program to be reinstated due to poor paramedic qualification outputs by CPUT
2. BAA program to be reinstated to train school leavers entering intern program
3. The Course redesigned for compliance with HPCSA accreditation standards.
4. Entrance level course for BAA ([1]) course. No longer required as limited capacity on BAA.
5. National Certificate not registered by CPUT. To be replaced by 2 year Mid-level worker program

Sub Programme 6.3 Bursaries

Objective	Indicator	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (target)	2008/09 (target)	2009/10 (target)
6.3.1 Nursing Bursaries	Input: 1. Number of new bursary students admitted to nurse training (basic and post-basic nursing)							
	1.1. Bridging Nurse Training – Mid Level (ENA To EN and EN To RN)							
	ENA to EN	27	0	0	40	40	50	100
	ENA to RN	35	24	89	60	20	50	150
	Sub-Total: Bridging Nurse Training	**62**	**24**	**89**	**100**	**60**	**100**	**250**
	1.2. Basic Nurse Training							
	R425 Nursing Diploma	169	0	174	200	270	300	350
	B Cur Nursing Science	188	407	181	300	230	350	350
	Sub –Total: Basic Nurse Training	**357**	**407**	**355**	**500**	**500**	**650**	**700**
	1.3. Post basic Nurse Training							
	(Clinical specialty/ non clinical for RN)	118	65	131	90	180	190	200
	TOTAL: Number of new students admitted to nurse training	**537**	**496**	**575**	**690**	**740**	**940**	**1150**
	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 to RN	35	26	35	32	34	50	50
	2.2. Basic Nurse Training							
	R425 Nursing Diploma	0	164	117	396	349	615	690
	B Cur Nursing Science	119	263	504	431	534	1035	1110
	Sub –Total: Basic Nurse Training	**119**	**427**	**621**	**827**	**883**	**1650**	**1800**
	2.3. Post basic Nurse Training	50	61	23	34	21	50	45
	TOTAL: Maintenance of existing nursing bursaries	**204**	**514**	**679**	**893**	**938**	**1750**	**1895**
	GRAND TOTAL: Nursing Bursaries	**741**	**1010**	**1254**	**1583**	**1678**	**2690**	**3045**
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	115	69	80	100	130	125	118
	1.1.2 Support Services	0	0	0	0	0	0	0
	Sub –Total:	**115**	**69**	**80**	**100**	**130**	**125**	**118**
	1.2 Part-time studies	71	0	69	108	125	80	90
	TOTAL: Number of new students admitted to health science training	**186**	**69**	**149**	**208**	**255**	**205**	**208**
	2. Maintenance of existing bursaries							
	2.1. Full-time studies.							
	2.1.1 Health Science	133	227	182	171	189	183	191
	2.1.2 Support Services	2	0	0	0	0	0	0
	Sub –Total:	**135**	**227**	**182**	**171**	**189**	**183**	**191**
	2.2 Part-time studies	95	64	48	69	88	77	82
	TOTAL: Maintenance of existing health science bursaries	230	291	230	240	277	260	273
	GRAND TOTAL: Bursaries for Health Science, excl. Nursing	416	360	379	448	532	465	481
TOTAL NUMBER OF BURSARIES		**1157**	**1370**	**1633**	**2031**	**2210**	**3155**	**3526**

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.

Sub Programme 6.4: Primary Health Care Training

Objective	Indicator	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (target)	2008/09 (target)	2009/10 (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	5467 [2]	3180	2206	3500	4000	4200	4500

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] Figures for generic non-service delivery included in total

Sub Programme 6.5: Training (Other)

Objective	Indicator	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (target)	2008/09 (target)	2009/10 (target)
6.5.1 Levy payment to HWSETA		R 1 654	R 1 873	R 1 942	R 2 065	R 2 170	R 2 280	R 2 394
Notes [1] Administrative levy payable to HWSETA in terms of skills development legislation.					**Target as per WSP**			
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	15286	15897	12184	10964	16600	16600	16000
6.5.3 Management and Leadership Development Skills 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	663	731	1217	1397	1500	1600	1600
6.5.4 ABET Ensure appropriate development of human resources to support health delivery through the provision of ABET training	Number of ABET learners registered for courses.	545	1189	474	350	350	330	300
	Number of ABET interventions		1189	1916	1200	1200	1100	1000

Objective	Indicator	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (target)	2008/09 (target)	2009/10 (target)
6.5.5 Learnerships	**Number of learnerships: employees: 1.1 Nursing**							
Ensure appropriate development of human resources to support health delivery through the provision of learnerships for personnel	1.1.1 EN to RN	0	20	7	45	40	20	25
	1.1.2 ENA to EN		116	50	38	35	65	70
	1.1.3 Post Basic: Critical Care		19	7	7	15	30	40
	1.1.4 Post Basic: Operating Theatre		11	1	6	15	20	30
	1.1.5 ENA		31	15	0	25	25	30
	Sub-Total: Nursing		**197**	**80**	**96**	**130**	**160**	**195**
	1.2 Pharmacist Assistant:	0						
	1.2.1 Basic		121	18	2	25	25	30
	1.2.2 Post basic		65	16	11	25	30	35
	Sub-Total: Pharmacist Assistant		**186**	**34**	**13**	**50**	**55**	**65**
	TOTAL: Learnerships: Employees: 18.1	**0**	**383**	**114**	**109**	**180**	**215**	**260**
Contribute to the goals of iKapa Elihlumayo through provision of learnerships for unemployed people	**Number of learnerships: Unemployed: 2.1 Nursing**							
	2.1.1 EN to RN				2	15	15	20
	2.1.2 ENA to EN	0	2	15	60	40	30	20
	2.1.3 ENA	19	75	50	0	20	30	40
	Sub-Total: Nursing	**19**	**77**	**65**	**62**	**75**	**75**	**80**
	2.2 Pharmacist Assistant	0						
	2.2.1 Basic		27	16	15	20	25	30
	2.2.2 Post basic		0	10	19	20	20	25
	Sub-Total: Pharmacist Assistant		**27**	**26**	**34**	**40**	**45**	**55**
	2.3 Diagnostic Radiography			15	35	35	30	35
	TOTAL: Learnerships: Unemployed: 18.2	**0**	**104**	**106**	**131**	**150**	**150**	**170**
	GRAND TOTAL: LEARNERSHIPS	**19**	**487**	**220**	**240**	**330**	**365**	**430**

Objective	Indicator	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (target)	2008/09 (target)	2009/10 (target)
6.5.6 Internships Partner Higher Education Institutions to contribute to the growth and development of the province through the provision of internships	Number of interns placed	21	77	127	130	130	130	130
6.5.7 Expanded Public Works Programme 7: Provide training opportunities for a significant number of the unemployed persons to facilitate access to employment	**Number of Community Based Health workers trained:**							
	1.1 General Education and Training Certificate : Ancillary Health Care NQF Level 1: 13 unit standards	N/A	N/A	N/A	1056			
	1.2 General Education and Training Certificate : Ancillary Health Care NQF Level 1: 17 unit standards					1050		
	1.3 General Education and Training Certificate : Ancillary Health Care: NQF Level 1					640	500	
	1.4 National Certificate : Fundamental Ancillary Health Care : NQF Level 2					915	916	460
	1.5 National Certificate : Community Health Work: NQF Level 3						360	843
	1.6 Further Education and Training Certificate: Community Health: NQF Level 4							332
	1.7 VCT / HRV Counselors: General Education and Training Certificate : Ancillary Health Care NQF Level 1: 13 unit standards				24			
	GRAND TOTAL: COMMUNITY BASED HEALTH WORKERS				**1080**	**2605**	**1776**	**1635**

Notes
1 Data collected via Quarterly Training Reports.
2 Target group is Senior Officials, Deputy Directors, and Assistant Directors. In addition personnel, in other categories who have financial / management responsibilities
3 Figures reflect ABET and AFET interventions from ABET level 1 to NQF level 4.
4 Learnerships: Enrolled Nurse Assistants, Enrolled Nurses, Post Basic Nursing. Pharmacist Assistants: Subject to funding by HWSETA.
5 The target will be revised due to the re-prioritisation by HWSETA of learnership funding.
6 Internships: workplace-learning opportunities for students (excludes Health Professional interns)
7 Funding available from 2006 / 2007 Financial Year.
8 The target will be revised due to service delivery pressures currently experienced resulting in the Non-Profit Organisations (NPO's) not being able to release the targeted numbers of learners for training.

