DEPARTMENT OF HEALTH

BUDGET SPEECH
2004/5

EMBARGOED – 10h00 – 23 JULY 2004

[1]ADDRESS BY THE MINISTER FOR HEALTH FOR KWAZULU-NATAL, DR ZWELI MKHIZE, MPP, ON THE PRESENTATION OF THE KWAZULU-NATAL HEALTH BUDGET TO THE KWAZULU-NATAL PROVINCIAL LEGISLATURE ON 23RD JULY 2004

Honourable Chairperson
The Honourable Premier

Cabinet Colleagues

Honourable Members of the Legislature.

It is my privilege to present to you the 2004/2005 budget for the KwaZulu-Natal Department of Health (Vote 7) in the MTEF cycle for 2004-2007. In presenting the budget this year, the tenth year of our democracy, it is hard for one not to marvel at how far we have come as a country. It is even harder not to recognise how far we still have to go in the provision of services for the most vulnerable members of our society women, children, the disabled, the elderly and the sick.

Honourable Chairperson, we will be approaching service delivery with the recognition that health is a basic human right in line with the provisions of the Constitution from which we derive our mandate. Chapter 2 Section 10 and 11 allude to the inherent dignity of every individual, the right to have their dignity respected and protected, as well as the right to life, whereas Section 27 (1) entrenches everyone's right to healthcare services, including reproductive health. Section 27 (2) of the same chapter states that "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights."

The people of our province Honourable Chairperson expect, and rightly so, a constant improvement in the quality, the accessibility and the level of the service we deliver. It is precisely for this reason that the 2004/ 2005 budget speech is more than just another budget speech. It is an operating manual for our department. It sets out unequivocally what has been achieved over the past decade, what we plan to do, why, by when and how. It is in line with the State President's State of the Nation and with the Premier's State of the Province address. Honourable Chairperson, we are tabling a concrete presentation of the people's contract to fight poverty (and disease in our case) and create employment. We make it clear what government will deliver, and what support we require from the community to complete the contract.

Even though our province has the largest health department in the country our per capita funding does not reflect this. Over the years KwaZulu-Natal has been fourth in terms of per capita funding of the uninsured population, but now it has slipped to fifth position. We have to find means of correcting this. Having said this, we would not use these budget constraints as an excuse for inadequacy in the service we deliver. We are only too aware of our constitutional obligations in this regard.

Our department has never been able to adequately fill all the vacancies within the establishment of integrated service since 1994. Our level of staffing remains far below what a department of this size (and with the challenges we have to deal with) requires. Quite frequently the delays in filling posts or freezing vacant posts has been a means of

cost containment. This is not by choice Honourable Chairperson, but because of the enormous pressures our department faces.

While generally our budget shows an increase, this is far from adequate to cover the increasing demands being made on the department. We are pleased to note however, that the provincial government is aware of the state of affairs as evidenced by the Provincial Treasury embarking on a process of reviewing the baseline funding of the department. The general understanding of this budget therefore should be that we are making an effort to meet the needs for good health for the province with the largest population in our country, with the most severe afflictions, epidemics, infectious diseases and rising levels of diseases of lifestyle.

Despite these budget limitations we have made great strides over the past decade. We can confidently say that for our department the past ten years have been a decade of solid delivery. Honourable Chairperson, we have a fully functional district management system that effectively manages health services at district level and works with local government structures and community leadership. This ensures a direct response to community health needs.

As the health department our core function is making sure that the largest number of people in our province live healthier lives for longer. To this end one of our main tasks is the reduction of morbidity and mortality. Simply put, our task is to improve the quality of life, reduce ill health and prevent avoidable deaths. In doing this it becomes imperative to track what it is that is killing the people of KwaZulu-Natal and to then put in place robust programmes of dealing with those major causes of sickness and death. There is no doubt that HIV /AIDS has emerged as one single significant factor contributing to morbidity and mortality in recent years, and has camouflaged gains achieved in healthcare. However, we need not lose focus on the overall picture while we also concentrate our major effort in the fight against the pandemic. In order to do this we are embarking on a focussed, target driven programme to reduce morbidity and mortality in KwaZulu-Natal.

