



**HEALTHCARE REFORM AND SERVICE DELIVERY: A CASE STUDY OF
MONTEBELLO HOSPITAL**

A dissertation submitted in fulfilment of the requirements for the degree

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ABSTRACT

The South African healthcare sector stands at the threshold of major restructuring in an attempt to address inadequacies as a result of fragmentation of health services in apartheid South Africa. The level of health services, particularly in rural areas, has decreased and has led to reduced quality and productivity of health services. For individuals residing in rural communities, access to health services can be arduous. Delivery of essential services has to meet the needs of marginalised people who live in remote areas.

In light of the above, the department of health is faced with growing expectations from citizens to use resources efficiently and effectively and to ensure that healthcare is affordable and accessible to all. National Health Insurance (NHI) is intended to bring about reform that will improve service provision.

The researcher undertook this study to explore healthcare challenges faced by South Africa and its people and how far progressive realisation of access to healthcare, as enshrined in the 1996 Constitution, is being implemented. A case study using a mixed method approach was adopted.

The literature reviewed indicated that issues of remuneration, ageing infrastructure and general management challenges, including financial management, are among the challenges that continue to hamper the public health system in South Africa. In addition, the HIV/AIDS epidemic has created more demand for healthcare as many more people become sick. The Green Paper outlining the government's broad policy proposals for NHI, released in August 2011, makes it clear that NHI is a long-term project that will be rolled out over 14 years. It aims to promote efficiency and equity to ensure that all South Africans have access to affordable, quality healthcare.

The findings of this study are useful not only to the case study institution, but to all District Hospitals, especially the department of health and the public management sector and may assist in taking the NHI forward.

DECLARATION

I, Melody Brauns, declare that:

- This dissertation is the result of my own independent work/investigation;
- This dissertation has not been submitted previously for any degree at any University;
- All references used have been acknowledged; and
- I give consent for my dissertation, if accepted, to be available for inter-library loans.

Melody Brauns

DEDICATION

I dedicate this work to my two cherished daughters, Mercedes and Brittany Brauns.

You believed in me before I believed in myself. The unexpected courtesy, consideration and thoughtful deeds are appreciated. Thank you for talking, listening and laughing with me, praising my wise actions and criticising my foolish ones, encouraging me and sharing in my joys, triumphs and sorrows. May I prove worthy to be called MUM.

Also, thanks to a wonderful husband Leon who helped me turn my mistakes into stepping stones and stayed awake with me as I completed this study. You have showed me that confidence comes from careful preparation and a belief in one's abilities to a point where fear deserts you and boldness takes over.

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LIST OF ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	African National Congress
ART	-	Anti-Retroviral Treatment
BTech	-	Bachelor of Technology
CEO	-	Chief Executive Officer
DHMB	-	District Health Management Board
DHMT	-	District Health Management Team
DHS	-	District Health System
DoH	-	Department of Health
DPSA	-	Department of Public Service and Administration
DUT	-	Durban University of Technology
GDP	-	Gross Domestic Product
HIV	-	Human Immunodeficiency Virus
ICT	-	Information and Communication Technology
IDP	-	Integrated Development Plan
MEC	-	Member of Executive Council
MoH	-	Ministry of Health
NEEDS	-	National Economic Empowerment and Development Strategy
NHA	-	National Health Act
NHI	-	National Health Insurance
NP	-	National Party
OPD	-	Out-Patient Department
OSD	-	Occupational Specific Dispensation
PHMT	-	Provincial Health Management Team
RDP	-	Reconstruction and Development Programme
SARPN	-	South African Regional Poverty Network
SHI	-	Social Health Insurance
STI	-	Sexually Transmitted Illness
SPSS	-	Statistical Package for Social Sciences
TB	-	Tuberculosis
UDHR	-	Universal Declaration of Human Rights
UK	-	United Kingdom
US	-	United States
WHO	-	World Health Organisation
WSTS	-	Waiting Service Time Survey
XDR-TB	-	Extreme Drug Resistant Tuberculosis

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CHAPTER 1

CONTEXT OF THE STUDY

1.1 Introduction

For several reasons, an extended and more effective South African healthcare system, financed largely by the taxpayer, is necessary. According to The Charter of the Health Sector of the Republic of South Africa (2005: 31), obtaining good-quality healthcare services is a complex issue of constitutional importance. The Charter goes on to mention that there are substantial numbers of people in South Africa who do not have adequate access to health services due to geographical, financial, physical, communication, sociological and other barriers. For individuals residing in rural communities, access to health services can be especially arduous. A lack of infrastructure, such as limited clinics and hospitals in rural areas, and a shortage of medical staff, represent an additional burden to the government.

As a result of these shortages, the level of health services, mainly in rural areas, has decreased, leading to reduced quality and productivity of health services, closure of hospital wards, increased waiting times, reduced numbers of available beds for inpatients, diversion of emergency services and underuse of personnel. An encouraging factor within the public health sector is that one can access healthcare during times of need, and in most cases, services are free. The public health system does deliver healthcare services, albeit plagued with incompetent and inadequate quality of care in some facilities. For those that have the ability to pay, on the other hand, the South African private health system is rated amongst the best in the world (Yach and Kistnasamy, 2006:4).

The Department of Health is faced with growing expectations from citizens and pressure groups to use resources efficiently and effectively, and to ensure that healthcare is affordable and accessible to all. These include improved communication between healthcare practitioners and patients, infrastructure development, transparency and accountability, and the transformation of care. National Health Insurance (NHI) is intended to bring about reform that will improve service provision. It aims to promote efficiency and equity so as to ensure that all South Africans have access to affordable, quality healthcare.

The recognition of health as a human right took a significant step in 1948 when the United Nations adopted the Universal Declaration of Human Rights (UDHR). The declaration makes provision for the following:

“Everyone has the right to a standard of living adequate for the health and well-being of himself/herself and of his/her family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control” (Universal Declaration of Human Rights, Article 25 (1) 1948).

Cloete (1994: 82) claims that efficiency in the public sector means fulfilling the most fundamental needs of the community to the greatest extent possible. The public healthcare system suffers from a shortage of human resources and limited specialist equipment. Delivery of health services is particularly difficult in rural areas which have been heavily affected by the HIV/AIDS pandemic and tuberculosis. HIV/AIDS is one of the major challenges facing South Africa today.

According to McLennan (2009: 41), delivery of essential services has to meet the needs of the marginalized population who live in remote areas. If not, segments of deprivation will abound, imitating apartheid patterns. Hassim (2007: 18) explains that the principal aim of health reform since 1994 has been to reverse the effects of the past and to realize a promise made in the Constitution which is to build a democratic state founded on the values of human dignity, the achievements of equality and the advancement of human rights and freedoms. In particular, section 27 (1) of the Constitution of the Republic of South Africa (Act 108 of 1996) states that: everyone has the right of access to healthcare services, including reproductive healthcare.

According to Ayodele (2009), South Africa has one of the most effective economies in Africa. However, it is caught up with some issues surrounding public healthcare that plague the rest of the continent. The state healthcare system is under-resourced and grossly understaffed. Moreover, the country has one of the highest HIV infection rates in the world. The South African government, particularly the ruling African National Congress (ANC), has to consider the historical disparities in

health provision and the fact that the country's population is largely uninsured with many unable to afford private insurance.

1.2 Research problem

This research explored healthcare challenges faced by South Africa and its people and how far progressive realisation of access to healthcare, as enshrined in the 1996 Constitution, is being implemented. The Constitution of the Republic of South Africa states that the state must:

“take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation” of the right of access to healthcare services (Section 27(2) of the Constitution of the Republic of South Africa - 1996).

Public services present the most basic forms of healthcare. This sector is severely under-funded - facilities are neglected and resources are limited and/or depleted. However, the over-used system is the only route for the majority of the population. The government is, therefore, confronted with great challenges in accomplishing its duty to ensure that all people are able to access healthcare services. This entails improving the social conditions that influence health and restructuring the management of healthcare services.

Some of the challenges are:

- The public healthcare sector is under-resourced; the most basic resource that the healthcare system relies on is funding;
- The private sector attracts most of the country's health professionals. There is a risk of collapse if hundreds of underpaid and overworked doctors leave the public healthcare sector. Professionals tend to migrate to areas where they believe their work will be more thoroughly rewarded;
- There is failure among political leaders to sustain the system; there is inappropriate financial management and a failure to plan properly for human resources;

- Apart from the issues of remuneration, ageing infrastructure and general management challenges, including financial management, are among the challenges that continue to hamper the public health system in South Africa; and
- The HIV/AIDS epidemic. HIV creates much more demand for healthcare as many more people get sick. HIV also undermines the capacity of healthcare workers, many of whom themselves are living with HIV.

Thomas (2007: 129) mentions that an additional challenge for leaders in healthcare organizations around the world is stricter and new forms of accountability. With the application of responsibility and authority comes the obligation to answer for performance.

Unfortunately, South Africa's current healthcare system is not well equipped to deal with the above-mentioned problems. Minister of Health, Doctor Aaron Motsoaledi, (BuaNews, 2011) has previously expressed his disappointment with the level of healthcare in many of the country's public hospitals. He has committed himself and his department to fast-track improvement in six key areas, namely: safety and security, long waiting times, drug availability, nursing attitude, infection prevention and control, and values of staff.

All citizens have a vested interest in how the government provides essential services. The provision of healthcare costs the citizens of this country money. One should, therefore, be aware of the services offered and how officials spend the funds which one provides. Therefore, it is important for this country to know at all times what elected officials are doing with public monies. The Constitution of the Republic of South Africa states that:

"Efficient, economic and effective use of resources must be promoted" (Section 195 (1b) of the Constitution of the Republic of South Africa - 1996).

The Freedom Charter, adopted by the Congress of the People in Kliptown, Soweto, on 25 and 26 June 1955, sets out this vision on health:

“A preventive health scheme shall be run by the state. Free medical care and hospitalisation shall be provided for all, with special care for mothers and young children. Slums shall be demolished, and new suburbs built where all have transport, roads, lighting, playing fields, crèches and social centres. The aged, the orphans, the disabled and the sick shall be cared for by the state” (The Freedom Charter, 1955).

1.3 Research objectives and questions

The aim of this research is to measure the quality of healthcare at Montebello Hospital, evaluating approaches and policies for improving healthcare delivery, and analysing health outcomes through evidence-based research. This hospital is a District Hospital in the iLembe Health District, which serves a population of ±180 000 people. It is situated on the road between Pietermaritzburg and Tongaat. It is located in a rural area which is serviced by the Ndwedwe Local Municipality in the iLembe District of KwaZulu-Natal.

The relevance of this study is necessary to highlight service delivery problems experienced in the public health sector, at a delivery site such as Montebello Hospital. The objective is to measure what is important to the patient if there is to be an improvement in the public healthcare system.

The research questions of this study are:

- What are the views of the patients and healthcare practitioners with regard to service delivery and patient care at Montebello Hospital?
- What are the patients' expectations in terms of quality healthcare and turnaround times?
- What do healthcare workers anticipate with regard to support from the Health Ministry in terms of funding, equipment, staffing and remuneration?

1.4 Significance of the study

The rationale of this research was for the academic and healthcare sectors and citizens to gain greater knowledge and understanding of healthcare reform and service delivery in the public health sector.

This research aspired to:

- Determine the improvement of health services through better governance, financing and staffing;
- Create knowledge to potentially change policy to alleviate problems;
- Collect and use data that will encourage communities and individuals to participate in policy formulation; and
- Identify future research and policy issues to help communities influence policy.

1.5 Scope of the study

The study did not cover all District Hospitals in KwaZulu-Natal, but was limited to Montebello Hospital in the iLembe District due to the following reasons:

1. **Access** – This study depended on having access to people, organisations and documents. Should access have been denied or limited, this could have caused delays in the progression of the research; and
2. **Time and cost constraints** – The study was confined to the selected area of iLembe as the researcher had a time factor to observe.

1.6 Overview of the literature

The preamble of the Constitution of the Republic of South Africa (Act 108 of 1996) states that one of its objectives is the endeavour to enhance the quality of life of all citizens. In addition, the objective of the National Health Act 61 of 2003, Section (2)

(c) (i) is to protect, respect, promote and fulfil the rights of the people of South Africa which includes the constitutional right of access to healthcare and healthcare services.

1.6.1 The Role of Government in Healthcare

According to Buchholz (1992: 79), the nature of goods and services that are provided by the state are made through a political process of public policy decisions. Of late, many countries no longer regard government as the sole supplier of all elements of economic and social life (Newbrander and Parker, 1992: 37). However, it is the private sector that is more geared to providing quality goods and services. This sector seeks to obtain maximum profit, minimum costs and a flexible environment that is better able to serve the needs of the population. Newbrander and Parker (1992: 38) argue that the onus is on the state to ensure that there is access to medical care for individuals with need. Healthcare is a citizen's right and should be affordable and accessible to all.

1.6.2 Introduction to National Health Insurance (NHI) in South Africa

The Green Paper outlining the government's broad policy proposals for National Health Insurance (NHI) was released in August 2011. It has taken almost 35 years to reach the stage of implementation. The significant inequity in healthcare delivery to the South African population makes it essential that government come up with a solution that is equitable and sustainable. Therefore, the Green Paper on the NHI was seen by many as a welcome document.

The paper makes it clear that NHI is a long-term project that will be rolled out over 14 years. The first five years will focus on building the health sector and preparing for NHI. The paper states that the primary phases of NHI will focus on improving the services of the public healthcare system. The Green Paper introduces the start of a complete transformation of the country's health system which would begin in a pilot phase in 11 districts.

On the 22nd March 2012, in Pretoria, the Minister of Health, Doctor Aaron Motsoaledi, announced the 11 districts where the NHI pilot programme will take

place. The 11 districts represent a district in each of the nine provinces, with three sites identified in KwaZulu-Natal. Motsoaledi mentioned that these districts were identified in KwaZulu-Natal because it has the second largest population in the country and it has the biggest burden of disease. According to Motsoaledi, the programme will begin on the 1st April 2012 simply because it coincides with the beginning of the financial year.

This marks the start of the three phases of the NHI, which will be implemented over 14 years, where the first phase will see a focus on the strengthening of primary healthcare and service delivery. The districts were selected according to their demographic composition, their socio-economic situation and burden of disease.

The selected NHI pilot districts per province are:

- 1) Eastern Cape – OR Tambo;
- 2) Mpumalanga – Gert Sibande;
- 3) Limpopo – Vhembe;
- 4) Northern Cape – Pixley ka Seme;
- 5) KwaZulu-Natal – uMzinyathi, uMgungundlovu and Amajuba;
- 6) Western Cape – Eden;
- 7) North West – Dr K Gaunane;
- 8) Free State – Thabo Mofutsanyane; and
- 9) Gauteng – Tshwane.

The pilot tests are the building blocks for the successful implementation of NHI. The programme will focus on the most susceptible sectors of the country and aims to strengthen the operation of the public health system.

1.6.3 What is NHI all about?

According to McIntyre (2011), the proposed NHI is about attaining a universal health system. This means that everyone enjoys financial protection from high healthcare costs; and everyone is able to access good health services. The reality for millions of South Africans is that they do not get appropriate healthcare when they are ill. The NHI is intended to address this reality.

It includes building new health facilities, upgrading existing ones, establishing community-based teams of health workers to take services to people's homes and improving the quality of care in public facilities to provide improved healthcare for all. The most under-resourced areas will be focused on first.

1.6.4 The cost of NHI

McIntyre (2011) mentions that the South African government does not have sufficient funds to provide good quality, accessible services for the 84% of the South African population who are heavily dependent on publicly-funded health services.

It is estimated in the Green Paper that the NHI will cost about R125 billion in 2012, escalating to R256 billion in 2025. It is significant to note that this is the total amount of money needed for publicly funded health services; it is not additional funding. The government has already projected to spend over R112 billion in the 2011/12 financial year on the health system and has budgeted to spend over R120 billion in 2012/13.

This gap can be funded by applying pressure to government to devote more general tax funds to healthcare. According to McIntyre (2011), in 2001, there was a commitment by African heads of state to allocate at least 15% of general tax funding to the health sector (currently, it is less than 12%). By doing so, the health budget would be nearly R230 billion by 2025. So, the gap for NHI funding would only be R26 billion. This could easily be funded by a relatively small health tax on personal income and a small payroll tax for employers. South Africa is thus aiming to step into line with the level of public funding needed to achieve universal coverage anywhere in the world.

1.6.5 International Experiences

Some Western health systems are demonstrating a weakened commitment to high taxation; this includes the United States whose healthcare system financing has been largely private (Caltrap, Ham and Rosenthal, 1992: 182). This can be mainly attributed to a weak world economy and slow economic performance. The result is that many governments have cut back on public expenditure, resulting in healthcare services being compromised.

In response to this urgency, the South African Government is initiating international searches for models to improve health standards. In the West, for example, a wide range of different hybrid models have been utilised or proposed. Saltman and von Otter have evaluated both the “public competition” and “mixed markets” models as follows:

“Both models utilise distinctively different market mechanisms in response to economic and political pressures from existing, allocation based, publicly operated health systems” (Saltman and von Otter, 1989: 44).

1.6.5.1 The Cuban-South African relationship

This relationship was devised in the mid-1990's as an attempt to deal with the serious challenges of the shortage of medical doctors. It was observed that the South African medical schools were not yet producing reasonable numbers of Black medical doctors within the context of the country's health demands.

South Africa and Cuba entered into an agreement which enabled South Africa to recruit doctors from Cuba whilst also sending young aspirant students from poor communities for medical training in Cuban universities (South African Government Information, 2010).

Foreign doctors can play a fundamental role in ensuring the successful implementation of the NHI. Doctor Aaron Motsoaledi has admitted that human resources are one of the biggest challenges his department faces as it establishes NHI.

1.6.5.2 The Cuban Healthcare Reform Model

According to Whiteford (2009: 109), the Cuban situation is matchless in many aspects due to its authoritarian political system, the sustained political determination supporting health and equity, the prolonged existence of its president, the relative lack of mobility of the populace and the Cuban culture itself. This study has suggested that there are many lessons that can be learnt for those interested in public health reform from Cuba. For instance, they can learn that universal access does not have to reduce the quality of health services. Rather, it can be associated with strengthening services. The Cuban case also demonstrates how community-based care and community participation support one another and that health promotion can lead to behavioural and lifestyle changes.

1.6.5.3 Advances in Healthcare in Cuba

According to Rosenberg (1992: 124), life expectancy in Cuba has improved from 65.1 years in 1960 to 73.5 years in 1984. The infant mortality rate which was 60 per 1 000 births is currently 16.3 per 1 000 (the US stood at 13.0 in 1985). Heart disease, cancer and strokes are the main health problems. However, attempts have begun to restrain the most harmful health problem in Cuba - smoking. Whatever one's political beliefs, one cannot deny that the current Cuban government has used its power to make impressive advances in healthcare. They have initiated a community-orientated public healthcare system that has given a new lease of health to their people and achieved a level similar to many developed countries.

1.7 Overview of the research methodology and design

1.7.1 Study type

The study utilised the mixed-method design approach which, according to Johnson, Onwuegbuzie and Turner (2007: 123), is a combination of qualitative and quantitative research approaches (such as the use of qualitative and quantitative viewpoints, data collection and analysis) for the aim of breadth and depth of understanding and corroboration.

According to Bennett (1991: 94), the term case study refers to a thorough investigation of a single unit. A case study can be a person, a small group of people, an institution or a large-scale community. Case study research excels at bringing an understanding of a complex issue and can add strength to what is already known through previous research. It cannot, however, allow one to generalise one's research, implying that the results or findings of one case study cannot apply to other similar case studies. Kothari (1990: 140) mentions that case studies are a popular method for qualitative data analysis and interpretation.

For the purposes of this study, a case study approach was utilised. One of the reasons that the case study was utilised was due to its versatile approach in that both qualitative and quantitative data may be used in the study. Yin (1984: 23) defines the case study research method as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used.

1.7.2 Target Population

Although Ndwedwe Municipality neighbours eThekweni, Stanger, Verulam and Tongaat, it has no proclaimed town of its own. According to the Ndwedwe Municipality, this has created many challenges, particularly with regard to accurate information of its population, as the majority of the residents live in remote areas away from the few roads running through the municipality. There have been a limited number of surveys done since 2000, and approximations vary from 152 495 (Census 2001), 167 500 (Integrated Development Plan (IDP) 2002/3) to 200 000, (Ndwedwe Municipality 2003).

The out-patient population is approximately 3700 per month regardless of their illness. For the purpose of manageability, the sample consisted of 200 patients, comprising of 100 males and 100 females who were 18 years and above. The reason for choosing males and females who were 18 years and above was because, as adults, they were more capable of understanding questions and can, therefore, be expected to answer appropriately.

1.7.3 Sampling Design

Questionnaire

The main data collecting instruments were questionnaires and interviews, which captured both qualitative and quantitative data. According to Brace (2008: 5), the questionnaire can be described as the channel of conversation between two people. The questionnaire was paper based because this is a rural community and most of the population do not have access to computers. According to King and Horrocks (2010: 1), interviewing is the most frequently used technique of data collection in qualitative research.

A prepared questionnaire was the instrument used to collect data from patients and healthcare practitioners. Quota sampling is more suited to this study on the basis that the study focused on both genders. Questionnaires were designed to capture both qualitative and quantitative responses from the sample population of 200 patients. In addition, 13 doctors, chosen from a reasonable cross selection of specialists, and 50 nurses, from Montebello Hospital participated in the survey. According to Collins (2010: 128), a large number of people or organisations can be covered due to the fact that questionnaires can be posted, e-mailed or faxed. No prior arrangement is necessary and they are reasonably cheap, thereby ensuring anonymity, privacy and avoiding any embarrassment on the part of the respondent. Questionnaires allow ample time for the respondents to prepare their responses and also avoid any interview bias.

In order to identify any misrepresentation of questions during the data collection phase, a pilot study was conducted to test the reliability and validity of the questionnaire. Following piloting, the research questionnaire was administered to the sample by a team made up of the researcher and three research assistants who were recruited from Bachelor of Technology (B.Tech) Public Management students from the Durban University of Technology (DUT). They were adequately trained by the researcher to conduct the process.

1.7.4 Semi-Structured Interviews

According to McCrady, Ladd, Vermont and Steele (2010: 116), *“Research interviews follow three formats”*:

- Structured interviews;
- Semi structured interviews; and
- Unstructured interviews.

Semi-structured interviews fall between ‘structured’ and ‘unstructured’ interviews. According to Welman and Kruger (2005: 166), semi-structured interviews require the researcher to have a list of themes and questions to be covered, which may vary from one interview to the next.

For the purpose of this research, the researcher has, in addition to administering survey questionnaires, undertaken semi-structured interviews. These interviews were conducted with selected patients and healthcare practitioners who had responded to the questionnaire. Interviews were conducted to obtain relevant information from the respondents. These interviews were guided by the respondents’ survey responses.

1.8 Data collection

Data collection consisted of a combination of both questionnaires and interviews in order to elicit the best information possible. A prepared questionnaire for interviews was the instrument used to collect data from the selected participants. Data collection forms a vital part of problem-solving processes to explain the purpose of any research (Pellissier, 2007: 24).

Both primary and secondary sources of data were used to achieve the study objectives. According to Dowdall, Logio, Babbie and Halley (2003: 19), the term used to illustrate a researcher’s analysis of data that he or she has collected is referred to as primary data analysis. Therefore, if a researcher generates his/her own questionnaire or interview schedule, he/she is doing primary data analysis. If

one brings together data that other people or organisations originally collected, one is doing secondary data analysis. Secondary data can be obtained from journal articles, relevant books, documents and legislation.

1.8.1 Validity

Validity refers to the degree to which the research findings signify what is really happening in the situation been studied (Welman and Kruger, 2005: 142). An effect or test according to Coolican (1992: 35) is acceptable if it establishes what the researcher thinks or claims it does. In as far as validation of qualitative research is concerned, Silverman (2006: 290) maintains that there are two forms namely:

1. Comparing different kinds of data (e.g. quantitative and qualitative) and different methods (e.g. interviews) to determine whether they corroborate one another. This form of comparison is called triangulation; and
2. Taking one's findings back to the subjects being studied where these people may verify one's findings.

Validity in qualitative research is necessary because failure to validate findings can result in reports being inadequately analysed and interpreted. The questionnaire was assessed by an experienced researcher prior to being administered, to ensure that the content was both meaningful and appropriate. In addition, interview questions were made available to the participants in advance.

Further questions were asked during interviews to obtain more information or to clarify issues that arose.

1.8.2 Reliability

The findings and the credibility of the research relate to reliability (Welman and Kruger, 2005: 145). The researcher aims to ensure reliability by utilising internal consistency. For example, if a participant performs well on a few items in such a measurement/test, the probability is good that he/she will fare equally well on the remaining items in the measurement/test (Welman and Kruger, 2005: 147).

According to Thomas (2009: 116), reliability signifies the extent to which a research instrument such as a test will give a constant result on various occasions.

1.9 Analysis of Data

The researcher has employed descriptive statistical analysis including graphs, tables, charts and some non-parametric inferential statistical analysis. Inferential statistics according to Welman and Kruger are:

“concerned with inferences that we can make about population indices on the basis of the corresponding indices obtained from samples drawn randomly from the population” (Welman and Kruger, 2005: 236).

The services of a statistician were engaged to assist with data analysis.

1.10 Potential outputs

This research may have a positive impact on the way that health services are organised and delivered, thereby creating stronger links between the government, citizens, service providers and policy-makers. Government agencies can visit their existing programmes and policies to make necessary improvements once the results of the research are made public.

The views of the public cannot be ignored. Through stakeholder meetings and consultation, citizens can actively participate in discussions surrounding pertinent issues to bring about desired change either individually or for the benefit of the community.

It is envisaged that the study will result in publication in journals and book contributions, resulting in an increase in the knowledge base of South Africa's Health Department, healthcare practitioners and the general population of South Africa. It is further envisioned that the study will contribute to the debate on health policy, health service provision and access to healthcare in South Africa.

1.11. Structure of chapters

This study is made up of six chapters:

Chapter 1: Context of the study

Chapter one is an introduction and highlights the motivation for the study. This chapter focuses on the purpose and rationale of the study, research objectives and the problem area.

Chapter 2: Literature Review

The researcher provides a comprehensive review of the literature relevant to healthcare reform and service delivery in the public health sector in South Africa, with reference to Montebello Hospital, the site of the research study.

Chapter 3: Background on Montebello Hospital

Chapter 3 presents the background of the case study (Montebello Hospital) and discusses amongst others the vision, mission, core values, staffing and services offered.

Chapter 4: Research Methodology

Chapter four explains the research methodology used and, in particular, the data collection method, the questionnaire design, the sampling method and data analysis.

Chapter 5: Data analysis and findings

Chapter five presents and discusses the results of the study. The results from the findings are interpreted.

Chapter 6: Conclusions and Recommendations

Chapter six contains a summary of the previous chapters, and presents conclusions and recommendations based on the findings. Recommendations are made for future research.

1.12 Conclusion

This chapter has provided a comprehensive background to the study by highlighting the research problem, aims and objectives including some of the challenges facing the public healthcare sector. It incorporates a short overview of the methodology used to conduct the investigation. It also includes an outline of how the chapters are organised.

The next chapter is a discussion of the literature reviewed in relation to the topic.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The previous chapter provided the background of this study. This chapter reviews literature relevant to healthcare reform and service delivery in the public sector. The chapter takes into account the introduction of an innovative system that has far reaching consequences for the health of South Africans. NHI aims to ensure that citizens have access to appropriate, efficient and quality health services. Proposals to reform the South African healthcare system suggest that fundamental change in the operation of healthcare delivery is needed.

Most of the population rely on a public healthcare system that has a significantly lower amount of financial and human resources at its disposal per head compared to the private sector. Since 1994, the healthcare sector in South Africa has experienced significant restructuring in an attempt to address these shortcomings.

The objective of this chapter is to review relevant literature together with a description and explanation of the status of NHI and service delivery in the health sector in South Africa and other countries, such as Kenya and Nigeria. A brief historical description of NHI prior to and post-1994 is introduced. In addition, this chapter identifies and describe problems regarding NHI and service delivery. This literature review investigates and explores the extent to which NHI can be used in the future and the extent to which there will be solutions to service delivery problems. It provides guidelines and recommendations for implementation as a model for use by the government in an effort to improve/enhance healthcare service delivery.

The aim of this chapter is to answer questions such as: why is there inequality in healthcare in South Africa? Why is people's access to healthcare services deteriorating? What are the factors underlying this fact and what can be done to prevent it? The ultimate aim is to build a common vision for realising the right to health and mobilise support for new campaigns for health such as NHI. In addition,

this chapter examines the importance of establishing a sound healthcare system specifically within poor communities where health conditions are most severe.

2.2 Defining health, healthcare reform and service delivery

2.2.1 Health

The most well-known definition of health is that established by the World Health Organisation (WHO) in 1946. Health was defined as *“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”* (World Health Organisation, 1946). This explanation is perhaps also the most criticised mainly because it is difficult to operationalise for achieving health. Unfortunately, for the majority of people in South Africa, the WHO’s definition of health is far from reality. The definition of health has long been a subject of debate. According to the encyclopaedia of health services research (2009: 453 – 454), there are two major contrasting perspectives that have been proposed. Established in the 1970’s from the traditional biomedical standpoint is the ‘naturalist view’ which defines health as freedom from disease. An opposing definition of health was proposed in the 1990’s. The ‘normativist view’ defines health as a person’s capacity to achieve his or her goals, given normal circumstances.

Several other generally accepted definitions of ‘health’ exist. For example, Bircher (2005: 336) defines health as a state of well-being characterized by a physical and mental potential, which fulfils the demands of life commensurate with age, culture, and personal responsibility, while Saracchi (1997, 1410) defines health as a condition of well-being, free of disease or infirmity, and a basic and universal human right.

2.2.2 Healthcare reform

The term healthcare refers to *“the provision of medical and related services aimed at maintaining good health in individuals or the public, especially through the prevention and treatment of disease”* (Encarta World English Dictionary, 1999: 865). When the ANC came to power in 1994, it planned to implement the principles of the Freedom Charter, which were set out, in more detail in a policy document known as the Reconstruction and Development Programme (RDP). Under

“HealthCare” the RDP promised that the government would develop a national health system proposing affordable healthcare, where the focus would be on primary healthcare to prevent disease and promote health, as well as to cure illness.

According to Thomas and Gilson (2004: 279), health reform is essentially political. Technical assessment is seldom enough to ensure the adoption of policy. Reforms aimed at promoting equity are likely to challenge vested interests and produce opposition.

2.2.3 Service delivery

In recent times, much attention has been paid to service delivery in all spheres of government. According to Ayeni (2002: 42), in South Africa, the buzz word is service delivery which is characterised in the principles of Batho Pele, meaning ‘people first’. Fox and Meyer (1995: 118) explain that service delivery is the provision of public activities, benefits or satisfactions. Services relate both to the provision of tangible public goods and to intangible services. The WHO (2001) defines service delivery as a fundamental element of any health system. It is crucial to the accomplishment of health-related millennium development goals. Service delivery is an essential factor in a population’s health status. The precise arrangement and content of health services will differ from one country to another.

The Batho Pele Handbook (2005:8) is an initiative to get public servants to be accountable, to strive for excellence in service delivery and to commit to continuous service delivery improvement. It is a mechanism which allows customers to hold the public service accountable for the type of service they deliver. The effectiveness of the public service is measured in its ability to respond to the needs of society, putting people first. In 1998, the Department of Public Service and Administration (DPSA) published the White Paper on Transforming Public Service Delivery in which it outlined the eight principles for service delivery (DPSA, 1997). Below is an explanation of the eight Batho Pele principles:

- **Consultation** - Citizens should be consulted about the quality of the services they receive, and, wherever possible, should be given a choice about the services being offered (Republic of South Africa, 1997:15);
- **Service standards** - Communities should be informed what level and quality of service they will receive so that they know what to expect (Republic of South Africa, 1997:17);
- **Access** - All citizens should have equal access to the services to which they are entitled (Republic of South Africa, 1997: 18);
- **Courtesy** - All members of the community should be treated with courtesy and consideration (Republic of South Africa, 1997: 19);
- **Information** - Communities should be given full and accurate information about the public services to which they are entitled (Republic of South Africa, 1997: 19);
- **Openness and transparency** - Citizens should be informed on how local authorities function and the information to which they are entitled (Republic of South Africa, 1997: 20);
- **Redress and handling of complaints** - If community members do not receive promised services they should be entitled to a full explanation and also to a speedy remedy (Republic of South Africa, 1997: 21); and
- **Value for money** - Services should be provided economically and efficiently in order to provide citizens with the principle of best value for money (Republic of South Africa, 1997: 22).

