MANAGEMENT OF PUBLIC HOSPITALS IN WATERBERG DISTRICT (LIMPOPO PROVINCE)

BY

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DECLARATION

I, Fikile Goodness Phasha declare that the mini-dissertation hereby submitted to the University of Limpopo, Turfloop campus, for a degree of Master of Public Health (MPH) has not been previously submitted at this or any other university; and that it is my own work in design and execution.

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DEDICATION

This work is dedicated to my mother Nkone Nancy Kgoele who single handedly raised me, and taught me to believe in myself and that anything is possible with God.

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DEFINITION OF CONCEPTS

Manager: Hellriegel and Slocum (2004), defines a manager as a person who allocates human and material resources and gives direction to the entire company or organization.

Performance Management and Development System (PMDS) is a strategy used for tracking and evaluating the performance of employees in an organization to improve service delivery (Malefane, 2010). In order for the evaluation to be effective, both the supervisor and the employee must be actively involved throughout the process of evaluation.

Health care institution - any hospital, convalescent hospital, health maintenance organisation, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick or aged person (The 'Lectric Law Library', 2014).

Health Care Professional –any person who by education, training, certification or licensure is qualified to and is engaged in providing health care (Medical dictionary, 2014)

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ABSTRACT

BACKGROUND: There were perceptions that doctors as Medical Superintendents were unable to provide proper financial management of hospitals, thus administrators were appointed to manage hospitals irrespective of qualifications. The aim of the study was to determine how public hospitals are managed in Waterberg district (Limpopo province).

METHOD: A cross sectional survey was conducted among 27 hospital managers in the Department of Health Limpopo province, in Waterberg district hospitals. A self -administered questionnaire was used for data collection. Data were analyzed using SPSS version 22.0, where both descriptive and inferential analysis was conducted.

RESULTS: Of the 27 managers, 59.3% were females 40.7% compared to males. 96.3% of managers reported that they did not correctly implement PMDS and polices on RWOP were not applied. There was no statistical difference in management styles, according to gender ($p>.05$) and managers had a fair working relationship among themselves.

CONCLUSION: According to the study, there is a great need to train hospital managers in management skills and other related policies, and giving them support in terms of resources such as: staffing especially health professionals, financial and working resources.
Keywords: Management; Public Hospitals; Service delivery; Challenges

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

The chapter provides an overview on the study and will provide information on the purpose of the study and the setting it was conducted. The chapter is outlined into Background of the study, problem statement, significance, justification and aim of the study, research questions and the objectives of the study.

1.2 BACKGROUND

The 1994 independence in South Africa has ushered in great transformation in the entire public sector. Amongst others, public health sector is affected. The health system is still one of the most challenging areas. Just like other public sectors, the health sector has been encountering challenges such as funding and staff shortages. There are still a lot of imbalances with regard to funding of healthcare sector. Private sector receives much more funding as compared to public sector, even though majority of South Africans are dependent on public health institutions for health care services (Cullinan, 2006).

Post 1994, South Africa adopted a new style of hospital management where-in there has been a shift from a traditional Medical Superintendent to Chief Executive Officers. Medical Superintendents, now Clinical Managers, are meant to manage clinical services; whereas the role of Chief Executive Officers (CEO) is to manage both clinical and administrative services.

There were perceptions that doctors as Medical Superintendents were unable to provide proper financial management of hospitals (www.emeraldinsight.com, 2008). According to a study about "Managerial competencies of hospitals managers in South Africa: a survey of managers in the

public and private sectors", there is a common perception that public sector hospitals are inefficient and there is a great health care service collapse, some argue that the whole CEO's management style has attributed to it. This perception often raised a question about whether the management of public health institutions by non-health professionals would be better than management by health professionals.

Public hospitals play a central role in South Africa's health system. Public hospitals serve the health care needs of the vast majority of the population, including teaching and training needs of the health professionals in the country. Thousands of people are employed in the public hospitals, which deal with the health care needs of the majority of South Africans. There is an overwhelming perception that the hospital sector needs to be managed effectively. Hospitals in South Africa reflect the stark contrast between health service provision in the public and the private sectors. The public sector serves the indigent population constituting more than 80% of the total population and is funded predominantly by the government from the general tax revenue. The private sector, which is highly developed, serves less than 20% of the population, comprising those who are insured or high-income earners (Cullinan, 2006).

The national and local media reports that there is a growing perception that public hospitals are inefficient and ineffective, while privately owned and managed hospitals provide superior care and are more sustainable. The underlying assumption is that there is a vast gap in management capacity between the two sectors. Post-apartheid, the National Department of Health and Social Development has taken a step to appoint non-clinicians as heads of public health institutions. These were political appointments with no regard to qualifications or managerial skills. Some appointees are former teachers and insurance brokers, without health background or management qualifications www.emeraldinsight.com, 02/06/2008).

There has been an outcry that political appointments precipitate sloping of service delivery in some institutions. In what reflects to an acknowledgement that all is not well in the country's hospitals, the President of the country, Thabo Mbeki in his State of the Nation Address to Parliament in February 2008, stated "To improve service delivery in our hospitals, by September, we will ensure that hospitals managers are delegated authority and held accountable for the functioning of hospitals, with policy issues regarding training, job grading and accountability managed by provincial Health Departments which themselves will need restructuring properly to play their role" (Mbeki,2008).

In 2007, the Democratic Alliance listed "the five worst hospitals" in the country. However, it did not establish baseline norms and standards against which to make this judgment, nor did it assess all 388 public hospitals to select the worst.

In December 2005 and in the run-up to the March 2006 local elections, the Health Minister has been paying "surprise visits" to various hospitals and pronouncing many to be working well, sometimes simply on the basis that the floors are clean (Cullinan, 2006).

The deterioration of healthcare service delivery and non-health political appointments has prompted the researcher to take great interest in this research project.

1.3 PROBLEM STATEMENT

Chief Executive Officers (CEO's) who do not have health background or management qualifications have been managing both clinical and non-health professional segments of hospitals. Whilst it is easier to manage non-professional segment, the challenges to manage professionals becomes evident for someone without health background. A decline in health care in public institutions is attributed to this trend, where the CEO's do not have a health background.

The media, (print and electronic) are undated with reports of deterioration in-service delivery in public hospitals. CEO's that have political connection are appointed to run hospitals, without health background or any management skills. This has led to many problems in health institutions, as characterized by decline in health care service delivery to the public, as evidenced by numerous negative reports about public healthcare institutions. There is a wide spread perception that services in hospitals have seriously deteriorated over the past few years.

In some institutions, the working relationship between the CEO's and Clinical Managers continues to deteriorate because of differing opinions between them, such as immediate professional services to be rendered in hospitals. Currently, as an example, public health institutions lack basic medical care, such as shortage of basic medicine. This then raises a question of how are hospitals managed and what are the challenges facing managers in managing public hospitals in Waterberg District, Limpopo Province?

1.4. SIGNIFICANCE OF THE STUDY

Currently there have been scanty documented studies investigating how hospitals are managed and challenges facing managers in management of these public health institutions in the Waterberg District. Most studies have been concentrating on service delivery in urban settings, and the researcher hopes that the findings of the study will add to the body of knowledge in this area and for those who are responsible for policy development and health institutions management will utilize the recommendations of the study.

1.5. RESEARCH QUESTIONS

- How are public hospitals managed in the Waterberg district in Limpopo Province?
- What are the challenges facing implementation of services in public hospitals in Waterberg District, Limpopo Province?

1.6. AIM OF THE STUDY

- To determine how public hospitals are managed in Waterberg district (Limpopo Province).

1.7. OBJECTIVES OF THE STUDY

To achieve the above mentioned aim, the following objectives were identified:

1.7.1 To determine the socio-demographic profile of managers in Waterberg hospitals.

1.7.2 To determine perspective of managers regarding service delivery in the public hospitals in Waterberg district, Limpopo.

1.7.3 To determine challenges faced by managers when rendering services in these hospitals.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In 1996, the new Constitution was adopted for the country. According to Clause 27.1 of the Constitution, “everyone has the right to have access to health care services, including reproductive health, food and water, and social security, including; if they are unable to support themselves and their dependents; appropriate social support. The Constitution compels the state to take “reasonable legislative and other measures within its available resources, to achieve the progressive realization of each of these rights”. If health care services are getting progressively worse rather than better, this is presumably unconstitutional.