Politicisation of the debates involving HIV/AIDS has tended to cloud attention to other very significant causes of ill-health and death. A recent study by Stats SA indicated that in our province 43% of deaths are caused by communicable diseases; 44% are caused by non-communicable /chronic degenerative diseases and 13% are caused by trauma. Given this, our programmes, processes and resources should be clearly and unambiguously allocated to dealing with those causes of death, particularly those deaths that are preventable. The same study showed that between 1997 and 2001 there has been a gradual increase in the number of deaths due to communicable diseases. These include HIV/AIDS, cholera, malaria, and tuberculosis, which in our province are among the worst in the country. This has a significant impact in the reduction of the life expectancy of residents of our province.

What all these figures mean for us is that we have to re-organise and re-engineer our department in such a way that we are able to make a significant impact on this life expectancy. To change life expectancy we need to change the socio-economic conditions that give rise to some of the diseases we face and we also need to conquer all the diseases that our national resources and currently available technology can effectively avoid. We are therefore approaching this second decade of our democracy with a focus on improving the quality of care so that we are able to achieve this goal of extending the life expectancy of the people of KwaZulu-Natal. This is at the core of the human rights ethos we want to entrench in the delivery of our services.

Over the past ten years we have established a proper referral pattern. Attention has been given to the quality of facilities and equipment through our hospital revitalisation and a regular maintenance programme. Greys Hospital is becoming a fully equipped tertiary hospital serving all hospitals in the Midlands, the north and the western part of the province. Inkosi Albert Luthuli Central Hospital, truly a feather in our cap, serves the coastal area as a tertiary hospital but the whole province as a central hospital. This state-of-the-art paperless facility is a true testament of what can be achieved when government and the private sector join forces. The sheer magnificence of this institution is a most fitting tribute to the hero it is named after. We are planning to develop a third tertiary complex in Uthungulu District to service the northern parts of the province. This will help reduce travel time and improve accessibility of tertiary services for communities in these areas to three hours or less.

We also want to ensure that the drive time to urban and rural district hospitals is less than two hours, irrespective of where a patient is in the province.

As part of improving access to health services two new 300-bed hospitals will be built at KwaMashu and Inanda. These institutions will be named in honour of the fathers of our liberation struggle and founders of the African National Congress who resided in the Inanda Valley. Perhaps, Honourable Chairperson, during a term in which we are focussing on human rights in our health care, it is most fitting that these two new hospitals are named after two of the men from our province who were pioneers in the struggle for freedom, justice and human rights. The hospital in KwaMashu will be named after Dr Pixley ka-Isaka Seme and the one in Inanda will be named after Dr John Langalibalele Dube, uMafukuzel' Onjengezulu. It is a source of immense pride for our department to be associated with an initiative that will ensure that their names live forever, as we did with Mahatma Gandhi and Inkosi uLuthuli.

With the construction of Inkosi Albert Luthuli Central Hospital it is now possible to begin the phasing out of services at Addington Hospital which is on a prime piece of real estate to make way for the rapid development of Point Waterfront in the beachfront area of Durban. That will be our contribution to the economic development of Durban and to job creation. We are confident that in the long term this will prove to have been a wise decision taken in the interest of the province.

The phasing out of services at Addington Hospital, together with the downgrading of Wentworth to a 300-bed district hospital now almost done, completes our process of rationalising health services. We do however still envisage upgrading the Cato Manor Health Centre into a District Hospital, and there still remains a need for further facilities in the south and west of Durban.