The accomplishment of Batho Pele will be determined by the advancement made in efforts to transform the public service. While an opportunity for success exists, there are limitations such as bureaucracy and excessive legal regulations (Khoza, 2002:34).

2.3 The South African health system pre-1994

Pre-1994, the South African healthcare system was characterised by racial discrimination, lack of commitment, poor administration, and discrimination. During this era, health services were deliberately fragmented to perpetuate discrimination. The system was founded on an apartheid ideology that was characterised by racial and geographical differences. The people, who needed the health services the most, had the least access to such services.

The American Association for the Advancement of Science and the Physicians for Human Rights Organization (1998) state that the South African healthcare system restricted access to healthcare for Blacks and often ignored quality-of-care standards. It established an environment in which abuses such as the denial of emergency care treatment, falsification of medical records and limitation of Blacks' access to continuous medical care.

Apartheid was a system based essentially on such deep discrimination that it robbed Black people of all human dignity. This racism was demonstrated in every aspect of health such as rigid segregation of health facilities; disproportionate spending on the health of Whites as compared to Blacks - resulting in world-class medical care for Whites while Blacks were usually referred to congested and dirty facilities; public health policies that disregarded diseases primarily affecting Black people and the denial of basic sanitation, supply of clean water and other components of public health to rural areas and townships. Moreover, people with mental illness and retardation were locked away in institutions, deprived of human rights and access to community-based programmes that would enable them to recover (The American Association for the Advancement of Science and the Physicians for Human Rights Organization, 1998).

It was not only the population that endured racial discrimination. Few Blacks were permitted into the medical field. Those who were accepted were subjected to schools with limited resources and, when admitted to White institutions, were demeaned by practices like prohibitions on Black medical students wearing white coats and stethoscopes in White hospitals. In addition, Black nurses were denied adequate training resources and the opportunity to use their skills in an appropriate

manner (The American Association for the Advancement of Science and the Physicians for Human Rights Organization, 1998).

The Government of National Unity embarked on a process of restructuring the health sector in South Africa to fundamentally bring greater equality in the provision of public health. Based on this historical background, reform in all the public services was necessary to redress the past imbalances that existed.

2.4 The South African health system post-1994

The legacy of apartheid is deep and grim, having a pronounced effect on the health of its people and services of the present day. After 18 years, South Africa is still grappling with the legacy of apartheid and the challenges of transforming institutions and promoting equity in the health sector.

One of the important political changes post-1994 was the translation of the 1993 Interim Constitution into a final constitution that guarantees social and economic rights such as adequate housing, education and health facilities for all South Africans. The elected ruling party set the stage to address the past and make the necessary legislative changes to start providing not only democracy but also access to healthcare for all (Ngwenya, 2001/2:26-44).

Since 1995, the South African public service has been engaged in the process of transforming itself in an efficient, effective, democratic and development-oriented instrument of service delivery. The publication of the White Paper on the transformation of public service (1995) (Notice 1227 of 1995) served as a point of departure for the transformation of the South African public service.

Indeed, the South African health system has come a long way since 1994, despite challenges inherited by the post-apartheid government. However, the country is plagued by four other health problems described in the Lancet report as the quadruple burden of disease; TB (directly related to HIV/AIDS), maternal, infant and child mortality, injury and violence and non-communicable diseases (Coovadia, Jewkes, Barron, Sanders, and McIntyre, 2009). The emergence of drug resistant tuberculosis (XDR-TB) and high rates of HIV/TB co-infection further complicate the

response to HIV/AIDS. According to the Joint United Nations Programme on HIV/AIDS-UNAIDS (2010: 180), the percentage of people living with HIV/AIDS in SA is amongst the highest in the world. It is estimated that some 5 600 000 people have contracted the virus, thereby creating more demand for healthcare as many more people get sick.

Schneider, Barron and Fonn (2007: 302) concur that the HIV epidemic has its origins in the massive social disruptions of apartheid; its impact felt in post-apartheid South Africa. It is the HIV interventions that have captured much of the transformation attention of the health system such as educational campaigns, condom distribution, control of sexually-transmitted infections and voluntary counselling and testing.

It is encouraging to note that significant achievements in healthcare have been made since 1994; such as free primary healthcare, choice on termination of pregnancy, clinic expansion and improvement, improved immunization programmes and improved malaria control. However, high levels of poverty and unemployment mean healthcare remains largely the burden of the state. The Department of Health holds overall responsibility for healthcare, with a specific responsibility for the public sector.

2.5 Introduction of NHI in South Africa – History of proposals on healthcare reform in South Africa

The Green Paper on NHI (Republic of South Africa, 2011) states that the history of healthcare reform actually dates back more than 80 years. NHI was recommended in 1935 for Whites. However, the proposal was never taken forward. The World Health Organisation (WHO) (2000:13) discloses the attempted introduction of a National Health Service in South Africa in the 1940s, stating that a scheme for a national health service similar to the British model was recommended in South Africa in 1944. Such a scheme was to consist of free healthcare and a network of community centres and general practitioners as part of a referral system, but it was not implemented.

2.5.1 National Health Service Commission (1942 – 1944)

The Green Paper mentions that, during the period 1942-1944, a commission led by Dr Henry Gluckman, called the National Health Service Commission, was set up. It proposed the implementation of a National Health Tax to ensure that free health services be provided to all South Africans. The Gluckman Commission proposals were accepted by the government led by General Jan Smuts; however, it was decided to implement them as a series of measures rather than in a single phase. Advances from the Gluckman Commission process were reversed after the National Party (NP) government led by General DF Malan was elected in 1948 (Phillips, 1993:1037- 1039).

2.5.2 Healthcare Finance Committee (1994)

The Green Paper confirms that by the early 1990's interest had again turned to the prospect of introducing some form of mandatory health insurance. After the 1994 elections, there were numerous policy initiatives that considered either social insurance or NHI. According to the Healthcare Finance Committee of 1994, it was recommended that all formally employed individuals and their immediate dependents should form the core membership of Social Health Insurance (SHI). This would eventually be expanded to cover other groups over time. It was proposed that a comprehensive set of services be covered under such a system and that both public and private providers be involved (Doherty, McIntyre and Gilson, 2003: 47 - 58).

2.5.3 Committee of enquiry on NHI (1995)

The 1994 Finance Committee was followed by the 1995 Commission of Enquiry on NHI which fully endorsed the recommendations of the Health Finance Committee.

2.5.4 The Social Health Insurance (SHI) Working Group (1997)

In 1997, the SHI Working Group developed the regulatory framework that resulted in the enactment of the Medical Schemes Act in 1998. This Act was meant to regulate private health insurance. However, the level of coverage for the national

population has remained below 16 percent and is only affordable to the relatively well-off (Gilson, Doherty, McIntyre, Thomas, Brijlal, Bowa and Mbatsha, 1999: 4).

2.5.5 Committee of enquiry into a Comprehensive Social Security for South Africa (2002)

The White Paper states that Professor Vivienne Taylor was appointed in 2002 by the Department of Social Development to chair the Committee of Enquiry into a Comprehensive Social Security for South Africa following principles outlined in the White Paper. The Commission proposed that there should be mandatory cover for all those in the formal sector earning above a given tax threshold and that contributions should be income related and collected as a dedicated tax for health. The Committee further recommended that the state should establish a national health fund through which resources would be routed to public facilities through the government budget process.

2.5.6 Ministerial task team on SHI (2002)

The Department of Health established the Ministerial Task Team on SHI in 2002 to implement the recommendations of the Taylor Committee. The task was to draft an implementation plan with proposals on how to advance towards SHI. In addition, the team had to create supporting legislative and institutional mechanisms to influence the long-term result in the enactment of legislation of NHI in South Africa. However, the path to achieving universal coverage was not widely supported resulting in the supporting proposals being stalled.

2.5.7 Advisory committee on NHI (2009)

The Ministerial Advisory Committee on NHI was established in August 2009. The committee was tasked with providing the Minister of Health and the Department of Health with recommendations regarding the relevant health system reforms relating to the design and roll-out of NHI. This was to carry forward the resolution passed at the ruling party's (ANC) conference in December 2007 in Polokwane.

According to Harrison (2009: 2), the reorganisation of the public health sector post-1994 attained considerable advancements in terms of access, and more equitable health expenditure. Fifteen years later, these early gains have been blemished by HIV/AIDS, a generally weak health management system and low staff morale. Table 1 summarises the principle accomplishments and shortcomings of the past 15 years:

Table 1: Summary of accomplishments and shortcomings over the past 15 years

Accomplishments	Shortcomings
Legislation and gazetted policy 1 Free primary healthcare 2 Essential drugs programme 3 Choice on termination of pregnancy 4 Anti-tobacco legislation 5 Community service for graduating health professionals Better health systems management 6 Greater parity in district expenditure 7 Clinic expansion and improvement 8 Hospital revitalisation programme 9 Improved immunisation programme 10 Improved malaria control	Insufficient prevention and control of epidemics 1 Limited effort to curtail HIV/AIDS 2 Emergence of Minimum Drug Resistant Tuberculosis (MDR-TB) and Extreme Drug Resistant Tuberculosis (XDR-TB) 3 Lack of attention to the epidemic of alcohol abuse Persistently skewed allocation of resources between public & private sectors 4 Inequitable spending patterns compared to health needs 5 Insufficient health professionals in public sector Weaknesses in health systems management 6 Poor quality of care in key programmes 7 Operational inefficiencies 8 Insufficient delegation of authority 9 Persistently low health worker morale 10 Insufficient leadership and innovation

Source: Harrison (2010:2)

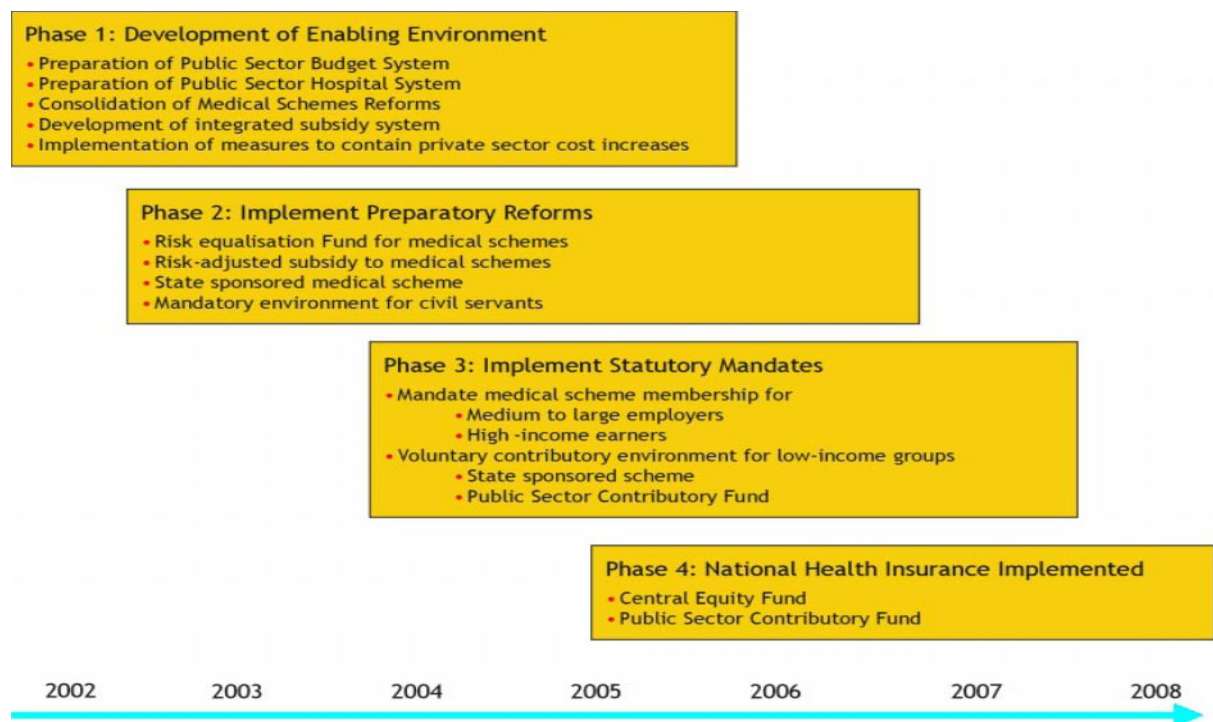
2.6 Rationale for healthcare reform in South Africa

The public service in South Africa prior to 1994 was characterised by poor quality of services, ineffectiveness and lack of commitment. The system was founded on an apartheid ideology that was characterised by racial and geographical differences. For those living in poor rural communities, access to healthcare was difficult. The first democratic election in April 1994 was an important landmark in the history of South Africa. Effectively, an end to White minority political rule was initiated and replaced by the adoption of a progressive constitution. Based on this historical background, reform in the public service was necessary to redress the past imbalances that existed.

In the NHI Policy Proposal (Republic of South Africa, 2009), it is stated that the rationale for introducing NHI is to remove the current tiered system where those with the greatest need have the least access and have poor health outcomes. The Taylor Committee Report of 2002 provides a vision for the transformation of healthcare reform. The Report (2002: 101) recommends that South Africa shift towards a NHI system based on multiple funds and a public sector-related environment. This is an essential document on healthcare reform and the recommendations are still being applied.

In the NHI Advisory Committee: Terms of Reference: (Republic of South Africa, 2009), the proposed NHI is based on the following key principles: First, that it is a constitutional right that the public has access to affordable and acceptable quality health services; secondly, that it is the responsibility of the state to ensure the progressive realisation of the right to health for all South Africans; and, thirdly, that it is important for health services to be funded in an equitable manner that promotes social solidarity. The ANC National Policy Conference, held at Gallagher Estate on 27–30 June 2007, reaffirmed the implementation of the NHI system (Figure 1).

Figure 1: Reform strategy and approximate timeline



Source: South African Regional Poverty Network (SARPN–2002:26)

2.7 Challenges and positive aspects of NHI

The real challenge in establishing an NHI system is to ensure that every South African, irrespective of socio-economic class, has an equal opportunity to be attended to in time of need.

Challenges

According to Cranke (2011) the following are the challenges facing NHI:

- The burden of disease will put the provision of healthcare services under pressure. This relates to: HIV/Aids and TB; maternal, child and infant mortality; non-communicable diseases like high blood pressure, diabetes, chronic heart disease, chronic lung disease, cancer and mental illnesses;
- Countries with NHI programmes all tend to have high net incomes, low unemployment and large and stable tax bases, none of which is prevalent in South Africa. This makes Government's objectives regarding job creation all the more critical in order to broaden the tax base;
- There is a severe shortage of health professionals in the public sector;
- Improvement of quality care in public hospitals is crucial to the success of NHI because it is assumed that citizens will transfer voluntarily from the private to the public healthcare systems. The potential for negative fallout if citizens have to pay a compulsory contribution to NHI and also fund their own private medical cover due to an underperforming public healthcare system is something that the ruling party will want to avoid at all costs;
- The central procurement system proposed will be complex and may be prone to corruption; and
- The ultimate implementation of NHI will mean that every beneficiary has to be issued with an NHI card. Presently, no system exists and the logistics and expense of getting this done as a precursor to NHI are significant.

Positive factors

- The Green Paper has been met with optimism with stakeholders signifying their acceptance of the principles of NHI and their willingness to participate in the process;
- The Green Paper recognizes the expertise available in the private sector in the areas of administration and management of insurance funds and has implied that NHI will draw upon that expertise;
- The implementation of NHI will be phased in over a period of 14 years, where 11 pilot districts have already been identified;
- Medical scheme cover will not be dissolved – citizens wanting to pay for this cover over and above their compulsory NHI contributions will be able to do so;
- The strong significance on primary care, through a totally re-engineered primary healthcare system, will realign healthcare from a predominantly curative to a preventative system, with resultant curtailment of downstream costs. The re-engineering process will see the appointment of: District Clinical Specialist Support Teams; School Health Services; Municipal Ward-based Primary Healthcare Agents; the establishment of an independent watchdog; and
- The improvement of the public hospitals should result in competition with private hospitals, which will have a positive impact on the price of services provided in the private sector.

2.8 The strategic framework of the public health system

There are many laws that affect the delivery of healthcare in South Africa. There are even laws that appear to have no association with health at all, but may affect people's rights of access to healthcare services. An example of such laws is that of trade which limits access to essential medicines. The Taylor committee report

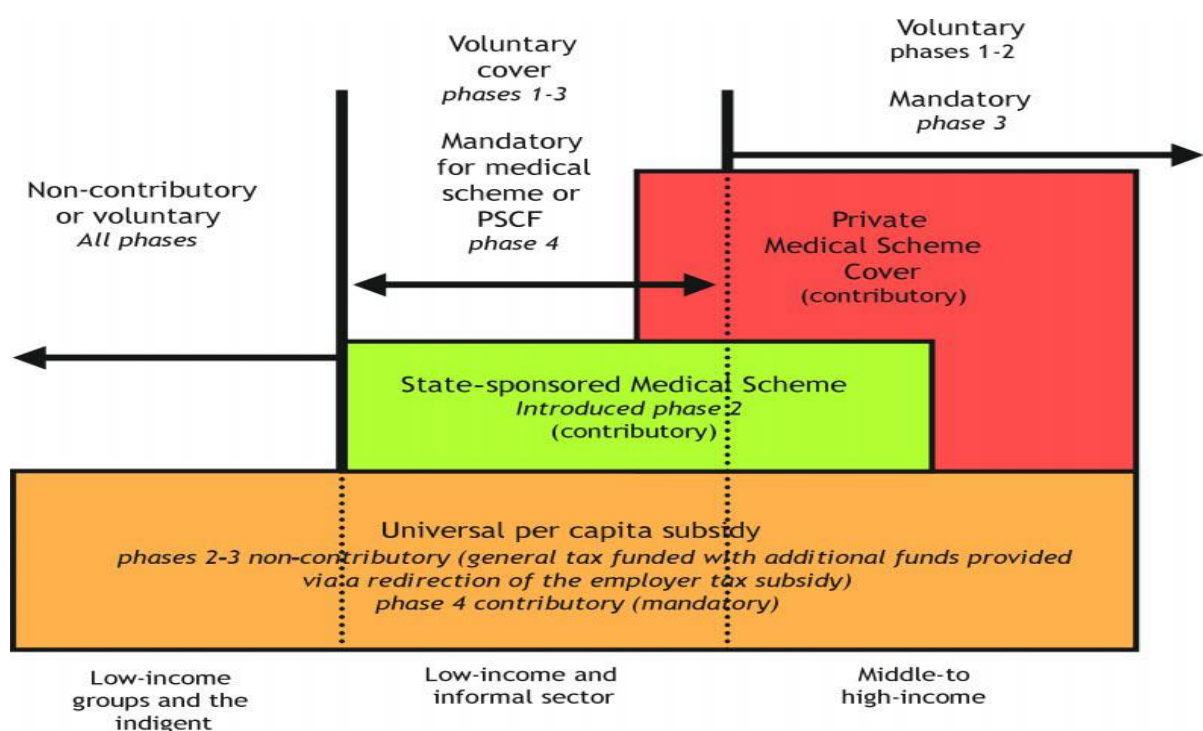
(2000: 100) maintains that there are challenges with the existing structure of the health system which has certain endemic perverse cycles that need to be reversed through interventions at an institutional level. The Taylor committee (2002: 100 - 1) identifies the central contributors to this negative cycle in four areas:

Cover: The public sector is faced with a growing population, both low-income and impoverished, whereas the private sector population is not expanding. The public sector has to take care of the sick and less healthy groups usually not covered by the private sector;

Burden of disease: As a result of HIV/AIDS, the public sector is confronted with a worsening liability of disease as well as rising levels of diseases and poverty;

Finance: The public sector health system faces a declining budget allocation in addition to an increasing population and disease burden. Figure 2 depicts the establishment of a state-sponsored medical scheme targeted at low-income groups, the informal sector, and middle-income groups who wish to obtain more cost-effective cover; and

Figure 2: Strategic financial framework for the South African health system



Source: South African Regional Poverty Network (SARPN-2002:90)

Providers: Apart from an increasing population, an increased disease burden, and a declining budget allocation, the public sector is losing clinical personnel to the private sector. As such, the private sector effectively exhausts resources from the state to provide cover to a fairly healthy and younger population. The private sector effectively receives a tax subsidy of approximately R7, 8 billion to reinforce this trend.

The health sector strategic framework 1999-2004

According to Naidoo and Van Wyk (2003:67 - 68), the Department of Health (DoH) in its Health Sector Strategic Framework 1999-2004 acknowledged that primary and community-based healthcare is its prime objective, driven by an efficient and preventative healthcare system.

According to the Health Sector Strategic Framework 1999-2004, the South African Government adopted a ten-point plan to strengthen implementation of efficient, effective and high quality health services. This includes, amongst others, ensuring that the needs of patients are met and that the quality of care is of an acceptable standard. Andrews and Pillay (2005: 4) state that the Minister of Health and the MECs for Health in 1999 adopted the Health Sector Strategic Framework, 1999-2004, which reflected the top 10 priorities for the health sector for this period. In 2004, a new set of priorities was identified. The strategic priorities for 2004-2009 evolved out of an assessment by the DoH of the work it had set itself for the period 1999-2004, as well as an overall assessment of its achievements of the past 10 years. The key priorities of the DoH are laid out in the Health Sector Strategic Framework 1999-2004 which outlines the major elements of the framework also known as the 10 point plan. These are:

- Reorganisation of certain support services;
- Legislative reform;
- Improving quality of care;
- Revitalization of hospital services;

- Speeding up delivery of an essential package of services through the district health system;
- Decreasing morbidity and mortality rates through strategic interventions;
- Improving resource mobilisation and the management of resources without neglecting the attainment of equity in resource allocation;
- Improving health human resource development and management;
- Improving communication and consultation within the health system and between the health system and communities; and
- Strengthening co-operation with international partners.

Taking the above into account, it is necessary that Government adopt a strategic approach to reforming the health system so that it cooperates fully with both the public and private sectors. The objective would be to achieve together what each cannot accomplish alone. The following section reflects significant legislation and policies that govern the South African health sector.

2.9 The legislative framework

Legislation plays a critical role in achieving health reform goals. According to Pillay, Marawa and Proudlock (2003:4), it establishes structures and mechanisms to put policy into practice and provides for sanctions, should the policy be breached. The National Health Act (NHA) (61 of 2003) can be regarded as the most important law setting out the legislative framework for healthcare delivery in South Africa. It replaced the previous Health Act, which focused on the apartheid era in which it was passed. According to its preamble, the NHA aims to:

- Provide for a system of cooperative governance and management of health services, within national guidelines, norms and standards, in which each province, municipality and health district must address questions of health policy and delivery of quality healthcare services;

- Establish a system based on decentralised management, principles of equity, efficiency, sound governance, internationally recognised standards of research and a spirit of enquiry and advocacy which encourages participation; and
- Promote a spirit of cooperation and shared responsibility among public and private professionals and providers and other relevant sectors within the context of national, provincial and district health plans.

2.9.1 Three levels of the health system

The NHA gives legislative effect to a public health system that is designed to function through three spheres: national, provincial and district. Below, is a summary of the functions of the three spheres of government:

- **National functions** include identifying national goals and priorities, and developing norms and standards for the provision of health services. The Minister of Health is given overall responsibility for discharging these duties;
- **Provincial functions** include taking care of public and private hospitals, providing specialised hospital care, ensuring that systems are in place to maintain quality control, and supporting districts in providing health services. The NHA also says that the head of department in a province must consult with communities regarding health matters. The MEC for health in each province is required to ensure the implementation of these responsibilities; and
- **District health structures** are meant to be at the centre of healthcare service delivery, particularly primary healthcare services provided through clinics. The boundary of each health district is the same as district and metropolitan municipal boundaries. However, to improve services in big municipalities, provincial governments are allowed to set up health sub-districts. These districts (and sub-districts) are responsible for providing municipal health services, as well as water and sanitation services.

2.9.2 Free healthcare services

The NHA gives legislative effect to free healthcare services for pregnant women and children under six. Equally important, the NHA says that all people (other than those who have medical scheme coverage) are entitled to free primary healthcare services. The NHA empowers the Minister to prescribe, through regulations, the provision of essential health services to all people who live in South Africa.

2.10 The policy framework – the White Paper on the Transformation of the Health System in South Africa

After the first democratic elections in 1994, the government began to implement a policy based on its vision of healthcare for all. This meant developing detailed proposals for health policy in South Africa, culminating in the release of the White Paper on the Transformation of the Health System in South Africa in 1997. The White Paper established a detailed framework for healthcare delivery, and identified the manner in which government intended to transform South Africa's healthcare system. It remains one of the most important policy documents and is a benchmark that guides health sector transformation today. The paper maintains that government's overall objective is to develop an integrated health system capable of providing quality healthcare to all. According to the White Paper, all health sector policy and legislation would be based on the following principles:

- The health sector must play its part in promoting equity by developing a single, unified health system;
- The health system will focus on districts as the major focus of implementation, and emphasise the PHC approach;
- The three spheres of government, NGOs and the private sector will unite in the promotion of common goals;
- The national, provincial and district spheres will play distinct and complementary roles; and

- An integrated package of essential PHC services will be available to the entire population at the first point of contact.

2.10.1 Vision, mission, values, goals and objectives

2.10.1.1 The vision statement

Nel, Werner, Haasbroek, Poisat, Sono and Schultz (2008: 554) describe a vision statement as the goal or the desired future state of the organisation. Nel *et al.* maintain that a vision describes, in an exciting and passionate way, the course the company wants to take. The time frame can be anywhere from six months to five years in the future. Management imparts this vision to employees, behaves in ways that are consistent with the vision and builds commitment with the vision.

According to Ehlers and Lazenby (2005: 48), when an organisation formulates a vision statement, there are several matters which should be taken into consideration to ensure that the vision statement is of value to the organisation. Firstly, as many managers as possible should contribute to the creation of a vision statement. Secondly, a vision statement should be achievable in the long-term; if not, it may lose its value to motivate. Thirdly, developing a vision statement involves thinking creatively about the future of the organisation, and not only developing a captivating slogan. Lastly, once a vision statement has been achieved it loses its power and has to be redeveloped to ensure continued focus on a desirable future.

2.10.1.2 The mission statement

According to Nel *et al.* (2008: 554), a clear mission statement describes the values and priorities of an organisation. Nel *et al.* (2008: 555) mention that a mission statement refers to the business in which the organisation is concerned and represents a strategy of how the organisation aims to achieve its objectives.

2.10.1.3 The Mission of the Department of Health

The White Paper states that, in order to realise the mission of the healthcare sector, it is essential to obtain the active participation and involvement of all sectors of

South African society in health and health-related activities. The mission statement reads as follows:

“To provide leadership and guidance to the National Health System in its efforts to promote and monitor the health of all people in South Africa, and to provide caring and effective services through a primary healthcare approach” (Department of Health, White Paper for the Transformation of the Health System in South Africa, 1997).

2.10.1.4 Values

According to Hartel, Fujimoto, Strybosch, and Fitzpatrick (2007:10) values are principles and beliefs that the organisation sets out to guide its employees' behaviour in the pursuit of its vision. Values are intended to shape how employees of the organisation think and act on a day-to-day basis.

2.10.1.5 Goals and objectives

Nel *et al.* (2008: 555) maintain that objectives are the outcome of planned activity; what is to be accomplished and by when. Objectives generally signify the task that the organisation wishes to carry out. Objectives are important for the overall success of the organisation because they give direction. David (2003:11) mentions that objectives should be challenging, measurable, consistent, reasonable and clear.

2.10.1.6 The goals and objectives of the Department of Health

The White Paper on the Health System Transformation (1997) sets out a plan for the transformation of the health system to ensure accessible and equitable healthcare for all. The objectives are:

- To unify fragmented health services at all levels into a comprehensive and integrated NHS;
- To promote equity, accessibility and utilisation of health services;

- To extend the availability and ensure the appropriateness of health services;
- To develop health promotion activities;
- To develop the human resources available to the health sector;
- To foster community participation across the health sector; and
- To improve health sector planning and the monitoring of health status and services.

2.10.1.7 The mission and vision of the Department of Health

An organisation's mission refers to its fundamental purpose for existing. Mission statements set the tone for the organisation and provide management with a broad set of directions for how it should develop further strategies (Berkowitz, 2011: 43). The mission of the National Department of Health is to build on achievements attained between 1994 and 1999, to improve access to healthcare for all, to focus on reducing inequities in healthcare and to improve the quality of care provided at all levels of the healthcare system with increases in the efficiency of service delivery.

According to Niven (2006: 83), the vision statement provides a word picture of what the organisation intends to achieve over the next period, e.g., 5, 10 or 15 years. It should provide everyone in the organisation with a shared mental framework that shapes the future before them. Typical elements of a vision statement include the desired scope of business activities, how the organisation will be viewed by its stakeholders and area of leadership. The vision of the National Department of Health is to play a role in securing a caring and humane society in which all South Africans have access to affordable and good quality healthcare.

According to Cummings and Worley (2008: 170), core values include the simple principles or beliefs that have stood the test of time and signify what the organisation stands for. Although the vision describes a desired future, it must

acknowledge the meaningful core values that have guided and will continue to guide the organisation over time.

2.10.1.8 Patients' Rights Charter

For decades, the majority of the South African population has experienced either a rejection or violation of fundamental human rights, including rights to healthcare services. To guarantee the realisation of the right of access to healthcare services, as guaranteed in the Constitution of the Republic of South Africa (Act No 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and, therefore, proclaims this patients' rights charter as a common standard for achieving the realisation of this right.

The Patients' Rights Charter is an example of a policy that consciously aims to validate health rights. Policy documents provide the detailed framework for government to exercise its constitutional duty, thus ensuring that the population of South Africa is able to access healthcare services. The Patients' Rights Charter (Republic of South Africa, DoH, 1999) makes provision for:

- A healthy and safe environment;
- Participation in decision-making;
- Access to healthcare;
- Knowledge of one's health insurance/medical aid scheme;
- Choice of health services;
- Being treated by a named healthcare provider;
- Confidentiality and privacy;
- Informed consent;
- Refusal of treatment;

- Being referred for a second opinion;
- Continuity of care; and
- Being able to complain about health services.

Patients have the right to know what services are available to them, what formalities need to be completed and what the waiting turnaround time is. Improving citizens' access to such information would lead to greater accountability, transparency and responsive behaviour which are the pillars of good governance, thus improving the service delivery mechanism. Should improved service delivery be made mandatory in government hospitals, there exists a danger that it would remain as a 'paper exercise'. There has to be sufficient enforcement from the higher levels of government and staff 'buy-in'.

2. 11 Change - essential to effective service delivery

Baker (2007: 2) suggests that change is constant. It is brought about through some form of metamorphosis or a transformation process. Baker goes on to explain that change may be made actively in a planned way, or it may seem to occur naturally, with an individual or an organisation adapting or evolving. Change is not, in itself, inherently good or bad. Baker (2007: 16) mentions that overseeing successful change within an organisation is about good leadership rather than effective management and that it is, therefore, not a process, but an approach. Baker argues, however, that even in the smallest organisations, changes are likely to be fundamentally interlinked and interwoven.

2.11.1 Change Management

There are many definitions of change management. However, the one favoured by the researcher is that described by Fincham and Rhodes (2006:525) which states that change management is the leadership and direction of the procedure of organisational transformation particularly with regard to human aspects and overcoming resistance to change. Baker (2007: 16) mentions that managing change is a task that can be embraced proactively or reactively.

2.11.2 Resistance to change

Hughes (2006:118) cites Stickland (1998: 37) who describes resistance as an on-going challenge for change managers who believe that the problem of resistance lies at the centre of most change problems. Organisations may face resistance to change not only from employees but also from other groups such as suppliers, distributors, stakeholders and consumers (Paton and McCalman, 2000:47). Baker (2007: 78) confirms that any change may bring about uncertainty for people, and a period of organisational instability can be unsettling and worrying for individuals and groups. Baker mentions that people are not – in general – deliberately awkward, and resistance does not, in itself, make them difficult employees. They want to understand whether change really is going to be better for them and the organisation. According to Baker (2007: 78), the key reasons why change is resisted in organisations include:

- Lack of awareness of the need for change;
- Fear of redundancy;
- Uncertainty of the future need for present skills or their ability to gain required new critical ones;
- Feelings of comfort with the way things are;
- Feelings of having to do more with the same resources or for the same pay; and
- Lack of understanding or knowledge and fear of being downgraded.

The manner in which resistance is handled will differ, depending on whether it is only a small number of people who are against the changes, or if it is a majority of those who need to be convinced. It is important for change managers to listen to criticisms and not criticize resistance. Those who oppose the changes may have good points to make, if allowed to make them (Baker, 2007: 78).