1.2 SERVICE DELIVERY IN PUBLIC HOSPITALS

Many provinces are still administratively weak and lack the capacity to do what they are supposed to do. In 2004, six out of nine provinces under-spent their health budgets because of a lack of capacity and skills. This is one managerial competency needed to run public health institutions effectively and efficiently. Norms and standards for the provision and delivery of healthcare services by public health institutions have been developed, which place greater responsibilities on these public health institutions, and managers are under constant pressure to show that they can meet these demands (National Department of health. A District Hospital Service Package for South Africa: A set of norms and standards).

Research on the management of hospitals has largely focused on technical, economic and infrastructural issues, where process issues are discussed; these tend to be at macro level, looking at

how policy is implemented in the health sector, rather than the process at a hospital (Collins & Green, 1999).

According to Hellriegel and Slocum (2004), a manager is person who allocates human and material resources and gives direction to the entire company or organization. Managers achieve an organization's objectives for the most part by arranging for others to do things, not by performing all the tasks themselves.

The term manager may mean many types of people. These include managers of businesses, chief executive officers of companies, and production supervisors. They further define management as planning, organizing, leading and controlling people working in an organization and the ongoing set of tasks and activities they perform. The organization's goals give direction to these tasks and activities.

There are three (3) levels of management, namely:

First-line manager: who is directly responsible for the production of goods or services.

Middle managers: who receives broad, overall strategies and policies from top managers and translate them into specific objectives and plans for first line managers to implement. Chief Executive Officers of public health institutions fall under this category.

Top managers: the managers who are responsible for the overall direction and operations of an organization.

All managers, irrespective of where or what they manage, perform four generic tasks. As mentioned above, these include planning, organizing, leading and controlling.

Planning involves defining goals and mapping out ways to reach them; organizing entails arranging and coordinating human, material and information resources aimed at achieving desired goals; leading involves motivating others to achieve organizational goals and controlling involves measuring performance and monitoring progress relative to objectives (www.humanresources-health.com, 02 April 2008).

Managers need to possess several competencies that will enable them to perform these functions effectively and efficiently. Managerial competencies are sets of knowledge, skills, behaviors and attitude that a person needs to be effective in a wide range of managerial jobs and various types of organizations (Hellriegel et al., 2004).

Of particular importance are strategic skills which relate to setting of key objectives, based on understanding of what is happening inside and outside the organization; task related skills which encompass functional and operational competencies which enable one to define the best approach to achieving objectives; given the resources available; people related skills which enable one to achieve objectives through and with others; and self-management skills which enable one to take responsibility for one's life at work and beyond.

The field of health care management, however, poses unique challenges as managers are expected to integrate modern business management practices with clinical and healthcare knowledge.

Although managers are key to overcoming the challenges facing health delivery in South Africa, there has been very little formal evaluation of the capacity of hospital managers, as well as their needs for future training, in South Africa (www.humanresources-health.com, 2008). Schaay et al.(1998), in technical report to chapter 9 of the 1998 SA Health review, emphasized the importance of determining the level of current management capacity and training required as part of overall management development process in our quest to improve policy implementation and health

system functioning. This aims to evaluate hospital managers' perceptions about their developed abilities for their current role as well as their needs for further training in health care management and health background.

The investigation, conducted by Karl von Holdt and Mike Murphy for the National Labour & Economic Development Institute (Naledi, 2006), describes public hospitals as "highly stressed institutions due to staff shortages, unmanageable workloads and management failures'.

The Naledi report recommends a radical re-organization of hospital services, based on full authority for hospital managers and the establishment of clear operational units within hospitals to ensure that sections are managed as a whole. The Naledi report calls for "considerable investment" in management capacity (www.worldproutassembly.org, 2008).

These proposals were accepted by cabinet's January Lekgotla, but remains to be seen whether government has the will to implement the measures with urgency. Buhlungu (2007), in State of the Nation: South Africa 2007, also confirms that good management of institutions can reduce institutional stress in public hospitals. The high level of this institutional stress in public hospitals is the product of managerial paralysis and disempowerment that follows from the lack of a clear focus on managerial authority and accountability at all levels. Most doctors and nurses interviewed in eight (8) South African public hospitals believe that staff shortages and management failure compromise patient care.

In a study article of defining competencies for hospital management: A comparative analysis of the public and private sectors, it was found that managers in both sectors feel that people management and self-management are the most valuable for the efficient and effective management of hospitals, followed by "hard management skills" and skills related to the ability to think strategically. Specific skills or knowledge related to health care delivery were perceived to be least important.

Public sector managers were also more likely to seek future training, and were also more adamant about the need for future management development programs (www.emeraldinsight.com, 2008).

This research provides the evidence that there is a great need, as well as a significant demand for a degree program in health management at South African institutions. The findings are useful in the conceptualization, design and delivery of health management programs aimed at enhancing current and future management and leadership capacity in the health sector.

CHAPTER 3

METHODOLOGY

3.1 Introduction

This chapter discusses the research design that was employed, the population and sample of health institutions managers that were used in the study, and the procedures that were followed to obtain the sample. Data collection processes and the mode of data analysis are discussed, as are ethical considerations, strengths and limitations of the study.

3.2 Study site

The study was conducted in public hospitals at Waterberg District in Limpopo province in South Africa. Waterberg is one of the six (6) districts of Limpopo province in South Africa. The district is situated at Southern side of Limpopo province. The majority of its 614 139 speak Northern Sotho and the population is largely rural (Census, 2001).

In this district, there are eight (08) hospitals, of which seven (7) are district hospitals and one a provincial hospital. There is only one (1) Health Centre in this district. The Waterberg district has six (6) municipalities.

3.3 Study design

Mouton (2002) defines a research design as a plan or blueprint of how one intends conducting a research. A quantitative approach and a descriptive design was used in this study. According to Sarantakos (1998), quantitative study approach assists in numerical measurement. Polit and Beck (2006) define research design as a “general plan for addressing research questions, including

specifications for enhancing the studies' integrity". The study is descriptive because the researcher wants to gain information about how hospitals are managed, according to manager's perspective.

3.4 Study population and sampling

Population is defined as the entire set of individuals of interest to a researcher (Gravetter and Forzano, 2009). The study focused mainly on hospital managers who are Chief Executive Officers, Nursing Managers and Deputy Managers, Clinical Managers, Clinical Support Deputy Managers, Deputy Managers Risk and Security, Deputy Managers Finance and Deputy Manager Communications in Waterberg district hospitals. A purposive sampling method was employed seeing that the total number of hospital managers in the Waterberg district was forty two (42) and the whole forty two conveniently formed the study sample. The sample is chosen on the basis of availability (Struwig & Stead, 2001). Because hospital managers are few, no sample size was calculated, all managers who agreed to participate were included in the study. A total of twenty seven (27) managers participated in the study.

3.5 Data collection Tools and Procedures

Tool: Data was collected using a self-constructed questionnaire containing both open and close ended questions (Appendix E). The questionnaire was developed by the researcher in English and no translation was needed because all participants were conversant with English. The questionnaire consisted of 3 sections, Section A: Socio-demographic profile, Section B: Service background and Section C: Challenges.

Participants were recruited using letters, and verbally. The researcher identified herself and stated the purpose of the research during the recruitment stage. Appointments were made with participants via emails and telephones. Participants were informed about the, purpose, potential and risks of the study. The participants were assured about the confidentiality of the information given in the letter

of consent for them to participate freely and offer informed consent. Data for the study was through free attitude conducted in English by the researcher as all managers were conversant with the language. It took less than 45 minutes to fill the questionnaire and therefore that gave an impression that filling the questionnaire did not impinge much on the manager's time.

3.5.1 Reliability, Bias and Validity

3.5.1.1 Testing Reliability

Pilot study was conducted on 6 managers and Chief executive officers from the nearby provincial hospital. The suggested changes were incorporated into the final questionnaire. Retesting of the questionnaire didn't yield any changes. A reliable questionnaire is the one that yields consistent findings across various samples. Reliability was ensured by minimizing sources of measurement error, like data collector bias. Literature from other studies with similar content was also sourced to ensure that questions asked were suitable to answer all objectives.

3.5.1.2 Bias

In systematic random sampling method there can be volunteer bias because participants can opt in of the study. People who participated in a study are often different than non-volunteers, as volunteers tend to be more motivated and concerned about their health. To prevent this, participants were educated about the effects and benefits of the study, and that it has no negative effects on the relationship with clinicians and national head office, with confidentiality highly emphasized.

Researcher bias was minimized by the researcher being the only one to administer the questionnaires and standardized conditions such as exhibiting similar personal attributes to all correspondents, for e.g., being available to explain where participants did not understand and maintaining a neutral stance when clarities are sort by participants.