The implementation of the referral system over the years has resulted in a reduction in outpatient visits to hospitals from 5 million to 4 million per annum in the last five years. This reduction is mainly because of the emphasis on Primary Health Care, which has seen the record of attendance at PHC centres increase from 10.6 million in 1996 to 19 million in 2003/2004. The number of pregnant women attending PHC facilities annually has also increased. The number of children being seen at these facilities has remained high. This has been largely because our policy of free health services for pregnant women and children prioritised mother and child health, in line with our focus on the protection of both these vulnerable groups. The past decade of our freedom has seen marked improvement in the accessibility of health services to our disadvantaged communities.

Building on this achievement, the Department of Health will construct 17 new and replacement clinics every year which have been planned with a view to achieving the World Health Organisation's target of 1 clinic per 10 000 people in the future. In our case there is a backlog of more than 200 new clinics to satisfy this norm.

Our drive to deal decisively with the major killers of our people has meant that we embark on a process of re-engineering in a manner that ensures we are more capable of delivering services with the impact we require. We have, for example, aggregated our services at head office to offer operational supervision at chief director level. We have also disaggregated policy and support services so that they are distinct from the operational services. We are confident that this will mean better co-ordination and more effective support to the units that are delivering services at local level. We have made a number of senior appointments in line with this policy shift so as to ensure better integration of our service delivery.

Honourable Chairperson, while diseases still account for a major percentage of the deaths in our province, deaths from trauma are still a major cost driver for our department. Trauma is more expensive to manage and more costly to our department in particular, and to our society in general. Although our department bears the cost of treating trauma, it is the responsibility of all of us to create conditions in our province - and indeed our country - that reduce deaths from trauma. It costs our department hundreds of millions of rands a year to manage trauma, and the cost to the country is even higher.

There is a demonstrable decrease in deaths from assaults and accidents from 13% to 9% between 1997 and 2001. This again underlines the need for various departments to work together with civil society to manage the major causes of deaths to our people. It is for this very reason that this year our department and the Department of Transport joined

forces to celebrate World Health Day in April as the focus was on the cost of road deaths to the health system. According to the National Injury Prevention Monitoring System, accidents are responsible for 37% of deaths due to trauma, 44 % are due to homicides and suicides account for 10% of the deaths. 9% of deaths remains undetermined.

All these figures underline the need for better categorisation and record keeping because many of the deaths in our province are still undetermined, which leaves a gap in our efforts to determine what is killing our people and how we can manage those causes. It is also important Honourable Chairperson, to bear in mind that for any one of these deaths from trauma, there are many survivors, who have to be cared for in our health system. To correct all this we need to create a caring, compassionate and nurturing society, a society that values human life and a society in which the culture of human rights is entrenched.

Part of our strategy to deal with deaths from trauma involves getting involved in the process initiated at national level of placing restrictions on alcohol, which is often a factor in homicides and accidents. We are also intensifying our fight against drug abuse and the use of other habit forming drugs, a new scourge that is facing our youth. A recent study by SANCA showed a most disconcerting trend about the easy availability of drugs in the rural areas of our province. Again, we hope that our colleagues from other departments will work with us in fighting this.

Our Emergency Medical Rescue Service has been transformed and reorganised into a more efficient machine. An additional 85 new vehicles will be purchased this financial year. Together with additional 300 emergency care personnel who will be employed in the current financial year, the ambulance response time will be reduced to 30 minutes in urban areas and 60 minutes in rural areas, making it a highly competitive service. There will be a progressive upgrading of the ambulance service and procurement of more vehicles to attain a fleet of 960 vehicles in 2009 and we hope to achieve our target of 1 vehicle per 10 000 population. This will improve the emergency care of survivors of trauma.

In order to do all this we are embarking on a focussed, target driven programme to reduce morbidity and mortality in KwaZulu-Natal. The Stats SA study referred to earlier indicates that among the non-communicable diseases 40% of deaths are caused by cardiovascular diseases, neoplasms account for 16% and diabetes accounts for 6% of the deaths. We therefore have to allocate our resources to improve the early detection, treatment and better management of these diseases.