2.11.3 Managing change successfully

Pettigrew and Whipp (1993:6) maintain that there are no rules with regard to managing change; rather, it requires linking the action by people at all levels of the business. Below, are some points that Pettigrew and Whipp propose for successfully managing strategic and operational change:

- **Environmental assessment**

Organisations, at all levels, need to expand their ability to collect and utilise information about their internal and external environments;

- **Leading change**

This requires the creation of a positive climate for change, the identification of future directions and the connecting of action by people at all levels in the organisation;

- **Linking strategic and operational change**

This is a two-way process of ensuring that strategic decisions lead to operational changes and that operational changes influence strategic decisions;

- **Human resource as assets and liabilities**

Just as the pool of knowledge, skills, and attitudes possessed by an organisation is crucial to its success, it can also be a threat to the organisation's success if the combination is inappropriate or managed poorly; and

- **Coherence of purpose**

This concerns the need to ensure that the decisions and actions that flow from the above four factors complement and reinforce each other.

2.12 Public Administration Models

According to Van der Walddt and Du Toit (1997: 61), public administration can be defined as an extensive combination of practice and theory which aims to support public policy-making, promote a greater understanding of the relationship between government and society and establish managerial practice directed at people's needs. Fox, Schwella and Wissink (1991: 2) define public administration as a system of structures and processes that operate within a particular society with the objective of facilitating the formulation and execution of policies. Therefore, public administration refers to the functions, processes and activities employed not only for the attainment of organisational objectives but also, more importantly, to provide goods and services for the well-being of the population.

This assignment will examine the two models that refer to public administration namely:

- Cloete's traditional approach to public administration; and
- Fox, Schwella and Wissink's contingency approach to public administration.

2.12.1 Cloete's traditional approach

According to Cloete (1998:85), the activities performed in public administration can be classified in four groups, namely:

- Generic administrative and delivery;
- Auxiliary;
- Instrumental; and
- Functional, also referred to as line functions.

The functions performed in an administrative executive institution are usually carried out concurrently and are incorporated to such an extent that it is often seldom possible to see where the one starts and the other ends. It is obvious that the administrative functions must always be commenced before a start can be made with the functional activities. Nothing can be done in the public sector before a policy on the matter has been accepted either by the legislature or an institution to

announce that an action must be taken in the matter. It is only when a policy has been provided that other generic administrative processes can commence. Administrative processes are performed in all public departments. Therefore, they are called generic administrative processes and consist of two dimensions, namely: (Cloete, 1998: 85).

- Conceptual (initiatory and innovative) and distinctive functions; and
- Delivery (managerial/operational functions).

The generic function of public administration has been defined as policy, organising, staffing, financing and determining work methods and procedures and control (Cloete, 1995: 91-205). These are discussed in detail below.

Policy making and implementation

According to Cloete (1998: 159), policy making is a prerequisite in the provision of goods or services. Officials within the public health sector concerned with the formulation and the implementation of policy must always be aware of techniques that may be used to improve the performance of the actions involved. Policy making involves identifying needs, preparing legislation, and analysing existing policies whilst policy implementation involves setting missions/objectives/goals, planning, programming, marketing of policy missions/objectives/goal and identifying and reporting shortcomings.

Organising

Organisational structures in the public sector have to be established. Such structures are usually prescribed by the institutions which have to undertake the conceptual and directive functions (Cloete, 1998: 186). Within the conceptual framework of the public health sector, organising will consist of devising and improving structures, whereas the delivery parts of organising will consist of the day-to-day duties of the employees such as delegation, reorganising, coordinating and teamwork.

Staffing

The staffing function always takes up a considerable part of the working hours of every supervisor (Cloete, 1998:241-244). Managers and supervisors within the public health sector are expected to perform the following core delivery tasks described below:

- Proposals for creation of posts

The reorganisation of personnel establishments usually originate in the work place. The supervisor will specify that steps be taken to create more posts or to abolish posts.

- On-the-job training

Training of subordinates is an on-going function. On-the-job training will consist of formal and informal training. It is the duty of the supervisor to identify shortcomings in the skills and knowledge of subordinates.

- Merit-rating

Continuous evaluation of employee performance is essential and applied by the various supervisors. Evaluations are made for the purpose of salary adjustments, training, promotion, and even dismissal.

- Leading and leadership

The main function of a supervisor is to lead subordinates to achieve the objective of the organisation. Supervisors must display leadership qualities if this is to be achieved. If a supervisor wants to use coercive power to obtain top performance from subordinates, this will always be a failure. Instead, a supervisor should rely on his/her expertise, skill and knowledge.

- Conflict resolution

There is bound to be conflict whenever two or more individuals work together. The cause of conflict ranges from duties, objectives and roles. Every supervisor should be on the look-out for conflicts and immediate steps taken to eliminate conflict.

- Counselling

From time-to-time, employees will experience stress in both their work environment and private lives. Employees should be given assistance in dealing with these strains and stresses. Supervisors should have the necessary knowledge to enable them to provide support to the employee.

- Disciplining

In situations where subordinates flout rules, disobey orders or render poor service, supervisors should follow procedures that set out the relevant regulations and procedure manuals to be followed. Subordinates found guilty of misdemeanour or unsatisfactory work performance may be reprimanded, transferred or suspended. Dismissal will be the last resort after every effort to rehabilitate the subordinate has failed.

- Development

Training can improve the knowledge and skill of an employee. The developmental needs of subordinates must be understood by the supervisor and steps taken to ensure that these needs are satisfied.

- Dealing with change and stress

Change is inevitable. A supervisor must anticipate change and prepare subordinates to accept change. There will, however, always be employees who will resist change due to uncertainty and fear of job loss.

Financing

A supervisor must always be cost-conscious and work within the limits of estimates of expenditure for the institution in which he/she is employed. The supervisor is bound by financial directives provided by legislation and regulations and is, therefore, accountable for all financial directives such as requisitioning for funds, costing of activities, checking transaction records, auditing, stores control and reporting (Cloete, 1998: 209).

Determining work methods and procedures

According to Cloete (1998: 260), work methods and procedures of public institutions are to formulate and render a multitude of goods and services to public and private institutions as well as to individuals. The methods and procedures employed in rendering these services should, therefore, be focused on the needs and interests of the public and not the requirements of service providers of goods and services. The approach should be a combination of teamwork among public and private functionaries and institutions.

Controlling

The control functions are vital at the workplaces where public goods and services are provided. Activities performed as a control function include; quality control, devising control methods, promoting productivity and auditing (Cloete, 1998: 279).

Criticism of Cloete's approach

Cloete's administrative process model has an effective influence in public administration in South Africa today. However, there have been several criticisms concerning his approach. Schwella (1990:1) states that the traditional approach concentrates on efficiency rather than political, ethical and moral problems. This approach also avoids ethical and political questions created by the policy of apartheid for South African public administration by attempting to suppress the introduction of management theory and techniques into public administration. Schwella (1990:2) discusses these in terms of reductionism, reification and relevance.

Reductionism – The generic administrative process model decreases the complex phenomenon of public administration to the administrative processes by equating public administration to the administrative process. The administrative process is further reduced to the six generic administrative processes of policy making, organising, financing, staffing, determining work methods and procedures and control. Public administration is thus reduced to six administrative functions.

Reification – This takes place when intellectual or abstract ideas are confused with reality. Many public administration academics were subjected to the regulating practices of government when they worked as public officials. As a result, practices in the South African public services were reified to the status of theory in public administration.

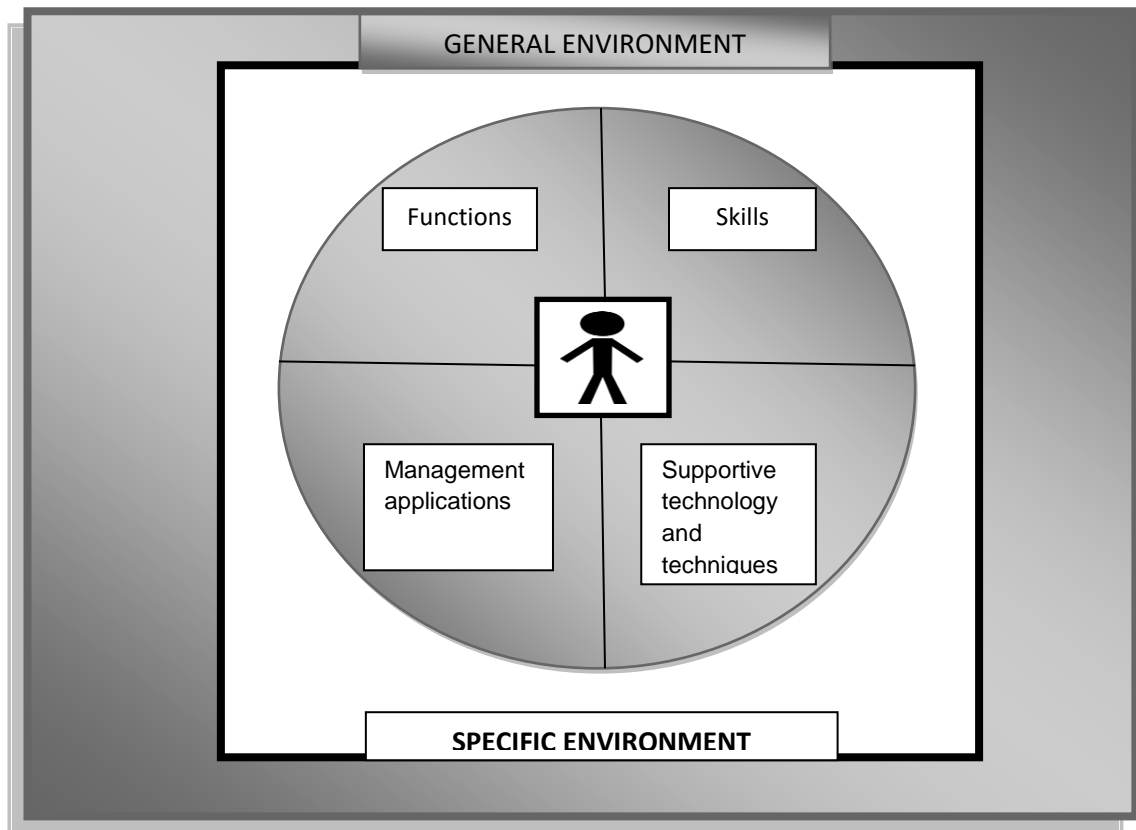
Relevance – Another criticism is that the very nature of the generic administrative process inhibits critical and relevant theorising about relationships between the system of public administration and society the in which it operates. Cloete's model does not take into account the ever-changing and troubled environment (political, economic, social, cultural and technological) of a society and the way in which this environment impacts on administrative activities.

2.12.2 Fox, Schwella and Wissink's contingency approach to public administration

This approach stresses the importance of the environment for the theory and practice of management. It emphasises that public management functions and public management skills should be continuously assessed in terms of the public management environment. Cloete's generic public administration functions have been described. This section will highlight Fox's public management model focusing on the environment.

Public administration takes place in an ever-changing environment. It is a complex environment affected by challenges of political, social, economic, technological and cultural circumstances. It is crucial that the public sector health manager takes the environment into account because disregarding the environment could have a negative effect on achieving departmental objectives. In a bid to strengthen public administration and to ensure effective service delivery, the public health manager must be aware of what is happening and take into account any environmental factors that that could impact on departmental outcomes. Figure 3 indicates the approach of Fox *et al.* to public administration.

Figure 3: Fox, Schwella and Wissink Public Administration Model



GENERAL ENVIRONMENT

Political, Social, Economic, Technological, Cultural

SPECIFIC ENVIRONMENT

Suppliers, Competitors, Regulators, Consumers

FUNCTIONS	SKILLS	APPLICATIONS
Policy-making	Decision-making	Policy analysis
Planning	Communication	Strategic management
Organising	Management of change	Organisation development
Leading	Management of conflict	SUPPORTIVE
TECHNOLOGY		
Control and evaluation	Negotiation	AND TECHNIQUES
		Computer technology and Information management
		Techniques for public management

Source: Fox, Schwella and Wissink (1991: 4)

Environment analysis

According to Fox, Schwella and Wissink (1991: 18), the public management environment consists of the general and specific environments. The general environment can be defined as everything external or outside the organisation which constantly influences the management of the organisation. Comparatively, the specific environment is defined as aspects that internally and directly influence the organisation. The specific environment is categorised as suppliers, competitors, regulators and consumers.

General environment

- Political environment

Management decisions are continually affected by the course of politics, especially the political pressures exerted by the ruling administration and its institutions. The government of the day affects the environment in a regulating capacity by means of legislation, the annual budget, taxation and health regulation (Nieuwenhuizen and Rossouw, 2012:29-30). According to Hodge and Anthony (1984: 205), the political environment refers to the way in which a society is ruled. This system has a major impact on organisations which should be considered by managers. Public institutions are influenced by national power structures such as pressure and interest groups, acts and regulations and political parties.

The health sector is focused on implementing NHI, intended to bring about equity, efficiency and affordability to ensure that all South Africans have equal access to healthcare service regardless of their ability to contribute to the fund. The Green Paper outlining the government's broad policy proposals for National Health Insurance (NHI) will be rolled out over 14 years. The Green Paper introduces the start of a complete transformation of the country's health system which has already commenced with the piloting stage in 11 districts.

- Social

According to Cronje, Du Toit and Motlatla (2000: 81), humans are products of their community and as such accept its language, values, customs and laws. The social environment represents the way of life of a group of people, it also influences an individual's way of life in terms of values, habits and expectations. Fox *et al.* (2004: 20) maintain that management and organisational factors include trends in housing, education and human development which are influenced by the needs of consumer groups as well as employees of the organisation. Policy makers and managers of public institutions have to give careful consideration to these factors.

Community hospitals and clinics are important to communities because these institutions help to build one's sense of pride and ownership in the community in which they live. This social aspect is not only committed to the delivery of services, but also with shaping the future and economic well-being of the community. To this effect, the livelihood of the community is improved, making communities pleasant and safe to live and work in, and where quality services are readily available.

- Economic

The economic well-being of a country is measured by the range and number of products and services it produces. Expressed in monetary terms, this is known as the Gross Domestic Product (GDP), in other words, the total value of all final goods and services produced within the boundaries of South Africa within a particular period. The economic recession has meant that the government's monetary policy has been affected in terms of interest rates and the strength of its currency (Cronje *et al.*, 2000: 77-81). According to Hodge and Anthony (1984: 65), the economic system is the manner in which society generates and distributes wealth. It is also the system which provides scarce resources to individuals and groups. National economic factors such as the structure of the economy, patterns of economic growth, inflation, savings and investments and rates of exchange have to be considered. International economic bodies such as the International Monetary Fund (IMF) and the World Bank have far reaching effects on the economy. Climatic conditions also have to be taken into consideration since they influence the availability of land, water, and mineral resources.

Unemployment is probably one of the greatest challenges that South Africa faces. Rural areas, in particular, face the harshest conditions of poverty and lack of access to basic services almost on a daily basis. Healthcare is a human right, yet large numbers of people continue to die prematurely from poor health. The government has made an effort since 1994 to ensure that everyone in this country has equitable access to necessary healthcare services. To ensure quality of healthcare services under NHI, there needs to be: 1) an improvement in the quality of services in public health facilities; 2) standards must be complied with; and 3) there needs to be a radical change to healthcare management within the public healthcare system in line with the 10 Point Programme of the Department of Health.

- Technological

Change in the environment is generally a manifestation of technological innovation through human capabilities. Technological breakthroughs, such as orthoscopic surgery, result in new products and services for consumers, lower prices and a higher standard of living. New technology and innovation often has unpredictable consequences. For example, the contraceptive pill has meant smaller families, more women at work and, therefore, more disposable income that the household would otherwise not have afforded (Cronje *et al.*, 2000: 74). Van Wyk (1988: 260) emphasizes that the interaction between the technological environment and public organisations should encourage public managers to cope with the changing environment through understanding the nature of these changes and by broadening their skills to handle these changes.

The use of information and communication technology (ICT) to improve managerial processes within the Department of Health is a key factor for successful management. However, with the advancement of technology comes the insatiable demand for capital. As new technologically improved products are constantly being introduced into the market, managers in the health sector will have to give careful consideration not only to the benefit this equipment will have for the organisation, but also to cost implications in relation to allocated budgets.

- Cultural

Nieuwenhuizen and Rossouw (2012: 160) describe the cultural environment as a system of values and norms that have developed in society over a period of time and in which all members share. These values and norms are created by people and transmitted from one generation to the next to ensure survival and to facilitate adaption to the circumstances of life. Hodge and Anthony (1984: 64) concur that the cultural system of a society is the society's beliefs, attitudes and interactions. The cultural values of a society are of importance when their preferences and requirements are to be assessed.

Different cultures embrace certain traditions and are generally transmitted from parent to children. In this process, the school, church and other social institutions play an important role. For example, male circumcision in the African culture is considered customary, while abortion is frowned upon.

Culture, which exists in organisations, is the established pattern of values, norms, beliefs, attitudes and assumptions that shape the ways in which people behave and things get done within an organisation.

Specific environment

The specific environment, according to Fox *et al.* (2004: 20-21), is that part of the environment which directly influences the availability of resources to the organisation.

- Suppliers

Although an organisation decides for itself how much capital will be invested in specific projects, the organisation still remains dependent on certain institutions in the external environment in order to commence and carry out its activities (Nieuwenhuizen and Rossouw, 2012: 21). According to Fox *et al.* (2004: 21-22), suppliers generate and distribute different kinds of resources to various organisations. Financial resources, allocated by policy making bodies, are of major importance in public organisations and are mobilised by means of taxes, levies or

service charges and then allocated to public organisations. Political support is another important resource that has to be supplied to public institutions. Examples of institutions acting as suppliers of financial and other political resources to public organisations include the legislative bodies such as Parliament, the electorate and the taxpayer.

The public health sector does not have the raw materials to manufacture the required products and, therefore, uses the products and services of other businesses in the external environment to carry out its activities. Tenders are a common method of the health sector securing supplies of goods and services.

- Competitors

Cronje *et al.* (2000: 69) define competition as a situation in the market environment in which several businesses, often offering more or less the same kind of product or service; compete for the patronage of the same consumers. The result of competition is that it keeps excessive profits in check, stimulates higher productivity and encourages innovation. Fox *et al.* (2004: 220) state that competitors consist of those institutions which vie for scarce resources with the particular public organisation concerned. Public organisations are in a monopolistic market situation where there are no competitors for the services that they deliver. However, strategies such as privatisation may create economic competitors in respect of service provision for public organisations.

- Regulators

According to Fox *et al.* (2004: 21), regulators control or regulate the relationship between the organisation and its suppliers, competitors and consumers. Regulators are usually assigned some form of influence to provide enforceable laws by which the organisations within their sphere of authority have to contend. These regulators also have authority to sanction irregular conduct of organisations. Examples of a regulatory function over public organisations are found within the legislative, judicial and executive governmental structures. Parliament, the law courts and the political executive constantly regulate the activities of public organisations within their sphere of jurisdiction.

- Consumers

According to Nieuwenhuizen and Rossouw (2012: 18), consumers carry out transactions in order to buy and sell goods and services. Fox *et al.* (2004: 220) state that consumers comprise of the users of the products or services of a particular public organisation. These consumers may voluntarily utilise the services provided or may even be compelled to use the services provided. Voluntary utilisation of services would include consumers using health services by going to a clinic or hospital whilst compulsory utilisation of services would include compulsory immunisation programmes against transmissible diseases.

2.13 Comparing healthcare systems in Africa: Two examples

2.13.1 Elements of a healthcare system

According to Dewar (2009:135), the essential elements of a healthcare system are financing, reimbursement and production methods, and the extent of choice over the healthcare provider. These features are significant because they impact on the operation and performance of the healthcare sector.

Two developing African countries have been reviewed - Kenya and Nigeria. South Africa is considered a developing country; therefore, the health development systems of these countries could provide meaningful contributions to healthcare reform and service delivery within the public sector. For instance, South African can learn from Kenya that despite having well focused national health policies and a reform agenda, overall implementation did not manage to make a breakthrough in terms of transforming the critical health sector interventions and operations towards meeting the most significant targets and indicators of health and socio economic development as expected.

2.13.2 Types of systems

2.13.2.1 The Kenyan healthcare system - Background on Kenya's healthcare system

The health sector in Kenya incorporates the public system, with major players including the Ministry of Health (MOH), parastatal organisations, and the private

sector. Health services are provided through a network of over 4 700 health facilities countrywide, with the public sector system accounting for about 51 percent of these facilities. The public health system consists of the following levels of health facilities: national referral hospitals, provincial general hospitals, district hospitals, health centres and dispensaries (National Coordinating Agency for Population Development Report – Nairobi Kenya, 2005: 13 - 26).

2.13.2.2 Structure of service delivery in Kenya

National Coordinating Agency for Population Development Report – Nairobi Kenya, (2005: 13 – 26) states that the Provincial Health Management Team (PHMT) provides supervision and management assistance to the districts and sub-districts within the province. At the district level, health services are provided by district hospitals and mission hospitals. Public health services are managed by the District Health Management Team (DHMT) and Public Health Unit of the district hospitals. The DHMT and District Health Management Board (DHMB) provide management and supervision support to rural health facilities (sub-district hospitals, health centres, and dispensaries).

At the sub-district level, both preventive and curative services are provided by the health centres as well as dispensaries and outreach services to the communities within the catchment areas. Currently, the private sector (both for-profit and not-for-profit) contributes over 40 percent of health services in the country, primarily providing curative health services and very few preventive services (National Coordinating Agency for Population Development Report – Nairobi Kenya, 2005: 13 - 26).

2.13.2.3 Financing the health sector in Kenya

Sufficient resources are critical to sustainable provision of health services. The Kenya policy framework of 1994 established several methods of health services financing, including taxation, user fees, donor funds, and health insurance. These methods have developed into important mechanisms for funding health services in the country. They reflect the cost of service provision as well as the ability of the population to pay. In the non-governmental sector, health services are funded

primarily through the revenue collected from fees and insurance premiums charged to service users. These are based on costs of service provision and on ability to pay ((National Coordinating Agency for Population Development Report – Nairobi Kenya, 2005: 13 - 26).

2.13.3 The Nigerian healthcare system - Structure of the Nigerian healthcare system

The first attempt at adopting a health insurance system in Nigeria started in 1962 during the first Republic after independence. The Nigerian civil war caused the matter to be shelved but was resuscitated by the health council in 1984. Over the years, costing, draft legislation and implementation guidelines were established. However, it was only in 2005 that the formal sector of the social health insurance scheme was commissioned by Chief Olusegun Obasanjo, the then president of the Federal Republic of Nigeria (Adesina, 2009).

2.13.3.1 The quality of healthcare in Nigeria

Communicable diseases exert the most toll amongst the various health-related ailments that affect Nigerians. The quality of healthcare services can have a large impact on the health of Nigerians. One of the goals of the National Economic Empowerment and Development Strategy (NEEDS) is to improve the health status of the population as a means to reduce poverty (The World Bank, 2010). According to McDikkoh (2010: 20), the health system in Nigeria is a lot worse off today in spite of so called improvements and advancements. McDikkoh argues that, with the new and improved technology, the quality of healthcare is also supposed to improve but this is not the case. McDikkoh is of the opinion that ordinary citizens still suffer unnecessarily despite these improvements.

2.13.3.2 National Health Insurance scheme in Nigeria

In May 1999, the government created the National Health Insurance Scheme, which encompasses government employees, the organized private sector and the informal sector. Legislatively, the scheme also covers children under five, permanently disabled persons and prison inmates. On 6th June 2005, the revised National Health

Insurance Scheme was launched with the main objectives being to provide good quality and cost effective healthcare services for insured persons and their dependents (Monye, 2006).

2.13.3.3 Objectives and benefits of NHI in Nigeria

According to Adesina (2009) the objectives of the NHIS include:

- To ensure that every Nigerian has access to good healthcare services;
- To protect families from the financial hardship of huge medical bills;
- To limit the rise in the cost of healthcare services;
- To ensure equitable distribution of healthcare costs among different income groups;
- To maintain high standards of healthcare delivery services;
- To ensure efficiency in the healthcare services;
- To improve and harness private sector participation in the provision of healthcare services;
- To ensure equitable distribution of health facilities within the federation;
- To ensure appropriate patronage of all levels of healthcare; and
- To ensure the availability of funds to the health sector for improved services.

The benefits derived from participation in the scheme are defined by law and include (Adesina, 2009):

- Hospital in-patient and out-patient care;
- General practitioner services in the communities;
- Physician specialist services;

- Medication;
- Ancillary Services such as X-Ray or Laboratory tests;
- Vision tests and spectacles;
- Prostheses, appliances and rehabilitation;
- Basic dental maintenances;
- Reconstructive dental care; and
- Preventive care including immunisation, family planning, ante-natal care, post-natal care and health.

2.14 Conclusion

The South African health system has come a long way since 1994. The foundation has been laid to provide a comprehensive health system that is underpinned by quality, a skilled workforce and appropriate infrastructure. South Africa has an impressive constitutional, legal and policy framework that should assure all persons in South Africa access to quality healthcare.

There may be much to be learnt from the experience of different countries about the balance of advantages and disadvantages of trying to implement healthcare and service delivery models. A comparison of the experiences of Kenya and Nigeria suggest that the advantage lies on the side of learning from other countries and establishing a thorough framework. For example, Nigeria provides free primary services to children under five and free primary and secondary services to pregnant women. Additional achievements of the NHIS project include improved facility infrastructure and quality of service delivery, a strengthened referral system, and elimination of financial burden for enrollees to access services.

The Kenyan health system is highly inequitable and policies aimed at promoting equity and addressing the needs of the poor and vulnerable has not been successful. Some progress has been made towards addressing equity challenges, including reducing user fees at primary healthcare facilities and developing a health

financing strategy. A series of reforms are under way to address equity challenges. Among these reforms is the development of a health financing strategy and the sector plan for health.

The literature review was undertaken to gain adequate and in-depth knowledge regarding healthcare reform and service delivery as set out in the framework of this study.

The following chapter presents an overview of the hospital.

CHAPTER 3

BACKGROUND ON MONTEBELLO HOSPITAL

3.1 Introduction

Montebello Mission hospital was initially known as Mater Misericordiae (Mother of Mercy). The hospital was founded as a Ministry of the Dominican Congregation of Montebello to uplift the standard of life and better the health status of the local community and the surrounding areas. Mother Euphemia, a teacher by profession from Oxford in the UK, selected three African girls to be trained as religious sisters at Montebello in 1925. During their home visits, they noticed the poverty and suffering of the local people and it was decided that a hospital should be built and that sisters should be trained as nurses. Permission was granted by the Provincial Health Administration with financial aid from government and German benefactors (KwaZulu-Natal Department of Health, 2001).

Sister Pelegrima Zwane acquired a hospital certificate in Chemistry at Mahlabathini Hospital and returned in 1943 to start a clinic under primitive conditions, treating school children with sores and injuries. There was no electricity or suitable water supply - water was collected from Egudwini River. In 1948, Sister Claver Dube, a qualified general nurse, returned from Nongoma Hospital. Sister Dolorosa Thusi, a general nurse and midwife, became the hospital's first matron. At this stage, maternity patients were being admitted and the hospital comprised of only 6 beds. In 1953, permission to build a bigger hospital was obtained. TB patients were admitted in 1954 and 1955; residences for two doctors with families were built. In the same year, registration and functioning of the new hospital began with 102 beds. 1956 saw the arrival of the first teaching sister, Sister E.S Zikalala, and two years later, the first resident medical doctor, Dr Seidel, from Germany, began working at the hospital. More sisters were sent for nurse training at different centres (KwaZulu-Natal Department of Health, 2001).

The kitchen and sisters' dining room were erected in 1956 and, in 1958, the nurses' home was built. Laboratory and X – ray services became essential and a mobile Siemens X – ray unit was bought. In 1958, an acceptable water scheme was

established to supply water to the hospital and convent. During 1965 and 1966, a nursing school with teaching facilities, doctors' accommodation and the hospital kitchen were built. In 1969, a maternity block with 45 beds and a spacious labour ward was constructed by Mr S. Pernish from Durban. By this stage, the hospital was delivering services to medical and surgical patients, TB patients, maternity patients and children. Montebello Hospital's outlying clinics were opened – Thafamasi, in 1977, Kwanyuswa, in 1980, and Wosiyane, in 1983 (KwaZulu-Natal Department of Health, 2001).

The objectives of this chapter are to provide an overview of Montebello Hospital. A brief description of the hospital's vision, mission and core values is introduced together with an indication of where the hospital is located. This chapter highlights the service offered at the hospital and describes staffing in terms of the number of healthcare practitioners employed, the current vacancy rate and the conditions under which they operate.

3.2 Vision, mission and core values of the hospital

Montebello Hospital has a defined vision, which is in line with and draws from the District, Provincial and National visions. The vision statement is written in terms of what the hospital wants to achieve for patients and the community. The mission statement is a commitment to efficient healthcare services as well as the core values that are to be adhered to. In addition, hospital management work according to an Operational/Service Plan to achieve this vision which is outlined below.

Vision

To strive for excellence by providing high quality, compassionate healthcare services to all persons in Ndwedwe Sub – District (KZ293) (KwaZulu-Natal Department of Health, 2001).

Mission

Montebello Hospital is committed to the provision of efficient quality healthcare services within the District Health System through promotion and implementation of

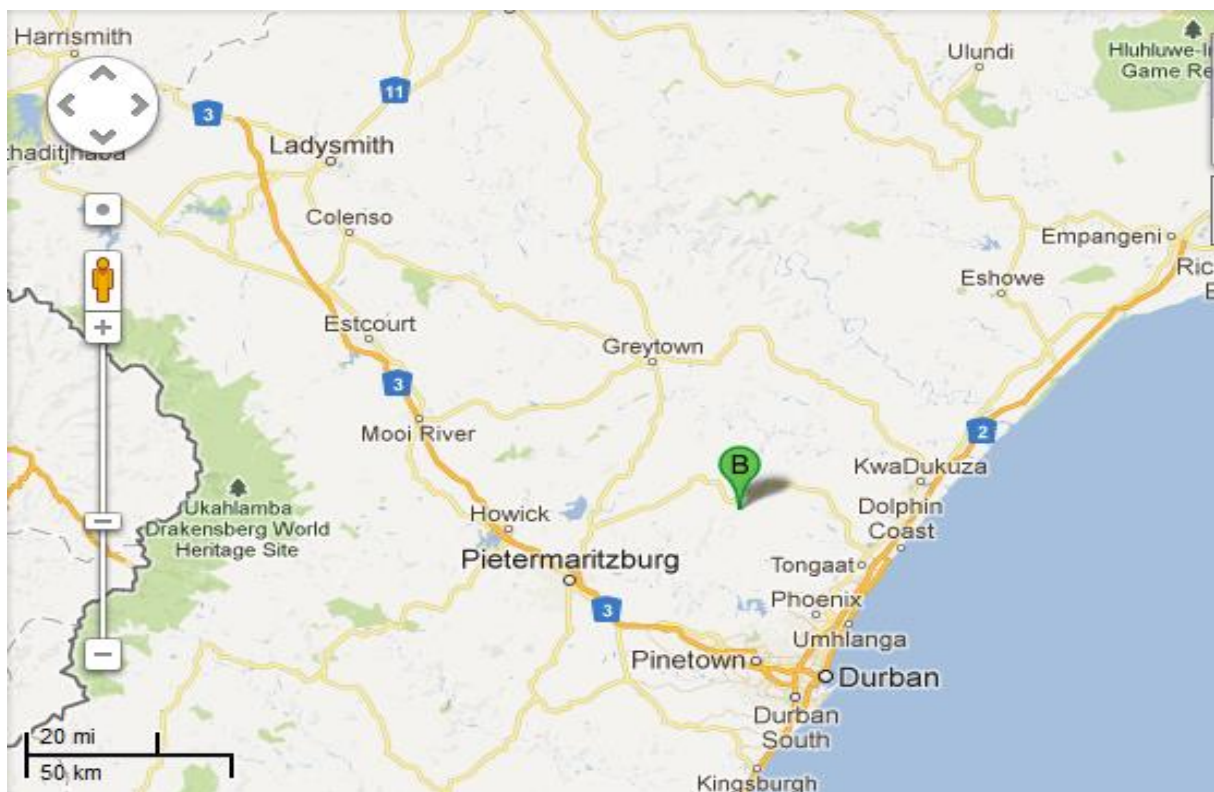
a comprehensive primary healthcare system. It further aims to provide quality services within the available resources and current health legislation whilst committing to continuous human resource development. In addition, the hospital strives to ensure good public relations and participation with all relevant stakeholders in line with Batho Pele principles (KwaZulu-Natal Department of Health, 2001).