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 6.5: 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	2008/09	2009/10	National target for 2007/08
Input											
1. Intake of medical students	No	201 US only	419 US + UCT	418 US + UCT	413 US + UCT	200 UCT	200 UCT	200 UCT			
2. Intake of nurse students	No	73	81	98	0						
3. Students with bursaries from the province	No	66	222	274	229	62					
Process											
4. Attrition rates in first year of medical school	%	23	17	23	20	0					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	129 US only	344 US + UCT	293 US + UCT	302 US + UCT	147 UCT					
7. Basic nurse students graduating	No	198	213	253	263	216	298	445			
8. Medical registrars graduating	No	32 US only	58 US + UCT	50 US + UCT	41 US + UCT	12 UCT					
9. Advanced nurse students graduating	No	133	214	299	341	154	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:

1. Information received from University of Cape Town reflects from years 2002/2003 to 2007 / 2008
   Information received from University of Stellenbosch reflects from 2001 / 2002 to 2004 / 2005
   Information from University of the Western Cape has not been received.

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.

A letter has been sent to the registrar's of the respective HEI's requesting this information and we await their response.

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

An earmarked allocation of R2,052 million in 2007/08 for the purpose of Emergency Medical Services training.

An earmarked allocation of R49,054 million in 2007/08 for the Expanded Public Works Programme (EPWP) which is intended to provide an opportunity for the training of unemployed persons as community based health workers, nursing assistants and pharmacist's assistants. A portion of these funds will also be allocated directly to the home-based care programme provided by contracted NPOs.

Health Sciences and Training is allocated 2.00 percent of the vote in 2007/08 in comparison to the 1,57 percent of the revised estimate of the budget that was allocated in 2006/07. This amounts to a nominal increase of 40,26 percent or R40,821 million.

Table 6.6: Trends in provincial public health expenditure for Health Sciences and Training (R million) [HR5]

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	71,115,814	73,541,000	79,009,000	101,393,000	142,214,000	177,064,000	187,459,000
Total per person	15.24	15.52	16.75	21.16	29.23	35.84	37.36
Total per uninsured person	20.88	21.26	22.94	28.99	40.04	49.08	51.17
Constant 2006/07 prices							
Total	80,360,870	80,159,690	82,959,450	101,393,000	134,961,086	160,419,984	169,837,854
Total per person	17.22	16.92	17.58	21.16	27.74	32.47	33.85
Total per uninsured person	23.59	23.17	24.08	28.99	37.99	44.47	46.36

Programme 7: Health Care Support Services

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

1. AIM

To render or provide the best Health Care Support Services to Hospitals, Clinics and Mortuaries.

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

Linen and Laundry services are provided by large central laundries located at Tygerberg, Lentegeur and George Hospitals. Several rural hospitals have small in-house laundries. A large portion of the service has been successfully outsourced resulting in reduced costs and improved availability of linen. The outsourcing has resulted in a reduction in overtime worked at in-house laundries.

During the 2006/07 financial year, a tunnel washer and the high speed ironer were purchased to the value of R12 million. It is envisaged that an additional R20 million will be required to replace ageing equipment and to conform to the South African National Standard.

3.2 Policies, Priorities and 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 priority has been 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.In the future, further outsourcing will be considered s this could lead to both cost savings and service improvement.

3.3 Constraints and Planned Measures

The relatively high salaries of in-house laundry personnel compared with the private sector are a significant constraint to making these laundries cost competitive. A gradual reduction in staff coupled with morale building and training has significantly improved productivity. The problem facing the laundry service is aging equipment that must be replaced at high cost.

The lack of capacity in the private sector in the Western Cape continues to have a negative effect on laundry service costs. Period contracts have been extended from 2 years to 5 years to make contracts financially viable for private contractors. A plan to build capacity has been developed and will incorporate a procurement process that provides time for emerging contractors to set up laundry operations.

3.4 Planned Quality Improvement Measures

There is plan to replace all ageing equipment over the next 5 years and maintain two in-house strategic laundries in the Cape Metropole, one at Tygerberg Hospital and one at Lentegeur Hospital. A tunnel washer was purchased and installed during the third quarter of 2006/07. The high speed ironer will delivered during the first week of March 2007 and will be commissioned before the end of March 2007. This will improve the service delivery including the production of pieces laundered in-house.

It is planned also to upgrade the Lentegeur Laundry as part of the new Mitchell's Plain Hospital project. The upgrade will include the purchase of new equipment.

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	2002/03 (actual)	2003/04 (estimate)	2004/05 (actual)	2005/06 (estimate)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)
Provide a laundry service to all provincial hospitals	Total number of pieces laundered:	21m	21m	18m	20m	20m	21m	21m	21m
	Number of pieces laundered: in-house laundries	14.4m	17m	14m	14m	14m	14m	14m	14m
	Number of pieces laundered: outsourced services	7.6m	5m	4m	6m	6m	7m	7m	7m
Provide cost effective in-house laundry service	Average cost per item	R1.50	R1.68	R1.81	R1.74	R1.74	R1.74	R1.74	R1.74
Provide cost effective out-sourced laundry service	Average cost per item	R1.10	R1.15	R1.30	R1.48	R1.60	R1.73	R1.73	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 HOSPITAL, CLINICAL AND GENERAL ENGINEERING SERVICES

4.1 SITUATION 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 currently there are no staff, or staff with limited capabilities. Two General Engineering Workshops (located at Bellville and Zwaanswyk) and one Clinical Engineering Workshop (located at Vrijzee, Goodwood) provides support to the hospitals, clinics and mortuaries. The Bellville, Goodwood and Zwaanswyk workshops employ engineers, technicians and artisans that are able to assist hospitals, clinics and mortuaries with larger and more complex maintenance and repair work based on medical equipments, general engineering equipments, buildings, etc.

4.2 POLICIES, PRIORITIES AND OBJECTIVES

The hospital workshop personnel and the Directorate Engineering and Technical Support do all hospital maintenance and repairs of hospital equipment.

Maintenance of buildings is a joint venture with Department of Transport and Public Works (DTPW). The latter undertake all major construction, repair and maintenance work at hospitals including clinics and mortuaries. The Directorate Engineering and Technical Support Services are responsible for prioritising and defining the repair and maintenance work to be done by DTPW.

The most urgent priority is to address the backlog of maintenance and rehabilitation of hospital infrastructure including clinics and mortuaries. This is to be achieved by focussed use of maintenance and Provincial Infrastructure Grant funding and the upgrading of Hospitals in terms of the Hospital Revitalisation Programme.

4.3 ANALYSIS OF CONSTRAINTS

4.3.1 Challenges

- History of an inadequate funding for the maintenance assets.
- Inadequate workshop personnel at institutions including Engineering Workshops.
- Lack of planned daily/monthly/quarterly inspections, conditional running inspections and/or situational analysis resulting in no preventative maintenance.
- No tracking system for asset movements or write off's of obsolete assets resulting in no asset management.
- No Quality Management System

4.3.2 Maintenance Backlog

4.3.2.1 Clinics and Community Health Centres

There is a large and as yet undefined backlog of maintenance work in respect of Community Health Facilities.
The transfer of 183 primary health care facilities to the Provincial Government from Local Government poses a major challenge. Future budgets will have to make provision for major maintenance work to these facilities and where appropriate replacement.

