ASSESSMENT OF THE CHALLENGES AFFECTING THE EFFICIENT AND EFFECTIVE MANAGEMENT OF DISTRICT HOSPITALS IN THE MOTHEO DISTRICT IN THE FREE STATE PROVINCE

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MAGISTER TECHNOLOGIAE:

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DECLARATION OF INDEPENDENT WORK

I, <u>Moeketsi Hendrick Toli</u>, student number: 209081902, do hereby declare that this research project submitted to the Central University of Technology, Free State for the MAGISTER TECHNOLOGIAE: PUBLIC MANAGEMENT degree, is my independent work; and complies with the Code of Academic Integrity, as well as other relevant policies, procedures, rules and regulations of the Central University of Technology, Free State; and has not been submitted before to any institution by myself or any other person in fulfillment of the requirements for the attainment of any qualification.

SIGNATURE OF STUDENT   DATE: 26 February 2014

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This dissertation has not been the product of the hand of the author alone.
Many people have provided their assistance, support and positive encouragement in order to assist me in the production of this body of work.

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EXECUTIVE SUMMARY

The *primary aim* of the proposed study is to investigate the technical problems affecting the efficiency and effectiveness of District Hospitals in the Free State Province. The proposed research therefore stands to contribute to the existing body of evidence on the efficiency and effectiveness of health care services, with regard to the existing problems in the health sector such as high staff turnover, facilities with lack of appropriate equipment, unmanageable workload, lack of appropriate infrastructure, a high absenteeism rate and low morale of the employees in the public health institutions. Therefore the study will identify potential shortcomings that are compromising the efficiency and effectiveness of the district hospitals. The findings of the study will be used to address some of the identified problems and also to describe how progress can be measured. The outcomes of this study are intended to raise important issues and to assist management of the Free State Department of Health to address the challenges that are affecting the functioning of the district hospitals. The findings will also assist the relevant managers in planning and implementation of policies that will address inequalities and problems as highlighted in the study. It will also create opportunities for shared responsibilities that management and the staff need to resolve jointly.

CHAPTER 1: BACKGROUND TO THE STUDY

1.1 INTRODUCTION

The mandate of the South African government is to provide a better life for all. One of the challenges facing the government is the provision of efficient and effective management of district hospitals in order to satisfy the unlimited needs of its citizens with limited resources. The uncontrolled growth of informal settlements in the townships poses a challenge to the government of the day as it increases the demand of health services, especially in the district health services. The government has developed strategies to communicate its services, goals and objectives, programmes as well as its activities to its citizens in order to increase the accessibility and availability of services.

This dissertation will therefore be based on the following topic: "Assessment of the challenges affecting the efficient and effective management of district hospitals in the motheo district in the free state province".

In this chapter, the background and reason for the study, formulation of the problem statement and a hypothesis, aim and objective of the study, research methodology, key concepts and the scope of the study will be outlined.

1.2 BACKGROUND AND REASON FOR THE STUDY

In 1994, mainstreaming district hospital and district health services in South Africa was an idea whose time had come (Kautzky & Tollman 2008:18), because a new democratic government had come to power in 1994. A popular government, with an overwhelming mandate to address those marginalized by apartheid would, it seemed, be capable of introducing a model, people-oriented health care system. This would be a system able to fulfill the aspirations of the founders of the democratic South African state. Almost immediately after the inauguration of the new

government, services at district hospitals and some primary health care centres became available throughout South Africa and were declared 'free' at the point of delivery. Reinforcing such a far-reaching health policy was the complementary educational policy to provide each school-going child with a nutritious food ration during the school day. Such measures were emblematic of the new government's intentions and signaled a dramatic shift from the old regime that would surely overcome any lack of managerial or leadership experience (Kautzky & Tollman 2008:18). In addition, health services in rural areas were few and not easily accessible, whilst in the urban areas they were abundant and easily accessible, but only for certain individuals. In view of the aforementioned, the new government adopted the mandate of "a better life for all" to rectify the previous inequalities. Amongst other imbalances or inequalities that affected the population were services for the disabled who had limited access to health institutions. Rural areas were mostly covered by mobile clinics, whilst currently established fixed clinics depended on the support given by district hospitals.

The provision of effective and efficient district hospital services was a major challenge in developing countries where poor geographical accessibility adversely affects the use of medical services and consequently the health of the local population. With the aim of ensuring the entire population's equal access to these services, the South African government has transformed its health system by making the first level of care, i.e. district hospitals, accessible to all. District hospital services have been incorporated into a decentralized district health system. In addition, the government has made some progress since 1994 in providing more services to more people, thereby ensuring equity in service delivery.

The South African health system faces the challenge of becoming part of the comprehensive programme aimed at redressing previous social and economic injustices. The South African government showed its commitment to implement the Reconstruction and Development Programme (RDP) and to develop a district health system based on district health care. The district approach in health care services has been instituted in the provincial sphere of government to give effect to and to support the objectives of section 27 of the Constitution of the Republic of South Africa, 1996, that states the following:

(1)   Every person has the right to have access to-

    (a)   Health care services, including reproductive health care;

    (b)   Sufficient food and water; and

    (c)   Social security, including if they are unable to support themselves and their dependents, appropriate social assistance.

(2)   The state must take reasonable legislative and other measures within its available resources, to achieve the progressive realization of each of these rights.

(3)   No one may be refused emergency medical treatment.

The White Paper on Transforming Public Service Delivery (1997:1) (Batho Pele White Paper) sets out eight transforming priorities, amongst which Transforming Service Delivery is the key priority. The Batho Pele document points out that the public service has to put the "People First" Principles into practice without delay. It will also step up the implementation to arrive at acceptable service levels and quality as soon as possible. The Batho Pele Principles are described as follows:

1.   Effectiveness in delivering services which meet the basic needs of all South African citizens.

2.   Formulation of health policies to allow free health care services, especially for children and pregnant mothers.

1.3   EXPECTED OUTCOME (MAIN OBJECTIVES/CO-OBJECTIVES) AND HYPOTHESIS

Significance refers to the reasons why a study is important or "significant" and how it contributes to the existing knowledge base in its field (Polit & Beck 2006:148). This study is significant because it will assess the nature and the influence of the key service delivery challenges in district hospitals in the Free State. The research will further investigate the specific factors that have a detrimental effect on the ability to

deliver quality health care in relation to personnel, financial and material resources in district hospitals. In addition, the following complementary objectives will address the research problem:

- Advance possible explanations for the observed disparities and challenges in district hospitals and how efficiency can be improved over time;

- Make recommendations on how the observed disparities and challenges can be addressed;

- Determine the extent of the political will to address the challenges identified;

- Identify and analyse the problems that demotivate personnel;

- Analyse the challenges that put district health care services in the Free State under pressure; and

- Assess the magnitude of disparities in technical, human and financial resources between different district hospitals in the Free State.

Encourage executive management and district management teams to use the key findings of the research to resolve some of the challenges that are identified as barriers towards achieving effectiveness of district hospitals.

1.4   RESEARCH METHODOLOGY

The methodology followed in any research project is the most important aspect since the validity of the research and the reliability of the outcome of the research will depend entirely on it. A researcher therefore has to choose a suitable method that will make the problem he or she wants to investigate accessible to him or her.

The research methodology also describes the steps, procedures and methods that a particular researcher has followed during the process of collecting and analysing data in a systematic way (Polit & Beck, 2006:509). A quantitative cross-sectional study design is most suitable for this study related to knowledge, attitude and practice. The method of data collection for this study is to conduct interviews using a structured

questionnaire. It does, however, not mean that, as the research progresses, some characteristics of a qualitative approach are not replicated, since some information may be re-used and re-interpreted, especially in cases where empirical studies have already been done to establish the availability and standard of services in the area as empirical studies form the basis of both these approaches (Technikon SA, 2000:8).

The data required for this study comprises the knowledge, perceived practices and facilitating factors of effectiveness of health service delivery among the health care workers and the availability of the resources required to deliver the service. It is also important to collect data on how the effectiveness is really measured in the participating institutions. Therefore, the research design for this study is a quantitative cross-sectional analytic study design. This will provide an analysis of the factors that influence health service delivery in district hospitals. The study will be conducted in the four district hospitals in the Motheo district in the Free State. The research participants will be selected from all the different categories of employees in the district hospitals, as this will yield the relevant data to determine the challenges affecting the efficient and effective management of district hospitals in the Motheo district. This research method will also provide an inside perspective of the challenges experienced during the service provision at district level.

The findings of this research will form the foundation for recommendations to achieve effective and efficient service provision in district hospitals in the Free State. The researcher is also of the opinion that the data collected and the conclusions arrived at could also be extended to all the other district health care facilities in the Free State

FIGURE 1.1 MANGAUNG METROPOLITAN MUNICIPALITY

Source: www.fshealth.gov.za

1.5   DEFINITIONS AND KEY CONCEPTS

Hospital:

A hospital is an integral part of a social and medical organization, the function of which is to provide complete health care for the population, both curative and preventive (WHO, 2001b:71-72).

Referral system:

It is a prescribed and documented system of referring a patient from one level of health care to another (National Indicator Data Set Definitions, 2005).

Mortality rate:

It is defined as a number of deaths in a particular area over a period of time expressed in percentage (STATSA, 2006).

District hospitals:

Services in district hospitals are within the skill base of general medical practitioners and do not require the intervention of a specialist including elementary surgery requiring a general anaesthesia (NDoH, Definition of Health Facility, and August 2006.)

Regional hospitals – Level 2 care (secondary):

Services in regional hospitals are sometimes beyond the normal scope of a general practitioner and require the input of a registered specialist (Definition of Health Facility, August 2006).

Tertiary hospitals:

Services at this level are sometimes beyond the normal scope of a specialist and require the input of a registered super-specialist.

Specialized hospitals:

There is a wide range of possible specialties that could be located in a specialized hospital, including spinal injuries, maternity, heart, infectious diseases, psychiatric conditions and many more. The following are two examples of a specialized hospital, but others can be added.

Psychiatric hospital:

A facility that provides in-patient care solely for patients with psychiatric or mental health conditions, such as old-age psychiatry; forensic psychiatry; substance abuse; liaison psychiatry; eating disorders; in-patient psychotherapy; social psychiatry; acute psychotic (complicated); and acute non-psychotic conditions (National Department of Health, 2006).

Tuberculosis hospital:

This is a facility that provides in-patient care solely for patients with tuberculosis (National Department of Health, 2006).

Effectiveness:

Effectiveness is defined as the extent to which the main objectives of an intervention have been attained and whether the results of the intervention are sustainable (Kusek & Rist, 2004:225).

Efficiency:

Efficiency is a measure of how economic resources or inputs (such as funds, expertise and time) have been converted to the satisfactory results for the person implementing the plan (Kusek & Rist, 2004:225).

Volunteers:

Volunteers are individuals that offer their time and service to any institution, such as a hospital, for the proper functioning of the institutions and this happens without any promise of reimbursement or payment (Fisher & Cole, 1985:45).

CHAPTER 2: INTRODUCTION AND ORGANIZATION OF THE RESEARCH

2.1   INTRODUCTION

District hospital services in the new millennium are defined as "integrated, comprehensive, needs-based health care delivered at all levels of the health care system". Hospital services include seamless and integrated promotional, preventive, curative and rehabilitative interventions that are designed to mitigate the main risk factors and causes of morbidity, disability and mortality (WHO 2003:1-5). Extensive and comprehensive district health services (DHS) form the backbone of health services in the Free State. According to Gray and Pillay (2006:7), 75%-80% of the South African population is dependent on the health care that is provided at public health facilities. Challenges such as a lack of medical consumables and financial and human resources are the most serious hindrances towards providing quality health care (Vermaak, 2006: 12).

Although DHS are rendered at district hospitals and clinics, in general there are health care service limitations; the biggest challenge is how management is responding to addressing the shortcomings of district hospitals. Following the presidential announcement on performance-based management, managers will receive their performance bonuses based on the performance of their facilities (City Press, May 2010). In order to implement the evidence-based management, there are critical service delivery issues that need to be addressed, namely:

- Implementation of provincial guidelines, norms and standards which should be instituted by the province to cover all areas of functioning within the limits of available resources;

- Restructuring with a view to establishing minimum staffing levels, which should be undertaken based on a number of factors such as agreed performance indicators; and

- Regular formal monitoring of key indicators needs to take place with the necessary analysis, to empower and supply more resources with the ultimate aim to improve service delivery.

The *South African National Health Act,* 2004 (Act 61 of 2004) provides the framework for a structured and uniform DHS of which district hospitals are part. DHS are based on the principles of health services which emphasize equal access to quality, comprehensive health care services, as well as effectiveness, efficiency and sustainability of service delivery (Act 61 of 2004). The system of district health services in the Free State serves a population of about 2 434 606 million people who live in the Free State, which is further divided into 1 Metro and 4 District Municipalities (Free State Province, 2010/11:12). The Free State Province has the following population figures:

- Xhariep District Municipality: **67 700;**

- Mangaung Metro: **299 722;**

- Lejweleputswa District Municipality: **378 506;**

- Thabo Mofutsanyane District Municipality: **396 583;** and

- Fezile Dabi District Municipality: **288 754** (StatsSA, 2009:1)

Although not all people in these districts are making use of the health services provided by the provincial government, the majority of them do. In order to provide effective and efficient services to these people, challenges like poor working conditions, lack of job satisfaction, low staff morale levels are all key issues that impact negatively on service delivery in the Free State. A healthy Free State community may be a difficult goal to achieve in the province if the fundamental issues are not addressed. The Free State situation is further exacerbated due to migration of health care personnel to provinces perceived to offer better pay and working conditions. Provinces like Gauteng, Mpumalanga and Limpopo are paying higher salaries than the normal national scale, because they have special permission to advertise their posts at a higher level due to the nature of the environment (National Department of Health 2008:10). The management of health care services in the Free

State needs urgent attention in order to achieve efficient and effective health care. Health equity also implies effective management that will ensure effectiveness and efficiency of health care interventions and management processes that would yield positive results on service provision (Katzenellenbogen, Joubert & Karim, 1997:149-50).

2.2   AIM OF THE STUDY

The main aim of the study is to investigate the challenges affecting the efficient and effective management of district hospitals in the Free State. An estimated 75% to 80% of the South African population is dependent on public health care services that are provided at district health care facilities (South Africa. Department of Health 2008:40). In the Free State 2 434 306 million (85.2%) of the uninsured population has no medical aid and therefore is dependent of public health services (www.fs.gov.za/app.2010/11). These facilities provide complex curative care and act as the first level of referral to the DHS. District hospitals constitute an essential source of service delivery for health services in the Free State. DHS are based on the principles of emphasizing equal access to quality and comprehensive health care services to the community. However, challenges such as the lack of financial resources, unavailability of medical equipment, dilapidated buildings and high staff turnover are directly affecting the proper management and functioning of these hospitals. The results of this study will provide evidence of the challenges experienced in the management of health care facilities at DHS-level in the Free State. These challenges need to be investigated in order to provide a solution for the effective and efficient management of DHS in the Free State province.

2.3   PROBLEM STATEMENT

Gray and Pillay (2006:7) point out that the budget allocation for health has decreased over the years due to a decreased population by, among other things, the scourge of the Human Immune Virus (HIV) and the migration of the population from specific areas of the country to where conditions are better. However, the burden of diseases

like tuberculosis (TB), diabetes and high blood pressure is increasing the pressure on health care facilities. It is further stated that the increase in lifestyle illnesses that are avoidable has a detrimental effect on the ability to deliver quality health care services.

According to the Department of Health, health has been identified as one of the key priorities of government in the next five years (National Department of Health 2009:30). The key service delivery challenges facing the Free State public health system include amongst others:

- Insufficient funding to the health care services even though there is scientific evidence that HIV and AIDS and chronic diseases are consuming much of the equitable budget;

- Mismatch between the funding and the health care package (the services that need to be rendered with a certain amount of a budget);

- Deterioration of the quality of health care services in general due to a lack of medical consumables;

- Shortage of clinical personnel;

- Lack of an appropriate health care structure; and

- Inefficient government procurement system and distribution of medical consumables.

Hugo (2008:7) indicated that a disempowered, stressed and overloaded management of district hospitals is the direct product of a dysfunctional health care system, which impacts on the general functioning of district hospitals in the Free State.

2.4 EXPECTED OUTCOME (MAIN OBJECTIVES/CO-OBJECTIVES) AND HYPOTHESIS

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The findings of this research will form the foundation for recommendations to achieve effective and efficient service provision in the district hospitals in the Free State. The researcher is also of the opinion that the data collected and the conclusions arrived at could also be extended to all the other district health care facilities in the Free State.

2.6   STUDY POPULATION

Burns and Grove (1993:235) defined population as an identification of a group of persons, agencies, places and other units of interest informing the entire aggregation of cases that meet a designated set of criteria. Pilot and Hungler (1995:468) describe sampling in the qualitative research as the process by which the researcher selects a certain portion of population in order to discover meaning and multiple realities. The research population for this study is the different occupational classes working in the Motheo district hospitals in the Free State. The study was done at the National, Botshabelo, Dr J.S. Moroka and Mantsopa district hospitals in the Motheo district. Therefore the study population in this case is defined as all the personnel working in the district hospitals of Motheo district**.**

2.7   SAMPLING SIZE

Samples of 293 (83.7%) employees were interviewed from the four district hospitals in the Motheo district. This sample size was based on a 5% margin of error with a confidence level of 95% and an estimate of 50% response distribution for the total. The target population for the study was 350 of which 293 or 83.7% were interviewed during the survey.

Inclusion criteria

All the officials in permanent appointment of the four (4) district hospitals in the past twelve (12) months were included in the study.

Exclusion criteria

Any officials who have worked less than twelve 12 months or are still on probation, community service officials, volunteers, interns and any person not employed in one of the 4 four district hospitals were excluded from the survey.

2.8 MEASUREMENT

The questionnaire was designed in such a way that it will elicit information on managerial issues (i.e. *performance rewards and policy implementation*), human resources (i.e. *human resources provide support to staff members and value added by staff in the organization)*, financial management (i.e. *availability of financial and material resources)*, health and safety (i.e. *physical security and safe environment*), productivity and personnel happiness at work (i.e. *overall impression of the quality of care rendered and career planning)*, information management (i.e. *availability of hard/software to perform a function*). Collected data was captured using *Microsoft Excel®*.

2.9 RESEARCH INSTRUMENT AND COLLECTION OF DATA

Data collection techniques commonly used for quantitative studies include observations, interviews and self-administered instruments such as questionnaires (Polit & Beck, 2006:294). A structured closed questionnaire was prepared for this study.

2.10 PILOT STUDY

A pilot study was undertaken by conducting preliminary interviews with a few nurses and general workers not included in the sample. This exercise was important in that it determined the actual product that will be produced during the actual interview of the participants. The pilot study assisted in the reformulation of some of the questions to avoid possible problems with the interpretation of questions.

2.11 DATA ANALYSIS

Data analysis is the process of bringing order, structure and meaning to the collected data (De Vos, 2002:339). According to Creswell (1994:153) there is no right or wrong approach to data analysis in the quantitative research approach. However, there are

general guidelines a researcher has to adhere to as well as strategies for analysis utilized by quantitative researchers. The analysis of data was done firstly by describing the sample data and by ordering and coding the data (data processing). The data will be summarized in such a way that interpretation becomes easier. The conclusion will be drawn and strategies for testing or confirming findings to prove that their validity will be developed. Statistical analysis of the data was done using **EpiInfo software** in the form of frequency analysis; correlation analysis, linear and logistic regression will be performed to assess the effect of the factors that influence effectiveness.

The researcher accordingly conducted formative, summative and diagnostic assessments on each of the stages of the data analysis with the intention of determining the specific challenges affecting the efficiency and effectiveness of district hospitals in the Motheo district, and whether the district health system is properly implemented, maintained and managed.

2.12 DATA EVALUATION

2.12.1   Formative evaluation

Formative evaluation was done to provide feedback in terms of the daily operations of district hospitals. This kind of evaluation gives the first indications of whether a programme is being implemented according to plan, whether it is working as it should, what (if any) difference has been made by the principals in district hospitals, which will be evident if the personnel are not happy and whether or not it should be modified or improved (Brink & Wood, 1998:132). The purpose of the formative evaluations carried out in this study was to provide managers with evidence that, while the workers are committed to work, there are challenges which are directly and indirectly affecting their overall performance and that in order to be successful there is a need for interventions.

2.12.2   Summative evaluations

The researcher conducted summative evaluations during the course of this study and used clear statements during the interview (Annexure A) questionnaire to measure the satisfaction level of the people employed in district hospitals as well as those factors that frustrate them in their daily operations (Brink & Wood 1998:132).

2.12.3   Diagnostic evaluations

Diagnostic evaluations were conducted to identify the specific weaknesses, problems or deficiencies that seem to be causing underachievement of health targets, (Wikipedia 2008). Diagnostic evaluations were conducted on lower level data (namely district, hospital data, individual officials) in order to narrow down the areas, facilities, activities and interventions on which the limited resources of the Department of Health should be concentrated.

2.13   ETHICAL CONSIDERATIONS

The necessary ethical principles and precautions that are routinely observed in this kind of study have been adhered to. This has included obtaining permission from the relevant authorities, managing resources honestly, fairly acknowledging the individuals, groups of people or departments that have contributed to the guidance or assistance, communicating results accurately, reflecting on the consequences of the research and adherence to basic research principles such as honesty, reliability, impartiality (Kumar, 2005:303-304; Polit & Beck, 2006:499). Only the employees of district hospitals were involved in the survey, no human subject matter like blood was directly involved in this study, and the data was collected without intrusive method. The specific ethical codes, standards and procedures that are compulsory when dealing with human subjects are therefore not relevant to this study and the study participants were informed accordingly, their participation was voluntarily.

2.14 PERMISSION TO DO THE RESEARCH

Attached as Annexure A, is the written request to the Head of the Free State Department of Health to conduct the research and to survey departmental officials. The research proposal and the research questionnaire were attached to the request. The letter of approval from the Head of the Free State Department of Health is attached as Annexure B.

2.15 VALIDITY AND RELIABILITY OF THE RESEARCH INSTRUMENT

The word "valid" means an assumption or statement that is based on sound reasoning or well-grounded in truth or logic. Validate means proving, showing, demonstrating and confirming that something is true or correct. "Reliable" means that data or information is very likely to be correct or trustworthy (Word Net [online] 2008). The validity and reliability of the study instrument (questionnaire) are valid for its original intention (Heavens, 1999:14 - 48).

2.16 METHODOLOGICAL MEASUREMENT OF ERRORS

A self-administered questionnaire was prepared with health professionals in mind, but simple language was used as much as possible. Any technical terms used are expected to be known to the respondents and they were also used as a measure of knowledge. A degree of variation in response was expected since staff members are on different levels of education, but were expected to respond to the same questions. The structure and wording of the instrument was made simple and very clear to reduce the interpretation difficulties of the instrument. The researcher was always available to clarify uncertainties.

2.17 LIMITATIONS

Limitations refer to restrictions in the methodology of a study that may decrease the possibility of generalising the findings (Kumar, 2005:203). There are certain limitations associated with this study as well. Firstly, the study focuses only on eliciting the views of employees in district hospitals and will not investigate the opinion of the general public on the quality of services rendered at district hospitals. This is done with the purpose of developing an in-depth investigation into the challenges experienced during the delivery of services as perceived by officials at district hospitals. Secondly, the study is confined to one district only, namely Motheo, with a population of 408 203 people, while the Free State province consists of five districts with a total population of 1 539 746. Although the research was done in the Motheo Metro the generalisation of the findings is justifiable due to the generic nature of the district health care package rendered in all district hospitals in the Free State.

