ANNUAL PERFORMANCE PLAN

2011/12-2013/14

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

Contents

Acronyms

AG	Auditor-General
AMC	Academic Medical Center
APP	Annual Performance Plan
ART	Antiretroviral Treatment
BoD	Burden of Disease
CCOD	Compensation Commission for Occupational Diseases
CHC	Community Health Center
CHW	Community Health Worker
CMS	Council for Medical Schemes
CRA	Comparative Risk Assessment
CSIR	Council for Scientific and Industrial Research
CTOP	Choice of Termination of Pregnancy
DBSA	Development Bank of Southern Africa
DHIS	District Health Information System
EDMS	Electronic Document Management System
EMS	Emergency Medical Services
FBO	Faith-Based Organisation
GDP	Gross Domestic Product
HAART	Highly Active Antiretroviral Therapy
HCT	HIV Counselling and Testing
HDACC	Health Data Advisory and Coordination Committee
HSRC	Human Sciences Research Council
HST	Health Systems Trust
ICT	Information Communication Technology
IMCI	Integrated Management of Childhood Illness
LBW	Low Birth Weight
MBOD	Medical Bureau for Occupational Diseases
MDG	Millennium Development Goal
MISP	Master Information Systems Plan
MMR	Maternal Mortality Rate
MRC	Medical Research Council
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHA	National Health Act
NHC	National Health Council
NHI	National Health Insurance
NHRC	National Health Research Committee
NHREC	National Health Research Ethics Committee
NICD	National Institute for Communicable Diseases
NIMSS	National Injury Mortality Surveillance System
NSDA	Negotiated Service Delivery Agreement
OPV	Oral Polio Vaccine
OSD	Occupation Specific Dispensation
PHC	Primary Healthcare
PMTCT	Prevention of Mother to Child Transmission

PPIP	Perinatal Problem Identification Programme
PPP	Public Private Partnership
QIP	Quality Improvement Plan
SAHPRA	South African Health Products Regulatory Authority
SANAC	South African National AIDS Council
SDA	Service Delivery Agreement
SRH	Sexual and Reproductive Health
S**TATSSA**	Statistics South Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
YFS	Youth Friendly Services

Foreword by the Minister of Health

The provision of strategic leadership and stewardship over the entire health sector was a crucial focus area in past financial year. It created vision and a rallying point for the health sector through the 10 Point Plan, which has been the foundation for our policies so far. An added impetus has come through the Negotiated Service Delivery Agreement (NSDA)|that the health sector has finalised in the last year. As government, we have adopted an outcome-based approach to service delivery, which consists of 12 outcomes. This is articulated in the revised Medium-Term Strategic Framework (MTSF) for 2009-2014. The main objectives of the NSDA are: (i) increasing life expectancy at birth; (ii) reducing maternal and child mortality rates; (iii) combating HIV and AIDS and TB; and (iv) strengthening the effectiveness of health systems. Thus the focus of the health sector over the planning cycle 2011/12-2013/14 will therefore be on the four (4) outputs entailed in the Minister's Performance Agreement with the President of the Republic, and elaborated on in the NSDA. The 10 point plan and the NSDA have cross linkages that have a common goal of ensuring better health outcomes for South Africans.

The NSDA seeks to respond to the many challenges facing the health sector such as: poor quality of services; poor equipment procurement practices and inadequate number and skills mix of the health workforce and spiralling costs in the private sector.

Recently, there has been a public outcry about the spiralling costs of health care in the private sector. Unattended, this can have major consequences on the entire sector as a whole as the insured population gets inadequate cover and ends up being dumped on the public sector. The department is looking into ways of making healthcare affordable and reducing equity gaps between public and private sector and urban and rural.

There have been gaps in the quality, extent and oversight of management, planning, development, deployment and utilisation of the health workforce. Recent trends indicate that we have stagnated in the production of certain key personnel and even worse have reversed in others. As recently demonstrated in a study by the Development Bank of Southern Africa (DBSA) we need to strengthen management skills to effectively address weaknesses in the hospitals and the whole health system. The appropriate skills mix is still a challenge when the numbers of middle level technical staff are lower than expected e.g. ratio of enrolled nurses to professional nurses. This results in inappropriate use and expensive model of service delivery. I have developed an integrated human resource (HR) strategy to address the above mentioned problem and to plan on increasing production of a skilled workforce. Additionally, we are setting norms and standards for the workforce to ensure we have the right numbers and skills mix.

I have embarked on a process of quality improvement based on six core areas; this is in response to the public's concerns about the poor quality of care in our institutions. Furthermore, this work is aimed at

overhauling the health system and in preparation for the National Health Insurance (NHI). The success of quality improvement policies can be measured by their ability to raise the average level of health and reduce variation in quality. The main thrust of our intervention is to target provider behaviour at the individual or the group level.

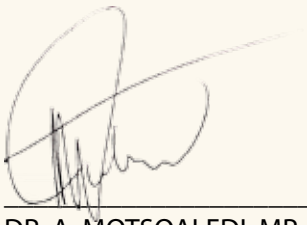
In line with the revitalised health system, family health and district teams to support the new model of service delivery will be mobilised. Specialist support teams for maternal and child health, are being put together in order to provide supervision and continuing education for the workforce at the coalface of service delivery. The department has had significant problems with procurement and maintenance of equipment. This has resulted in poor service delivery and major concern from the public. Consequently, in the past year I have setup a national Ministerial Advisory Committee on Health Technology. This committee will assist in developing a strategy for the procurement of equipment and conducting an audit.

Over the past year we have intensified our efforts in combating tuberculosis (TB) and HIV. The HIV Counselling and Testing HIV (HCT) campaign has managed to sensitise South African to the need to know their HIV status so that they could respond appropriately. On the one hand, those who are HIV infected can be prepared to receive antiretroviral treatment (ART). On the other hand the HIV uninfected individuals have also been assessed and received counselling if found engaging in behaviours that place them at risk of contracting HIV infection. The success of this campaign has resulted in excess of 6 million South Africans knowing their status, this fits in well with our NSDA priorities of increasing the life expectancy as ART have significantly reduced those dying of HIV and improved the quality of life for people living with HIV.

The HCT campaign has added impetus to our disease prevention strategies as patients do not only get HIV testing but also get screened for TB. We must expand our screening strategies to include non-communicable diseases such as diabetes and hypertension. This information is going to be used for planning purposes and intervention design as more people will know if they have developed these chronic diseases and can then embark on secondary prevention.

The TB control program has received significant attention through the HCT campaign. The 1 million HIV infected patients diagnosed through the HCT campaign have also received screening for TB. This is the beginning of our intensive case identification strategy ensuring that we detect TB early and provide treatment to prevent spread in the family and community. Additional strategies are being developed to reduce the diagnostic turn- around time to minimise the number of infective people due to a delay in diagnosis.

There is ongoing work to prepare for the National Health Insurance some of this work includes strengthening Information and Communication Technology (ICT) systems and our ability to track performance both in terms of finance and service delivery. Major milestones have been reached and we are on course towards introducing NHI which will ensure universal and equitable access to health for all South Africans.



DR. A. MOTSOALEDI, MP
MINISTER OF HEALTH
DATE: 05-03-2011

Statement by the Director-General

I am pleased to present the department's annual performance plan for the financial year 2011/12 including the MTEF cycle up to 2013/14. During the last year, we have made progress towards improving the health outcomes of South Africans and establishing a platform for realising the objectives of the Negotiated Service Delivery Agreement (NSDA) that the Minister of Health has signed with the President. Outcome 2 of the NSDA, specifically relates to Health i.e. "A long and Healthy Life for All South Africans". Therefore, it is our mandate as a department to take lead and work with other departments in executing the mandate from the NSDA. I would like to emphasise the need for intersectoral collaboration as the health and other developmental challenges are intertwined and no one department can address the health and social challenges alone.

In this context, we are committed towards reducing the leading causes of disease, injury, disability and death. Our priorities emanate from the NSDA and the interventions are based on appropriate and current scientific evidence. The South Africa Comparative Risk Assessment (CRA) ranks 17 risk factors and diseases that result from or are associated with these risk factors. These findings of the CRA and the burden of disease report confirm that the priorities in the NSDA are indeed the biggest challenges facing the health system and they need to be prioritised in terms of intervention to ameliorate their effects. The interventions that will be developed henceforth will be aimed at achieving the objective of outcome 2. This will require a skilled health workforce and a department that is well structured and has the ability and flexibility to respond to these health needs.

Consequently, the department has been restructured to provide an enabling environment for managers to work effectively and systematically in order to improve the health outcomes of South Africans. This plan thus addresses the new program areas and structure as approved by national treasury. There are six programs in the new structure and the APP is aligned to these programs. They are administration; health planning and system enablement; HIV and AIDS, TB and maternal, child and women's health;

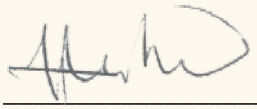
primary healthcare services; hospitals, tertiary services and workforce development.

This structure is fit for purpose and will ensure that the delivery of health services is planned, managed, monitored and evaluated appropriately. This will enhance our efforts to mobilise and allocate resources for disease prevention, treatment and rehabilitation. This structure has to rest on certain fundamental pillars if it is going to work. These pillars therefore are the essential elements that enable the healthcare system to function (i.e. provide services to the public) and include information, management, human resources, and financing.

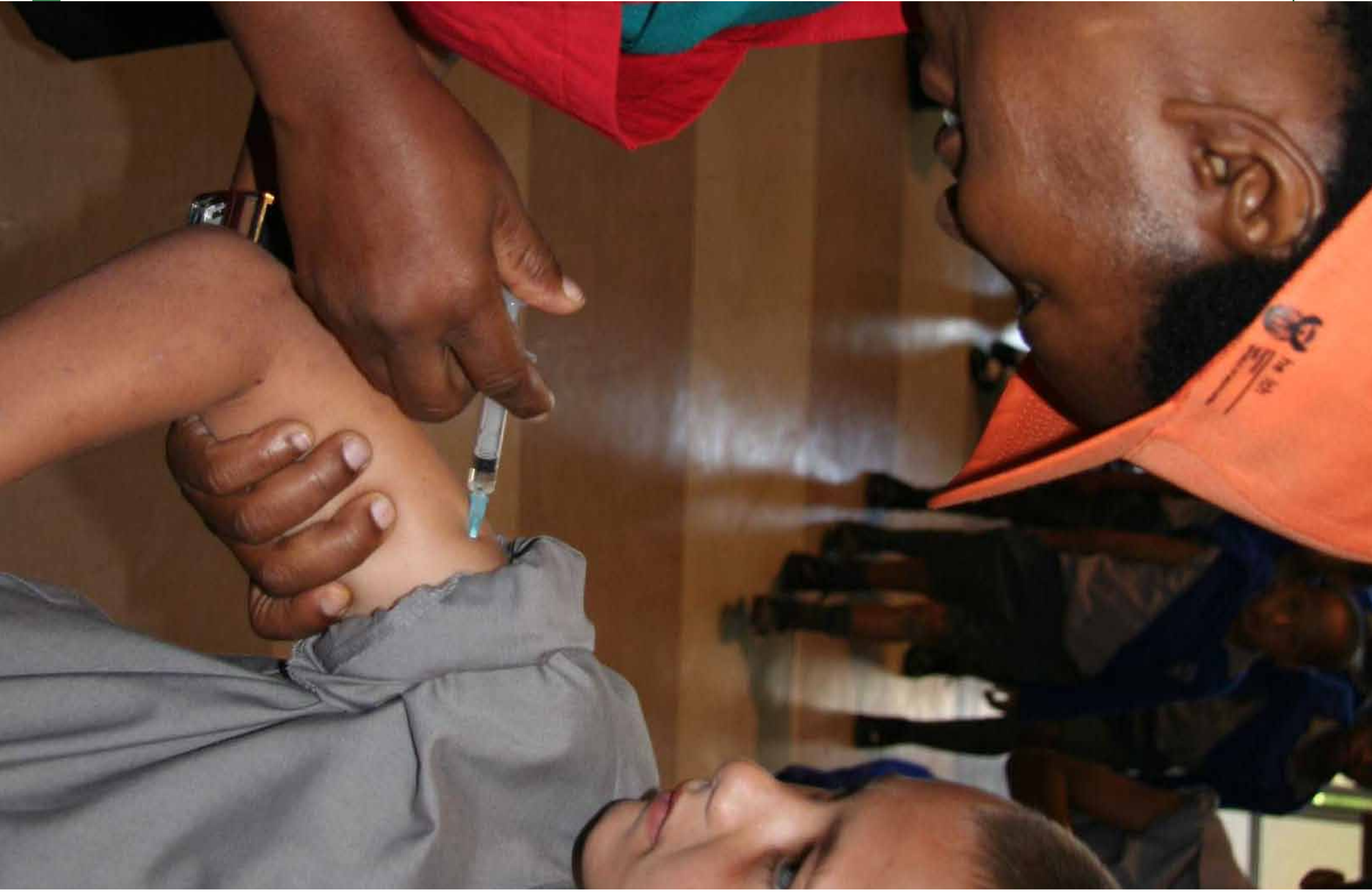
Quality of care is an integral part of our service delivery model and it is underpinned by the principles of equity and fairness ensuring that care is consistent across geographic, gender, ethnic, and socioeconomic lines. We have begun the process of overhauling the health system for better outcomes and in preparation for the National Health Insurance. Delivering a health service that is in line with the principles in the constitution, the National Health Act (NHA) based on the Batho Pele principles is our priority. The core elements of our quality are patient safety; cleanliness; infection control; staff attitudes; waiting times and drug supply.

Over the medium term, the key priority for the department is to begin preparatory work for the NHI. This process has been initiated through the policy document that has been developed. Additional preparatory work will focus on accrediting facilities and working with provinces and districts to ensure that we are prepared at all levels. Additionally we will be strengthening the production of the workforce through increasing training of designated clinical and non clinical staff such as clinical technicians who will play a critical role in infrastructure maintenance.

We believe that this structure will be able to enhance health sector's response to the poor health outcomes. Additionally, it is geared towards achieving the key priorities of the NSDA.



MS MP MATSOSO
DIRECTOR-GENERAL
DATE: 04-03-2011



PART A: STRATEGIC OVERVIEW

1. VISION AND MISSION

VISION
Long and healthy life for all South Africans

MISSION

To improve health status through the prevention of illnesses and the promotion of healthy lifestyles and to consistently improve the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability.

2. SITUATION ANALYSIS

2.1 Demographic Profile

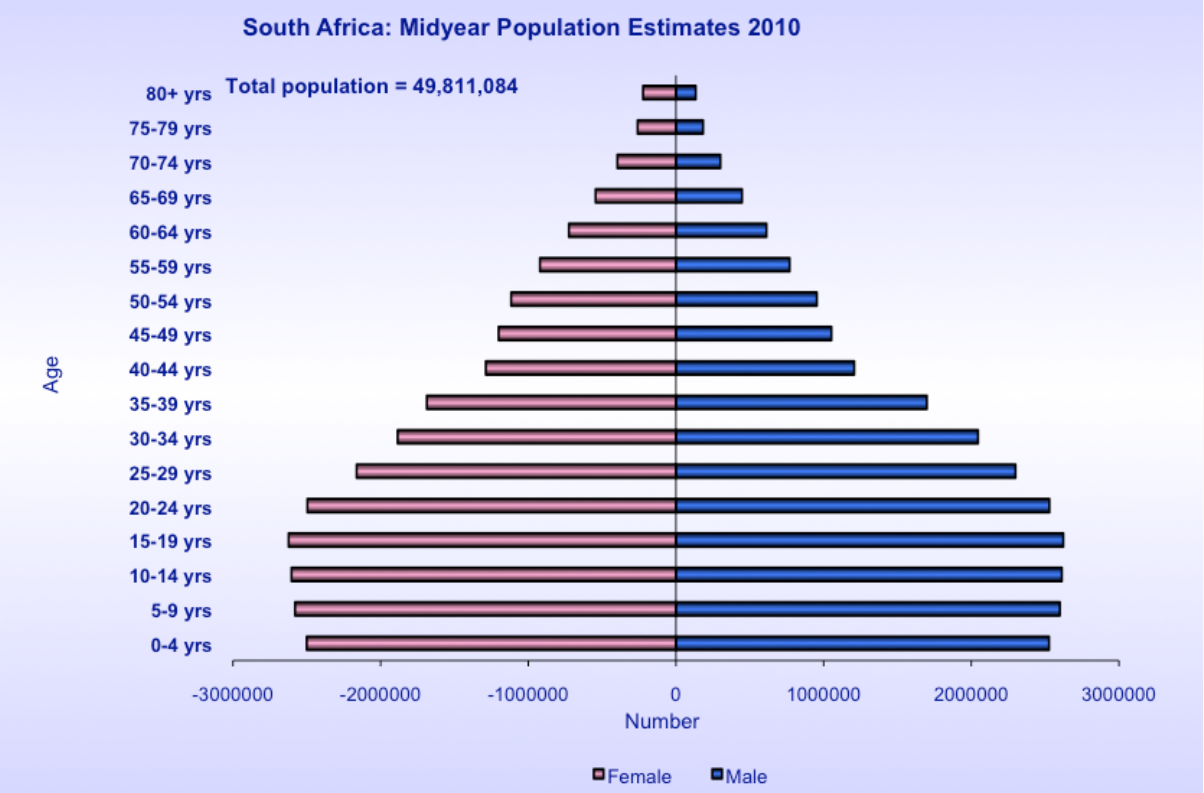
The mid-year population estimates released by Statistics South Africa (STATSSA) in July 2010 indicate that South Africa's population grew slightly from 49,320,147 in 2009 to 49,991,300 in 2010. A comparative analysis of population growth between 2004 and 2010 reflects an overall growth of 7.1%. This is reflected in Table 1 below.

Table 1: South Africa's Population in 2004 and 2010

	2004	Percentage Share	2010	Percentage Share	% change
Gauteng	9,577,200	20.5%	11,191,700	22.4%	16.9%
KwaZulu-Natal	9,914,605	21.2%	10,645,400	21.3%	7.4%
Eastern Cape	6,558,090	14.1%	6,743,800	13.5%	2.8%
Western Cape	4,980,573	10.7%	5,223,900	10.4%	4.9%
Limpopo	5,080,831	10.9%	5,439,600	10.9%	7.1%
Mpumalanga	3,463,432	7.4%	3,617,600	7.2%	4.5%
North West	3,293,469	7.1%	3,200,900	6.4%	-2.8%
Free State	2,811,045	6.0%	2,824,500	5.6%	0.5%
Northern Cape	985,077	2.1%	1,103,900	2.2%	12.1%
South Africa	**46,664,322**	**100.0%**	**49,991,300**	**100.0%**	**7.1%**

(Source: Statistics South Africa, mid-year population estimates, July 2004 and July 2010)

Gauteng Province experienced the highest growth in population (16.9%), followed by Northern Cape (12.1%), relative to their 2004 population. Almost half of the South African population is made up between Gauteng and KwaZulu-Natal. Gauteng has the largest share of the country's population (22.4%), followed by KwaZulu-Natal (21.3%). The only province that reflects a decrease in population is North West (-2.8%). Merafong municipality was redemarcated from the North West into Gauteng Province. Population growth in KwaZulu-Natal (7.4%) and Limpopo (7.1%) is consistent with the national growth of 7.1%.



(Source, DHIS midyear population estimates: http://www.hispkerala.org/latest_downloads/.)

The midyear population estimates for 2010 are depicted in the pyramid above. The biggest share of the population is between the ages 15-54 which 49.3% followed by under 14 years of age constituting about 30%. The population 45 years and older constitutes the remaining 20%. There is an equivalent split between males and females within all age groups. Additionally there is a broad base and tapering top which is typical of a developing country population and the health challenges and responses should directly relate to this.