Core Values

At the forefront of the hospital's core values are human dignity, respect and holistic care. The core values of the hospital form the foundation on which innovativeness, courage to meet challenges, to learn and to change are built. In addition it strives for cost effectiveness and accountability whilst ensuring service excellence. More importantly, the value of human dignity, respect and holistic care are at the forefront on the hospital's core values (KwaZulu-Natal Department of Health, 2001).

Map 1 indicates driving directions to Montebello Hospital.

Map 1: Directions to Montebello Hospital



Source: Google maps, KwaZulu-Natal (2012)

Point B on the map indicates the location of the hospital. It is situated on the road between Pietermaritzburg and Tongaat, located in a rural area which is serviced by the Ndwedwe Local Municipality in the iLembe District of KwaZulu-Natal.

3.3 Services offered at Montebello Hospital

The District Health System (DHS) has been adopted to deliver Comprehensive Primary Healthcare Services in South Africa. These services comprise of community-based services, services available at mobile/fixed clinics and community health centres. Since district hospitals form part of the district health system, services provided in district hospitals will be fully integrated with services provided in primary care (District Hospital Service Package for South Africa, Department of Health, 2002: 3). Table 2 outlines the services that are offered at Montebello Hospital.

Table 2: Services offered at Montebello Hospital

Wards	Outpatient Department (OPD) Hospital Clinics	Hospital Clinics	Fixed Health Care Clinics	Rehabilitation	Outreach	Training	Additional services
<ul style="list-style-type: none"> • General female • General male • Paediatric • Maternity 	<ul style="list-style-type: none"> • Hypertension clinic • Epilepsy clinic • Asthmatic clinic • Diabetic clinic 	<ul style="list-style-type: none"> • Chronic • Antenatal • Communicable diseases (ARV, STI & TB) • Under 5s • Orthopaedic • Occupational health • Wellness clinic 	<ul style="list-style-type: none"> • Thafamasi • Wosiyane • Chibini • Esidumbini • KwaNyuswa • 23 Mobile points, serviced by two teams 	<ul style="list-style-type: none"> • Physiotherapy • Occupational therapy • Dietetics • Speech therapist 	<ul style="list-style-type: none"> • Montebello chronic sick home • Community health workers and home-based carers 	<ul style="list-style-type: none"> • Adult based education and training (ABET) 	<ul style="list-style-type: none"> • Operating theatre • Dental • Ophthalmic • Medical Laboratory • X-Ray • Pharmacy • Social work

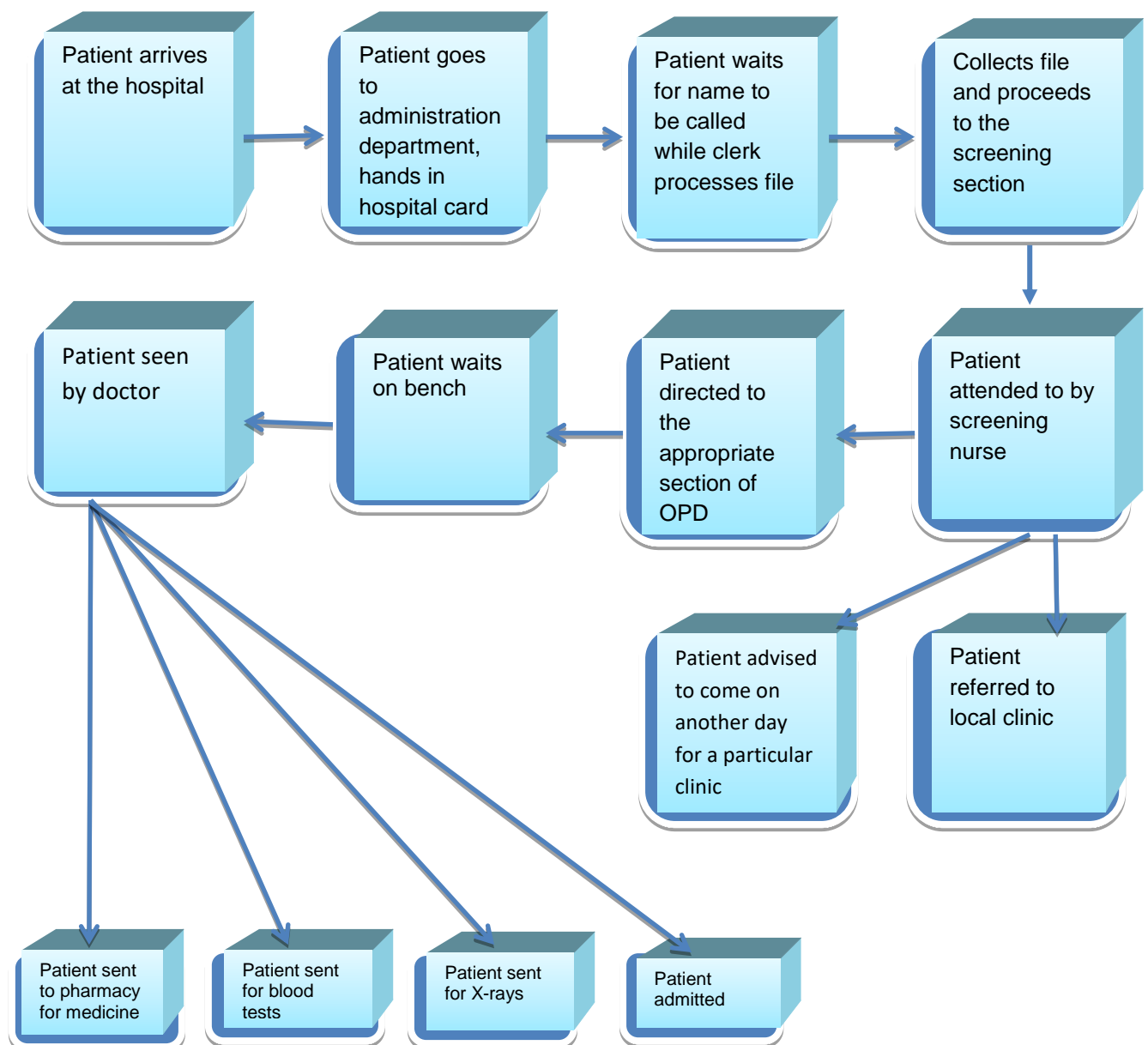
Source: KwaZulu-Natal Department of Health (2001)

The district hospital plays a key role in supporting primary healthcare and as a gateway to specialist treatment. The district hospital provides generalist services to in-patients and outpatients who have been referred from a community health centre or clinic. Montebello Hospital has 168 beds, a 24-hour emergency service and an operating theatre. Generalists from a range of clinical disciplines provide the

services. In some situations, primary healthcare services are delivered where there is no alternative source of this care within a reasonable distance (Department of Health, 2002: 3).

Figure 4 depicts the sequential steps typically followed by the patient of Montebello Hospital.

Figure 4: Flow chart of patient activity at Montebello Hospital



Source: *The Guidebook for District Hospital Managers* (2005: 74)

3.4 Staffing at Montebello Hospital

A telephone conversation with the acting Human Resource Manager, Mr M.J Ndamane on the 08th October 2012, revealed the following information concerning staffing at the hospital. The hospital employs eight doctors on a full-time basis and eight doctors on a part-time basis. The current vacancy rate for doctors stands at 12. He mentioned that funds were budgeted for the vacant posts and the posts had been advertised. However, it has proved difficult in terms of attracting, recruiting and retaining doctors in rural areas indicating that doctors do not want to live in rural areas. He went on to say that the scarcity of doctors in rural areas can be attributed to various factors such as:

- Allowances such as rural, scarce skills and other incentives do not appease them for the inconvenience;
- The non-availability of schooling for their children;
- Long distances to travel for recreation;
- Burnout due to longer hours and a shortage of staff;
- Lack of equipment; and
- Lack of work opportunities for spouses of health workers.

Doctors leave rural areas in droves for better conditions elsewhere. Every time a rural community such as Montebello loses one of its doctors, the impact is severe because these communities can't easily fill the doctor vacancy. The loss of one doctor in that community means that people may have to travel to Appelsbosch Hospital located in the uMgungundlovu health district which is ±18km's to receive medical attention, said Mr Ndamane.

People living in rural areas generally have poorer health outcomes, higher rates of chronic disease and die unnecessarily because of where they live. With rural KwaZulu-Natal already experiencing chronic doctor shortages and higher rates of illness and death, it is essential that doctors fulfil their community service obligations

both in terms of giving back to the community and also acquiring the necessary skills and work experience (Ngcobo, 2012: 1).

Table 3 indicates that the iLembe district, where the hospital is situated, has a vacancy rate of 48% for doctors.

Table 3: Vacancy rate per district

Vacancy rate Per district	Doctors	Pharmacists	Professional Nurses	Specialists
Ugu	39%	49%	32%	86%
UMgungundlovu	33%	25%	12%	53%
uThukela	56%	62%	25%	79%
uMzinyathi	58%	47%	15%	100%
Amajuba	35%	28%	11%	61%
Zululand	64%	43%	23%	100%
UMkhanyakude	60%	48%	24%	100%
UThungulu	45%	48%	17%	65%
iLembe	48%	23%	37%	65%
Sisonke	69%	64%	31%	86%
eThekweni	39%	19%	23%	41%

Source: Ngcobo (2012: 1)

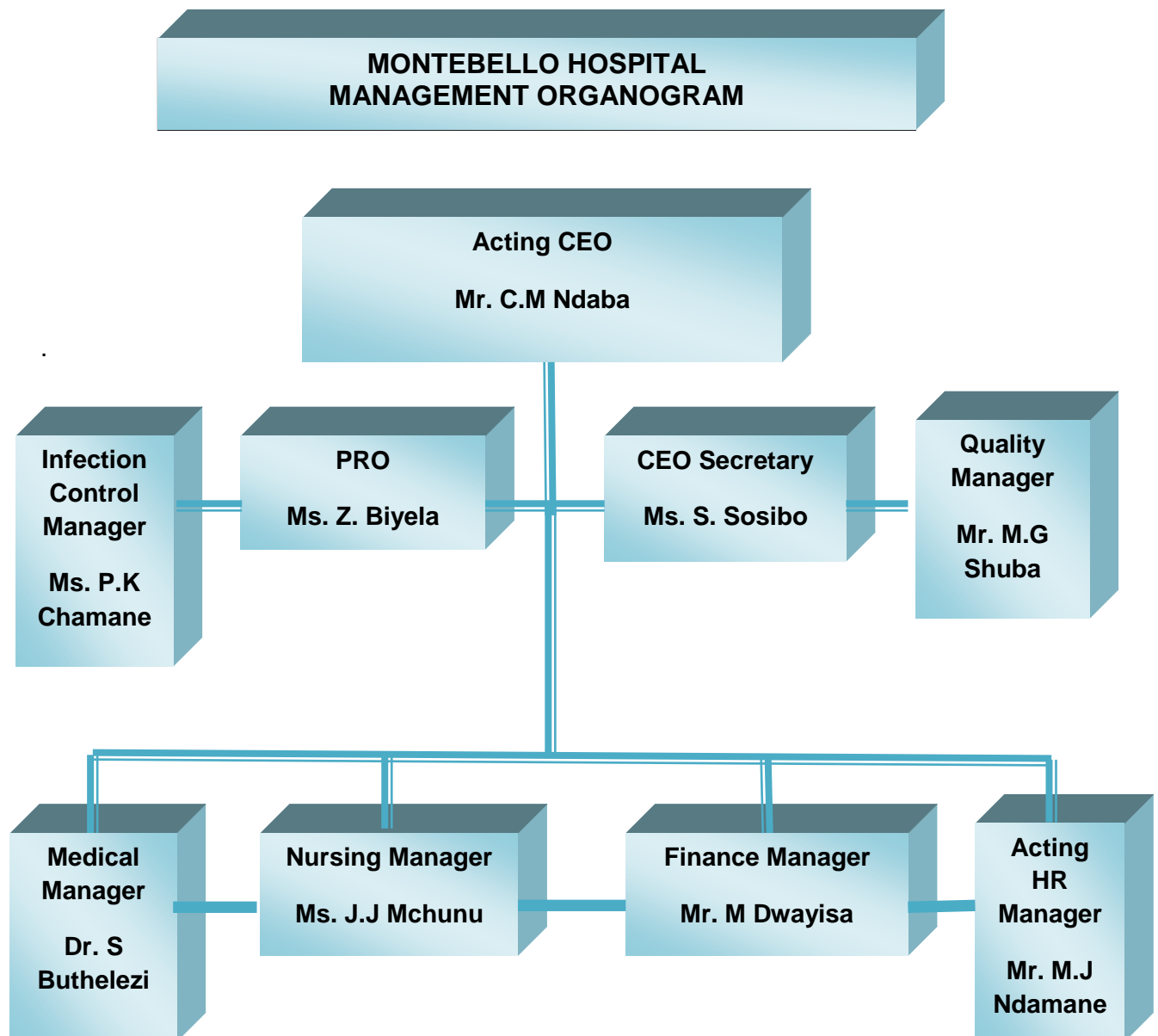
Of the 11 districts that were surveyed, iLembe district represents the sixth highest district in terms of vacant posts for doctors. The vacancy rate for pharmacists in the iLembe district is 23%, compared to 62% in the uThukela district. ILembe district has the highest vacancy rate of professional nurses (37%), whilst specialists constitute 65% of the vacancy rate in iLembe.

Montebello hospital currently employs 176 nurses. The acting Human Resource Manager said that the hospital is experiencing a shortage of nurses in specialised areas such as theatre, nursing science and primary healthcare. He added that long and inconvenient working hours, uncompetitive salaries, poor working conditions and a lack of safety were some of the reasons for nurse shortages. He went on to explain that the shortage of nurses at the hospital and across South Africa can be attributed to decreasing numbers of nurses being trained in the country because

there are not enough training colleges and lack of faith in the profession. These unfavourable working conditions have resulted in nurses and doctors pursuing careers outside of South Africa.

The organogram in Figure 5, represents the executive management team at Montebello Hospital.

Figure 5: Organogram of executive management at Montebello Hospital



Source: Montebello Hospital (2012)

The objective of the executive management at this hospital is to use the available resources in the most efficient manner in order to promote and improve the welfare

of the community it serves. It is the duty of the Chief Executive Officer (CEO), who is the highest ranking member of senior management, to prioritise the organisation's vision to staff, patients and the community. In addition, the CEO works closely with the senior management to develop strategic direction and major policies for the hospital.

3.5 Conclusion

As the pilot phase of the NHI rolls out, the public sector needs to work towards a common goal of successfully implementing a healthcare system that works towards benefiting the entire population. In acknowledgment of the health challenges in KwaZulu-Natal, the province was allocated three districts in the NHI pilot. These are Pietermaritzburg's UMgungundlovu, Dundee's Umzinyathi districts and Amajuba in Newcastle. There are many issues to contend with before there can be significant improvement. For example, staff shortages coupled with the high numbers of vacancies are critical, particularly in rural areas placing strain on an already overburdened staff. The reality is that state hospitals lack skilled medical practitioners as most work in the private sector or seek employment abroad.

The following chapter relates to the method of study.

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CHAPTER 4

RESEARCH METHODOLOGY

4.1 Introduction

The intent of this chapter is to describe methodologies, sources of data, and indicators that can be used to analyse the performance of the public health sector as a way of improving healthcare services. The researcher has interpreted the collected data utilising qualitative and quantitative methods and presented research findings. Through such an assessment, it is envisaged that planners would be able to identify areas within the public health sector that are operating inefficiently, thereby allowing them to design more appropriate strategies.

4.2 Objectives of the study

The aim of this research was to measure the quality of healthcare at Montebello Hospital, evaluating approaches and policies for improving healthcare delivery, and analysing health outcomes through evidence-based research.

The relevance of this study is to highlight service delivery problems experienced in the public health sector, at a delivery site such as Montebello Hospital. The objective is to measure what is important to the patients if there is to be an improvement in the public healthcare system.

The research questions of this study are:

- What are the views of the patients and healthcare practitioners with regard to service delivery and patient care at Montebello Hospital?
- What are the patients' expectations in terms of quality healthcare and turnaround times?
- What do healthcare workers anticipate with regard to support from the department in terms of funding, equipment, staffing and remuneration?

4.3 Research design and methods: Case study comprising of qualitative and quantitative techniques

According to Robson (2002: 178), case studies comprise cases or phenomena in their actual life context utilising many types of data. Dyer (1995: 48 - 9) suggests that case studies are descriptive and detailed, linking subjective and objective data. The advantage of a case study approach, according to Wimmer and Dominick (2010: 141), is that it is most valuable when the researcher wants to gain a wealth of information about a research topic. Thomas(2003:35) suggests that a case study allows the researcher to uncover the way a variety of factors have interacted to create the unique character of the entity that is the focus of the research.

For the purpose of this dissertation, a case study, utilising the mixed-method approach, was adopted. Yin (2003: 15) mentions that although case studies are often qualitative, case study research can equivalently embrace the quantitative concept and be founded on any mix of quantitative and qualitative substantiation. Therefore, a case study approach was the most suitable in that case studies are appropriate when conducting research in organisations where the objective is to study systems, individuals, programmes or events. Johnson and Onwuegbuzie (2004:21) maintain that the mixed-methods approach is a rich field for combining data because, with this design, words, pictures and narrative can be applied to add meaning to numbers.

4.4 Rationale for using the mixed-method approach

The reasons for adopting the mixed-method approach can be attributed to the following: *triangulation*, which, according to Jick (1979: 602), refers to the application of more than one method while studying the same research question. The researcher merges the data collected by all methods in the study to enhance or confirm the credibility of the research findings. Triangulation ultimately fortifies and enriches a study's conclusions, making them more appropriate to support both quantitative and qualitative methods.

The second reason for incorporating the mixed-method design was *complementarity*. This allows the researcher to gain a comprehensive

understanding of the research problem. This was accomplished by using both quantitative and qualitative data.

Mixed-methods assist the researcher's understanding of the research problem: this understanding represents the third reason for using mixed-methods: *development*. According to Greene, Caracelli and Graham (1989: 259), mixed-methods often support the development of a research project by producing a synergistic effect, whereby the outcome from one method helps develop or inform the other method.

The fourth reason for using the mixed-method was *initiation*. The outcome of a study may produce findings that raise questions or queries that require clarification, thereby prompting a new study. The effect of the new study would be to include new insight to the current theories and the phenomenon under examination. Findings from this study might uncover and lead to a completely new research topic (Greene *et al.*, 1989: 259).

This leads to the fifth reason for conducting mixed-methods research: *expansion*, which, according to Greene *et al.* (1989: 259), is focused on extending the breadth and range of the investigation.

4.5 Research design

Ghebremedhin and Tweeten (1994: 4) define research as a scientific method to examine hypothetical propositions of supposed relations among phenomena, while Leedy and Ormrod (2005:4) concur that research is the systematic process of collecting and analysing information in order to enhance one's awareness of the phenomenon about which one is concerned. Although these definitions make important statements about research, the following definition by Ethridge is offered as an accurate and comprehensive definition:

"Research is a systematic approach to obtaining and confirming new economics and reliable knowledge" (Ethridge, 2004: 16).

A research design, which is a function of the research objectives, is defined as:

“...a set of advance decisions that makes up the master plan specifying the methods and procedures for collecting and analysing the needed information”
(Burns and Bush, 2002:120).

According to Kerlinger (1983: 300), research design is the plan, structure and strategy of analysis in order to obtain answers to research questions. Ragin (1994: 191) agrees that a research design is a plan for collecting and analysing evidence that make it possible for the investigator to answer whatever question he or she has posed, while Welman and Kruger (2005: 52) maintain that research design is a plan whereby researchers identify participants and gather information from them.

4.5.1 Types of research design

Research designs can be classified into the following three categories: Exploratory research, according to Kent (2001: 8), is directed at generating ideas, insights or hypotheses, instead of measuring, evaluating or testing them. Hair, Celsi, Money, Samouel and Page (2011: 148) state that exploratory research is more dependent on qualitative techniques, although it is possible to use quantitative approaches.

Kent (2001: 244) mentions that descriptive research is related to measuring or estimating the sizes, quantities or frequencies of characteristics. In such research, it is doubtful that hypotheses will be implied in advance of undertaking data collection. Hair *et al.* (2011:158) suggest that descriptive research is intended to acquire data that explains the characteristics of the topic of intent in the research.

Kent (2001: 243) states that causal research makes a distinction between dependent and independent variables and looks at the degree of influence of one or more independent variables.

This study utilised the mixed-method design approach, which, according to Creswell and Plano Clark (2007:5), is a method which concentrates on collecting, analysing and mixing both qualitative and quantitative data in single or multiple studies. Johnson and Onwuegbuzie (2004: 14 - 26) indicate that mixed-method research is

the category where the researcher combines quantitative and qualitative research techniques, methods, approaches and concepts into a single study. Plano Clark (2005: 4) maintains that mixed-methods research mixes qualitative and quantitative data collection and data analysis within a single study. Tashakkori and Teddlie provide the following definition of mixed-methods:

“Mixed-method studies are those that combine the qualitative and quantitative approaches into the research methodology of a single study or multiphased study” (Tashakkori and Teddlie, 1998:17 - 18).

The rationale for mixing is that neither qualitative nor quantitative methods are sufficient by themselves to capture the trends and details of the situation being researched.

The instrument used to collect data was designed in such a way that the data collected was interpreted both qualitatively and quantitatively. The research strategy was to explore and describe the views of patients and healthcare practitioners with respect to service delivery at Montebello Hospital.

According to Denzin and Lincoln (2000:2), qualitative research is a form of scientific inquiry that involves different disciplines, fields, and subject matter and combines many varied approaches. Creswell provides an accurate definition of qualitative research:

“....an approach useful for exploring and understanding a central phenomenon. To learn about this phenomenon, the inquirer asks participants broad, general questions, collects the detailed views of participants in the form of words or images, and analyses the information for description and themes. From this data, the researcher interprets the meaning of the information drawing on personal reflections and past research. The structure of the final report is flexible, and it displays the researcher’s biases and thoughts” (Creswell, 2002: 58).

One of the advantages of quantitative research is that the use of numbers allows greater precision in reporting results (Wimmer and Dominick, 2010:49). Creswell (1994: 2) defines quantitative research as a type of research that explains

phenomena by obtaining numerical data that is analysed using mathematically based methods such as statistics.

Table 4 differentiates between the qualitative and quantitative methods.

Table 4: Claimed features of qualitative and quantitative methods

Qualitative	Quantitative
Soft	Hard
Flexible	Fixed
Subjective	Objective
Political	Value-free
Case Study	Survey
Speculative	Hypothesis testing
Grounded	Abstract

Source: Halfpenny (1979: 799)

4.5.1.1 Survey

According to Flink (2006: 1), surveys are a compilation of information methods used to describe, compare or explain individual and societal knowledge, feelings, values, preferences and behaviour. A survey can be a self-administered questionnaire that an individual completes with or without assistance. Subsequently, a survey can be an interview conducted in person, on the telephone or via teleconference.

The advantage of a survey approach, according to Wimmer and Dominick (2010:185-186), is that surveys permit researchers to investigate problems in realistic settings. A disadvantage of a survey is that its data can be unreliable because people regularly answer in ways that are socially acceptable as opposed to ways that are reflective of their true attitudes. This is referred to as subject bias. Leedy and Ormrod (2005: 183) explain that survey research entails obtaining information about one or more groups of people (characteristics, opinions, attitudes or previous experiences) or by posing questions and tabulating the answers.

For the purpose of this study, data was collected through the administration of a self-administered structured questionnaire. Patients and healthcare practitioners responded to the structured questionnaire while interviews were conducted with management. The questionnaire was divided into two sections. Section A comprised six questions requiring biographical information. Section B measured the level of agreement and disagreement regarding service delivery at Montebello Hospital.

To increase the response rate, the researcher identified and trained fieldworkers to administer the questionnaires. The questionnaires were completed within a two-week period with the assistance of field workers. Data was collected from 19 to 30 March, 2012. Prior to the commencement of data collection, permission was obtained from the Human Resource Manager at Montebello Hospital to conduct the study.

4.5.1.2 Sampling techniques

According to Tashakkori and Teddlie (2003a: 715), sampling entails choosing units of analysis (e.g., people, groups, artefacts, settings) in a way that maximises the researcher's capacity to answer research questions.

There are two broad categories of sampling techniques that can be applied by researchers. The first is known as 'probability' sampling and the second as 'non-probability' sampling (Denscombe, 2003: 12). Welman and Kruger (2005: 56 - 57) maintain that the advantage of probability sampling is that it enables the researcher to estimate sampling error which is a term related to the unrepresentativeness of a sample. Leedy and Ormrod (2005: 199) indicate that probability sampling can afford the researcher an indication in advance that each segment of the population will be represented in the sample. This is the distinction that sets it apart from non-probability sampling.

Random selection means selecting a sample in such a way that each member of the population has a similar chance of being selected. According to Welman and Kruger (2005: 59), the most attractive type of probability sampling is random sampling, whereas Greenhalgh (2010:182) suggests that with random sampling a

target group is distinguished and a random selection of people within that group is invited to participate.

Non-probability sampling, according to Leedy and Ormrod (2005: 206), implies that the researcher has no way of assuring that each element of the population will be represented in the sample. Moreover, some members of the population have little or no chance of being sampled. According to Gliner and Morgan (2009: 149), non-probability samples are used when probability samples, which rely on random or systematic selection of participants, are not viable. The advantages of non-probability samples are accessibility and economy.

4.5.1.3 Defining the population

According to Antonisamy, Christopher and Samuel (2010: 56), a population is a collection of individuals in the population from which a sample is obtained. The first stage in a sampling design is to define the population to be studied. Defining the target population is a significant and often challenging part of the study.

The population need not, however, be composed of people. The unit of analysis can be something other than individuals such as groups or programmes. Welman and Kruger (2001: 46) identify the population as the objective of the study which may consist of individuals, groups or organisations.

For the purpose of this study, the target population was doctors, nurses and patients at Montebello Hospital. The sample consisted of 100 male patients and 100 female patients from a population of approximately 3700 out-patients per month. At the time of conducting the questionnaire, the population of nurses was 205. The sample consisted of 50 nurses. The hospital employs eight doctors on a full-time basis and eight doctors on a part-time basis; the questionnaire was administered to 13 doctors (eight full-time and five part-time). Consequently, the researcher applied quota sampling to select the respondents. Quota sampling appealed because it was convenient, costs were reduced in terms of travelling and data was collected speedily.

4.5.1.4 Identification and selection of participants and the study site

The topic is considered relevant, current and well-timed due to the commonly held negative perceptions surrounding service delivery in South Africa. The population surrounding Montebello Hospital is relatively small and the number of participants and healthcare practitioners willing to participate in the study was also small. A single hospital was studied because the researcher was able to get a depth and understanding of service delivery that would not have otherwise been discovered if, for instance, more than one hospital was surveyed.

Although currently employed at Durban University of Technology, the researcher was previously employed by the Department of Health at Montebello Hospital. Due to this exposure, coupled with accessibility, the researcher was able to make multiple visits to the hospital for data gathering purposes.

4.5.1.5 Defining the sample for the study

Once the researcher has established the scope of the population, a sampling frame is then obtained. A sampling frame is a list of the population elements. It is from this list that the researcher selects a sample (DeVaus, 2002:70). The sample frame is preferably the entire population. Brace and Brace (2011: 17 - 18) state that when the sample frame does not correspond with the population, it is called undercoverage, which stems from omitting population members from the sample frame. Even when the sample frame and the population match, a sample is not a perfect representation of a population. Therefore, information drawn from a sample may not accurately match corresponding information from the population. This is known as a sampling error which is caused by the fact that the sample does not perfectly represent the population.

According to Leedy and Omrod (2005: 207), the basic rule when determining the sample size is, "*the larger the sample the better*". However, such a generalised rule is not helpful to a researcher who has a practical decision to make about a specific research situation. Gay and Airasian (2003: 113) offer the following guidelines for selecting the sample size:

- For small populations (fewer than 100 people or units) there is little or no point in sampling. Survey the entire population;
- If the population size is around 500, 50% of the population should be sampled;
- If the population size is around 1,500, 20% should be sampled; and
- Beyond a certain point (about 5,000 units or more), the population size is almost irrelevant, and a sample size of 400 should be adequate.

4.6 Data collection

Data collection is indispensable to conducting research. According to O'Leary (2004: 150), collection of credible data is a challenging task, where one method of data collection is not inherently better than another. Leedy and Ormrod (2005: 88) maintain that research is a feasible approach to a problem only when there is data to defend it. The term *data* is plural and comes from the Latin verb *dare*, which means 'to give'. Furthermore, Leedy and Ormrod (2005: 89) state that research seeks through data to determine underlying truths.

There are two approaches to information gathering, namely: primary and secondary data. Kothari (2008: 95) maintains that primary data is that which is collected for the first time. Secondary data is that which has already been collected by someone else and thus already been passed through the statistical process. In this research, a mixed-method study was adopted.

4.6.1 Questionnaire

According to Johnson and Christensen (2010: 162 - 163), questionnaires can be used to collect qualitative, quantitative and mixed data. In addition, questionnaires can be used to obtain data about the thoughts, feelings, attitudes, beliefs, values and perceptions of research participants. According to Sharp and Howard (1996: 145), questionnaires have become a common method of gathering information.

The main appeal of questionnaires, according to Dörnyei and Taguchi (2010:6), is effectiveness in terms of time, effort and financial resources. By distributing a questionnaire to a group of people, one can collect a vast amount of information within a relatively short period. The personal investment would be a fraction of what would have been needed for interviewing the same number of people. An additional advantage of the questionnaire, according to Connaway and Powell (2010: 146), is that questionnaires tend to encourage frank answers, thereby eliminating interviewer bias.

4.6.1.1 Questionnaire design

The goal of questionnaire design was to meet research objectives by obtaining valid data from respondents (Azzara, 2010: 18). According to Grigoroudis and Siskos (2009 : 179), there are several decisions which have to be taken into consideration in the questionnaire design process such as the type of wording and the structure of the questionnaire. The actual wording and phrasing of questions is one of the most challenging aspects of research design. Struwig and Stead (2001: 89) state that the response to a questionnaire is voluntary; therefore, a questionnaire should be designed to maintain the interest of the respondent.

4.6.1.2 Questionnaire format

According to Babbie (2010: 278), the format of a questionnaire is just as essential as the wording of the questions asked. An improperly arranged questionnaire can lead to respondents overlooking questions, confuse them about the nature of the data required and even lead them to cast the questionnaire aside.

For the purpose of this research, semi-structured questionnaires were used. Questionnaires comprised of open-ended questions and close-ended-questions. Simon (2006: 166) explains that semi-structured questionnaires are the most extensively used because their mixed format makes them appropriate in a diverse range of situations.

4.6.1.3 Administering questionnaires

Devising questionnaires for respondents to complete individually is one of the most common methods in research. Nardi (2006: 67) explains that an important element in obtaining reliable and valid information is the composition of a well-written questionnaire. In addition, Nardi (2006: 67) is of the view that self-administered questionnaires are best designed for the following:

- Measuring variables;
- Investigating attitudes and opinions;
- Describing characteristics of a large population; and
- Studying behaviours that may be difficult for people to tell someone face-to-face.

For the purpose of this study, questionnaires were administered to patients and medical practitioners at Montebello Hospital by hand. Delport (2002: 174) explains that researchers sometimes utilise the services of fieldworkers to distribute questionnaires so that respondents can fill them in their own time and then collect them at a later stage. An advantage of hand-delivered questionnaires is that time is saved and response rates increased due to personal contact. The limitations of hand-delivered questionnaires are that fieldworkers may find the respondents have lost the questionnaire or simply did not complete it.

The questionnaire was designed as follows:

Patients

Section A : Biographical and background information of respondents

Section B : To obtain patients' views on service delivery at Montebello Hospital

Healthcare practitioners

Section A : Biographical and background information of respondents

Section B : To obtain healthcare practitioners' views on service delivery at Montebello Hospital

4.6.1.4 Pilot test of research instrument

Prior to instituting the survey, a pilot study was necessary, to analyse the draft questionnaire and made amendments, where necessary. A pilot study can be referred to as the pre-testing or 'trying out' of a particular research instrument (Baker, 1994: 182 - 183). Pilot studies increase awareness about where the research project could fail, or whether proposed methods or instruments are unsuitable or too complex. De Vaus (1993: 54) maintains "*Do not take the risk, pilot test first.*" The purpose of a pilot test is to obtain information to improve the questionnaire content and format.

A pilot study was conducted to test the reliability and validity of the questionnaire and to identify any misrepresentation of questions during the data collection phase. According to Wimmer and Dominick (2010: 141), a pilot study is used to refine both the research design and field procedures. The pilot study also allows the researcher to try different data-gathering approaches and to observe different activities from several trial perspectives. The results of the pilot study are used to revise and polish the study protocol. The information emanating from the analysis was quantitatively and qualitatively interpreted.