4.3.2.2 Provincial Hospitals

The maintenance backlog is increasing annually. A survey undertaken by the Department of Transport and Public Works in 1999 and estimated the backlog of urgently needed maintenance backlog to be approximately R500 million.

Table 7.2: Maintenance backlog per institution

	R'0000
Boland / Overberg Region	14,635
Southern Cape / Karoo Region	34,035
West Coast Region	8,180
Metropole Region	40,100
Groote Schuur Hospital	72,960
Tygerberg Hospital	93,525
Red Cross Hospital	53,485
APH (Associated Psychiatric Hospitals)	35,987
CHC (Community Health Centres)	43,900
Engineering	19,030
TOTAL	**415,837**

4.4 PLANNED QUALITY IMPROVEMENT MEASURES

- The possibility of outsourcing some of the critical maintenance services is being considered. This initiative could eradicate maintenance backlog including the above mentioned challenges. CSIR is currently conducting study around the outsourcing of some of the engineering services. The phase 1 of the study will be completed at the end of March 2007 and a way forward will be proposed during April 2007.
- There are plans regarding the implementation of an effective preventive maintenance programme for all the Department facilities including critical equipments. The aim being to reduce major breakdowns and the associated costs and overtime related to major repair work. This plan will linked to the Asset Maintenance Management System.
- There are plans regarding the procurement of an updated Asset Maintenance Management System to:
  1) Track asset movement and write-off of equipment and assets.
  2) Provide accurate and useful maintenance reports.
  3) Provide an asset register including a help desk for all calls/queries.
  4) Comply with the requirements of the Public Finance Management Act and Supply Chain Management.

Table 7.3: Planned Maintenance Expenditure by type [HFM 1]

R 000's	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Maintenance & minor capital	71677	65102	48538	73197	84269	89380	102787
Equipment	92679	123948	114436	116000	120000	124000	128000
Equipment (Donor RCCH)	9 734	3 737	0	0	0	0	0
Equip maintenance	50426	55871	58665	61598	64678	67912	71308
Total capital	**224516**	**248658**	**221639**	**250795**	**268947**	**281292**	**302095**

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 7.4 Physical condition of hospital network

Hospitals by type	Average 1996 NHFA condition grading[1]	*Estimated grading 2005	Outline of major rehabilitation projects since last audit
DISTRICT HOSPITALS			
Beaufort West	4	4	The replacement air conditioning system including ventilation. New admin, pharmacy and casuality.
Caledon	4	3	Replacement of incinerator; routine maintenance; and internal repairs & renovations including painting.
Ceres	5	4	Installation of new air conditioning units including incinerator; routine maintenance; and internal & external repairs and renovations.
Citrusdal	4	4	Internal and external renovations and painting.
Eerste River	N/A	3	Routine maintenance only
False Bay	4	4	Internal and external renovations. Extended the OPD
Hermanus	4	2	Internal and external repairs & renovations; and Routine maintenance.
Knysna	4	3	OPD Internal and external renovations and painting.
Ladismith	4	4	Routine maintenance only.
LAPA Munnik	4	4	Routine maintenance only.
Montagu	2/3	3	Internal and external renovations and painting.
Mossel Bay	4	2	Partial internal and external renovations and painting. New causality.
Otto du Plessis	3/4	4	Routine maintenance only.
Oudtshoorn	4	4	Routine maintenance only.
Riversdale	4	3	External renovations and painting.
Robertson	4	3	Routine maintenance only.
Stellenbosch	4	3	Roof replaced.
Swartland	4	3	Roof replaced and kitchen upgraded.
Swellendam	4	3	Routine maintenance only.
Vredenburg	3	2	Comprehensive revitalisation is progress
Vredendal	4	4	Casualty upgraded.
Wesfleur	2	3	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			
Eben Donges	4	3	Comprehensive revitalisation in progress.
GF Jooste	4	3	Casualty upgraded OPD and staff amenities block added
George	4	5	Comprehensive revitalisation in progress.
Hottentots Holland	3	1	Maternity wing upgraded.
Karl Bremer	4	4	Central steam installation converted to point of use electrical heating. Wards and reception upgraded for "private" and hospital patients.

Hospitals by type	Average 1996 NHFA condition grading[1]	*Estimated grading 2005	Outline of major rehabilitation projects since last audit
Paarl	3	2	Casualty upgraded. Central steam installation converted to point of use electrical heating. Revitalisation in progress
Somerset	4	2	Central steam installation converted to point of use electrical heating.
Victoria	2	1	Substantial external renovation of buildings. Central steam installation converted to point of use electrical heating.
CENTRAL HOSPITALS			
Groote Schuur	5	3	Major renovations and improvements to maternity block and OPD.
Red Cross	4	3	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. New Trauma Unit added. New oncology ward built. The upgrading of the Ward is in progress
Tygerberg	3	2	Pharmacy upgraded. Several wards renovated.
TUBERCULOSIS HOSPITALS			
Brewelskloof	4	4	Extensive internal and external repairs and renovations
Brooklyn Chest	4	2	Ongoing internal and external renovation of wards. Installation of UV lights in progress.
PROVINCIALLY AIDEDED TB HOSPITALS			
DP Marais SANTA	4	4	Ablutions upgraded.
Harry Comay SANTA	1	1	Minor renovations and painting.
PSYCHIATRIC HOSPITALS			
Alexandra	3	3	Administration and teaching/clinic blocks upgraded. Standby generator replaced.
Lentegeur	4	4	Renovation of ward blocks in progress.
Nelspoort	3	3	Central steam installation converted to point of use electrical heating. The upgrading of the wards has been completed
Stikland	4	2	Several ward blocks renovated.
Valkenberg	3	2	New admissions ward has been added.
CHRONIC MEDICAL AND OTHER SPECIALISED HOSPITALS			
KBH Rehabilitation			None – has been relocated to Lentegeur
Mowbray Maternity	3	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 HOSPITALS			
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

*The estimated 2005 grading is based on routine inspections by the Engineering personnel and the requirements of Healthcare 2010.

HFA grading

Category	Description
5	As new; appropriate (purpose designed) for proposed use; requires almost no attention; annual maintenance allowance should be 1% of budget; zero backlog maintenance
4	Good condition; generally suitable for use; needs normal maintenance, or minor repairs or alterations to remain in use; annual maintenance allowance should be 3% of budget; zero backlog maintenance
3	Poor condition; requires major repairs and/or is unsuitable for its proposed use, but rehabilitation or alterations will not exceed 65% of replacement cost; annual maintenance allowance should be 8% of budget; average cost of refurbishment 50% of replacement cost
2	Replace; requires major repairs or is unsuitable for its current function, such that renovation costs would exceed 70% of replacement cost; annual maintenance allowance should be at least 8% of budget, but may not be worthwhile unless no replacement will be available
1	Condemn; should be demolished and replaced; effectively no useful value

4.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.2

Table 7.5: 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:** R4 700 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	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)
Effective maintenance of buildings and engineering installations	Maintenance backlog as % of replacement value	9%	8%	8%	7%	7%	6%	6%
Efficient engineering installations	Cost of utilities per bed	R3 600	R5 560	R4 200	R4 700	R5 500	R5 500	R5,500
Safe working environment (Buildings, machinery and equipment)	Number of reportable incidents	300	291	300	300	220	180	160
Cost effective maintenance of medical equipment	Number of jobs completed – in-house/ outsourced	11 200	10 507	12 800	13 800	15 300	16 700	17 000

5. SUB-PROGRAMME 7.3 – FORENSIC SERVICES

Funding for Forensic Services has been transferred to Sub-programme 2.8

6. SUB-PROGRAMME 7.4 – ORTHOTIC AND PROSTHETIC SERVICES

6.1 Situation Analysis

The Orthotic and Prosthetic service is provided from a single provincial centre situated in Pinelands. Orthotists and prosthetists attend orthopaedic clinics throughout the province. The service in the Southern Cape/Karoo has been outsourced.