Most developing countries are facing a transition in the epidemiological profile from a context with high fertility rates and high mortality from preventable causes to one in which a combination of lower fertility rates and changing lifestyles has led to aging populations and epidemics of tobacco use, obesity, cardiovascular disease, cancers, diabetes, and other chronic ailments. South Africa is also in the midst of this transition; however we also have a significant burden from communicable disease mainly HIV/AIDS and TB as described in the section discussing the quadruple burden of disease.

2. 2 Performance Delivery Environment

2.2.1 Epidemiological Profile

The country faces a quadruple Burden of Disease (BoD) consisting of a)HIV and AIDS and TB b) High Maternal and Child Mortality c) Non-Communicable Disease and d) Violence and injuries. This is in the face of reasonable amounts of health expenditure as a proportion of GDP. Available evidence indicates that 8.7 per cent of its Gross Domestic Product (GDP) on health, this is significantly more than any other African country; even though we spend such amount the country has poor health indicators and outcomes. This situation is exacerbated by adverse social determinants of health such as poverty and inadequate access to essential services including proper sanitation and access to potable water. It is further aggravated by the inequitable distribution of human and financial resources between public and private sector a situation

favouring the private sector. For example, the doctor patient ratio is as high as 1: 4000 in the public sector while it is 1:250 in the private sector.

The poor health outcomes can be attributed to a number of factors but are evidenced through reduced life expectancy as a result of HIV_with close to 12 per cent of the population affected. Maternal mortality and peri-natal mortality have increased due to HIV but also other structural issues such as poor management of facilities and infrastructure, lack of transport in emergency cases and delay in ART initiation for pregnant women and children. TB is a major problem and there is wide inter-provincial variation. According to the District Health Information System (DHIS) the TB defaulter rate is at 7 per cent while the cure rate is still below the target of 85 per cent. Early detection of TB and treatment adherence is critical, it is estimated that government spends R400 on treating every patient with ordinary TB. However, when patients discontinue treatment and develop a multidrug resistant form of TB, the cost of treatment dramatically increases to R24 000, including hospitalisation and more expensive drugs. (SA Year Book 2007/08)

The burden of disease from Non Communicable Diseases (NCD) account for close to a third of total BOD measured by DALYs in 2004. Cardio Vascular Diseases, Diabetes Mellitus, Respiratory diseases and cancers contributed 12% of the overall burden. Lack of focused disease prevention programs and interventions, poor health seeking behaviour and late detection of diseases are some of the factors contributing to the high burden of non communicable diseases. Consequently, healthcare costs and morbidity and mortality are increased. (NSDA)

Violence and Injury are contributing significantly to the burden of disease-the National Injury Mortality Surveillance System (NIMSS) 2005 report demonstrated that unintentional injury deaths accounted for 44% of all injury-related deaths when the manner of death was known. Of all unintentional injury deaths, the NIMSS showed that three-quarters were attributable to transport-related injuries and the remaining were the result of 'other unintentional injuries'. The South African annual road traffic fatality burden was estimated to be in the region of 18 000 with a road traffic death of 43 per 100 000. Among transport-related deaths, the leading external cause was pedestrian injury (42%) while burn injury was the leading cause among 'other unintentional injury' (43%) death. (MRC-UNISA CVILP 2005).

For many years the health system has been characterised by poor coordination and integration. There were weaknesses in financial management and the structure was not fit for purpose to lead and deliver a national health system that could respond to the country's challenges. Consequently, there were no national norms, standards and guidelines in many areas, and in certain cases where these were available, implementation has been sub-optimal and varied considerably across the nine provinces. There are serious weaknesses in facility management and planning and equipment maintenance. This has a negative impact negatively on service delivery and staff morale. It was reported that basic diagnostic and medical equipment, especially at lower level hospitals and clinics, is lacking across the country.

Table 2: South Africa- Health Indicators

Health Indicator	MDG Target	Data Source 1	Data Source 2	Data Source 3
Maternal Mortality Ratio	38/ 100 000	StatsSA 625 (2007) 369 (2001) SADHS 150 (1998)	Trends in Maternal Mortality 1990-2008) 230 (1990) 260 (1995) 380 (2000) 440 (2005) 410 (2008) 95% CI 411 (300-549)	Institute for Health Metric & Evaluation (Hogan et al 2010) 2008 95% CI (200-299) World health Statistics Report 400 (2009)
Infant Mortality Rate	18/1 000	UN Interagency Group (2010) 54 (2001) 53 (2007)	UNICEF 49 (1990) 46 (2007) 43 9 20090	
Under five Mortality Rate	20/ 1000 (Stats SA) 21 (UNICEF)	StatsSA 97 (2001) 104 (2007) 59 (SADHS 1998)	UNICEF 64 (1990) 59 (2007) 62 (2009)	World Health statistics 2009 Report 113 (1970) 64 (1990) 59 (2007)
Life expectancy	70 Life expectancy at birth for males and females	StatsSA 57.6 (2001) males 55.3 (2007) males 68.8 (2001) females 60.4 (2007) females	UN Population Division 50 (2007)	World Health statistics 2009 Report 53 (1970) 62 (1990) 50 (2007)

The table above reports on various health indicators from South African, multilateral and other agencies working to track health outcomes for the country. The common finding is that there are serious challenges facing the health system irrespective of the data source use. However, there is no agreement on the magnitude of the problem, this is necessary for planning in order to set appropriate and realistic targets. Henceforth we have established a Health Data Advisory and Coordination Committee (HDACC) which consists of experts from institutions that have produced figures for these indicators and includes skills ranging from researchers, demographers and other experts. This team is working closely with Statistics South Africa to review our mortality rates and will release a report soon. This work will enable the department to have confidence when reporting on progress made towards achieving the Millennium Development Goals (MDG) and the Negotiated Service Delivery Agreement.

In October 2010, South Africa's Millennium Development Goals (MDG) Country Report, was submitted to the United Nations (UN). This report reflects that the country is on track towards achieving two (2) targets towards MDG 4, namely: fully immunising all children under the age of 1 against all vaccine preventable diseases and immunising all children under the age of 1 against measles. However, we have been slower than expected in progress towards meeting other MDG goals particularly in child and maternal mortality.

HIV prevalence measured among pregnant women attending public health antenatal clinics has increased from 0.7% in 1990 to 29.4% in 2009. The prevalence trend since 2006 suggests HIV prevalence is stabilising. Provincial trends in HIV prevalence show variations across provinces districts and age-groups. Provincial variations range from 16.1% in the Western Cape to 38.7% in KwaZulu-Natal in 2009. Women bear the brunt of the epidemic as they constitute 55% of all people living with HIV in the country. There is evidence that the prevalence of HIV among pregnant women has been stabilising since 2006. In 2009 the distribution of the HIV prevalence by district varied from 0.0% in Namakwa District in the Northern Cape to 46.4% in Uthukela District in KwaZulu-Natal. This inter-district variation suggests that a blanket approach to developing

interventions is unlikely to succeed. We need to develop, test and implement culturally appropriate and targeted and specifically tailored behaviour change interventions.

The health landscape in South Africa has been characterised by concerted efforts to confront the quadruple burden of diseases (BoD). The health systems response and our planned, systematic way to tackle the above mentioned problems is geared towards ensuring improvement of the health outcomes for the people of South Africa. The following section summarises our approach to the many challenges we face, this is in the context of the government's 12 key outcomes as outlined in the NSDA.

2.2.2 Response of the health system to the challenges and the quadruple burden of disease

Strategies and interventions to deal with this burden of disease are intertwined with the negotiated service delivery agreement and enhanced efforts towards accelerating progress in achieving MDGs. It is therefore critical that we address social determinants of ill-health such as, poverty; lack of portable water; lack of proper sanitation and child neglect. Some of these are responsibilities of other government departments; however as the department of health we will take a leadership role in working through government clusters to ensure that the goal of a long and healthy life for all South Africans is realised.

In the light of the developmental challenges facing our country, government adopted an outcomes based approach to service delivery and performance management. As part of this approach there are 12 key outcomes to be achieved during this term of office. The health sector is leading and harnessing the efforts to achieve Outcome 2: "A long and healthy life for all South Africans". Four key outputs must be produced namely:

- Increasing life expectancy;
- Reducing maternal and child mortality rates
- Combating HIV and AIDS and TB
- Strengthening the effectiveness of the health system.

For the department to be effective and achieve better outcomes, external reviews on the implementation of health sector policies and plans have to be undertaken. This will assist the department in deciding which programs are effective and enhance those. Furthermore, this will also inform the department of interventions that are unlikely to be successful and the need to design new interventions in their place. This exercise will be conducted with partners such as, academic institutions, the medical research council and Non-governmental Organisations (NGOs) and private companies with expertise in research and program evaluation.

Specific interventions of the health sector to achieve these outputs are elaborated in detail in the Negotiated Service Delivery Agreement (NSDA) 2010-2014. The summary below is what we have done to respond to some of the challenges we face due to the quadruple burden of disease.

We have outlined new policies and interventions to strengthen efforts to combat HIV and AIDS. These include the provision of ART to all pregnant women with a CD4 count of 350 or less to ensure maternal survival. Additionally, ART will also be provided to TB-HIV co-infected patients with a CD4 count of 350 or less, all children less than one year of age would be placed on treatment irrespective of CD4 count and finally-pregnant women who do not qualify for HAART would receive dual therapy for the prevention of mother to child transmission from 14 weeks of pregnancy until post delivery.

Furthermore, in 2010 we launched the HIV and Counselling and Testing (HCT) Campaign, the goal of this campaign is to test 15 million South Africans for HIV, TB, hypertension and diabetes. This community based approach is expected to assist in improving health seeking behaviour as the testing is accessible beyond traditional health systems settings. This is one of our key priorities in the reorganization of health services i.e. make interventions and program available in the community.

Other key HIV prevention interventions include: widespread male and female condom distribution where the female condom distribution as increased six fold. Efforts to enhance the early treatment of Sexually Transmitted Infections (STIs) are linked to referral for HIV counselling and testing to ensure a consistent message across the board. We provide post exposure prophylaxis for survivors of sexual assault and health care workers injured on duty. Progress has been made in preparing provinces for male medical circumcision and all provinces have program plans that they are busy implementing. These plans have clear targets on numbers to be reached each financial year. Safe blood transfusion is one of the greatest achievements for South Africa as the current methods take extra care to make the risk of HIV transmission through this route negligible. Increasing access to ART is a priority for the department and we have embarked on various strategies to achieve this objective. Some of these include, training of nurses to initiate ART; increasing the number of ART service points from 490 to 1500.

In terms of infection per population we are ranked as number one in the world with a TB-HIV co-infection of 73%. In the light of this high burden of TB and HIV, we have intensified the fight against TB by increasing our diagnostic capability by putting more resources at district and facility level. Furthermore, there are strategies and interventions focusing on active case finding which is expected to lead to early treatment. We will also develop strategic behaviour communication intervention to encourage health seeking behaviour.

A number of diverse interventions have been implemented to improve the health of women, mothers and children. These range from immunising against vaccine preventable diseases; conducting perinatal reviews to monitor and evaluate causes of perinatal deaths. The latter intervention has been institutionalised in 92% of maternity facilities country wide resulting in improvement in follow up of mothers and babies within the stipulated 6 days after discharge from facilities. The department has established mortality committees to monitor maternal morbidity and mortality and develop early warning signs for areas needing intervention.

Emphasis has been placed on interventions working towards improving health seeking behaviour through community based screening programs such as the current HCT campaign. Mental health issues are also receiving special attention as they could be an entry point for other ill-health. We are auditing our facilties on how they respond to sexual assault survivors, the management of violence and injury. This work is being conducted with some of our UN partners including United Nations Development Programme (UNDP).

The health system will be reinvigorated in 2011 based on the primary healthcare approach, this new model places greater emphasis on the family rather than the individual. Furthermore, it puts health promotion and disease prevention at the core of delivering health services. This is a shift from the current curative focused system with poor referral service. The new approach will ensure integration and continuity of care where families have a close relationship with service providers in their catchment area. We believe this model will accentuate strong community participation and improve multisectoral collaboration as envisaged by the National Health Act.

Data from the district health information system indicates that the average workload for doctors at primary healthcare (PHC) in 2008/09 was 22.3 whilst that of nurses was 24.9. The highest work load for doctors was seen in Mpumalanga at 29.0 in contrast with the nurses at 33.0 in the Free State. North West and Limpopo have the lowest for doctors (12.3) and nurses (17.8) respectively. Expanding the health workforce is a key priority for the department. Henceforth each health science faculty will be approached to take on an extra number of students with the initial focus being on medical students, expanding to other professions. Based on current plans we will be mobilising resources for this activity from within the allocated funds. The specific

detail of how the funds will flow will be finalised between the department and the training institutions.

Primary Healthcare reengineering and strengthening has begun earnestly. During 2011, we will see the deployment of PHC outreach teams consisting of professional nurses, enrolled nurses and community health workers in different wards across the country. The focus will be on health promotion, disease prevention and referral to curative and rehabilitative services to improve health outcomes. These teams will be supported by technical teams consisting of medical specialists with expertise in maternal and child health.

Appropriate health facility planning and management is crucial in responding to the health challenges we face**.** In the early phases of our democratic government, we embarked on building a substantial number of clinics and community health centres. This was driven by a goal of improving access to health services by the citizens of the country. Today, most areas even the most remote have a clinic, a health post or a mobile service point. The table below shows the extent of infrastructure development and outlines the number and types of facilities we have to address the health needs of the population.

Table 3: Distribution of Public Facilities in South Africa, 2010

South Africa	Number of Facilities	2010 estimated Population per Health Facility
Clinic	3595	13,718
Community Health Centre	332	148,533
District Hospital	264	186,817
National Central Hospitals	9	5,479,966
Provincial Tertiary Hospital	9	3,522,835
Regional Hospital	14	930,560
Specialised Psychiatric Hospital	53	1,972,788
Specialised TB Hospitals	41	1,202,919
Grand Total	4,333	

Health facilities management has been improving steadily, the hospital revitalisation program focussed on the improvement of infrastructure, equipment and clinical governance encompassing both management aspects and quality of care. Treasury sources indicate that the budget grew at an average of 22.9 % between 2005/06 and 2008/09 and has increased sharply by 44.6 % for 2009/10 period. Over the Medium Term Expenditure Framework (MTEF) period it is expected that the spending will grow at a pace of 22.4 % per annum

The department has been characterised by poor equipment maintenance in the past which has led to shorter life span of key equipment. This was accompanied by poor and unplanned procurement processes. A ministerial advisory committee has been established for the purpose of setting standards and assessment of current technology needs culminating in a national health technology strategy. There will be an audit of essential equipment in all provinces and a report will be produced. Furthermore, we have embarked on an intensive artisan training programme to ensure that the department has expertise to maintain this expensive equipment. An additional strategy that will be finalised and implemented over the reporting period is the information communication and technology strategy.

Expenditure in the Emergency Medical Services (EMS) has increased at a rate of 9.4 per cent per annum. This increase was in response to policy shifts namely: locating ambulance services close to communities to enable an improved response time of 15-45 minutes; and ensuring two person ambulance crews. (Source: National Treasury)
The introduction of the National Health Insurance (NHI) is one of the priorities of the 10 point plan for

the health sector for 2009-2014. A solid foundation has been laid and the department is on track towards achieving the set targets of producing a policy document and the white paper on NHI in 2011.

In order to improve the health outcomes we need adequate numbers and correct mix of highly skilled professionals. In 2011 we will have a nursing summit to review amongst other things the content and structure of the nursing curriculum. One of the key deliverables of this exercise will be interventions to improve the nursing care and the quality of nurses we produce. We will work with all partners towards realisation of these objectives. In the following two years of the MTEF, similar processes will be embarked upon with all the relevant professional categories.

Indications from national treasury are that public health spending has increased by 16.7 per cent annually between 2005/06 and 2008/09. Based on current trends, public health spending is expected to double by 2011/12 compared to the 2005/06 expenditure. The substantial increase in funding allocation to health attest to the priority that has been placed by government on our department. In line with the new outcomes based performance management system, it has become necessary to restructure the department to fulfil this mandate. The restructuring has been approved by national treasury and the programs in this document reflect the new structure aligned to the NSDA.

2.2.3 Key Strategic Issues: Health Sector 10 Point Plan

Health priorities have been set for different epochs in South Africa. The health sectors' 10 Point Plan for 2009-2014 has served as an important overarching and macro framework for overhauling the health system, to enhance its capacity to improve health outcomes, and to harness focused interventions towards the MDGs.

The priorities comprising the 10 Point Plan are as follows:

(a) Provision of strategic leadership and creation of a social compact for better health outcomes;
(b) Implementation of National Health Insurance (NHI);
(c) Improving the quality of health services;
(d) Overhauling the healthcare system
(e) Improving human resources, planning, development and management;
(f) Revitalisation of infrastructure
(g) Accelerated implementation of HIV and AIDS and Sexually Transmitted Infections National Strategic Plan, 2007-2011 and reduction of mortality due to TB and associated diseases;
(h) Mass mobilisation for better health for the population;
(i) Review of the Drug Policy; and
(j) Strengthening research and development

Synopsis of progress towards the 10 point plan

Providing Strategic Leadership

Stewardship over the national health system is provided by the Minister of Health and the 9 Provincial MECs of Health, who constitute the National Health Council (NHC). Key focus has been on strengthening the governance of the health system, ensuring that it acts in unison in the pursuit of a common vision and common goals, and that agreed policies are implemented consistently throughout the system.

Major focus has been on providing leadership in efforts to combat HIV and AIDS, and charting a new discourse to alter national and international perceptions of an ineffective government. Leadership in the field of HIV and AIDS has ensured that South Africa's image globally has been elevated, with global

recognition for the massive efforts and interventions designed to combat the HIV and AIDS and TB at national, provincial and local level. South Africa received a sustained and lengthy standing ovation for reporting on the intensification of efforts in combating these diseases at the International AIDS conference at the Vienna Conference in 2010. A national healthcare provider initiated HIV Counselling and Testing (HCT) Campaign was launched by the President of South Africa in April 2010, and is being implemented in all 9 provinces and 52 heath districts.

Scale of Health Interventions

Diverse health interventions have been implemented at a massive scale, to improve access to health care. These are briefly outlined below.

Improving Child Health

Several areas of progress have been identified especially in terms of reducing the effect of childhood illnesses. Improving immunisation coverage ranks high amongst renowned strategies for improving child health. Immunisation campaigns have been markedly successful – for preventable diseases including polio and measles.

A mass immunisation campaign against polio was conducted during the first quarter of 2010. During the first round of this campaign, a total of 5,012,528 doses of Oral Polio Vaccine (OPV) were administered, against a target of reaching 5,026,796 children between the ages of 0-59 months. OPV coverage of 100% was achieved, which exceeded the target of 90%. During the second round of the polio mass immunisation campaign, a total of 4,298,148 doses of OPV were administered, against a target of 5,026, 796 children between the ages of 0-59 months. An OPV coverage of 86% was achieved, against a target of 90%. Provinces that recorded lower OPV coverage during the second round included Northern Cape (52%); North West (62%); and Western Cape (73%). Mop up campaigns were also conducted to improve polio immunisation coverage.

A mass immunisation campaign against measles was also conducted during the first quarter. This strategy targeted two age groups namely 6-59 months and 60-179 months. For the 6-59 months age category, the target was to reach 95% of children. Numerically, this target translates to 4, 345, 722 children aged 6-59 months. A total of 5,325,764 children aged 6-59 months were immunised against measles, which represented coverage of 117%. Far more children were reached than the original target.