Among the neoplasms affecting women the major causes of death are cervical and breast cancer. Focussing on neoplasms for women means that we will ensure that the female population of our province has access to cervical screening and mammography services. We shall embark on a massive health education campaign to enable our community to take charge of their health. This is critical in making sure that health problems are

detected early and is in line with the human rights and promotion of women's rights approach to health that our department is taking.

For men, cancers of the respiratory system, oesophagus and cancer of the prostrate are among the most common cause of death. These will also be tackled head on.

We take a similar approach to respiratory diseases, diabetes and diseases of the digestive tract, which have been identified as the top three causes of death of our people in this category. To this end our anti smoking campaign and other health promotion initiatives have to be intensified, including mass publicity campaigns about healthy diets, the hazards of a sedentary lifestyle as well as a highly stressful lifestyle. In this regard, more than in any other Honourable Chairperson, knowledge really is power. It is by giving the people of this province information that we will enable them to make lifesaving lifestyle and health choices.

Our programmes will also focus on cardiovascular diseases. If we can reduce these, we can reduce the overall cost of healthcare to our department. I wish to repeat my recommendation for fitness clubs or gyms for all the Members of this House to keep them fit, healthy and alert.

In line with the spirit of upholding human rights the department is dealing effectively and decisively with mental illness Honourable Chairperson, particularly as Chapter 2 Section 12 of the Constitution entrenches every person's right to bodily and psychological integrity. We have embarked on a vigorous programme that will ensure the prevention, early detection, treatment and rehabilitation of those members of our society who are afflicted with mental illness. Again, the campaign against substance abuse and our call for peace, are the major factors requiring inter-sectoral collaboration.

Communicable diseases are another focus area for our department this term. With improved access to services and a better co-ordination in the delivery of those services, we should be in a better position to manage this group of diseases, which account for 44% of the deaths in our province. However, a recent survey shows that there has been roughly a 12% increase in mortality from communicable diseases between 1997 and 2001, while there has been a steady relative decline in mortality from non-communicable diseases over the same period.

We are intensifying our programme of preventing communicable diseases such as malaria, cholera and TB. The incidence of malaria shall be reduced by 1/1000 annually for the next five years. The death rate from malaria has been significantly reduced over the last five years. We are aiming for the eradication of endemic malaria by 2009 with a view of only having to deal with imported cases of the disease by 2009.

We are most encouraged that the National Institute of Communicable diseases has declared the cholera epidemic over. It still remains important, however, for our province to put in place processes and resources that will ensure that our province never has to deal with a cholera epidemic again.

There are about 70 000 reported cases of tuberculosis in the province. Our objective is to increase the cure rate for TB. To achieve this we have put in place a programme to deal with early detection of TB infection, the reduction of the default rate and the reduction of the recurrent infection rate. Our target is to achieve a cure rate of 80% within the next five years. We will rely heavily on the support of the community, in particular the DOT supporters. We trust that all this will enable us to stop the increasing trend of multiple drug resistant TB, which at the moment stands at 7.7 % of all re-infection cases.

The department is involved in an intensive campaign to reduce mortality due to human rabies. A training programme involving 600 health workers has assisted in ensuring early recognition and diagnosis and treatment of this disease. It has been noted that there has been a gradual increase in the numbers of deaths from human rabies. Whether this is a result of absolute increase in the infection or because of improved recording, it is unclear. However, our success in this matter depends entirely on a collaborative inter-sectoral approach.