6.2 Policies, Priorities and Objectives

The current policy is to provide 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. Management is currently evlautating the possibility of totally outsourcing this service due to the challenges faced in keeping the service viable and cost effective. The broader strategic objective remains currently to ensure continuity of service delivery through an optimum mix of in-house and outsourced services.

6.3 Constraints and Planned Measures

A major constraint is the inability to attract and retain suitable skilled and experienced personnel. This can be attributed to a shortage of qualified orthotists and prosthetists and surgical boot-makers, coupled with uncompetitive salaries. The shortage is being addressed by in-house training programmes.

In order for to eradicate the current backlog, the following short terms and long terms are will be implemented during 2007/08:

- Procurement of Stock Ankle Foot Orthotics
- Salary level evaluation and possible adjustment
- Provide bursaries for people to train as Orthotists and Prosthetists. These bursaries will have contractual obligations.
- Outsource the backlog of prosthetic orders

6.4 Planned Quality Improvement Measures

Quality improvement focused 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.

Table 7.6: 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:** 5 400 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)	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (target)	2007/08 (target)	2008/09 (target)	2009/10 (target)
Render an Orthotic and Prosthetic service for the Province	Number of devices manufactured	4,500	5,884	**4,109**	5,200	6,000	6,000	6,300	6,910
Provide quality Orthotic and Prosthetic devices	% of devices requiring remanufacture	5%	3%	**3%**	3%	2%	2%	2%	2%
Provide a responsive Orthotic and Prosthetic service	Number of patients on waiting list waiting over 6 months	600	600	**705**	800	400	400	200	100

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 and in smaller quantities to smaller institutions. The academic hospitals generally buy directly from suppliers and tend to use the CMD as a top-up service.

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 is responsible for the break up of bulk stock into manageable quantities to be used at institutions.

7.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The intention is to provide a comprehensive pharmaceutical and Medical and Surgical supply service to health institutions. Hence the Family Planning unit as well as the ARV depot will be incorporated as part of the Medical Depot. In order to render an effective service it is critical that the depot be relocated. Plans are underway to ensure that a suitable alternative venue is procured. A new computerised system will be implemented to ensure that all purchases and warehouse functions and issues to institutions are properly accounted for

The CMD needs sufficient working capital to maintain stock levels to provide adequate safety against supplier inefficiency and unplanned demands from institutions. The Capital Account was therefore augmented by R 2 million during the 2006/07 financial year. However, this amount of R43,808 million is still insufficient to meet all the demands as the depot on average carry R50m worth of stock at any given point in time. An inflationary increase has been provided in the 2007/08 financial year.

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 and other stock, taking into account the annual turnover of the CMD.

The current depot is inadequate to service demands effectively and the current physical infrastructure is being upgraded. A process is underway to find alternative premises to relocate the depot in the long term.

Compliance to the Pharmacy Act still remains a challenge. The current premises are under repair to ensure compliance to the Act.

The current establishment is inadequate to render an effective service to demanders. Work-study investigation was undertaken and is in the process of finalization to address this issue.
Another factor that also impacts on the CMD's ability to trade efficiently is the normal increase in the price of goods. Pharmaceuticals have increased in price on average by 8% per annum. Certain items have shown an abnormally high price increase, which has been masked by the unweighted averaging used.

7.4 PLANNED QUALITY IMPROVEMENT MEASURES

The CMD building is currently being renovated to ensure compliance with the Pharmacy Act requirements. Training of staff is underway to ensure that they meet the legislative standards. A new depot manager has been appointed that is currently developing and implementing best supply management practices.

1.1.1 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.5

Table 7.7: 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
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	Working capital	Working capital	1	Medsas	Yes

Objective	Indicator	2002/03 (actual)[2]	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/07 (estimate)	2007/08 (target)	2008/09 (target)	2009/10 (target)
Adequate working capital to support adequate stockholding	Working capital	R30,000,000	R32,000,000	R36,103,000	R41,268,000	R43,808,000	R50,000,000	R54,000,000	R58,320,000

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

Health Care Support Services is allocated 1,20 percent of the vote in 2007/08 in comparison to the 1,45 percent of the revised estimate of the budget that was allocated in 2006/07. There is a decrease of R8,200 million or 8,76 percent in nominal terms.

Table 7.8: Trends in Health Care Support Services expenditure (R million) [SUP2]

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	73,837,075	82,752,000	93,075,000	93,601,000	85,401,000	92,795,000	98,361,000
Total per person	15.82	17.46	19.73	19.54	17.55	18.78	19.60
Total per uninsured person	21.68	23.92	27.02	26.76	24.04	25.72	26.85
Constant 2006/07 prices							
Total	83,435,894	90,199,680	97,728,750	93,601,000	81,045,549	84,072,270	84,688,960
Total per person	17.88	19.04	20.72	19.54	16.66	17.02	16.88
Total per uninsured person	24.50	26.08	28.37	26.76	22.82	23.31	23.12

Programme 8: Health Facilities Management

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 Provincial 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

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.

3. SITUATION ANALYSIS

3.1 Community health facilities

On 1 March 2006 the Department of Health assumed responsibility for personal primary health care (PPHC) in the rural districts. The rural Local Authority clinics and Community Health Centres (CHC's) are in the process of being transferred to the Provincial Government by the Department of Transport and Public Works. Many of these facilities require additional infrastructure and changes to meet the requirements of the comprehensive service package. A superficial assessment and an initial estimate of costing to correct the primary health care facilities has been done. The initial estimate of funding needed amounts to R102,6 million. A more comprehensive assessment is now in progress and it is clear that the cost of upgrading will be substantially greater. It appears that a figure of R300 million is more realistic.

The PPHC facilities currently operated by the City of Cape Town in the Metro Region will continue to be operated by the City pending the resolution of the funding and transfer of the services to the Provincial Government.

3.2 Emergency Medical Services (EMS)

The EMS is a highly visible and essential service rendered by the Department. Unfortunately, the accommodation currently occupied by this service largely does not reflect the importance of the essential life saving service it renders.

The ambulance service was transferred from local government to the Provincial Government. A large number of the ambulance stations are still on municipal property. The remainder are located at provincial health facilities. Only a few ambulance stations are purpose built. The majority are accommodated inappropriately in buildings originally designed for other purposes and that have been severely neglected over the years. The cost upgrading and providing new ambulance stations is estimated at R85 million.

3.3 District Hospital Services

Healthcare 2010 underpins the district level health care model as the entry point to health care services and aims to provide equal access to quality health. The most densely populated area in the Western Cape, being the Cape Flats, is also the area were there are no district hospitals. An urgent requirement is for district hospitals to be provided for the uninsured population on the Cape Flats, and the construction of hospitals in Khayelitsha and Mitchell's Plain will begin to address the need. It is envisaged that the two new 230 bed hospitals will be funded as part of the Hospital Revitalisation Programme.

3.4 Provincial Hospital Services

The strengthening of the rural Regional Hospitals was identified as a priority for the implementation of Healthcare 2010. The revitalised George Hospital was opened in June 2006. Construction work on the revitalisation of Worcester and Paarl Hospitals is in progress.

The campaign to prevent the spread of TB and to provide adequate treatment for those infected requires a major improvement of the physical infrastructure. Most of the TB hospitals are housed in buildings that are no longer fit for purpose. A major concern is infection control to prevent cross infection between patients and to protect the hospital personnel.