For the second age group i.e. 60-179 months, the target was to have 10, 395, 789 children in this category immunised. The program managed to reach a total of 9, 266, 957 children who were immunized against measles, this represents a coverage of 89%. This was lower than the set target of 95% for the campaign however; annual overall national measles coverage of 98% was recorded.

For child health, there are carefully planned and systematic interventions that have been adopted; this is based on the NSDA objectives. The interventions are targeting various phases namely: *pre-pregnancy*; *pregnancy*; *birth*; *newborn/postnatal* and *childhood including Intergrated Management of Childhood Illness (IMCI) and adolescent*. The interventions are based on a three tiered health promotion and disease prevention strategy i.e.: prevent unintended pregnancies (primary prevention); preventing complications (secondary prevention) and preventing death or disability from complications (tertiary prevention).

Postnatal and newborn interventions include: early and exclusive breast feeding, warmth provision, infection control and provision of Vit A to the mother when indicated. Community based interventions will be piloted such as increasing home visits by community workers within 10 days of delivery for normal weight babies and an additional 3 in the subsequent 3 weeks for Lower Birth Weight (LBW) to province extra care for LBW infant and early identification and referral for sepsis. Improving referral channels

between community health workers and midwives will be enhanced to ensure success of the intervention. The Perinatal Problem Identification Program (PPIP) needs to be expanded to include more facilities so that areas with significant problems can be prioritised. Currently it has 244 sites nationally and data has been collected since 2000. This information is crucial in identifying key areas of intervention as they have identified namely: delayed response to complications due to poor health education, administrative problems where there is no transportation and lack of skilled staff, poor monitoring during labour and poor response to identified problems. Interventions aimed at reducing neonatal deaths should focus on: reducing intrapartum asphyxia, development and use of protocols and proper monitoring of labour (incl the use of partograph), implementing syphilis screening and treatment.

School Health Services: the target for this program and intervention is to be proactive and use disease prevention strategies at school through screening for common problems. Our programs will ensure a continuum of care, and integration of services ensuring appropriate care for the child's development from neonate to adolescent. The program aims to increase the proportion of schools which are visited by a school nurse; to conduct health screening of learners in grade1 for eyes, ears and teeth and most importantly prevention of heart disease through providing prophylactic treatment for the prevention of rheumatic heart disease.

Improving Maternal and Women's Health

Maternal and women's health interventions have been a success in many areas – including areas where skilled birth attendance has improved, access to maternity services and contraceptive coverage. While we acknowledge that some of the factors affecting maternal mortality include the effects of HIV and AIDS, we also know that many causes of death can be tackled – as is the case in countries with far smaller economies and public health funding levels.

Women's health: issues tend to be coalesced with maternal issues which sometimes lead to a gap and poor access to services for the non-pregnant woman. Evidence informs us that women tend to have a higher burden of disease (15%) than men (12%) and will therefore need our services more (Disease Control Priorities Program 2). Our services have to be reorganised in such a way that we can meet this need. A package of interventions for women's health include: family planning and contraceptive services; care following sexual assault, treatment of sexually transmitted infections and a focus on disease specific to women such as cancer of the cervix. While our services have provided these services in various ways, we have intensified our efforts in having very focussed and clear women's health interventions and to avoid missed opportunities. The provision of education to a non-pregnant woman will go a long way in preparing them for their pregnancy and ensure on time booking for antenatal care. These are some of the interventions that seek to strengthen women's health

Sexual and Reproductive Health (SRH) interventions include contraceptive information services; safe termination of pregnancy and reproductive health education and services. In this period, forty per cent (40%) of designated health facilities provided the Choice on Termination of Pregnancy (CTOP) services, in keeping with the target for the period under review. However, areas of unmet need persist.

Sexual Assault is an area needing strengthening; for example there has been very weak intersectoral collaboration between the provincial departments of health, NGOs, the police and the justice system. Providers across the country were unlikely to have any relationship with NGOs and therefore seldom referred patients to them for counselling. Referrals for counselling occur much less than any other aspect of the management of sexual assault. In 2011 we will conduct an audit on how our services are geared towards providing a quality and comprehensive care for sexual assault clients.

Adolescent health: Key interventions here include increasing coverage for the Youth and Adolescent Friendly

Health services (YFS) in all PHC facilities. Available data indicate that 40-50 % of facilities are implementing this intervention. Over the MTEF cycle this figure will be increased to 70 per cent of facilities. Additionally, the draft Youth Health strategy will be finalised in 2011 and disseminated to all 9 provinces and districts are to guide health services response to the heath needs of our young people. The 2008 Youth Risk Behaviour Survey has indicated that special interventions are needed for the following health problems: injuries (intentional and unintentional); mental health as the rates of attempted suicide and completed suicide have increased; smoking, alcohol and drug use with the latter two needing particular emphasis; hygiene, nutrition and exercise and sexual and reproductive behaviours seen through high unintended and unwanted pregnancies. The department will ensure that the Youth strategy will place emphasis on intervention development targeting the unhealthy behaviours among the youth.

Maternal health: Reports from facilities indicate that 42% of new mothers and babies were reviewed within 6 days after delivery and discharge from health facilities. This figure is set to improve with our campaign to take healthcare to communities through revitalising primary healthcare provision. In order to enhance the gains mentioned above, we are embarking on a safe motherhood strategy to comprehensively deal with maternal morbidity and mortality. The interventions are multipronged (individual and community based approaches) and multi layered being delivered at various platforms (such as at home, primary level, secondary level). There will be community level interventions which will focus on advocacy and social marketing regarding: nutritional advice; iron and folate supplements; and clinical interventions including blood pressure screening; screening and treatment of syphilis and urinary tract infections (UTIs) and fast tracking pregnant women to ART as elaborated in previous sections.

Additional intervention will focus on improving the skills of doctors and nurses emphasising training on the following key area of competence: provision of skilled assistance during deliveries, prompt referral for obstetric complications and emergencies, and improving post partum care. A concerted effort to improve skills and supervision in handling cases involving mothers and children is a key feature of our interventions going forward and already, nursing professionals and training providers including higher education institutions have been engaged on their contribution to this critical area of need. In 2011, a national Nursing Summit will be convened with a variety of professionals, students, academics, retired professionals, and professionals in the Diaspora. This is a timely event and it comes at a time just before the 29th Triennial Congress of the International Confederation of Midwives which will be meeting for the first time on African soil in our country in June 2011.

Combating HIV and AIDS and TB

HIV Prevention

Prevention remains the cornerstone of efforts to combat HIV and AIDS in South Africa. Leadership in this critical area has ensured that South Africa's image globally has been elevated, with global recognition for the massive efforts and interventions designed to combat the HIV and AIDS and TB at national, provincial and local level. In addition, the provider-initiated HIV Counselling and Testing campaign initiated in April 2010 is showing promising results in terms of its original aims which were to ensure that more people test and know their status. For the first time, a systematic, well planned and concerted drive through public and private sector facilities ensured community level communication and motivated people to take action and conduct an HIV test in order to know their HIV status.

From April to December 2010, we have managed to reach 6,208,157 South Africans as part of the HCT campaign. Of this figure, a total of 6 million tests were conducted. This demonstrates that South African have heeded the call to take responsibility for their lives and know their status. About 1 million people tested positive for HIV which constitutes an 18% prevalence rate. In the same period, 1, 6 million people were screened for TB and of these, 252,000 were referred for further diagnostic investigations.

Without the aggressive HCT campaign, the additional 6 million South Africans would not have known their status, which is a first step towards taking responsibility towards one's life and encourage HIV prevention. Approximately 2.942million would not have known their status and therefore not been in a position to protect their negative status.

Prevention of Mother to Child Transmission (PMTCT) of HIV

Our PMTCT (Prevention of Mother to Child Transmission) program is yielding results – with sustained declines observed in transmission rates while program coverage is increasing. There is a high uptake of treatment for PMTCT – 98% of HIV infected mothers tested were put on treatment.

Male circumcision and HIV prevention

The uptake of male circumcision, which has been found to be linked to a reduction in susceptibility to HIV infection, has been very promising, even in communities which normally do not practice male circumcision – the province of KwaZulu-Natal, being one example. Data indicate that from April to December 2010, about 49,803 male medical circumcisions had been conducted nationally with a significant proportion male (22,000) were done in KwaZulu-Natal. This augurs well for HIV prevention efforts in the health system in general. Modelling studies conducted in South Africa suggests that large scale provision of medical male circumcision to achieve 80% coverage could significantly reduce HIV incidence by 25 to 35 per cent. Health policy requires that medical male circumcision be provided as part of male sexual and reproductive health, and in combination with the provision and consistent use of condoms and promotion of sexual partner reduction.

Improving Access to ART

We have had a promising uptake in access to treatment in response to our campaigns. The annual target for new adults initiated on Antiretroviral Treatment (ART) will be met if roll out continues as in the first half of the year. 42% of the target of 400 000 new adults on ART had been met by September 2010. By the end of December 2010, a total of 1,3 million people were receiving ART in our country with a total of 14,556 (58%) of TB/HIV co-infected patients eligible for ART were started on ART.

Combating Tuberculosis (TB)

Much work has been done relating to reporting of TB management, specifically treatment outcomes. By mid-year, the TB cure rate for the year had been achieved (70.4%) though it remains 15 percentage points below the World Health Organisation (WHO) target cure rate of 85%. Treatment completion rates and default rates are on track, while 17 facilities were made available for diagnosing and initiating treatment for drug resistant TB patients. Over 5,000 health professionals and 3,200 were trained in TB management – representing 3% of the public health workforce. However, despite these achievements, Government will need to work harder on finding TB cases, initiating TB/HIV co-infected and Drug Resistant TB patients on ARV Treatment, as well as strengthening laboratory services for diagnosis and management.

Combating Communicable Diseases and Non-Communicable Diseases (NCDs)

Work on reducing the impact of chronic conditions (non-communicable diseases) or so called 'lifestyle-related health conditions" resulted in the hosting of The Diabetes Leadership Forum Africa 2010 held in South Africa in September 2010. An Implementation Plan for the Diabetes Declaration is being printed. A chronic diseases management register was also implemented in the first half of the year. The focus on alcohol and violence is well documented and intersectoral work on this issue will be the focus of the

partnerships at community level. The Phuza wise campaign and the strengthened primary healthcare teams are aimed at addressing this national scourge.

The burden of respiratory and diarrhoeal diseases is a cause for concern, these may be related to HIV and AIDS however there is still a component that is not linked to HIV and need to be addressed in this context. Disease outbreaks such as Rift Valley Fever and Cholera among adults and measles among children have recently resurfaced intermittently. To respond adequately to these outbreaks we need to strengthen our response to disease outbreak and surveillance systems. We will continue to provide support to the National Institute for Communicable Diseases (NICD).

Government's efforts to combat malaria incidence have been largely successful, available data demonstrate a downward trend compared to the year 2000. The incidence for the first 6 month of 2010/11 is 0.42 per 1000 population at risk, in three targeted provinces which border neighbouring countries.

Improving Quality of Care

The 10-point plan for health reflects the importance of improving the quality of care in our institutions as one of the priorities. This is further reflected in the recently-signed Negotiated Service Delivery Agreement where quality is one of the key sub-outputs in "Improving Health System Effectiveness".

The concerns voiced by our patients and the public regarding the public health services are numerous. Serious problems have been raised through patient complaints and media reports as well as client satisfaction surveys and in-depth studies. Some of these include poor hygiene and cleanliness, inadequate infection control systems and the negative staff attitudes towards patients.

There are also problems of very poor outcomes regarding deaths of patients from hospital acquired infections in spite of the resources we are putting into the system.

Six priority areas have been identified for immediate improvement, namely (a) improving staff attitudes and the values under-pinning them, (b) reducing the long waiting times or delays in receiving care, (c) ensuring all our facilities are spotlessly clean and tidy, (d) protecting the clinical as well as the physical safety of the patients and staff, (e) the measures needed to avoid transmission of infections and cross-infection, and (f) ensuring that basic medicines and supplies are available when patients are seen. These form part of a wider set of Core Standards for 'Quality Health Care' that would need to be complied with across all our health services.

One of the underlying factors that underpin the problems at our facilities is the lack of accountability throughout the system for meeting basic standards of good clinical care and health service management, especially given that health is a complex area of work where many different factors can result in poor outcomes and negatively affect patient experience. It is however hard to hold managers accountable when there is no uniform set of standards against which to measure them, nor a standardized and credible system for doing this. A set of National Core Standards has been developed, approved and published for application in our national health system, which will be used as the basis for strengthening quality of provision of health services locally, provincially and nationally. The common standards emanate from our consensus as a country of what is expected of our health services, both in hospitals and primary health care services. A standardised assessment process is being progressively rolled-out across the country to enable public establishments to identify and address critical gaps and benchmark themselves against similar establishments, prior to an external inspection to certify compliance.

In order to ensure compliance across the system, an independent body will be established to develop mechanisms to enforce these standards, and to objectively measure and report on whether all health

establishments in both the public and private sector meet the prescribed set of standards. To this end, National Health Amendment Bill has been published for comment. The draft Bill makes provision for the establishment of an Office of Health Standards Compliance which will advise the Minister on mandatory norms, standards and systems to improve the functionality of all health facilities in our country – particularly those delivering primary healthcare services at community level; will inspect all establishments to assess compliance, and will also have powers to investigate and report on any serious complaint regarding the quality of care or services provided. The Bill is at an advanced stage and will, when enacted, form the basis for the implementation of a national health system which is accessible to all in our country.

To date, there has been heartening progress in facility-level quality improvement. In the period under review, there have been wide consultations on the content and format of Quality Improvement Plans (QIP) with key partners across nine provinces. Thus, available data from our partners show that they are supporting close to 1,200 health facilities across all nine provinces and have develop these plans focussing on the six priority areas of patient safety, infection control, cleanliness, staff attitudes, waiting times and drug supply; and monitoring of such improvements in 54 hospitals is nearing completion.

Overhauling the health care system to enhance our capacity to improve health outcomes

Re-engineering Primary Healthcare (PHC)

A re-engineered primary healthcare (PHC) model for South Africa is at an advanced stage of development by a Ministerial Task Team appointed following a study tour to gain a better understanding of the Brazilian model. The model emphasises a population oriented service delivery approach (rather than a health facility-based one); deployment of multidisciplinary PHC teams across well defined geographic areas; effective utilisation of the skills of community-based resources such as Community Health Workers (CHW), and greater community involvement in securing and promoting health.

Improving the functionality and management of the Health System

The Development Bank of Southern Africa (DBSA), conducted a diagnostic assessment of the competencies of Hospital CEOs and district managers to assist in designing interventions at facility level intended to support the improvements in health outcomes envisaged in the Health Sector Negotiated Service Delivery Agreement signed earlier this year. The National Department of Health is also in the process of realigning its form and configuration with the requirements for successfully achieving MTSF Outcome 2: A Long and healthy life for all South Africans.

Improving Human Resources, Planning, Development and Management

A concerted effort to improve skills in handling cases involving mothers and children is a key feature of our interventions going forward and already, nursing professionals and training providers including higher education institutions have been engaged on their contribution to this critical area of need. In 2011, a national Nursing Summit will be convened with a variety of professionals and students, academics, retired and active professionals, and professionals in the diaspora to focus on practical solutions to some of these issues relating to challenges in our health system and the role of nurses and midwives in addressing our problematic health outcomes. This is a timely event and it comes at a time just before the 29th Triennial Congress of the International Confederation of Midwives which will be meeting for the first time on African soil in our country (in June 2011). We will therefore be prepared, through the Nursing Summit to focus on practical steps and actions we will take in the health system (and in the professions) to reverse our track record in recent years in the area of mother and child health outcomes.

Improving the working conditions of health workers

The health sector has continuously implemented efforts to improve the conditions of service for health care workers. The Occupation Specific Dispensation (OSD) was therefore introduced as an integrated career development framework comprising remuneration, career progression and patching, and performance management of the professional or clinical workforce based on roles and function. The main focus of the system so far has been on remuneration.

However, the performance management aspects of the OSD will be refined and elaborated as the roll out of the OSD intensifies. OSD implementation started with the roll out to nurses (in 2007), and incorporation of additional health professional categories such as Dentists, Medical Practitioners and Medical Specialists, Pharmacists, Pharmacist assistants, EMS personnel (in 2009). Barely a month ago, on 15t^{h} October 2010, had the State as the Employer tabled the final offer OSD for Allied Health Professionals in the Medical, Diagnostic and Therapeutic Services. The offer was accepted and signed by 4 of 5 trade unions in the PHSDSBC namely: NEHAWU; DENOSA; Public Servants Association of South Africa (PSA); NUPSAW/SADNU, on the 05th November 2010. Only HOSPERA did not sign. The estimated costs of this agreement, which reflects an implementation date of 01 July 2010, amount to R576 million. These resources have been made available from the national fiscus. There has been mixed variable results from the implementation of the OSD policy and this has necessitated a review which is currently underway.

Improving Health Infrastructure

Over 2,100 individual infrastructure related projects exist in health facilities in our country – ranging from maintenance and minor repairs through to renovation and major construction works. Of these projects, 138 clinics and 38 Community Health Centers (CHCs) were being constructed nationally (an increase of 4% in the total number of primary healthcare facilities in South Africa). These projects were valued at a total of R9 billion – a substantial portion of the fiscus. An infrastructure support model has been implemented - a component of which includes the appointment of engineers in each province to provide consistent technical expertise for managing active projects in the health sector. 4 provinces have finalized their appointments and other appointments are in process.

Eighteen (18) major revitalisation projects have been initiated in hospitals around the country which are in urgent need of infrastructure development. Five of these 18 projects are identified as Flagship projects supported through a Public Private Partnership (PPP) and the balance will be through a more streamlined Hospital Revitalisation Programmed which now incorporates a much improved provincial resource planning and allocation model – enabling a reduction in unspent funding on infrastructure projects country-wide. In addition, the assistance of Infrastructure development resource persons and built environment specialists from the DBSA and Council for Scientific and Industrial Research (CSIR) has been secured to strengthen implementation, monitoring and evaluation in all provinces.

It is anticipated that the pace of implementation will accelerate as a result of these interventions in the coming period. In addition, measures for better financial management and planning will ensure a decline in the amounts of rollovers and unspent funds for infrastructure development in our country. This will be a positive influence in improving access to health services in our country.

Implementation of National Health Insurance (NHI)

Work on the National Health Insurance (NHI) is at an advanced stage. A Ministerial Advisory Committee (MAC) was established in 2009 by the Minister of Health and has developed a report which was considered by Cabinet, and which led to the formation of an Inter-Ministerial Committee (IMC) on the NHI. Cabinet requested comprehensive work to be done (on costing, economic modelling, a description of the role of primary health care services in the NHI, and the elaboration of migration of funding mechanisms, and a

communication strategy) and this has now been completed for consideration by the IMC. By 2011, it is anticipated that a detailed implementation plan for NHI will be produced.

Work has begun on an integrated audit of health facilities covering staff, technology, equipment, infrastructure, the 6 areas of priority for quality improvement, systems, and processes in order to bring these to bear on the roll out of implementation of the NHI and will be concluded early 2012. In the meantime, monitoring and evaluation mechanisms are being strengthened at facility level especially in order to better align the health system at all levels to the requirements for achieving the NSDA outputs – particularly those relating to Health System Effectiveness. This will necessarily mean some rearrangement or realignment of existing or established structures and processes, but these will result in a better, more accessible health system for all our people.