2.18 SCOPE OF THE STUDY

The study consists of five chapters. Chapter one deals with the introduction of the research topic, the background and reasons for the study, formulation of the research problem, formulation of a hypothesis, aims and objective of the research, research methodology, definition of concepts and the scope of the study. In chapter two the conceptualisation and legal framework for district hospital care services are put into context. The main focus for chapter three is the working environment and transparent decision-making processes by management. Political, financial and administrative challenges affecting the function of a district hospital are highlighted in chapter four. The findings, recommendations and the conclusion of the study are discussed in the fifth and final chapter.

2.19 DISTRICT HOSPITAL HEALTH CARE SERVICES IN CONTEXT

The district health care system is under increasing pressure to deliver improved health care services, but with increasingly fewer resources. Many factors contribute to such pressure, including the health care demands of an ageing population, the

development of diseases like HIV and AIDS, greater expectations of access to health services, and limits on the availability of health workers and limited government funding and higher expected levels of service.

2.20 DEFINITION OF DISTRICT HOSPITAL HEALTH CARE SERVICE

The Free State Provincial Health Act, 2009 (Act 3 of 2009), makes provision for the establishment of a District Health Authority (DHA) for each of the district council areas in the province. The DHA is authorized to govern the affairs of a district hospital.

The functions of the District Health Authority are:

- To make sure that acceptable, affordable, effective, integrated and comprehensive health services are provided to all people living within the health district;

- To manage its resources in line with the needs of the people in the health district;

- To develop strategic health plans and annual operational plans for the Department of Health;

- The organization of health services according to the district health system (DHS) model, which includes the participation of communities and inter-sectoral collaboration; and

- The constitutional principle of cooperative governance.

2.21 DISTRICT HOSPITAL HEALTH CARE SERVICES BEFORE 1994

Before 1994, hospital health care services were segregated according to different racial groups. It was a dreadful situation, because the disadvantaged groups, especially in the rural and township areas, where limited resources such as

ambulances and medical equipment were available, experienced many problems such as high death rates and stillborns (Tollman, 2008:11). Those who had money were able to go to private clinics or hospitals for better treatment or service. The public hospitals were overcrowded, because of the limited number of beds, which resulted in poor service delivery. The services were also not affordable and accessible, especially to the poor. Some had to travel long distances before reaching a clinic due to the attitude and the behaviour of the health employees. The above statement is further supported by Kautzky and Tollman (2008:21) who indicate that the formal separation of health services falls into different ethnic groups. The poor management in the former black hospitals, such as public district hospitals, resulted inevitably in a grossly inefficient and costly, poorly planned health system. In addition, shortcomings in health personnel, poor facilities, lack of funding, the racial segregation and the politicization of health services perpetuated discrimination in health care services.

2.22 SERVICES RENDERED IN DISTRICT HOSPITALS

The following services are available 24 hours five days a week in district hospitals (District Health Package, 2011:24).

- 24-hour casualty services

- Maternity services

- General paediatric services

- General surgical procedures

- Pharmaceutical services

- Theatre service

- X-ray services

- Dietetic services

The following services are not always available in district hospitals. They are rendered as outreach services by the specialist from a higher level of care (Free State Annual Performance Plan, 2011/12 to 2013/14).

- Occupational therapy services;

- Physiotherapy services;

- Speech and audiology services; and

- Oral health care services.

2.23 THE CHARACTERISTICS OF AN IDEAL DISTRICT HEALTH CARE SERVICE

According to Hattingh, Dreyer and Roos (2006:64) a health service should possess the following characteristics: it should be accessible, affordable, acceptable, equal, effective, efficient, sustainable, caring, comprehensive, comfortable, considerate, scientifically advanced and careful with the patient's safety. Each one of the characteristics will be briefly explained.

2.23.1   Accessibility

District hospital health care should be accessible to all the people that it serves (Roos, 2006:64).

2.23.2   Affordability

Health care services should not only be affordable to those who have money and medical aid, but everyone should access the health care service evenly, as the National Health Institute (NHI) is proposing. Health services should be rendered as economically as possible and cost containment should be an ongoing process.

2.23.3   Acceptability

Acceptability is the foundation on which all health services should be rendered. A health service that is not accessible, affordable, available, equal, effective, efficient,

continuous, caring, comprehensive and comfortable, will not be acceptable to the patient.

2.23.4   Availability

This entails that services should not only be comprehensive but should be available at the time when there is a need for the service.

2.23.5   Geographical location

District health care services should not be situated more than 10–15 kilometres from where the patient stays. It is important that health facilities are situated within walking distance of communities. But due to a lack of financial and material resources this is not practically possible in South Africa.

2.23.6   Functionality

Services must be rendered after hours and over weekends so that the patients can visit the health institution after hours as well.

2.23.7   Financial affordability

Patients should not be refused health services because they are unable to pay for the services. The district health services are free for children, pregnant women and pensioners. However, for those with medical aid the services must be provided at minimal fees, not exorbitant ones because the person is a member of a medical aid (Negotiated Service Delivery Agreement, 2010 – 2014).

2.23.8   Communication bias

Communication should be in the language preferred by the patient. This is especially necessary when communicating with the very young and the elderly who can be very insecure when communicating in a language they are not familiar with. The health care professional should also keep religious perceptions in mind.

2.23.9 Equality

No difference should be made in the provision of services based on the grounds of gender, age, occupation, race or language.

2.23.10 Effectiveness

Only appropriately qualified staff should render health services, in other words staff members must not do procedures they are not qualified for.

2.23.11 Efficiency

Efficiency is a measure of how economical resources or inputs (such as funds, expertise and time) have been converted to the satisfactory results for the person implementing the plan (Kusek & Rist, 2004:225).

2.23.12 Sustainability

Sustainability relates to the use of resources so that they are not depleted before the objective is realized.

2.23.13 Courtesy

The way in which patients are being treated at health care facilities should be according to the *Batho Pele* Principles which put people first, no matter who the patient is (Department of Public Service and Administration, 1997: 40).

2.23.14 Comprehensiveness

An 'all inclusive approach' should be followed. This is applicable to all community members going to district hospitals, but is emphasized more for rural people and foreigners living in our province. This means that comprehensive health services should be available to everyone entering the hospital setup.

2.23.15 Comfortable environment

Overcrowded district health care facilities are uncomfortable for the patient. Neither are they comfortable for the health care professional who has to cope with this problem. A comfortable environment provides safety, security and contributes to human dignity.

### 2.23.16	Uniqueness of patients

Patients are not the same in terms of health care problems and personalities and should therefore be treated as such by health care professionals.

### 2.23.17	Scientifically advanced

Even though district hospital services are not providing specialized health care services, they must still be scientific in nature and delivered by well-trained officials. These services should still be based on recent best practices.

### 2.23.18	Safety of the patient

Ensuring patient safety is a national priority, and everyone involved in the health care system has a role, including the patient. Patients can assist in making their health care experience safer by becoming active, involved and informed members of the health care team.

CHAPTER 3: CONCEPTUALIZATION OF THE CONSTITUTIONAL, WORLD HEALTH ORGANIZATION AND LEGAL FRAMEWORK ON THE DELIVERY OF DISTRICT HEALTH SERVICES (DHS) IN THE SOUTH AFRICAN CONTEXT

3.1   INTRODUCTION

Established in the Second World War, bodies such as the World Health Organization (WHO) have served to influence policy makers in the world, including South Africa (WHO, 1999).   Organizations such as the WHO have assisted in shaping the perception on the provision of health care. Over the years, the WHO and similar organizations have prompted various health care philosophies such as district health system (DHS) and primary health care (PHC). In the 1990s South Africa was one of the few countries in the world where complete transformation of the health system had begun with a clear political commitment to, inter alia, ensure equity in resource allocation, restructure the health system according to a district health system (DHS) and deliver health care according to the principles of the PHC approach. This chapter attempts to describe the various forms of decentralization and how they are being implemented in the health system. In addition, the research will explain why the DHS was adopted and what progress has been made to date in its implementation.

3.2   LEGACIES OF THE PAST AND TRANSFORMATION OF THE HEALTH SECTOR

After South Africa's first democratic elections in 1994, the dismantling of the country's race-based health system began. Previously, hospitals were assigned to particular racial groups and most were concentrated in white areas. With 14 different health departments, the system was characterized by fragmentation and duplication. Post-1994 the health sector has undergone rapid change to make it more equitable and accessible to the needy. From 1994 to 2010, more than 1800 clinics have been built throughout the country (District Health Information System, 1999: 10). With specific

reference to the Free State Province, clinics have increased from 129 to 312 and free services for children under six, and for pregnant or breastfeeding mothers, have also been introduced (Medical Research Council, 1999: 23).

A number of tertiary hospitals and other hospitals have been completed in recent years. In 2011 alone 29 hi-tech hospitals were under construction all around South Africa. The renewal of hospital stock focused initially on renovation and maintenance, but has progressed to major rebuilding under the Hospital Revitalization Programme. In terms of the health department's overall investment in this scheme, by the end of the 2007/2008 financial year the total investment was about R5.4-billion. In the 2008/2009 financial year the programme received an allotment of R2.8-billion, R3.1-billion in 2009/2010, and R3.6-billion in 2010/2011 (Revitalization Project Report, 2011:112-114).

By June 2010 there were 400 provincial public hospitals. A service package with norms and standards has been developed for district hospitals and is being extended to regional hospitals. The number of private hospitals and clinics continues to grow and there are 200 private hospitals. The mining industry also provides its own hospitals, and has 60 hospitals and clinics around the country (District Health Information System, 1999:14).

The release of the National Health Amendment Bill has paved the way for the establishment of a new independent body, the Office of Standards Compliance, to ensure that South Africa's hospitals and clinics comply with minimum health standards (http://www.doh.gov.za/docs/legislation-f.html). All health care centres, including private ones, will have to get accreditation from this office. Another process is the certificate of need (CON), which applies to all health establishments, from the smallest GP practice to the largest private hospital built by a developer. An application for the certificate of need must be lodged by whoever wants to set up a health establishment (http://www.doh.gov.za/docs/legislation-f.html).

The establishment of the office follows the government's commitment to improve the quality of health care in South Africa's public health facilities and to strengthen the country's health system through enhanced accountability. Health Minister Aaron Motsoaledi said that the office would ensure that complaints received from health

care users or the public were properly and independently investigated in South Africa (National Department of Health 2006: 11b). The office will also advise the minister on the development of standards, norms and quality management systems for the national health system; inspect and certify health establishments as compliant with prescribed norms and standards; and monitor indicators of risk as an early warning system relating to breaches of standards (http://www.doh.gov.za/docs/legislation - quality assurance).

In order to address the problems within the health sector the Department of Health developed policies on a wide range of issues that are contained in the White Paper for the Transformation of the Health Sector in South Africa released in April 1997. The White Paper lays out the vision of the Department of Health. Some of the issues covered by the White Paper range from the mission and goals of the department, the structure of the national health system, to the role of non-governmental organizations and health goals for 2000. Objectives and indicators of the country were achieved, but with some challenges. The White Paper tries to present what needs to be done to correct the ills of the health system and proposes how the department ought to go about the process of reconstruction. A significant departure from the past is the decision to create a unified but decentralized national health system based on the DHS model. One of the main reasons for this is the belief that this system is deemed to be the most appropriate vehicle for the delivery of district health services. In addition, the decision to decentralize the delivery of health care is consistent with the overall policy to decentralize government.

3.3   DECENTRALIZATION AND HEALTH SECTOR REFORM

The Government of National Unity has adopted decentralization as the model for both governance and management. Decentralized governance is embodied in Chapter 3: section 40 of the Constitution in the form of the powers and functions of the three spheres of government. The powers and functions of the local sphere of government bear testimony to the importance of this sphere in particular. In trying to understand what the concept 'decentralization' means, a definition is required. In general terms the concept implies the shift of power, authority and functions away

from the centre. It is seen as a mechanism to achieve the following: greater equity and efficiency; greater involvement of and responsiveness to communities; the reduction in the size of the bureaucracy far removed from the communities being served; and greater coordination between social sectors. The World Bank views the decentralization of public health services as potentially the most important force for improving efficiency and responding to local health conditions and demands (World Bank, 1993:34). According to Bossert (1996:143) decentralization can take many forms. One set of typologies is the following:

- Deconcentration;

- Devolution;

- Delegation; and

- Privatization.

3.3.1 Deconcentration

Deconcentration is defined by Bossert as "shifting power from the central offices to peripheral offices of the same administrative structure". In the South African case the establishment of provincial regional and district offices for health is an example of deconcentration (Bossert, 1996:147). Powers are delegated to the peripheral unit to be semi-autonomous, but the peripheral unit is bound to the centre by a common bureaucracy. According to Smith, decentralized personnel are typically full-time career officials, appointed, promoted, remunerated, controlled and deployed by the bureaucratic means applicable to all members of the organization. Deconcentration emphasizes policy cohesion with central planning, control and allocation of resources (Smith, 1979:23).

3.3.2 Devolution

Devolution, on the other hand, is the shifting of power and responsibility to separate administrative structures which are still within the public sector. It often implies "the transfer of functions or decision-making authority to legally incorporated local governments, such as states, provinces, districts or municipalities" (Rondinelli, 1983:106). As such it is dependent upon the existence of sub-national levels of

government. In South Africa, the existence of provincial and local government bodies with responsibilities to provide and manage health services is an example of devolution. Delegation represents the shifting of responsibility to semi-autonomous 'agencies' which may vary from parastatals, functional development authorities or special project implementation units. The key distinction is that these agencies operate free of central government regulations concerning personnel, recruitment, contracting, budgeting, procurement and other matters, but as agents for the state in performing prescribed functions, the ultimate responsibility for them remains with the central government (Rondinelli, 1983:114).

Bossert (1987: 67) views privatization as a form of decentralization. However, Collins (1994:100) puts forward that it is confusing and inappropriate to suggest that privatization is a form of decentralization as it infers a transfer within a particular sector or organization and not between the public and the private sectors.

In the devolution method the contractual relationship between the private and public sectors is the focus of attention. In our context the proposed accredited provider system and the district surgeon system is an example of decentralization as resources from the private sector are employed. The use of the private sector to deliver long-term and specialized hospital care is another example (Collins, 1994:98-100).

The decentralization of the health system has already begun. It is occurring in many different ways, but it is not without problems (Pillay, 1995:13). Whilst deconcentration and devolution are used to strengthen the public sector, the South African government is also thinking of creative ways of using the resources in the private sector to generate a more coherent and useful public-private combination within the health system. However, a more coherent position towards the private sector is required. Such a position, whose development is beyond the scope of this chapter, must take into consideration factors such as:

- Optimal resource utilization;

- Equity;

- Ethical considerations; and

- The commodification of health.

Thus there is a need within a decentralized system to move away from a bipolar approach that sees power and authority merely shifting between two ends of a centre-periphery spectrum, to one that sees power and authority being appropriately shared in a non-polarised system consisting of different levels of government and administration that can ensure national coherence, efficiency and equity within the delivery of health care. In other words, a well-functioning decentralized health system must not be seen in terms of the centre versus the periphery, but in terms of a system that allows the centre and the periphery to work together in a way that allows the potential benefits of a decentralized system to be realized.

An important condition for making a decentralized system of governance and administration work effectively is the acknowledgement that there is no ideal or perfect system. Regardless of what kind of structure of decentralization and government is adopted, there will always be an overlap of functions and responsibilities between different parts of the system. The structure of the system can only hope to help define some of the boundaries and rules by which the different actors and groups within the system are expected to work together and collaborate to achieve the multiplicity of health aims and objectives (McCoy, Buch & Palmer, 2000:56).

3.4 RATIONALE FOR AND PRINCIPLES UNDERLYING DHS DEVELOPMENT IN SOUTH AFRICA

In terms of the development post-Alma Ata there was a clear recognition that unless one creates a coherent vehicle to manage the delivery of DHS the objectives set at Alma Ata would not be met. This recognition resulted in the development of the DHS concept that has been promoted by the World Health Organisation (WHO).

A DHS is defined as follows:

A DHS is a system of health care delivery; it comprises a well-defined population living within a clearly defined geographic area. It includes all the relevant health care activities in the area, whether governmental or non-governmental (Tarimo, 1991:4). The WHO (1996:40) views the DHS as a vehicle for the delivery of integrated health care. This is an important consideration given the Department of Health's policy decision, reflected in the White Paper on the Transformation of the Health System in South Africa, that service delivery must be both integrated and comprehensive. The White Paper also notes that the establishment of the DHS is a key health sector reform strategy that is also based on the Reconstruction and Development Programme (RDP).

This level of the health care system should be responsible for the overall management and control of its health budget, and the provision and/or purchase of a full range of comprehensive primary health care services within its area of jurisdiction. Effective referral networks and systems will be ensured through co-operation with the other health districts. All services will be rendered in collaboration with other governmental, non-governmental and private structures (RDP 1994:30).

The following aspects are roles of the DHS in South Africa and are emphasized as follows:

- Delivery of comprehensive and integrated services up to and including district hospital services;

- Decentralized management responsibility, authority and accountability;

- The planning and management of services delivered at district level;

- The need for effective referral mechanisms within and between districts and levels of care;

- The need to deliver care in the most efficient and effective manner possible;

- The option of purchasing services; and

- The importance of utilizing all district resources effectively, whether public, private or non-government organization (NGO).

3.5 PROGRESS IN DHS IMPLEMENTATION IN SOUTH AFRICA IMPLEMENTING DISTRICT HOSPITAL SERVICES POST-1994

3.5.1 Policy development process

As stated earlier, the rationale for adopting the DHS was included in the African National Congress (ANC) Health Plan and the RDP. What was needed as well, however, was a more extensive development policy and implementation strategy. This was drafted by a team of officials from the nine newly established provinces under the leadership of the national Department of Health. The policy document entitled 'A policy for the development of the district health system for South Africa' was released for public comment at the end of 1995 (RDP document, 1994).

A formal study of the process and some of its outputs was conducted in 1995 as part of a WHO multi-country study, and the results of this study form the basis of many changes that are taking place in the South African health system. This investigation identified the following weaknesses (Gilson et al, 1995):

- Regions may become an obstacle to district development;

- Implementation strategies may have overlooked some critical groups;

- Top-down implementation runs counter to the PHC approach;

- The linear strategy adopted is inflexible;

- There is little change in the management style of provincial and national managers; and

- A lack of management capacity and skills; and there is no monitoring and evaluation system.

3.6 PUBLIC-PRIVATE-PARTNERSHIPS AND COLLABORATION AS SOLUTION TO PUBLIC HEALTH SECTOR PROBLEMS

Public-Private Partnerships and Collaboration (PPPs and PPC) in the health sector are important and timely in light of the challenges the public sector is facing in health care finance, management, and provision. Many governments are confronted by fiscal constraints that force them to carefully prioritize and restrict public expenditures. Moreover, many public health systems are already indebted and face further fiscal pressures, such as the need to provide care to increasingly aging populations, improve quality, or invest in often expensive medical treatment and technology advances. For those governments that wish to explore this approach, turning to the private sector can, when appropriately structured and executed, help address specific cost and investment challenges, deliver improvements in efficiency (e.g. improved service provision and management at reduced costs), and enhance service quality (e.g. increased expertise, more rapid and substantial investments in infrastructure and new medical technologies, a potential to attract and retain better performing staff). However, leveraging partnerships and collaboration with the private sector to address the challenges governments face in health care today may not be easy. PPPs and PPC may take a long time to establish and bring to fruition, and in many cases may not be the most effective or efficient option available. Careful evaluation of the conditions for success and sustainability is required on a case-by-case basis so as to assess the costs and benefits and the likelihood of success of such an approach (Schneider, 2006:8-9).

3.7 DEFINITIONS AND KEY TYPES

PPPs and PPC in the health sector can take a variety of forms with differing degrees of public and private sector responsibility and risk. They are characterized by the sharing of common objectives, as well as risks and rewards, as might be defined in a contract or manifested through a different arrangement, so as to effectively deliver a service or facility to the public (1). The private sector partner may be responsible for all or some project operations, and financing can come from either the public or private sector partner or both. In practice, several key types of PPPs and PPC are frequently encountered in the health sector, as listed in the following figure and

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discussed in more detail below (2). Contracting-out involves publicly financed investments aiming to improve efficiency and/or quality by awarding a service contract, a management contract, a construction, maintenance, and equipment contract, or various hybrid contracts to serve a specific need or situation, or a lease to a private partner or partners. Service contracts are entered into by public and private partners for provision of a defined service (e.g. laboratory services, catering) aiming to leverage comparative technology, to improve efficiency and/or the quality of the service. Management contracts involve the transfer of authority from a public partner to a private partner to manage a public facility and provide services, including full responsibility and authority to manage all necessary functions and staff (e.g. employ and manage staff, procure medicines and equipment), with the objective of enabling more efficient management. Construction, maintenance, and equipment contracts are typically entered into for development, refurbishment, or maintenance of a health care facility. Hybrid contracts may involve a variety of elements of the contracts mentioned above to serve a specific need or a situation, such as an IT (World Bank, 2002:241).

3.8 POTENTIAL BENEFITS AND RISKS OF MANAGING PUBLIC PRIVATE PARTNERSHIPS (PPP and PPC)

Partnering with the private sector carries the potential for meaningful benefits to be gained for the public partner and the health sector. Potential benefits can include reduced government spending (e.g. eliminating large up-front investments of scarce public funds), greater efficiency (e.g. due to private partners' operational efficiency), or better health care management (e.g. of hospital services and infrastructure). In the health sector, partnering can also be particularly valuable as a method of leveraging technical or management expertise (e.g. performance-based monitoring and incentives), and spurring technology transfer, all of which can lead to quality improvements. Partnering can also reduce or better allocate risks (e.g. the private partner may be better able to manage cost and schedule overruns). Appropriate convergence of interests and expertise in a PPP or PPC in practice may also lead to a better managed project execution. Finally, in a PPP or PPC, the public partner can take steps to ensure that the above-mentioned benefits are obtained, the risk is

minimized, and that public funds are used in accordance with the partnership's stated objectives through introduction of payment and reward mechanisms that set incentives for better performance and improved outputs (Taylor, 2004:200).

There are also important risks to managing, and planning an effective PPP or PPC involves careful review of the allocation of financial risks and rewards, decision-making mechanisms and responsibilities, and the applicable regulatory and contractual framework. Accordingly, an accurate up-front evaluation of the likely trade-offs and benefits are key to appropriately designing and pro-actively managing a PPP or PPC. Such evaluation can uncover risks stemming from an inadequate regulatory framework or low institutional capacity, which may need to be addressed either through special provisions built into the contract or through separate reforms undertaken by the government (e.g. enhancing accreditation systems, updating patient rights policies, enabling transparency in health providers' performance). Other situation-specific risks may also need to be addressed, such as the frequently encountered risk of creating excess capacity or new capacity in the wrong place in the health system. Such risks can be mitigated through an effective planning and licensing system that allows for a needs-based distribution of services. In many situations, an adequate licensing system should not only selectively issue licences to operate health facilities based on a set of pre-defined criteria, but might also include the option of a special regulation of high-risk interventions, such as, for example, through a so-called certificate of need procedure (World Bank, 2002:241-250).