The upholding and protection of the rights of women and children has become a central theme of our democratic dispensation. At the core of this matter is the provision of better health for mothers and children. Our objective is therefore the reduction of the mortality for children under the age of five years, with a special emphasis on perinatal and infant mortality rate. Although the achievement of this objective is dependent on a variety of developmental factors in addition to the health services provided, targets have been set to guide the provision of our services with regard to child health. It is important to focus on preventing deaths immediately before and after delivery (perinatal mortality). This we will do by improving access to and the quality of maternity services offered to pregnant women as well as the health care available for the children within the first year after birth to reduce the high number of deaths during this period (infant mortality). The Department of Health has targeted a reduction of the perinatal mortality rate, currently 50 deaths per 1000 births, and infant mortality rate which for our province is 52 deaths per 1000 births, by 1.3 deaths per 1000 each for the next five years.

To achieve these targets we have plans to improve antenatal care and to effectively manage deliveries at our institutions. During this term of office, we also are aiming to have all deliveries being supervised by a skilled midwife. This is particularly achievable because the National Demographic Health Survey conducted in 1998 showed that 86% of deliveries occurred with professional supervision. By 2003 this had improved to 95%.

The survey further identified the major obstetric causes of perinatal mortality as intra-uterine deaths due to asphyxia, antepartum haemorrhage, hypertension and pre-term labour. Among the neonatal causes of deaths are pre-maturity and birth trauma. Reduced poverty, improved nutrition of pregnant women, together with better antenatal care, will improve this.

Despite these efforts, our province has a very high under-five mortality rate, estimated at 92 deaths per 1000 births. To deal with this our Maternal, Child and Women's Health programme will be accelerating the introduction of Integrated Management of Childhood Illnesses and paying special attention to premature deliveries using the Kangaroo Mother Care Method, which helps premature babies survive in under-resourced conditions. The improvement in our Expanded Programme on Immunisation has been an encouraging development, recording the current coverage of 89% in 2003, compared to 76% in 1999. The current campaign for the elimination of polio and reduction of measles is another significant contribution in this regard. South Africa as a country is gearing itself for the successful eradication of polio.

Part of the strategy will be the promotion of breastfeeding as a safe, sound and sustainable feeding method for our children as well as the administration of vitamin A capsules and prevention of other forms of micronutrient deficiency. To this end more and more of our institutions are being accredited as being baby friendly. We congratulate those institutions, which have successfully prepared their facilities to be baby friendly.

Another major priority for our department, as alluded to earlier, is the reduction of the maternal mortality rate. Due to the importance of this issue it is monitored through regular reports of Confidential Enquiries into Maternal Deaths, which are conducted nationally. According to this report, causes of maternal deaths have been classified as pregnancy related and non-pregnancy related (indirect). Our programmes targeting the pregnancy-related causes should focus on hypertension, haemorrhage and sepsis as identified in the latest report for KwaZulu-Natal. These complications can be averted through the improvement of our services. According to the same report, in 1999 44% of maternal deaths were due to causes not directly related to pregnancy, among which is HIV/AIDS.

Several factors contribute to the avoidable causes of maternal deaths, such as lack of information or the inaccessibility of services. Similarly, poor attendance at antenatal clinics, self-induced termination of pregnancy and ineffective management of clinical conditions are contributory factors. To deal with these challenges the department will focus on health education and health promotion, targeting women in particular. Capacity building will be intensified to improve clinical management of causes of maternal deaths as reflected in the report on Confidential Enquiries Into Maternal Deaths.

The success of the above programmes is dependent on our successful fight to limit, not only the spread, but also the devastating impact of the HIV/AIDS epidemic. Our comprehensive strategy to manage this scourge cannot be faulted in its scope, depth and content. Fundamental to the approach is the recognition of the fight against HIV/AIDS as a fight for basic human rights, a fight that can only be won through a multi-faceted all-encompassing programme to mobilise all available resources, different sectors and strata of our society. We emphasize the acceptance of HIV positive individuals as part of our society deserving of our love and support. The recognition of food security and a healthy lifestyle as determinants of better prognosis in this pandemic must be underlined. The department of health provides a supportive basis for this campaign. Mobilisation of communities has taken us to a point where we believe an AIDS forum should be established in every ward by the end of the five-year term, thus devolving responsibility to care for one another to communities in a defined locality. The battle against this epidemic will not be won in hospitals and clinics by nurses and doctors, but it will be won in villages and townships by ordinary people of this country.