4.6.2 Interviews

According to Johnson and Christensen (2010: 198), an interview is a data collection method in which an interviewer obtains answers from an interviewee. In other words, the interviewer collects data from the interviewee.

One advantage of face-to-face interviews, according to Jackson (2011: 98 - 99), is that they allow the researcher to document not only oral answers, but also any facial or bodily reactions such as grins or shrugs. According to Brace (2008: 22), the key benefits of having an interviewer administer the questionnaire are:

- Queries about the meaning of a question can be dealt with;
- A misunderstood question can be corrected; and
- Respondents can be encouraged to provide deeper responses to open questions.

According to Kumar (2005: 131), the advantages of interviews are:

- The interview is more appropriate for complex situations;
- It is useful for collecting in-depth information;
- Information can be supplemented;
- Questions can be explained; and
- Interviewing has a wider application.

On the other hand, interviews also have certain disadvantages (Kumar, 2005: 131):

- Interviewing is time consuming and expensive;
- The quality of data depends on the quality of interaction;
- The quality of data depends on the quality of the interviewer;
- The quality of data may vary when many interviewers are used; and
- The interviewer may be biased.

For this study, face-to-face interviews were selected as the survey data collection technique. Interviewers visit respondents, ask questions, and fill in answers on the questionnaire form. The quality of the collected data tends to be good, but, face-to-face interviewing can be expensive as it can require the interviewer to do a lot of

travelling. Prior to the interview, permission was sought from the respondents to record the interview with the use of a digital voice recorder. This device ensured accuracy in the data capturing process.

Face-to-face interviews were conducted with hospital management and senior staff. This afforded the interviewer an opportunity to ask the respondents to clarify any issues or questions that were not clearly understood. The researcher found it useful to make time immediately after the interview to review notes and make additions so that they made sense at a later stage. Even though the sessions were recorded, a small amount of time was invested in a preliminary write-up which saved hours of listening to tapes and pouring over transcripts later on. The interviews were all conducted in English.

4.6.3 Researcher's observation and reflective journal

When conducting interviews, it is not advisable for the researcher to concentrate on writing notes as there is a possibility of distracting the participants or even misrepresenting information. For this reason, the entire interview proceedings were recorded to enable the researcher to document in an observation journal only what could not be captured through auditory means.

4.6.4 Document analysis

When documents are studied and analysed, the technique of document study, known as a data collection method, becomes operative. It is essential that the researcher measures the authenticity, validity and reliability of the documents. According to Babbie and Mouton (2001: 285 - 286), there are different ways in which the validity and reliability of documents can be tested. They are:

- It is sometimes possible to compare the relevant document with other written documents or data;
- Data can be verified by interviewing other informants or persons in the same roles or persons knowledgeable on the subject; and

- Institutional documents can become research data because they provide material for the study. Therefore, various institutional documents were examined to determine procedures, protocols, decisions and the level of decision making within the organisation.

Various documents were studied such as the waiting times survey, patient satisfaction report, the vision, mission, aims and objectives and hospital organogram in order to elicit meaning, gain understanding and develop empirical knowledge. The procedure entailed finding, selecting, appraising and synthesising data contained in documents.

4.6.4.1 Institutional document analysis

For the purpose of this research, document analysis proved useful in terms of investigating why the documents were prepared, who prepared them and what they had been used for. According to Lindlof and Taylor (2011: 234 - 35), the advantages of document analysis can be summarised as follows:

- **Informational richness** – Documents are often rich sources of information. Richness of documents originates not only from the amount of information but also the quality. That is, they can be richly imbedded in history, idiomatic speech, and cultural logics of the people who made them;
- **Availability** – Documents are almost always available on a low cost or free basis. Most institutional archives adhere to a policy of free access to and usage of their collections. There may be occasions when it is necessary to expend time and money in locating documents. The Internet makes available an extensive range of information resources and services, such as the inter-linked hypertext documents of the World Wide Web (WWW) and the infrastructure to support email; and
- **Truth value** – Information contained in documents may be used as a reliable basis for organisational decisions and actions and is validated by internal or external authorities that are regarded as a trustworthy source.

4.6.4.2 Secondary analysis

Secondary analysis, according to Rubin and Babbie (2001: 385), refers to the networking of already analysed data over which the researcher has no control or direct involvement. Babbie and Mouton (2001: 269) refer to secondary data as an empirical exercise on data already collected.

4.7 Reliability and validity

To obtain valid and reliable data, one must ensure, before implementing the study, that the measurement procedures and the measurement instruments to be used have acceptable levels of reliability and validity. Validity and reliability are the two most important concepts in the context of measurement (Strydom and Delport, 2002: 166).

4.7.1 Reliability

Reliability has to do with the consistency or repeatability of a measure or an instrument. High reliability is achieved when the measure or instrument yields the same results if the research is repeated on the same sample (Maree and Petersen, 2007: 147). According to Durrheim and Painter (2006: 153 - 154), there are several ways of determining if the measures used are reliable. They are:

4.7.1.1 Test-retest reliability

This is the reliability of an instrument over time. A distinction is drawn between the first set of scores and the second set by calculating a correlation coefficient. The meaning of correlation here is defined as a matter of degree.

4.7.1.2 Parallel form reliability

This type of reliability is accomplished by administering the instrument, and then on a second occasion, administering an equivalent instrument, measuring the same construct to the same participants. Evaluating the two sets of scores by means of a correlation coefficient gives the degree of this type of reliability of the instrument.

4.7.1.3 Split half reliability

The parallel forms method is inefficient since the researcher must construct two separate tests, only one of which is retained as the true measure. A more popular way of testing reliability is to construct a single measure made up of a number of items, and then split these items randomly to make up two parallel halves.

4.7.1.4 Internal reliability

Internal consistency measures of reliability do not rely on either parallel forms or the splitting of tests. They are, however, the most common measures of reliability. Internal consistency is usually determined mathematically by a formula that assesses the average inter-item correlation.

In this study, 20 of the participating patients and ten of the participating medical practitioners were asked to complete the questionnaire as a pilot study. In this process, questions of a dubious nature were identified and rectified accordingly. Two weeks before the data collection commenced, another round of testing was done in order to test/retest reliability. The questionnaire was adapted until it produced the same results. This was confirmed by the statistical analysis, during data analysis.

4.7.2 Validity

Validity estimates the extent to which the test or set of data or design actually measures what it is supposed to measure, i.e., the degree to which the research conclusions are sound. The objective of reliability is to help researchers estimate validity (Ridenour and Newman, 2008: 39). Validity is reliability. Therefore, validity cannot exist without reliability.

The reliability of data obtained was strengthened by measures such as peer review and pilot testing. The following methods of estimating the validity of data collecting instruments were used (Strydom and Delport, 2002: 166 - 167):

4.7.2.1 Face Validity

Face validity is not technically a form of validation since it does not refer to what an instrument actually measures, but rather to what it appears to measure. Nevertheless, face validity is a desirable characteristic of a measuring instrument. A questionnaire was developed with an acceptable format with clear and easily understood wording. The questionnaire was an appropriate instrument and the best way to establish that which the researcher wanted to discover.

4.7.2.2 Content Validity

This is concerned with the representativeness of the content of an instrument. An in-depth literature review was conducted to give a comprehensive description of the content and research problem. After the researcher had critically reviewed the literature, a questionnaire was constructed to cover the known content represented in the literature.

4.7.2.3 Construct validity

This type of validity is necessary for standardisation and is concerned with how the construct(s) covered by the instrument are measured by different groups of related items. Construct validity of an instrument should first be tested and shown to be present before it can be said to be a standardised instrument. Construct validation is an extensive, involved procedure that uses data from a diverse range of sources.

4.7.2.4 Criterion validity

This comprises of several measurements and is established by comparing scores on an instrument with an external criterion known to or believed to measure the concept, trait or behaviour being studied. It is essential in this approach that there be one or more external or independent measures with which to compare the scores on an instrument.

4.8 Data analysis

The reason for analysis is to attain meaning from the data. Procedures used to analyse the data differed depending on the research design selected and the data gathered. According to Polonsky and Waller (2011: 96), analysis of data from qualitative research is unique compared to the more statistical analysis of quantitative data. The analysis portrays the significance of the data and transfers the data into meaningful information. Thus, the researcher acquires information that can be employed to answer research objectives and the overall research problem. After the data has been analysed, distinct recommendations can be established based on the current research. Hesse-Biber and Leavy maintain that:

“... analysis and interpretation are not two distinct phases in the process of qualitative research processthe researcher often engages simultaneously in the process of data collection data analysis and interpretation of the research findings” (Hesse-Biber and Leavy, 2006: 355).

The process of data analysis was conducted after all data was collected. Onwuegbuzie and Teddlie, as quoted by Tashakkori and Teddlie (2003: 373 - 377), maintain that data analysis for mixed-methods analysis consists of the following seven stages:

Stage 1: Data summary

Summarising data involves reducing the dimensionality of the qualitative data, for example, via exploratory thematic analysis and profile analysis, and quantitative data, for example, via descriptive statistics, exploratory factor analysis and cluster analysis. At a more micro level, qualitative data reduction includes writing summaries, coding, writing memos, making clusters and making partitions.

Stage 2: Data display

This refers to describing visually the qualitative data, for example, by means of graphs, charts matrices, networks, checklists, rubrics and Venn diagrams, and quantitative data, for example, by means of tables and graphs.

Stage 3: Data transformation

This refers to the stage wherein qualitative data are converted into numerical codes that can be analysed statistically.

Stage 4: Data correlation

This involves qualitative data being correlated with quantitised data or quantitative data being correlated with qualitisised data.

Stage 5: Data consolidation

This is where both qualitative and quantitative data are combined to create new or consolidated variables, codes or data sets.

Stage 6: Data comparison

The researcher might not be able to correlate/or consolidate the two types of data. Instead, the analyst might decide to compare these data. This data comparison stage involves comparing data extracted from the qualitative and quantitative components.

Stage 7: Data integration

In this stage, both qualitative and quantitative data are integrated into a coherent whole or two separate sets of coherent wholes. Data integration leads to an initial data interpretation whereby inferences are made.

4.9 Statistical analysis of the questionnaire

As researchers collect many pages of text, they may want to use a computerised software programme to analyse their data. In this study, the survey instrument was examined using the Statistical Package for the Social Sciences (SPSS) for Windows (version 18.0). The SPSS is an unimimidating and dynamic software programme useful for those with little or no background in data analysis and SPSS.

Besides the basics of using SPSS, this researcher has learned to describe data, test the most frequently encountered hypotheses, and examine relationships among variables. The programme was easy to understand and statistically sound. It contained explanations and interesting examples which assisted in learning the fundamentals of data analysis without being overwhelmed.

This study employed a basic descriptive statistical analysis using frequencies and cross-tabulation data. The descriptive techniques helped to present the collected information in summary fashion such as tables and graphs, while inferential techniques were used to estimate additional characteristics of the larger population from which the case was drawn.

4.10 Conclusion

This chapter outlined the research method and design that was adopted for this study. In line with the study's objectives and questions, the mixed-method design approach was adopted to study the sample population, use data collection instruments and to gather and analyse data.

The planning of the pilot study, designing and administering of the questionnaire and reliability and validity were all presented and discussed.

In the next chapter, a detailed description and analysis of data gathered from the sources of the study will be presented.

CHAPTER 5

DATA ANALYSIS AND DISCUSSION OF FINDINGS

5.1 Introduction

The previous chapter outlined the research methods adopted for this study. This chapter presents and analyses the data that emerged. The data collected from the responses was analysed with the IBM SPSS Statistics Version 20.0. The results are presented in the form of graphs, cross tabulations and other figures. This chapter analyses data gathered from questionnaires conducted with participants, namely, patients and healthcare practitioners at Montebello Hospital with the following sub-objectives:

- To determine the views of the healthcare practitioners and patients with regard to service delivery and patient care at Montebello Hospital;
- To determine the patients' expectations in terms of quality healthcare and turnaround times; and
- To identify what healthcare workers need with regard to support from the Healthcare Ministry in terms of funding, equipment, staffing and remuneration.

The analysis was completed in 2 parts. Part 1 was the analysis of quantitative data obtained by questionnaires completed by 263 participants. Part 2 was the analysis of qualitative data obtained from interviews and document analysis.

5.2 Part 1: Analysis and discussion of quantitative data

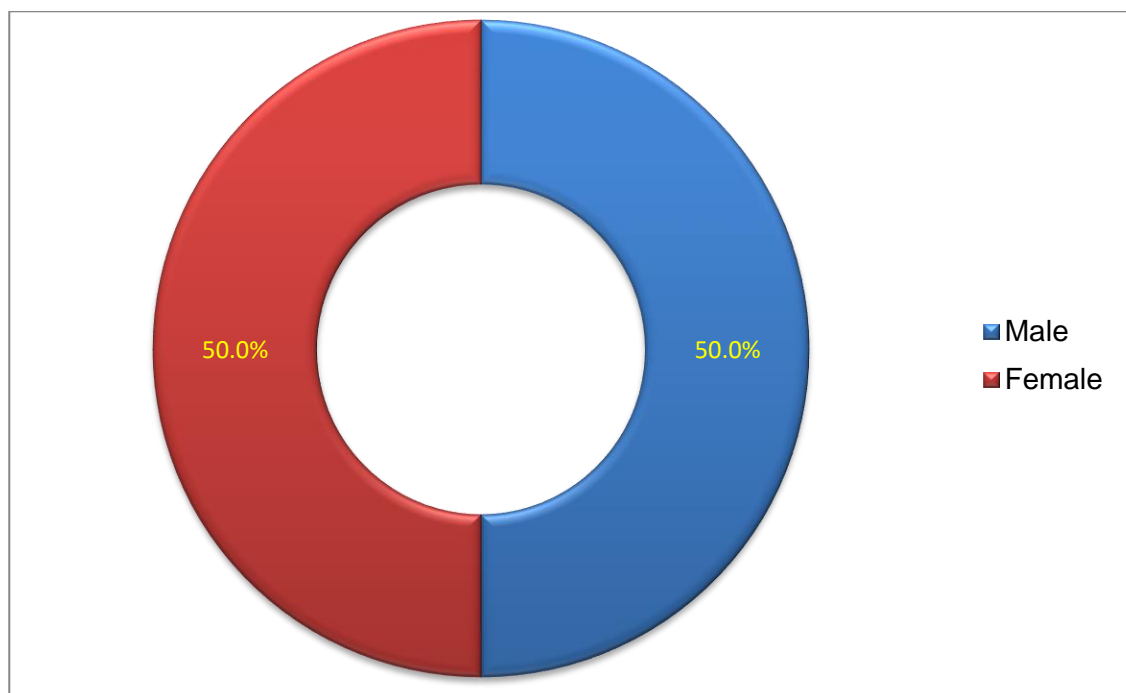
A questionnaire was chosen as the instrument to collect data. The questionnaire was designed to obtain information from patients concerning quality healthcare, turnaround times, staff attitudes, cleanliness and availability of medication, whilst information obtained from healthcare practitioners determined their perceptions on funding, equipment, staffing and remuneration.

On average, the out-patients department (OPD) at Montebello Hospital services 3700 patients per month. The sample consisted of 100 male patients and 100 female patients. At the time of conducting the questionnaire, the number of nurses employed at Montebello Hospital was 205. The sample consisted of 50 nurses. The number of doctors employed at the hospital is 16; the questionnaire was administered to 13 doctors (eight full-time and five part-time).

5.2.1 Background information of patients

Figure 6 indicates the gender of the respondents.

Figure 6: Gender of respondents



The sample constituted of an equal number of males and females. Equal representation of genders was important as both require hospital services.

The National Policy Framework for Women's Empowerment and Gender Equality (2000: xvii) defines gender as the social roles assigned to women and men in particular societies. Accordingly, the Gender Equality Report of the United Nations Development Programme (2008: 38) maintains that gender determines what is allowed and valued in a man or woman in a given context.

In terms of the racial composition, table 5 provides details by gender.

Table 5: Representation of gender

	Gender		Total
	Male	Female	
Count	94	100	194
% of Total	47.0%	50.0%	97.0%
Count	5	0	5
% of Total	2.5%	0.0%	2.5%
Count	1	0	1
% of Total	0.5%	0.0%	0.5%
Count	100	100	200
% of Total	50.0%	50.0%	100.0%

All of the female patients were Black, whilst the majority of the male population (47%) were also Black. The remaining three percent were Asian male patients (2.5%) and Coloured male patients (0.5%). It is noted that Blacks are in the majority by far, while Asians (2.5%) and Coloureds (0.5%) hardly visit this hospital. There are no Whites reported as none visited the hospital.

A district hospital is defined as a facility at which a range of out-patient and in-patient services are offered. District hospitals play an essential role in the provision of health services at community level, particularly in rural areas. The majority of district hospitals are situated in rural areas, with medical services in these hospitals being rendered by general practitioners. For many South Africans, especially those in rural areas, district hospitals are the only hospitals for admission of patients. In an endeavour to improve the local health services, the District Health System (DHS) has been adopted as the vehicle to deliver Comprehensive Primary Healthcare Services in South Africa. They include community-based services, services available at mobile/fixed clinics and community health centres. This means that services provided in district hospitals should fully integrate with services provided in primary care. District management teams have the task of finding ways in which the hospital-based resources can be harnessed to strengthen the delivery of all primary care services.

Figure 7 illustrates the age of respondents.

Figure 7: Age of respondents

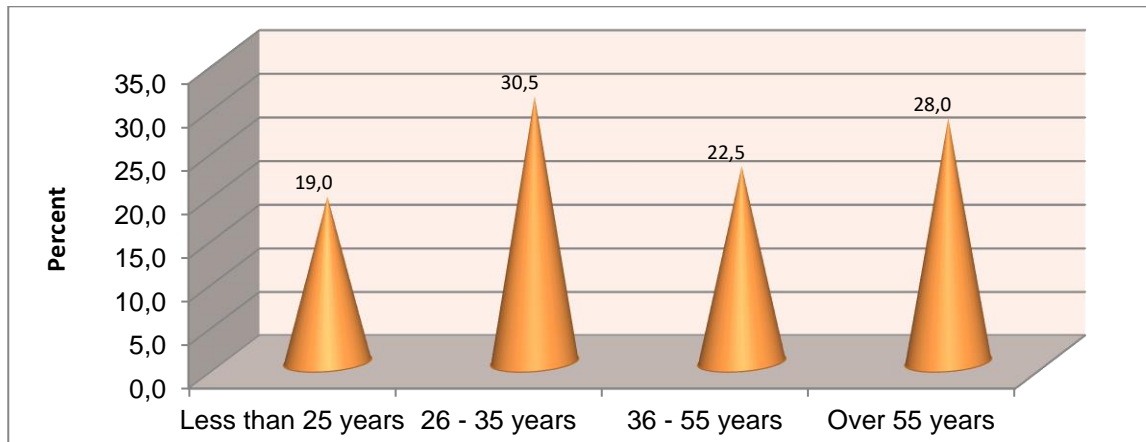


Figure 7 indicates that 30.5% of the patients were between the ages of 26 to 35 years. Only 19.0% of the respondents were younger than 25 years. The respondents between 36 to 55 years accounted for 22.5% of the responses. The figure indicates that 28.0% were over the age of 55 years.

The frequency of visits to the hospital is related to the type of treatment required. This is detailed in table 6, using 5 categories.

Table 6: Frequency of hospital visits

		How often do you visit Montebello Hospital?					Total
		Once in two weeks	Once a month	Once in three months	Once in six months	Once a year	
Count		10	67	3	3	5	88
% of Total		5.0%	33.5%	1.5%	1.5%	2.5%	44.0%
Count		16	45	6	0	0	67
% of Total		8.0%	22.5%	3.0%	0.0%	0.0%	33.5%
Count		3	6	1	2	1	13
% of Total		1.5%	3.0%	0.5%	1.0%	0.5%	6.5%
Count		9	19	1	2	0	31
% of Total		4.5%	9.5%	0.5%	1.0%	0.0%	15.5%
Count		0	1	0	0	0	1
% of Total		0.0%	0.5%	0.0%	0.0%	0.0%	0.5%
Count		38	138	11	7	6	200
% of Total		19.0%	69.0%	5.5%	3.5%	3.0%	100.0%

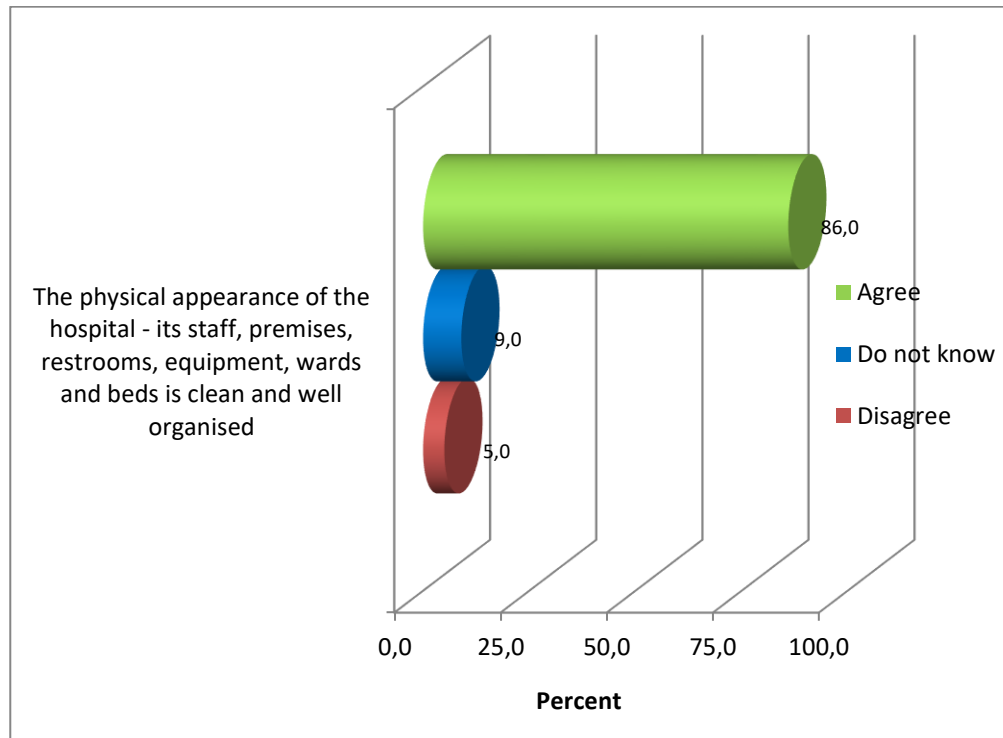
Table 6 indicates that more than two-thirds of the respondents (69%) visit the hospital once a month. The primary reason for this was chronic treatment which constituted 33.5% of the count. Repeat treatment made up 2.5% of the count. There are 19.0% of respondents who visit the hospital on a fortnightly basis; the main type of treatment required is repeat treatment (8.0%) and chronic treatment (5.0%). Of the 5.5% respondents who frequented the hospital once in three months, the primary reason was for repeat medication (3.0%), and chronic medication (1.5%). There are 3.5% respondents who visit the hospital once in 6 months, 1.5% required chronic treatment, and 1.0% required emergency treatment while the remaining 1.0% required a general check-up. The number of respondents who frequent the hospital once a year is 3.0%. Chronic treatment is the primary reason for 2.5% while emergency treatment makes up the balance of 0.5%.

5.2.2 Patients' perceptions of service delivery at Montebello Hospital

This section dealt with patients' perceptions of service delivery at Montebello Hospital. The patients' views are important in identifying what is important to them. This section, therefore, analysed patients' perceptions of staff reliability, appearance of the hospital, waiting times, patient supervision, skills and attentiveness of healthcare practitioners, equipment, manner of communication and availability of beds and medication.

The results are summarised in figures 8, 9, 10, 11 and 12.

Figure 8: Physical appearance of the hospital



There are high levels of agreement for the above statement. Most respondents (86.0%) agree that the physical appearance of the hospital is clean and well organised. Meanwhile, 5.0% indicated that the physical appearance of the hospital is one of disrepair and the staff, equipment, wards and beds are not well organised.

The findings indicate that, due to the geographical location of Montebello, some patients' choice of hospital may be limited by financial constraints, poverty, lack of transport and medical plans. Patients in this area have basically been exposed to one hospital. They begin to see this institution as a lifeline in terms of healthcare and do not necessarily want to jeopardise the relationship. The high levels of acceptance in the physical appearance of the hospital indicate not only that the patient has grown accustomed to the appearance of the hospital, but the patient does not expect or demand better.

Figure 9: Reliability of staff

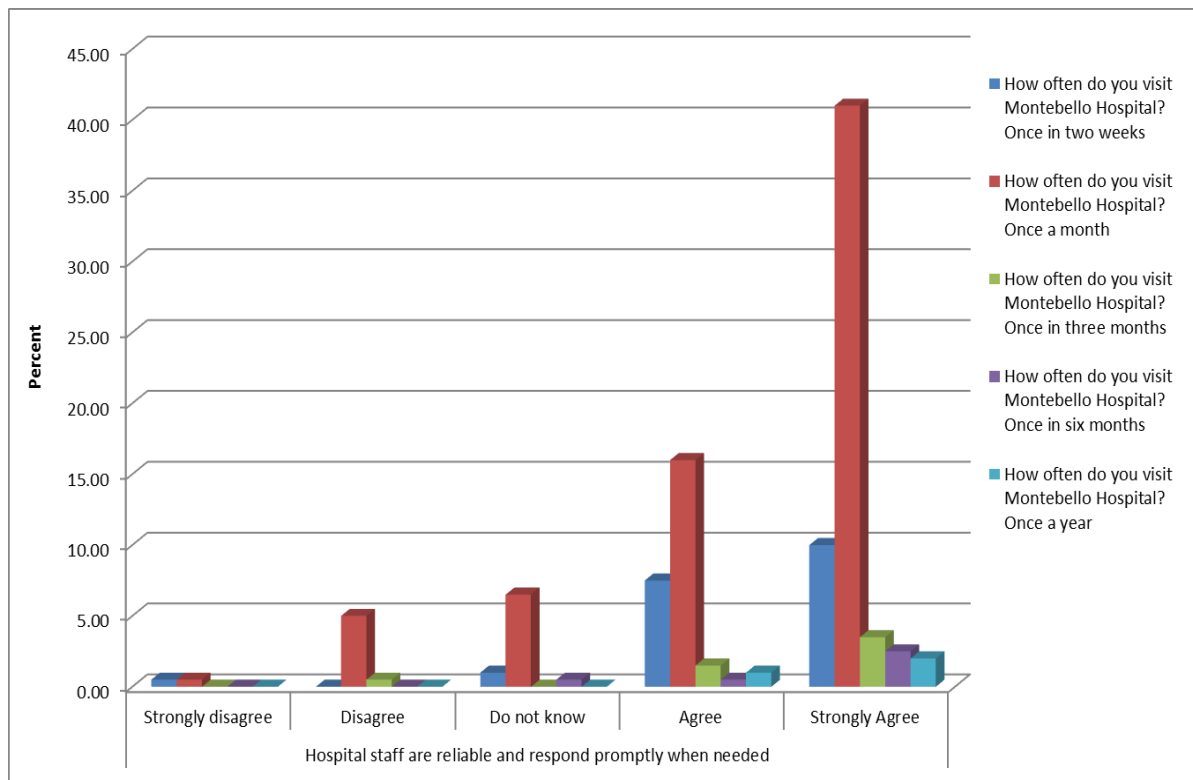
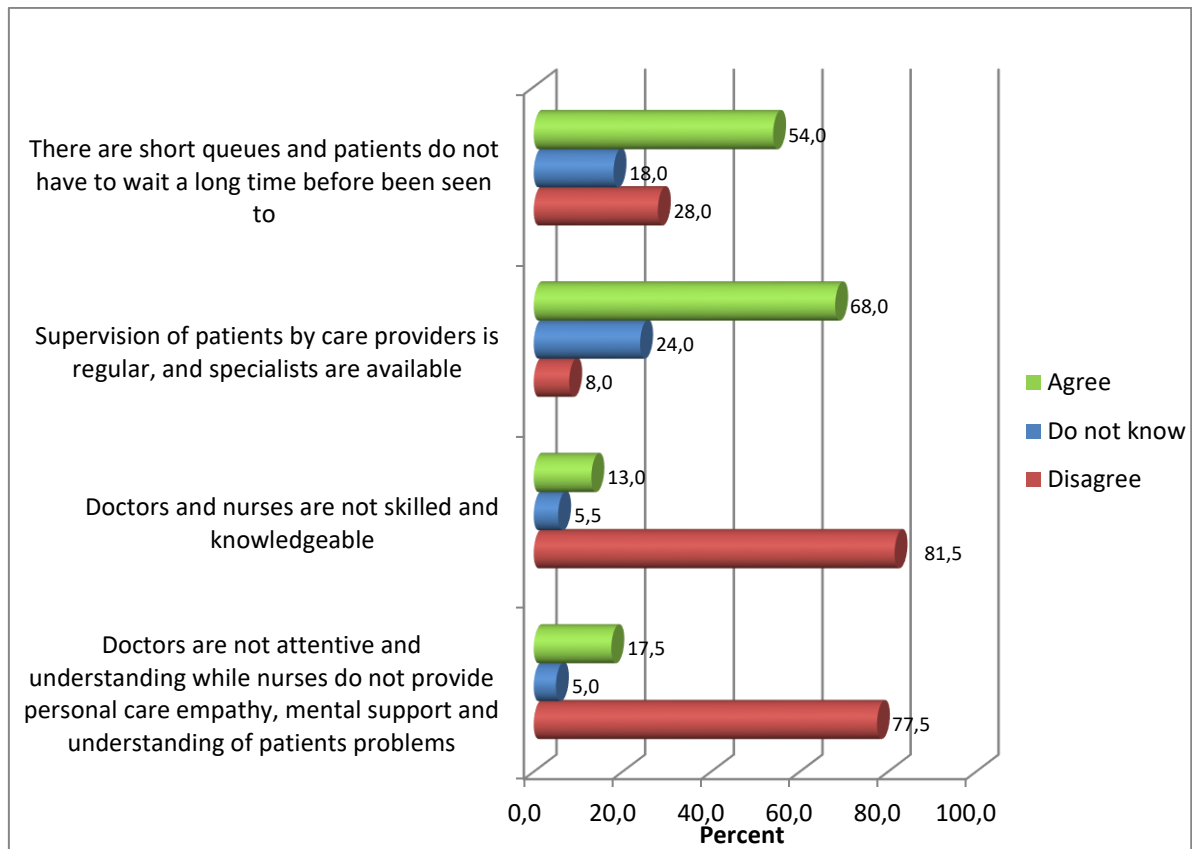


Figure 9 indicates that the highest proportion of patients that strongly agree with this statement are those that frequent the hospital at least once a month (slightly more than 40.0%), followed by those who visit the hospital once in two weeks (slightly less than 10.0%). However, the overall proportion of those which disagree is insignificant.

The findings indicate that most of the population surrounding the hospital does not have a choice of hospitals. They depend on the knowledge and skill of the healthcare practitioners at Montebello to cater for their healthcare needs. More than just knowledge and skill is required; they should be courteous and easily gain the confidence and loyalty of the patient, while portraying a positive image of the institution. Unreliable staff, bad attitudes and scarcity of staff are challenges that may prevent South African public hospitals from complying with legislation in terms of successfully rolling out NHI.