3.9 POST-APARTHEID RESTRUCTURING: 1994 – 1999

The first five years of democracy in SA (1994-1999) saw major health system restructuring. Significant changes include the amalgamation of 14 previously racially divided health departments into one national health system, the removal of user fees for PHC and the removal of registration at hospitals including at hospitals for pregnant women and for children under six years. The key policies for the health system in DHS were realized (www.hst.org/publication/southafrican-health-review).

A popular government, with an overwhelming mandate to address those marginalized by apartheid would, it seemed, be capable of introducing a model,

people-oriented health care system. This would be a system able to fulfil the aspirations of the founders of the democratic South African state. Almost immediately after the inauguration of Nelson Mandela as the country's president, primary health care became available at public sector clinics throughout South Africa and was declared 'free' at the point of delivery. Reinforcing such a far-reaching health policy was the complementary educational policy to provide each school-going child with a nutritious food ration during the school day. Such measures were emblematic of the new government's intentions, and signaled a dramatic shift from the old regime that would surely overcome any lack of managerial or leadership experience (Kautzky & Tollman, 2008:18). In addition, health services in rural areas were few and not easily accessible, whilst in the urban areas they were abundant and easily accessible. In view of the aforementioned, the new government adopted the mandate of "a better life for all" to rectify the previous inequalities. Amongst other imbalances or inequalities that affected the population were that the disabled had limited access to health institutions. Rural areas were mostly covered by mobile clinics, whilst fixed clinics are currently being established.

The provision of primary health care services is a major challenge in developing countries, where poor geographical accessibility adversely affects the use of medical services and consequently the health of the local population. With the aim of ensuring equal access to these services for the entire population, the South African government has transformed its health system along DHS principles. DHS services have been incorporated into a decentralized district health system. The fixed clinic is the basic health facility and principal point of contact, offering primary health care in rural districts (Tsoka & Le Sueur, 2004:329). In addition, the government has made some progress since 1994 in its attempt to deliver service by providing more services to more people, thereby ensuring equity in service delivery.

The South African health system faces the challenge of becoming part of the comprehensive programme aimed at redressing previous social and economic injustices. The South African government showed its commitment to implement the Reconstruction and Development Programme (RDP) and to develop a district health system based on the Primary Health Care Approach as declared at Alma-Ata in 1978

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(Mashia & Van Wyk, 2004:36). The above statement is supported by section 27 of the Constitution that:

(1)   Every person has the right to have access to -

      (a)   Health care services, including reproductive health care;

      (b)   Sufficient food and water; and

      (c)   Social security, including, if they are unable to support themselves and their dependents, appropriate social assistance.

(2)   The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.

(3)   No one may be refused emergency medical treatment.

The White Paper on Transforming Public Service Delivery (1997) sets out eight transforming priorities, amongst which Transforming Service Delivery is the key priority. The Batho Pele document points out that the public service has to put the "People First" Principles into practice without delay. It will also step up the implementation to arrive at acceptable service levels and quality as soon as possible. The Batho Pele Principles are described as follows:

1.   Effectiveness in delivering services which meet the basic needs of all South African citizens; and

2.   Formulation of health policies to allow free health care services especially for children and pregnant mothers.

3.10 CHALLENGES OF BURDEN OF DISEASES ON DISTRICT HOSPITALS: 1999–2004

In its second term of office the South African government faced dual challenges; a health system still dealing with the legacy of apartheid, and a range of new obstacles

precipitated by the growing burden of the HIV epidemic. There was an increase in the provincial and national mortality rates and a decline in the expectancy index, which includes women from 54.4 to 64.4 years. Total deaths increased from 381 820 to 579 709 in 2006 (www.mrc.ac.za/bod/cause_death_StatsSA). This period in the development of SA's health system also includes growing antagonism between the government and civil society due to the lack of interventions (South African Health Review Report: 2011).

3.11 THE CAUSES OF INADEQUATE PERFORMANCE IN DISTRICT HOSPITALS POST 2004

According to the WHO, the inadequate performance of state institutions has been a subject of many years. This report revealed consensus that the SA health system provides low value for money and that there is a large gap between good health policies and the implementation of the aforementioned strategies. Despite the access and equity gains in terms of health care delivery, district health care services have been poor compared with other countries, and the prospects of achieving Millennium Development Goals (MDG) for health appear to be far from being realized. According to the WHO, the main causes for this inefficiency have been described as both structural (Weak DHS) and regulatory, i.e. lack of accountability by those in leadership (WHO, 2011:12).

3.11.1 Increasing the relevance of the district health care service

The government, in its endeavour to address the imbalances as mentioned earlier, introduced the Patient Rights Charter (PRC) according to which, amongst others, all patients are entitled to be treated in any health services of their choice, have access to health care service and referral for a second opinion (Patient Rights Charter 2010:1). In addition, the Batho Pele ("People First") Principles, amongst others, also stipulate that access to decent public services is the rightful expectation of all citizens especially those who were previously disadvantaged. All citizens have equal access to the services to which they are entitled (White Paper on Transforming Public Service Delivery, 1997:9).

This Patient Rights Charter and the Batho Pele Principles are more beneficial to patients that can read. Those who are unable to read do not receive adequate information because there is a lack of awareness, and there are staff members who still have a negative attitude towards patients. The shortage of personnel poses a challenge when it comes to educating the patients about their rights and Batho Pele Principles. Personnel usually have a hands-on approach and there is no delegated person to constantly inform people. Materials, e.g. pamphlets, are neither enough nor available for patients to go and read at their own pace.

The World Health Organization (2008:2) states:

In calling for a return to Primary Health Care, the values, principles and approaches of Primary Health Care are more relevant now more than ever before. Several findings support this conclusion. According to the WHO report, inequalities in health outcomes and access to care are much greater today than they were in 1978. In far too many cases, people who are well-off and generally healthier have the best access to the best care while the poor are left to fend for themselves. Health care is often delivered according to a model that concentrates on diseases, high technology, and specialist care, with health viewed as a product of biomedical interventions and the power of prevention largely ignored. Specialists may perform tasks that are better managed by general practitioners, family doctors, or nurses. This contributes to inefficiency, restricts access, and deprives patients of opportunities for comprehensive care. When health is skewered towards specialist care, a broad menu of protective interventions tends to be lost.

3.12 CONCLUSION

It is one of the axioms of the WHO that existing effective and affordable interventions provided through good health provisioning can save the lives of many people in the Free State province. Inadequate health systems can, however, result in health inequities and poor health outcomes because the basic care cannot be provided, therefore effective interventions cannot be offered where they are most needed due to a lack of effective and efficient service delivery. This is not caused by a lack of money, skills or knowledge, but is brought about by health care managers who fail to

apply existing resources and personnel in those areas where needs and deficiencies are the highest. Failures in management also impede the implementation of global health initiatives and the achievement of global health goals such as the Millennium Development Goals (WHO, 2006: 2 - 5).

Although South Africa has committed itself to the implementation of the DHS, and while it has a good working system and DHS, and has implemented several strategies to improve the effectiveness of the health system; poor resource management and negative reports about general health care service delivery indicate that the Free State province is not on track towards achieving an effective and efficient health care service. The researcher's experience, together with information gathered from the literature review, is proof that health care managers are aware of the legislative and constitutional requirement of delivering efficient and effective health system.

CHAPTER 4: MANAGEMENT FUNCTIONS WITHIN THE CONTEXT OF DISTRICT HEALTH CARE SERVICES

4.1 INTRODUCTION

District health care management is the backbone of success of the government programme "a healthy life to all". This is a level of care that is very close to the PHC and support PHC services to ensure service delivery and that services are available and accessible to the public. Managers are the driving force of an organization, because they are responsible, inter alia, for managing the implementation of organizational strategies. According to Smith and Cronje (1997:5), managers are the people who make decisions about the qualities and quantities of products that must be produced. Louw and Oosthuizen (2001:7) describe a manager as a person who plans, organizes, directs, and controls the allocation of human, material, financial, and information resources in pursuit of the organization's goals. Cronje, Du Toit, Marais and Motlatla (2003:122) state that management does four things: it decides **what** has to be done; it decides **how** this should be done; it **orders** that it be done; and finally it **checks** that its orders have been carried out.

Together with other role-players in the organization, management has a role to set objectives and to determine the goals of the organization. It is important that this process be well coordinated and takes cognizance of available resources because management has to ensure that resources are efficiently utilized. According to Wetzel (2004:1) management is the coordination and the direction of the activities of oneself and others towards a specific objective.

This may lead to the division of labour or convergence of labour. In this rubric, the theoretical overview of management functions within the context of the district health care service will be discussed as well as policies governing district health care services and their implementation.

4.2   The nature of management

In order for any organization to achieve its goals and objectives successfully, there should be a management team that will drive the process. For the purpose of this study, the management team refers to the Chief Executive Officer, Chief Medical Officer, Head of Administration and Head of Nursing. Management's task is to combine, allocate, coordinate and deploy resources or inputs in such a way that organizational goals are achieved as productively as possible (Smith, et al. 2007:8). Management goes about this by following a specific process which can be simplified as a systematic way of doing things. All managers, regardless of their skills or the level at which they are involved, engage in certain interrelated activities to achieve their desired goals. This entails the four fundamental management functions discussed below.   All these functions of management should be viewed as a continuous cycle and they have to be coherent in order to yield the best results.

4.2.1 Organizational planning

FIGURE 4.1: TYPES OF ORGANIZATIONAL PLANS
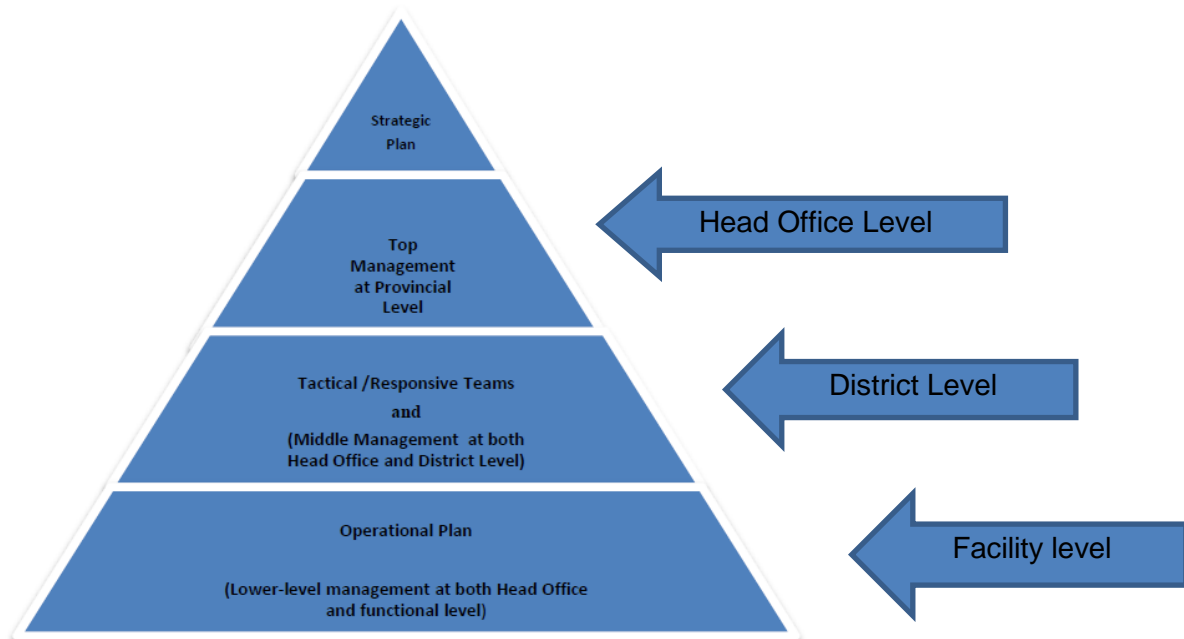
Source: Smith et al. (2007:118)

4.2.1.1 Strategic planning

Strategic planning is mostly done for a 5-year term. This stage is essential in order for the PHC component in the district to align its goals and objectives to the National PHC Directorate's goals and objectives. The Free State Department of Health's top management formulates the strategic plans and gives guidelines about the strategic policies, priorities, goals, and objectives. The strategic planning should be **kept straight and simple** (KISS) and the role-players (middle management and operational staff) who are going to help with the implementation of the plan should be involved right from the onset in order to have a sense of ownership or buy-in. Top-down management should be avoided. However, this is the practice of the day where there is a top-down type of management and when there is failure, the top structure blames the implementers and the implementers blame top management.

Nieman and Bennett (2006:89-91) state that strategic planning includes developing a vision, mission statement and long-term objectives. This is done by considering the norms, values and philosophy of management and the employees of the

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organization, its internal strength and weakness and the external opportunities and threats in the organization's business environment. Nieman and Bennett (2006:81) describe strategic planning as the process of (1) analyzing the organization's external and internal environments, (2) developing a mission and a vision, (3) formulating overall goals, (4) identifying general strategies to be pursued, and (5) allocating resources to achieve the organization's goals.

According to Goal and Rajneesh (2001: 72) a plan is a pre-determined course of action that is firmly based on the nature and extent of socio-economic problems from which priority resources are devised. Planning is one of the core functions of management. It is the planning process that helps managers to achieve the departmental goals and objectives. Planning is a future process that can be done for short, medium or long-term goals. At this stage, an attempt is made to try and address questions or problems before they arise. The following questions need to be addressed through the planning process, i) **what** activities should be performed? ii) **how** should they be performed? iii) **who** is responsible for the implementation of the activities? iv) **when** is the activity taking place? v) **when** is the activity going to be finalized/completed vi) **where** is the activity taking place? and vii) **why** must the activities take place? The success of planning depends on the availability of resources, amongst others, funds, human resources, equipment and/or material.

Planning in district hospitals is informed by the District Health Plan, through which all services, activities and the budget of the previous financial year as well as the first quarter of the current financial year are tabled in order to anticipate/project for the next financial year. This process is crucial in determining resource needs and preparing budgets and it is an important aspect of planning because resources like personnel and finance are often limited. As a result the CEOs and other managers in district hospitals should take into account the district priorities and also take note of the activities and strategies to achieve the target as stated in the DHP as it may be necessary to economize on scarce resources.

Different writers analyse this process in different ways; however, the one thing common to all views is how important this aspect of management is to an organization. Du Toit, Van der Waldt, Bayat and Cheminais (1998:175) define

planning as a process that focuses on the formulation of future objectives for the organization, and on the means and methods of reaching these identified objectives. This management instrument allows proactive public managers to timeously identify potential problems and opportunities within and outside the organization, and consequently to formulate and operationalize related actions.

Nieman and Bennett (2006:91) describe planning as the starting point of the management process. Planning as the primary management task is the formal process of selecting the organization's vision, mission and overall goals. These overall organizational goals are further related to divisional, departmental, and even individual goals. Goel and Rajneesh (2001:72) further indicate that "planning involves choosing from among alternatives the proper course of action and calls for decision-making which is an intellectual process". Planning is not guesswork, *but rather a logical approach as to what needs to be done in order to achieve specific objectives*. "It is conscious determination and projecting a course of action for the future and is based on objectives, facts and considered forecasts". (Goel and Rajneesh 2001:80). Planning then is just a rational approach to the future. Raturi and Evans (2005:293) define planning as the step needed to execute the project, *it also* determines who will perform certain tasks and identifies their start and completion dates. Planning entails activities such as constructing a work breakdown structure and a project schedule.

Even the best of plans may fall apart if the managers have failed to set clear objectives and realistic time frames. Planning helps to identify the needs and risks, it also helps in analysing the strengths, weaknesses, opportunities and threats (SWOT analysis). Planning is the most important aspect of management because it requires managers to anticipate all situations ahead of time. Managers ensure that the organizations they manage have specific, measurable, attainable, relevant timeframes (SMART), goals and objectives. In the process of planning, managers have to ensure that they put resources in place and ensure that all staff members play their roles by making them to be part of the team and that staff members share the same vision as managers. Thereafter it is possible to set realistic/achievable goals. Planning also helps, amongst others, with the success of the implementation process, the control process as well as the evaluation process. If activities are well

planned beforehand, the end results are positive. Good planning, when properly communicated to subordinates, improves working relationships. Through the planning process, crises are anticipated and delays are avoided because this is when actions to evade difficulty/problems are decided upon.

There are campaigns that the districts conduct every year which are either on the international or national health calendar. Some campaigns occur after discovering an outbreak of certain diseases, for example De-worming, Vitamin A, Measles, Polio and Hepatitis B campaigns. These campaigns need thorough planning beforehand so that the programmes run successfully from start to finish. Adequate personnel and vaccines need to be available to ensure the sustainability of a campaign. Transport and cold storage facilities should be made available or the campaign will not take off.

Before conducting such campaigns, district hospital managers need to do situational analyses which are informed by the WHO or national guidelines on immunization. This is important for health workers to determine whether the community understands the necessity of the campaign, so that community participation is achieved. Useful information on the community's perceptions and customs may also be obtained during situational analyses and this information may be used to plan for further health programmes customized for that particular community.

District managers also have to plan for the adverse events that may occur during the campaigns, for example, if a patient reacts negatively to certain medication or injections, these effects must be recorded and noted and corrective measures must be taken to ensure that such adverse events do not recur.

4.2.1.2   Functional planning

Middle management is responsible for the planning of activities of different functional areas. The communication of middle management with top and operational management should be effective for the success of planning. They should be well informed about the vision and mission of the organization in order to sustain it. Middle management will establish or develop performance or action plans for the operational or junior members. They will monitor the impact of performance and where attention is needed they will facilitate, together with their junior members,

corrective measures if some weaknesses are identified and organize workshop sessions to improve the service accordingly.

The National Department of Health sets targets for different PHC programmes. Each institution within the Motheo district submits the statistics to the district office on a monthly basis to compile the district health plan (DHP). The DHP is presented at the district management meeting and the management team scrutinizes the report to assess whether there are any discrepancies (i.e. the output is lower than the set target). The local area manager is then tasked to investigate the reasons for the discrepancies and to come up with corrective measures that will improve the situation. Nieman and Bennett (2006:89-91) point out that functional planning refers to medium-term planning carried out by middle management (in cooperation with top management) for the various functional departments to realize their objectives (which are derived from the long-term goals).

4.2.1.3   Operational planning

Operational planning is guided by the district health plan which bears reference to the departmental 5-year strategic plan. The first-line management is responsible for the operational planning. Through this process, implementation plans as well as the monthly reports are produced. Weaknesses identified are addressed and corrective measures implemented. Progress will be monitored and if not satisfactory, other means will be taken to correct them and these are evaluated quarterly. All the strategies and activities that are outlined in the DHP are put into operation. Operational plans have short-term objectives that should be met in less than one year (Nieman & Bennett 2006:89-91).

4.2.1.4   Health care concepts and principles important in health care planning in the district health services

According to Hattingh, et al. (2006:121) 'health' for planning purposes must be seen in its broader context, i.e. as a state of complete physical, mental and social well-being. Health viewed in this wider context is affected by a number of factors, all of which must be considered in planning, as they can have a negative or positive impact on the total health of communities and individuals in a particular situation. This

broader perception of health, which involves a wide section of society in the promotion of health, has required that in the planning process:

- Communities and/or key role-players should play a more proactive role in their own health and that of others and that provision be made for this in the health planning process;

- Greater attention be given to the perceived needs of the health care consumer and other health care providers;

- A more decentralized approach be used for health planning purposes;

- Provision be made for greater community involvement and participation in decision-making throughout the health planning process; and

- Provision be made for a 'health-by-the-people' approach in the changes made for the future.

The above statement emphasizes the fact that community involvement in the health planning process should not be underestimated as they play a crucial role. The Department of Health should therefore ensure that the community is included in all planning processes.

4.2.1.5 Implementing the plan

Implementation plays a crucial role in management as it puts the principles decided upon during the planning phase into practice. After having selected possible options the selected plan or plans have to be implemented (Hattingh et al. 2006:121). The main focus during implementation then becomes performance and achievement. For implementation purposes decisions about standards of performance, responsible persons and time schedules have to be made. These decisions are often represented in a particular programme linked to the plan. This programme could specify time schedules, expected standards of performance and areas of responsibility.

For implementation to succeed, it is essential that all activities agreed upon during the planning phase are carried out as planned and that time schedules are adhered to.

The budget and programmes constitute and create measures and standards of control against which the progress of a plan can be evaluated. Such evaluation is of importance to ensure that the desired results are obtained. Cronje, et al. (2003:156) elaborate that the first two phases of the planning process deal with formulating objectives and devising plans - management must decide who is to be responsible for the activities to be carried out, and what means or resources are to be used in doing so. The implementation of the chosen plan therefore involves the development of a framework for its execution, leadership to set the plan in motion, and the exercising of control to determine whether the performance of the activities is going according to plan. In short, the third phase of planning, that is the implementation of the plan, forms part of the other three elements of the management process.

4.2.1.6   Organizing

Organizing is the management process that helps managers to organize the functions which the organization must carry out, identify the number of personnel (human resources) who will complete the tasks as well as the type of skills needed to carry out that task. This is vital in order to enhance productivity. A manager has to know the capabilities of his/her staff to know what output can be expected from them. Staff development decisions are essential during organizing as some personnel may require in-service training to ensure that they carry out their tasks accordingly. In order for a health team or manager to reach the set targets (the national, provincial, district as well as the sub-district targets as tabled in the DHP), awareness campaigns should be structured in order to reach out to the community. District health managers need to ensure that resources, such as equipment, stationery, means of communication as well as the health promotional material, are available in district hospitals.

Green and Bowie (2005:14) believe that most health care facilities utilize a top-down format so that authority and responsibility flow downwards through a chain of command. Kroon (1991:231) states that organizing can be defined as the management function that deals with the assignment of duties, responsibilities and authority to people and departments. Therefore duty rosters and standard operating procedures are essential. Marx and Gouws (1983:62) in Kroon (1991:231) further state that "it includes the determination of the relationships between the above in order to promote co-operation, and the systematic performance of the work and the achievements of objectives in the most efficient way". The continuity of organizing must be emphasized. Organizing is not only done at the initial establishment of the enterprise, but it should be a continuous process. Raturi and Evans (2005:293) define organization as "the stage that focuses on orchestrating the resources so as to execute the plan cost-effectively". This means, for instance, during a massive campaign all renewable resources need constant monitoring of stock levels, the use of stock and how it is disposed of. The PHC manager also has to check that all resources are procured within the budgetary limits. Raturi and Evans (2005:293) further state that organizing involves activities such as forming a team, allocating resources, calculating costs, assessing risk, preparing project documentation, and ensuring good communication.

If organizing is performed successfully, it is easy to avoid the shortfalls, duplication of tasks, discrepancies, threats and opportunities, to measure performance and time frames, know exactly how many people are needed for each job and how much budget is needed. Organizing, like planning, is an integral and indispensable component of the management process (Cronje et al. 2003:159). Without it, the successful implementation of plans and strategies is out of the question because of the absence of a systematic allocation of resources and people to execute the plans. Leadership and control are not possible if the activities of management and subordinates are not organized, or if the business does not clearly designate the individuals responsible for specific tasks. Successful organizing, then, makes it possible for a business to achieve its goals. It coordinates the activities of managers and subordinates to avoid the unnecessary duplication of tasks, and it obviates

possible conflicts. It also reduces the chances of doubts and misunderstandings, enabling the organization to reach its goals efficiently.

4.2.1.7   Internal organization

The district health manager's responsibility is to organize tasks/activities towards the achievement of district goals and objectives, for example, to centralize or decentralize tasks.