3.5.1.3 Testing Validity

Validity concerns the degree to which a measure accurately reflects and captures the construct it attempted to measure and it must be demonstrated in order for the findings to be respected by the scientific community. The questionnaire was given to experts in the department of Public Health to ensure Content Validity and their expert advice was incorporated into the final design of the questionnaire before it was piloted.

3.6 Data Capturing and Analysis

Data were captured on SPSS program, version 22.0 for analysis. Descriptive statistics such as frequencies, percentages and graphs were utilized to analyze data. For categorical data, the frequency of responses to questions and percentage of the total sample was calculated. Chi square test was used to analyze cross tabulations between variables and to determine any associations between demographic variables, management styles, health background of managers and service delivery in the hospitals. The results were then presented in the form of frequency tables, graphs and charts.

3.7 Ethical Considerations

Ethical clearance was received from the school of Health Care Sciences Research and Ethics Committee (SREC) and from Medunsa Research and Ethics Committee (MREC) of the University of Limpopo. The permission to conduct the study was requested and approved from the Head of Department of the Limpopo Department of Health (Appendix C). Written informed consent was obtained from the employees who participated in the study (Appendix D). Study participants were assured of respect of person and that confidentiality of their information would be maintained. To protect the participants' confidentiality, the questionnaires (Appendix E) were completed anonymously. Furthermore, the data collected were used for the purpose of the study.

Participants were thoroughly informed before commencement of the study about the objectives of the study, its importance, qualifications and experience of the researcher, and that participation was voluntary and participants could withdraw from the study if they wished to do so without being penalised for whatever reason.

3.8 Summary

This chapter discussed the methods used in data collection, data analysis and both qualitative and quantitative methods were used for data collection.

The following chapter will discuss the results of the study.

CHAPTER 4

RESULTS

4.1 Introduction

This chapter presents and describes the findings of the data collected in the study. The results are presented using both tables and graphs. The chapter comprises of five sections as illustrated on the research instrument: Socio- demographic characteristics of participants.

4.2 Socio-demographic characteristics of participants

Table 4.1 Socio-demographic profile of the participants (% in columns)

Variables n = 27		Frequency	Percentage %
Age	25 – 35 yrs	05	18.5
	36 – 45 yrs	06	22.2
	> 45 yrs	16	59.3
Level of education	Diploma	06	22.2
	Degree	21	77.8
Years of service as a manager	<10yrs	21	77.8
	≥10yrs	06	22.2

Table 4.1 shows that 40.7% of the participants are ≤45 yrs of age and 59.3% are >45yrs of age. The majority of the participants, , (77.8%) of respondents had worked as managers for less than 10yrs and only 22.2% were managers for more than 10yrs.

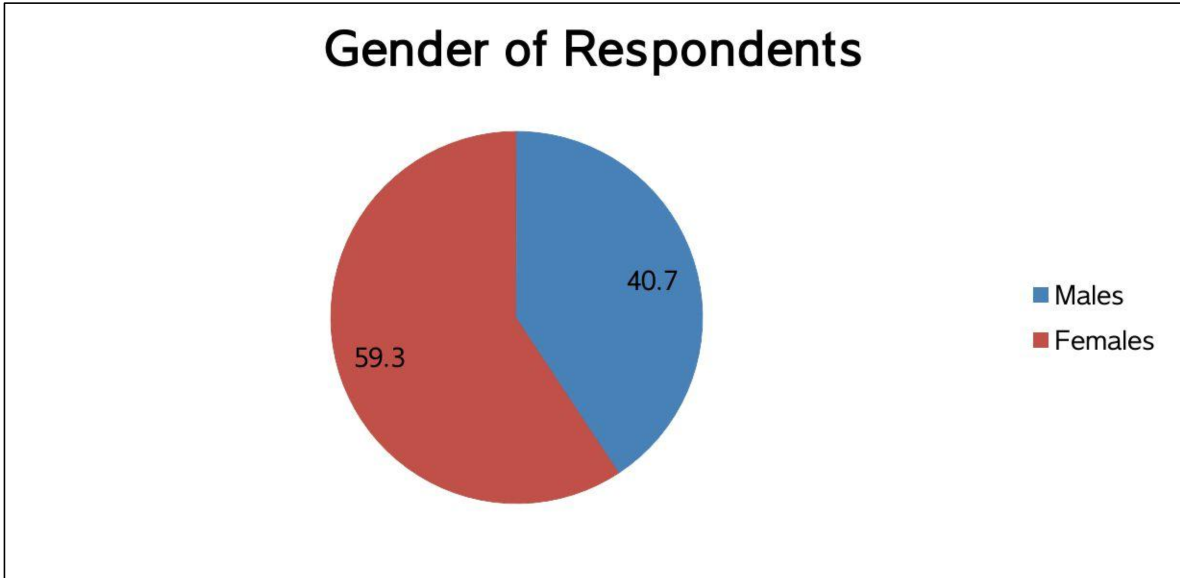

Fig 4.1: Gender distribution of respondents

Figure 4.1 shows that 59.3% of respondents were females and 40.7% were males.

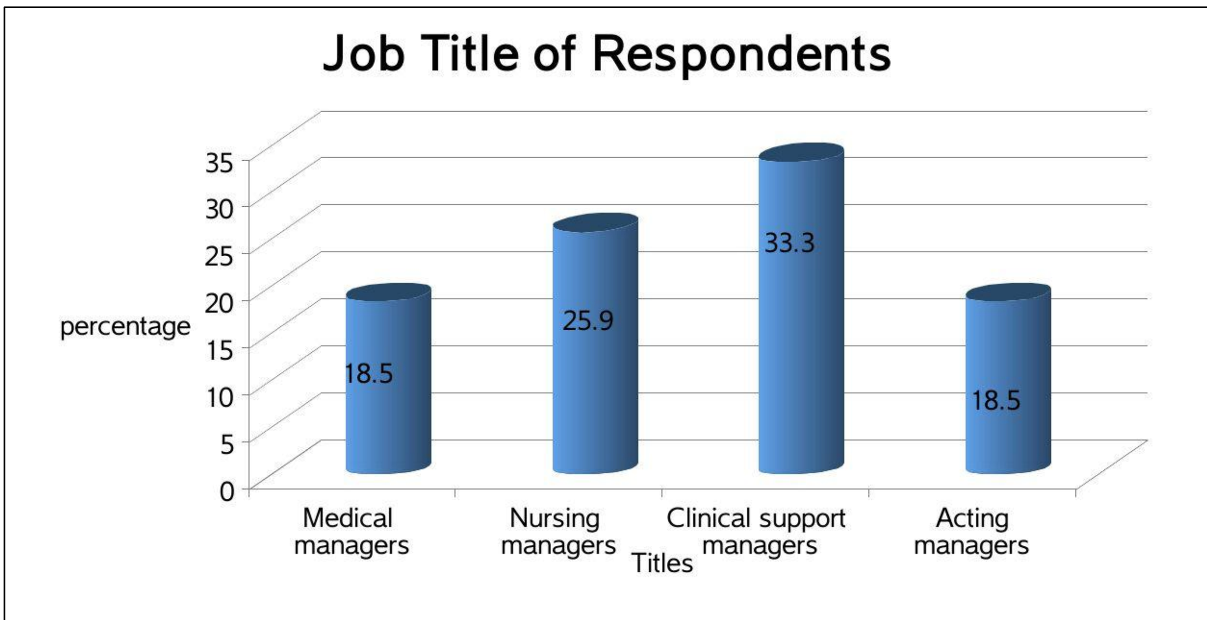

Fig 4.2: Job Title of respondents

Figure 4.2 above shows that 33.3% of respondents were clinical support managers, 25.9% nursing managers and 18,5% were medical managers and acting managers.