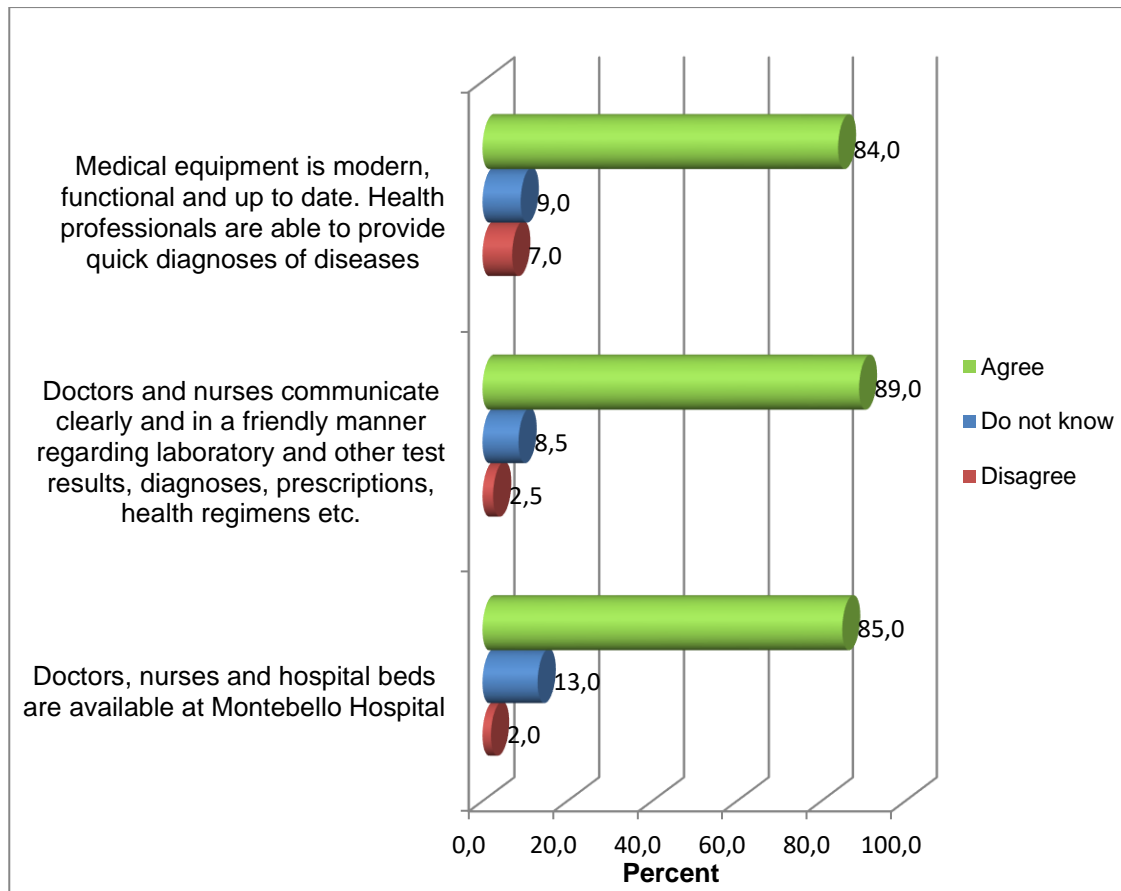
Figure 10: Waiting times, patient supervision, skills and attentiveness of healthcare practitioners



A little more than half of the respondents (54%) agreed that the queues were short, as were the waiting times, whilst 28% disagreed with this observation. More than two-thirds (68%) of the respondents agreed that patient care was regular. Nearly a quarter (24%) was not sure.

Meanwhile 13.0% of the respondents indicated that doctors and nurses are not skilled and knowledgeable. Less than one quarter (17.5%) of the respondents is of the opinion that doctors and nurses are not attentive. There are strong levels of disagreement with the last two statements which are negative statements relating to the professionalism and empathy provided by doctors and nurses.

Figure 11: Type of equipment, manner of communication and availability of beds



There are high levels of agreement with each of the statements in this section.

Well over two-thirds (84.0%) of the respondents agreed that the medical equipment is modern, functional and up to date and that health professionals are able to provide quick diagnoses. However, 7.0% disagreed with this observation.

Similarly 89% of the respondents agreed that doctors and nurses communicate regularly and in a friendly manner. Meanwhile, 85.0% of the respondents agreed that staff and beds are almost always available.

There are low levels of disagreement with the last two statements, which are negative, relating to the level of communication and availability of beds within the institution. This finding implies that respondents are satisfied with the manner in which test results are communicated to them and the availability of beds.

Figure 12: The availability of medication

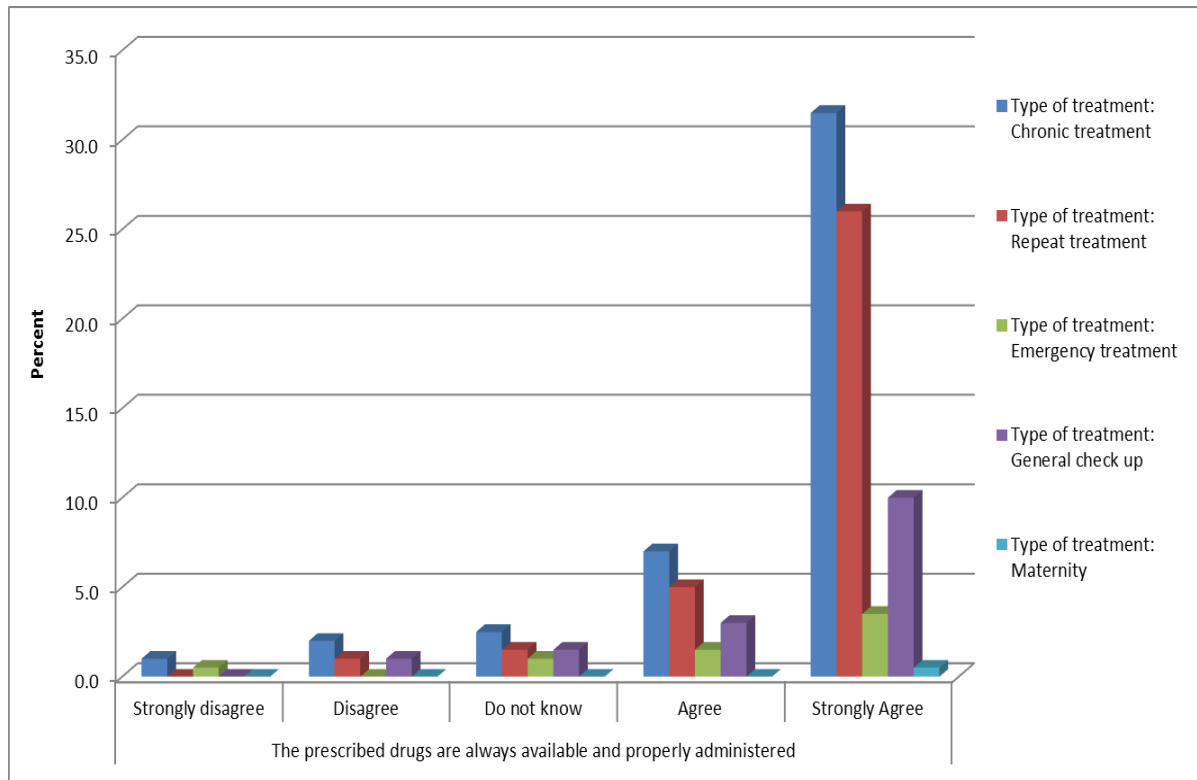


Figure 12 indicates that an overwhelming minority strongly disagree with the statement that the prescribed drugs are always available and properly administered. Amongst those patients who strongly disagree are chronic treatment patients, and the remainder are emergency treatment patients. Conversely, those who strongly agree constitute chronic treatment patients, followed by repeat treatment, and general check-up patients. The significant point is that most of the patients who strongly disagree are chronic patients.

The findings indicate that chronic patients are in disagreement concerning the availability of medication at the hospital. Amongst the reasons why medication is not always available for these patients could be the hospital's purchasing procedures and practices are not clearly aligned with government and the Department of Health and pharmaceutical purchases fail to meet government procurement standards.

Table 7 summarises the results of the chi square tests with reference to service delivery.

Table 7: Chi square tests – service delivery

	Gender	Race	Age	How often do you visit Montebello Hospital?	What type of treatment do you require?	What department are you visiting?
Hospital staff are reliable and respond promptly when needed	0.974	0.829	0.206	0.769	0.156	.000*
The physical appearance of the hospital - its staff, premises, restrooms, equipment, wards and beds are clean and well organised	.034*	.002*	0.128	0.497	0.195	0.239
There are short queues and patients do not have to wait a long time before being seen to	0.179	0.163	.033*	0.188	0.061	0.154
Supervision of patients by care providers is regular, and specialists are available	0.082	0.398	.050*	.002*	0.462	.000*
Doctors and nurses are not skilled and knowledgeable	0.454	0.816	0.144	.034*	0.723	0.052
Doctors are not attentive and understanding while nurses do not provide personal care, empathy, mental support and understanding of patients' problems	0.061	0.848	0.442	.045*	0.254	.000*
Medical equipment is modern, functional and up to date. Health professionals are able to provide quick diagnoses of diseases	0.275	0.054	0.450	.000*	0.625	.001*
Doctors and nurses communicate clearly and in a friendly manner regarding laboratory and other test results, diagnoses, prescriptions, health regimens etc.	0.584	0.199	0.135	0.083	0.466	.002*
Doctors, nurses and hospital beds are available at Montebello Hospital	0.205	.007*	0.343	.024*	0.243	.001*
The prescribed drugs are always available and properly administered	.034*	.000*	0.807	0.405	0.805	.001*

It is noted that the frequency for the department that was visited by the respondents yielded the most number of significant relationships with the statements that constituted this section. However, the statement “what type of treatment do you require” yielded no significant relationship as these values exceeded the level of significance of 0.05.

The p-value between “Race” and “the physical appearance of the hospital - its staff, premises, restrooms, equipment, wards and beds are clean and well organised” is 0.002 (which is less than the significance value of 0.05). This means that there is a significant relationship between the variables. That is, race did play a role in terms of how respondents rated the statement above.

All highlighted values imply that the row and column variables did play a role in terms of how respondents rated them.

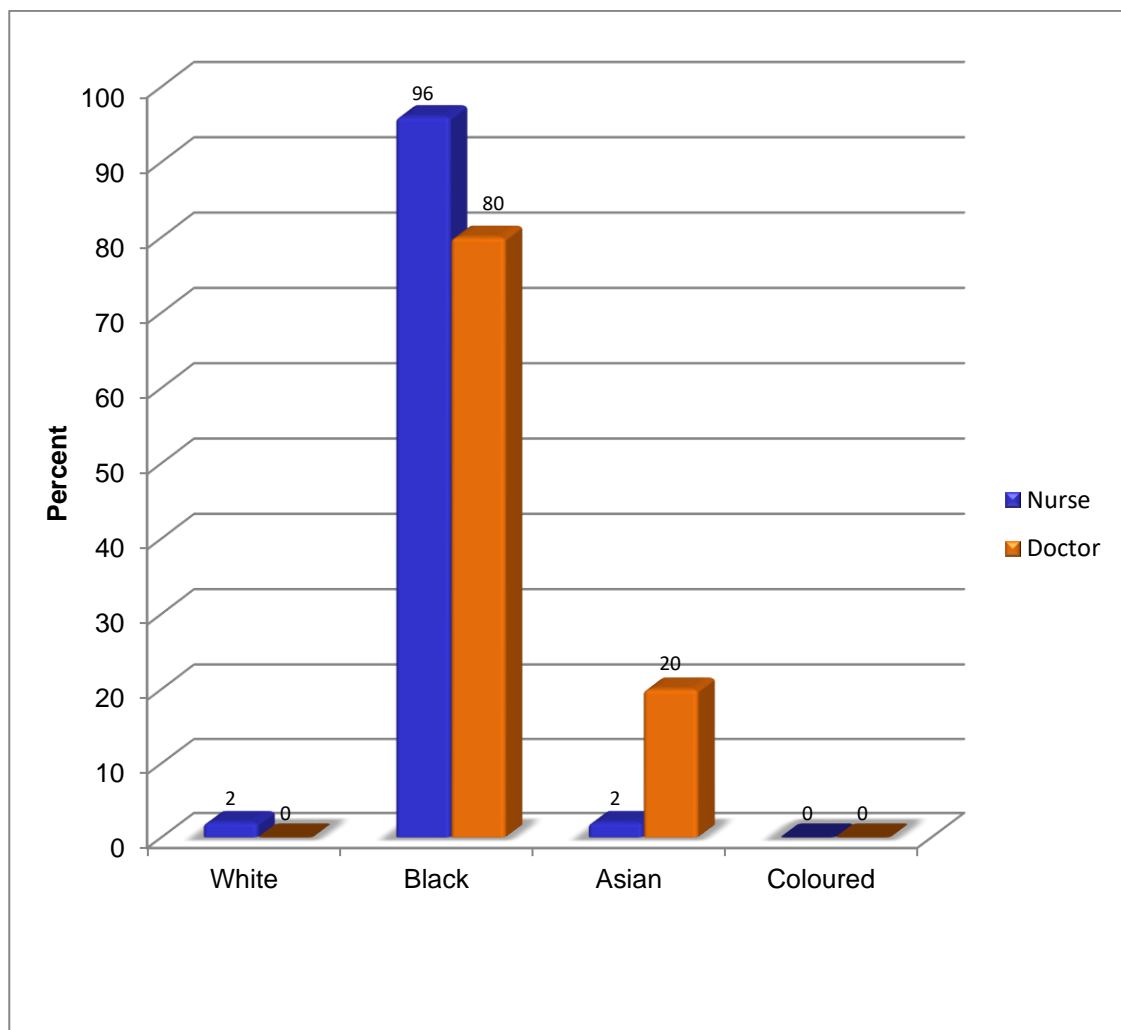
5.2.3 Responses from healthcare professionals

This section was aimed at obtaining insight into the healthcare practitioners' perceptions of service delivery at Montebello Hospital.

5.2.3.1 Biographical Data

The tables and figures below present the biographical data of healthcare practitioners.

Figure 13: Race of respondents



In terms of race, most of the respondents for both the groupings were Black. The only other significant value was that for Asian doctors (20%) within the doctors' sample.

Table 8 presents the composition of the medical staff sample by age and gender by category (nurse and doctor) and then as a total.

Table 8: Gender and age distribution of the respondents, excluding race

Group		Gender		Total
		Male	Female	
	Count	1	4	5
	% of Total	2.0%	8.0%	10.0%
	Count	4	16	20
	% of Total	8.0%	32.0%	40.0%
	Count	3	21	24
	% of Total	6.0%	42.0%	48.0%
	Count	0	1	1
	% of Total	0.0%	2.0%	2.0%
	Count	8	42	50
	% of Total	16.0%	84.0%	100.0%
	Count	4	2	6
	% of Total	40.0%	20.0%	60.0%
	Count	4	0	4
	% of Total	40.0%	0.0%	40.0%
	Count	8	2	10
	% of Total	80.0%	20.0%	100.0%
	Count	1	4	5
	% of Total	1.7%	6.7%	8.3%
	Count	8	18	26
	% of Total	13.3%	30.0%	43.3%
	Count	7	21	28
	% of Total	11.7%	35.0%	46.7%
	Count	0	1	1
	% of Total	0.0%	1.7%	1.7%
	Count	16	44	60
	% of Total	26.7%	73.3%	100.0%

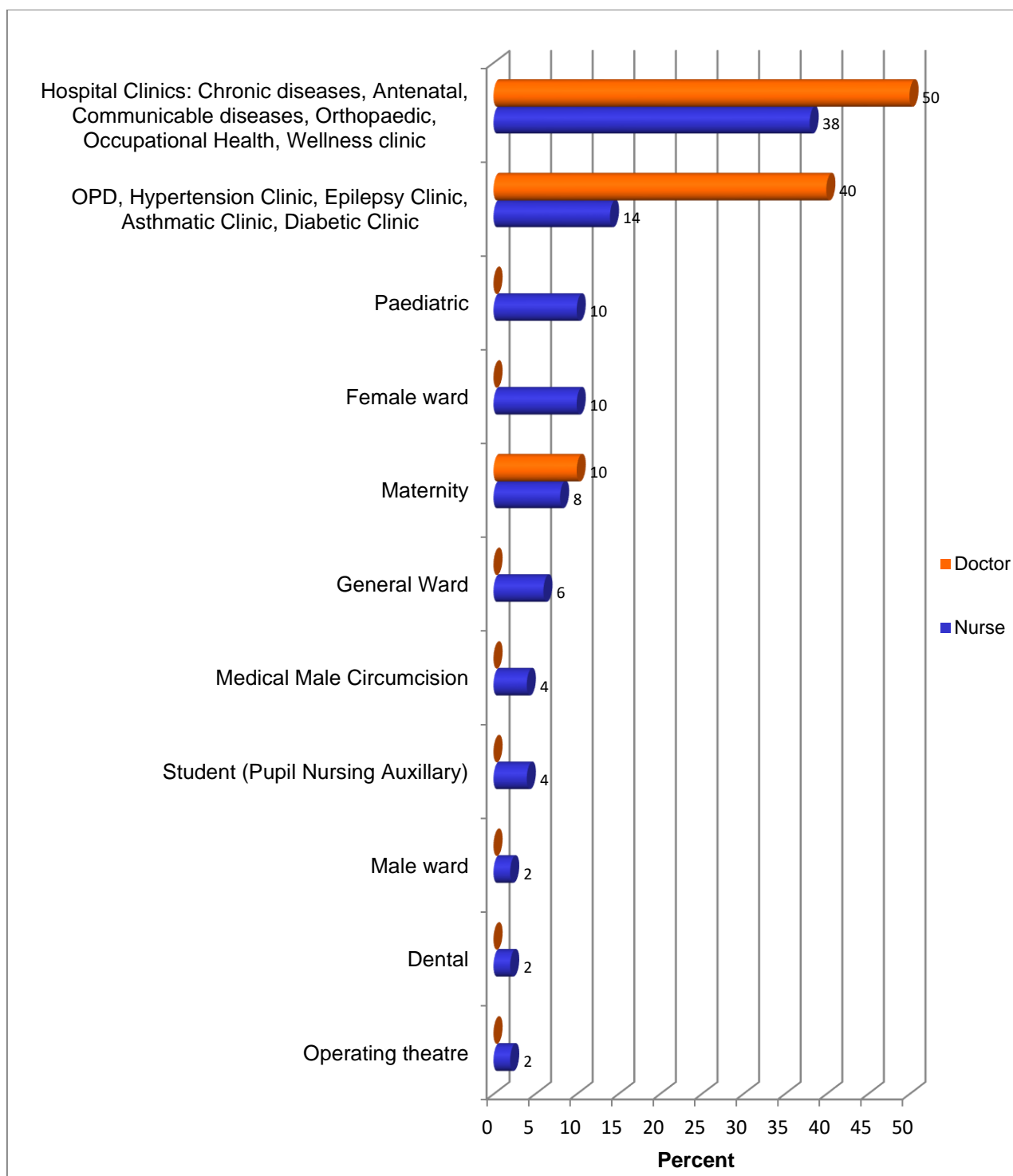
Table 8 indicates that 2.0% of nurses, who are less than 25 years, are male. In the same age category, 8.0% are female. Amongst the nurses, females between the ages of 26 to 35 years constitute 32.0% of the count, whilst male nurses make up 8.0% in this category. In the 36 to 55 age group, female nurses constitute 42.0% of the count while male nurses are 6.0%. Amongst the nurses, 2.0% were female over 55 years. There were no male nurses over the age of 55 years.

It is noted that female doctors between the ages of 26 to 35 constitute 20.0% of the count while male doctors constitute 40% of the count. Amongst the doctors, 40.0%% were male between the ages of 36 to 55 years. There were no female doctors in this age category.

Overall, amongst all of the medical professionals (nurses and doctors combined), a little more than a quarter (26.7%) were male.

The departments in which medical professionals work are highlighted in figure 14.

Figure 14: Departmental employment of medical professionals



Most of the medical staff were from the “Hospital Clinics: Chronic diseases, Antenatal, Communicable diseases, Orthopaedic, Occupational Health, Wellness clinic” and “OPD, Hypertension Clinic, Epilepsy Clinic, Asthmatic Clinic, Diabetic Clinic.”

Table 9 indicates the time period that medical staff has been working at the hospital

Table 9: Employment of medical staff

Group		What position do you hold in this organisation?						Total
		Doctor	Professional Nurse	Enrolled Nurse	Enrolled Nursing Assistant	Dental assistant	HIV Counsellor	
	Count		7	5	11	1	0	24
	% of Total		14.0%	10.0%	22.0%	2.0%	0.0%	48.0%
	Count		2	4	5	0	1	12
	% of Total		4.0%	8.0%	10.0%	0.0%	2.0%	24.0%
	Count		3	1	0	0	0	4
	% of Total		6.0%	2.0%	0.0%	0.0%	0.0%	8.0%
	Count		7	1	2	0	0	10
	% of Total		14.0%	2.0%	4.0%	0.0%	0.0%	20.0%
	Count		19	11	18	1	1	50
	% of Total		38.0%	22.0%	36.0%	2.0%	2.0%	100.0%
	Count	8						8
	% of Total	80.0%						80.0%
	Count	1						1
	% of Total	10.0%						10.0%
	Count	1						1
	% of Total	10.0%						10.0%
	Count	10						10
	% of Total	100.0%						100.0%
	Count	8	7	5	11	1	0	32
	% of Total	13.3%	11.7%	8.3%	18.3%	1.7%	0.0%	53.3%
	Count	1	2	4	5	0	1	13
	% of Total	1.7%	3.3%	6.7%	8.3%	0.0%	1.7%	21.7%
	Count	1	3	1	0	0	0	5
	% of Total	1.7%	5.0%	1.7%	0.0%	0.0%	0.0%	8.3%
	Count	0	7	1	2	0	0	10
	% of Total	0.0%	11.7%	1.7%	3.3%	0.0%	0.0%	16.7%
	Count	10	19	11	18	1	1	60
	% of Total	16.7%	31.7%	18.3%	30.0%	1.7%	1.7%	100.0%

Table 9 indicates that professional nurses employed for less than five years constitute 14.0% of the count while enrolled nursing assistants employed for less than five years at the hospital constitute 22.0%. Professional nurses employed for more than fifteen years represent 14.0% of the count, while enrolled nurses signify 2.0% for the same period.

Doctors employed for less than five years constitute 8.0%, while doctors employed between 5 to 10 years constitute 10.0%. Significantly, doctors employed between 10 to 15 years are also 10.0%.

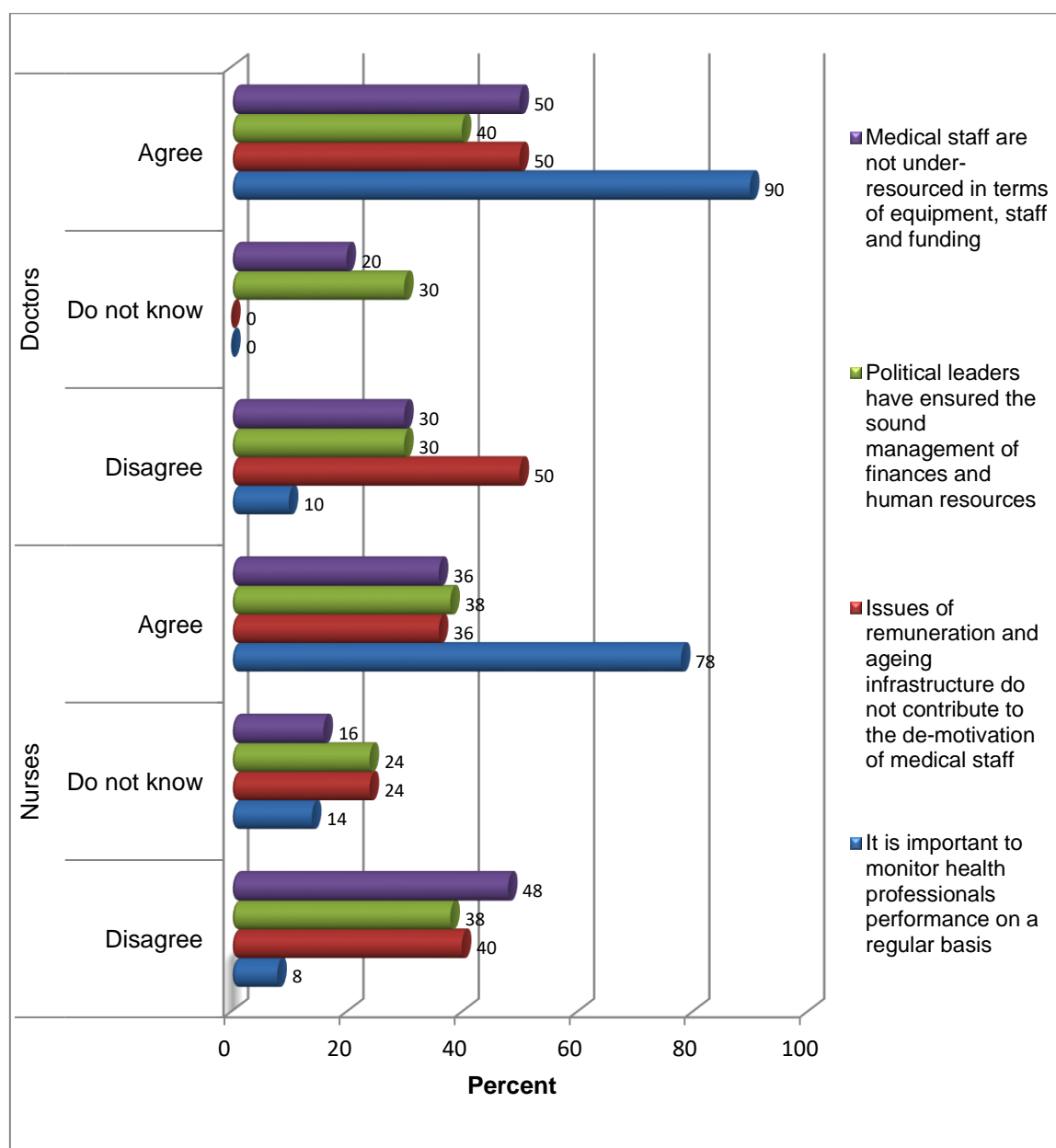
When the time periods for nurses and doctors are combined, table 9 reveals that more than half (53.3%) of healthcare professionals have been employed at the hospital for less than five years. This is followed by slightly less than one-quarter (21.7%) employed for between 5 to 10 years. The least number of healthcare professionals have been employed from 10 to 15 years (8.3%).

5.2.4 Healthcare professionals' perceptions of service delivery at Montebello Hospital

This section is concerned with healthcare professionals' views on service delivery in the public healthcare sector.

The results are presented in figure 15.

Figure 15: Availability of resources, the management of finances and issues of remuneration



There are high levels of agreement between healthcare professionals who believe that their performance should be monitored on a regular basis. Figure 15 indicates that 10.0% of doctors disagree with this statement, while 8.0% of nurses disagree.

Exactly half (50.0%) of the doctors maintain that issues of remuneration and ageing infrastructure contribute to the demotivation of medical staff. Less than half (40.0%) of the nurses support the doctors on this issue.

There is a difference of 8.0% between doctors and nurses who maintain that political leaders have not ensured the sound management of finances and human resources, while there is a difference of 2.0% who believe that political leaders have ensured the sound management of finances and human resources.

Exactly half (50.0%) of doctors are of the view that medical staff are not under-resourced, while 36.0% of nurses agree with this statement. Less than half (48.0%) of nurses believe that medical staff are under-resourced and 30.0% of doctors support this statement.

The findings indicate that the issue of doctors being overworked is not new to South Africa and, indeed, to Montebello Hospital. Posts have been advertised and still remain unfilled. Doctors constantly work under pressure. There is a lack of adequate staff and equipment, resulting in patient care been diminished. Skilled and experienced doctors are reluctant to occupy posts in rural areas, such as Montebello, due to these issues and yet government does not provide an attractive incentive for medical practitioners to work in rural areas.

Figure 16: The impact of HIV/AIDS on service delivery, continuous training programmes, and employing private sector principles

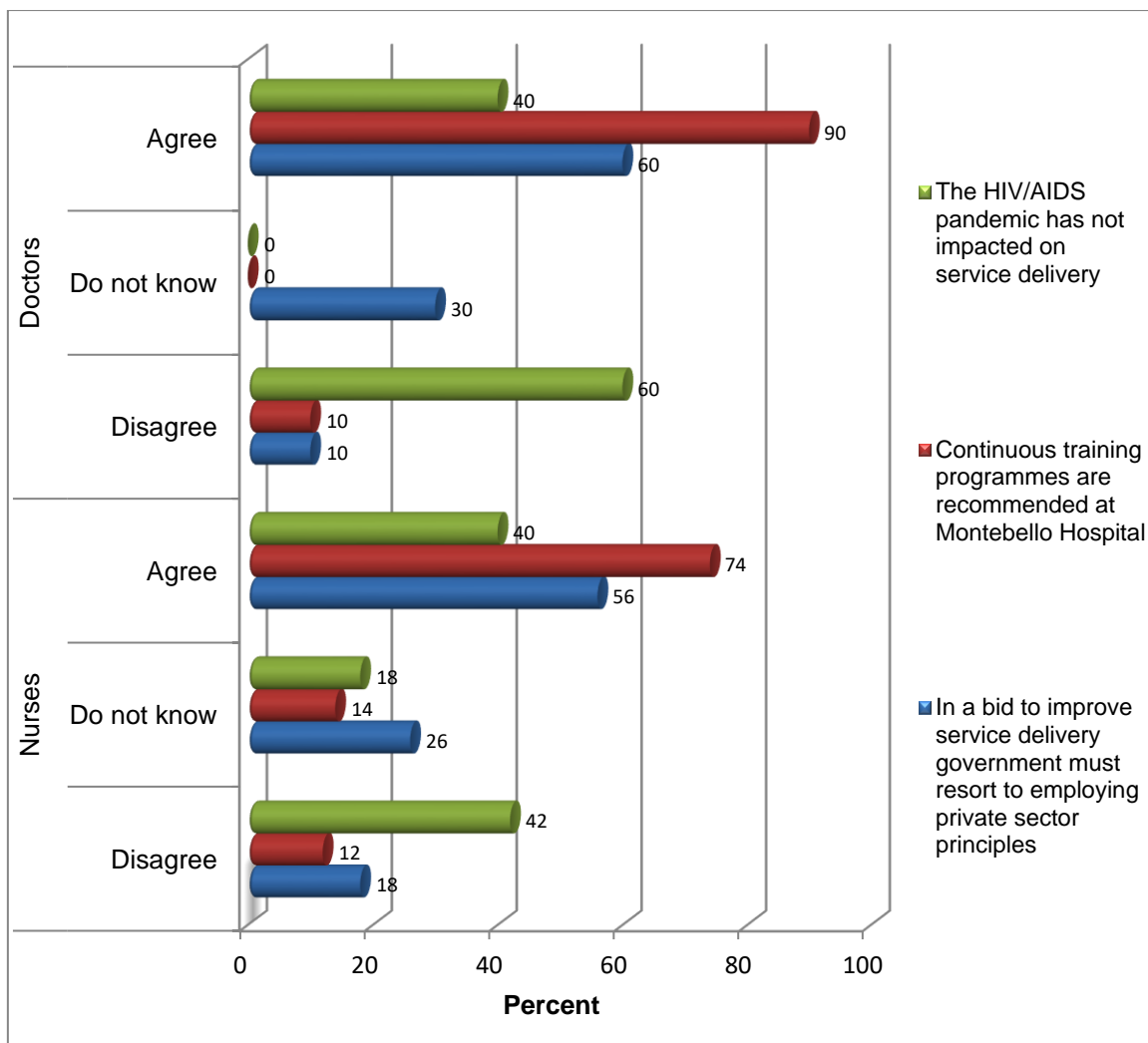


Figure 16 indicates that there are high levels of agreement in support for continuous training programmes at Montebello Hospital. An overwhelmingly number (90.0%) of doctors are in support of continuous training, while 74.0% of nurses supported this statement.

The same number of doctors and nurses have agreed with the first statement, while there is a difference of 18.0% between healthcare professionals who maintain that the HIV/AIDS pandemic has impacted on service delivery.

More than 60.0% of doctors indicated that the government must employ private sector principles in a bid to improve service delivery. This was closely followed by 56.0% of nurses who were in agreement with this statement.