Review of the Drug Policy

Various challenges continue to be experienced in the health sector with the supply of drugs and pharmaceuticals. Sporadic drug stock-outs occurred in health facilities, resulting from multiple factors, both internal and external to the health sector. These included: financial constraints resulting in delays in the payment of suppliers; drug supply management problems; suppliers' incapacity to deliver according to demand; suppliers' inability to adhere to lead times; and tender prices higher than international prices.

A Task Team appointed to investigate these challenges completed its work and presented a set of recommendations to the NHC on the reform of medicine procurement systems in the public sector. These included strategies to: improve drug procurement and payment systems to ensure reliable and uninterrupted supply; ensure a more cost-effective procurement of drugs through the centralization of the authority for procurement; and address systems failures resulting in medicine shortages.

The outcome of the work of the task team has helped in reducing tender prices of ART to the value of R4, 2 billion over two years. This has resulted in savings of R4, 7 billion (53%) which will enable the health sector to place more people on ART. Access to ART will be expanded by half a million people each financial year for the MTEF. A central procurement authority will be established to improve efficiency systems including procurement of vaccines, TB meds, ART and reproductive health products.

Strengthening research and development

We have forged partnerships aimed at strengthening research and development with other government departments such as Science and Technology; entities such as the Medical Research Council (MRC); Human Sciences Research Council (HSRC); the Health Systems Trust (HST), as well as academic institutions. The Department of Science and Technology has established three Centres of Competence in Malaria, TB, HIV/AIDS Cancer, and Diabetes, in conjunction with the National Department of Health.

The National Health Research Committee (NHRC) and National Health Research Ethics Committee (NHREC) have also been established in terms of the National Health Act of 2003. The duties of the NHRC are to: determine the health research to be carried out by public health authorities; ensure that health research agendas and research resources focus on priority health problems; *develop* and advise the Minister on the application and implementation of an integrated national strategy for health research; and coordinate the research activities of public health authorities.

The Medical Research Council was established in 1969 by an Act of Parliament. The objects of the MRC are, through research, development and technology transfer, to promote the improvement of the health and quality of life of the population of the Republic, and to perform such functions as may be assigned to the MRC by or under this Act.

These research bodies which have been established in terms of the statutes will scale up their efforts in building research capacity in the country, consistent with our priorities the research agenda will be designed to respond accordingly.

A need exists for South Africa to develop a model for the translation of evidence generated through empirical research into national health policy. In an iterative manner, research must also review health policy implementation. To this end, a health and policy technical unit has been budgeted for in the MTEF period 2011-2013 to develop and institutionalise this capacity within the department.

2.2.4 Key Strategic Issues: Health Sector Negotiated Service Delivery Agreement

Thus the focus of the health sector over the planning cycle 2011/12-2013/14 will therefore be on the four (4) outputs entailed in the Minister's Performance Agreement with the President of the Republic, and elaborated on in the Negotiated Service Delivery Agreement for 2010-2014. These are: Increasing Life Expectancy; Reducing Maternal and Child Mortality Rates; Combating HIV and AIDS and decreasing the burden of diseases from Tuberculosis and Strengthening Health System Effectiveness. Strategies for achieving these are reflected in the relevant medium term plans of health departments.

Government has adopted an outcome-based approach to service delivery, which consists of 12 outcomes. This is articulated in the revised Medium Strategic Framework (MTSF) for 2009-2014.

The 12 Outcomes are as follows:

- Improved quality of basic education
- **A long and healthy life for all South Africans**
- All people in South Africa are and feel safe
- Decent employment through inclusive economic growth
- A skilled and capable workforce to support an inclusive growth path
- An efficient, competitive and responsive economic infrastructure network
- Vibrant, equitable and sustainable rural communities with food security for all
- Sustainable human settlements and improved quality of household life
- A responsive, accountable, effective and efficient local government system
- Environmental assets and natural resources that are well protected and continually enhanced
- Create a better South Africa and contribute to a better and safer Africa and World
- An efficient, effective and development oriented public service and an empowered, fair and inclusive citizenship

The health sector is responsible for the achievement of Outcome 2 namely: A long and healthy life for all South Africans.

The strategic thrust of the health sector for 2010-2015 will be the centred around the four outputs of the Negotiated Service Delivery Agreement (NSDA) 2010-2014 namely:

- **Output 1**: Increasing Life Expectancy
- **Output 2**: Decreasing Maternal and Child mortality
- **Output 3**: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis
- **Output 4**: Strengthening Health System Effectiveness

Major targets include the following:

- Life expectancy must increase from the current at 53.5 years for males and 57.2 years for females (Statistics SA 2009) to 58 years for males and 60 years for females by 2014.
- South Africa's Maternal Mortality Ratio (MMR) must decrease from the estimated 400 per 100,000 to 100 (or less) per 100,000 live births by 2014. MDG country report estimates MMR at 625 per 100,000. These figures are currently under review.
- The child mortality rate must decrease from the current 104 per 1,000 live births to 45 deaths (or less) per 1,000 live births by 2014.
- The TB cure rate must improve from 64% in 2007 to 85% by 2014
- 80% of eligible people living with HIV and AIDS must access antiretroviral treatment.
- New HIV infections must be reduced by 50% by 2014.

Table 4

Outputs	Sub-outputs
Output 1: **Increasing Life Expectancy**	• Rapidly scaling up access to Antiretroviral Therapy (ART) for people living with HIV&AIDS, especially identified vulnerable groups. • Strengthening of the National TB Control Programme; • Strengthening immunisation programmes to protect South African children against vaccine preventable diseases • Increasing the early detection of people with chronic conditions (hypertension, diabetes) • Implementing upstream strategies to reduce intentional and non-intentional injuries.
Output 2: **Decreasing Maternal and Child mortality**	• Enhancing the clinical skills of health workers in Emergency Obstetric Care and Comprehensive Emergency Obstetric Care; • Enforcing the use of clinical guidelines and protocols; • Increasing the national immunisation coverage. • Expanding coverage with IMCI Household Community Component • Provision of PMTCT to eligible pregnant HIV positive women • Increasing access to Highly Active Antiretroviral Therapy (HAART) for eligible HIV positive pregnant women and children • Increasing access to school health services • To ensure that polymerase chain reaction (PCR) test is performed on all HIV-exposed babies. • Improving Reproductive Health Services • Increasing access to safe Choice on Termination of Pregnancy (CTOP) services Institutionalising the review maternal and perinatal deaths across the health sector
Output 3: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis	• Implementing health care provider-initiated HIV Counselling and Testing (HCT) in all health facilities. • Rapidly scaling up condom distribution at all health facilities • Scaling up access to Antiretroviral Treatment • Enhancing the clinical skills of health professionals in TB management • Improve active case finding and strengthening laboratory diagnostic services • Strengthening community involvement in the TB DOTS Programme

Outputs	Sub-outputs
Output 4: **Strengthening Health System Effectiveness**	• Strengthening Primary Health Care (PHC) approach to service delivery. • Producing a revised Human Resources Plan for Health by the end of 2010/11. • Assessing with partners the functionality, efficiency and appropriateness of the organisational structure of each hospital. • Supporting Public Health Facilities to produce and implement Quality Improvement Plans • Improve Health Care Financing and Strengthening Financial Management • Accelerating Health Infrastructure Improvement. • Ensuring appropriate technologies are procured maintained and supported • Strengthen Information management and enhance monitoring and evaluation

The four outputs carry different weights, and can be stratified into four layers; inputs; output; outcomes and impact.

An increased life expectancy for all South Africans is the highest impact that the country seeks to attain. Thus it is an apex priority of the 4 outputs that the health sector seeks to deliver on.

The second layer consists of improving health outcomes such as infant and child mortality rates, and morbidity and mortality from HIV&AIDS and Tuberculosis. This is by virtue of the fact improved health outcomes will contribute to enhancing life expectancy.

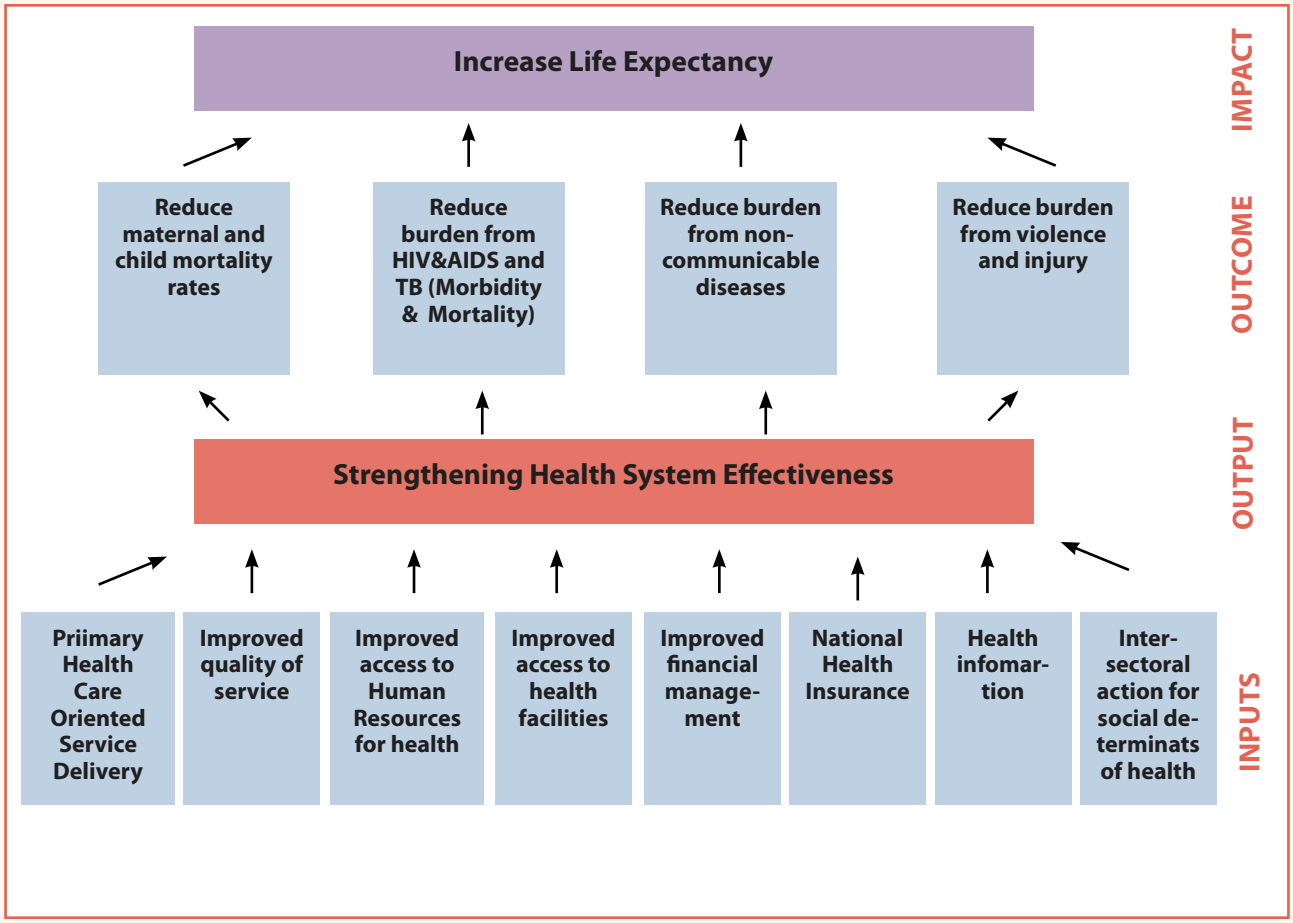
Strengthening the effectiveness of the health system is the foundation on which successful interventions to improve health outcomes can be built. International experience points to the fact that only a strengthened health system, further fortified by effective intersectoral collaboration to address social determinants of health, can improve health outcomes. A weak health system will collapse in the face of major health demands.

WHO defines quintessential six building blocks for a health system namely: service delivery; health workforce; information; medical products, vaccines and technologies and financing.[1]

Service delivery encompasses the packages; delivery models; infrastructure; management; safety and quality; demand for care. Health workforce issued include national workforce policies and investment plans; advocacy; norms, standards and data. Information entails facility and population based information and surveillance systems; global standards, tools. Issues around medical products encompass norms, standards, policies; reliable procurement; equitable access; quality. Emphasis on financing includes national health financing policies; tools and data on health expenditures; costing. Leadership and governance focuses on the development of health sector policies; as well as their harmonization and alignment; and provision of oversight and regulation.

Implementation of the six building blocks must be characterised by increased access to services for the population, increased population coverage with essential interventions; improved quality and safety. Special emphasis should be placed on improving access to health care to rural communities and the urban poor. This is highly likely to lead to the key desired outcomes, which are the functions of the health system namely: improved health (level and equity); health system responsiveness; social and financial risk protection; and efficiency.

[1] Everybody's Business: Strengthening Health Systems to improve health outcomes, World Health Organisation (WHO)'s Framework for Action, WHO, 2007



2.3 Organisational Environment

The organisational structure of the National Department of Health will be significantly transformed during 2011/12 and 2012/13, to align it to the four NSDA outputs, and to enable it to improve its oversight function across the health system. Conventional wisdom in organisational development postulates that structure must follow function. Over time, these structural changes will be effected at other levels of the health sector.

The focus of the National Department of Health during the planning cycle 2011/12-2013/14 will be on results-based management, '*a management strategy focusing on performance and the achievement of outputs, outcomes and impacts*'. Every single intervention listed in this Annual Performance Plan (APP) must contribute logically, systematically and sequentially to the attainment of the objectives outlined in the NSDA 2010-2014, and eventually to the desired impact on the lives of the people of South Africa.

3. HEALTH LEGISLATION

Legislation governing the functioning of the department is outlined below, with a brief description of their provisions

3.1 Legislation falling under the Minister's portfolio

- **Constitution of the Republic of South Africa Act, 108 of 1996**
  Pertinent sections provide for the rights of access to health care services, including reproductive health and emergency medical treatment.

- **National Health Act, 61 of 2003**
  Provides for a transformed national health system for the entire Republic

- **Medical Schemes Act, 131 of 1998**
  Provides for the regulation of the medical schemes industry to ensure consonance with national health objectives.

- **Medicines and Related Substances Act, 101 of 1965**
  Provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficacy. The Act also provides for transparency in the pricing of medicines**.**

- **Mental Health Care Act, 17 of 2002**
  Provides a legal framework for mental health in the Republic and in particular the admission and discharge of mental health patients in mental health institutions with emphasis on human rights for mentally ill patients.

- **Choice on Termination of Pregnancy Act, 92 of 1996**
  Provides a legal framework for termination of pregnancies based on choice under certain circumstances.

- **Sterilization Act, 44 of 1998**
  Provides a legal framework for sterilizations, also for persons with mental health challenges.

- **SA Medical Research Council Act, 58 of 1991**
  Provides for the establishment of the SA Medical Research Council and its role in relation to health research.

- **Tobacco Products Control Amendment Act, 63 of 2008**
  Provides for the control of tobacco products, prohibition of smoking in public places and advertisements of tobacco products as well as sponsoring of events by the tobacco industry.

- **National Health Laboratory Service Act, 37 of 2000**
  Provides for a statutory body that provides laboratory services to the public health sector.

- **Health Professions Act, 56 of 1974 as amended**
  Provides for the regulation of health professions, in particular, medical practitioners, dentists, psychologists and other related health professions, including community service by these professionals.

- **Pharmacy Act, 53 of 1974 as amended**
  Provides for the regulation of the pharmacy profession, including community service by pharmacists.

- **Nursing Act, of 2005**
  Provides for the regulation of the nursing profession.

- **Allied Health Professions Act, 63 of 1982 as amended**
  Provides for the regulation of health practitioners like chiropractors, homeopaths and others, and for the establishment of a council to regulate these professions.

- **Dental Technicians Act, 19 of 1979**
  Provides for the regulation of dental technicians and for the establishment of a council to regulate the profession.

- **Hazardous Substances Act, 15 of 1973**
  Provides for the control of hazardous substances, in particular those emitting radiation.

- **Foodstuffs, Cosmetics and Disinfectants Act, 54 of 1972 as amended**
  Provides for the regulation of foodstuffs, cosmetics and disinfectants, in particular, setting quality and safety standards for the sale, manufacturing and importation thereof.

- **Occupational Diseases in Mines and Works Act, 78 of 1973**
  Provides for medical examinations on persons suspected of having contracted occupational diseases especially in mines and for compensation in respect of those diseases.

- **Council for Medical Schemes Levy Act, 58 of 2000**
  Provides for a legal framework for the Council to charge medical schemes certain fees.

- **National Policy for Health Act, 116 of 1990**
  Provides for the determination of national health policy to guide the legislative and operational programmes of the health portfolio.

- **Academic Health Centres Act, 86 of 1993**
  Provides for the establishment, management and operation of academic health centres.

- **Human Tissue Act, 65 of 1983**

  Provides for the administration of matters pertaining to human tissue.

3.2 Other legislation in terms of which the department operates

- **Public Service Act, Proclamation 103 of 1994**
  Provides for the administration of the public in its national and provincial spheres, as well as provides for the powers of ministers to hire and fire.

- **Promotion of Administrative Justice Act, 3 of 2000**
  Amplifies the constitutional provisions pertaining to Administrative law by codifying it.

- **Promotion of Access to Information Act, 2 of 2000**
  Amplifies the constitutional provision pertaining to accessing information under the control of various bodies.

- **Labour Relations Act, 66 0f 1996**
  Regulates the rights of workers, employers and trade unions

- **Compensation for Occupational injuries and Diseases Act, 130 of 1993**
  Provides for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, for death resulting from such injuries or disease.

- **Basic Conditions of Employment Act, 75 of 1997**
  Provides for the minimum conditions of employment that employers must comply with in their workplaces.

- **Occupational Health and Safety Act, 85 of 1993**
  Provides for the requirements that employers must comply with in order to create a safe working environment for employees in the workplace.

- **The Division of Revenue Act, 7 of 2003**
  Provides for the manner in which revenue generated may be disbursed.

- **Skills Development Act, 97of 1998**
  Provides for the measures that employers are required to take improve the levels of skill of employees in workplaces.

- **Preferential Procurement Policy Framework Act, 5 of 2000**
  Provides for the implementation of the policy on preferential procurement pertaining to historically disadvantaged entrepreneurs.

- **Employment Equity Act, 55 of 1998**
  Provides for the measures that must be put into operation in the workplace in order to eliminate discrimination and promote affirmative action.

- **State Information Technology Act, 88 of 1998**
  Provides for the creation and administration of an institution responsible for the State's information technology system.

- **Child Care Act, 74 of 1983**
  Provides for the protection of the rights and well being of children.

- **The Competition Act, 89 0f 1998**
  Provides for the regulation of permissible competitive behaviour, regulation of mergers of companies and matters related thereto.

- **The Copyright Act, 98 of 1998**
  Provides for the protection of intellectual property of a literary, artistic musical nature that is reduced to writing.

- **The Patents Act, 57 of 1978**
  Provides for the protection of inventions including the gadgets and chemical processes.

- **The Merchandise Marks Act, 17 of 1941**
  Provides for the covering and marking of merchandise, and incidental matters.

- **Trade Marks Act, 194 of 1993**
  Provides for the registration of, certification and collective trademarks and matters incidental thereto.

- **Designs Act, 195 of 1993**
  Provides for the registration of designs and matters incidental thereto.

- **Promotion of Equality and the Prevention of Unfair Discrimination Act, 4 of 2000**
  Provides for the further amplification of the constitutional principles of equality and elimination of unfair discrimination.

- **State Liability Act, 20 of 1957**
  Provides for the circumstances under which the State attracts legal liability.

- **Broad Based Black Economic Empowerment Act, 53 of 2003**
  Provides for the promotion of black economic empowerment in the manner that the State awards contracts for services to be rendered, and incidental matters.