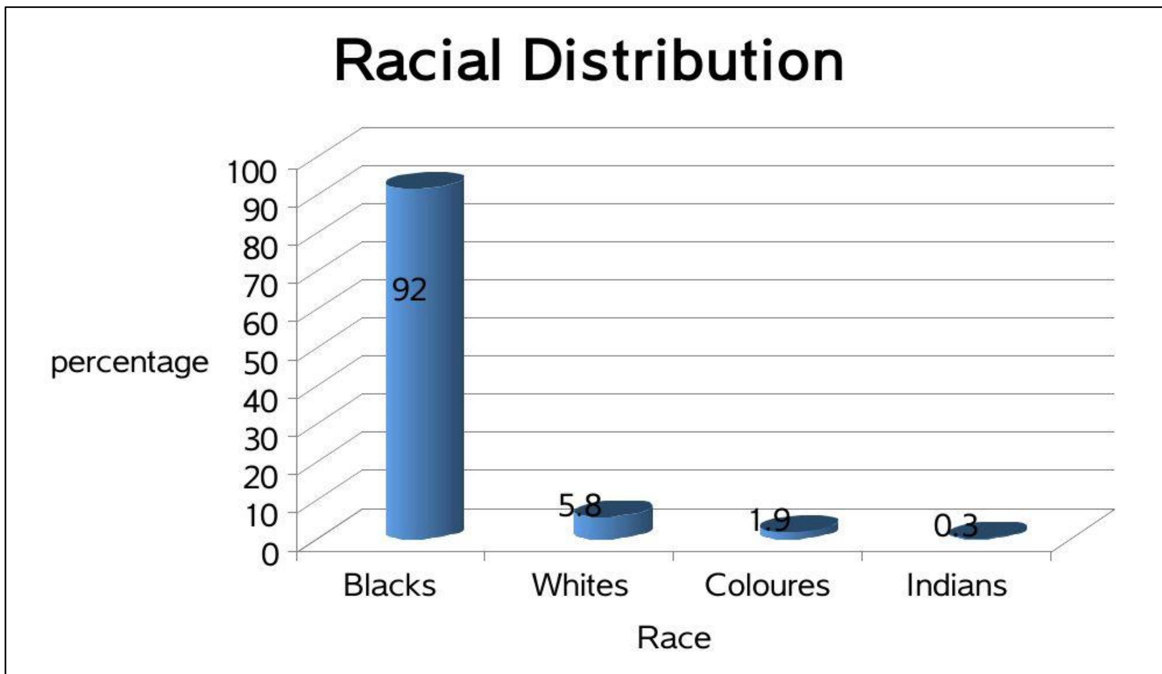

Fig 4.3: Racial presentation of staff in participating hospitals

Fig 4.3 shows that 92.00% of employees in the institutions are black and 5.9% are white and only 2.1% are other races.

4.3 Staffing

Table 4.2: Manager's perspective on staffing at the hospital (n=27), % in rows

Staffing	Manager's Perspectives on staffing			
	Adequate N(%)	Understaffed N(%)	Fair N(%)	Not sure
Medical officers (n=27)	06(22.2)	17(63.0)	04(14.8)	0(0.0)
Nurses (n=27)	06(22.2)	13(48.2)	02(7.4)	6(22.2)
Clinical Support staff (n=27)	08(29.6)	07(25.9)	06(22.2)	6(22.2)
Pharmacists (n=27)	09(33.3)	05(18.5)	05(18.5)	8(29.6)
Oral health (n=27)	11(40.7)	04(14.8)	03(11.1)	9(33.3)
Psychology (n=27)	02(7.4)	12(44.4)	01(3.7)	12(44.4)

Table 4.2 shows that 63.0% of managers feel that there is understaffing for Doctors, and Nurses (48.1%), whilst 29.6%; 33.3% and 40.7% of managers feel that there is adequate staffing of clinical support staff, pharmacists and oral health respectively.`

Table 4.3 Manager's perspective on Staff recruitment and retention in the hospitals

Manager's Perspectives (n=27)	Yes n(%)	No n(%)	Not sure n(%)
Adequate Human resource	05(18.5)	14(51.9)	08(29.6)
High staff turnover	15(55.6)	05(18.5)	07(25.9)
More employees left the public service	09(33.3)	09(33.3)	9(33.3)
More community service officers joining the hospital	13(48.1)	05(18.5)	09(33.3)
Most employees working part time	03(11.1)	14(51.9)	10(37.0)
Most employees threatening to leave Public sector	10(37.0)	08(29.6)	09(33.3)
Service delivery at best	03(11.1)	16(59.3)	08(29.6)

Table 4.3 shows that 51.9% of managers feel that there is a general shortage of human resource whilst 29.6% were not sure. 37.0% of managers indicated that most employees threatened to leave public service and 59.3% reported that service delivery is not at its best in hospitals.

4.4 Reasons for staff resignation

Table 4.4 Reasons for staff resignation as reported by Managers (n=27, % in rows)

Reasons	Yes N (%)	No N (%)
Staff going abroad	1 (3.7)	26 (96.3)
Staff going for Private practice	15 (55.6)	12 (44.4)
Staff going back to school	7 (25.9)	20 (74.0)
Staff moving to other hospitals	16 (59.3)	11 (40.7)
Staff prefer to do Sessions	19 (70.4)	8 (29.6)
Staff Don’t want to work in rural areas	26 (96.3)	1 (3.7)
Staff want to move next to family	24 (88.9)	3 (11.1)
Poor working conditions	26 (96.3)	1 (3.7)

Table 4.4 shows that the majority of managers (96.3%) report that most staff do not want to work in rural areas and 88.9% of managers’ report that staff prefer to work close to their families (88.9%), whilst 70.4% report that staff only want to work on sessional basis.

Table 4.5: Staff Comments on Exit interviews as reported by managers N(%)

Comments by staff on exit	Yes N(%)	No N(%)
Lack of incentives in public sector	14(51.9)	13(48.1)
Low staff morale	25(92.5)	02(7.5)
No promotions in the public sector	26(96.3)	01(3.7)
Better salaries in the Private sector	24(88.8)	03(11.1)
Competent packages abroad	24(88.9)	03(11.1)
Poor working conditions in the institution	25(92.6)	02(7.4)

Table 4.5 shows that 92.6% of manager's report that staff resign because of poor working conditions in their institutions, whilst 92.5% and 96.3% of manager's report that low staff morale and lack of promotion as reasons for leaving during exit interviews.

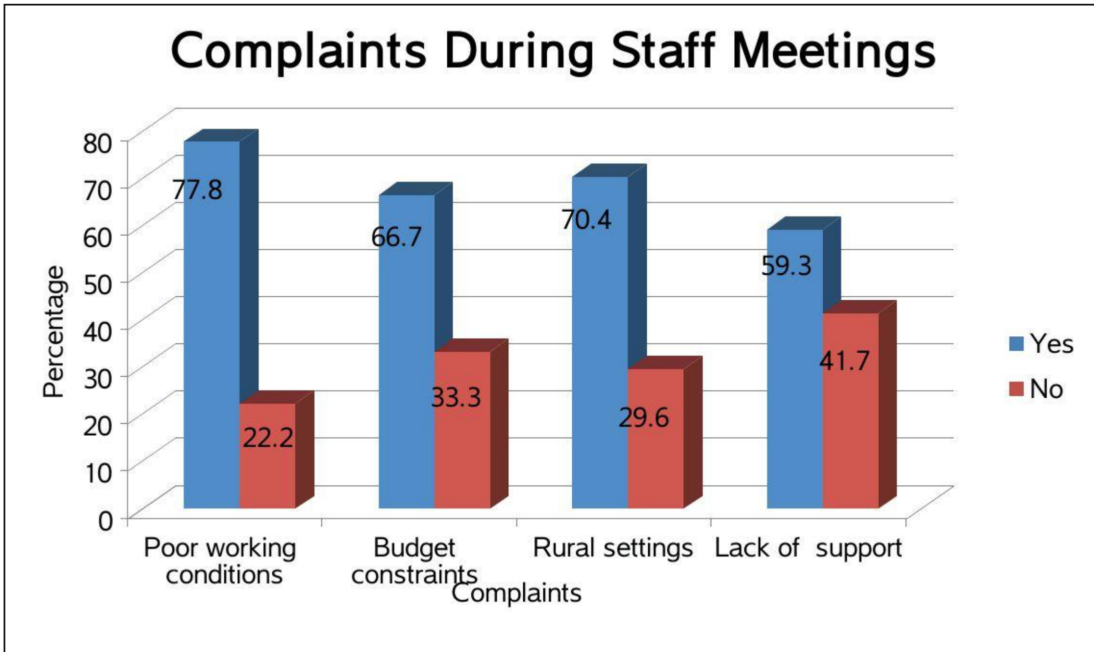

Fig 4.4: Managers report on main complaints presented by staff during staff meetings

Figure 4.4 above indicates that 77.8% of managers report that staff's complain of poor working conditions, whilst 70.4% and 66.7% of managers report poor infra-structure and budget constraints as main complaints of staff during staff meetings respectively.