Once strategic planning has taken place within a government institution, it is important for DHS to organize itself in the district implementation team or strategic teams. Internal organization is important because of the diversity of activities for which an executive institution or a section thereof, is responsible. For example, if the objective is to manage the finances of the district, the team will ensure that the activities are done according to the plan and feedback is given to the broader team in terms of the progress. According to Cloete (133-139) in Du Toit, et al. (1998:50) internal organization involves the following:

- A horizontal division of work;

- The assignment and delegation of authority;

- Coordination;

- Setting lines of communication; and

- Control mechanisms.

Horizontal division of work

This aspect of management is done to achieve a team approach towards achieving a common set of objectives. Managers must assign a balanced proportion of each staff category to the work that must be done. This will ensure the effectiveness of the district health teams.

Assignment and delegation of authority

Delegation of authority is the process by which managers assign the right to subordinates to make decisions and act in certain situations (Hellriegel 2001:214).

Unless the manager can delegate properly and well, he/she will end up attempting to do all the work himself/herself. Assignment and delegation of authority is done to prevent unnecessary delays and to also empower subordinates. As illustrated in 3.2.1 figure 2, district hospitals are accountable for performance to the district health services of the Mangaung Metro; however, certain decision-making authority is delegated to the district manager who, in turn, delegates to health facility managers. The process of delegation is cascaded down to the level of the unit matrons or supervisor. If a manager is not on duty there should be somebody who is appointed in writing to act on his/her behalf. The assignment of authority to officials is, according to Cloete (1996:136), a sensible arrangement to promote the flow of work, and it is sometimes referred to as the vertical division of work.

Thus, in addition to assigning a task to a subordinate, the manager also gives the subordinate adequate decision-making power to carry out the task effectively. Delegation starts when the structure of the organization is being established and tasks are divided. It continues as new tasks are added during the day-to-day operation. Delegation does not relieve a manager of responsibility and accountability. A manager remains responsible and accountable for the use of his or her authority, for personal performance as well as the performance of subordinates. The delegation of authority by managers to employees is necessary for the efficient functioning of any organization, because no manager can personally accomplish or completely supervise all of what happens at an organization. When managers have difficulty in delegating, they try to do everything themselves and this then limits the manager's and the employee's development.

Coordination

Achieving coordination is one of the most important and difficult tasks of the manager and also forms an integral part of organizing. Activities listed during the planning phase must now be made into a schedule/timetable with succinct time frames and

responsible personnel for the completion of each activity. Coordination prevents unnecessary delays and saves time and costs. For example, certain divisions like Supply Chain Management (SCM) and Human Resource Management (HRM) can be strategically located in one area to improve coordination, thus avoiding delays in the submission of documents and processing of payments and orders. Health institutions within the same area coordinate transport to different activities or meetings they normally attend outside their area, for example, district hospitals in Thaba Nchu and Botshabelo, which are ±10 km apart, often coordinate transport to workshops and staff meetings in Bloemfontein.

Wetzel (2004: 35) states that coordination is what managers do in order to bring all the elements of the organization together and make sure they are pulling in the same direction. An organization, which is badly coordinated, features individuals and groups working without reference to each other, is often wasting effort, sometimes working at cross-purposes. In a well-coordinated organization, everyone is aware of what everyone else is doing and is working in harmony towards the same goal. It goes without saying that good communication is vital to coordination.

Lines of communication

Managers should ensure that any changes, all legislation, policies, procedures, circulars and other related matters are communicated effectively to their subordinates for effective service delivery and to avoid misconduct due to lack of knowledge. If there is a communication breakdown in the institution or department, there is always dissatisfaction amongst workers and productivity fails.

The new services and changes should also be communicated to different stakeholders and the community to avoid a negative response. Managers should also ensure that telephone systems and the electronic mail systems are working properly for effective communication with their subordinates, superiors as well as the outside world and for the effective receiving, processing and sending of internal and external messages.

They should also schedule meetings with their subordinates on a regular basis in order to update them on new developments and report on progress relating to the annual performance plans, achievements and failures. According to Kroon (1991:410) the aim of communication can be to control behaviour, explain duties, or to establish or reinforce authority relations. It can also be to provide information used for making decisions, motivate workers, and reflect emotions and feelings about actions and decisions within and outside the organization.

Cloete (1998:179) further indicates that if the officials are to cooperate with each other and coordinate their efforts, they have to be in continuous communication with one another. The task of setting lines of communication is, therefore, part of the organizational function needing specific provision. All supervisors should therefore continually be reminded that they do not work in isolation and that they should remain in contact with their peers employed in adjoining fields, perhaps even outside their own institution.

According to Smith and Cronje (2002:192) and Smith, et al. (2007:188) this ensures that communication is effective and that all information required by managers and employees at all levels of the organization effectively reaches them through the correct channels so that they can perform their jobs effectively.

4.2.1.8 Leading

The quality of leadership is what often determines the success of an organization. There should be someone with capacity to lead the processes/projects or tasks, the one who will be in a position to guide the tasks and be able to come up with suggestions or solutions. Where weaknesses are identified the person should be in a position to apply intervention measures, have a sound relationship with others and always endorse teamwork amongst the workers. According to Reynders (1987:47) in Kroon (1991:387) the fundamental characteristics of leadership are to bring people to work together effectively as a team, to inspire their loyalty towards the group and generally bringing them to make a meaningful contribution to the achievement of objectives.

District managers should ensure that every clinic has a supervisor who will give guidance to subordinates, coordinate the activities, and give feedback about the services and challenges facing the hospitals. He/she has to ensure that all the required reports are submitted to district health offices in time and that the information is available in the required format. Ideally, this supervisor should have excellent interpersonal skills and should maintain close contact with all team members to ensure effective and efficient management.

Goel and Rajneesh (2001:256) define leadership as the process to direct and coordinate the activities of members of an organization towards the achievement of goals, honestly and efficiently. A leader is a person who plans, organizes, makes decisions and influences people. Leaders have a positive attitude towards people and towards their work. They are always hopeful and expect their efforts to lead to success. The above statement is supported by Hattingh et al. (2006:128) that during this phase of management, the manager or leader produces an environment that is conducive to implementing tasks and getting the work done. The amount and quality of work accomplished directly reflects the motivation of the staff. Therefore, the manager or leader should create an environment that maximizes the development of human potential. To motivate staff, the following aspects could be applied to enhance the work climate:

- Recognizing every individual's unique contribution;

- Identifying the value system of the group;

- Applying emphatic community skills such as active listening, trust, concern and respect for identifying problem areas;

- Encouraging self-growth and self-actualization;

- Maintaining a positive and enthusiastic image as a role model;

- Encouraging mentoring, sponsorship and coaching of individuals;

- Creating a supportive atmosphere;

- Providing feedback;

- Providing systems of promotion;

- Identifying and rewarding achievements;

- Managing conflict; and

- Limiting harmful stressors.

4.2.1.9   Controlling

Control is pivotal to good management. Controlling is the process by which all work entrusted to subordinates is made to produce the results originally planned for. The supervisor/manager should ensure that the subordinates understand and accept the objectives of the organization before the work begins. The results of the organization are achieved through the control exercised by managers and supervisors. If each one effectively controls the activities for which he/she is responsible, the organization will function according to plan. Control allows for ease of delegation of tasks to team members.

There are different types of control measures that are implemented in district hospitals in order to ensure that the set goals and objectives are achieved, the legislation, policies and procedures are implemented and to ensure that planned activities are executed accordingly. These measures include monthly reports which reflect the challenges, achievements, concerns and support needed by the district health services report which reflect, amongst others, the casualty head count, and doctors to patient ratio and general workload of the hospital.

Raturi and Evans (2005:293) mention that control assesses how well a project is meeting its goals and objectives and makes adjustments as necessary. Controlling involves collecting and assessing status reports, managing changes to baselines, and responding to circumstances that can negatively affect a project.

Cronje, et al. (2003:262) point out that an organization needs a control process because the best of plans may go wrong. A control process is necessary in an organization for the following reasons:

- The nature of the management process itself and, in particular, the task of planning;

- The constantly increasing size of organizations;

- Managers and subordinates are capable of making poor decisions and committing errors;

- The delegation of tasks to a subordinate does not mean that the job of management has been completed;

- Control enables management to cope with change and uncertainty;

- Competition is a significant factor;

- Control is applied to ensure that the organization's resources are deployed in such a way that it reaches its goals; and

- Control usually results in better quality.

Control mechanisms

In order to meet the objectives of the department, managers/supervisors should always monitor the work of their subordinates to establish whether the task assigned to the subordinates will be completed in time and if procedures and policies are followed. According to Muller (1996:30) in Du Toit et al. (1998:52) it seems that the role of public managers in the control of resources, especially natural resources, will be that of reviewing, monitoring and auditing. This role is of crucial importance as far as the exploitation and utilization of resources are concerned.

Cloete (1998:180) further outlines the tasks of the supervisor as having to explain the objectives of the particular organizational unit (department, branch, division, subdivision, section) to subordinates, to fix standards of work (in terms of quality and

quantity) to ensure that everything done by subordinates is aimed at achieving the objectives of the institution (either by way of example or by providing appropriate training) and to require the subordinates to give account of the work they do. Control therefore focuses on work progress, staff performance and service achievement. In district hospitals this is achieved through the process of performance appraisals, the performance development management system (PDMS) where the supervisor assesses the individual performance of subordinates. That official whose performance exceeds the expected standards receives a cash bonus.

4.2.1.10   The control process

- **Setting standards of work performance:** Some job advertisements state that a performance agreement will be signed, but some do not specify this. It is the duty of each manager to ensure that his/her subordinates sign the work performance agreement based on the job description and also inform them of the vision and mission of the department before signing the agreement. This helps each individual to be responsible and accountable for all the tasks attached to his/her post and also to be eager to meet the goals and objectives of the organization. This also helps the supervisor to assess the subordinates accordingly.

  According to Smith and Cronje (2002:394) and Smith, et al. (2007:389), in order to make the control process possible and meaningful, performance standards should be realistic, attainable, and measurable, so that there is no doubt about whether the actual performance meets the standard or not. Suitable performance standards can therefore be developed, and they include, among others, staff development standards, which indicate personnel training programmes that the organization should provide.

- **Measuring actual performance:** An analysis of strengths, weaknesses, opportunities and threats (SWOT) are based on the tasks to be performed and can be undertaken and a performance plan of action can be discussed indicating the key performance areas, the standards, indicators, time frames and evaluation process. The district health services use different tools for different functional areas, to check the efficient and effectiveness of the district services. Cloete (1998:190) mentions that measuring actual performance involves acquiring

information and data about the actual performance, in terms of quality and quantity, by making use of a wide array of methods.

Performance measurement should comply with the following requirements in order to be effective:

- Measurement must be *reliable*;

- Measurement must be *valid*;

- Measurements must be *linked to the organization's objectives; and*

- Measurements must *concentrate* on critical points.

Smith and Cronje (2002:394) and Smith, et al. (2007:390) mention that as with performance standards, the variables should be quantified to make meaningful comparison possible. A further important requirement for observing performance is that reporting should be absolutely reliable. Unless the data is accurate, control will not be effective. Moreover, observation and measurement should be in accordance with the control system, that is, they should occur at the strategic points and according to the standards determined by the control system.

- **Comparing performance with required standards:** The skills, experience and knowledge of the individuals should be acknowledged. Each district hospital has its own indicator/target which helps to compare the actual performance with the required performance. Smith and Cronje (2002:395) and Smith, et al. (2007:391) share a similar view that it is important to know why a standard is merely equaled, and not exceeded.

Smith and Cronje (2002:395) and Smith, et al. (2007:391) further state that it is necessary to make sure that the discrepancies are genuine, that is, the performance standard and the actual performance should be realistically set and observed. Management must decide whether the differences are significant enough to merit further attention. Upper and lower limits should be set for each deviation, and only those differences that fall outside the limits should be

investigated. All the variables that could possibly be responsible for the deviation should be identified.

Take corrective actions to rectify the matter: It is the duty of the PHC supervisor to empower his/her subordinates if they are underperforming; the supervisor should take corrective measures to develop him/her. For instance, in the antenatal care the main aim is to assess the level of health by taking a detailed history and offer appropriate intervention like doing a HIV test, diabetes test and hypertension test related to pregnancy (2008:237).

Fraser 2000:10 said the aim of the antenatal care is to monitor the progress of pregnancy in order to have a normal maternal and fetal life.

This process will provide an opportunity for the woman and her family to express and discuss any concerns they might have about their current pregnancy, previous loss and birth process (De Kock: 2004:0). If performance dropped, corrective steps will be taken based on the outcome of the investigations. The officials might, for example, need retraining, mentoring or coaching. If it is due to a shortage of resources, attention will also be paid in that regard in order to give appropriate antenatal care.

The cause of the discrepancy from standards should be corrected and the corrective action should be discussed with the subordinates who are affected. A time should be set aside in advance for supplying help and information whenever needed. According to Du Toit, et al. (1998:190) corrective actions to rectify the matter should be taken if it appears that the current course of action deviates from the desired course in reaching the objectives of the organization. This may involve correcting or improving performance reviewing and possibly adjusting standards of performance or both.

The views discussed in Smith and Cronje (2002:395) concur with those of Smith, et al. (2007:391) where they believe that corrective action is action aimed at achieving or bettering the performance standard and ensuring that differences do not recur in the future. If actual performances match the performance standard, no corrective action is necessary, provided that the standards have been set

realistically. If actual performance does not match the performance standard, management has three options:

1. Actual performance can be improved to attain the standard;

2. The strategy can be revised to attain the performance standards set; and

3. The performance standards can be lowered or raised to make them more realistic in the light of prevailing circumstances.

Cronje, et al. (2003:266) point out that the implication is that control should focus on the effective management of the resources as outlined below:

- Physical resources. This involves factors such as inventory control, quality control and control of equipment;

- Human resources. This involves orderly selection and placement, control over training and personnel development, performance appraisal and remuneration levels;

- Information sources. This relates to accurate market forecasting, adequate environmental scanning, and economic forecasting; and

- Financial resources. Financial resources are situated at the centre of the other three resources not only because they are controlled in their own right (for example, cash-flow or debtor control), but also because most control measures or techniques (such as budgets, sales, production costs, market share, and various other magnitudes) are quantified in financial terms.

4.2.1.11   Other forms of control

- **Internal control:** According to Du Toit, et al. (1998:191) internal control refers to those control processes and measures within the organization, such as internal audits, inspections, work performance appraisals, institutional procedures and regulations. Internal control measures are implemented in order to avoid over/under spending or corruption as well as to keep all role-players accountable and responsible in their field of work. For example, the internal control checklist

on which the CEO should check whether items that are procured have been budgeted for on the acquisition plan so as to prevent over-expenditure.

- **External control:** External control refers to control measures and processes emanating from outside the organization, such as the watchdog role of the media, investigations by the Auditor-General, the Public Protector, standing committees of Parliament, enquiries by interest groups and political parties, petition by the community, etc. (Du Toit, et al. 1998:191). The external control measures should be implemented in order to avoid negative publicity. All functions should be executed according to the policies and procedures of the department, different stakeholders should be involved in the decision-making of health-related issues affecting health services in their area. An example is the stringency measures that the Department of Health implements immediately when the department is projecting over-expenditure.

4.3 ASSESSMENT

This is an important function of management because it measures the value of a particular programme. Because management is concerned with improving achievement and performance, evaluation is a tool which allows managers to measure the quality of the work which has been done. Evaluation looks at effectiveness, efficiency in the use of resources and performance activities. This process often involves the following steps:

- Measurement of observed achievement;

- Comparison with previously stated norms, standards or intended results;

- Judgment of the extent to which certain areas or values are satisfied; and

- Decision on what to do next.

4.4 CONCLUSION

Management has a crucial role to play in the running of district hospitals. In order for district health services to be effective and to reach the disadvantaged communities, management has to be enforced through sound management functions. The realization of effective and efficient service delivery management functions, as discussed above, is subject to constant practice. The role of management functions of district hospitals cannot be overemphasized as it forms a coherent framework within which excellent service delivery can be established.

CHAPTER 5: SOUTH AFRICAN HEALTH CARE REFORM WITHIN THE CONTEXT OF DISTRICT HEALTH CARE FUNCTIONS AND SERVICES

5.1 INTRODUCTION

Over the last few years the South African National Department of Health (NDOH) has initiated a number of reform initiatives to improve the governance of the health system and service delivery. One of the considerations, in terms of implementation, is that the various reform initiatives need efficient coordination and sequencing for maximum contribution to the government's vision of 'A Long and Healthy Life for All South Africans' (as expressed in the Negotiated Service Delivery Agreement for Outcome 2010: 2). This chapter will provide an overview of the broad spectrum of reform and organizational development initiatives currently under way within the South African public health sector at national, provincial and district level. These reforms or changes will affect service delivery at provincial and local level, and ultimately, the attainment of the four health sector strategic priorities identified in the Negotiated Service Delivery Agreement (NSDA) 2010: 4. This will be followed by an analysis of the strategic linkages between the reforms in the primary health care, district health care service and district hospitals as the second level of care in the district health care services. Another reform that will be assessed is the introduction of the National Health Insurance and its relevance to the South African health care system. An assessment of the relevance to the intended health service outcomes and health impacts as outlined in The Ten Point Plan and Outcome 2 of the Negotiated Service Delivery Agreement (NSDA): 'A Long and Healthy Life for All South Africans'. The chapter highlights the potential areas of risk or the possible gaps, including those related to the sequencing of different interventions, and makes recommendations for creating greater synergy between the various reforms in the health care system (NSDA, 2010:24).

5.2 HEALTH CARE CHALLENGES EMANATING FROM THE APARTHEID ERA

Before 1994, there were clinics specializing in the provision of one programme, e.g. TB, Antenatal Care Service (ANC), Mental Health Services or Sexually Transmitted Infections (STI), etc. The programmes were also running vertically. Resources (both human and funding) were not allocated equitably to different population groups. Patients, especially from the disadvantaged groups, had to be satisfied with whatever service they received, because there were no service standards or patients' rights. Kautzky and Tollman (2008: 21) point out that, perhaps not widely realized at the time, health care worldwide was in turmoil, as most national health systems were highly fragmented and focused on the provision of costly, curative care for elite segments of the population without ensuring adequate preventive and basic health services for the majority. However, in recognition of a growing health crisis, an International Conference on Primary Health Care was organized by the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) at Alma-Ata in the former Union of Soviet Socialist Republics (USSR) in 1978. Attended by 134 nations and many governmental and non-governmental organizations (NGOs), the conference introduced and endorsed the philosophy and practice of primary health care (PHC) as the means to achieving universally available health care and of attaining 'Health for all' (http://www.who.int/whosis/whostat/EN_WHS124).

5.3 IMPACT OF THE PRE - 1994 CHALLENGES ON DISTRICT HEALTH SERVICES

The challenges that were inherited from the previous government, such as accessibility to the Mangaung Metropolitan health services, led to the separation and handing over of the Mantsopa municipality and the Naledi municipality to Xhariep and Thabo Mofutsanyane respectively, which led to the closure of the following clinics in Bloemfontein: Heidedal, Aandrus, Mangaung Community Development Corporation (MCDC), Monument, Hilton and Hostel number 1. All the above clinics, previously under the Mangaung municipality, did not adhere to the National Department of Health norms as stipulated in the PHC package that "access, as measured by the proportion of people living within a five kilometre radius of a clinic, is improved",

which also indicated the effectiveness of district health services. The same clinics were within 5km (the national norm) of the nearest clinics that offered the full PHC package. The closing down of these clinics resulted in a positive outcome for the Department of Health, because the resources (amongst others, personnel and equipment) were transferred to the nearest clinics that offered the full package and were thus optimally utilized. Although the department followed all essential procedures (i.e. amongst others, consultation with different stakeholders) before closing down the clinics, their (clinics) closure was perceived by part of the community as unnecessary due to the difficulty of changing attitudes and mindsets with regard to relocating to different health facilities. This situation also resulted in community members protesting against the Department of Health, which brought bad publicity for the Motheo district as well.

5.4 CONTEMPORARY ISSUES RELATING TO PRIMARY HEALTH CARE (PHC) POST-1994

According to Kautzky and Tollman (2008:23), immediately following the election of the Government of National Unity in 1994, a range of pro-equity policies and programmes were initiated throughout the public sector, many of which were elements of the Reconstruction and Development Programme (RDP). In addition to a dynamic building programme for PHC facilities, the RDP also introduced free maternal and child health care, which was later extended to include free PHC for everyone using the public health sector; infrastructural development targeting increased access to water and electrification; the comprehensive extension of social welfare grants to previously disadvantaged populations; and a national school nutrition programme. The above statement is relevant to the Motheo district, because after 1994 the government built more facilities in the rural areas to enhance availability and accessibility. In areas without clinics, for example on farms, PHC services are rendered through mobile clinics. As a result, many people are visiting the clinics, including those who can afford medical aid.

5.5 INCREASING RELEVANCE OF DISTRICT HEALTH SERVICES

The government in its endeavour to address the imbalances as mentioned earlier, introduced the Patient Rights Charter (PRC) according to which, amongst others, all patients are entitled to be treated in any health service of their choice, have access to health care service and referral for a second opinion (Patient Rights Charter, 2010:1). In addition, the Batho Pele ("People First") Principles, amongst others, also stipulate that access to decent public services is the rightful expectation of all citizens, especially those previously disadvantaged. All citizens have equal access to the services to which they are entitled (White Paper on Transforming Public Service Delivery 1997:9).The Patient Rights Charter and Batho Pele Principles are more beneficial to those patients that can read. Those who are unable to read do not receive adequate information because there is a lack of awareness, and there are staff members who still have a negative attitude towards patients. The shortage of personnel poses a challenge when it comes to educating the patients about their rights and Batho Pele Principles. Personnel usually have a hands-on approach and there is no delegated person to constantly inform people. Materials, e.g. pamphlets, are neither enough nor available for patients to go and read at their own pace.

The World Health Organization (2008:2) states that:

> In calling for a return to Primary Health Care, the values, principles and approaches of Primary Health Care are more relevant now than ever before. Several findings support this conclusion. According to the WHO report, inequalities in health outcomes and access to care are much greater today than they were in 1978. In far too many cases, people who are well-off and generally healthier have the best access to the best care while the poor are left to fend for themselves. Health care is often delivered according to a model that concentrates on diseases, high technology, and specialist care, with health viewed as a product of biomedical interventions and the power of prevention largely ignored. Specialists may perform tasks that are better managed by general practitioners, family doctors, or nurses. This contributes to inefficiency, restricts access, and deprives patients of opportunities for

comprehensive care. When health is skewered towards specialist care, a broad menu of protective interventions tends to be lost.

5.6 LEGISLATIVE AND POLICY FRAMEWORK SUPPORTING DISTRICT HEALTH SERVICES

In order to reach its goals and objectives, PHC is rendered through various legislative/policy frameworks ranging from national to provincial government. The relevant Acts and policy documents are discussed below: National Health Act, 2003 (Act 61 of 2003) section 2 of the National Health Act, 2003 stipulates that the objects of this Act are to regulate national health and to provide uniformity in respect of health services across the nation by:

(a) Establishing a national health system which -

   (i) encompasses public and private providers of health services; and

   (ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford.

(b) Setting out the rights and duties of health care providers, health workers, health establishments and users; and

(c)   Protecting, respecting, promoting and fulfilling the rights of:

  (i) the people of South Africa to the progressive realization of the constitutional right of access to health care services, including reproductive health care;

  (ii) the people of South Africa to an environment that is not harmful to their health or well-being;

  (iii) children to basic nutrition and basic health care services contemplated in section 28(d) of the Constitution;

  (iv) vulnerable groups such as women, children, older persons and persons with disabilities.