The number of beds at the Psychiatric Hospitals have been substantially reduced over the past 10 years. The bed distribution is close to the 2010 bed plan. The upgrading of psychiatric hospitals has been prioritised by the National Department of Health. Valkenberg has been accepted into the Hospital Revitalisation Programme and planning for a replacement hospital is in progress. Stikland Hospital has been identified by the Province as the next priority psychiatric hospital for Revitalisation funding.

3.5 Central Hospital Services

The CSIR has completed a report on the condition and suitability of the physical infrastructure at Tygerberg Hospital. The recommendation is that it will be more economical to construct a new hospital than to upgrade and renovate the existing hospital.

The renovation and upgrading of the Red Cross Children's Hospital continues. The work is being funded by the Children's Hospital Trust with financial and technical assistance from the Provincial Government.

4. POLICIES, PRIORITIES AND STRATEGIC GOALS

4.1 Community health facilities

The community health facilities are to be upgraded to facilitate the shift of healthcare to the lowest appropriate level. In the MTEF period the priority will be to provide new CHC's in line with the requirements of the comprehensive Service Plan.

The construction of new CHC's in Simondium, Swellendam, Montagu, Stanford and Wellington is in progress. During the MTEF period new CHC's are planned for, Knysna (Witlokasie), Plettenberg Bay (Kwanakuthula), Malmesbury (Wesbank), Du Noon, Khayelitsha and Mitchells Plain, funding permitting.

4.2 Emergency Medical Service (EMS)

The substantial improvement of the Emergency Medical Service has been identified as a priority for the Department of Health. In support of this policy the intention is to relocate all ambulance stations to purpose built accommodation at appropriate hospital premises. It is planned to achieve this in the next 5 years utilizing Provincial Infrastructure Grant (PIG) funding.

The construction of new ambulance stations in Beaufort West and Atlantis is in progress. During the MTEF period new ambulance station are planned for, Hermanus, Riverdale, Caledon, Bredasdorp, Lentegeur, Ceres, Swellendam, Worcester and Vredenburg.

District Hospital Services

The provision of adequate Level 1 (District) beds in the Metropole is a priority for the Department of Health. During the MTEF period construction should commence on new District hospitals for Khayelitsha and Mitchell's Plain.

Hospital Revitalisation funding has been requested for new District hospitals to replace the Hottentots Holland and Mossel Bay Hospitals. Hospital Revitalisation funding has also been requested to build a replacement Victoria Hospital with additional Level 1 beds. It is also planned to build a replacement the Somerset hospital as part of the preparations for the Soccer 2010 World Cup. This hospital will provide Level 1 and Level 2 beds.

4.4 Provincial Hospital Services

Regional Hospitals are being strengthened to improve level 2 services and will expand the accessibility of general specialist services to the communities that need them most.

All of the TB Hospitals will be provincialised. To improve TB treatment, the hospitals presently operated by Local Authorities and NGO's will require significant upgrading after transfer to the Provincial Government. A proposal has been submitted to the National Department of Health for Brooklyn Chest Hospital to be improved and expanded as part of the Hospital Revitalisation Programme.

In respect of the Psychiatric Hospitals, Stikland Hospital has been identified as the next priority for Revitalisation funding.

4.5 Central Hospital Services

A business case has been submitted to the National Department of Health requesting that the rebuilding of Tygerberg hospital be part of the Hospital Revitalisation Programme. The existing infrastructure is not sustainable and its replacement is a high priority.

The priority projects at the Red Cross Children's Hospital are the upgrading of the wards and the extension and renovation of the operating theatre suite. The wards are being upgraded by the Trust using Provincial Infrastructure Grant funding. The Trust is in the process of raising R50 million from donors for the operating theatre project. Construction on the operating theatre complex is planned to commence in 2007.

5. ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.1 Hospital maintenance backlog

There is a serious backlog of maintenance work. In 1999 a survey done by Public Works estimated the backlog to be R500 million. It is estimated that this has grown to R800 million.

The construction of new hospitals under the Hospital Revitalisation Programme to replace the most dilapidated infrastructure will substantially reduce the hospital maintenance backlog. Similarly the upgrading of facilities using Provincial Infrastructure Grant funding will reduce the backlog. However, only once the additional funding for maintenance that is part of the Healthcare 2010 plan materialises will the maintenance reach the required level.

5.2 Community Health Facilities: Capital and maintenance backlog

There is a large and as yet undefined backlog of both capital and maintenance work in respect of Community Health Facilities. Capital funding has been allocated in the MTEF period to address the most urgently needed facilities. Additional capital funding should come from the disposal of surplus hospital property (e.g. Conradie Hospital) for new and replacement CHC's and clinics.

The transfer of 183 Community Health Facilities to the Provincial Government poses a significant challenge. No funding has been earmarked for major maintenance work to these facilities. Future budgets will have to make funding available.

5.3 Planning, design, construction and commissioning

There is a major capacity deficiency in respect of experienced technical and professional personnel both in the Departments of Health and of Transport and Public Works. This deficiency is hampering the planning, design, construction and commissioning process.

The appointment of personnel to comply with the requirements of the Hospital Revitalisation Programme will improve the capacity within Health. Public Works have advertised positions in an attempt to attract retired Engineers, Architects and Quantity Surveyors to improve capacity.

5.4 Programme management and accountability

The management of this programme poses a challenge, and in particular that which relates to financial administration and accountability. The present arrangement makes the Accounting Officer of Health accountable for all expenditure and the programme performance, while having no direct jurisdiction over the actions that lead to such expenditure. A Service Delivery Agreement has been signed between the Departments of Health, and Transport and Public Works. The Service Delivery Agreement was amended during 2006 to promote an integrated and team approach to project development and management.

Table 8.1: Historic and planned capital expenditure by type [HFM1]

R 000's	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Major capital (Health)	17,350	43,741	18,000	32,566	16,434	18,000	18,000
Major capital (HRP)	81,939	124,115	103,445	178,236	191,796	376,944	326,974
Major capital (PIG)	36,324	54,411	55,229	61,829	80,262	85,880	94,468
Major capital (Other)				1,003	36,511	21,885	19, 856
Major capital (Donor RCCH)	9, 147	11,400	16,000	0	25,000	25,000	0
Maintenance & minor capital	71,677	65,102	48,538	72,442	80,197	85,105	88, 927
Equipment	92,679	123,948	114,436	116,000	120,000	124,000	124,000
Equipment (Donor RCCH)	9, 734	3,737	0	0	0	0	0
Equip maintenance	50,426	55,871	58,665	64,531	67,758	71,145	74,703
Total capital	**369,276**	**482,325**	**414,313**	**526,607**	**592,958**	**782,959**	**746,928**

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	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Equitable share	232, 132	288, 662	239, 639	285, 539	284, 389	298, 250	305, 630
Revitalisation grant[1]	81, 939	124,115	103,445	178, 236	191,796	376,944	326,974
Infrastructure grant	36, 324	54, 411	55, 229	61, 829	80, 262	85, 880	94, 468
Donor funding (RCCH)	18, 881	15, 137	16,000		25, 000	25, 000	
Other				1, 003	36, 511	21, 885	19, 856
Total capital	**369, 276**	**482, 325**	**414, 313**	**526,607**	**592,958**	**782,959**	**746,928**

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]

	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
New hospitals	1	1	0	0	0	0	0
New clinics / CHC's	0	0	0	2	3	1	3
Upgraded hospitals		1	2	2	2	2	1
Upgraded clinics / CHC's	0	0	2	0	1	0	0

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	-	-	-	-	-	-
Programme 2						
Clinics and CHC's	300 000	15	20 000			
Mortuaries	75 000	3	25 000			
District hospitals	2 000 000	10	200 000			
Programme 3						
EMS infrastructure	85 000	5	17 000	-	-	-
Programme 4						
Regional Hospitals	390 000	5	78 000			
Psychiatric hospitals	910 000	7	130 000	-	-	-
TB hospitals	550 000	10	55 000	-	-	-
Other specialised hospitals	30,000	6	5 000	-	-	-
Programme 5						
Provincial tertiary and national tertiary hospitals[1]	1 400 000	10	140 000	-	-	-
Other programmes						
Compliance with Pharmacy Act.	96 000	10	9 600	-	-	-
Total all programmes	**5 836 000**		**679 600**			

Note on table 8.4 [HFM 4]

1. The above figures are for building work only and specifically exclude equipment and furniture
2. The planning horizon is based on expected available cash flows. The assumption is that the HRP projects will be fully funded. 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 2007.
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.