Table 4.6 HIV/AIDS impact on staffing in the hospitals as reported by managers

Manager's Perspectives on HIV/Aids	Agree N(%)	Neutral N(%)	Disagree N(%)
The hospital loses staff in 14(51.8)		04(14.8)	09(33.4)
huge numbers because of HIV			
HIV does not have any impact on staff performance	09(33.3)	07(25.9)	11(40.7)
Only a small number of employees are affected	09(33.3)	07(25.9)	11(40.7)
Management is aware of HIV problem and contingent plan is in place	10(37)	09(33..3)	08(29.6)

Table 4.6 shows that 51.8% of managers reported that the hospitals lose employees due to HIV/AIDS, whereas 40.7% report that HIV/AIDS does not have any effect on staff performance. 37.0% indicated that management is aware of the HIV problem and there are contingent measures in place.

Table 4.7 Performance Agreements as reported by managers (% in rows)

Manager's response	Yes	No
Managers apply the RWOP policy (Remuneration work outside public service)	13 (48.2)	14(51.8)
Managers correctly implement PMDS (Performance Management Development System)	01(3.7)	26(96.3)
Managers counsel employees on financial management	04(14.8)	23(85.2)
Managers Motivate for better remuneration packages for health professionals in public sector	03(11.1)	24(88.9)
There is nothing that can be done	03(11.1)	24(88.9)
Employees are not interested in RWOP	03(11.1)	24(88.9)

Table 4.7 shows that 48.2% of managers do apply RWOP policy, whilst only 3.7% believe that they correctly implementation PDMS. Also, 14.8% believe that counselling of staff on financial management is essential.

Table 4.8: Manager's report on what the Department should do to improve Performance management development system (PMDS)

Aspects to be improved	Frequency	Percentage
Proper training and monitoring of PMDS	18	66.7
A new system to be introduced	07	25.9
OSD should be incorporated into the PMDS	11	40.7
Deserving employees should be remunerated	13	48.1
Appoint managers with skills	18	66.7

Table 4.8 shows that 66.7% of managers believe that proper training of managers on PMDS and monitoring should be done whilst 66.7% believed that managers with proper management skills should be appointed, whereas 25.9% reported that PMDS is not working properly, thus a new system needs to be incorporated. (Open-ended questions)

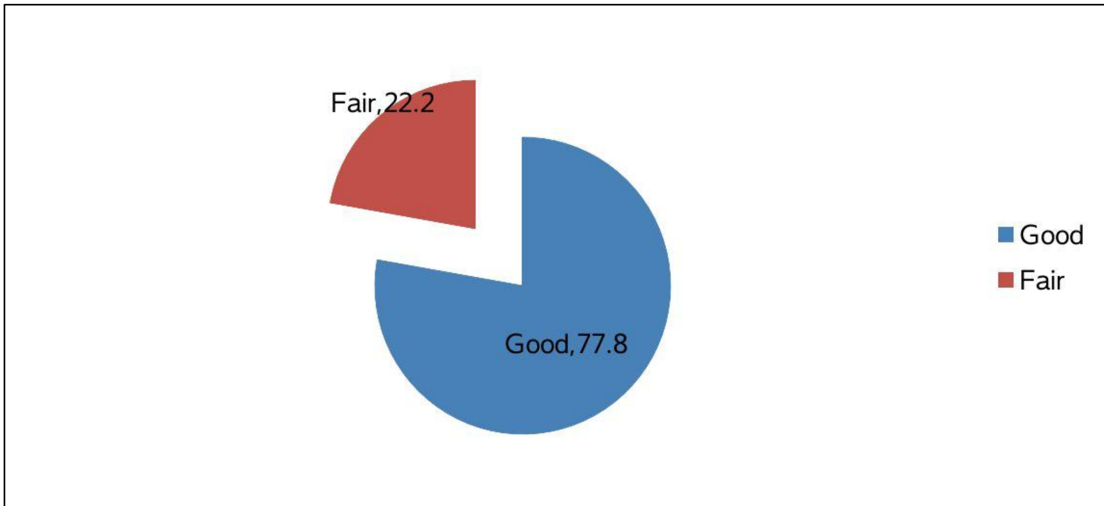

Fig 4.5 Working relationships between managers

Fig 4.5 shows above that 77.8% of managers reported that they have good working relationships with each other, whereas 22.2% reported that the working relationship is fair.

Table 4.9 Major challenges faced by the institution as reported by Managers (n = 27)

Challenges	Frequency	Percentage
Shortage of staff and other resources	05	18.5
Lack of funds	11	40.7
Poor management skills	06	22.2
People acting on higher posts for long	03	11.1
Low staff morale and poor working conditions	02	7.4

Table 4.9 shows that 40.7% of managers reported that budget constraints is the major challenge faced by hospitals, and 22.2% reported poor management skills. 18.5% complain of staff shortage whilst 11.1% complain of people acting on higher posts for long.

Table 4.10: Preferred leadership style by managers

Leadership Style	Frequency	Percent
Democratic Leadership	9	29.6
Autocratic	0	0
Free-reign style	0	0
Combination of the above three	18	66.7
Total	27	100.0

Table 4.10 shows above that two thirds of managers(66.7%) preferred a combination of leadership styles and 29.6% preferred a demographic leadership style.

Table 4.11: Gender vs Preferred Leadership style by managers (% in rows)

		Leadership/Management style		P value
		Democratic Leadership n(%)	Combination of the above three	
Gender	Male	3(27.3)	8 (72.7)	.498
	Female	6(37.5)	10(62.5)	
Total		9	18	

Table 4.11 above shows that there is no significant difference in leadership style preference between males and females, $p>.05$

Table 4.12 Manager's responses on whether institutions are using strategic planning as reported by the respondents

Responses	Frequency	Percentage
Yes	24	88.9
No	3	11.1

Table 4.12 shows that the majority (88.9%) of the managers' report that the hospital is using the Strategic planning, and 11.1% report that they don't.

Fig. 4.6 Rating of service delivery by the respondents

Fig 4.6 shows that 44.4% of managers rate their service delivery as moderate; 33.3% as good; 14.8% as fair and 7.4% as poor.

Table 4.13 Staff adequacy v/s Age group, Gender and Level of education

		Adequacy + fair	Understaff	Not sure	X2 P value
Age group	25 – 35yrs	2 (40.0)	3(60.0)	0	X = .131 P = .936
	36 – 45yrs	2(33.3)	2(33.3)	2(33.3)	
	≥46yrs	10(62.5)	4 (25.0)	2(12.5)	
Gender	Male	3(27.3)	5(45.5)	3(27.3)	X = .307 P = .449
	Female	5(31.3)	10(62.5)	1(6.3)	
Level of education	Diploma	2(33.3)	4(66.7)	0	X =.100 P = .695
	Degree	5(23.8)	12(57.1)	4(19.1)	

Table 4.13 shows that age, gender and level of education do not have any significance on staff adequacy reporting, since P value is > 0.05.

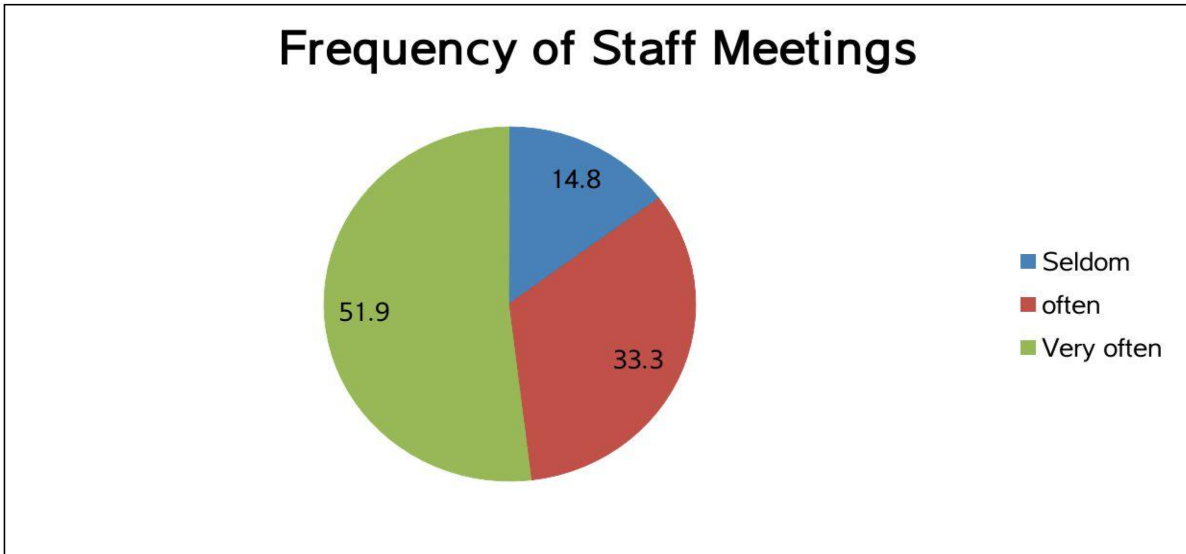

Fig 4.7: Frequency of Staff meetings as reported by Managers

Fig 4.7 shows that 51.9% of manager's report that they very often hold staff meetings, whilst 14.8% report that they seldom hold staff meetings.