Free State Provincial Health Act, 2009 (Act 3 of 2009)

The National Health Act, 2003 gives a mandate to the provinces to implement health services, including district health and PHC services. The aim of the Free State Provincial Health Act, 2009 is to provide for the establishment of a health system that is compatible with the structured uniform national standards; to establish health governance structures; to bring the provincial health legislation in line with Chapter 2 of the National Health Act, 2003 and to replace Chapter 4 of the National Health Act, 2003 in as far as it deals with health issues that are dealt with in this Act.

Occupational Health and Safety Act, 1993 (Act 85 of 1993)

The objective of the Occupational Health and Safety Act, 1993 is to create a healthy and safe environment for both personnel and clients in primary health care settings. For example:

- To ensure that infection control measures are in place, e.g. the wearing of protective clothing;

- To prevent communicable diseases by giving immunization to personnel, e.g. Hepatitis B; and

- Routine screening of all personnel by the Occupational Health Nurse. The community that uses the PHC facilities suffers from different types of illnesses, some of which are infectious. Section 1 of the Occupational Health Act, 1993, provides guidelines on how patients suffering from different types of illnesses should be handled.

5.7   BATHO PELE PRINCIPLES

The Batho Pele (People First) Principles document was passed by the Minister of Public Services and Administration to improve public service delivery. The principles contained in the document guide and lead not only the public health sector, but also apply equally to all state employees. Specific guidelines have to be adhered to by health care practitioners in order to prioritize patients' needs.

A comprehensive Primary Health Care Service Package for South Africa 2001: The National Department of Health developed an implementation plan to be utilized by all primary health care institutions in the country. The package establishes the national norms and standards as a move towards greater equity in PHC service provision. It indicates the scope of the tasks that should be performed in the PHC services and the skills needed to perform those tasks. The type of services, equipment and infrastructure are also indicated in order to render the requisite services according to the different levels of services offered to the community, e.g. mobile, clinic or community health centres.

The above health-related policies serve as a guide to health care workers and they should be interpreted positively. They also assist the workers in executing their daily tasks effectively and efficiently. Each and every health worker should have a copy of the documents for consultation purposes. This means that all facilities ought to comply with these Acts.

5.8 PROGRESS IN THE REFORM OF THE SOUTH AFRICAN HEALTH SYSTEM

The South African government has made tremendous gains over the last 17 years in establishing excellent public health legislation and policies and an intended unified national health system that will provide universal coverage to all (Negotiated Service Agreement, 2010:10). For example, increasing infrastructure at district health care level, removing user fees for maternal and child health services, introducing a system of social support grants, ensuring the steady increase of immunization coverage, and supporting the world's largest HIV/AIDS treatment programme. However, despite this, a review of the country's progress towards the Millennium Development Goals (MDGs) showed that while the country had made some progress towards several inter-sectoral goals, its progress has been insufficient in other areas, such as HIV/AIDS, Millennium Development Goal 4 (child survival) and non-communicable diseases like sugar diabetes and high blood pressure (Kibel, 2010:24).

5.9 GOVERNMENT-LED INTERVENTIONS TO ADDRESS THE HEALTH CRISIS

In light of the growing concern about the country's health outcomes, the government has initiated a number of intended interventions to address the challenges of health care service. To assist the country to meet the MDGs and monitor improvements in the health system, the Presidency and the Department of Health addressed the need for some form of decisive action to strengthen the country's health system and take forward the country's health-related policy vision. This has resulted in a series of government-led interventions, spearheaded by senior members of the African National Congress (ANC) and state officials (Development Bank of Southern Africa, 2010:13).

The first was the health sector road map, a diagnostic process of the key challenges facing the health sector commissioned by the ANC's National Executive Committee (NEC) sub-committee on Education and Health in 2008 and coordinated by the Development Bank of Southern Africa (DBSA, 2010: 22).

The 'road map' document, along with its accompanying consultations and background papers, resulted in an important output which is called a ten-point plan intended "to guide government health policy and identify opportunities for coordinated public and private health sector efforts, in order to improve access to affordable, quality health care in South Africa" (Rispel, 2010:20).

Intended to assist the country to meet the MDGs and monitor improvements in the health system, the proposed ten-point plan (see table below), paved the way for the development of the National Department of Health Strategic Plan 2010/11–2012/13, in which many of the DBSA road map's recommendations were *incorporated into its priorities.*

5.10 TEN POINT PLAN

1. Provision of strategic leadership and creation of a social compact for improved health outcomes

2. Implementation of the National Health Insurance

3. Health service quality improvement.

4. Strengthen health care system management.

5. Improve human resource development, planning and management.

6. Infrastructural revitalisation.

7. Accelerated implementation of HIV, STI & TB-related strategic plans.

8. Intensify health promotion programmes and mass mobilization.

9. Review of drug policy.

10. Strengthen research and development (National Department of Health Strategic Plan, 2010/11).

5.11 RE–ENGINEERING PRIMARY HEALTH CARE SERVICES

This initiative was conceptualized as a result of a visit by the health minister and provincial health leaders to Brazil in May 2010, and the renewed global interest in primary health care given the promising evidence that emerged from Thailand and Brazil in terms of its application (Macinko, 2007:28).

In order to strengthen the district health system (DHS), the South African government, through the implementation of Chapter 5 of the National Health Act, together with the District Health Management Team (DHMT), has been given the responsibility for DHS management and the consequent accountability for the health of its population. The initiative is managed by and builds on current provincial initiatives which support a more community-orientated and participatory approach to health sector programming, a ward-based PHC model with community caregivers as the driving engine. It is informed by the Brazilian Programa Saúde da Família (or Family Health Programme) model (Macinko 2007:30); and current debates and growing consensus around the role, competencies, training, employing agency (non-profit organizations versus State) and formalization of community care workers, as a category of health worker in South Africa.

In essence, the PHC re-engineering initiative aims to achieve the following objectives:

Primary health care re-engineering places greater emphasis on the delivery of community-based services by 'more pro-actively reaching out to families', with an emphasis on disease prevention, health promotion and community participation. This represents a shift away from the predominantly curative focus that characterizes the delivery of health services at present. It is envisaged that the community outreach activities will be facilitated by a PHC outreach team consisting of both nurses and community health workers, who in turn are supported by facility-based and specialist support teams of health professionals (Macinko, 2007:10).

To pay greater attention to those factors outside of the health sector that impact on health, i.e. the social determinants of health (or 'upstream factors'), for example, through the alignment of inter-sectoral programmes at district level with integrated development planning processes outreach teams, consisting of both nurses and community health workers, who in turn are supported by facility-based and specialist support teams of health professionals (http://www.info.gov.za).

5.12 THE NATIONAL HEALTH INSURANCE SCHEME

Over three decades ago, signatories to the Alma-Ata Declaration noted that 'Health for All' would contribute not only to a better quality of life, but also to global peace and security. It gave recognition to the fact that promoting and protecting health is essential not only for human welfare but also for sustained economic and social development (WHO, 2010:19).

The Constitution, in its preamble, established its constitutional imperative to improve the quality of life for all citizens and to free the potential of each person. Section 27(1)(a) of the Constitution affirms that everyone has the right to have access to health care services, including reproductive health care. Section 27(2) places an obligation on the state to take reasonable legislative and other measures within its available resources to achieve the progressive realization of this right. In 2004 the National Health Act, 2004 (Act 3 of 2004) was promulgated to provide a framework

for a structured and uniform health system that took into account the obligations imposed by the Constitution. The Act identifies in its preamble, inter alia, the socio-economic injustices, imbalances and inequities of health services of the past, the need to establish a society based on social justice and fundamental human rights, and the need to improve the quality of life for all in the country as the background context for its enactment. Section 3 of the Act places the responsibility for the provision of health care onto the shoulders of the Minister of Health. One of the objectives of the Act is the provision of the best possible health services that are available from affordable resources in an equitable manner for the population of South Africa.

In its 2000 Report, the World Health Organization (WHO) stated that the government carried the ultimate responsibility for the overall performance of a country's health system and that all sectors in society should be involved in working towards positive outcomes under the government's stewardship. Managing the well-being of the population carefully and responsibly is the very essence of good government. The best and fairest health systems possible with the available resources need to be established. "The health of the people is always a national priority: government responsibility for it is continuous and permanent. Ministries of health must therefore take on a large part of the stewardship of health systems."

In August 2011, the Green Paper on the National Health Insurance (NHI) was released for debate and comment by all in the country. The proposed NHI is a step towards health care reform as espoused in the Constitution and the National Health Act and a move towards the Alma-Ata's 'Health for All'. The seven principles of the NHI, i.e. the right to access, social solidarity, effectiveness, appropriateness, equity, affordability and efficiency, could be interpreted as the value assumptions of the proposed reforms. The objectives of the NHI are:

1.   To improve access to quality health services for all;

2.   To pool risks and funds in order to achieve equity and social solidarity;

3.   To procure services on behalf of the entire population and to efficiently mobilize and control key financial resources; and

4.   To strengthen the public health sector so as to improve health systems' performance.

Major reform in health financing is required if these objectives are to be realized. In 2005, member states of the WHO committed to develop their health financing systems so that the goals of universal coverage would be achieved. The WHO identified three fundamental, interrelated problems that restrict countries from moving closer to universal coverage. The first was the availability of resources. Even the richest of countries have not been able to ensure that everyone has immediate access to every technology and intervention that may improve their health. Over-reliance on direct payments at the time that people need care was another barrier to universal coverage. Even where some form of health insurance is available, patients may still need to contribute, e.g. in the form of co-payments or deductibles (http://www.who.int/whosis/whostat/EN_WHS10). On the path to universal coverage, many are prevented from receiving health care because of the need for direct payments. Others are driven into poverty and financial ruin because of this. Inefficient and inequitable use of resources was the third obstacle impeding the passage towards universal coverage. A conservative estimate placed the wastage of health care resources at 20-40%. Corruption could be added to this list as a fourth hurdle, as is the case in South Africa. Corruption erodes 10% of all health expenditure in South Africa, and within the private sector this is estimated to be between five and fifteen billion rand yearly (https://apps.who.int/whr/2000/en/report.htm).

At the recent National Health Insurance Conference: Lessons for South Africa (National Consultative Health Forum), members of the World Bank, the WHO and leading health economists in the country expressed the view that the financing of universal coverage is not beyond the reach of South Africa, as currently funds are available within the system. However, what is urgently required is the efficient management and use of the funds coupled with the elimination of corruption. In addition, employment taxation together with other innovative methods of revenue collection will be necessary. Reforming the health care financing system in South Africa dates back as early as 1928 when a Commission on Old Age Pension and National Insurance recommended the establishment of a health insurance scheme to cover medical, maternity and funeral benefits for all low-income formal sector

employees in urban areas. (http://www.hst.org.za/publications/green-paper-national-health-insurance-southafrica). In 1935, similar proposals were recommended by the Committee of Enquiry into National Health Insurance. Between 1942 and 1944, the National Health Service Commission (also known as the Gluckman Commission) was set up. It recommended the implementation of a National Health Tax that would allow for the provision of free health services at the point of delivery for all South Africans. Health centres providing primary care services were to be core to the health system. Some of the recommendations were implemented, but gains from these were reversed after the National Party government was elected in 1948. The Health Care Finance Committee of 1994 recommended that all formally employed individuals and their immediate dependants initially form the core membership of social health insurance arrangements, which would be expanded to cover other groups over time. More work on this was done by the Committee of Enquiry on National Health Insurance (1995), the Social Health Insurance Working Group (1997), the Committee of Enquiry into a Comprehensive Social Security for South Africa (2002) and the Ministerial Task Team on Social Health Insurance (2002). In 2009, the Ministerial Advisory Committee on National Health Insurance was established with the objective of providing recommendations on relevant health system reforms and matters relating to the design and roll-out of a National Health Insurance as per Resolution 53 passed at the ANC's conference in Polokwane in December 2007. While several committees, commissions and working groups have been established since 1994 to work towards a way forward for universal coverage, displaying positive political will in this direction, it has only been under the stewardship of the current Minister of Health that positive political commitment towards 'Health for All' has materialized (https://apps.who.int/whr/2000/en/report). The two areas that are to be worked on as a priority, as articulated by the Minister, are improving the quality of care in the public sector and decreasing the cost of private health care. While we embark on the journey towards universal coverage, it is important to remember that there are also other barriers to accessing health services. Green Paper: National Health Insurance in South Africa. (http://www.hst.org.za/publications/green-paper-national-health-insurance-southafrica). Proper financing will help poor people obtain care, but will not solve the problem completely. Lack of transport and transport costs would also pose an impediment to access. In addition, other social determinants are a prerequisite for

ensuring the attainment of health, e.g. food and clean water. Because health is so dependent on its social determinants, it cannot be viewed as a silo. It will be imperative for the other ministries to come on board, and perhaps the comprehensive package to be offered by the NHI should include some of the social determinants. In addition, while we have so many highly skilled and dedicated people working at all levels to improve the health of our people, we also have the harsh realities of severe shortages of human resources and health care workers with poor attitudes, in part because of the conditions that they find themselves in.

The Green Paper, which outlines broad policy proposals for the implementation of the NHI, is currently undergoing a consultation process where public comment and engagement with the broad principles are encouraged. This will be followed by the policy document or the White Paper. Thereafter draft legislation will be developed and published for public engagement before being finalized and submitted to Parliament for consideration as a Bill. Health reform as proposed by the NHI is history in the making, and it is vital that we as citizens of South Africa engage with and interrogate the document and all the subsequent processes that follow. There are a number of positive aspects to the Green Paper. There are also a number of concerns and insufficient clarity on some extremely important issues.

The indicator of success of the National Health Insurance will be the achievement of universal coverage. Under discussion at the moment is not whether the NHI should be implemented, but how this should be done and what method of financing would be the most fair. Trade-offs will be inevitable. This is the experience in countries that have achieved universal coverage and financial security for their people. The trajectory is going to be long and challenging, but worth it for the future of our country and its people. The National Health Insurance (NHI) scheme is the concept which was first introduced into the public sphere in 2007 at the ANC's national policy conference in Polokwane (Human Resource Centre 2011:12). The proposed NHI, as a funding mechanism, will pool mandatory contributions and public sector finance to purchase services from accredited public and private sector providers, with the aim of achieving universal health care coverage and access to quality health services. According to McIntyre, a 27-member Ministerial Advisory Committee (MAC) on the NHI was established to advise the Minister on the development of the policy, of

legislation and the development of a detailed implementation plan on NHI introduction. Considerable investment has also been made in establishing a number of technical sub-groups, examining different costing scenarios and economic benefits of the NHI; and exploring how the transition from the current health system configuration to one based on an NHI would take place (McIntyre 2010:30). Key considerations are in relation to the NHI and its financial feasibility, human resource requirements, and health systems performance.

The National Health Insurance as introduced in the Green Paper, is aimed to be an innovative system of health care financing that will ensure that everyone has access to appropriate, efficient and quality health services as a result of major changes in the service delivery structures, administrative and management systems (Government Gazette 2011:12). The key focus is on the strengthening of the health system through:

- Management of health facilities and health districts;

- Quality improvement;

- Infrastructure development;

- Medical devices and equipment;

- Human resources planning, development and management;

- Information management and systems support; and

- Establishment of the NHI fund as a government-owned entity that is publicly administered.

5.13 NATIONAL QUALITY HEALTH PROGRAMME AND OFFICE OF STANDARD COMPLIANCE

The recognition of the need for service improvement, a national quality health programme and an Office of Health Standards Compliance, has initiated a number of programmes for quality improvement mechanisms. First, based on existing sets of

policies and guidelines and through an extensive consultation and piloting process, a revised set of core standards, the National Core Standards for Health Establishment in South Africa (2011:40), has been developed, approved and published for implementation in both the public and private health sectors. These standards provide an overall guide to the quality of care and set out a common definition of the type of quality of care that should be found in all health establishments. They establish a benchmark against which health establishments can be assessed, gaps identified and strengths appraised, and provide a national framework to certify health establishments as compliant with standards. The core standards consist of seven domains, the first three of which relate to 'the core business of the health system: delivering quality health care to our users or patients'. These are: Patient rights; safety, clinical governance and care; and clinical support services (Annual Performance Plan, 2011: 20).

The remaining four domains are essentially the support systems that ensure 'core business is delivered', with staff seen as key to achieving this. They are: Public health, leadership and corporate governance, operational management, and facilities and infrastructure. For measurement purposes, a set of criteria for each National Core Standard, along with an auditing tool aligned to the district health information system (a module of the DHS) have been designed to assess health facilities' compliance with these standards.

To support facilities in implementing self-assessments and quality improvement, the NDOH has developed an 'implementation guide' and a 'database guide' which will assist teams to incorporate their quality-related assessments as part of the routine data management (Annual Performance Plan 2011: 24).

5.14 HEALTH CARE MANAGEMENT AND GOVERNANCE SYSTEM

The aim of the Health Care Management Project, initiated by the Ministry of Health and facilitated by the Development Bank of South Africa (DBSA), was to assess the competency of public hospital chief executive officers (CEOs) and district managers (MDs), based on a competency ranking system. The DBSA's work on the health road

map highlighted the problem of inappropriately skilled managers in charge of district health services and hospitals resulting in poor service delivery. Management has a critical role to play in the transformation of the health system (McKinsey, 2010: 1). The ultimate aim of the project was to assess and establish the appropriate placement, support and re-training of CEOs and district managers, and improve systems for performance management. This would enable a proper system of delegation of administrative responsibilities to hospital and district managers, since effective delegation depends on the capacity and competence of CEOs. The data obtained from the CEO assessment served as an input to the content and sequencing of new delegations. It will further be used to inform training and mentorship programmes, and will help shape a human resources policy. It is envisaged that delegations will be tailored to the capacity of each institution. The process will further assist the NDOH and provinces in better targeting in-service training and supervision. Re-determining at least some CEO roles is a possible outcome of the study, in order to ensure that appropriate retention and redeployment policies are in place (McKinsey, 2010:20).

The project has developed a governance model for hospitals and district health services, in relation to future delegations and management competencies. It also investigated systemic and institutional factors affecting the performance of hospitals and districts in the public health sector. A set of proposals for the governance of public hospitals and health districts, based on international experience and appropriate for the South African context, has been presented to the NDOH for review. By the end of 2010, approximately 400 hospitals, CEO and district manager assessments had been completed (Annual Performance Plan 2011/2012:24). The results have been released to Premiers of the provinces, but have not been made more broadly available. Despite its politically sensitive nature, this knowledge needs to be placed in the hands of provincial managers empowered to act on it, before the high degree of mobility at a management level within the health sector renders the information irrelevant. In his health budget speech of 2011 to the National Assembly, the Minister of Health acknowledges that the department cannot move forward with the proposed major reforms such as the re-engineering of the PHC system and the NHI without looking at health workforce development and improving the management

of the health care institutions and health districts - hence, in August 2012, Government Publication: 2011. Government Publication 2011: August 21). The National Policy on Regulating Management of Hospitals is aimed at ensuring that the management of hospitals is underpinned by the principles of effectiveness, efficiency and transparency, and with the objectives of:

- Ensuring implementation of applicable legislation and policies to improve the functionality of hospitals; and

- Ensuring the appointment of competent and skilled hospital employees.

CHAPTER 6:   KEY RESEARCH FINDINGS

6.1   INTRODUCTION

Data analysis is the process of categorizing, ordering, manipulating and summarizing data so that it can be displayed in a meaningful way that will provide answers to the research questions (Mouton, 1996:110). This chapter shows how the study was conducted and presents the findings of the study carried out in the Mangaung Metro.

The results obtained are from the questionnaires that were distributed in the four district hospitals of the Mangaung Metro. All the data assembled in this section was obtained from the questionnaires that were distributed in the four district hospitals within the boundaries of the Motheo district that participated in the study.

GRAPH 6.1:   PERCENTAGE OF INSTITUTIONS THAT PARTICIPATED IN THE STUDY
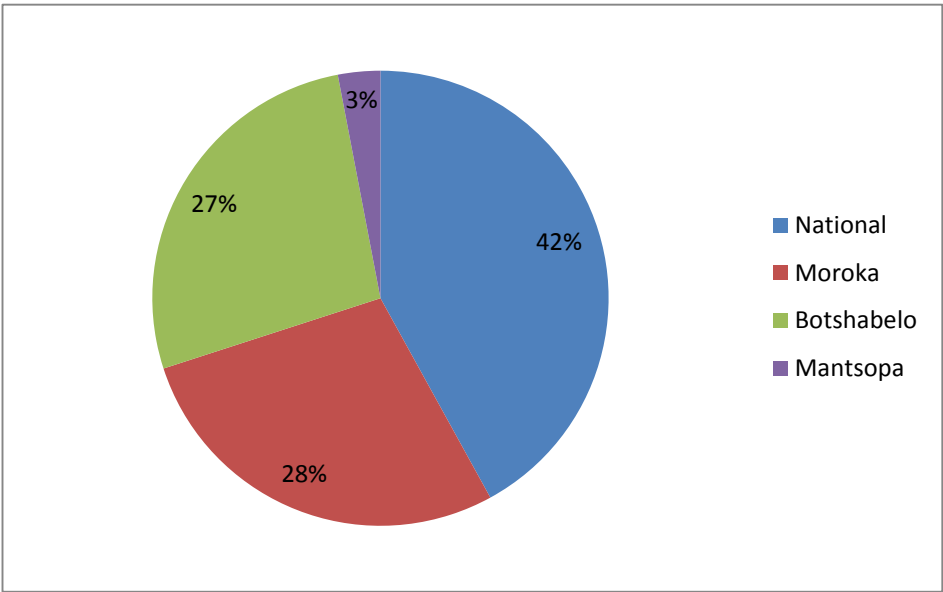
6.2   GENDER DISTRIBUTION

Figure 6.2 below shows that the majority of the respondents were females, namely 71%, and only 29% were males as the staff at the district hospitals are mainly female.

GRAPH 6.2: GENDER DISTRIBUTION
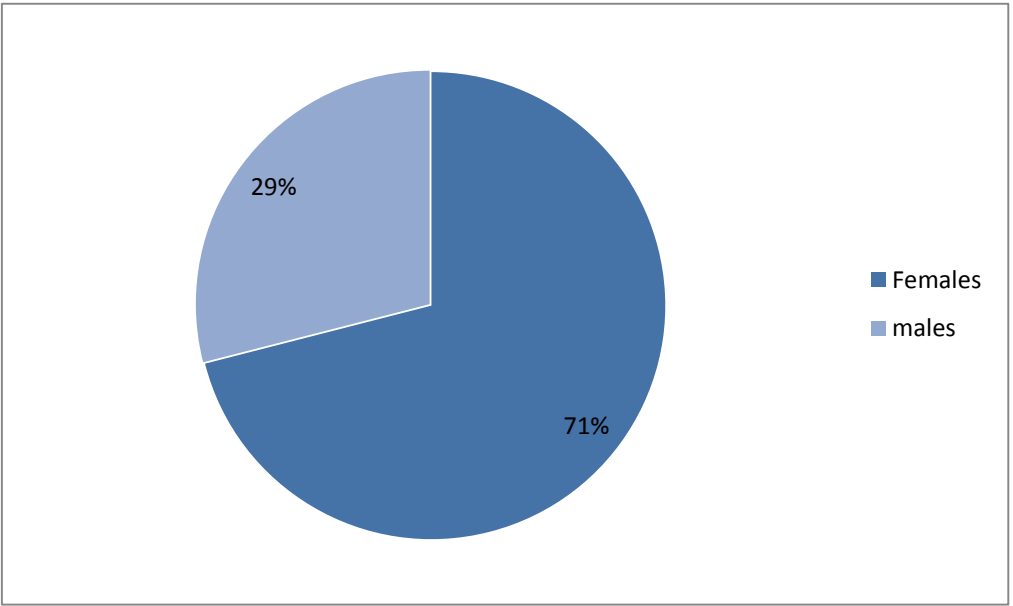
6.3   EMPLOYMENT EQUITY

The population of Africans for this study is 95.8%, Whites are 2.8% and they are followed by 1.4% for Coloured. Since the questionnaire was distributed randomly at the hospitals on a particular day, no specific method was followed to determine the percentage. The figures are basically those of the people that were available when the study was done. Despite the vast difference in the rates of the racial distribution of the study, it is evident that section 33 of the Employment Equity Act shows to have been applied consistently in the province. This means that different racial groups were appointed in the facilities where the study was conducted. See Table 6.1 below.