Figure 17: Work reward, overworked doctors leaving the public healthcare sector, implementation of the Batho Pele principles

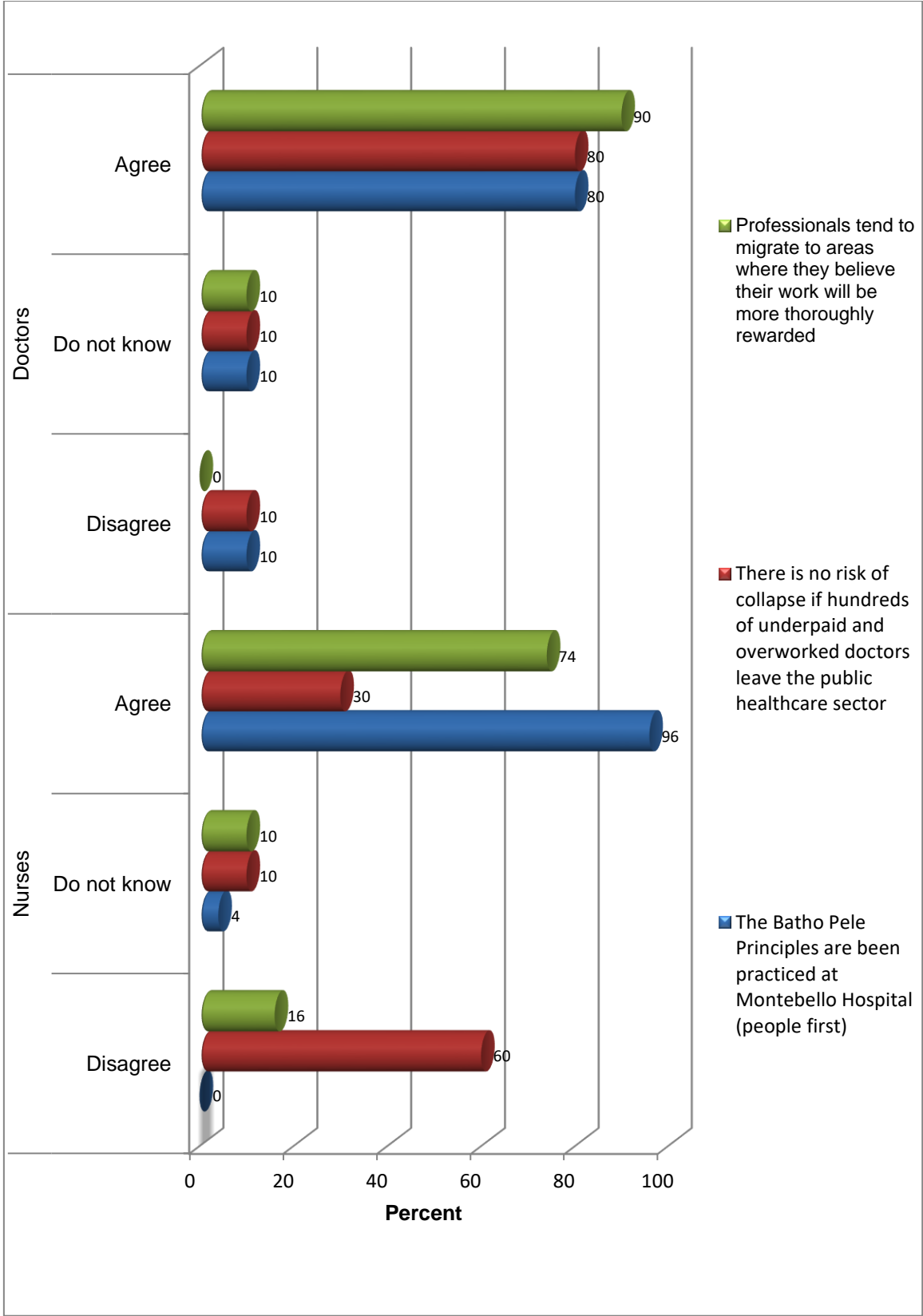


Figure 17 indicates that there is a difference of 16.0% between doctors and nurses who believe that the Batho Pele principles are being practised at Montebello Hospital. Only 10.0% of doctors disagree with this statement, while 4.0% of nurses believe that the Batho Pele principles are not being practised.

There is a 50.0% disparity between doctors and nurses who believe that there is no risk of collapse if underpaid and overworked doctors leave the public healthcare sector. More than half (60.0%) of the nurses disagreed with the second statement maintaining that should underpaid and overworked doctors leave the public healthcare sector, there is a risk of collapse. Only 10.0% of doctors disagreed with the second statement.

Doctors tend to agree that professionals migrate to areas where they believe their work will be more thoroughly rewarded. Nurses were also in agreement with this statement, although slightly less so than doctors.

The findings indicate that the environment in which healthcare practitioners operate plays an important role in retaining their services. Proper housing, infrastructure, equipment and job rotation are elements that the government must take cognisance of in order to attract and retain doctors in rural areas. Another protest for doctors in rural areas is the issue of major discrimination in remuneration. Doctors who work in urban public hospitals receive the same incentive as those who are employed in rural areas. In spite of limited resources, healthcare practitioners agree that the Batho Pele principles are been practised at the hospital.

5.3 Part 2: Analysis and discussion of qualitative data

5.3.1 Interviews

Interviews with hospital management and senior staff were chosen because they are executive and front-line staff, empowered with the task of ensuring that service standards are met, policies are implemented and control is exercised over staffing, finances and human resources. This was to ascertain management's perception of service delivery at the hospital.

Management and front-line staff consisted of the following individuals:

- Hospital Manager;
- Finance Manager;
- Human Resource Manager;
- Deputy Human Resource Manager;
- Deputy Finance Manager;
- Senior Administration Clerk;
- Administration Clerk;
- Stores Manager;
- Supply Chain Manager; and
- Deputy Supply Chain Manager.

The tables and figures below are a summary of the responses from the managers and front-line staff.

Table 10: Gender of the respondents by ages

	Gender		Total
	Male	Female	
Count	0	1	1
% of Total	0.0%	10.0%	10.0%
Count	6	3	9
% of Total	60.0%	30.0%	90.0%
Count	6	4	10
% of Total	60.0%	40.0%	100.0%

All of the managers were Black. Ninety percent (90.0%) of the managers were between the ages of 36 to 55 years. Of these, 60.0% were male and 40.0% were female. Females between the ages of 26 to 35 years constituted the remaining 10.0% of the count.

Figure 18: Departments in which respondents work

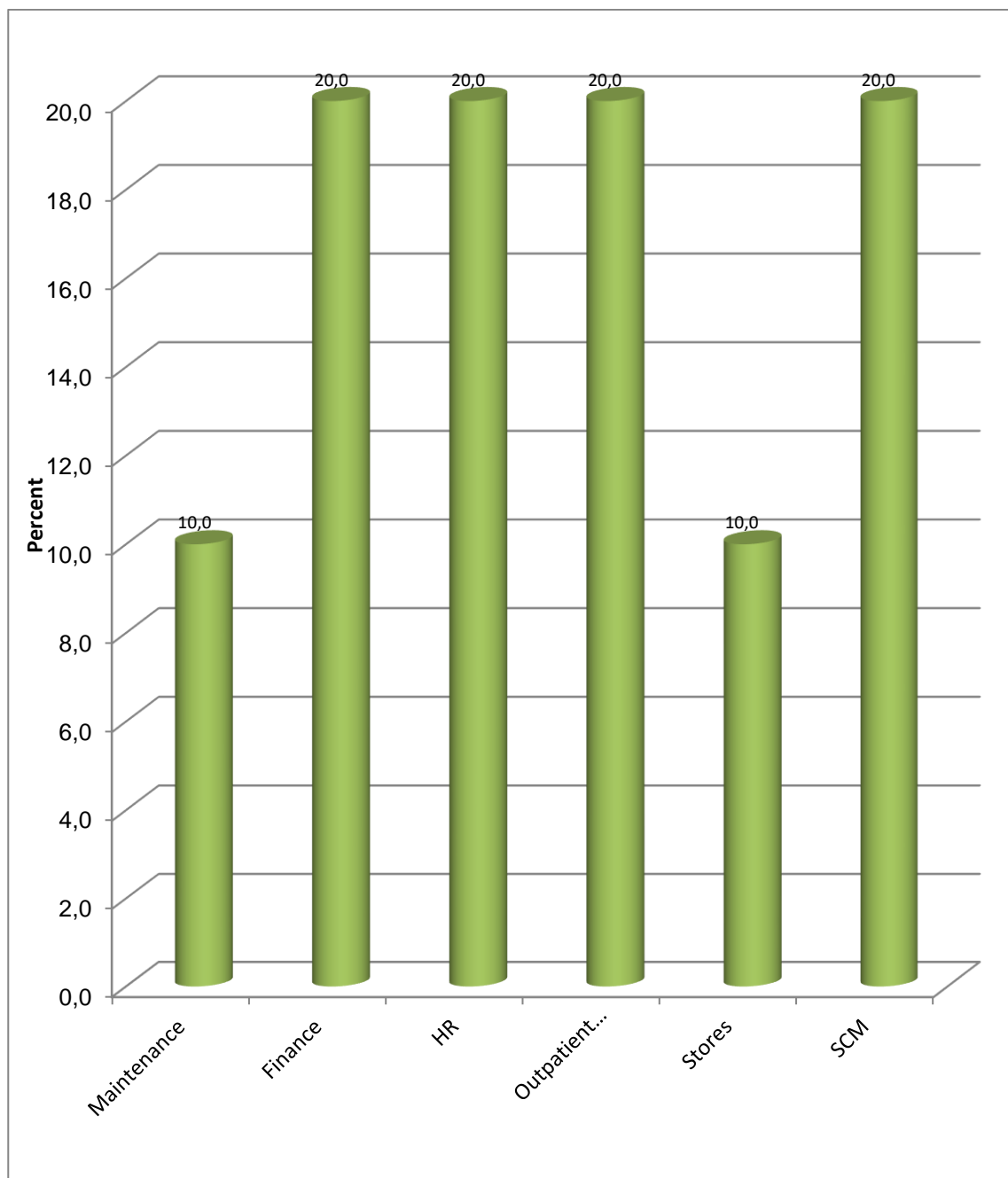
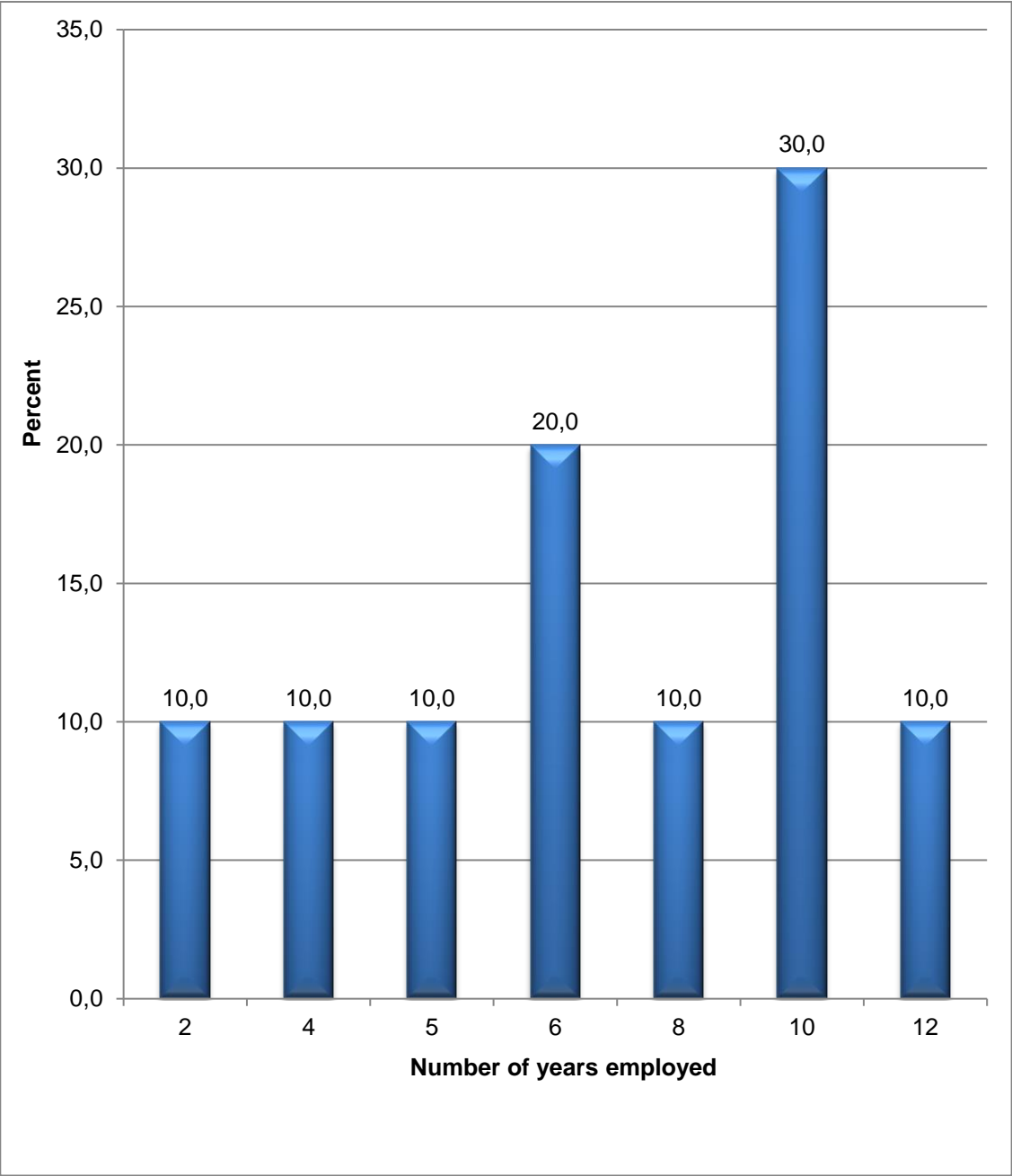


Figure 18 indicates that the majority of respondents are employed in Finance, Human Resources, Outpatient Department and Supply Chain Management. These departments each contribute 20.0% of the score, while the Maintenance Department and Stores Department contribute 10.0%, respectively.

Figure 19: Period of employment of the respondents



Thirty percent of the respondents had worked for a minimum of 10 years. A further 20.0% had been employed for 6 years.

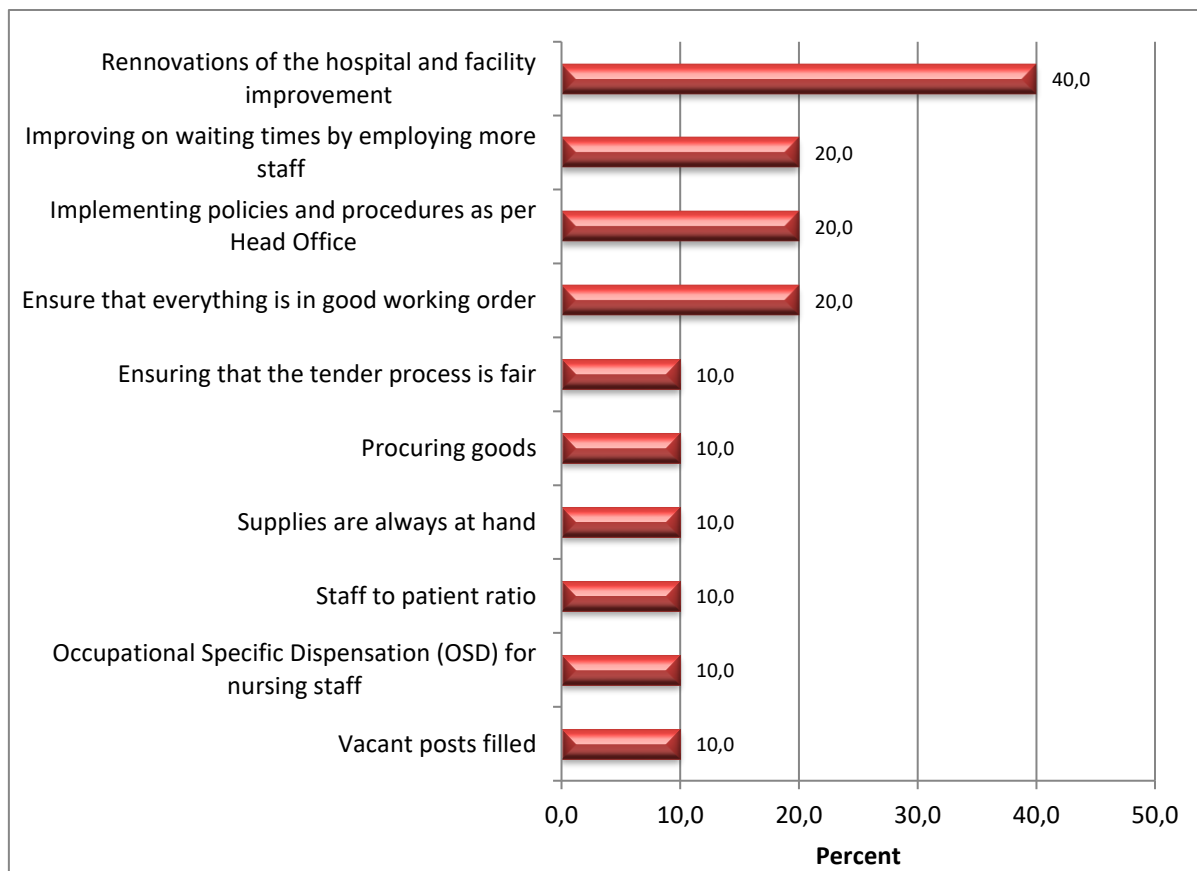
Table 11: Number of courses, seminars and workshops attended by respondents

	Frequency	Percent
7-8 per year	2	20.0
4-5 per year	4	40.0
1-2 every three months or quarter	1	10.0
Twice a year	1	10.0
3-4 per year	1	10.0
5-6 per year	1	10.0
Total	10	100.0

The highest frequency (40.0%) was for 4 – 5 times per year. This was followed by the second highest frequency (20.0%), where respondents indicated that they attended courses, seminars and workshops between 7 – 8 times per year.

Similar responses were obtained for the question “How would you rate the relationship between management and support staff?” All respondents believed that the relationship was good.

Figure 20: Frequency percent response, per question, for management overseeing improvement of service levels within the institution



Forty percent of the managers reflected that physical improvements have taken place at the hospital. Twenty percent of the managers believed that waiting times could be improved by employing additional staff. With regard to implementing policies and procedures, 20.0% were of the opinion that these are implemented timeously, while a further 20.0% indicated that management does ensure that all equipment is in proper working order.

5.3.2 Document analysis

5.3.2.1 The waiting time survey

The waiting time survey and the patient satisfaction survey were two of the major sources of information that were examined pertaining to institutional document analysis.

Waiting times are an important determinant of patient satisfaction. Long waiting times is the most common complaint of patients attending public health facilities. It may increase patients' frustration and decrease the patients' sense of control.

The waiting and service time survey (WSTS) is a survey conducted by Department of Health institutions (facilities) annually. The survey was conducted at Montebello Hospital during an average day of the week, which was Wednesday the 25th of November 2009. The purpose was to measure the total time a patient spends within the institution for receiving services (Montebello Hospital waiting and service times survey 2009 report).

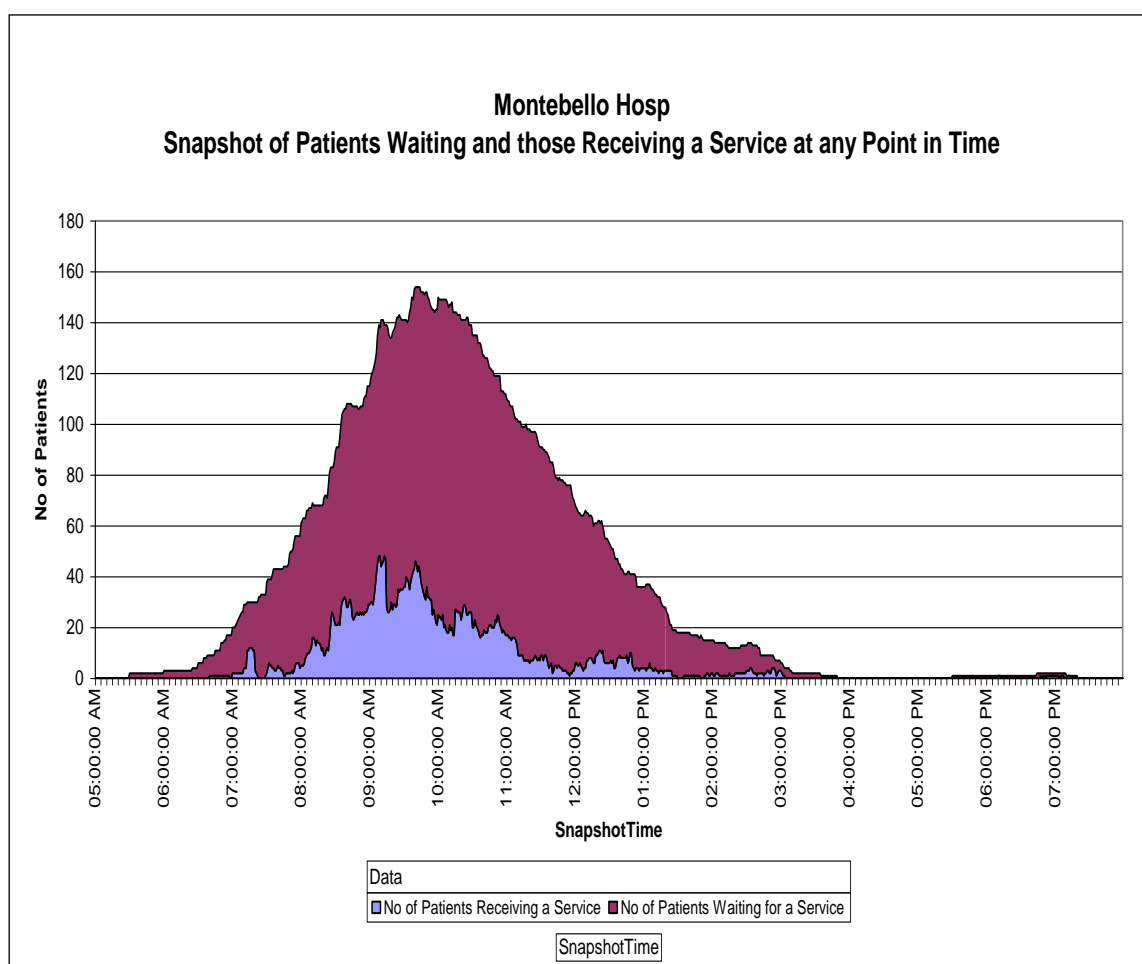
The purpose of the waiting time survey was to:

- Identify ways of improving patient service, which translates into better care and happier patients;
- To recognize new opportunities in order to be more effective and efficient;
- To promote informed decision-making by gaining statistically reliable data;
- Decrease waiting time for patients;
- Ensure appropriate service times for patients;
- Increase patients satisfaction;
- Reduce inequity and ensure similar workload for Staff; and

- Improve staff morale.

The efforts of healthcare practitioners should focus on shortening waiting times as well as improving patients' perceptions about long queues at the hospital because longer periods increase patient frustration.

Figure 21: Patients' waiting times and those receiving a service at any time



Source: Montebello Hospital waiting and service times survey (WSTS) 2009 report

The waiting times survey revealed that patients start arriving at the hospital from 05:00a.m. These patients were already receiving services by 07:00a.m. By 09:00a.m, the snap shot reveals that there were approximately 190 patients within the hospital of which approximately 86% were actually receiving a service. After 09:00a.m, the number of patients arriving decreases and this includes the number of patients seeking treatment. Between 11:30a.m and 12:00p.m, there was a small number of patients receiving care. From 16:00p.m until 17:30p.m, there was no patient waiting

and receiving services. Between 17:45p.m and 20:00p.m, there was as a small number of patients requiring assistance.

5.3.2.2 Patient satisfaction survey

Patient satisfaction can be described as the patients' overall assessment of his/her experience with health services (Andaleeb, 1998: 181 - 87). Patient satisfaction is considered one of the most important quality indicators which play an increasingly important role in the growing push towards accountability among healthcare practitioners. The skill of healthcare practitioners, their friendliness and their courtesy are important factors in patient satisfaction. Patient satisfaction surveys measure a variety of situations, such as effectiveness of treatments, effectiveness of patient care, and satisfactory or unsatisfactory doctor's visits.

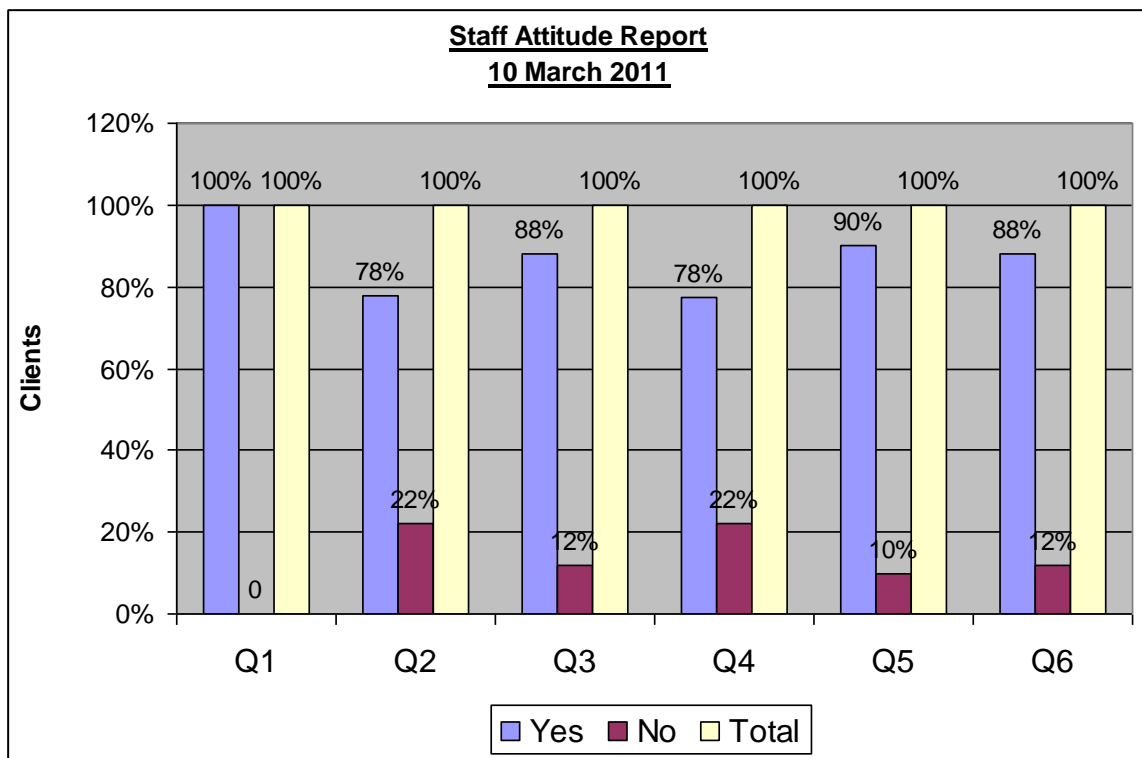
One of the core values of the hospital is to promote service excellence, thereby ensuring that patients will be satisfied with their entire experience in their patient visit and/or hospital stay. It must be noted, however, that patient satisfaction will differ depending on the severity of the case. For example, patients in a great deal of pain are more likely to be dissatisfied (Montebello Hospital patient satisfaction survey 2011 report).

The purpose of the patient satisfaction survey was to:

- To demonstrate that the hospital is interested in service delivery and is looking at ways to improve;
- To build a culture of service excellence at Montebello Hospital; and
- To identify and quickly correct issues concerning patient processes.

The results of the patient satisfaction survey are illustrated in the figures and tables below.

Figure 22: Staff attitude report



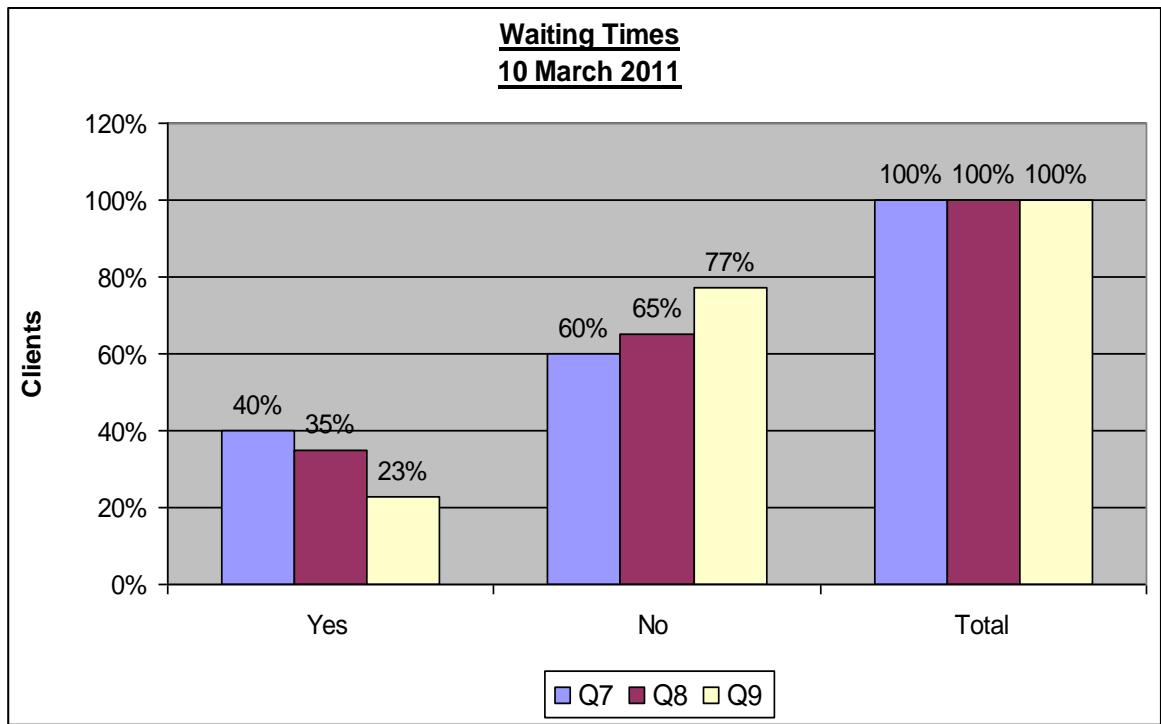
Source: Montebello Hospital client satisfaction survey report (March 2011)

Table 12 provides an explanation of figure 22.

Table 12: Interpretation of staff attitude report

Staff Attitude	Yes	No	Total
1. The clerk was friendly and helpful	100%	0	100%
2. The nurse explained the findings before seeing the doctor	78%	22%	100%
3. The doctor asked for permission before examination	88%	12%	100%
4. Doctor explained my condition to me	78%	22%	100%
5. Were you treated in a respectful manner?	90%	10%	100%
6. Advice was given on how to improve my health status	88%	12%	100%
AVERAGE PERCENTAGE	87%	13%	

Figure 23: Waiting times report



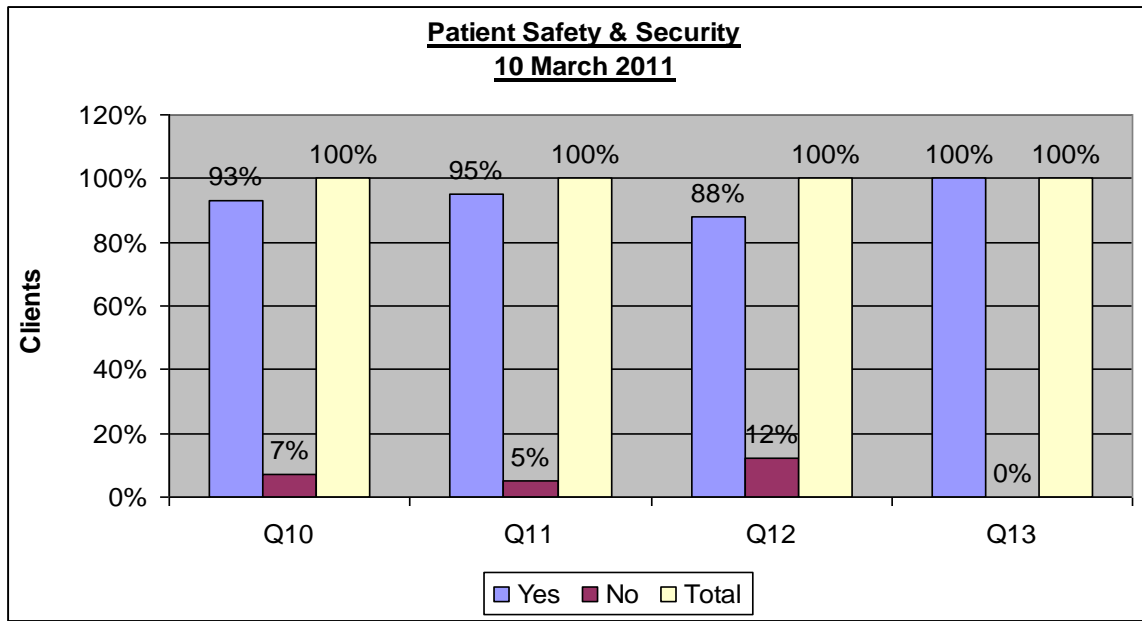
Source: Montebello Hospital client satisfaction survey report (March 2011)

Table 13 provides an explanation of figure 23.