Table 4.14 Staff meetings frequency according to type of manager

Job title	Frequency of staff meetings			P value
	Seldom	Often	Very often	
Medical managers	0	1(16.67%)	5(83.33%)	0.0287
Nursing managers	4(12.50%)	4(50%)	3(37.50%)	
Clinical support managers	0	4(40%)	6(60%)	

Table 4.14 shows that frequency of meetings is significantly related to job title of managers, p = .0287

Table 4.15 complaints received from the community according to classification of managers

Job title	Do you receive complaints from the community served by the hospital			P value
	Seldom	Sometimes	Often	
Medical Managers	2(25%)	4(50%)	2(25%)	0.013
Nursing managers	0	5(37.50%)	3(62.50%)	
Clinical support managers	1(9.1%)	7(63.6%)	3(27.3%)	

Table 4.15 shows that 62.5% of nursing managers often receive complaints from the community served by the hospitals compared to clinical managers and medical managers, p = .013.

Table 4.16 Working relationship between managers

Job title	working relationship between managers		P value
	Good	Fair	
Medical managers	3(37.50%)	5(63.50%)	0.089
Nursing managers	7(87.50%))	1(22.50%)	
Clinical support managers	11(100%)	0	

Table 4.16 shows that there is no significant difference between manager category and working relationship.

Table 4.17 Service delivery rating according to category of manager

	Rating of service delivery			P value
	Good	Moderate	Poor	
Medical managers	3(37.50%)	5(62.50%)	0	0.418
Nursing managers	4(50%)	4(50%)	0	
Clinical 2(22.22%)		6(55.00%)	3(27.3%)	

Table 4.17 shows that all most of managers rate service delivery moderate, whereas only 27.3% of managers of clinical support rated service delivery as poor, no statistical significance according to job title, p=.418.

4.5 Summary

This chapter presented the analysis of results. The chapter that follows will discuss the results of the study, conclude the study and recommendations.

CHAPTER 5

DISCUSSION, CONCLUSION AND RECOMMENDATION

5.1 INTRODUCTION

The aim of this study was to determine how public hospitals are managed in Waterberg district (Limpopo province). This chapter discusses the findings of the research. The discussion will cover objective individually. It will finally end with a conclusion statement, recommendations and limitations of the study.

5.2 DISCUSSION

Objective 1: To determine socio-demographic profile of managers in their hospitals

Gender, age and qualifications of respondents

The results of this study show that the majority of respondents were females than males. With increasing numbers of women moving into decision making positions in organizations (Powell.1988), coupled with the importance of conflict management skills in providing effective leadership, there has been an increased focus on the possible existence of sex differences in the ability to manage conflict. For example, some have expressed scepticism about women's ability to adopt managerial roles and responsibilities, with the managerial role often associated with the possession of masculine rather than feminine characteristics as early as in the 1970's (Brenner, Tomkiewicz & Shein, 1989; Powell & Butterfield, 1979). Literature reveals that females have a relationship-oriented type of management. From this study, it is therefore expected that most females will indeed adopt an avoiding- management style, however, this was not the case in this study, most females reported that they preferred a combination of leadership styles which include both democratic, free-reign and autocratic leadership styles. This is supported by Leah (2005))who

also reported that gender does not have as much influence when it comes to conflict resolution and managerial effectiveness in work places. The fact that there was no significant association between leadership style and gender show that management styles will be similar from one manager to another, irrespective of the discipline.

Studies indicate that female managers tend to use interpersonal, comprising, collaborative, accommodating, integrating, cooperative avoiding and communicative methods (Akintayo, 2005; Adeyemo, 2005). In contrast, there is evidence that male managers used more aggressive, competitive, confronting, assertive and coercive strategies more often than female managers in this study. In contrast, Hart (2012) reported that there is no difference between women and men in leader's pool. However, there are some significant differences in their profiles. Women can be as good as or bad leaders as men). This has occurred despite findings from research examining conflict management and leadership style in general, that suggest males and females who occupy equivalent managerial positions behave in much the same way (Eagly & Johnsons, 1990; Korabik, Baril & Watson, 1993; Powell, 1988).

The results of this study also showed that the majority of managers were over the age of 45 years, meaning that most will have more work experience and will present with years of experience in their respective fields. A study by Lehman and Simonton suggest that age of managers is directly related to management style. However, Pirola-Merlo et al (2002) contrasts this, as they report that qualifications, rather than age, will influence the management style of individual managers. Thus evidence of a decline in productivity with age does not necessarily mean that older managers perform less well.

In this study, it was found that the majority of the managers had degrees and had worked as managers for less than 10 years. In their study, Brenner, Tomkiewicz and Shein (1989) reported that the more educated the managers are, the more advanced they become when it comes to decision making and how they run the institutions. It is therefore expected that these managers in the current study will excel in how they manage the hospitals, seeing that the majority are well educated and have been managers for more than 10years. However, though this may not necessarily be the case, other factors may hinder the success of any manager, even if they have the correct qualifications and the correct years of experience. At times the smooth running of the institution is hindered by shortage of personnel, equipment and medication, which unfortunately reflects negatively on any manager.

Age

The results of this study showed that majority of respondents were over the age of 45yrs, which is of advantage, in terms of level of maturity. Studies show that individual's productivity peaks around the age 30–40yrs, after which it declines, focus on individual outputs such as research publications (Lehman, 1993; Simonton, 1997).The results of this study showed that most managers preferred democratic style of management. Democratic style of leadership will mean that every staff member has a fair share of a say on how the institution is run. A study by Pirola-Merlo et al (2002) found that team manager's leadership styles significantly impacted on team performance, but this impact was mediated via effective team processes. Thus, evidence of a decline in productivity with age does not necessarily mean that older managers' perform less well as shown in Pirola-Merlo (2002) study.

Level of education and Job title of respondents

The results of this study showed that the majority of respondents have health background, ranging from medical officers, nurses and other allied Health professionals. This would therefore make it easy for managers to have insight into the needs of the clusters they manage. Bandura (1977) posts that, efficiency is an important factor in human competency, creative system and familiarity with subject matter enhances the ability to competently manage it. According to Lepak & Snell, (1999), individual's education attainments are not only part of any company's human capital but also of a community's core assets. In many localities, generous subsidies for education are largely based on the assumption that government investments in human capital will strengthen the economy as a whole by enhancing the employees' productivity (Lanzi, 2007; Trusty &Niles, 2004). It is therefore encouraging that the government has selected mainly highly educated personnel to manage the hospitals, meaning, they will not only be having insight to the needs of each profession, but will use their education background to enhance service delivery.

Johnson and Elder (2002) found that compared to high school graduates, those who have college degrees tend to attach greater importance to altruistic rewards (for example, helping others). This study suggests, as level of education increased, achievement orientation increased as well. Because management also involve appropriate allocation of resources (including Budget), for efficient running the hospital it is therefore imperative that managers should strive to improve efficiency through additional training, besides the qualifications they have. It is however not clear whether the managers did receive this management training or not. Bloom et al, (2013) further suggest that efficiency can be increased through competition, which puts pressure on hospitals to improve management and therefore productivity.

OBJECTIVE 2: To determine the perspectives of managers regarding service delivery in the public hospitals in Waterberg district, Limpopo

Manager's perspective on staffing in the hospital

Generally, the public health institutions are stressed institutions because of workload rising from staff shortage and management failures (Landman et al, 2001). The results of this study showed that two thirds of managers feel that there is generally a shortage of human resource, and that service delivery is not at its best in hospitals they are managing. Though shortage of human resource is not unique to Waterberg district, staff shortage eventually lead to stressed institutions which cannot function optimally with varying strength of management. According to von Holdt & Murphy, (2006), staff shortage can be attributed to rapid exodus of healthcare practitioners to stressful environment they operate in. However, the appointment of new staff and community service officers is not always a good move, especially if the new staff has no work experience also, the fact that there is no upward mobility can discourage older staff from remaining in the institution. Managers in this current study report that there is high staff turnover and services delivery is at lowest in this hospital. Of note is the fact that most managers were not sure whether human resources was adequate or service delivery was best or not, in the hospital they manage. This finding is interesting because efficient managers are supposed to know the status of affairs in their own institutions, so that they are able to device means to improve service delivery.