TABLE 6.1: RACIAL GROUPS

POPULATION GROUP	FREQUENCY (PARTICIPANTS)	PERCENTAGE OF POPULATION
AFRICAN	275	95.80%
COLOURED	4	1.40%
WHITE	8	2.80%
ASIAN	0	0%

6.4 AGE GROUP OF PARTICIPANTS PARTICIPATED IN THE SURVEY

The age distributions were arranged as follows: 25-30 years, 31-40 years, 41-50 years and 50+ years. Out of the arranged age group, the highest proportion was from the participants of the age of 31–40 years at 48%. They were followed by 37% of participants within the age group of 41–50 years. The lowest were 12% and 3% representing the age group of 50+ years and 25–30 years, respectively. The graph below indicates that within five years the age group of 51–60 years will need to be replaced as they will be eligible for pension. There should be a mechanism to replace those aged 51–59 years. These figures are clearly indicated, see figure 6.3 below.

GRAPH 6.3: AGE GROUP PER PARTICIPANT
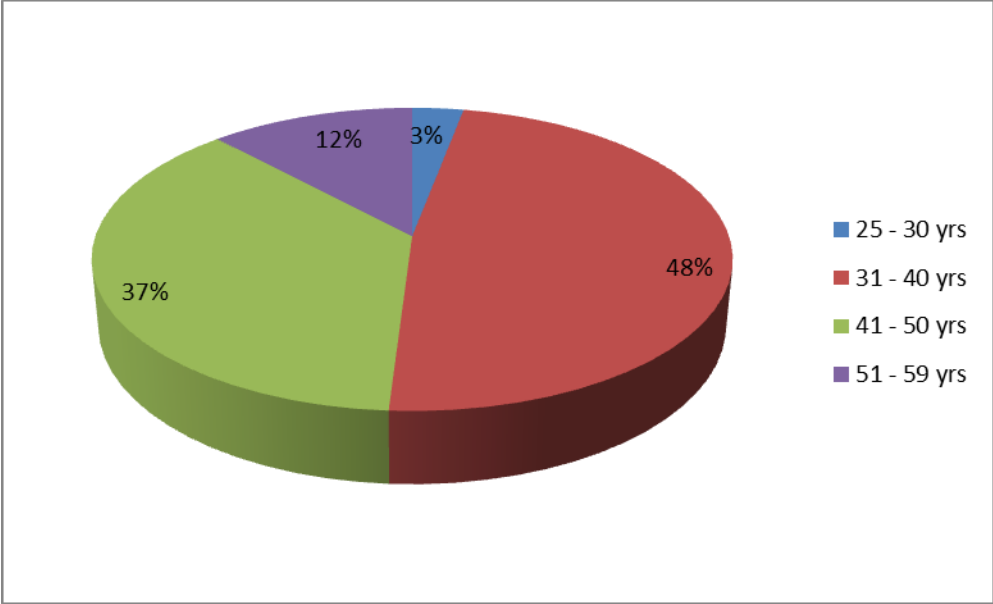
6.5   NUMBER OF YEARS IN SERVICE

Figure 6.4 indicates the percentage of participants' years in the service of the Department of Health. The highest percentage of participants, namely 29%, had between 5 and 10 years of service, followed by 28.6% that were employed for a period of 1 to 5 years and those employed between 10 and 15 years were 28%. The lowest percentages, namely 13.2% and 6.3% of the participants were employed for a period between 16 and 20 years and 21 and 30 years, respectively.

GRAPH 6.4: NUMBER OF YEARS IN SERVICE

Bar chart showing:
- 21 - 30 yrs: 6%
- 16 - 20 yrs: 13%
- 10 - 15 yrs: 28%
- 5 - 10 yrs: 30%
- 1 - 5 yrs: 29.00%
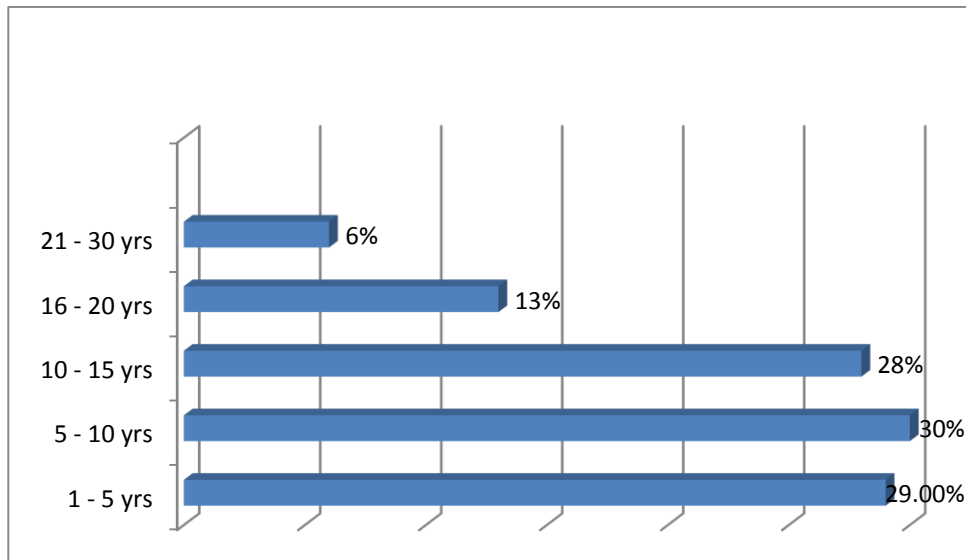
6.6 WORK ENVIRONMENT PROVIDES EXCITEMENT AND OPENNESS

Cause for celebration is when team members acknowledge the achievement by one team member or members as a group. The organization needs to afford the team members the celebration of their accomplishments. Moreover, by achieving specific goals, people gain a sense of personal accomplishment and self-worth (Locke & Latham 1984: 24) which helps to improve the performance of the organization, and thus promotes a positive image of the institution. Dedicated people always want to work for a successful agency.

GRAPH 6.5: THE WORK ENVIRONMENT PROVIDES FOR OPPORTUNITY AND ENTERTAINMENT
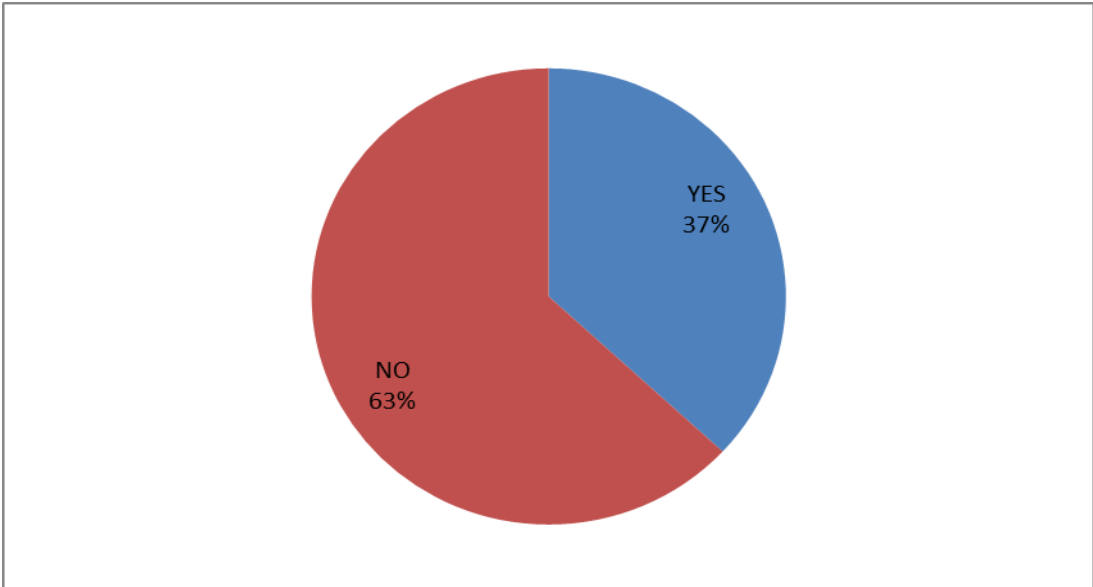
6.7 GOOD PERFORMANCE APPRECIATED AND REWARDED

Recognition of good performance has been identified as the greatest influence on the performance of workers in hospitals. Due to a lack of recognition and rewards in their workplace workers seem to look for greener pastures. These factors account for fifty percent of the staff turnover in public health institutions. According to Brown (2000:169) there are two factors that are classified as pushing factors in the public sector which force high staff turnover. The graph below clearly demonstrates and justifies that good performance is not recognized and is not properly rewarded. As a result, the biggest challenge facing district hospitals is to retain the 57.80% of staff that are not satisfied with how the reward system is applied in the Department of Health.

GRAPH 6.6: PERFORMANCE APPRECIATED AND REWARDED
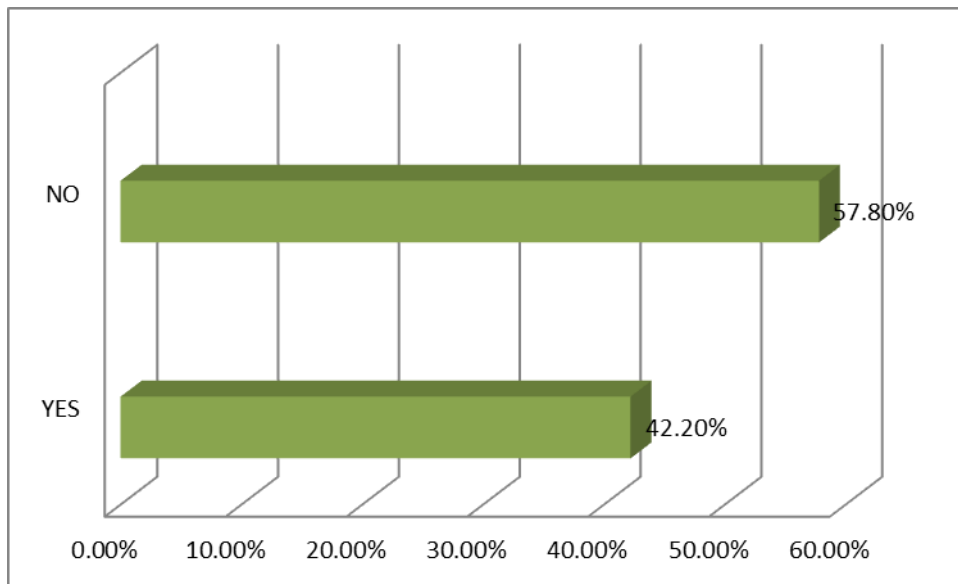
6.8 PERFORMANCE EVALUATION IS DONE REGULARLY ACCORDING TO THE PERFORMANCE DEVELOPMENT MANAGEMENT SYSTEM (PDMS) POLICY:

Employee performance measurement and evaluation in many government departments is a challenge. In its quest to improve employee performance, government invests a lot of money and time in the improvement of working conditions and the wage increase of employees with the aim of motivating employees. According to the study conducted, the Performance Development Management System (PDMS) has a motivational and performance impact on personnel. The PDMS is one of the strategies implemented to motivate employees, and to improve the quality of health care in the working environment. Motivation is the willingness to exert high levels of effort towards organizational goals conditioned by the ability of the efforts to satisfy some individual and team needs. Motivation represents the forces within individuals that affect their direction, intensity and persistence in voluntary behaviour (Franco, 2004:344).

Figure 6.7 below shows the response of personnel to the current evaluation system that is not done according to the policy of the department. As a result, interviewed staff members are very negative towards the PDMS system because it is incorrectly implemented and favours certain individuals.

GRAPH 6.7: PERFORMANCE EVALUATION IS DONE REGULARLY ACCORDING TO PDMS POLICY
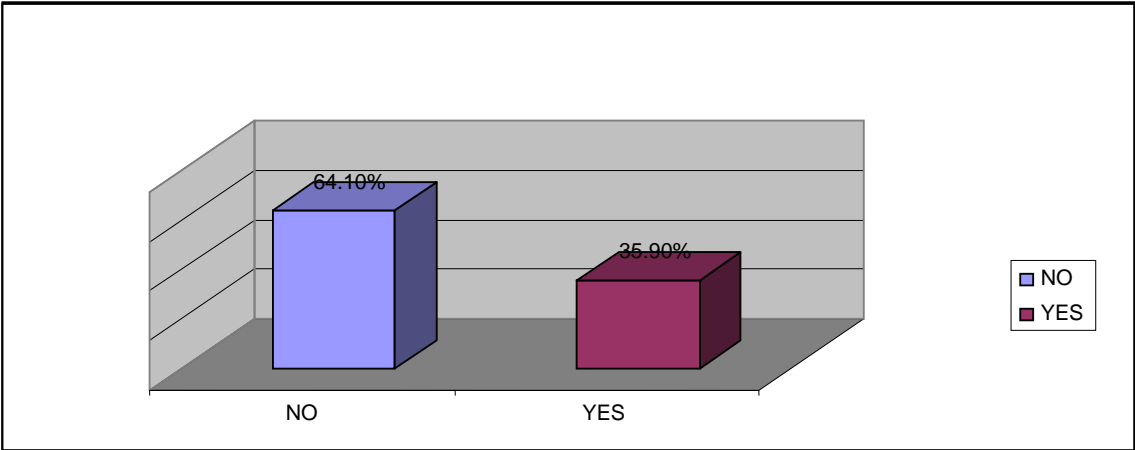
6.9   FEEDBACK ON EMPLOYEE PERFORMANCE

The public service in South Africa is generally known for its poor service delivery and poor performance. Although there is no scientific research to substantiate this claim, it will be worthwhile to examine the contributing factors to poor performance. Figure 6.8 clearly indicates that personnel evaluation and performance management are not consistently done and no feedback is received on the performance of employees. The majority of the respondents in the Motheo district, namely 67.90%, reported that they had not received any feedback on their performance. As a result, they were requested to recall all the activities they had done during the course of the year in order for them to be evaluated. Only 32.10% agreed that they had received some feedback on their performance evaluation.

GRAPH 6.8: FEEDBACK ON EMPLOYEE PERFORMANCE
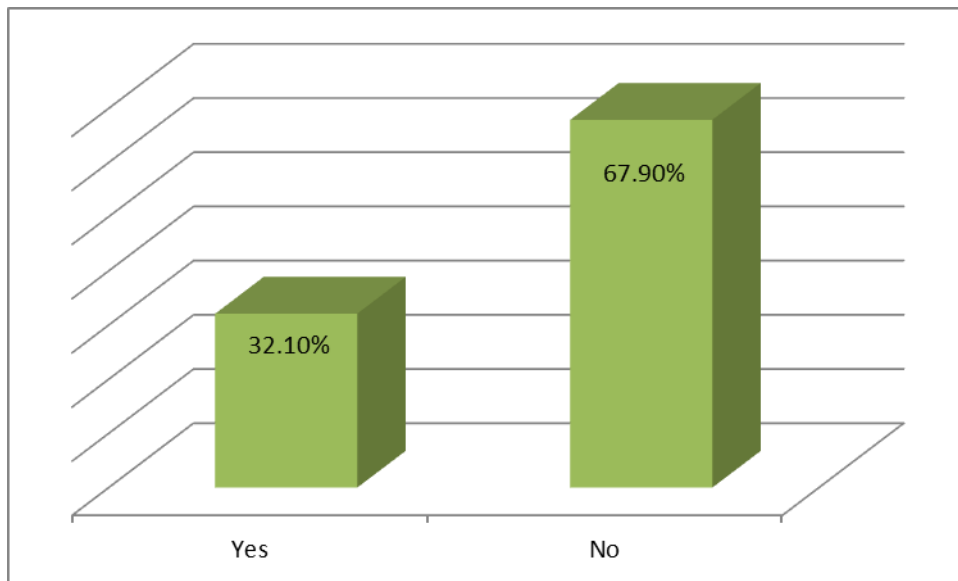
As stated above, the principles of performance measurement are not effectively practiced in the district hospitals that participated in the study.

According to Kaplan and Norton (1996:20) all significant work-related activities must be measured due to the following:

- Work that is not measured or assessed cannot be managed because there is no objective information to determine its value. Therefore it is assumed that this work is inherently valuable regardless of its outcomes. The best that can be accomplished with this type of activity is to supervise a level of effort;

- Unmeasured work or performance should not be allowed due to the fact that when there is deviation from good performance it cannot be noticed;

- Desired performance outcomes must be established for all measured work;

- Outcomes provide the basis for establishing accountability for results rather than just requiring a level of effort;

- Performance reporting and variance analyses must be accomplished frequently and frequent reporting enables timely corrective action;

- Frequent reporting enables timely corrective action; and

- Timely corrective action is needed for effective management control.

Kaplan and Norton (1996:20) further emphasized that, if performance is not measured:

- How would one know where to improve?

- How do you know where to allocate or re-allocate money and people?

- How do you know how you compare with others?

- How do you know whether you are improving or declining?

- How do you know whether or which programmes, methods, or employees are producing results that are cost-effective and efficient?

6.10 TIME TAKEN TO REPLACE OR REPAIR BROKEN EQUIPMENT IN A HOSPITAL

In this analysis, hospital efficiency is assessed on the basis of the input into the management of the system. In this sense, efficiency can be measured by the time it takes to replace or repair broken equipment in the hospital. The question was designed firstly to check the time it takes to repair the equipment, secondly to consider if it is too long for life-saving devices, i.e. two (2) months was regarded as long and one (1) month as acceptable. In all the responses received, 55.70% said the time taken to repair the broken items was extremely long and was frustrating for the service providers in hospitals, and this affects service delivery negatively.

Nursing care is the foundation of clinical and patient care, and bears the brunt of increasing negative remarks by patients; and a shortage of staff and management failure are also highlighted. It has been noted that when equipment is broken and not fixed within a reasonable time, this undoubtedly has an impact on the image of the Department of Health (Von Holdt & Murphy, 2006:2).

**GRAPH 6.9: TIME TAKEN TO REPLACE OR REPAIR EQUIPMENT**
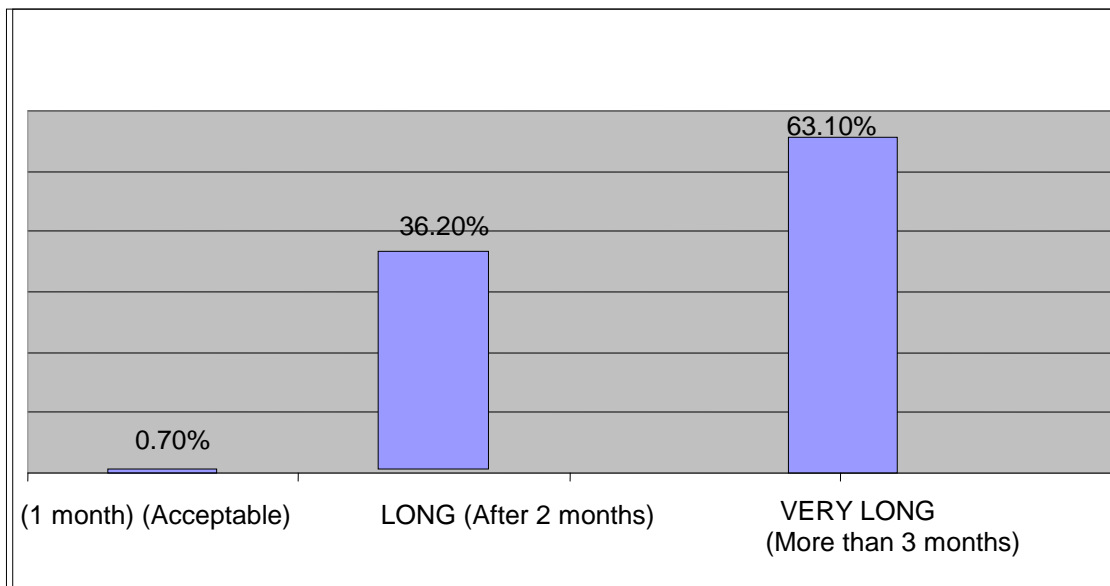
6.11 EARLY WARNING SYSTEM WHEN MEDICATION AND MEDICAL CONSUMABLES ARE DEPLETED

Quality health care is often measured through health care outcomes like effectiveness, efficiency and quality; outcomes are measured in terms of effectiveness and efficiency (Katzenellenbogen, et al. 1997:149). Effectiveness measures success in producing a given result and efficiency indicates the optimal use of inputs in monetary terms. Since the 1950s the system's approach has emphasized effectiveness and efficiency so as to ensure optimal outcomes for organizational inputs (Heavens, 1999:45-48).

Outcome evaluations measure whether the best possible quality of health care is provided at optimal cost, or, in other words, whether management and interventions are effective and efficient in terms of finance, human resources and health gains (Heavens, 1999:45&47). In the case where the system does not proactively indicate when the medical consumables are depleted, it is less effective and does not assist in accomplishing the objective of effective service delivery. As stated in Figure 6.10 these are the examples of indicators for measuring the effectiveness and efficiency of the health institution. The yes in the graph indicates that there are minimal measures

that inform the managers when critical medical consumables are depleted. Only 15.70% agreed that there is a system in place, whereas 84.30% agree there are no systems in place to report when medical consumables are depleted.

GRAPH 6.10:   EARLY WARNING SYSTEM FOR MEDICATION AND MEDICAL CONSUMABLES
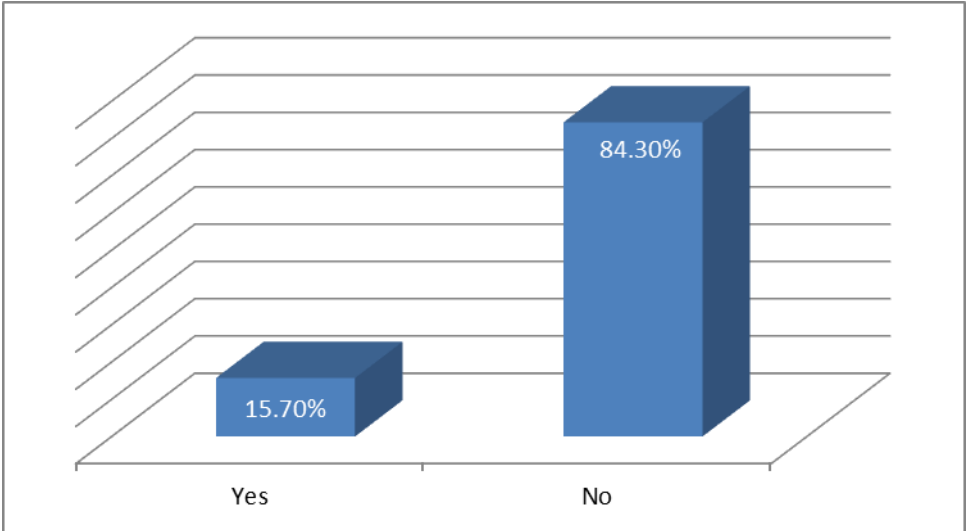
## 6.12 ARE DELIVERED MEDICAL CONSUMABLES OF A HIGH QUALITY?