- **Unemployment Insurance Contributions Act, 4 of 2002**
  Provides for the statutory deduction that employers are required to make from the salaries of employees.

- **Public Finance Management Act, 1 of 1999**
  Provides for the administration of State funds by functionaries, their responsibilities and the incidental matters.

- **Protected Disclosures Act, 26 of 2000**
  Provides for the protection of whistle-blowers in the fight against corruption.

- **Control of Access to Public Premises and Vehicles Act, 53 of 1985**
  Provides for the regulation of individuals entering government premises, and incidental matters.

- **Conventional Penalties Act, 15 of 1962**
  Provides for the enforceability of penal provisions in contracts.

- **Intergovernmental Fiscal Relations Act, 97 of 1997**
  Provides for the manner of harmonisation of financial relations between the various spheres of government, and incidental matters.

- **Public Service Commission Act, 46 of 1997**
  Provides for the amplification of the constitutional principles of accountability governance, and incidental matters.

4. OVERVIEW OF 2011/12 BUDGET AND MTEF ESTIMATES

Budget summary

	2011/12				2012/13	2013/14
R million	Total to be appropriated	Current payments	Transfers and subsidies	Payments for capital assets	Total	Total
MTEF allocation						
Administration	326.1	318.0	0.4	7.7	325.3	344.4
Health Planning and Systems Enablement	160.8	157.5	0.4	2.9	178.0	189.8
HIV and AIDS, TB and Maternal, Child and Women's Health	8 026.5	357.6	7 664.7	4.2	9 377.1	11 188.2
Primary Health Care Services	730.0	123.4	593.0	13.6	143.0	150.1
Hospitals, Tertiary Services and Workforce Development	15 962.7	97.1	15 864.3	1.3	17 015.8	17 663.7
Health Regulation and Compliance Management	525.4	155.8	366.4	3.2	571.6	600.5
Total expenditure estimates	**25 731.6**	**1 209.3**	**24 489.3**	**32.9**	**27 610.8**	**30 136.7**
Executive authority	Minister of Health					
Accounting officer	Director-General of Health					
Website address	www.doh.gov.za					

Expenditure estimates

Programme	Audited outcome			Adjusted appropriation	Revised estimate	Medium-term expenditure estimate		
R million	2007/08	2008/09	2009/10	2010/11		2011/12	2012/13	2013/14
Administration	213.6	241.0	269.9	282.1	282.1	3261.1	325.3	344.4
Health Planning and Systems Enablement	88.1	120.0	142.0	135.5	124.5	160.8	178.0	189.8
HIV and AIDS, TB and Maternal, Child and Women's Health	2 414.3	3 394.4	4 923.5	6 678.6	6 668.6	8 026.5	9 377.1	11 188.2
Primary Health Care Services	639.4	703.1	775.2	711.9	699.9	730.0	143.0	150.1
Hospitals, Tertiary Services and Workforce Development	9 844.4	11 550.3	12 618.1	14 827.9	13 947.2	15 962.7	17 015.8	17 663.7
Health Regulation and Compliance Management	378.8	415.5	440.0	496.4	496.4	525.4	571.6	600.5
Total	**3 578.6**	**16 424.5**	**19 168.6**	**23 132.5**	**22 218.7**	**25 731.6**	**27 610.8**	**30 136.7**
Change to 2010 Budget estimate				1 635.5	721.7	2 023.6	1 766.1	-

Economic classification								
Current payments	**728.9**	**916.8**	**1 089.7**	**1 173.3**	**1 140.3**	**1 209.3**	**1 260.0**	**1 322.0**
Compensation of employees	258.6	292.5	333.0	385.0	385.0	424.0	465.0	492.0
Goods and services	470.3	624.3	756.7	788.3	755.3	785.3	795.0	830.0
of which:								
Advertising	*30.5*	*16.7*	*95.2*	*106.3*	*102.3*	*77.2*	*92.9*	*102.9*
Consultants and professional services: Business and advisory services	*112.6*	*124.5*	*39.0*	*103.0*	*95.0*	*116.2*	*120.8*	*121.6*
Inventory: Medical supplies	*76.8*	*103.9*	*325.5*	*187.3*	*187.3*	*150.9*	*136.0*	*141.0*
Travel and subsistence	*88.1*	*125.2*	*67.9*	*111.1*	*100.1*	*114.4*	*119.4*	*122.5*
Transfers and subsidies	**12 827.6**	**15 466.1**	**18 065.8**	**21 914.2**	**21 033.5**	**24 489.3**	**26 316.2**	**28 778.2**
Provinces and municipalities	12 368.6	14 988.7	17 523.8	21 363.7	20 483.0	23 947.7	25 746.5	28 175.2
Departmental agencies and accounts	301.9	315.9	335.9	355.6	355.6	361.2	377.1	397.9
Universities and technikons	0.4	0.7	0.5	1.1	1.1	1.1	1.2	1.2
Non-profit institutions	156.0	160.2	202.8	193.8	193.8	179.3	191.4	203.8
Households	0.7	0.6	2.9	–	–	–	–	–
Payments for capital assets	**22.0**	**41.4**	**13.0**	**44.9**	**44.9**	**32.9**	**34.7**	**36.6**
Buildings and other fixed structures	–	–	–	2.8	2.8	–	–	–
Machinery and equipment	21.7	41.4	11.7	42.1	42.1	32.9	34.7	36.6
Software and other intangible assets	0.3	–	1.3	–	–	–	–	–
Payments for financial assets	**0.1**	**0.2**	**0.0**	**–**	**–**	**–**	**–**	**–**
Total	**13 578.6**	**16 424.5**	**19 168.6**	**23 132.5**	**22 218.7**	**25 731.6**	**27 610.8**	**30 136.7**

Expenditure trends

Spending over the MTEF period will focus on supporting Provinces and Municipalities to strengthen the implementation of an effective response to HIV and AIDS through the National Strategic Plan for HIV and AIDS 2007 – 2011, building additional capacity in the provinces and partially subsidising funding for the provision of antiretroviral treatment. The bulk of the spending will be on making transfers to provinces and municipalities from the HIV and AIDS, TB and Maternal, Child and Women's Health and the Hospitals, Tertiary Services and Workforce Development budget programmes. Provinces will also receive support to fund costs associated with training of health professionals, developing and recruiting medical specialists in under serviced provinces and strengthening undergraduate and post graduate teaching and training processes in health facilities. National Health Insurance is a key priority in the 2011/12 budget and several budget allocations are intended to support its preparatory phase.

Expenditure grew from R 13.6 billion in 2007/08 to R 23.1 billion in 2010/11 at an average annual rate of 19.4 per cent. Over the medium term, expenditure is expected to grow to R30.1 billion at average annual rate of 9.2 per cent. The increase in both periods is driven largely by the transfers to provinces and municipalities.

The Budget includes new allocations of R442 million for 2011/12; R692 million for 2012/13 and R2.2 billion for 2013/14 for spending on the following policy priorities:

- R10 million per year to forensic chemistry laboratories to purchase equipment and appoint staff to address backlogs
- R10 million to the South Africa Health Products and Regulatory Authority to establish itself and to deal with the medicine registration backlogs. This is a once off payment, based on the understanding that SAHPRA will generate and retain its own revenue going forward.
- R30 million in 2011/12, and R30 million in 2012/13 and 2013/14 to progressively increase the distribution of condoms
- R9 million, R5 million and R5 million to nursing colleges to plan and coordinate the second phase of upgrading, recapitalising and maintaining nursing colleges following the infrastructure audit
- R3 million, R5 million and R7 million for the Health Systems Trust to support health systems research activities including the annual health review and district health barometer
- R2 million per year to publish standardised annual health statistics in the new annual health statistics publication to facilitate performance auditing and better inform the public and health service providers
- R5 million, R6 million and R7 million for the Compensation Commissioner for Occupational Diseases (CCOD) to address backlogs in compensation, improve systems and address problems identified in audit reports
- R60 million in 2011/12 and 2012/13, R60 million and R1.4 billion in 2013/14 for the HIV and AIDS conditional grant for the rapidly growing treatment programme and to strengthen prevention programmes including R60 million per annum for male circumcision

NHI Related Expenditure

The expenditure below is towards preparatory work for NHI.

- R10 million, R20 million and R10 million to Office of Standards Compliance and Quality Assurance to establish itself and to support its inspectorate, certificate of compliance and ombudsman functions
- R21 million, R17 million and R13 million for infrastructure management and private public partnerships to build up capacity in the department to oversee the hospital revitalisation projects and to support planning and transaction advisor cost for large private public partnership projects
- R5 million, R7 million, and R9 million for health technology to support provincial upgrading of engineering workshops and equipment audits and to develop equipment packages and systems for health technology
- R5 million per year for National Health Insurance to support development work and projects including the ministerial advisory committee
- R4 million in 2011/12 and 2012/13 and R5 million in 2013/14 to develop improved hospital tariff schedules for use by provinces and the Road Accident Fund, including improved uniform patient fee structure, Road Accident Fund reimbursement and tariff structure, and developing diagnosis related groups system.
- R5 million per year for health information systems to support national workgroup investigations of new patient based IT system and to propose next steps in IT infrastructure to support the district health information system
- R2 million, R3 million and R4 million to monitor and support provinces in order to stabilise provincial finances and improve audit outcomes
- R250 million, R500 million and R750 million for the national tertiary services conditional grant to support public hospitals to achieve norms and standards partly in preparation for the National Health Insurance and to implement standards and guidelines of the Office of Standards Compliance and Quality Assurance, as well as to address differential costs of doctor occupation

specific dispensation

The ratio of administrative costs to line function programme costs was 2% for the 2009/10 year, 1% for the 2010/11; 2% for 2011/12; 1% for 2012/13 and 1% for the 2012/13 year.

Donor funding for the health sector is estimated to be between 1-2% of the total health expenditure. International development partners work closely with the department enhancing the effectiveness of our programs. Some of the efforts are focussed towards the expansion and addressing of gaps in the national response to HIV and AIDS by expanding and strengthening the role of Non-Governmental Organisations (NGOs) and Faith-Based Organizations (FBOs). The main thrust is on prevention, care and support and health systems strengthening. This includes mass media, community outreach, condom distribution, training, HIV counselling and testing, care for Orphans and Vulnerable Children (OVC), and institutional capacity building. While some have focused on specific programs (HIV&AIDS and TB) others have partnered with us to strengthen the health system. These include projects such strengthening financial management and fairer financing of high quality health services for all ; strengthening health systems to facilitate effective programme implementation and providing access to primary health care through funding access to primary health care through funding nongovernmental organisations. There has been a concerted effort from partners to strengthen capacity of NGOs to develop effective program address HIV/AIDS, gender equality and activation of CBO's with special emphasis on community based activities.

Infrastructure spending

The previous infrastructure grant to provinces has been subdivided into its functional components. R1.7 billion, R1.8 billion and R1.9 billion over the MTEF, which make up the previous grant's health component, has been added as a new conditional grant in the department. This grant has helped to fund health infrastructure such as primary health care, maintenance and smaller hospital projects.

Allocations for the hospital revitalisation grant over the MTEF period are R4.1billion, R4.3 billion and R4.1 billion. The department has commenced with the planning and design phase for five flagship private public partnership projects for the following hospitals: Chris Hani Baragwanath, Garankuwa, King Edward VII, Polokwane and Port Elizabeth.

Reporting on personnel

The Department's organogram structure has been revised. The number of personnel employed is currently 1249. The filling of vacant posts was affected by envisaged restructuring as well as limited funding. Provision has been made in the medium term to address the vacancy rate with technical staff and other administrative critical posts based on identified priorities aligned to the Service Delivery Agreement (SDA).

Departmental receipts

The main source of revenue is from fees for registration of medicines by the South African Health Products Regulatory Authority (SAHPRA). Modern technological advancements such as an Electronic Document Management System (EDMS) are being introduced to enhance the efficiency of the Authority. Efficient information systems will also enhance SAHPRA ability to effectively generate record and account for its own revenue. To achieve this going forward, substantial investments are required in the development stages of this regulatory institution.

Departmental receipts

R thousand	Audited outcome			Adjusted estimate	Revised estimate	Medium-term receipts estimate		
	2007/08	2008/09	2009/10	2010/11		2011/12	2012/13	2013/14
Departmental receipts	**41 193**	**31 188**	**45 190**	**31 457**	**31 457**	**32 776**	**32 919**	**36 211**
Sales of goods and services produced by department	39 447	29 676	38 355	30 451	30 451	31 766	32 265	35 492
Sales of scrap, waste, arms and other used current goods	67	71	57	84	84	88	92	101
Interest, dividends and rent on land	297	249	1 012	252	252	252	263	289
Transactions in financial assets and liabilities	1 382	1 192	5 766	670	670	670	299	329
Total	**41 193**	**31 188**	**45 190**	**31 457**	**31 457**	**32 776**	**32 919**	**36 211**

PART B: PROGRAMMES AND SUB-PROGRAMMES

5. PROGRAMME 1: ADMINISTRATION

5. 1 Programme Purpose

Purpose: Overall management of the department and centralised support services.

There are five sub- programmes:

- *Ministry*
- *Management*
- *Financial Management*
- *Corporate Services*
- *Office Administration*

5.2. Strategic Objective, Performance indicators and Annual targets for 2011/12 to 2013/14

The table below summarise the key measurable objectives, indicators and three-year targets for the various sub-programmes funded from the Administration Programme.

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
To ensure effective financial management and accountability	Un qualified audit opinion from AG	Qualified Audit Opinion	Qualified Audit Opinion	Unqualified Audit Opinion	Unqualified Audit Opinion	Unqualified Audit Opinion	Unqualified Audit Opinion	Unqualified Audit Opinion
	Audit opinion of the Auditor General: Provincial DoHs	1/9 Provincial DoHs with Unqualified Audit Opinions	1/9 Provincial DoHs with Unqualified Audit Opinions	2/9 Provincial DoHs with Unqualified Audit Opinions	4 provincial DOH with unqualified audit outcomes	5 provincial DOH with unqualified audit outcomes	6 provincial DOH with unqualified audit outcomes	7 provincial DOH with unqualified audit outcomes
	Number of provinces with over expenditure	-	-	-	6/9	5/9	3/9	1/9
	Total number of Provinces with financial improvement plans	-	-	9	9	9	9	9
To ensure that Information Communication Technology (ICT) supports the business objectives of the Department.	Master Information systems plan (MISP) to support the business functions produced	-	-	-	-	MISP Produced	Phase I of the MISP implemented	Phase II of the MISP implemented
	Produce a ICT Business Continuity Plan which incorporates a Disaster Recovery Plan	-	-	-	-	ICT Business Continuity Plan inclusive of a disaster recovery plan produced	ICT Business Continuity Plan tested and distributed	Business Continuity Plan
	Produce a comprehensive ICT policy that govern the use of ICT facilities	-	-	-	-	Comprehensive ICT policy produced	-	ICT policy reviewed.
	Governance body for all ICT services established	-	-	-	-	Information Technology Committee (ITC) established	Functional Information Technology Committee for the Department	Functional Information Technology Committee for the Department

5.3 Quarterly targets for 2011/12

The Reporting Period for all indicators under programme 1 is Annual.

5.4 Reconciling Performance targets with the Budget and MTEF

Expenditure estimates

Administration

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R million	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Ministry[1]	17.5	22.6	22.1	28.8	31.7	32.6	34.3
Management	19.7	22.9	20.6	24.7	37.2	38.5	40.3
Corporate Services	125.1	133.0	159.6	148.2	156.3	151.8	159.9
Office Accommodation	38.2	41.6	46.4	51.6	55.3	58.8	61.7
Financial Management	13.1	21.1	21.2	28.8	45.5	43.6	48.2
Total	**213.6**	**241.0**	**269.9**	**282.1**	**326.1**	**325.3**	**344.4**
Change to 2010 Budget estimate				17.3	26.2	(5.6)	–

1. From 2008/09, the current payments relating to the total remuneration package of political office bearers are shown, before this, only salary and car allowance are included.

Administrative and other subprogramme expenditure may in addition include payments for capital assets as well as transfers and subsidies.

	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R million	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Economic classification							
Current payments	**206.1**	**218.5**	**265.6**	**264.0**	**318.0**	**316.8**	**335.0**
Compensation of employees	75.6	86.7	100.5	114.4	121.2	128.5	134.9
Goods and services	130.6	131.8	165.1	149.6	196.8	188.3	200.1
of which:							
Advertising	*10.2*	*7.2*	*15.6*	*7.0*	*7.4*	*7.4*	*7.8*
Consultants and professional services: Business and advisory services	*4.9*	*2.8*	*2.7*	*3.8*	*10.3*	*10.4*	*14.1*
Travel and subsistence	*30.6*	*28.5*	*15.7*	*24.1*	*24.3*	*25.1*	*25.1*
Transfers and subsidies	**0.4**	**0.4**	**0.4**	**0.4**	**0.4**	**0.5**	**0.5**
Departmental agencies and accounts	0.3	0.3	0.3	0.4	0.4	0.5	0.5
Households	0.2	0.1	0.0	–	–	–	–
Payments for capital assets	**7.0**	**22.0**	**4.0**	**17.8**	**7.7**	**8.0**	**8.9**
Buildings and other fixed structures	–	–	–	2.8	–	–	–
Machinery and equipment	7.0	22.0	3.9	15.0	7.7	8.0	8.9
Software and other intangible assets	0.0	–	0.1	–	–	–	–
Payments for financial assets	**0.0**	**0.1**	**0.0**	**–**	**–**	**–**	**–**
Total	**213.6**	**241.0**	**269.9**	**282.1**	**326.1**	**325.3**	**344.4**

Expenditure grew from R214 million in 2007/08 to R282 million in 2010/11 at an average annual rate of 9.7 per cent. Over the medium term, expenditure is expected to grow to R344 million at an average annual rate of 6.9 per cent. The bulk of the increase in both periods goes towards filling critical vacant management and administrative posts as well as for spending on goods and services related to the high audit fees, communication, property leases and travel and subsistence.

6. PROGRAMME 2: HEALTH PLANNING AND SYSTEMS ENABLEMENT

6.1 Programme Purpose

Purpose: Improve access and quality of health services through planning, integration of health systems, reporting, monitoring and evaluation and research.

There are six sub programmes:

- ***Technical Policy and Planning:*** Provides advisory and strategic technical assistance on policy and planning and supports policy implementation.
- ***Health Information Management, Monitoring and Evaluation****: Develops* and maintains a national health information system and commissions and co-ordinates research. This entails the development and implementation of diseases surveillance programmes, the coordination of health research and monitoring and evaluation of strategic health programmes.
- ***Sector Procurement and Policy:*** Provides rules and regulations that are set in place to govern the process of acquiring goods and services required by the sector. A central procurement authority is being established to improve the efficiency of procurement systems.
- ***Financial Planning and Health Economics:*** Undertakes health economics research and develops policy for medical schemes and public-private partnerships and provides technical oversight for the Council for Medical Schemes (CMS).
- ***National Health Insurance:*** Develops and implements policies, legislation and frameworks for the expansion of health insurance to the broader population and oversees the coordination of research into alternative health care financing mechanisms for achieving universal coverage
- ***International Relations:*** develops and implements bi-lateral and multi-lateral agreements to strengthen the health system, including agreements on the recruitment of health workers from other countries, as well as provision of technical capacity to South Africa in fields such as health technology management, *surveillance systems*, amongst others.

6.2 Strategic Objective, Performance indicators and Annual targets for 2011/12 to 2013/14

The table below summarise the key measurable objectives, indicators and three-year targets for the various sub-programmes funded from the Health Planning and Systems Enablement Programme.