Table 8.5: Situation analysis indicators for health facilities management [HFM5]

Indicator	Type	Province wide value 2002/03	Province wide value 2003/04	Province wide value 2004/05	Province wide value 2005/06	National target 2003/4
Input						
1. Equitable share capital programme as % of total health expenditure	%	0.22	0.40	0.90	0.31	1.5
2. Hospitals funded on revitalisation programme	%	3	5	6	8	17
3. Expenditure on facility (building) maintenance as % of total health expenditure	%	0.78	1.64	1.33	0.85	2.5
4. Expenditure on equipment maintenance as % of total health expenditure	%	1.25	1.15	1.14	1.03	2
Process						
5. Hospitals with up to date asset register.	%	0	0	0	0	100
6. Health districts with up to date PHC asset register (excluding hospitals)	No					All
Quality						
7. Fixed PHC facilities with access to piped water	%	100	100	100	100	100
8. Fixed PHC facilities with access to mains electricity	%	100	100	100	100	100
9. Fixed PHC facilities with access to fixed line telephone	%	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	270,000,000	30
11. Average backlog of service platform in district hospitals	R	23,361,284	23,601,284	22,341,281	1,285,000,000	30
12. Average backlog of service platform in regional hospitals	R	120,437,291	120,437,291	116,151,577	660,000,00	30
13. Average backlog of service platform in specialised hospitals	R	54,626,936	54,293,641	43,071,419	42,738,086	30
14. Average backlog of service platform in tertiary and central hospitals	R	357,921,375	356,254,708	352,921,375	1,400,000	30
15. Average backlog of service platform in provincially aided hospitals	R	13,066,667	13,066,667	13,066,667	13,066,667	30
Outcome						
16. District hospital beds per 1000 uninsured population	No	0,45	0,45	0.50	0.53	100
17. Regional Hospital beds per 1000 uninsured population	No	0,58	0,58	0.61	0.61	65
18. Population within 5km of fixed PHC facility	%	93	93	93	94	85

Notes
1. Indicator 5: The asset registers for hospitals are reflected in Programme 1.
2. Indicator 6: The PPHCs are Chief Users of district hospitals and information regarding asset registers are incorporated in the statistics for hospitals.
3. Indicators 10 – 15:: Average backlog of service platform is for building work only and specifically excludes equipment and furniture. Figures updated to reflect current building costs and backlog in terms of HRP criteria where applicable.

Table 8.6: Provincial objectives and performance indicators for health facilities management [HFM6]

Objective	Indicator	2004/05	2005/06 Actual	2006/07 Projection	2007/08 Projection	2008/09 Projection	2009/10 Projection
Improve ambulance stations	% of ambulance stations built for purpose	38%	42%	47%	60%	73%	76%
Provide district hospital infrastructure that is fit for purpose	Total infrastructure expenditure as a % of backlog		2,3%	5,9%	3,5%	9,3%	11,9%
Provide provincial hospitals with the physical infrastructure that is fit for purpose	Total infrastructure expenditure as a % of backlog		5,2%	6,7%	7,2%	10,8%	6,2%
Provide central hospitals with the physical infrastructure that is fit for purpose	Total infrastructure expenditure as a % of backlog		2,6%	2,4%	3,6%	4,9%	4,8%

6. SPECIFICATION OF MEASURABLE OBJECTIVEWS AND PERFORMANCE INDICATORS

Table 8.7: Performance indicators for health facilities management [HFM7]

Indicator	Type	2004/05	2005/06 Actual	2006/07 Projection	2007/08 Projection	2008/09 Projection	2009/10 Projection	National target 2007/08
Input								
1. Equitable share capital programme as % of total health expenditure	%	0.92	0.31	0.50	0.24	0.24	0.22	2.5
2. Hospitals funded on revitalisation programme	%	5	**8**	**12**	**14**	**14**	**18**	25
3. Expenditure on facility maintenance as % of total health expenditure	%	1.37	0.85	1.12	1.21	1.17	1.14	4
4. Expenditure on equipment maintenance as % of total health expenditure	%	1.18	1.03	1.00	0.97	0.93	0.91	4
Process								
5. Hospitals with up to date asset register.	%	0	33	100	100	100	100	100
6. Health districts with up to date PHC asset register (excluding hospitals)	N	Refer to note below						All
Quality								
7. Fixed PHC facilities with access to piped water	%	100	100	100	100	100	100	100
8. Fixed PHC facilities with access to mains electricity	%	100	100	100	100	100	100	100
9. Fixed PHC facilities with access to fixed line telephone	%	100	100	100	100	100	100	100
10. Average backlog of service platform in fixed PHC facilities	R	270 000 000	270 000 000	265 000 000	300 000 000	255 000 000	240 000 000	15
11. Average backlog of service platform in district hospitals	R	22 341 281	1 285 000 000	1 285 000 000	2 000 000 000	2 000 000 000	2 000 000 000	15
12. Average backlog of service platform in regional hospitals	R	116 151 577	660 000 000	600 000 000	390 000 000	250 000 000	150 000 000	15
13. Average backlog of service platform in specialised hospitals (including TB & psychiatric hospitals)	R	2 043 071 419	2 042 738 086	2 039 071 405	2 030 000 000	2 030 000 000	2 030 000 000	15
14. Average backlog of service platform in tertiary and central hospitals	R	352 921 375	1 400 000 000	1 400 000 000	1 400 000 000	1 400 000 000	1 400 000 000	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	13 066 667	15
Efficiency								
16. District hospital beds per 1000 uninsured population	No	0,45	0,50	0,53	0,53	0,55	0.59	90
17. Regional Hospital beds per 1000 uninsured population	No	0,55	0,58	0,61	0,61	0,61	0.63	60
18. Population within 5km of fixed PHC facility	%	93	94	94	95	95	95	95

Notes

1. Indicator 5: The asset registers for hospitals are reflected in Programme 1.
2. Indicator 6: The PPHCs are Chief Users of district hospitals and information regarding asset registers are incorporated in the statistics for hospitals.
3. Average backlog of service platform is for building work only and specifically excludes equipment and furniture Figures updated to reflect current building costs and backlog in terms of HRP criteria where applicable.

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

Programme 8 is allocated 5,20 percent of the vote in 2007/08 in comparison to the 5,25 percent that was allocated in the revised estimate of the budget in 2006/07. This translates to a nominal increase of 8,57percent or R29,095 million.