In the current study, the majority of managers reported that most staff do not want to work in rural areas, and most resign because of poor working conditions in their institutions, which implicate that working conditions is a major driver at work. When more staff working in rural areas resign, this will obviously impact on service delivery as this will create staff shortage Human resource studies

and other research have provided vital insights on ways in which work space design features can help or hinder the accomplishment of work (Ulrich, 1992).

According to WHO (2006), there is direct relationship between the ratio of health workers to population and survival of women during child birth and children in early infancy. As the number of health workers declines, survival declines proportionately. WHO also indicated that health needs across the globe cannot be met without well trained, adequate and available health workforce. Nurses usually bear the brunt of staff shortages; as a result, they suffer from burnout more than other disciplines, resulting in high absenteeism, according to DENOSA, (2003).

The results of this study further showed that the majority of staff resigned from hospital to join private practice and prefer to do sessional work in private hospitals. These reasons further emphasize that salaries play a major role in an employee's decision to continue working in public institution or not. This has been seen in exit interviews of staffs that resigned from hospital, which cited that lack of incentives were the main reason for them leaving. The government has tried to improve salaries by implementing rural allowance in order to retain professionals within the rural areas, however, working conditions that impede of good service delivery, some- how make it impossible for staff to stay in these areas. Countries such as Indonesia offer specialist training as an incentive to serve in remote areas, but this incentive may speed turnover as personnel uninterested in general practice perform their services in rural regions where they are unlikely to return as specialists (Liaw et al, 2005).

OBJECTIVE 3: To determine challenges faced by managers in the hospitals

Working Conditions

The results of this study revealed that working conditions were a major driver of staff resigning as reported by majority of the respondents. The working conditions are very important to any organization, including the hospital. Hospitals have been reported to be the high risk for occupational hazards, even riskier than mining sector. If staffs work under strenuous conditions, they tend to lose concentration and resultant injuries such as needle stick injuries occur.

If the employees have negative perception of their working conditions, they are likely to have stress related illness and subsequently be absent from work due to illness, and their productivity and commitment tend to be low. On the other hand, organisations that have a friendly, trusting and safe environment, experience greater productivity, commitment, creativity and financial health (Kreitzer et al, 1997). Hamilton (2007) also reported that productivity is related to working conditions, which in turn is related to absenteeism, retention and the adoption of new methods and technologies. Hamilton (2007) further stated that all of those factors are related to how people are trained and encouraged are generally treated within the system.

Noble (2009) states that more attention should be paid in identifying and dealing with working conditions because when employees have negative perception to their environment, they sometimes suffer from chronic stress.

Hospital running vs National Head office expectations

There seems to be a gap between head office requirements and how hospitals are run. Managers are expected to hold regular meetings, as per requirement of the head office. Though this activity is crucial in keeping the staff informed of new rules, circulars and it is also a platform for staff to air their problems, these meetings seriously impact on service delivery.

As discussed above, in the current study, the majority of managers reported that they hold meetings regularly and during these meetings, the majority of staff complained of poor working conditions, whilst others cited not being happy with the rural setting and infrastructure.

Disgruntled Staff

Furthermore, A study by Omole et al (2005), reports that doctor's unwillingness to continue in their assigned posts negatively impacts continuity of care and may mean that many workers in rural areas are inexperienced. Managers in South Africa believe that the inexperience of health professionals sent to rural areas resulted in slower, poorer care of some patients (Omole & Marincowitz, 2005).

This current study further revealed that more than half of managers reported that staff complained about lack of support. Though managers could be there to support staff, but mainly, the national government still put priority urban than rural health institutions. This leads to inequality in service rendering to these two settings in terms of budget, stock-outs, and safety gears.

Lack of Understanding of Performance Assessment Tools

The managers in this current study reported that they are guided by the strategic planning developed to manage the institutions. As much as they use the Strategic plans, most do not achieve their hospitals 'Vision, Mission and Objective. In this study, the majority of managers reported that they do not implement Performance Management Development System (PDMS) correctly. PMDS is a tool that is a strategy used for tracking and evaluating the performance of employees in an organization to improve service delivery. Often, this PMDS is given to managers by head office without explaining how it works; as a result, most managers fail to implement it. According to the PMDS operational manual (2004), managers supervising PMDS must possess knowledge and skills and have good understanding of the system. It is interesting to find that 96% of managers reported that they do not implement PMDS correctly in the current study; it is possible that they do not understand how this system works. Success in the use of PMDS was achieved in a wide range of international private companies in the USA, Europe and Australia, from the research conducted by the Development Dimensions International. PMDS is also used in many other departments in South Africa; however, it remains unclear whether other institutions know how to implement it.

Lack of Skills

Literature reveals that the majority of employees lack basic skills in financial management, irrespective of how much they earn. From this study, the majority of managers reported that they do not counsel staff on financial management. Though this may not be part of their job description, it would be important that such courses are organised by managers so that staff can benefit and indirectly reduce their stress levels emanating from financial problems. Managers also reported that

they do not negotiate for better remuneration packages for staff. This shows that there is a gap between head office and institutions involvement in such activities.

Head office is currently using a top down approach, without liaising with subordinates in this regard. Also, results show that the majority of managers reported that there is nothing that can be done to improve service delivery from the hospital. In a qualitative study conducted by von Holdt & Murphy (2006), one hospital managers was quoted saying " head office do not know what is happening on the ground, we battle to retain staff and head office doesn't have competence to do their task". Another hospital manager in the same study was quoted saying "Province does not know manage, I was appointed as CEO but I had no experience, no training, but I am getting demands for quarterly report. When I raise problems with the district manager, she just notes it and nothing happens. ". Though this study was mostly a close-ended quantitative approach, such insights would be helpful when exploring why managers did not implement PMDS correctly.

Manager's recommendations on what the department should do to improve PDMS implementation

Despite the fact that PMDS is believed to be a better tool for performance management, major challenges in its implementation exists. The majority of managers did not know how to implement PMDS, two thirds of managers suggested that there must be proper training and monitoring of PMDS. Van Rooyen (2010) and Saravanja, (2011) report that challenges of PMDS implementation in South Africa could be lack of alignment of performance instruments with the company' strategic plan, poor design of the tools, budget and operational plan. Communication is an important element in PMDS implementation and it is required through all the phases, however, it seems that the

majority of managers do not know how to implement PMDS; one wonders how they are able to communicate it to subordinates. However, most of managers do want to be trained on this tool in this current study.

Working Relationship between Managers

This study found that there was a good working relationship between managers in this hospital. This is viewed as a positive way of motivating each other and sharing of information. For the smooth running of any institution, it is essential that managers are seen to be working in harmony. Doherty (2014) posit that good leadership is the one that clarifies different roles especially those that are in leadership position with focus on building collaborative teams between all manager and subordinates. Of note is the fact that there must be a healthy working relationship between management and healthcare practitioners according to Brooks (2006). If no relationship exist between managers from different units, it becomes difficult for the hospital to improve service delivery. Also, Bloom et al, (2013) encourage competition between managers, to improve management quality. With the rapidly rising healthcare costs as a proportion of each country's GDP, Centres for Medicare, (2009) suggest competition will put pressure on hospitals to improve management and therefore productivity.

Service delivery

Manager's perspective on staffing

All respondents complained of understaffing in the hospitals. There is critical shortage of doctors, nurses, Clinical support staff, Psychologists and Pharmacists.

The results showed that there is generally shortage of human resource in the hospitals, with high staff turnover. There is also indication that community service personnel improve shortage each year.

A study by Cavender et al (1998), confirms that many health professionals object to compulsory service programmes. Reasons given include: costs, utility and sustainability of programmes, poor rural facilities, and lack of transportation, inadequate clean water, electricity, equipment and medications, making performance of some skills learnt in medical schools impossible.