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
Facilitate and coordinate evidence based planning for all levels of the health care system, aligned to the health sector's 10 point plan and negotiated service delivery agreement.	Revised guidelines for planning developed and implemented	-	-	-	-	Planning guidelines revised and implemented	1 National APP and 9 Provincial Annual Performance Plans (APPs) developed according to guidelines	1 National APP and 9 Provincial APPs developed according to guidelines
	9 Provincial APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided	9 Provincial Strategic plans and APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided	9 Provincial APPs analysed and feedback provided
	Annual National Health Plan Developed for each year of the planning cycle	Annual National Health Plan for 2007/08 developed	Annual National Health Plan for 2009/10 developed	Annual National Health Plan for 2010/11 developed	Annual National Health Plan for 2010/11 developed	Annual National Health Plan for 2011/12 developed	Annual National Health Plan for 2012/13 developed	Annual National Health Plan for 2013/14 developed
To develop and implement an integrated monitoring and evaluation system aligned to outcomes contained in the negotiated service delivery agreement.	Integrated monitoring and evaluations system developed and implemented	-	-	-	-	Integrated monitoring and evaluation system for health developed	Monitoring and evaluation system for Health implemented and maintained	Monitoring and evaluation system for Health implemented and maintained
Monitor HIV and syphilis prevalence by conducting the annual national HIV survey	Annual National HIV and Syphilis Survey reports published	2006 National HIV and Syphilis prevalence estimates and trends report published	2007 National HIV and Syphilis prevalence estimates and trends report published	2008 National HIV and Syphilis prevalence estimates and trends report published	2009 Annual National HIV and Syphilis prevalence estimates and trends report published during November 2010	2010 Annual National HIV and Syphilis prevalence estimates and trends report published by July 2011	2011 Annual National HIV and Syphilis prevalence estimates and trends report published by July 2012	2012 Annual National HIV and Syphilis prevalence estimates and trends report published by July 2013

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
Strengthen research and development	National health research priority identified	-	-	-	New National Health Research Committee appointed. Subcommittee: Health research priorities established	National health research priority list finalised	National health research priority list used for publicly funded health research	National health research priority list used for publicly funded health research
Prepare for the implementation of the National Health Insurance (NHI)		-	-	Draft policy document presented to Cabinet Committee. The Cabinet committee requested a revision of the document.	Drafting of policy and legislation	NHI, Pilot sites established and funding model developed	Facilities in preparation for NHI accredited	Phased implementation of NHI
Provide stewardship and leadership for improving health outcomes through working with international development partners, SADC and AU	Number of Cross border initiatives facilitated to manage communicable diseases along SA's border	-	-	1 Cross border initiatives facilitated	2 Cross border initiatives facilitated	3 Cross border initiatives facilitated	4 Cross border initiatives facilitated	5 Cross border initiatives facilitated

6.3. Quarterly targets for 2011/12

Performance indicator	Reporting period	Annual target 2011/12	Quarterly targets			
			1st	2nd	3rd	4th
Revised guidelines for planning developed and implemented	Annual	Planning guidelines revised and implemented				
9 Provincial APP's analysed and feedback provided	Bi Annual	9 Provincial APPs analysed and feedback provided		1st Draft of Provincial APP's analysed and feedback provided		2nd Draft of Provincial APP's analysed and feedback provided
Annual National Health Plan Developed for each year of the planning cycle	Annual	Annual National Health Plan for 2011/12 developed				
Integrated monitoring and evaluations system developed and implemented	Annual	Integrated monitoring and evaluation system for health developed				
Annual National HIV and Syphilis Survey reports published	Annual	2010 Annual National HIV and Syphilis prevalence estimates and trends report published by July 2011				
National health research priority identified	Annual	National health research priority list finalised				
National Health Insurance Established	Annual	NHI Pilot sites established and funding model developed				
Number of Cross border initiatives facilitated to manage communicable diseases along SA's border	Quarterly	3 Cross border initiatives facilitated	1	2	3	3

6.4. Reconciling Performance targets with the Budget and MTEF Expenditure estimates

Health Planning and Systems Enablement

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R million	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Technical Policy and Planning	–	–	–	–	16.8	29.9	35.1
Health Information Management, Monitoring and Evaluation	25.6	27.7	39.5	30.6	38.5	39.6	41.4
Sector Procurement Policy	14.4	13.9	15.2	15.5	18.6	19.2	20.2
Financial Planning and Health Economics	10.2	15.6	50.7	35.9	21.9	22.6	23.4
National Health Insurance	1.2	1.4	1.7	2.8	8.0	8.1	8.2
International Relations	36.7	61.5	35.0	50.7	57.1	58.6	61.6
Total	**88.1**	**120.0**	**142.0**	**135.5**	**160.8**	**178.0**	**189.8**
Change to 2010 Budget estimate				(14.6)	(1.0)	6.9	–
Economic classification							
Current payments	**86.5**	**117.7**	**108.8**	**129.0**	**157.5**	**174.4**	**186.0**
Compensation of employees	38.1	44.7	48.8	59.8	71.5	87.4	95.5
Goods and services	48.4	73.0	60.0	69.3	85.9	87.0	90.5
of which:							
Advertising	*–*	*1.2*	*0.7*	*0.8*	*1.8*	*1.2*	*1.3*
Consultants and professional services: Business and advisory services	*5.8*	*2.9*	*6.2*	*7.1*	*18.8*	*19.1*	*19.7*
Travel and subsistence	*13.9*	*33.2*	*11.0*	*21.8*	*25.3*	*25.7*	*26.9*
Transfers and subsidies	**0.6**	**0.4**	**30.4**	**0.4**	**0.4**	**0.5**	**0.5**
Provinces and municipalities	–	–	30	–	–	–	–
Departmental agencies and accounts	0.4	0.4	0.4	0.4	0.4	0.5	0.5
Households	0.2	0.0	0.1	–	–	–	–
Payments for capital assets	**1.0**	**1.9**	**2.8**	**6.1**	**2.9**	**3.2**	**3.4**
Machinery and equipment	0.9	1.9	1.9	6.1	2.9	3.2	3.4
Software and other intangible assets	0.0	–	0.9	–	–	–	–
Total	**88.1**	**120.0**	**142.0**	**135.5**	**160.8**	**178.0**	**189.8**
Details of selected transfers and subsidies							
Provinces and municipalities							
Province							
Provincial Revenue Funds							
Households							
Households social benefits							
Current	**–**	**–**	**30.0**	**–**	**–**	**–**	**–**
2010 World Cup health preparatory strategy grant	–	–	30.0	–	–	–	–

Expenditure trends

Spending over the MTEF period will be mainly in the *Health Information Management, Monitoring and Evaluation; Financial Planning and Health Economics and International Relations Programmes*.

Expenditure has grown from R88.1 million in 2007/08 to R135.5 million in 2010/11. Over the medium term, expenditure is expected to grow to R189 million. The bulk of the increased expenditure will go to strengthening health planning in consultation with all the nine provincial departments to ensure that there is one national health system and strengthening monitoring and evaluation systems across the country to ensure credible health information in preparation for the national health insurance.

7. PROGRAMME 3: HIV&AIDS, TB AND MATERNAL, CHILD AND WOMEN'S HEALTH

7.1 Programme Purpose

Purpose: Coordinates, manages and funds for HIV and AIDS, Tuberculosis (TB) and maternal, child and women's health programmes. Develops and oversees implementation of policies, systems and norms and standards.

There are two sub-programmes:

- ***HIV and AIDS and TB*** develops national policy and administers the national HIV and AIDS and sexually transmitted infections programmes, including coordinating the implementation of the comprehensive HIV and AIDS plan and TB Plans and related conditional grant. The programme also manages strategic partnerships and provides secretariat to the South African National AIDS Council (SANAC).
- ***Maternal, Child and Women's Health*** monitors policies, guidelines, and norms and standards for maternal, child and youth, and women's health.

7.2 Strategic Objective, Performance indicators and Annual targets for 2011/12 to 2013/14

The table below summarize the strategic objectives, indicators and three-year targets for the various sub-programmes funded from the HIV&AIDS, TB and Maternal, Child and Women's Health

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
To scale up combination of prevention interventions to reduce new infections	Number of male condoms distributed	3.6 million	283.4 million	445.1million	520 million	1 billion	1 billion	1 billion
	Number of female condoms distributed	3.6million	4.276million	3.6million	6 million	6 million	6 million	6 million
	Number of Medical Male circumcisions conducted	-	-	-	100 000	500 000	600 000	600 000
	HCT uptake rate	-	-	-	80%	85%	90%	90%
To improve the quality of life of people living with HIV and AIDS by providing an appropriate package of care, treatment and support services to at least 80 per cent of people living with HIV and AIDS	Number of new patients put on ART per year	483 084	781 907	539 819	440 000	625 000	650 000	6750 000

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
To reduce infant, child and youth morbidity and mortality	National immunisation coverage rate(children under the age of 1 year)	87% (899 256)	92.1% (926 168)	97.4% (955 485)	95% (1 066 401)	95% (1 066 401)	95% (1 066 401)	95% (1 066 401)
	Measles immunisation coverage rate (second dose)	71.2% (736 098)	78% (797 617)	90% (900 347)	95% (1 066 041)	95% (1 066 041)	95% (1 066 041)	95% (1 066 041)
	Number of sub-districts implementing school health services	-	-	60 out of 232 sub-districts	100 out of 232 sub-districts	150 out of 232 sub-districts	200 out of 232 sub-districts	232 out of 232 sub-districts
	Number of Primary Schools per province implementing primary preventative health programme	-	-	-	-	60 out of 232 sub-districts	100 out of 232 sub-districts	100 out of 232 sub-districts
	Number of sub-districts implementing school health services at secondary schools with a focus on life skill based HIV and AIDS education	-	-	-	-	60 out of 232 sub-districts	100 out of 232 sub-districts	100 out of 232 sub-districts

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
To reduce maternal mortality	Antenatal care coverage rate	101.5%	111.8%	109.4%	100%	100%	100%	100%
	Antenatal coverage before 20 weeks	31.3%	32.9%	34.5%	37%	40%	50%	60%
	Proportion of deliveries taking place in health facilities under the supervision of trained personnel	83.3%	87.9%	88.5%	88%	90%	92%	95%
	Facilities providing safe CTOP services	-	-	25%	40%	45%	50%	55%
	Percentage of Mothers and Babies that received post natal care within 6 days after delivery.	-	-	30%	40%	60%	70%	80%
To improve access to reproductive health	Cervical cancer screening coverage	36.3%	45.8%	47.7%	50%	52%	54%	56%
	Couple year protection rate	30.1%	31.3%	32%	32%	33%	35%	37%

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
Expand the PMTCT coverage to pregnant women	Percentage of pregnant woman tested for HIV	80.3%	86.5%	92.7%	96.2%	100%	100%	100%
	Antenatal client initiated on HAART rate	-	-	76.9%	87%	100%	100%	100%
	Percentage of babies testing PCR positive 6 weeks after birth out of all babies tested	12.3%	9.2%	10.9%	10%	7.5%	7%	6.5%
	HIV positive antenatal clients on AZT for any period before labour uptake rate	-	10.4%	65.4%	86%	100%	100%	100%
To reduce the burden of Tuberculosis	TB Cure rate	60%	60%	68%	70%	75%	80%	85%
	TB treatment defaulter rate	7%	8.5%	7.9%	7%	6%	5%	5%
Combating TB and HIV by reducing co-infection burden	Percentage of HIV positive patients screened for TB	41%	48%	58%	70%	85%	90%	100%
	Percentage of TB patients tested for HIV	71%	76%	77%	80%	85%	90%	100%
	Percentage of TB/HIV co-infected patients receiving Cotrimoxazole Prophylaxis Therapy (CPT)	70%	77%	78%	90%	98%	100%	100%
	Number of HIV positive patients receiving Isoniazid Preventive Therapy (IPT)	5642	15 558	30 047	45 000	60 000	70 000	80 000

7.3 Quarterly targets for 2011/12

Performance indicator	Reporting period	Annual target 2011/12	Quarterly targets			
			1st	2nd	3rd	4th
Number of male condoms distributed	Quarterly	1 billion	250 million	250 million	250 million	250 million
Number of female condoms distributed	Quarterly	6 million	1.5 million	1.5 million	1.5 million	1.5 million
Number of Medical Male circumcisions conducted	Quarterly	500 000	125 000	125 000	125 000	125 000
HCT uptake rate	Quarterly	85%	81%	82%	84%	85%
Number of new patients put on ART per year	Quarterly	625 000	156 250	156 250	156 250	156 250
National immunisation coverage rate(children under the age of 1 year)	Quarterly	95% (1 066 401)	95%	95%	95%	95%
Measles immunisation coverage rate (second dose)	Quarterly	95% (1 066 041)	95%	95%	95%	95%
Number of sub-districts implementing school health services	Annual	150 out of 232 sub-districts				
Number of Primary Schools per province implementing primary preventative health programme	Annual	60 out of 232 sub-districts				
Number of sub-districts implementing school health services at secondary schools with a focus on life skill based HIV and AIDS education	Annual	60 out of 232 sub-districts				
Antenatal care coverage rate	Quarterly	100%	100%	100%	100%	100%
Antenatal coverage before 20 weeks	Quarterly	40%	37%	38%	39%	40%
Proportion of deliveries taking place in health facilities under the supervision of trained personnel rate	Annual	90%				
Facilities providing safe CTOP services	Annual	45%				
Percentage of Mothers and Babies that received post natal care within 6 days after delivery.	Quarterly	60%	45%	50%	55%	60%
Cervical cancer screening coverage	Quarterly	50%	50%	50%	50%	50%
Couple year protection rate	Quarterly	33%	33%	33%	33%	33%
Percentage of pregnant woman tested for HIV	Quarterly	100%	100%	100%	100%	100%
Antenatal client initiated on HAART rate	Quarterly	100%	100%	100%	100%	100%
Percentage of babies testing PCR positive 6 weeks after birth out of all babies tested	Quarterly	7.5%	9%	8.5%	8%	7.5%
HIV positive antenatal clients on AZT for any period before labour uptake rate	Quarterly	100%	100%	100%	100%	100%
TB Cure rate	Annual	75%				

Performance indicator	Reporting period	Annual target 2011/12	Quarterly targets			
			1st	2nd	3rd	4th
TB treatment defaulter rate	Annual	6%				
Percentage of HIV positive patients screened for TB	Quarterly	85%	70%	75%	80%	85%
Percentage of TB patients tested for HIV	Quarterly	85%	80%	82%	84%	85%
Percentage of TB/HIV co-infected patients receiving Cotrimoxazole Prophylaxis Therapy (CPT)	Quarterly	98%	92%	94%	96%	98%
Number of HIV positive patients receiving Isoniazid Preventive Therapy (IPT)	Quarterly	60 000	15 000	15 000	15 000	15 000

7.4 Reconciling Performance targets with the Budget and MTEF

Expenditure estimates

HIV and AIDS, TB and Maternal, Child and Womens' Health

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R million	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
HIV and AIDS and TB	2 394.3	3 370.9	4 868.0	6 620.7	7 974.8	9 344.1	11 153.6
Maternal, Child and Women's Health	20.0	23.5	55.4	57.9	51.7	32.9	34.6
Total	**2 414.3**	**3 394.4**	**4 923.5**	**6 678.6**	**8 026.5**	**9 377.1**	**11 188.2**
Change to 2010 Budget estimate				101.8	15.4	28.8	–
Economic classification							
Current payments	**254.3**	**350.9**	**345.7**	**433.4**	**357.6**	**366.5**	**385.0**
Compensation of employees	36.2	39.1	43.5	49.6	54.7	57.5	60.4
Goods and services	218.1	311.8	302.2	383.8	302.9	309.0	324.6
of which:							
Advertising	*15.7*	*1.8*	*76.6*	*93.0*	*61.9*	*77.6*	*86.7*
Consultants and professional services: Business and advisory services	*92.2*	*103.8*	*4.9*	*9.5*	*8.8*	*9.8*	*10.0*
Inventory: Medical supplies	*76.1*	*103.3*	*181.2*	*186.5*	*150.0*	*135.0*	*140.0*
Travel and subsistence	*20.5*	*27.1*	*17.7*	*30.5*	*26.9*	*29.1*	*29.5*
Transfers and subsidies	**2 158.8**	**3 043.0**	**4 576.8**	**6 241.2**	**7 664.7**	**9 006.2**	**10 798.5**
Provinces and municipalities	2 006.2	2 885.4	4 376.1	6 051.8	7 493.0	8 824.6	10 606.7
Universities and technikons	0.4	0.7	0.5	1.1	1.1	1.2	1.2
Non-profit institutions	152.1	156.6	198.1	188.4	170.6	180.4	190.6
Households	0.1	0.2	2.0	–	–	–	–
Payments for capital assets	**1.2**	**0.6**	**1.0**	**4.0**	**4.2**	**4.5**	**4.7**
Machinery and equipment	1.2	0.6	1.0	4.0	4.2	4.5	4.7
Total	**2 414.3**	**3 394.4**	**4 923.5**	**6 678.6**	**8 026.5**	**9 377.1**	**11 188.2**

Details of selected transfers and subsidies							
Provinces and municipalities							
Provinces							
Provincial Revenue Funds							
Current	**2 006.2**	**2 885.4**	**4 376.1**	**6 051.8**	**7 493.0**	**8 824.6**	**10 606.7**
Comprehensive HIV and AIDS Grant	2 006.2	2 885.4	4 376.1	6 051.8	7 493.0	8 824.6	10 606.7
Non-profit institutions							
Current	**152.1**	**156.6**	**198.1**	**188.4**	**170.6**	**180.4**	**190.6**
Lifeline	15.0	16.0	-	12.2	13.0	13.6	14.3
Lovelife	40.0	55.0	-	77.4	62.0	66.1	70.4
Soul City	17.0	14.0	-	17.0	13.0	13.9	14.8
Maternal Child and Women's Health	0.6	-	0.6	1.1	1.2	1.3	1.3
NGOs							
HIV and AIDS: NGOs	53.6	58.1	193.8	65.1	69.0	72.5	76.1
Tuberculosis: NGOs	2.9	3.5	3.7	3.9	-	-	-
South Africa AIDS Vaccine Initiative	23.0	10.0	-	11.7	12.4	13.0	13.6

Expenditure trends

The spending focus over the MTEF period will be on strengthening HIV and AIDS prevention programmes. Expenditure has grown from R2.4 billion in 2007/08 to R6.7 billion in 2010/11 at an average annual rate of 40.4 per cent. This was done equitably on the basis of the burden form disease that each province carries and progress on treatment uptake. Over the medium term, expenditure is expected to increase to R11.2 billion at an average annual rate of 18.8 per cent. Growth between 2007/08 and 2010/11 is mostly due to transfers to provinces for the HIV&AIDS conditional grant, which has increased as a result of high numbers of new patients being placed on Antiretroviral Treatment (ART). The growth over the medium term is due to additional funding of R60 million in 2011/12 and 2012/13, and R1.4 billion in 2013/14 for the HIV and AIDS conditional grant to provinces. The additional grants are to allow the provinces to significantly expand access to ART for people living with HIV and AIDS, and to implement the HIV Counselling and Testing (HCT) Campaign and initiate the male circumcision programme.

8. PROGRAMME 4: PRIMARY HEALTH CARE SERVICES (PHC)

8.1 Programme Purpose

Purpose: Develops and implements a uniform District Health System. Develops policy for district health services (PHC and district hospitals), identifies and promotes centers of excellence and supports planning, delivery and monitoring.