Table 8.8: Trends in provincial public health expenditure for health facilities management (R' million) [HFM8]

Expenditure	2003/04 (actual)	2004/05 (actual)	2005/06 (actual)	2006/7 (estimate)	2007/08 (MTEF projection)	2008/09 (MTEF projection)	2009/10 (MTEF projection)
Current prices							
Total	196,176,000	288,464,000	217,025,000	339,594,000	368,689,000	565,929,000	528,369,000
Total per person	42.04	60.88	46.00	70.88	75.78	114.54	105.31
Total per uninsured person	57.59	83.39	63.01	97.08	103.79	156.88	144.23
Constant 2006/07 prices							
Total	221,678,880	314,425,760	227,876,250	339,594,000	349,885,861	512,731,674	454,925,709
Total per person	47.51	66.36	48.30	70.88	71.92	103.78	90.67
Total per uninsured person	65.08	90.90	66.16	97.08	98.50	142.14	124.19

Table 8.9: Provisional priorities for hospital revitalisation

Priority	HOSPITAL	2010 Classification	2004 BEDS	2010 beds	ESTIMATE R'million	Start	End
1	George	Provincial	202	265	90	2003	2009
2	Eben Donges	Provincial	213	307	208	2003	2009
3	Vredenburg	District	56	80	134	2003	2009
4	Paarl	Provincial	250	327	328	2005	2009
5	Khayelitsha	District	0	210	400	2006	2011
6	Mitchells Plain	District	0	210	400	2006	2011
7	Valkenberg	Psychiatric	385	315	497	2006	2011
8	Brooklyn Chest	TB	305	721	300	2008	2011
9	Tygerberg	Central	1273	1194	1,500	2008	2013
10	Hottentots Holland	District	121	120	200	2008	2011
11	Victoria	District	159	180	300	2008	2011
12	Mossel Bay	District	90	90	180	2009	2011
13	Hermanus	District	37	60	120	2009	2011
14	Harry Comay	TB	90	169	150	2010	2012
15	Stikland	Psychiatric	371	330	360	2010	2013
16	Swartland (+ID Hospital)	District	85	147	210	2010	2013

Notes on the above provisional priorities:
1. Estimates include equipment – with the exception of Tygerberg

Schedule 1 Capital Projects Funding

No	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Completion Target Date	Estimated Total cost	2006/07 R'000	2007/08 R'000	2008/09 R'000	2009/10 R'000
1	Atlantis hospital – Replace ambulance station	Ambulance station	Construction	24	2005/04	2007/03	4,430	3,600	664	166	
2	GF Jooste Hospital: New ARV Clinic	Clinic	Construction	8	2007/08	2008/03	5,470		4,570		
3	Grassy Park CHC	Clinic	Inception	24	2008/04	2010/03	7,114		600	7400	
4	Malmesbury – Wesbank - CHC	Clinic	Inception	18	2008/10	2010/03	8,400		200	3,200	5,000
5	Montagu Community Health Centre	Clinic	Construction	21	2006/07	2008/03	7,034	3,000	2,234		
6	Plettenberg Bay – Kwanaokuthula CHC	Clinic	Inception	18	2008/10	2010/03	16,500		500	6,400	8,000
7	Robbie Nurock – Replacement Clinic	Clinic	Inception	18	2009/10	2011/03	16,500			1,000	3,000
8	Simondium community health centre	Clinic	Construction	21	2006/07	2008/03	6,500	3,000	2,600		
9	Stanford community health centre	Clinic	Construction	21	2006/07	2008/03	6,500	3,000	2,600		
10	APH Hospitals supply and delivery	Standby Generator	Supply & delivery	14	2006/06	2007/07	4,500	3,500	1,000		
11	Hermanus & Victoria Hospital	Standby Generator	Supply & delivery	14	2006/06	2007/07	700	600	100		
12	Karl Bremer & Oudtshoorn Hospital	Standby Generator	Supply & delivery	7	2007/01	2007/07	1,778	702	1,076		
	Total own new construction						88,627	21,902	16,434	18,000	18,000

Schedule 2 Provincial Infrastructure Grant

No	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Completion Target Date	Estimated Total cost	2006/07 R'000	2007/08 R'000	2008/09 R'000	2009/10 R'000
1	Alexandra hospital – Rationalisation	Hospital	Inception	24	2009/02	2011/03	18,000			1,000	7,000
2	Atlantis Hospital - Replacement of roof	Hospital	Complete	7	2005/08	2006/02	3,365	3,300	65		
3	Beaufort West - New ambulance station	Ambulance station	Construction	21	2006/07	2008/03	8,885	3,150	4,588	1,147	
4	Browns Farm Izamezabantu CHC	New CHC	Retention	20	2005/08	2007/03	8,039		20		
5	Bonnievale - New ambulance station	Ambulance station	Inception	24	2008/04	2010/03	7,100			500	5,500
6	Bredasdorp hospital - Ambulance station	Ambulance station	Tender	6	2007/01	2007/06	975	600	360	15	
7	Caledon hospital	New wards & Ambulance station	Tender	27	2006/01	2009/03	22,000	2,000	9,840	8,460	1,700
8	Cape Medical Deport - Air conditioning	Depot	Construction	21	2006/07	2008/03	12,350	8,323	3,,016	1,011	
9	Ceres hospital - new Ambulance station	Ambulance station	Inception	24	2008/04	2010/03	8,000			1,000	6,000
10	De Doorns - new Ambulance station	Ambulance station	Planning	24	2008/04	2010/03	8,000			1,000	6,010
11	Eerste River Hospital casualty	Hospital	Inception	18	2008/01	2009/06	13,348		500	9,300	3,468
12	Groote Schuur Hospital – Upgrade of Lift Installation	Hospital	Construction	7	2006/12	2007/06	2,600	200	1,800	600	
13	Groote Schuur Hospital	Workshop	Relocation	9	2007/09	2008/05	2,500		700	1,700	100
14	Groote Schuur Hospital – Linac Installation	Hospital	Construction	5	2006/11	2007/03	3,930	3,700	130	100	
15	Groote Schuur Hospital – Ph1 NMB Fire Detection Phase 1	Hospital	Construction	19	2006/10	2008/04	10,200	3,500	3,580	2,500	520
16	Groote Schuur Hospital – Ph2 NMB Fire Detection Phase 2	Hospital	Inception	19	2008/09	2010/03	11,000			1,000	6,000
17	Groote Schuur Hospital – Upgrade of Security at Trauma	Hospital	Inception	8	2009/08	2010/03	2,000				1,000
18	Groote Schuur Hospital – Upgrade of D23 Dept Anaesthesia	Hospital	Inception	20	2008/08	2010/03	2,000			1,000	1,000
19	Groote Schuur Hospital – Creation of toilet facilities for E- Floor	Hospital	Inception	20	2008/08	2010/03	1,500			500	1,000