VCT sites will be increased from 465 to 600 during this financial year. Lay counsellors will be increased from 1500 to 3000 with the assistance of funds from the Global Fund Against Tuberculosis and Malaria. Prevention of mother-to-child transmission has been extended to all clinics in this province. Post Exposure Prophylaxis is available for staff in all institutions and for survivors of sexual assaults in major institutions where a special caring environment has been created to promote privacy and healing to those affected.

The introduction of ARVs has been embraced with enthusiasm. The department is aiming to reach 20 hospitals by the end of July and 30 hospitals by end of March 2005. This will result in 20000 patients receiving ARVs by end of March 2005. Considering the complications associated with ARVs, village support groups will be created to support clinics and hospitals. NGOs, churches and various community formations will be approached to increase the number of community volunteers to assist with home based care. We have embarked on an extensive collaboration with community structures such as traditional leaders and have encouraged co-operation with traditional healers. Religious leaders have been appointed as mentors to support our staff suffering from burn-out as a result of nursing and counselling large numbers of people who have lost hope and are dying.

We will increase our reliance and utilisation of the services of Community Health Workers whose numbers will be increased by 1000 every year to a target of 15 000 by 2015.

Our objective will be the promotion of a culture of abstinence and safe sexual conduct, especially among the youth. The youth and adolescents will be specially targeted. We aim to make all our clinics to be adolescent friendly and to utilise youth peer education and counselling to adapt the conduct of youth life so that our precious youth can survive

the stormy age of AIDS. Liaison will be increased with the Youth Council of this province to strengthen our project on life skills training.

In the midst of this storm that ravages our community we remain optimistic that we shall overcome. The challenge is a mammoth one indeed, but so is our strength, determination and desire to save our people from this pandemic.

Honourable Chairperson, we believe the issue of client satisfaction and quality of care needs to be taken seriously if our focus on human rights is to have an impact. We want to ensure that the quality of care at public institutions is improved to be relatively on a par with that provided at private institutions. In this regard the department has embarked on a strategy that will ensure a significant reduction in patient waiting times. Our target for this financial year is a 50% reduction in patient waiting times at our outpatients departments. To achieve this a combination of capacity building incentives and disincentives will be implemented. Gone will be the days of rude indolent non-caring staff. Batho Pele and the Patient's Charter will become a way of life, not a decorated chart on the walls of hospital wards and clinics.

We want to do away with unmanageably excessive delays, which require our people to wake up at the crack of dawn to wait in unacceptably long queues of outpatients departments. To achieve this target, we intend to respond to community concerns raised at Izimbizo and other forums for the extension of our services. We have identified 129 clinics with residential accommodation where all patients who arrive before 4pm will be attended to on the same day. No clinic will close its doors early when there are patients waiting to be seen.

A 24-hour emergency service will also be available at these clinics. To this effect a calculated overtime pay for staff in these clinics, which are mainly in rural areas, will be paid. This will also reduce the number of patients who bypass clinics for various reasons and tend to clog up the services and contribute in creating long queues at hospitals. Closely linked to this will be an improvement in our patients transport system to link referral facilities. Unfortunately, current financial constraints will not allow us to reduce waiting time for surgery.

We also seek to improve the physical appearance of all facilities. This will include appropriate signage. Improved accessibility for people with disabilities will be given top priority.

To improve our serious staff shortage we make a call to the nurses and doctors in private practice and retirement to join the department under contract terms to alleviate the overloading of our current hard-working staff. We are deeply grateful for the dedication and support of our staff, who are truly the backbone of our service delivery. In

recognition of their support we have made available a Scarce Skills and a Rural Allowance to retain their loyalty and to ensure that rural areas do not lose highly skilled staff.