Table 13: Interpretation of waiting times report

Waiting Times	Yes	No	Total
7. Was the waiting time to get a folder long?	40%	60%	100%
8. Was the waiting time in the outpatient department long?	35%	65%	100%
9. Was the waiting time at the pharmacy/dispensary long?	23%	77%	100%
AVERAGE PERCENTAGE	33%	67%	

Figure 24: Patient safety and security report



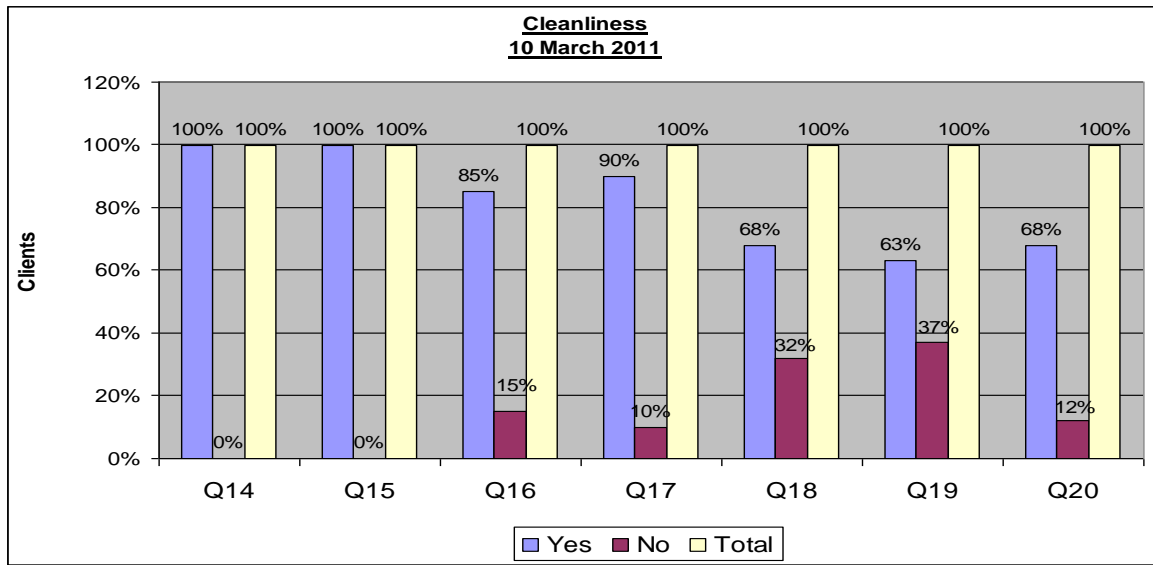
Source: Montebello Hospital client satisfaction survey report (March 2011)

Table 14 provides an explanation of figure 24

Table 14: Interpretation of patient safety and security report

Patient Safety & Security	Yes	No	Total
10. Signage to indicate where the toilets are is clear	93%	7%	100%
11. Signage to different areas of the hospital is clear	95%	5%	100%
12. The security personnel were visible	88%	12%	100%
13. All the passages were well lit	100%	0%	100%
AVERAGE PERCENTAGE	94%	6%	

Figure 25: Cleanliness report



Source: Montebello Hospital client satisfaction survey report (March 2011)

Table 15 provides an explanation of figure 25.

Table 15: Interpretation of cleanliness report

Cleanliness	Yes	No	Total
14. The outpatient department was clean	100%	0%	100%
15. The pharmacy department was clean	100%	0%	100%
16. The toilets were clean	85%	15%	100%
17. There was toilet paper in the toilet	90%	10%	100%
18 There was soap to wash hands with in the toilet	68%	32%	100%
19. There were paper towels/air dryer to dry hands in the toilet	63%	37%	100%
20. Did the staff wash/spray their hands before and after examining you?	88%	12%	100%
AVERAGE PERCENTAGE	85%	15%	

5.3.2.3 Montebello Hospital's report on patient satisfaction based on document analysis

Why would patients recommend Montebello to family and friends?

- The staff are friendly and helpful; and
- The facility is clean.

How can services be improved?

- Renovate and paint the hospital (cleanliness);
- Employ more doctors and nurses (waiting time);
- Chronic clinic waiting area to be covered (patients' rights);
- More toilets and bathrooms at the wards (patients' rights); and
- Provide mattresses for patients who sleep-over when referred (patients' rights).

5.3.2.4 Montebello Hospital's general comments about the survey

- Communication of doctors and nurses with clients is poor; and
- Average score for waiting time is 67%.Waiting time at OPD might be affected at times by availability of doctors as clients commented about a need for more doctors.

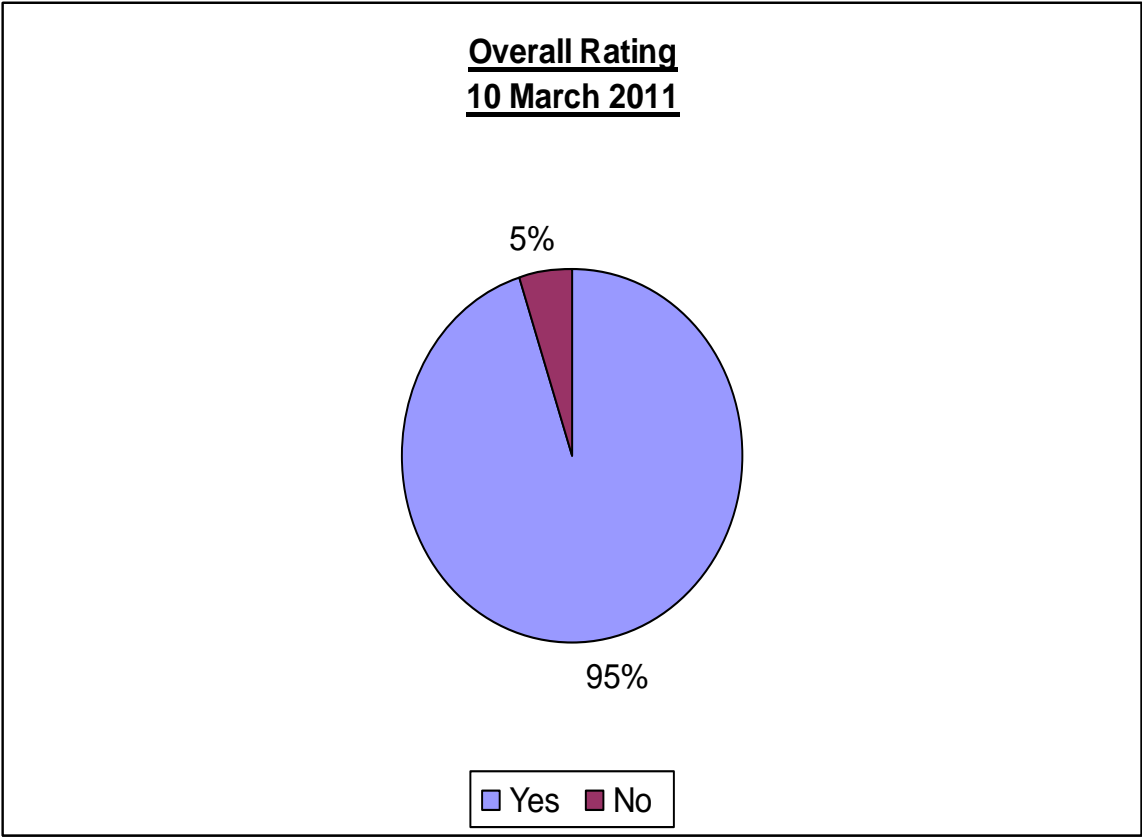
Table 16: Action plan for patient satisfaction

PRIORITY AREA	CHALLENGE	ACTIVITIES	TIME FRAME
Staff attitude	Poor communication with clients	<ul style="list-style-type: none"> • In-service training on Batho Pele • In-service training on six (6) key priority areas 	<ul style="list-style-type: none"> • 31/04/2011 • 31/04/2011
Waiting time	Long waiting time at chronic clinic on clinic days	<ul style="list-style-type: none"> • Conduct waiting time survey to establish baseline service standard 	<ul style="list-style-type: none"> • 06/05/2011
Cleanliness	Shortage of cleaning material and equipment	<ul style="list-style-type: none"> • Include needed equipment in procurement plan for 2011/12 • Request for equipment • Monitor stock levels and restock in advance • In-service training of staff on cleaning techniques 	<ul style="list-style-type: none"> • 18/03/2011 • 15/04/2011 • Continuous • 31/04/2011

Source: Montebello Hospital client satisfaction survey report (March 2011)

Figure 26: Overall rating of Montebello Hospital

Overall Rating	Yes	No	Total
Would you recommend this hospital to others?	95%	5%	100%



This figure shows that 95.0% of respondents would recommend this hospital to others, while 5.0% said that they would not.

5.4 Conclusion

This chapter has presented data obtained via interviews and document analysis utilising the quantitative approach. Interviews were conducted with management to determine their perceptions of service delivery at the hospital. Information from management and front-line staff is important because it gives opinions on the levels of service delivery. Front-line staff has the opportunity of experiencing a range of patients' views and have practical knowledge of providing services. The outcome of the survey revealed a commitment by management to contribute to service delivery by attending regular workshops and seminars. In addition, the loyalty of managers at this hospital is depicted by the number of years employed where more than one-quarter (30.0%) have been employed in excess of 10 years. A further 20.0% had been employed for more than 6 years.

The main source of document analysis was the waiting times survey and patient satisfaction report. The analysis of the patient satisfaction report revealed evidence of improved staff attitude, waiting times, patient safety and security and cleanliness.

To conclude this research, a summary of conclusions and recommendations will be outlined in the following chapter.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

The purpose of this study was to explore, understand and analyse the views of patients and healthcare practitioners with regard to service delivery at Montebello Hospital within the iLembe District. The recommendations contained in this chapter are mainly specific to Montebello Hospital.

Based on the above, the researcher undertook the study with the objective of determining the level of service delivery within the hospital itself. The literature reviewed in Chapter 2 indicated that service delivery challenges are not new to the public health sector. Further research revealed limitations in the literature reviewed relating largely to the shortage of published journal articles and books on the topic.

Montebello Hospital was the institution selected for the case study. Chapter 3 provided an overview of the hospital. A brief description of the hospital's vision, mission and core values was introduced together with an indication of where the hospital is located. This chapter highlighted the service offered at the hospital and described staffing in terms of the number of healthcare practitioners employed, the current vacancy rate and the conditions under which they operate.

Chapter 4 highlighted and discussed the methodology used which comprised of questionnaires that were administered by trained field workers to patients and healthcare practitioners. Interviews were also conducted with relevant senior managers and frontline workers to determine their views concerning service delivery. Institutional documentation such as waiting time surveys and patient satisfaction surveys were analysed to determine patients' perceptions and effectively implement interventions to enable the institution to realise its goals which are:

- human dignity, respect, holistic care and a caring ethos;
- innovativeness, courage to meet challenges, to learn and to change;

- cost effectiveness and accountability;
- service excellence; and
- open communication and consultation.

Chapter 5 revealed the research results which were presented, interpreted and discussed in relation to respondents' answers, and the literature reviewed. Recommendations have been formulated, based on the outcome of data analysed.

6.2 Responding to the research questions

Research question 1

What are the views of the patients and healthcare practitioners with regard to service delivery and patient care at Montebello Hospital?

The study revealed that patients were of the opinion that staff are reliable and respond promptly when needed. They indicated that the physical appearance of the hospital – premises, restrooms, equipment, wards and beds are clean and well maintained. Only a small portion (13.0%) indicated that doctors and nurses are not skilled and knowledgeable. Some 5.5% patients maintained that medication was not always available.

Healthcare practitioners believed that their performance should be monitored on a regular basis to promote accountability and transparency. They support continuous training programmes and are of the opinion that the Batho Pele Principles are indeed practised at the hospital.

Healthcare practitioners play an important role in patient satisfaction. Despite their courageous efforts, those who depend on public health services are frequently unable to access an acceptable level of healthcare. The conditions that patients are subjected to can be regarded as abuse of human rights. When patients lie unwashed, or share a bed with another patient, or when patients are left in soiled bed sheets and urine seldom collected from wards, and when staff is in short supply, equipment outdated and hospital buildings run down, it becomes obvious that the rights of patients are not being respected and that urgent action is required.

Unfortunately, the shortage of doctors and nurses at this hospital poses constraints on health service delivery. In order to restore a climate of compassion and care it is, therefore, suggested that the following recommendations be considered regarding service delivery and patient satisfaction at the hospital:

i) Implement an incentive scheme that would encourage doctors to work in rural areas. This scheme should take into account the availability of schooling for their children, suitable accommodation and scarce skills allowances;

ii) Sound leadership and management skills are important in ensuring patient satisfaction. The hospital manager must pay specific attention to the environment when planning and organising resources for quality healthcare. Thus, it is significant to bear in mind that an analysis of planning and managing political, social, economic, technological and cultural aspects is fundamental to the functioning of the hospital; and

iii) With the intended implementation of NHI, provision must be made for managers to improve performance and build a firm foundation of public trust. The health department needs to instil greater performance orientation among public servants. This signifies that performance management must become vital to the work of hospital managers. They need to be prepared for the challenges that will confront them as they seek to ensure accountability and avoid bias. Beyond this, public managers' should work to reduce waste, pursue public interest and advance a strong sense of public ethics.

Research question 2

What are the patients' expectations in terms of quality healthcare and turnaround times?

Patients indicated that the queues are short and they do not necessarily have to wait a long time before being seen to. A total of 28.0% of the respondents revealed that there are lengthy queues and turnaround times were slow. Patients were in agreement that healthcare practitioners provide personal care, empathy, mental support and understanding concerning their problems. In addition, there was

consensus among patients that doctors and nurses communicate clearly and in a friendly manner regarding test results, diagnoses, prescriptions, health regimes etc.

There is widespread perception that services in government hospitals have deteriorated over the past few years, largely due to the growing HIV/AIDS epidemic and staff shortages. Even the well performing hospitals are struggling to deal with the HIV/AIDS epidemic and the massive shortages of healthcare practitioners – the two biggest challenges facing the overburdened healthcare system in South Africa.

In order to meet patients expectations in terms of quality healthcare, hospital managers must be held accountable for the functioning of hospitals, policy issues, training and job grading managed by provincial Health Departments which themselves need proper restructuring to play their role in ensuring effective service delivery

For the hospital to operate at its optimum, it is suggested that the following recommendations be taken into consideration concerning quality healthcare and turnaround times:

- i) The hospital management team should be granted greater authority in order to move decision making closer to the point of delivery;
- ii) The community should be made aware of the services being rendered at the hospital and that rendered services are prominently displayed for the knowledge of patients. The Batho Pele White Paper compels the hospital to set standards which should be published and communicated to the patients. Service standards are a means of educating patients about services rendered at the hospital. With the service standards, patients are made aware of where, how and when services will be delivered, and patients' expectations are managed;
- iii) Patients complaints, suggestions and queries should be addressed through visible complaint registers and suggestion boxes. This enables patients to lodge complaints regarding the quality of service, or even to give recommendations for improving service delivery; and

iv) Patients should have a clear indication about the time-frame for delivery of healthcare services. This would save the hospital from undue expectations and enable it to project patient capacity. Awareness of turnaround times would also enable patients to better understand the capacity of the hospital to deliver services within a specific time-frame. Patients have the right to know what the waiting turnaround time is. Long waiting times is the most common complaint of patients, which may increase patients' frustration and decrease the patients' sense of control.

Research question 3

What do healthcare workers anticipate with regard to support from the healthcare Ministry in terms of funding, equipment, staffing and remuneration?

Most healthcare practitioners believe that they are under-resourced in terms of equipment, staff and funding. Less than half believe that political leaders have not ensured the sound management of finances and human resources. Many felt that it is important to monitor performance on a regular basis.

Malfunctioning equipment has dire consequences concerning patients' health. This is particularly serious for equipment used in case of emergencies. Resuscitation trolleys are often not properly equipped, staff members are not trained to use these and there is sometimes a shortage of oxygen. Extensive staff shortages suggest that those who are employed in the public health sector are required to perform more and more duties. This leads to burn-out, discouragement and a high level of absenteeism.

It is, therefore, suggested that the following recommendations be considered concerning funding, equipment, staffing and remuneration:

- i) Strategic direction be provided by the hospital management team through proactive leadership, risk management and planning, ensuring that the provincial health department provide guidance on matters related to good governance;
- ii) It is further recommended that the hospital has an appropriate management structure in place which is familiar to all staff. The human resource allocation plan

should provide for sufficient staff to meet the hospitals service delivery levels. This is to ensure that staff is managed efficiently, and recruitment, administrative and registration processes are prioritised;

iii) The strategies involved in prioritising the day-to-day responsibilities of effective patient care include, management of human resources, finances, assets, consumables and information and records. To this affect, the hospital should have an approved staffing plan in place whilst maintaining the most up-to-date human resource policies and legislation. The human resources crisis, coupled with poor working conditions and poor pay, needs to be urgently addressed, as does the urgent need to train more health professionals; and

iv) Expenditure should be closely monitored to ensure compliance within the legal frameworks. In a bid to enhance service delivery, the process of purchasing and tendering ought to be transparent and reflect the planned needs of the hospital. It is clear that assets should be properly registered, managed and controlled to extend use and reduce loss.

6.3 Discussion of the research questions

Service delivery failures are reported frequently in the print media. Such failures can play a powerful role in shaping patients' negative attitudes and dissatisfaction with healthcare services. Concern over the quality of healthcare services has led to loss of faith in public hospitals. Most countries in the world experience a shortage of healthcare workers, yet, poor management, lack of proper guidelines (such as procedures and policies) and unethical practices exacerbate problems within the health sector in South Africa. However, an assessment of this hospital's healthcare system has revealed a favourable situation. Whether this represents a bias among patients evaluating the services, whether it was the hospital that was selected, or whether it is because no better service is expected, the findings reveal that Montebello Hospital is doing something right.

Contrary to the perceived perception that the public health sector is plagued by poor service delivery, this research has revealed that the efforts of Montebello Hospital are in the right direction. For example, research question 1 shows the availability of

doctors and nurses, as well as their positive behaviour and attitude are of major benefit to the institution. Particularly reassuring is the abundance of empathy of the healthcare practitioners, their sympathetic demeanour, their elevated levels of competence and their awareness for the suffering that patients endure. The skill and knowledge of the doctors and nurses provide a sense of assurance that they have the patients best interest in mind and that services at the hospital are delivered with integrity.

The physical appearance was an additional factor that contributed to patient satisfaction at the hospital. Patients indicated that the hospital was clean and organised, which included its premises, equipment, restrooms, wards and beds. The survey revealed that the hospital is not lacking in these attributes. Therefore, the better the physical appearance of the institution, the greater is the patients' satisfaction. In addition, there is a regular supply of medication at the hospital premises.

Responding to research question 2, patients indicated that healthcare practitioners showed empathy and understanding towards their problems and needs. Doctors and nurses were attentive and understanding towards them and provided personal care and mental support. This has greatly influenced patient satisfaction. It is conceived that due to the empathy received from healthcare practitioners at the hospital, patient satisfaction has increased.

The required equipment is functional and healthcare practitioners are able to provide quick diagnoses of diseases. Laboratory reports, diagnoses of disease and appropriate explanations to queries, have influenced patient satisfaction because healthcare practitioners communicate clearly and in a friendly manner.

6.4 Limitations of the study

The major limitations of this research are described below:

Focus on one organisation: This study focused on one hospital due to the feasibility of conducting multiple surveys and taking into account the time factor. It would have been better if the study consisted of two or more similar hospitals.

Coverage of only four sets of participants: Participation was restricted to patients, doctors, nurses and management of Montebello Hospital. An expanded research population which could have possibly included pharmacists, radiographers, administration staff and other categories may have enriched the study.

Generalisation of research results: Generalisation of the research results was limited to the iLembe district. All the respondents were of African descent, with the exception of 2 doctors that were Asian. It is for this reason that the respondents used in this study are not representative of the broader South African public hospital population and these results might not be generalizable to the Coloured, White and Indian populations.

Access to healthcare practitioners and management: Due to the nature of the positions held by healthcare practitioners and management, time to participate in this study was a significant factor.

Non-availability of documentation: Another challenge was that of obtaining documentation. In some instances, documents were not always available and considered confidential. Staff was also reluctant to part with certain documentation.

6.5 Contributions of the study

The rationale of this research was for the healthcare sector and citizens to gain greater knowledge and understanding of healthcare reform, specifically NHI and service delivery in the public health sector. This study has, therefore, made a contribution in confirming and strengthening some existing theoretical propositions and has also generated knowledge.

6.5.1 Generation of new knowledge

The current study is unique in that the findings were based on primary data from patients and healthcare practitioners who provided first-hand knowledge of their experiences concerning service delivery at the hospital. In addition, this study has highlighted some of the many issues that need to be dealt with for NHI to work in

South Africa, such as building stronger relations with the private sector to build an effective NHI system and appropriate allocation of scarce human resources.

6.6 Recommendations for future research

A case study of only one district hospital was conducted. This is particularly needed in view of widespread concerns, adverse publicity etc. which are current but do not seem justified by the Montebello study. Thus, the findings may not be generalised to other district hospitals in KwaZulu-Natal. It is, therefore, recommended that a comprehensive survey, which could include provincial and tertiary hospitals, be included in future research. Moreover, surveys typically make use of data gathering instruments and methods that accommodate larger samples than case studies. Further research could identify other avenues of service delivery such as cost effectiveness, quality of service and so forth. This research could not look into all the above mentioned aspects of service delivery. Additional research may be conducted to compare service delivery before and after the implementation of NHI.

6.7 Final comments

The researcher believes that this research has been conducted at a time when South Africa stands at the threshold of revolutionising the entire healthcare sector. The recommendations presented in this study indicate that the way towards improved service delivery is through participation, community involvement, greater commitment from government, better governance, accountability, transparency and improved political purpose within the DoH.

Doctors in private practice will be instrumental in strengthening the success of the government's proposed NHI. They should be compensated with an adequate wage if they are to set aside three hours of their working day to look after patients in the public sector - as proposed in the new draft policy. According to Health Minister, Aaron Motsoaledi, the Department of Health will guarantee the payment of private general practitioners, who work in public clinics in the NHI pilot districts.

Encouraging foreign doctors to work in rural areas could reduce staff shortages. However, the Health Professions Council of South Africa takes an excessively long

time to register these doctors and staff appointments can take up to five months to be approved. Thus, doctors resort to finding employment in the private sector or abroad. In order to deal with the shortage of doctors in South Africa, Doctor Aaron Motsoaledi announced that the number of matriculants sent to Cuba for medical training would increase dramatically - 1 000 matriculants will leave in September 2012. So far 304 doctors have been trained in Cuba, where 406 are currently studying and 98 will graduate this year. Only 1 200 doctor's graduate from South Africa's eight medical schools each year (Wild, Kahn, Gernetzky, Child and Beukes, 2012).

Government has the prime responsibility of ensuring access to healthcare for all, especially for the most vulnerable groups. It is important for government to ensure that services are brought closer to the people and that communities be made aware of services being rendered pertaining to where, how and when services will be delivered. The Batho Pele White Paper requires departments to set standards which should then be published and communicated to citizens. Government must ensure that hospitals and clinics have fully equipped offices with staff that display the necessary knowledge and skills.

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ANNEXURE A

APPLICATION TO CONDUCT RESEARCH AT MONTEBELLO HOSPITAL

Regional Governance and Development
Public Management
19 Aberfeldy Road
Scottsville
Pietermaritzburg
3201

09 November 2011

Chief Executive Officer
Montebello Hospital
Private Bag X506
Dalton
3236

Attention: Mr S. Khawula

Dear Sir

RE: APPLICATION TO CONDUCT RESEARCH AT MONTEBELLO HOSPITAL

I am currently studying at the Durban University of Technology (DUT) towards a Masters degree in Public Management. My research project is entitled: **HEALTHCARE REFORM AND SERVICE DELIVERY: A CASE STUDY OF MONTEBELLO HOSPITAL**. This research is being conducted under the supervision of Professor Malcolm Wallis and Dr Rishi Balkaran from the Department Regional Governance and Development.

I hereby, request your permission to conduct interviews with patients seeking treatment, including nurses and doctors working at Montebello Hospital.

The focus of the study is to explore and describe the quality of healthcare at Montebello Hospital, evaluating approaches and policies for improving healthcare delivery, and analysing health outcomes through evidence-based research. The researcher will make recommendations as part of the research, and forward a copy of the end result to you.

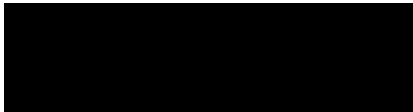
Should permission to conduct the research be granted, the interviews will be scheduled for December 2011/January 2012 at a time and place suitable to the participants. The researcher undertakes to adhere to all ethical principles of research. Participants will

also be fully informed of the purpose of the research. Participation will be on a voluntary basis and participants may withdraw at any point, should they so desire.

Copies of the proposal and participant information letter are enclosed for your approval. Should you have any queries, please contact my supervisor, Professor M. Wallis, during office hours at (031) 373 5130 or Dr R. Balkaran, during office hours (031) 373 5151.

Thank you for considering my request.

Yours faithfully

A solid black rectangular box used to redact the signature of Melody Brauns.

Melody Brauns

ANNEXURE B

APPLICANT'S REQUEST TO PARTICIPATE IN RESEARCH

Regional Governance and Development

Public Management

19 Aberfeldy Road

Scottsville

Pietermaritzburg

3201

09 November 2011

REQUEST TO PARTICIPATE IN RESEARCH

Dear Participant

You are hereby requested to participate in a research study. The researcher wants to know the views of patients and health practitioners at Montebello Hospital. This research will be conducted as part of my studies at the Durban University of Technology (DUT). The study will be available in DUT libraries for public scrutiny. Please feel free to ask the researcher to clarify anything that is not clear to you.

To participate, you need to complete the questionnaire, to be administered by a field worker. The completed questionnaire will be collected from you within two days after it has been administered.

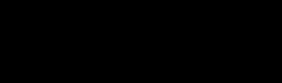
You have the right to query concerns regarding the study at any time. Please report any problems you may experience during the study, to the researcher. The contact numbers of the researcher is as follows: feel free to call (033) 845 8893 or 079 754 7878 and ask for Melody Brauns.

Participation in this study is completely voluntary. You are not obliged to take part in any research. If you choose not to participate, you are free not to accept the questionnaire and you will not incur any penalty and/or loss of benefits to which you may be entitled.

Please note that you are not required to divulge your identity on the questionnaire: therefore, no-one will know your name or other details. The Biographical information requested is generic in nature and will assist the researcher on different variables.

This request has been prepared in compliance with current statutory guidelines.

Yours sincerely



Melody Brauns



ANNEXURE C

QUESTIONNAIRE – HEALTHCARE PROFESSIONALS

QUESTIONNAIRE

SECTION A

Biographical information – Health Professionals

Please provide the following information regarding your position in the organisation, by placing an X in the appropriate block.

1. Gender

a. Male	
b. Female	

2. Race

a. White	
b. Black	
c. Asian	
d. Coloured	

3. Age

a. Less than 25 years old	
b. 26 years – 35 years	
c. 36 years – 55 years	
d. Over 55 years of age	

4. In which department are you employed?

a. Out-Patient Department (OPD):Hypertension Clinic, Epilepsy Clinic, Asthmatic Clinic, Diabetic Clinic	
b.Hospital Clinics: Chronic Diseases, Antenatal, Communicable Diseases (ARV, STI & TB) Under 5s, Orthopaedic, Occupational Health, Wellness clinic	
c.Operating Theatre	
d. Dental	
e. Ophthalmic	
f. Other (please specify)	

5. How long have you been in the employment of this organisation?

a. Less than 5 years	
b. Between 5 and 10 years	
c. Between 10 and 15 years	
d. More than 15 years	

6. What position do you hold in this organisation?

a. Doctor	
b. Professional Nurse	
c. Enrolled Nurse	
d.Enrolled Nursing Assistant	
e.Other (please specify)	

SECTION B – Health Professionals

The views of health professionals regarding service delivery in South Africa are important.

Please answer the following questions, by encircling the appropriate number

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
a.	Medical staff are not under-resourced in terms of equipment, staff and funding	5	4	3	2	1
b.	Political leaders have ensured the sound management of finances and human resources	5	4	3	2	1
c.	Issues of remuneration and ageing infrastructure do not contribute to the de-motivation of medical staff	5	4	3	2	1
d.	It is important to monitor health professionals' performance on a regular basis	5	4	3	2	1
e.	The HIV/AIDS pandemic has not impacted on service delivery	5	4	3	2	1
f.	Continuous training programmes are recommended at Montebello Hospital	5	4	3	2	1
g.	In a bid to improve service delivery, government must resort to employing private sector principles	5	4	3	2	1
h.	Professionals tend to migrate to areas where they believe their work will be more thoroughly rewarded	5	4	3	2	1
i.	There is no risk of collapse if hundreds of underpaid and overworked doctors leave the public healthcare sector	5	4	3	2	1
j.	The Batho Pele Principles are been practised at Montebello Hospital (people first)	5	4	3	2	1

ANNEXURE D

QUESTIONNAIRE – PATIENTS

QUESTIONNAIRE

SECTION A

Biographical information – Patients

Please provide the following information regarding your position in the organisation, by placing an X in the appropriate block.

1. Gender

a. Male	
b. Female	

2. Race

a. White	
b. Black	
c. Asian	
d. Coloured	

3. Age

a. Less than 25 years old	
b. 26 years – 35 years	
c. 36 years – 55 years	
d. Over 55 years of age	

4 How often do you visit Montebello Hospital?

a. Once in two weeks	
b. Once a month	
c. Once in three months	
d. Once in six months	
e. Once a year	

5. What type of treatment do you require?

a. Chronic treatment	
b. Repeat treatment	
c. Emergency treatment	
d. General check-up	
e. Other (please specify)	

6. What department are you visiting?

a. Obstetrics and Gynaecology	
b. Paediatrics and Child Health	
c. General Surgery	
d. Family Medicine	
e. Other (please specify)	

SECTION B - Patients

The views of patients regarding service delivery in South Africa are important.

Please answer the following questions, by encircling the appropriate number

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
a.	Hospital staff are reliable and respond promptly when needed	5	4	3	2	1
b.	The physical appearance of the hospital - its staff, premises, restrooms, equipment, wards and beds is clean and well organised	5	4	3	2	1
c.	There are short queues and patients do not have to wait a long time before been seen to	5	4	3	2	1
d.	Supervision of patients by care providers is regular, and specialists are available	5	4	3	2	1
e.	Doctors and nurses are not skilled and knowledgeable	5	4	3	2	1
f.	Doctors are not attentive and understanding and nurses do not provide mental support and understanding of patients problems	5	4	3	2	1
g.	Medical equipment is modern, functional and up to date. Health professionals are able to provide quick diagnoses of diseases	5	4	3	2	1
h.	Doctors and nurses communicate clearly and in a friendly manner regarding laboratory and other test results, diagnoses, prescriptions, health regimens etc.	5	4	3	2	1
i.	Doctors, nurses and hospital beds are always available at Montebello Hospital	5	4	3	2	1
j.	The prescribed drugs are always available and properly administered	5	4	3	2	1

ANNEXURE E

QUESTIONNAIRE – MANAGEMENT OF MONTEBELLO

INTERVIEWING SCHEDULE FOR MANAGEMENT AT MONTEBELLO HOSPITAL

SECTION A

Biographical information – Management

Please provide the following information regarding your position in the organisation, by placing an X in the appropriate block.

1. Gender

a. Male	
b. Female	

2. Race

a. White	
b. Black	
c. Asian	
d. Coloured	

3. Age

a. Less than 25 years old	
b. 26 years – 35 years	
c. 36 years – 55 years	
d. Over 55 years of age	

4. In which department are you employed

5. What position do you hold in this institution?

6. How long have you been in the employment of this organisation?

7. How many courses, seminars, and workshops have you attended for the past five years?

8. Do you believe that National Health Insurance (NHI) will improve access to quality healthcare services?

9. How would you rate the relationship between management and the supporting staff?

10. What has management done to improve the level of service delivery within the institution?

ANNEXURE F

LETTER OF CONSENT FROM MONTEBELLO HOSPITAL



health

Department:
Health

PROVINCE OF KWAZULU-NATAL

Montebello Hospital, R614 Noordsberg Road, Dalton 3236
Private Bag x 506, Dalton 3236
Tel: 033 5067058, 5067025, 5067057, Fax: 033 5061156
Email: bawinile.hadebe@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Mrs BG Hadebe
Date: 19/12/2011
Tel: 033-5067025

Ms M. Brauns
161 Melsetter Road
Woodlands
Pietermaritzburg
3201

Dear Ms Brauns

RE: REQUEST FOR THE PERMISSION TO CONDUCT RESEARCH

1. Your letter dated 09 November 2011, requesting permission to conduct research pertaining to "HEALTHCARE REFORM SERVICE DELIVERY: A CASE STUDY OF MONTEBELLO HOSPITAL" refers.
2. Approval is being granted for the above, on the provision that:
 - It does not interfere with the work of the interviewees.
 - The interviewee voluntarily agrees to participate in the study.
3. Kindly be advised that you are granted a 6 Months period to conduct your research.
4. I hereby confirm that permission is granted.

Yours Faithfully


MR X D SELEPE
HUMAN RESOURCE MANAGER