There are 4 sub-programs:

- ***District Health Services and Environmental Health****:* promotes, co-ordinates and institutionalises the district health system, integrates the implementation of programmes, including health promotion and environmental health at all levels of the health care system including community based service, and ensures that there are norms and standards for all aspects of primary health care.
- ***Communicable Diseases****:* develops policies and supports provinces to ensure the control of infectious diseases and supports the National Institute of Communicable Diseases.
- ***Non-Communicable Diseases****:* establishes policy, legislation and guidelines and assists provinces in the implementation and monitoring of chronic diseases, disability, older people, eye care, oral health, mental health and substance abuse, injury prevention, organ transplantation and forensic pathology services. The cluster has oversight over the Forensic Chemistry Laboratory Service, Human Tissue and the Forensic Mortuaries**.**
- ***Health Promotion and Nutrition:*** Formulates and monitors policies, guidelines, and norms and standards for health promotion and nutrition.

8.2 Strategic Objective, Performance indicators and Annual targets for 2011/12 to 2013/14

The tables below summarise the key measurable objectives, indicators and three-year targets for the various sub-programmes funded from the Primary Health Care Services (PHC) Programme.

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
To eliminate Malaria by 2018 by reducing the local transmission of malaria cases to 0 per 1000 population at risk, through the implementation of the malaria elimination strategy	Malaria incidence per 1000 population at risk	1.6	1.13	0.49 – confirmed local cases 0.70 – aggregate of local cases and cases of unknown origin	0.46 - confirmed local cases 0.66 - aggregate of local cases and cases of unknown origin	0.43 confirmed local cases 0.62 - aggregate of local cases and cases of unknown origin	0.40- confirmed local cases 0.58 - aggregate of local cases and cases of unknown origin	0.37 - confirmed local cases 0.54 - aggregate of local cases and cases of unknown origen
To prevent and manage non-communicable diseases by implementing the chronic care model and strengthening the implementation of the long term care model for diabetes over the MTEF period.	No of districts implementing the Chronic Care model	–	–	–	–	3 Districts implementing the Chronic care model	3 Districts implementing the Chronic care mode	8 Districts implementing the Chronic care mode
	No of districts implementing the long term model for diabetes and hypertension	-	-	-	43 Districts	48 Districts	52 Districts	52 Districts
To strengthen the implementation of Health Promotion Initiatives	Integrated Health Promotion Strategy Developed and Implemented	-	-	-	-	Integrated Health Promotion Strategy Developed	Implementation of integrated Health Promotion Strategy	Implementation of integrated Health Promotion Strategy
To strengthen the quality of Environmental Health Services	Norms and Standards for Environmental Health Services Developed	-	-	-	-	Draft Norms and Standards for Environmental Health services Developed	Norms and Standards for Environmental Health Services finalised	Monitor the implementation of Norms and Standards for Environmental Health Services
Reducing morbidity and mortality from injuries and violence	Develop a plan targeting injuries	-	-	-	-	Plan developed		
	Develop a plan for response to violence	-	-	-	-	Plan developed		

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
Improve community participation, in supporting the delivery of PHC services by establishing governance structures in line with National Health Act (2003) by 2011/2012.	No of districts with functional Districts Health Councils	31	47	43	43	43	52	52
	Percentage of functional facility committees established for PHC facilities (Clinics and Community Health Centres)	30%	60%	-	-	50% 1964 out of 3927	55% 2160 out of 3927	60% 2356 out of 3927
	Number of District Hospitals with functional hospitals boards	-	-	Guidelines for Hospital Board revised	53	75	100	120
Conduct a comprehensive primary health care audit including district hospitals by March 2012	Audit conducted	-	-	-	Preparation for the Audit Completed	Audit report submitted	-	-
Improved access to primary health care services.	PHC Utilisation rate	2.4 visits	2.4 visits	2.5 visits	2.5 visits	2.6 visits	2.8 visits	3 visits
Improve the management of District Hospitals	Average length of Stay for District Hospitals	4.5 days	4.4 days	4.3 days	4.4 days	4 days	3.8 days	3.6 days
	Bed utilisation rate for Districts Hospitals	65.2%	67.8%	66.9%	54.4%	70%	75%	75%
Start up and entrench enhanced community based services in each district by establishing family health teams in all 9 provinces	No of family health teams established	–	–	–	–	54	100	250

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
Improve health outcomes through ensuring that 52 district health plans are used for planning, monitoring, and reporting and programme implementation by providing direct and indirect support to the District Management Teams during the process of developing District Health Plans.	No of district health plans analysed and feedback provided	47	47	20	36	52	52	52
	No of districts conducting quarterly performance reviews	26	47	Not Measured	Not Measured	42	52	52
Improved supervision and management of PHC facilities	Fixed PHC facilities with monthly supervisory visits rate	70%	70%	70%	75%	75%	80%	85%
Reduction of vitamin A deficiency in under 5 year olds	Vitamin A supplementation coverage among children 12-59 months	28.9%	32.4%	36.6%	38%	40%	42%	45%
Improve nutritional status of people living with HIV & AIDS and TB	Proportion of PHC facilities implementing nutritional intervention for PLHIV & AIDS and TB	–	–	–	77%	80%	85%	88%
Improve initiation and support for exclusive breastfeeding	Number of newly accredited BFHI facilities	22	13	13	23	25	25	25

8.3 Quarterly targets for 2011/12

Performance indicator	Reporting period	Annual target 2011/12	Quarterly targets			
			1st	2nd	3rd	4th
Malaria incidence per 1000 population at risk	Annual	0.43 confirmed local cases 0.62 - aggregate of local cases and cases of unknown origin				
No of districts implementing the Chronic Care model	Annual	3 Districts implementing the Chronic care model				
No of districts implementing the long term model for diabetes and hypertension	Annual	48 Districts				
Integrated Health Promotion Strategy Developed and Implemented	Annual	Integrated Health Promotion Strategy Developed				
Norms and Standards for Environmental Health Services Developed	Annual	Draft Norms and Standards for Environmental Health services Developed				
No of districts with functional Districts Health Councils	Annual	43				
Percentage of functional facility committees established for PHC facilities (Clinics and Community Health Centres)	Annual	50% (1964 out of 3927)				
Number of District Hospitals with functional hospitals boards	Annual	75				
Audit conducted	Annual –once off	Audit completed and report available				
PHC Utilisation rate	Quarterly	2.7	2.6	2.65	2.68	2.7
Average length of Stay for District Hospitals	Quarterly	4 days	4 days	4 days	4 days	4 days
Bed utilisation rate for Districts Hospitals	Quarterly	70%	63	65	68	70
No of family health teams established	Bi- annually	54		14		40
No of district health plans analysed and feedback provided	Annual	52				
No of districts conducting quarterly performance reviews	Quarterly	42	15	25	30	40

Performance indicator	Reporting period	Annual target 2011/12	Quarterly targets			
			1st	2nd	3rd	4th
Fixed PHC facilities with monthly supervisory visits rate	Quarterly	75	75	75	75	75
Vitamin A supplementation coverage among children 12-59 months	Quarterly	40	32	35	38	40
Proportion of PHC facilities implementing nutritional intervention for PLHIV & AIDS and TB	Quarterly	80	78	79	80	80
Number of newly accredited BFHI facilities	Quarterly	25	5	5	10	5

8.4 Reconciling Performance targets with the Budget and MTEF

Expenditure estimates

Primary Healthcare Services

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R million	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
District Health Services	7.9	11.7	11.6	46.4	23.6	20.5	21.8
Communicable Diseases	5.3	8.1	204.2	17.0	14.5	15.1	15.8
Non-Communicable Diseases	607.6	656.8	548.1	628.3	669.5	84.2	88.2
Health Promotion and Nutrition	18.7	26.6	11.3	20.2	22.5	23.2	24.3
Total	**639.4**	**703.1**	**775.2**	**711.9**	**730.0**	**143.0**	**150.1**
Change to 2010 Budget estimate				16.6	(3.9)	(622.2)	–
Economic classification							
Current payments	**72.0**	**92.6**	**218.7**	**139.6**	**123.4**	**126.0**	**132.5**
Compensation of employees	36.8	42.4	47.5	54.6	58.5	62.4	65.5
Goods and services	35.3	50.2	171.2	85.1	65.0	63.6	67.0
of which:							
Advertising	*3.6*	*5.1*	*1.5*	*4.2*	*5.1*	*5.5*	*5.8*
Consultants and professional services: Business and advisory services	*2.5*	*1.5*	*3.0*	*35.2*	*13.1*	*9.7*	*10.1*
Inventory: Medical supplies	*0.7*	*0.5*	*144.3*	*0.7*	*0.7*	*0.9*	*0.9*
Travel and subsistence	*8.9*	*15.0*	*7.1*	*13.6*	*13.6*	*13.8*	*14.3*
Transfers and subsidies	**556.3**	**596.0**	**553.8**	**559.5**	**593.0**	**2.8**	**2.9**
Provinces and municipalities	551.8	594.5	551.9	557.0	590.4	–	–
Departmental agencies and accounts	3.0	0.4	–	–	–	–	–
Non-profit institutions	1.4	1.0	1.9	2.5	2.6	2.8	2.9
Households	0.1	0.2	0.0	–	–	–	–
Payments for capital assets	**11.1**	**14.5**	**2.7**	**12.8**	**13.6**	**14.3**	**14.7**
Machinery and equipment	10.9	14.5	2.4	12.8	13.6	14.3	14.7
Software and other intangible assets	0.2	–	0.3	–	–	–	–
Total	**639.4**	**703.1**	**775.2**	**711.9**	**730.0**	**143.0**	**150.1**
Details of selected transfers and subsidies							
Departmental agencies and accounts							
Departmental agencies (non-business entities)							
Current	**3.0**	**0.4**	**-**	**-**	**-**	**-**	**-**
Human Science Research Council	3.0	0.4	-	-	-	-	-
Provinces and municipalities							
Provinces							
Provincial Revenue Funds							
Current	**551.8**	**594.5**	**551.9**	**557.0**	**590.4**	**-**	**-**
Cholera conditional grant	-	-	50.0	-	-	-	-
Forensic pathology services conditional grant	551.8	594.5	501.9	557.0	590.4	-	-

Expenditure trends

Spending over the MTEF period will be focused in the *Communicable Diseases; Non-Communicable Diseases*, *District Health Services* and *Health Promotion* sub programmes.

Expenditure grew from R639.4 million in 2007/08 to R711.9 million in 2010/11. The growth was driven mostly by expenditure in the *Non- Communicable Diseases* sub-programme for the forensic pathology conditional grant, which grew to facilitate the relocation of forensic mortuaries from the South African Police Services, for the refurbishment of infrastructure at theses mortuaries, and where required, for construction of mortuaries. Over the medium term, spending decreases to R150.1 million The decrease is mainly due to shifting the forensic pathology conditional grant from this programme into the provincial equitable share in 2012/13 (R620 million in 2012/13 and R654 million in 2013/14). Provinces have been advised to continue funding the grant.

9. PROGRAMME 5: HOSPITALS, TERTIARY SERVICES AND WORKFORCE DEVELOPMENT

9.1 Programme Purpose:

Develops policies, delivery models and clinical protocols for hospital and emergency medical services. Ensures that Academic Medical Centers (AMCs) and health workforce development programs are aligned.

There are six sub-programmes

- ***Health facilities infrastructure management:*** focuses on enabling provinces to plan, manage, modernise, rationalise and transform infrastructure, health technology, hospital management and improvement of the quality of care in line with national policy objectives. This subprogramme is responsible for funding the conditional grant for the revitalisation of hospitals and new health infrastructure grant.
- ***National Tertiary Services management:*** will focus on developing credible, long-term provision of tertiary and high quality specialized services in a modernised and reconfigured manner and identifies tertiary and regional hospitals that should serve as centres of excellence for the dissemination of quality improvements. The subprogramme is responsible for the management of national tertiary services grant.
- ***Hospital Management*** deals with national policy on hospital and emergency medical services by focussing on developing an effective referral system to ensure clear delineation of responsibility by level of care, clear guidelines for referral and improved communication , and development of detailed hospital plans.
- ***Human Resource Policy Research and Planning*** is responsible for medium-to-long-range human resource (HR) planning in the national health system. This entails implementing the national human resources for Health Plan; facilitating capacity development for sustainable health workforce planning; and developing and implementing human resource information systems for planning and monitoring purposes.
- ***Sector Labour Relations and Planning*** supports negotiations and collective bargaining and the prevention, management and resolutions of disputes and labour unrest in the Public Health and Social Development Sectoral Bargaining Council
- ***Health Human Resources and Workforce Management and Development*** is responsible for developing sector specific strategic workforce management and development policies, including the development and introduction of new health professional categories, clinical in-service training programmes and coordinating and harmonising sector specific employment policies and practices.

9.2 Strategic Objective, Performance indicators and Annual targets for 2011/12 to 2013/14

The tables below summarise the key measurable objectives, indicators and three-year targets for the various sub-programmes funded from the Hospitals, Tertiary Services and Workforce Development

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
Accelerate the delivery of health infrastructure	National Infrastructure plan developed in collaboration with Provincial Infra Structure Units	-	-	-	-	National Infrastructure plan developed in collaboration with Provincial Infra Structure Units	Phase 1 of National Infrastructure plan implemented	Phase 2 of National Infrastructure plan implemented
	Sustainable set of universally adopted national norms and standards, guidelines and benchmarks for all levels of health care facilities	-	-	-	-	Health infrastructures norms and standards for all levels developed	Lifecycle framework for Health infrastructure norms and standards reviewed and updated	Lifecycle framework for Health infrastructure norms and standards reviewed and updated
	Infra Structure Project management information system established	-	-	-	Procurement of PMIS	Infra Structure Project management information system designed, developed and piloted	Maintenance of the Infra Structure Project management information system	Maintenance of the Infra Structure Project management information system
To ensure appropriate health technology are available and efficiently managed.	Health Technology Strategy developed and approved	-	-	-	Draft Health Technology Strategy developed	Health technology strategy finalised	Implementation of Health technology strategy commenced	Implementation of Health technology strategy continued
	Essential Equipment lists for the different levels of care developed	-	-	-	-	Essential equipment list finalised for Primary Health Care	Essential equipment list finalised for Secondary and Tertiary Health Care	-
	Optimisation of Health Technology maintenance	-	-	-	-	Standards for the use and maintenance of Health Technology drafted	Standards for use and maintenance of Health Technology finalised	Standards for use and maintenance of Health Technology implemented

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
Improve Health Workforce planning, management and development	Human Resource Plan responsive to service delivery finalised	-	-	-	1st Draft Health Workforce Plan Developed	Health Workforce Plan responsive to service delivery platform finalised and resources mobilised	Implementation of the Health Workforce Plan commenced	Health Workforce plan implemented
	Human Resource strategy responsive to rural health needs	-	-	-	Situational analysis of the rural health workforce challenges incorporated into draft Health Workforce Plan	Strategy for rural health workforce developed and incorporated into the National Health Workforce Plan	Strategy for rural health workforce initiated in NHI real life demonstration sites	Roll out of rural health workforce strategy
	Develop norms and standards for health workforce	-	-	-	-	Develop norms and standards for Health Workforce for Primary Health Care and Secondary Health Care	• Health Workforce norms and standards implementation monitoring and gap analysis. • Resource mobilisation for additional workforce interventions	-

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
	Community Health Worker Policy finalised	Started the process of reviewing the CHW Programme with other stakeholders in the provinces by doing rapid assessment of the programme including working conditions and remuneration	Continue with the process and started a major project of reviewing the 2004 Policy Framework document and the development of a new draft policy document	Draft policy document completed but was put on hold as a new process started in the CHW environment. A task team for CHW was formed with new objectives	The Task Team developed new objectives for for CHW's to be part of the Re-engineering of Primary Health Care. A work plan was developed and send to the Task Team on PHC for Phase 1 to: ▪ review objectives ▪ to do an audit of the CHW Programme. ▪ Finalise roles in the PHC team. ▪ Employment ▪ Policy completion	Phase II: Integration into the Health System of CHW's. Review remuneration package and develop new remuneration packages and job descriptions for CHW. Start process of Monitoring and evaluation	Standardized training programmes in place. Work with FET and HWSETA to implement. Monitor and evaluate training.	Provincial visits for M&E of CHW Programme. Review and recommend changes through research and audits

9.3 Quarterly targets for 2011/12

The Reporting Period for all indicators under programme 5 is Annual.

9.4 Reconciling Performance targets with the Budget and MTEF

Expenditure estimates

Hospital, Tertiary Services and Workforce Development

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R million	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Health Facilities Infrastructure Management	2 901.7	3 702.7	4 199.7	5 522.5	5 877.1	6 193.5	6 024.2
National Tertiary Services Management	5 321.7	6 134.8	6 616.4	7 398.9	8 052.2	8 692.3	9 392.8
Hospital Management	7.4	7.5	8.1	9.1	12.3	12.6	13.2
Human Resources Policy Research and Planning	3.9	7.5	17.2	8.9	9.6	10.0	10.5
Sector Labour Relations and Planning	2.0	2.9	3.5	4.0	4.3	4.5	4.8
Health Human Resources and Workforce Management and Development	1 607.7	1 695.0	1 773.3	1 884.7	2 007.2	2 102.8	2 218.1
Total	**9 844.4**	**11 550.3**	**12 618.1**	**14 827.9**	**15 962.7**	**17 015.8**	**17 663.7**
Change to 2010 Budget estimate				1489.5	1 955.5	2 309.2	–

Economic classification							
Current payments	**33.1**	**41.2**	**50.7**	**71.7**	**97.1**	**92.5**	**93.7**
Compensation of employees	19.4	23.7	28.5	31.0	36.4	38.2	40.1
Goods and services	13.8	17.5	22.2	40.7	60.6	54.3	53.6
of which:							
Advertising	*0.1*	*0.5*	*0.2*	*0.7*	*0.7*	*0.7*	*0.8*
Consultants and professional services: Business and advisory services	*1.7*	*0.2*	*10.5*	*23.1*	*33.0*	*25.3*	*22.4*
Travel and subsistence	*5.1*	*6.3*	*4.5*	*7.9*	*10.9*	*11.3*	*11.9*
Transfers and subsidies	**9 810.6**	**11 508.8**	**12 565.9**	**14 755.0**	**15 864.3**	**16 921.9**	**17 568.6**
Provinces and municipalities	9 810.6	11 508.8	12 565.8	14 755.0	15 864.3	16 921.9	17 568.6
Households	0.0	0.0	0.1	–	–	–	–
Payments for capital assets	**0.6**	**0.4**	**1.5**	**1.2**	**1.3**	**1.4**	**1.4**
Machinery and equipment	0.6	0.4	1.5	1.2	1.3	1.4	1.4
Total	**9 844.4**	**11 550.3**	**12 618.1**	**14 827.9**	**15 962.7**	**17 015.8**	**17 663.7**

Hospital, TertiaryServices and Workforce Development (Continued)

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R million	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Details of selected transfers and subsidies							
Provinces and municipalities							
Provinces							
Provincial Revenue Funds							
Current	**8 994.7**	**10 548.8**	**11 363.4**	**13 284.1**	**14 162.5**	**15 100.9**	**15 647.4**
Health professional training conditional grant	1 596.2	1 679.1	1 759.8	1 865.4	1 977.3	2 076.2	2 190.4
National tertiary services grant	5 321.2	6 134.1	6 614.4	7 398.0	8 048.9	8 688.8	9 389.2
Hospital revitalisation grant	2 077.3	2 735.6	2 989.1	4 020.7	4 136.3	4 335.9	4 067.9
Capital	**815.9**	**960.0**	**1 202.4**	**1 470.9**	**1 701.9**	**1 821.0**	**1 921.1**
Health infrastructure grant	815.9	960.0	1 202.4	1 470.9	1 701.9	1 821.0	1 921.1

Expenditure trends

The spending focus over the MTEF period will be on the health infrastructure planning across the provinces as well as strengthening of tertiary services. Expenditure has grown from R9.8 billion in 2007/08 to R14.8 billion in 2010/11. The growth was mainly in the transfers and subsidies of the infrastructure grant to provinces.