Community participation in our institutions will be entrenched in line with the new regulations as a mechanism to guarantee client satisfaction. To this end all hospital boards will be appointed and trained according to new legislation in the next six months. All clinic committees will also be installed and trained within one year. Among the functions of these community supervisory structures will be to monitor community grievances and to ensure that these are dealt with at the appropriate managerial level. Clinic committees will also be assigned the responsibility of following up on defaulters and patients with notifiable diseases, as well as patients on chronic medication.

These activities will be co-ordinated with the operations of the department and the departments Ombudsperson located at head office level.

Our department is a multibillion rand investor in the economy of this province and as such is committed to black economic empowerment and the economic development of previously disadvantaged individuals. In areas such as security, cleaning and gardening services, the department has achieved more than a 90% shift in favour of historically disadvantaged individuals, but this accounts for a comparatively small percentage of our budget. We are facing the challenge of rooting out “fronting” head on. We also want to ensure that genuine skills transfer occurs. We have noted that our procedures have not assisted in significantly attracting the emerging entrepreneurs from the African community. However, some of the services that the department procures are of a highly technical nature and to date these services are mainly delivered by old, established companies. In an effort to correct this, the department will in the next four months embark on a programme of learnerships in these areas. These will include electrical, plumbing, refrigeration and engineering. We will also directly approach within the next few months all the major suppliers to enforce the empowerment provisions of legislation.

Budget Provision

Honourable Chairperson, let us now consider the Budget Provision for 2004/2005 and the material reality the department faces in terms of service delivery. The total amount of R8,767 billion requested for the forthcoming financial year reflects an increase of R509,2 million compared to the revised budget for 2003/04, or a 6,17% increase. The growth in real terms is however negative (minus 0.21% or minus R17,6 million), if one takes into account that certain increases are forced by improvements in the conditions of service, negotiated centrally; the inflation rate on medicine and medical equipment which is presently in the region of 9%; an increase in the conditional grants for infrastructure development (additional work) of R105 million, and the additional provision for HIV/AIDS, including the rollout of the ARV treatment programme of R100 million.

Revenue

The sources of funding for Vote 7: Health consists of conditional grants amounting to R1,529 billion and an allocation from the equitable share amounting to R8,264 billion representing increases of R383 million or 5,44% and R137 million or 11,46% respectively. The increase in the conditional grant is in real terms substantially higher (R289 million or 24,1%) than in the previous year, which included the allocation for the Primary School Nutrition programme which was transferred to the Department of Education with effect from 1 April 2004.

As will be seen from table 7.2 of the Budget Statement, the Department is expected to increase its own revenue from R121 million to R128,5 million. The main increase is expected to be in the Patient Fee Revenue from R98,7 million to R105,7 million.

Payments

Honourable Chairperson, the amount requested to be appropriated will be distributed to the various programmes as follows:

Programme 1: Administration.....R175million

For this programme, which is for the Head Office management function, an amount of R175 million, representing an increase of 9,38% is requested. The increase is mainly due to Improvements in Conditions of Service and the filling of the vacant managerial posts during the latter part of the previous financial year. The spending on this programme is still within the target of a maximum of 2% of the total allocation.

Programme 2: District Health Services.....R4,041billion

For the provision of District Health Services an amount of R4,041 billion is being requested, representing an increase of R274,5 million or 7,29%. This increase is somewhat misleading as the main increase is under HIV/AIDS, but at the same time there is a reduction in the provision for nutrition services. If these are taken into account the actual increase is R377 million or 10,01% to cover the Improvements in Conditions of Service as well as a moderate development of services in underserved areas. These services include Clinics, the fight against HIV/AIDS, the further roll-out of the PMTCT and PEP programmes as well as combating Communicable Diseases including Tuberculosis, Malaria and Cholera. A provision of R64 million by way of a conditional grant has been made available for the rollout of the antiretroviral treatment programme. The National Department has negotiated with National Treasury an increase in the Conditional Grant for HIV/AIDS Awareness and Prevention Campaigns as well as the rollout of the ARV programme from R85,6 million to R186,3 million thus assisting the Department to increase the total allocation for HIV/AIDS campaigns by 37,4%.