Since health is regarded as a human right, there is growing consensus in the modern world that better health care systems are essential for the improvement of health outcomes, and should be rendered through safe and high quality products (WHO, 2006:2-3).

According to Kusek and Rist (2004:57) the quality of life and the health care standards of the community can only be improved by rendering a good service and showing commitment. It is a process in which inputs, activities and outputs arise out of predetermined outcome goals and targets. In those cases where the outcomes and impact targets are not being met, it becomes necessary to evaluate the inputs, e.g. money, processes (nursing and medical processes) and outputs, namely discharged patients, whether they are satisfied with the service they received from the hospital; and if they are not satisfied, that the problems are identified and

remedied. As indicated in Figure 6.11, 73.20% of respondents indicated that they were not satisfied with the quality of the medical consumables procured, especially from the small emerging BEE companies. However, as these consumables are the only ones available during an emergency, staff is compelled to use them. Only 26.30% of respondents were satisfied with the quality of the medical consumables. All management failures lead to inadequate and inefficient services (WHO 2003:35-36). For quality service to be rendered properly, one needs standardized parameters such as a management tool that will assess the quality of the medical consumables used by both nurses and doctors. These measures will provide simple and reliable ways of measuring the quality of products used in district hospitals.

GRAPH 6.11:   ARE DELIVERED MEDICAL CONSUMABLES OF A HIGH QUALITY?
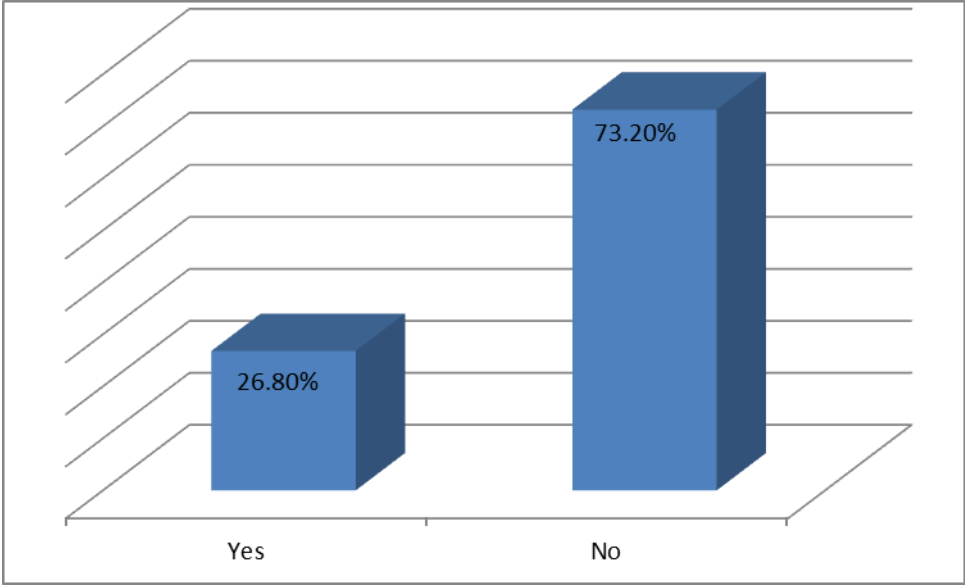
6.13 PERFORMANCE EVALUATION IS DONE REGULARLY AND ACCORDING TO PDMS POLICY

The recognition and rewarding of good performance have been identified as having the greatest influence on the performance of workers both internally and externally to the organization (De Vos, 2002:280). According to Brown (2000:169), there are two

factors that make employees happy or in turn unhappy. They are classified as pushing and pulling factors in the public sector which force high staff turnover. Figure 6.12 clearly indicates that the respondents are of the opinion that good performance is not recognized and is not properly rewarded. As a result, the biggest challenge facing district hospitals is to retain the 53.81% of staff that are not happy with the performance management issues; undoubtedly they will have to retain them through a specific retention strategy to keep them in their service. Robbins, Odendaal and Readt (2003:35–40) conclude that although workers have been loyal, dedicated and shown team spirit, principals are unable to recognize the good that has been done by providing good service to the communities.

GRAPH 6.12: PERFORMANCE EVALUATION IS DONE REGULARLY AND ACCORDING TO PDMS POLICY
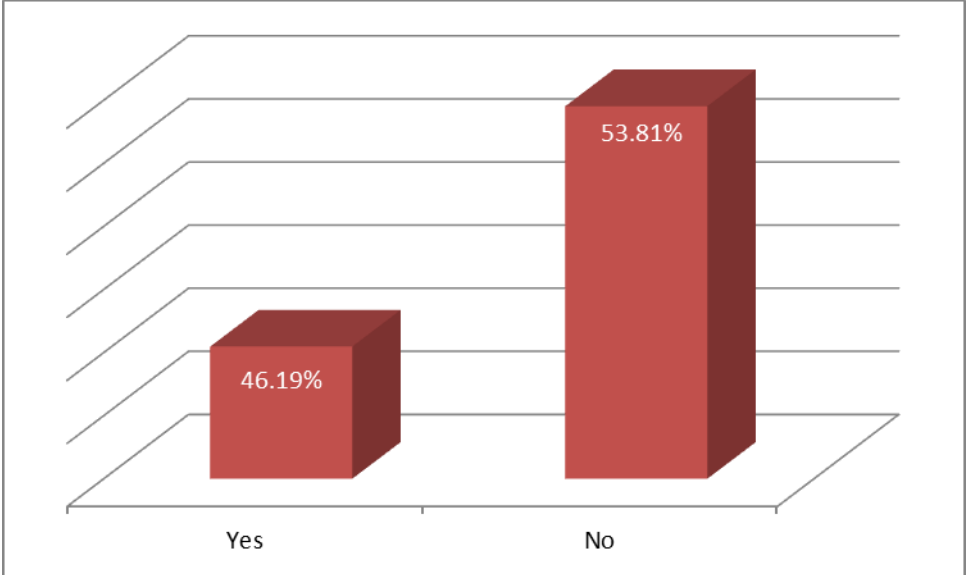
## 6.14 PDMS INFLUENCES EMPLOYEE PERFORMANCE

The evaluation of employee performance in many government departments is a challenge. In their quest to improve employee performance, government invested substantial amounts of money and time in the development of policies and a legislative framework aimed at motivating employees. Different motivational efforts do not have the same impact on all employees, because what motivates individual employees is as complex and diverse as the human being itself. The PDMS policy

proved to have different motivational and performance impacts on personnel. The PDMS is one of the strategies implemented to motivate employees, and to improve both employee and employer achievement in the working environment.

Motivation is the willingness to exert high levels of effort towards organizational goals conditioned by the ability of efforts to satisfy some individual and team needs. Motivation represents the forces within individuals that affect their direction, intensity and persistence in voluntary behaviour (Franco, 2004:344).

The graph in Figure 6.13 shows the response of personnel to PDMS as a positive strategy to encourage them to do more.

GRAPH 6.13:   PDMS INFLUENCES EMPLOYEE PERFORMANCE
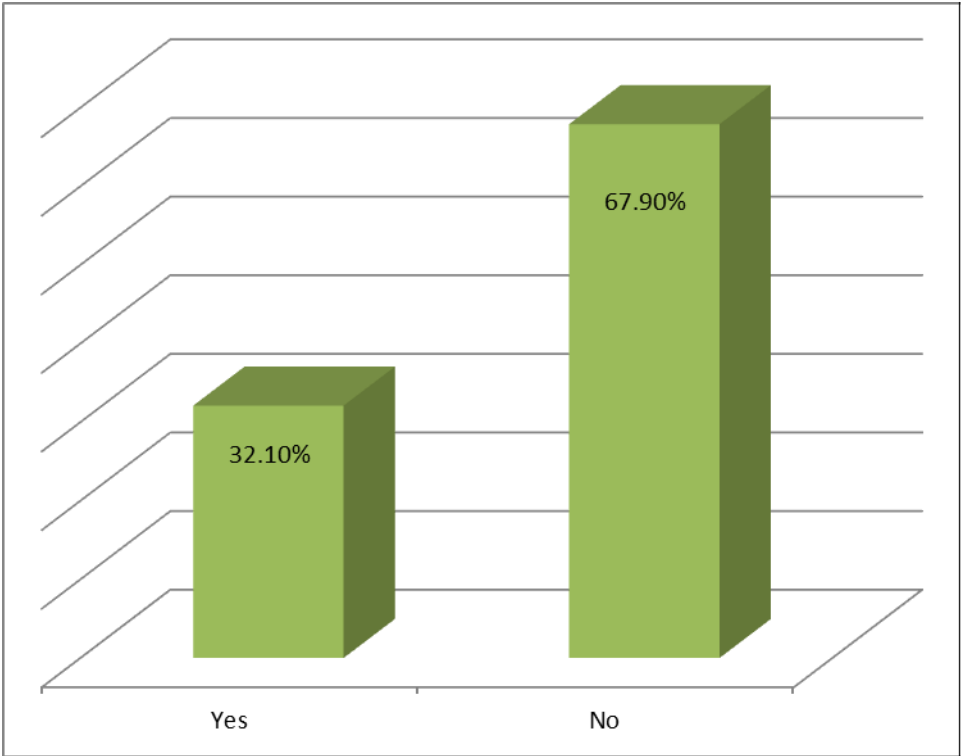
**GRAPH 6.14:**   **EVALUATION OF PERFORMANCE ASSESSMENT IN DISTRICT HOSPITALS**
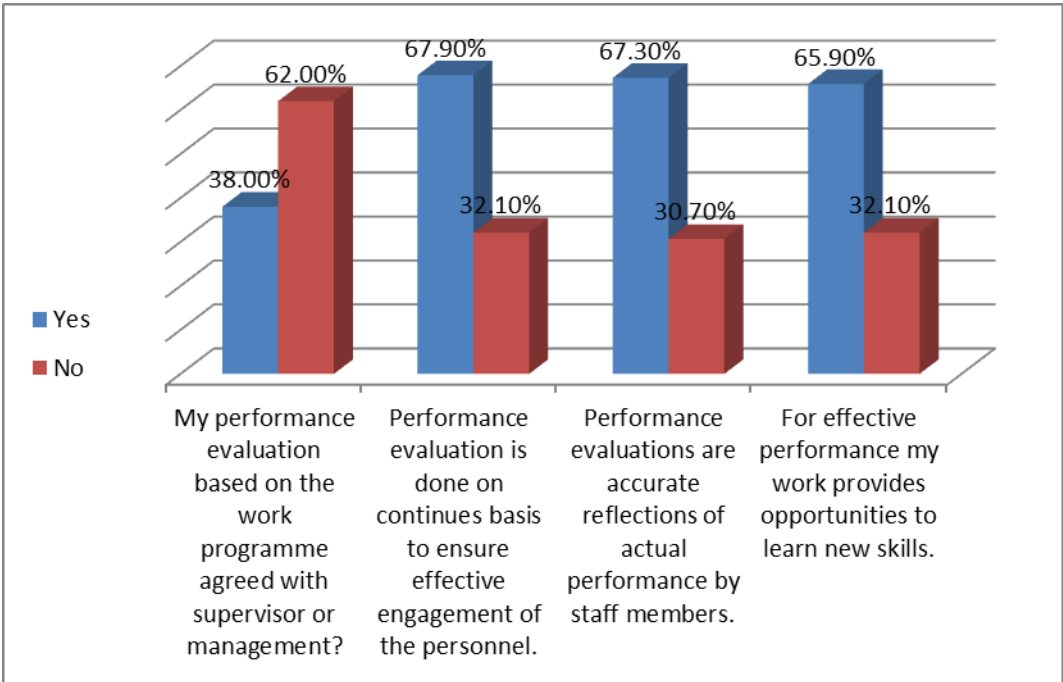
6.15 THE REASONS FOR MEASURING PERFORMANCE

The fundamental purpose behind measuring the quality of services rendered is to improve performance where it is not effective. To evaluate performance, managers need to determine what an institution is supposed to accomplish with limited resources (Schalk, 2006:8). Many factors, such as lack of medical consumables and a high work load; health demands, the development of new and more expensive medical technologies; and access to health services as well as sufficient funding for health services, contribute to great pressure. As performance evaluation is not done in accordance with the prescripts it is not possible to quantify the current level of efficiency/inefficiency in Motheo district hospitals, as illustrated in Figure: 6.14.

6.16 IS THERE PROPER DEVELOPMENT OR CAPACITY BUILDING IN DISTRICT HOSPITALS?

District hospitals play a very critical role in the delivery of health services at community level, especially in those places that are regarded as rural areas. District hospital health facilities provide comprehensive level-one district hospital health services to all the Free State communities in that particular district. The skills development and capacity building of health officials need attention. Some of the hospitals are situated in rural areas, making it necessary for categories of staff to undergo training that will address the knowledge and skills that are needed in the rural areas. Figure 6.15 shows that 67.90% of the respondents indicated a lack of opportunities to acquire new skills and only 32.10% agreed that skills acquisition opportunities are provided for them in district hospitals with a view to further development. The result of the survey confirms that the lack of skills development hampers the improvement of services due to the fact that officials are not capacitated with new skills.

**GRAPH 6.15:   IS THERE PROPER SKILLS DEVELOPMENT IN DISTRICT HOSPITALS?**
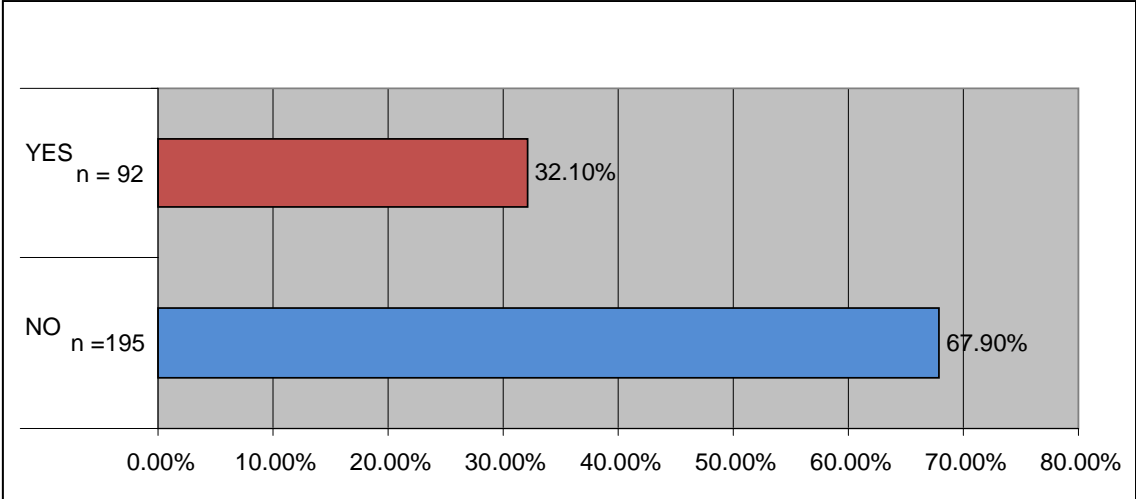
6.17 PATIENTS' SAFETY IN DISTRICT HOSPITALS

Patient and personnel safety is the indicator that needs to be taken into account when considering hospital efficiency. In previous studies conducted in the country by the National Department of Health (2009: 7) on hospital effectiveness and efficiency,

patient and personnel safety was used as a good indicator of efficiency in a district hospital. According to the results of this study, 80.80% of patients felt safe in district hospitals; whereas 19.20% felt that the safety measures in district hospitals were not sufficient. The variables of patient assault and theft of property were used to check their safety as a measure of quality and efficiency.

**GRAPH 6.16:   PATIENTS' SAFETY IN DISTRICT HOSPITALS**
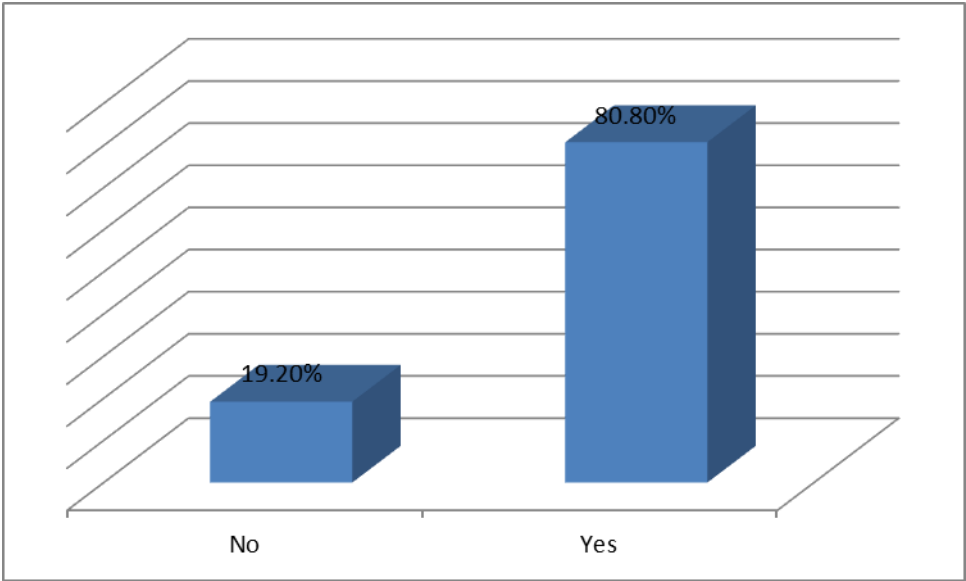
6.18 ROLE OF MANAGERS IN DISTRICT HOSPITALS

Manager are regarded as Stewardship' is a term developed by the WHO to guide health policies and the management of health systems by governments. It is extensively used by the current South African government to characterise its relationship to the whole health system, private as well as public, and to justify its policies.

According to the WHO the main elements of stewardship are: careful and responsible management of the well-being of the population; establishing the best and fairest health system possible; concern about the trust and legitimacy with which activities are viewed by the citizenry; and maintaining and improving national resources for the benefit of the population (Reforming in health Care in South Africa report, 2011:28). By adopting this framework and claiming the rights expressed in it, over the private as well as the public health sector, the South

African government invites assessment of its performance on these criteria (WHO.2008:48, accessed on 31 August 2010).

GRAPH 6.17: **ARE YOU SATISFIED WITH THE ROLE PLAYED BY MANAGEMENT IN YOUR HOSPITAL?**
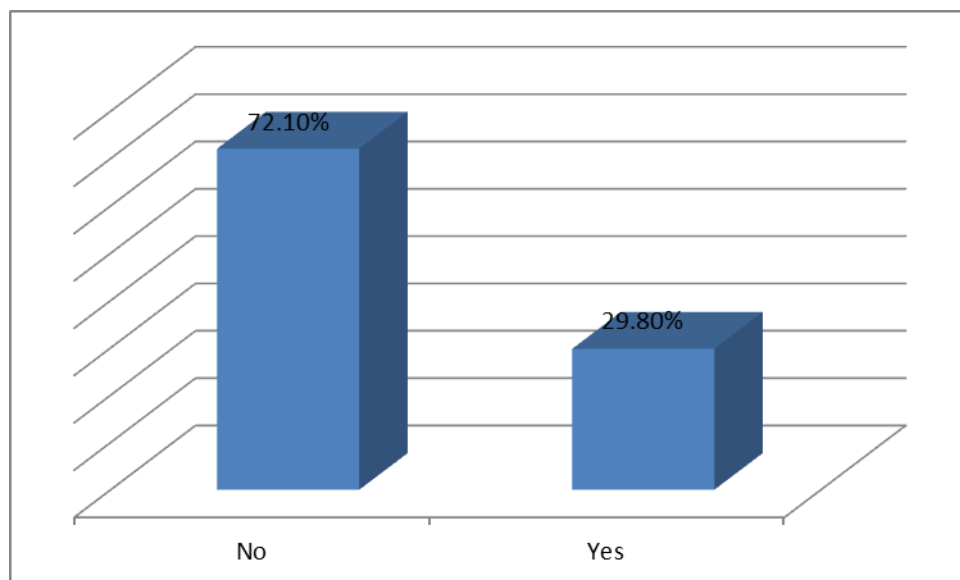

It is the duty of district hospital managers to ensure that district hospital health care services are available and accessible to the public. Managers are the driving force of any organization because they are responsible for, inter alia, managing the implementation of organizational strategies and policies. According to Smith and Cronje (1997:5), managers are the people who make decisions about the quality and quantities of products that must be produced. Klopper and Oosthuizen (2001:7) describe a manager as a person who plans, organizes, directs, and controls the allocation of human, material, financial, and information resources in pursuit of the organization's goals. Cronje, Du Toit, Marais and Motlatla (2003:122) state that management does four things: it decides **what** has to be done; it decides **how** it should be done; it **orders** that it be done; and finally it **checks** that its orders have been carried out.

Together with other role-players in the organization, management has to set objectives and determine the goals of the organization. It is important that this process be well coordinated and takes cognizance of available resources because management has to ensure that resources are efficiently utilized. According to Witzel (2004:1) management is the coordination and the direction of the activities of oneself and others towards some particular end of the project. According to Figure 6.18, it is clear that the management teams of district hospitals in the Free State lack the qualities of a true leader. This may lead to the division or convergence of labour.