Over the medium term, spending is expected to increase to R17.7 billion. Additional allocations of R250 million, R500 million and R750 million over the medium term were made for the national tertiary services grant over to support public hospitals' preparing for the national health insurance and to implement the standards and guidelines of the of the Office of Standards Compliance.

10. PROGRAMME 6: HEALTH REGULATION AND COMPLIANCE MANAGEMENT

10.1 Programme Purpose:

Regulates procurement of medicines and pharmaceutical supplies, including trade in health products, promotes accountability and compliance by regulatory bodies for effective governance and quality of health care.

There are six sub-programmes:

- ***Food Control and Regulation***: regulates foodstuffs and non-medical health products to ensure food safety by developing and implementing food control policies, norms and standards, and regulations.
- ***Public Entities Management****:* provides policy framework for health public entities with regard to planning, budgeting procedures, financial reporting and oversight , ownership, governance, remuneration and accountability.
- ***Office of Standards Compliance****:* deals with quality assurance, compliance with national standards and patient complaints and radiation control.
- ***Compensation Commissioner for Occupation Diseases***: is responsible for the payment of benefits to active and ex-miners who have been diagnosed with lung related diseases as a result of the risk work they have performed in the mines or classified works.
- ***Occupational Health Management****:* regulates and increases access to benefit medical examinations (BME) for ex-mine workers at the Medical Bureau for Occupational Diseases and improves the quality of occupational health services for mines and the health sector.
- ***Pharmaceutical Trade and Product Regulation****:* regulates the procurement of medicines and pharmaceutical supplies, and regulates and provides the oversight of trade in health products to ensure access to safe and affordable medicines**.**

10.2 Strategic Objective, Performance indicators and Annual targets for 2011/12 to 2013/14

The tables below summarise the key measurable objectives, indicators and three-year targets for the various sub-programmes funded from the Health Regulation and Compliance Management

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
Improve the registration of medicines and reduce the time to market through reducing the backlog on medicine registrations by building in house capacity, training and aggressive recruitment of evaluators , clinical trail management and performing inspections on an ongoing basis.	Registration timelines of 12 months for NCE and 6 months for generics	-	-	Registration time lines of 36 months for NCE and 24 months for generics	Registration time lines of 24 months for NCE and 18 months for generics Backlog for safety updates eliminated	Registration time lines of 30 months for NCE and 18months for generics	Registration time lines of 28months for NCE and 15months for generics	Registration time lines of 24 months for NCE and 12 months for generics
To improve oversight over the registration of Pharmaceutical and related products	Establish the Pharmaceutical and related product regulation and management authority	–	–	Ministerial task team appointed to assist with the establishment of the Pharmaceutical and related product regulations and management authority	Legislation developed to support the establishment of the Pharmaceutical and related product regulations and management authority	Legislation finalised for the establishment of a new Regulatory Authority	Migration of the MCC to SAHPRA	-

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
Improve the quality of health services	Establishment of an independent Office of Health Standards Compliance as a national quality certification body	–	–	–	National Health Amendment Bill published for comment	National Health Amendment Bill promulgated. OHSC established	Functional Office of Health Standards Compliance	Functional Office of Health Standards Compliance
	% of complaints resolved within 25 days	-	-	25%	40%	60%	75%	80%
	% of hospitals conducting a patient satisfaction survey at least once per year	-	-	-	30% of 400 public sector hospitals	60% of 400 public sector hospitals	90% of 400 public sector hospitals	100% of 400 public sector hospitals
	No of health facilities assessed for compliance with the 6 priorities of the core standards	-	-	-	180 facilities assessed by provinces	20% (800) facilities assessed	40% (1600) facilities) assessed	60% (2400) facilities)assessed
To improve access to occupational health services through expanding comprehensive occupational health units in district hospitals	No of district hospitals with comprehensive occupational health units	-	22/264	50/264	70/264	100/264	150/264	200/264
	No of ex-mine workers who undergo Benefit Medical Examination	24624	19240	20 000	23 000	26 000	28 000	30 000

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
Strengthening food control risk management measures related to development/ publication/implementation of relevant national legislation, based on international standards adopted by the FAO/WHO Codex Alimentarius, where applicable	Nutrient profiling model available and implemented to evaluate health claims and determine foodstuffs with an unhealthy nutrient profile foodstuffs for listing in 2nd phase of labelling regulations	-	-	-	Partnership formed with the University of North West and WHO to develop a nutrient profiling model to evaluate health claims and determine foodstuffs with an unhealthy nutrient profile	Nutrient profiling model available and tested in respect of the evaluation of health claims and to determine foodstuffs with an unhealthy nutrient profile	2nd Phase of labelling regulations finalized which will include measures related to the approval of health claims and listing of foodstuffs with an unhealthy nutrient profile	Nutrient profiling Model utilized for evaluation of health claims for approval and list of foodstuffs with an unhealthy nutrient profile drafted
	Participation in 12 Codex activities and inclusion of FAO/ WHO Codex Alimentarius standards in food legislation where applicable	-	-	12 Codex related activities participated in and inclusion of standards in 4 sets of legislation	12 Codex related activities participated in and inclusion of standards in 4 sets of legislation	12 Codex related activities participated in and inclusion of standards in 4 sets of legislation	12 Codex related activities participated in and inclusion of standards in 4 sets of legislation	12 Codex related activities participated in and inclusion of standards in 4 sets of legislation
	5 sets of regulations drafted, published for comments and/or final regulations published	8 sets of regulations drafted, published for comments and/or final regulations published	10 sets of regulations drafted, published for comments and/or final regulations published	4 sets of regulations drafted, published for comments and/ or final regulations published	7 sets of regulations drafted, published for comments and/ or final regulations published	5 sets of regulations drafted, published for comments and/ or final regulations published	5 sets of regulations drafted, published for comments and/ or final regulations published	5 sets of regulations drafted, published for comments and/ or final regulations published

Strategic objective	Performance Indicator	Audited/Actual performance			Estimated performance 2010/11	Medium-term targets		
		2007/08	2008/09	2009/10		2011/12	2012/13	2013/14
To strengthen and facilitate good corporate and management governance of public entities and statutory health professional councils	Public health entities governance and management framework	-	-	-	-	Public health entities governance and management framework developed	Public health entities governance and management framework implemented and reports provided bi-annually	Public health entities governance and management framework implemented and reports provided bi-annually
Monitor compliance and implementation of policies and legislative prescripts relevant to public entities	Public entities' quarterly compliance report	-	-	-	-	Public entities' quarterly compliance report guided by performance guidelines	Public entities' quarterly compliance report guided by performance guidelines	Public entities' quarterly compliance report guided by performance guidelines
Establish a forum of statutory health professional council in terms of Section 50 of the National Health Act, 2003	Functional Forum of Statutory Health Professional Councils	-	-	-	-	Forum of Statutory Health Professional Councils (FSHPC) established	Bi-annual submission of functionality reports of the FSHPC	Bi-annual submission of functionality reports of the FSHPC

10.3 Quarterly targets for 2011/12

Performance indicator	Reporting period	Annual target 2011/12	Quarterly targets			
			1st	2nd	3rd	4th
Registration timelines of 12 months for NCE and 6 months for generics	Annual	Registration time lines of 30 months for NCE and 18months for generics				
Establish the Pharmaceutical and related product regulation and management authority	Annual	Legislation finalised for the establishment of a new Regulatory Authority				
Establishment of an independent Office of Health Standards Compliance as a national quality certification body	Annual	National Health Amendment Bill promulgated. OHSC established				
% of complaints resolved within 25 days	Annual	60%				
% of hospitals conducting a patient satisfaction survey at least once per year	Annual	60% of 400 public sector hospitals				
No of health facilities assessed for compliance with the 6 priorities of the core standards	Quarterly	20% (800) facilities assessed	150	200	225	225
No of district hospitals with comprehensive occupational health units	Quarterly	100/264	70	80	90	100
No of ex-mine workers who undergo Benefit Medical Examination	Quarterly	26 000	6500	6500	6500	6500
Nutrient profiling model available and implemented to evaluate health claims and determine foodstuffs with an unhealthy nutrient profile foodstuffs for listing in 2nd phase of labelling regulations	Quarterly	Nutrient profiling model available and tested in respect of the evaluation of health claims and to determine foodstuffs with an unhealthy nutrient profile	Liaise with WHO Geneva and Country Office to determine extend of possible financial support, if required, approach DG for approval for utilizing departmental funding in addition	Finalizing appointment of University of North West to commence with developing the nutrient profiling model as per the agreed ToR., and assist as needed	Development of nutrient profiling model continues, including testing of criteria for evaluating health claims and to determine foodstuffs with unhealthy nutrient profile	Nutrient profiling model available and tested in respect of the evaluation of health claims and to determine foodstuffs with an unhealthy nutrient profile, commence with drafting of 2nd phase of labelling regulations

Performance indicator	Reporting period	Annual target 2011/12	Quarterly targets			
			1st	2nd	3rd	4th
Participation in 12 Codex activities and inclusion of FAO/ WHO Codex Alimentarius standards in food legislation where applicable	Quarterly	12 Codex related activities participated in and inclusion of standards in 4 sets of legislation	Participation in 3 Codex activities and inclusion of FAO/ WHO Codex Alimentarius standards in food legislation where applicable	Participation in 3 Codex activities and inclusion of FAO/ WHO Codex Alimentarius standards in food legislation where applicable	Participation in 3 Codex activities and inclusion of FAO/ WHO Codex Alimentarius standards in food legislation where applicable	Participation in 3 Codex activities and inclusion of FAO/ WHO Codex Alimentarius standards in food legislation where applicable
5 sets of regulations drafted, published for comments and/or final regulations published	Quarterly	5 sets of regulations drafted, published for comments and/or final regulations published	1 set of regulations drafted, published for comments and/or final regulation published	1 set of regulations drafted, published for comments and/or final regulation published	1 set of regulations drafted, published for comments and/or final regulation published	2 sets of regulations drafted, published for comments and/or final regulations published
Public health entities governance and management framework	Quarterly	Public health entities governance and management framework developed	Draft public health entities governance framework	Submission of the Draft Public entities governance framework for approval	Draft implementation Plan of the Framework	Approval of the Implementation plan
Public entities' quarterly compliance report	Quarterly	Public entities' quarterly compliance report guided by performance guidelines	Quarterly compliance report for public entities	Quarterly compliance report for public entities	Quarterly compliance report for public entities	Quarterly compliance report for public entities
Functional Forum of Statutory Health Professional Councils	Quarterly	Forum of Statutory Health Professional Councils (FSHPC) established	-	Forum of Statutory Health Professional Councils (FSHPC) established by the end of July 2011	First meeting of the Forum held by October 2011	-

10.4 Reconciling Performance targets with the Budget and MTEF

Expenditure Estimates

Health Regulation and Compliance Management

Subprogramme	Audited outcome			Adjusted appropriation	Medium-term expenditure estimate		
R million	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Food Control and Regulation	4.3	6.4	5.4	6.2	7.8	8.1	8.5
Public Entities Management	298.9	315.7	335.3	355.7	364.9	382.8	405.5
Office of Standards Compliance	12.7	17.7	16.3	29.7	41.2	62.3	54.5
Compensation Commissioner for Occupational Diseases	10.6	10.4	12.3	12.0	18.1	19.1	27.7
Occupational Health	14.3	16.9	16.4	19.8	22.1	23.0	24.1
Pharmaceutical Trade and Product Regulation	37.9	48.4	54.2	72.9	71.3	76.3	80.1
Total	**378.8**	**415.5**	**440.0**	**496.4**	**525.4**	**571.6**	**600.5**
Change to 2010 Budget estimate				24.8	31.4	49.0	–
Economic classification							
Current payments	**76.8**	**96.0**	**100.2**	**135.6**	**155.8**	**183.8**	**189.7**
Compensation of employees	52.6	55.9	64.2	75.6	81.7	91.0	95.6
Goods and services	24.2	40.1	36.0	60.0	74.1	92.8	94.2
of which:							
Advertising	*0.9*	*1.0*	*0.5*	*0.6*	*0.4*	*0.4*	*0.4*
Consultants and professional services: Business and advisory services	*5.5*	*13.4*	*11.6*	*24.1*	*32.1*	*46.5*	*45.3*
Inventory: Medical supplies	–	*0.0*	*0.0*	*0.1*	*0.1*	*0.1*	*0.1*
Travel and subsistence	*9.1*	*15.1*	*11.9*	*13.2*	*13.5*	*14.5*	*14.8*
Transfers and subsidies	**300.8**	**317.6**	**338.6**	**357.8**	**366.4**	**384.4**	**407.2**
Departmental agencies and accounts	298.3	314.9	335.2	354.8	360.3	376.2	396.9
Non-profit institutions	2.5	2.6	2.8	2.9	6.1	8.3	10.3
Households	0.0	0.1	0.7	–	–	–	–
Payments for capital assets	**1.1**	**1.9**	**1.2**	**3.0**	**3.2**	**3.4**	**3.5**
Machinery and equipment	1.1	1.9	1.2	3.0	3.2	3.4	3.5
Total	**378.8**	**415.5**	**440.0**	**496.4**	**525.4**	**571.6**	**600.5**
Details of selected transfers and subsidies							
Departmental agencies and accounts							
Departmental agencies (non-business entities)							
Current	**295.6**	**312.5**	**331.5**	**352.2**	**357.6**	**373.2**	**393.9**
Council for Medical Schemes	3.3	6.2	3.9	4.0	4.2	4.3	4.5
National Health Laboratory Services	69.1	70.2	76.5	77.7	82.2	84.6	88.9
Medical Research Council	223.3	236.1	251.1	270.5	271.2	284.3	300.5
Non-profit institutions							
Current	**2.5**	**2.6**	**2.8**	**2.9**	**6.1**	**8.3**	**10.3**
Health Systems Trust	2.5	2.6	2.8	2.9	6.1	8.3	10.3
Departmental agencies and accounts							
Social security funds							
Current	**2.6**	**2.4**	**3.7**	**2.6**	**2.8**	**2.9**	**3.1**
Compensation Fund	2.6	2.4	3.7	2.6	2.8	2.9	3.1

Expenditure trends

The spending focus over the MTEF period will be on making transfers to public entities, mainly the Medical Research Council (MRC) and National Health Laboratory Services.

Expenditure has grown from R378.8 million in 2007/08 to R496.4 million in 2010/11 at an average annual rate of 9.4 per cent. Over the medium term, spending is expected to grow to R600.5 million at an average annual rate of 6.6 per cent. The largest spending increase is in the Office of Standard Compliance sub-programme to create and independent agency for quality assurance and accreditation of health facilities. There is also a strong growth in Pharmaceutical Trade and Product Regulation sub-programme to reduce large backlogs in medicine registration and establish the South African Health Product Regulatory Authority.

PART C: LINKS TO OTHER PLANS

11. CONDITIONAL GRANTS

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Indicator targets for 2011/12
Health Profession's Training & Development Grant	To support provinces to fund operational costs associated with training of health professionals; development and recruitment of medical specialists in under-served provinces; and support and strengthen undergraduate and post graduate teaching and training processes in health facilities	• Under graduate Students-	• 38149
		• Registrars-	• 1599
		• Expanded specialists and teaching infrastructure in target provinces	• 125 specialists
National Tertiary Services Grant	• To compensate tertiary facilties for the additional costs associated with the rendering of tertiary service provision and spill-over effects	• Inpatient separations • Day patient separations • In-patient days • Out-patient first attendance • Outpatient follow-up attendance	• There are no set targets for this grant as it funds recurrent activities with respect to the provision of tertiary services
Forensic Pathology Grant	• To continue the development and provision of adequate mortuary services in all provinces	• No of mortuaries to be built	• 18 mortuaries built
		• Number of staff to be recruited	• 271 new staff members recruited
		• Equipment procured and extra machines for mortuaries	• For 11 Mortuaries
		• IT equipment / Computers	• For 18 Mortuaries
		• Vehicles to be procured	• 46 forensic pathology vehicles purchased
Comprehensive HIV and AIDS Grant	• To enable the health sector to develop an effective response to HIV and AIDS including the universal access to HIV counselling & testing (HCT) • To support the implementation of the National Operational Plan for Comprehensive HIV and AIDS treatment and care • To subsidize in-part funding for antiretroviral treatment programme.	Number of individuals counselled and tested	20 million
		Percentage of HIV positive patients screened for TB	85%
		Percentage of TB patients tested for HIV	85%
		Number of sub-districts implementing school health services at secondary schools with a focus on life skill based HIV and AIDS education	60 out of 232 sub-districts
		Number of MMC conducted	500 000
		Number of new patients initiated on ART	625 000
		Number of community health workers	36 101

Name of conditional grant	Purpose of the grant	Performance indicators (extracted from the Business Cases prepared for each Conditional Grant)	Indicator targets for 2011/12
Hospital Revitalisation	• To provide funding to enable provinces to plan, modernise, rationalise and transform the infrastructure, health technology, monitoring and evaluation of hospitals; and to transform hospital management and improve quality of care in line with national policy objectives.	• Number of Hospitals receive funding from Hospital Revitalisation Grant	Compliance with the target set on approved 2011/12 Project Implementation Plans for: • 41 hospitals to be under construction • 25 hospitals to be on planning
		• Number of PPP Flagship Projects accepted	All five tertiary hospitals should complete the Feasibility study by March 2012 • Chris Hani Baragwanath Hospital • George Mukhari Hospital • Limpopo Academic Hospital • King Edward VIII Hospital • Nelson Mandela Academic Hospital

12. PUBLIC ENTITIES

Name of public entity	Mandate	output	Current Annual Budget	Date of next evaluation
Council for Medical Schemes	The Council for Medical Schemes is the national medical schemes regulatory authority established in terms of the Medical Schemes Act (1998). The council's vision for the medical scheme industry is that it is effectively regulated to protect the interests of members and promote fair and equitable access to private health financing.	- Increasing access to good quality medical schemes - Strengthening governed and responsiveness of Medical schemes and other regulated entities - Ensuring that CMS is responsive to the needs of the environment by being and effective and efficient organisation - Providing influential strategic advice and support for the development and implementation of strategic health policy, including support to the NHI development process	**98,642,717**	**Quarterly evaluation of performance reports**
South African Medical Research Council	The Medical Research Council was established in terms of the South African Medical Research Council Act (1991). The objectives of the council are to promote the improvement of health and quality of life through research, development and technology transfer.	- Improving health through research, development and innovation - Establish effective and efficient research support	**271,205** **(11/12FY) transfer from DoH**	**Quarterly evaluation of performance reports**
The National Health Laboratory Service	The National Health Laboratory Service was established in terms of the National Health Laboratory Service Act (2000). The service supports the Department of Health by providing cost effective diagnostic laboratory services to all state clinics and hospitals. It also provides related health science training and education, and supports health research. It is recognised as the largest diagnostic pathology service in South Africa and services over 80 per cent of the population, through a national network of approximately 265 laboratories.	- Deliver affordable services to the public sector - Determine a best-fit service delivery model - Deliver quality, customer-focused services - Align resources, support services and infrastructural development for service delivery - Become "employer of choice" for laboratory services - Position NHLS as the "provider of choice" for NHI - Prioritise innovation and research - Become the health information powerhouse - Drive stakeholder collaboration - Protect our community and environment	**224,989**	**Quarterly evaluation of performance reports**

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