No	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Completion Target Date	Estimated Total cost	2006/07 R'000	2007/08 R'000	2008/09 R'000	2009/10 R'000
20	Groote Schuur Hospital – Alterations to Pharmacy Store to improve security	Hospital	Inception	10	2009/08	2010/05	3,000				1,000
21	Groote Schuur Hospital – General security Improvements	Hospital	Inception	6	2009/02	2009/07	5,000			500	4,000
22	Groote Schuur Hospital – Relocation of the NMB E-Floor Management suite & Dept. Dietetics to E4	Hospital	Inception	20	2008/08	2010/03	3,000		800	2,200	
23	Heidelberg - new ambulance station	Ambulance station	Inception	12	2009/02	2010/01	8,000			1,000	5,500
24	Hermanus – new ambulance station	Ambulance station	Tender	9	2006/10	2007/06	5,700	2,200	2,720	780	
25	Hottentots Holland Hospital	New OPD	Tender	6	2007/04	2007/09	7,000	400	5,200	1,400	
26	Hottentots Holland Hospital	New Ward	Tender	6	2007/03	2007/08	8,100	150	6,120	1,830	
27	Karl Bremer	Trauma Upgrade	Inception	9	2008/06	2009/02	6,000		700	3,800	500
28	Khayelitsha CHC Site B	Casualty					5,000		5,000		
29	Khayelitsha New CHC	Clinic	Inception	24	2008/09	2010/08	19,000			2,000	11,000
30	Lamberts Bay hospital - Ambulance station	Ambulance station	Planning	20	2008/06	2010/01	1,600			1,500	100
31	Lentegeur hospital - Ambulance station	Ambulance station	Tender	9	2006/11	2007/07	4,900	650	2,916	1,234	
32	Maitland CHC	Clinic	Inception	23	2008/06	2010/04	9,960			2,000	4,000
33	Mitchells Plain CHC 90	Clinic	Inception	19	2008/09	2010/03	12,000			3,960	6,570
34	Mowbray maternity hospital	Hospital	Construction	31	2004/09	2007/03	48,500	47,050	1,250	200	
35	Oudtshoorn hospital - Ambulance station	Ambulance station	Tender	5	2006/11	2007/03	1,220	780	400	40	
36	Oudtshoorn hospital - Medical depot	Hospital	Tender	6	2006/10	2007/03	4,500	1,800	2,500	200	
37	Red Cross Hospital - Ward Upgrades	Hospital	Inception	3	2008/04	2008/06	15,000			7,000	7,000
38	Red Cross Hospital – New Site access	Hospital	Inception	7	2007/04	2007/10	4,000			4,000	
39	Red Cross Hospital - CSSD/X-Ray	Relocation	Inception	23	2007/09	2009/07	13,000		7,000	6,000	
40	Riversdale Hospital Phase 1 Upgrade	Hospital		9	2007/02	2007/10	5,600	350	3,800	1,450	
41	Riversdale hospital phase 2	Hospital	Inception	25	2008/03	2010/03	7,948	500	1,195	3,141	4,500

No	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Completion Target Date	Estimated Total cost	2006/07 R'000	2007/08 R'000	2008/09 R'000	2009/10 R'000
42	Stellenbosch hospital - Ambulance station	Ambulance station	Tender	4	2006/11	2007/02	927	900	27		
43	Swellendam ambulance station	Ambulance station	Planning	12	2007/04	2008/03	1,000			1,000	
44	Tygerberg - Fire Doors Phase 1	Hospital	Construction	9	2006/08	2007012	4,000	3,500	500		
45	Tygerberg Hospital – Fire Doors Phase 2	Hospital	Inception	12	2008/04	2009/03	3,050			2,050	
46	Tygerberg Hospital - Kitchen	Hospital	Inception	24	2008/04	2010/03	7,000			23,000	3,000
47	Tygerberg Hospital	Relocation Psychiatric Outpatient Dept		12	2009/04	2010/03	3,500				1,000
48	Tygerberg Hospital	Ward F L-Ground Upgrade		12	2009/04	2010/03	3,500				1,000
49	Tygerberg Hospital	Burns Unit Upgrade		12	2009/04	2010/03	5,000				2,000
50	Tygerberg Hospital	Linear accelerator installation	Final Account	6	2006/02	2006/07	3,460	3,440	20		
51	Valkenberg hospital: Admissions	Hospital	Complete	45	2002/10	2006/04	23,835	23,800	35		
52	Vredendal Hospital	Upgrading Xray & CSSD	Construction	26	2005/05	2007/06	6,002	2,200	3,040	762	
53	Vredendal Hospital – New Ambulance Station	Hospital	Inception	13	2008/03	2009/03	7,000			2,000	4,000
54	Wellington CHC	New Clinic		13	2006/08	2007/08	19,100	3,000	12,440	3,000	
TOTAL: PIG							431,194	115,493	**80,262**	**85,880**	**94,468**

Schedule3: Hospital Revitalisation

No	Name of the project/ Programme	Type of infrastructure	Current project stage	Project duration (months)	Start target date	Completion target date	Estimated Total cost	2006/07 R'000	2007/08 R'000	2008/09 R'000	2009/10 R'000
1	George - Final Phase	Hospital	Inception	24	Apr'08	Mar'10	28,000		1,000	29,000	12,000
2	George	Hospital	Complete	57	Jul'03	Mar'08	94,780	93,280	1,500		
3	Khayelitsha	Hospital	Planning	30	Apr'08	Sept'10	495,000	13,400	5,000	80,000	90,000
4	Mitchell's Plain	Hospital	Planning	27	Oct'08	Dec"10	468,000	11,200	2,462	16,700	80,000
5	Paarl	Hospital	Construction	37	Apr'06	Apr' 09	355,000	70,000	75,000	120,000	50,000
6	Valkenberg	Hospital	Planning	72	Apr '09	Mar '15	550,000	500	1,000	22,000	1,000
7	Valkenberg	Security Fence	Construction	7	Aug '06	Feb '07	8,000	5,700	2,000	300	
8	Vredenburg Upgrade Phase 2	Hospital	Construction	9	Jul'07	Mar '08	65,538	1,120	6,500	40,944	16,974
9	Vredendurg Upgrade Phase 1	Hospital	Retention	35	Jul '03	May '06	62,260	61,260	1,000		
10	Worcester	Hospital	Construction	53	Jun'03	Oct'07	211,762	170,000	31,300	8,000	
11	Worcester Hospital	New DMC & ambulance Station		10	Nov'06	Aug'07	11,200	600	9,600	1,000	
12	HRP Head Office	-	-	-	-	-	-	-	5,000	5,000	5,000
13	HMQIG- District								5,984	6,178	5,149
14	HMQIG/Equipment	-	-	-	-	-	-		12,275	11,822	9,851
15	George Hospital		Equipment						13,000	8,000	2,000
16	Paarl Hospital		Equipment						5,675	16,000	30,000
17	Vredenburg Hospital		Equipment						5,000	2,000	

No	Name of the project/ Programme	Type of infrastructure	Current project stage	Project duration (months)	Start target date	Completion target date	Estimated Total cost	2006/07 R'000	2007/08 R'000	2008/09 R'000	2009/10 R'000
18	Worcester Hospital		Equipment						8,500	10,000	2,000
19	Khayelitsha Hospital		Equipment								13,000
20	Mitchell's Plain Hospital		Equipment								10,000
	TOTAL						**2,349,540**	**427,060**	**191,796**	**376,944**	**326,974**

Note: Funding for years beyond 2009/10 is not indicated

The hospital revitalization funding is used for new hospitals, large upgrades for which National Treasury authorize the funding based on an approved business case that motivates the need and the priority of the proposed project in terms of the strategic fit.

Schedule 4: Upgrade of the forensic and pathology service

No	Name of the Project	Type of infrastructure	Current project stage	Project duration months	Start target date	Completion target date	Estimated Total cost	2006/07 R'000	2007/08 R'000	2008/09 R'000	2009/2010 R'000
1	New Forensic Pathology Laboratories (George, Hermanus, Worcester, Paarl)	Forensic Mortuary	Construction	26	April 06	May '08	45, 407	5,440	24,789	**8,200**	**726**
TOTAL							**45, 407**	**5,440**	**24, 789**	**8,200**	**726**

Schedule 5: Recurrent Maintenance

Name of the project/ Programme	Type of infrastructure	Brief need/ proposed outcome	2006/07 R'000	2007/08 R'000	2008/09 R'000	2009/10 R'000
Vote 6 : Health	Community Health facilities	Maintain Serviceability		9,130	9,678	**9,678**
	District Hospitals	Maintain Serviceability		10,000	11,000	**12,000**
	Provincial Hospitals	Maintain Serviceability		20,928	21,725	**22,533**
	Central Hospitals	Maintain Serviceability		36,139	37,702	**38,716**
	Other Facilities	Maintain Serviceability		4,000	5,000	**6,000**
TOTAL				**80,197**	**85,105**	**88,927**

Contact Details

Department of Health
Western Cape
P.O. Box 2060
Cape Town, 8000

Room 20-08, 4 Dorp Street, Cape Town

Tel: 021 483 3245
Fax: 021 483 6169

ISBN NR: 978-0-620-38403-2