6.19 THE NATURE OF MANAGEMENT FUNCTIONS

In order for any organization to achieve its goals and objectives successfully, there should be an experienced management team that will drive the process. For the purpose of this study, the management team refers to the chief executive officer and his or her management team. The task of management is to combine, allocate, coordinate and deploy resources or inputs in such a way that organizational goals are achieved as productively as possible (Smith, et al. 2007:8). Management goes about this by following a specific process which can be simplified as a systematic way of doing things. All managers, regardless of their skills or the level at which they are involved, engage in certain interrelated activities to achieve their desired goals.
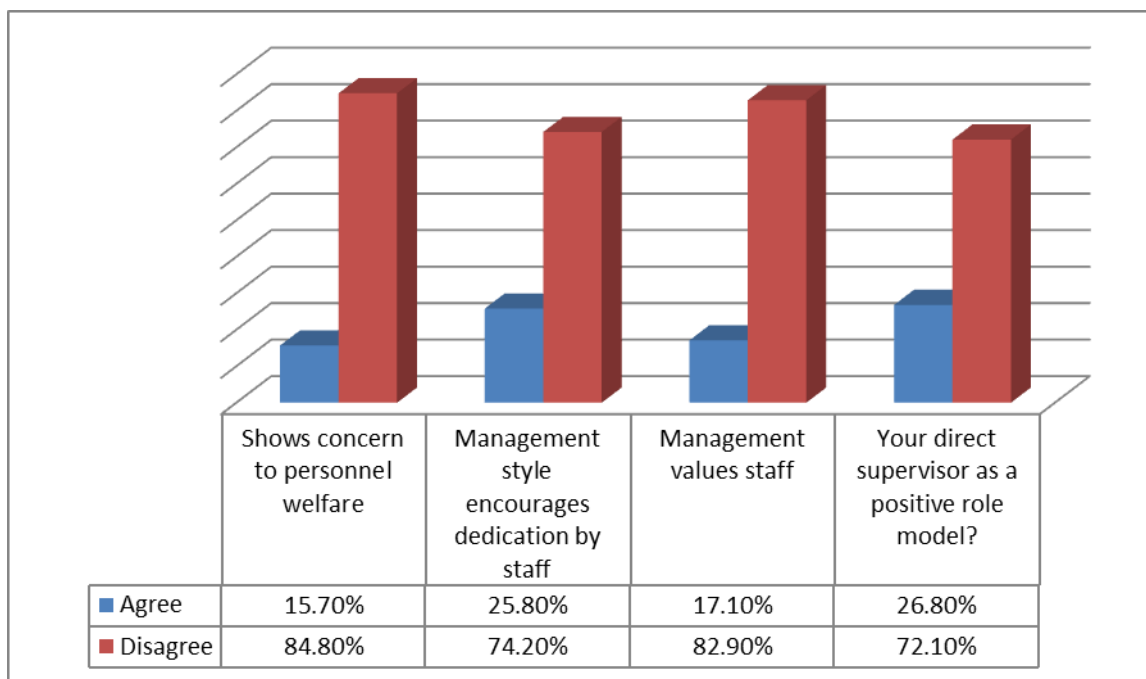
GRAPH 6.18: SATISFACTION WITH DISTRICT HOSPITALS AS A WORKPLACE
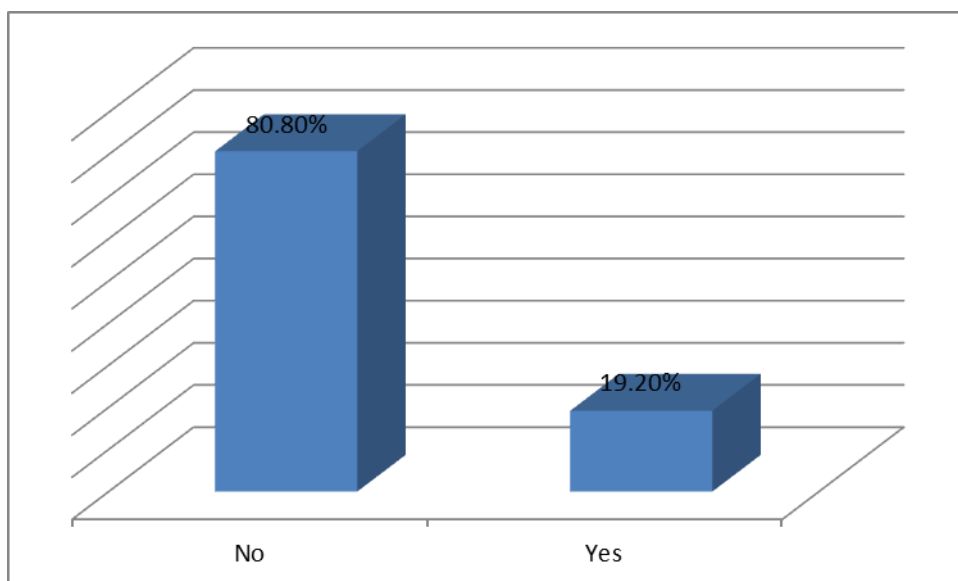
According to Figure 6.18, it is clear that the officials working in the district hospitals of Motheo are not happy with district hospitals as a place of work. It is obvious that the Free State Department of Health will have to provide job satisfaction for its workers and to ensure satisfactory working conditions to allow them to offer the best service, be dedicated and friendly to all patients. It has also been noted during the study that personnel are aware of the challenges as dissatisfied patients turn into former patients due to bad and unpleasant treatment received in the hospitals. In order for management to address the challenges affecting the district health services there is a need to strengthen the critical link, which is the personnel, by focusing on their employees, giving them the power to be the best. This will increase their ability and motivation to deliver their best service. It must be well understood by management that service failure, due to a shortage of medical consumables, lack of food for patients and non-functioning equipment negatively affects the morale of personnel. This state of affairs results in high staff turnover requires hard work and presents an uphill battle to gain the confidence of personnel. It must be acknowledged that satisfied employees lead to satisfied customers, and the only way to do it is to afford employees the true satisfaction of having what is needed to do the job.

GRAPH 6.19:   EVALUATION OF LEADERSHIP IN DISTRICT HOSPITALS

	Shows concern to personnel welfare	Management style encourages dedication by staff	Management values staff	Your direct supervisor as a positive role model?
Agree	15.70%	25.80%	17.10%	26.80%
Disagree	84.80%	74.20%	82.90%	72.10%

6.20 LEADERSHIP AS ROLE-MODEL IN DISTRICT HOSPITALS

The leadership qualities that are required to make a good leader can vary in different companies, teams and situations. They are context-dependent. In theory, the ideal scenario is for a leader to have infinite flexibility. That means you are able to adapt your leadership style according to the situation and/or the state of the team, e.g. to be an *executive leader* when forming a team one needs to be involved, and to be a *participative leader* when a team is performing well they all acknowledge the credit of good work (Blanchard & Hersey, 1960:51). White (1998:22) further explains that a good leader has an exemplary character. It is of utmost importance that a leader is trustworthy to lead others. A leader needs to be trusted and be known to live their life with honesty and integrity. A good leader "walks the talk" and in doing so earns the right to have responsibility for others. True authority is born from respect for the good character and trustworthiness of the person who leads (White, 1998: 22). All these attributes are the personal characteristics that are the foundation of good leadership. Some characteristics may be more naturally present in the personality of a leader. However, each of these characteristics can also be developed and strengthened. A good leader, whether they naturally possess these qualities or not, will be diligent to consistently develop and strengthen them in their leadership role and this is what is needed in the public sector in order to address its challenges (www.groco.com).

TABLE 6.2: SUMMARY OF CLOSED QUESTIONS:

QUESTIONS	PERCENTAGE : YES	PERCENTAGE: NO	DOMAIN
7, 8, 9, 10 and 13	• 30 (17.80) • 50 (17.40) • 45 (15.70) • 77 (26.80)	• 256 (82.20) • 237 (89.50) • 242 (84.30) • 210 (73.20)	**Effectiveness of district hospitals**

QUESTIONS	PERCENTAGE : YES	PERCENTAGE: NO	DOMAIN
11, 12, 14,15, 44 and 45	• 51 (17.80) • 87 (30.10) • 95 (33.10) • 147 (51.20) • 63 (22.00) • 79 (27.50)	• 236 (82.20) • 200 (69.70) • 192 (66.90) • 140 (48.80) • 224 (78.00) • 208 (72.50)	**Efficiency of district hospitals**
17, 18, 20, 21 and 24	• 178 (62.00) • 166 (57.80) • 109 (38.00) • 92 (32.10) • 92 (32.10)	• 109 (32.00) • 121 (42.20) • 178 (62.00) • 195 (67.90) • 195 (67.90)	**Personnel satisfaction**
29, 30, 31, 33, 34, 35, and 36	• 53 (18.50) • 70 (24.40) • 39 (13.60) • 80 (27.90)	• 236 (82.50) • 217 (75.60) • 248 (86.40)	**System failure**

QUESTIONS	PERCENTAGE : YES	PERCENTAGE: NO	DOMAIN
	• 206 (71.80) • 133 (46.30) • 136 (47.40)	• 207 (72.10) • 81 (28.20) • 154 (53.70) • 151 (52.60)	
48,50, 51, 52, 53, 54 and 55	• 62 (21.60) • 81 (28.20) • 111 (38.70) • 181 (63.10) • 36 (12.50) • 45 (15.70) • 74 (25.80)	• 216 (75.30) • 205 (71.40) • 176 (61.30) • 106 (36.90) • 250 (87.10) • 247 (84.30) • 213 (74.20)	**Leadership and management in hospitals**
38, 39, 40, 41, 42 and 43	• 61 (21.30) • 55(19.20) • 69 (24.00) • 85 (29.60) • 75 (26.10) • 66 (23.00)	• 226 (78.70) • 232 (80.80) • 218 (76.00) • 202 (70.40) • 212	**Safety and security in district hospitals**

QUESTIONS	PERCENTAGE : YES	PERCENTAGE: NO	DOMAIN
		(73.90) • 221 (77.00)	
38, 39 and 47	• 61 (21.30) • 55 (19.20) • 69 (24.00)	• 226 (78.70) • 232 (80.80) • 218 (76.00)	**Quality of service**

## TABLE 6.3: SUMMARY OF OPEN-ENDED QUESTIONS

MOST COMMON CAUSES OF STAFF TURNOVER AND DISSATISFACTION IN DISTRICT HOSPITALS IN THE MOTHEO DISTRICT:

REASONS FOR RESIGNATION	PERCENTAGE CITING
Career opportunities elsewhere	*1.4 %*
Better compensation	*3.4%*
Bad image attached to Department of Health due to unavailability of medication and equipment	*20.0%*
Bad behaviour of a line manager	*40.1%*

REASONS FOR RESIGNATION	PERCENTAGE CITING
Poor management	*12.1%*
Lack of resources	*0.5%*
Allocation of OSD	*16.2%*
Allocation of monetary rewards (PDMS)	*1.5%*
Poor state of district hospitals	*2.5%*
Poor relations with institutional management	*2.3%*
TOTAL PERCENTAGE	**100%**

GRAPH 6.20: **SUMMARY: MOST COMMON CAUSES OF STAFF TURNOVER AND DISSATISFACTION IN DISTRICT HOSPITALS IN THE MOTHEO DISTRICT**
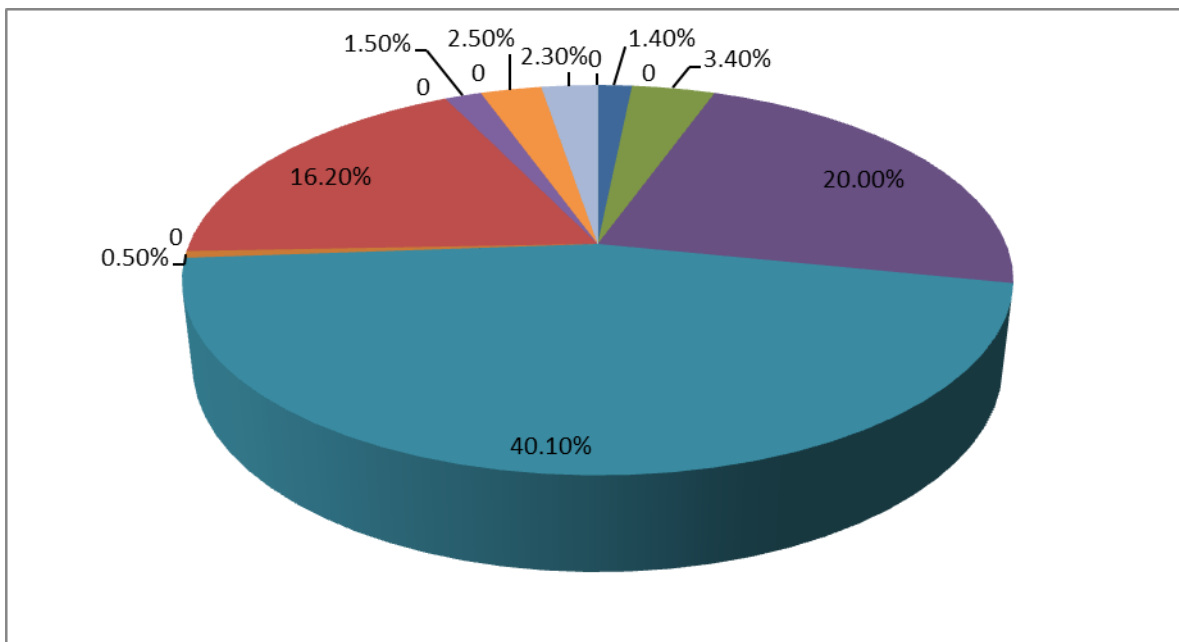
6.21 CONCLUSION

The hypothesis of the study predicted that challenges such as insufficient human resources, lack of medical instrument and financial resources, high staff turnover are the main causes of challenges in district hospitals. To confirm this hypothesis, a correlation analysis was conducted to investigate the relationship between these different variables. The results of the correlation are presented in Chapter 4 dealing with the results of the survey.

The importance of a quantitative survey such as this is to highlight the subjective or soft issues that are as critical as the technical and structural issues in the way in which they impact on health service delivery and total quality care delivered in the facilities. . They are aware of, and appreciate the main transformation policies for the promotion of district health services and service excellence. Whilst they are largely positive about these policies, they have difficulties and frustrations with the implementation, including organizational problems, staff limitations and patient demands for good health care.

Despite this, all the employees at different sections and levels feel that they have been able to make positive contributions and these contributions are not appreciated by management in the district and at the provincial office. Senior management are experienced as both a strong positive, enabling factor as well as a negative, demotivating factor, depending on the quality and approach of management. The importance of support and affirmation from senior management, and of including staff in decision-making, clearly stand out as being critical to the development of staff and their ability to deliver quality services. Good leadership is defined as supportive, affirming, and able to involve staff in decision-making and provide them with opportunities for learning and career development. For example, a compliment about a job well done appears to make a big difference and makes workers feel appreciated in a facility where they are overloaded and frustrated by the working conditions.

Where there is good leadership, the officials in the facility seem to be motivated and able to cope better with technical and operational difficulties. The importance of the internal, personal commitment of the individuals working as facility managers should be clear so that subordinates can learn from the good examples of managers. Their love for working in the health services, their affinity for dealing with patients, staff and the community, their leadership qualities and their ability to cope in difficult situations, are all crucial factors in maintaining and developing the services. They all recognize the value of good facility management. In the literature review of this study it is indicated that health workers have identified people management and financial management as skills that need further development. They use their internal strengths to adjust to difficult changes, to tackle the challenges of policy implementation and places, and to seek out opportunities for quality improvements. However, many a time these internal strengths are worn down by the frustrations they encounter along the way.

People are clearly the biggest resource of the health care services. The challenge therefore, is to find a way for health services to build on the internal resources of its staff and to find ways of resolving all the challenges affecting the efficiency and effectiveness of health in district hospitals. Concrete examples include adequate remuneration of the employees according to their experience and years in service, and if this is done it will ensure positions and support to district and provincial management. Building and strengthening the internal resources of staff, combined with optimizing management systems, remains one of the key human resource management challenges in the government sector. Finally, the results will be beneficial to the Department of Health, Free State province regarding the general feeling of the employees in terms of their work environment. In order to have the district health services rendering a good health service the management of district hospitals in the Free State has to be strengthened so that quality care can be guaranteed to all citizens of the Free State community.

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Annexure A: Approval to conduct research in the Free State Department of Health

Annexure B: Questionnaire

ANNEXURE A: LETTER OF APPROVAL TO CONDUCT RESEARCH

health
Department of
Health
FREE STATE PROVINCE

Mr MH Toli
9565 Grassland
Heidedal
Bloemfontein
9306

Dear Mr Toli

Subject: Request to do research Project in the Department of Health: Free State

The above mentioned correspondence dated 23 January 2009 bears reference.

Permission is hereby granted for the above – mentioned study on the following conditions:

- The report is not published to external sources without permission of the Free State Department of Health.

- Protocol approved by Ethics Committee.

- Research results shared with the Department as well as all reports made available to the Free State Department of Health.

- Research does not impact negatively on service delivery.

- Voluntary participation by staff; freedom to withdraw at any time.

Trust you find the above in order.

Regards.

Prof PL Ramela
HEAD: HEALTH

Date: 05/02/2009

ANNEXURE B: QUESTIONNAIRE

QUESTIONNAIRE TO ASSESS THE EFFICIENCY AND EFFECTIVENESS OF DISTRICT HOSPITALS IN THE FREE STATE

WHAT IS THIS QUESTIONNAIRE ABOUT?

Background:

This questionnaire is circulated by one departmental employee doing his research on the above mentioned topic. Your cooperation will be appreciated in completing the questionnaire. This also in a way will assist management of the department to understand the challenges of district hospitals in service delivery.

What is the purpose of this questionnaire?

In an attempt to understand the efficiency and the effectiveness of the district hospitals in the general health delivery, the high staff turnover and etc. We ask you for 10 minutes of your time to please complete this questionnaire <u>anonymously</u>. This exercise will only have value if employees provide honest answers.

Who must complete this questionnaire?

The primary objective of the study is to get all the district hospitals involved, it is critical that this questionnaire is also completed by all staff members from different departments of the district hospitals as this will ensure meaningful representation.

What to do with the completed questionnaire?

Email to: M.H.TOLI

Or fax to: (051) 408 1074

Or mail to: Tolimh@shealth.gov,za

Post: Mr M.H.TOLI

Department of Health, Free State

P.O.BOX. 227

Bloemfontein, 9300

SCALE:

Please indicate your level of agreement with each statement. You have the option to "neither agree nor disagree", however, we ask you to make use of this option as little as possible.

You will notice the numbers 1,2,3,4 and 5 appearing next to each statement. The numbers have the following meaning:

Yes	No	
If you are completing the questionnaire in soft copy (electronically) – please place an **"X"** next to the nr that accurately describes your level of agreement with each statement. If you are completing the questionnaire in hard copy (on paper) - please **<u>CIRCLE</u>** the nr that accurately describes your level of agreement with each statement.		
1. E.g. Considering my role (work and responsibility) I am paid fairly.	**X** **YES**	**NO**

1.	**District**						
2.	**Staff or Management**	Professional i.e. (Nursing, Doctor etc.)					
		Technical personnel					
		Administrative Support cleaner, workshop artisans)					
3.	**Section/ Unit**						
4.	**Gender**	Male		Female			
5.	**Race**	White	Black	Coloured	Indian	Other	
6.	**Age**					60+	
7.	**Years with this department**	0-1	2-4	5-9	10-15	16-20	21- 30	30 +
8.	**Job Title (optional)**						

STATEMENTS: *Managerial Issues*

1.	The work environment provides opportunity for celebration, fun, excitement and openness.	**Yes**	**No**
2.	My manager/supervisor is accessible.	**Yes**	**No**
3.	Recruitment and selection procedures and police are in place.	**Yes**	**No**
4.	Recruitment and selection procedures are fair and effectively implemented.	**Yes**	**No**
5.	Good performance is recognised, appreciated and praised.	**Yes**	**No**
6.	Good performance is properly rewarded.	**Yes**	**No**
7.	Each individual is treated with dignity and differences are openly respected and shared.	**Yes**	**No**
8.	I am empowered to make decisions about how work should be done.	**Yes**	**No**
9.	I find my work challenging.	**Yes**	**No**
10.	I have the computer software I need to do my job (necessary programs, database access, recent versions, or updates, etc.).		**No**

STATEMENTS: *Information Management*   SCALE:

11.	I have the information that need to do my job (data, reports, reference materials, etc.).	**Yes**	**No**
12.	I have the computer hardware I need to do my job (reasonably fast machine, enough memory, large enough monitor, etc.).	**Yes**	**No**
13.	I have the equipment I need to do my job (tools, fax machine, forms, office equipment, paper, pens, staples, etc.).	**Yes**	**No**
14.	There is proper communication between management and staff.	**Yes**	**No**
15.	There is proper communication between staff members.	**Yes**	**No**
16.	Messages from management to employees, stakeholders and clients are consistent all the time.	**Yes**	**No**
17.	Standards are applied consistently by management.	**Yes**	**No**

STATEMENTS: *Human Resource Management*

18.	My job is important to the success of the department.	**Yes**	**No**

19. Departmental procedures and policies are in place and effectively applied	**Yes**	**No**
20. Management values their employees.	**Yes**	**No**
21. HR provides the necessary support to staff.	**Yes**	**No**
22. The HR component performs optimally.	**Yes**	**No**
23. Performing duties that are within your scope of practice.	**Yes**	**No**
24. Performance evaluations are accurate reflections of actual performance.	**Yes**	**No**
25. Employees have a vision and direction that commits them to working hard.	**Yes**	**No**
26. My work provides opportunities to learn new skills.	**Yes**	**No**
27. Grievance procedures are in place.	**Yes**	**No**
28. Grievance procedures are followed in my institution.	**Yes**	**No**
29. The number of medico legal cases are alarming	**Yes**	**No**
30. Managers practice favouritism.	**Yes**	**No**
31. My skills are optimally utilised by the department.	**Yes**	**No**
32. Overall, I am satisfied with my working conditions.	**Yes**	**No**
33. Employees receive support, guidance and feedback from their supervisor.	**Yes**	**No**
34. Career planning is done with all the employees.	**Yes**	**No**
35. Overall Impression and impact of COHSASA in the district hospitals	**Yes**	**No**
36. After accreditation is the quality of care good in the facility?	**Yes**	**No**
37. The current PDMS contributes towards increased productivity.	**Yes**	**No**
38. Employees receive regular feedback on their performance.	**Yes**	**No**
39. There is a culture of ownership in the department (I am part of the organisation).	**Yes**	**No**
40. There is a culture of trust in the department.	**Yes**	**No**
41. There is a culture of accountability in the department.	**Yes**	**No**
42. I have opportunities for advancement.	**Yes**	**No**
43. I can take special leave for developmental purposes.	**Yes**	**No**
44. Management listens to feedback from employees.	**Yes**	**No**
45. Punishment / disciplinary action is applied with consistency.	**Yes**	**No**
46. I would easily find another job at a higher pay.	**Yes**	**No**

STATEMENTS: Health & Safety Issues

47. The level of physical security (concerning assault or theft) at my workplace is satisfactory.	**Yes**	**No**
48. The level of physical safety (accidents or unsafe work conditions) at my workplace is satisfactory.	**Yes**	**No**
49. Management are aware of employee concerns and complaints.	**Yes**	**No**
50. HR actively strives towards retaining the department's staff members.	**Yes**	**No**
51. The institution is running its finances according to the prescripts	**Yes**	**No**
52. Institutional resources are properly managed according to the prescripts	**Yes**	**No**
53. Equipment used are modern type and equal to nature of complications used for?	**Yes**	**No**
54. There is enough material resource to perform the health related duties	**Yes**	**No**
55. The department encourages dedication by all staff members	**Yes**	**No**
56. Management is transparent when taking the decisions.	**Yes**	**No**
57. HR efforts are aligned with the department's strategic objectives.	**Yes**	**No**

STATEMENTS: Personnel Evaluation & General HR

Questions		
58. Overall impression of the public on the quality of service rendered in this institution.	Yes	No
59. Job interview questions are properly linked to job requirements.	Yes	No
60. There are induction procedures / programmes for new employees in place.	Yes	No
61. Overall, managers are held accountable for their performance.	Yes	No
62. Departmental procedures and policies encourage (and not prevent) optimal performance.	Yes	No
63. Overall impression on the use of Volunteers in your institution	Yes	No
64. Departmental procedures and policies encourage (and not prevent) optimal performance.	Yes	No
65. I receive the job-specific training I need to do my job.	Yes	No
66. Management style encourages professional growth and development.	Yes	No
67. There are good interpersonal relationships between management and staff.	Yes	No
68. My skills and abilities fit good for my position.	Yes	No
69. New employees are clearly explained their roles and responsibilities.	Yes	No
70. Employees have confidence in the management team.	Yes	No
71. My roles and responsibilities are clear to me.	Yes	No
72. Employee morale and motivation is high.	Yes	No
73. I experience high levels of job satisfaction.		
74. Are you planning to be with the department in 5 years time?		
75. Are you currently looking for other employment?		

THANK YOU FOR YOUR TIME!

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