Programme 3: Emergency Medical Services.....R337 million

For the provision of Emergency Medical Services an amount of R337 million is being requested, representing a substantial increase of 27,65%.

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Programme 4: Provincial Hospital Services..... R2,405 billion.

This programme deals with Regional hospital services as well as Hospitals providing hospitalisation of Mental Health, Tuberculosis and convalescent patients. The requested allocation of R2,405 billion represents a decrease of R153 million or 6%.

Programme 5: Central Health Services.....R875.3million.

This programme now deals exclusively in this Province with the tertiary and central health services as opposed to the other provinces where the central hospitals have a large District and Regional component. This Programme is mainly funded through a conditional grant from the National Department of Health. A substantial increase in this grant has been negotiated by the Department to ensure equity between the provinces which provide these services. Although this Province was of the opinion that the increased allocation should be phased in over a period of not more than three years, the National Treasury has ruled that the equity be phased in over a period of five years and we are now in the third year of the dispensation.

Members will note in table in 7.17 of the Addendum to the Budget Statements that an amount of R875,3 million is requested which is an increase of R95,2 million or 12%. The main portion of this increase results from an increase in the conditional grant of R67,6 million. It is important to note in this

regard that according to National norms and the Provincial Strategic Positioning Statement that this province needs to enhance its tertiary services from the above provision to R1,4 billion (an increase of R524 million) to be on par with other Provinces providing similar services.

Programme 6: Health Sciences.....R351,8million

This programme provides for Nurse and other training as well as the granting of bursaries. The acute shortage of health professionals in all occupational classes requires of the Department to invest in the accelerated training of these professionals. The amount of R351,8 million requested represents an increase of R42,9 million or 14%. This increase will be insufficient to do the doubling of the nurse intake during this financial year.

Programme 7: Health Care Support Services.....R10.6million

This programme deals with the funding of the increase in the stock levels at the Provincial Medical Supply Centre. Prior to 2002/03 the standard stock account value remained for a number of years at R30 million, which has resulted in the store running out of stock as it had an unacceptably high turn-over rate of 18%. The present turnover of

the store of R420 million per annum requires a stock level valued at R52,5 million. The Department has decided in 2002/03 to increase the R30 million stock level to the required stock level over a period of three years. The provision of R10,6 million requested plus the funds provided in previous years will increase the value to the acceptable level, which will assist the timeous delivery of medicine to all the institutions.

Programme 8: Health Facilities Management.....R570.4million

This programme is utilized for the capital expenditure and maintenance of physical facilities of the Department. The amount of R570,4 million requested represents an increase of R162 million or 40% on the previous year's revised budget. The increase is due to increases in the revitalization and health infrastructure conditional grants (R105,3 million) received from the National Department of Health and the Provincial Treasury respectively.

It must be emphasized that the requirements for the Department to make a meaningful contribution to address the major problems experienced in the ageing building stock is estimated to be R910 million per annum for the next eight years. The allocation to this programme over the MTEF period is only about 62% of the requirements. At this rate the backlog cannot be eliminated and will require serious consideration of other avenues to address the problem. The inability to allocate the required funding for this programme is resulting in a worsening of the real estate of the

Department and increasing the gap, which will lead to a subsequent larger expenditure. One of the major problems in regard to the performance of the Department in upgrading its facilities is the constant non-performance of other role-players in capital works programme.

In closing, Honourable Chairperson, I wish to move to this House, Vote 7 for Health, requesting a total amount of R8,767 billion as presented in the Budget Statements and the Addendum thereto.