Reasons for staff resignation

The result of the study showed that majority of hospital employees prefer to work in private sectors than public hospitals. Booyens'(1985), reported that the primary factors associated with the shortage of Professional medical staff and in respect of the medical staff leaving the profession and alsotheir current employment, related to the following sources of dissatisfaction: irregular hours of duty and poorly organized shifts, insufficient differentiation in salaries in respect of varied responsibilities undertaken by nursing personnel- as well as the quantity and quality of the nursing service delivered, a belief that nurses were underpaid.

This current study found that two thirds of the respondents indicated that they were unhappy with their salaries, poor support from nursing service managers (a main complaint being that nurses felt that they were not given enough recognition for their efforts), insufficient opportunities for promotion and insufficient opportunities for participation in decision making. Additional sources of dissatisfaction identified by Booyens (1985) related to dissatisfaction with the calibre and abilities of junior student nurses, not enough autonomy and an undervaluing of professional judgement, and insufficient opportunities for further education and advancement in the clinical situation.

Interestingly 'job satisfaction' was not found to be a factor contributing to the turnover/ shortage of medical personnel.

HIV/AIDS impact on staffing in the hospitals

As much as most hospitals lose young and talented employees due to HIV/AIDS, it is not really hampering service delivery in the hospitals as management reported that they have contingent measures in place. The increasing incidents of HIV/AIDS infection among health workers lead to more absenteeism, reduced productivity and higher training and recruitment cost. Some countries have been experiencing 5 to 6 folds increases in health worker illness and death rates. The increased workloads and stress might further spur the departure of health workers into the private sector or even abroad. The quality of care suffers, as does the capacity to provide essential HIV/AIDS services, such as voluntary counselling and testing. Beyond the increased strain on hospitals and health care facilities, the cost of providing basic health care soars as the epidemic expands (UNAIDS, 2002)

5.3 CONCLUSION

This study provided us with relevant details on challenges faced by managers in the hospitals.

According to the study, there is a great need to train hospital managers in management skills and other related policies, and giving them support in terms of resources such as: staffing especially health professionals, financial and working resources.

There is also a challenge of health professionals not preferring to work in rural areas due to poor infrastructures, including lack of resources. These are aspects that the government should take into cognisance and prioritise improving working conditions and support anyone who is willing to work in rural areas.

Furthermore, the study revealed that majority of personnel resign due to low staff morale and lack of promotions to higher posts Though this is a generic problem in all public institutions, the perception that people progress quicker when they are in the urban settings than rural setting is a reality and such inequalities need to be addressed so that professionals do not need to relocate to urban areas for work promotions.

The study found that service delivery is not at its best in all health care facilities. . The fact that management does not understand how to implement PDMS, which is the only tool to assess service delivery of staff, means that there is dire need to change this situation and head office must ensure that they improve communication with managers and train them on how to manage the hospital. Management report that stock-outs and staff shortage lead to low morale of those staffs that are remaining, such issues need to be attended to avoid further loss of staff to private sector.

5.4 RECOMMENDATIONS

The provincial government should employ more medical professionals to ensure quality service in the rural health sector. This will also improve the working conditions of medical staff by reducing the long working hours which are in conflict with labour laws and international working standards.

It will also help to reduce the unnecessary accidental deaths and occupational injuries in the work place due to fatigue.

Employ managers with good health management skills or those who are already in the positions be trained on how to manage the institution.

Develop infrastructure in line with the growing population and ensure that it provides world class service in line with the populations needs.

Have a succession plan to ensure that continuity and build a pipeline of clinical managers to deal with the brain drain.

Ensure that there is synergy between public and private hospitals to deal decisively with skills shortage within the public sector in general.

Encourage communities to be part of improvement plan for the hospitals. Research has shown that projects that are planned with affected communities are more likely to succeed compared to projects were there is no buy-in from affected communities.

The above recommendations need an integrated management plan in place, since they involve different role players within the public sector. For example infrastructure development will need both department of public works and social development etc. it also needs the national department of health and labour to interrogate the conditions under which most medical staff work under not only in Limpopo but in South Africa in general.

5.5 LIMITATIONS OF THE STUDY

There are few limitations to this study but care was taken to minimise the effect on the results.

Only managers of sections in the hospitals were interviewed at the time of the study. Probably including all other hospital staff would give more information on how they feel they are managed.

In addition, some managers were on acting capacity during the time of the study, thus might give a different view as compared to those on permanent bases.

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APPENDICES

APPENDICE A: MREC CERTIFICATE

APPENDICE B: LETTER FOR PERMISSION

P O BOX 4683

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MOKOPANE

0600

22 February 2012

Department of Health & Welfare: Limpopo Province Polokwane.

APPLICATION TO CONDUCT RESEARCH IN THE HOSPITALS IN WATERBERG DISTRICT

I am Fikile Goodness Phasha, Master of Public Health (MPH) Student at the University of Limpopo. I hereby request permission to conduct research in the hospitals in the Waterberg District involving mostly managers in these institutions.

The title of my study is "Management of public hospitals in Waterberg district (Limpopo Province, South Africa")."

The aim of this study is to determine if health background is the key factor in the management of public health institutions.

The objectives are: To determine the socio-demographic profile of managers in Waterberg hospitals.

To determine perspective of managers regarding service delivery in the public hospitals in Waterberg district, Limpopo.

To determine challenges faced by managers when rendering services in these hospitals and

To influence policy makers on appointment of Chief Executive Officers in public health institution.

The study will be conducted in the form of questionnaires to managers in different areas.

The proposal for the study has been approved by the Research and Ethics Committees of the University of Limpopo.

Thanking you in advance.

APPENDICE C: DEPARTMENT OF HEALTH PERMISSION LETTER

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald

Ref:4/2/2

Phasha FG

University of Limpopo

Sovenga

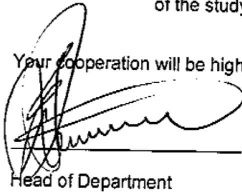
0727

Dear Mrs Phasha

Re: Permission to conduct the study titled: Management of public health institutions by non-health professionals in South Africa-the case of Waterberg District in Limpopo Province, South Africa.

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
    - Further arrangement should be made with the targeted institutions.
    - In the course of your study there should be no action that disrupts the services.
    - After completion of the study, a copy should be submitted to the Department to serve as a resource.
    - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.



Head of Department

2012/06/26

Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

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APPENDICE D: CONSENT FORM

LETTER OF CONSENT (UNIVERSITY OF LIMPOPO CONSENT FORM)

Statement concerning participation in a Research project

Name of Project:Management of public hospitals in Waterberg district

I have the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this study/project is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from my regular doctor.

I know that this study/project has been approved by the Research, Ethics and Publications Committee of faculty of Medicine, University of Limpopo (Medunsa Campus). I am fully aware that the results of this study/project will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study/project.

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Name of Patient/volunteer Signature of patient or guardian

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Place Date Witness

Statement by the Researcher

I provided verbal information regarding this study/project.

I agree to answer any future questions concerning the study/project as best as I am able. I wil adhere to the approved protocol.

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Name of researcher	Signature	Date	Place

APPENDICE E: QUESTIONNAIRE

QUESTIONNAIRE

(Please mark with an "X" on the blank spaces provided. Some of the questions may require more than one answer. Kindly feel free to provide more answers to such questions).

1. Identifying Information

Gender

Male	1	Female	2

1.2 Age: ------------------------

1.3 Level of education

Grade 12	Grade 12 + Diploma	Degree	Post-graduate	Other (please specify)
1	2	3	4	5

1.4 Medical/Health background

Medical officer	Professional nurse	Clinical support officer	Other(please specify)
1	2	3	4

2. Service background

2.1 How long have you worked as a CEO/Nurse/Clinical Manager/Deputy manager Clinical support/Finance/Risk & Security/Communication in your institution?

0 -3 Years	4 - 6 Years	7 - 9 Years	10 - 12 Years	13 Years or more
1	2	3	4	5

2.2 Do you have adequate Doctors, Nurses, Clinical support, Pharmacists, Oral health or Psychological staff in your institution?

Doctors	Adequate	1	Understaffed	2	Fair	3	Badly staffed	5
Nurses	Adequate	1	Understaffed	2	Fair	3	Badly staffed	5
Clinical support staff	Adequate	1	Understaffed	2	Fair	3	Badly staffed	5
Pharmacists	Adequate	1	Understaffed	2	Fair	3	Badly staffed	5
Oral health staff	Adequate	1	Understaffed	2	Fair	3	Badly staffed	5
Psychology staff	Adequate	1	Understaffed	2	Fair	3	Badly staffed	5

2.3 If "Yes", what was the case with staff recruitment and retention in the past three years in your institution?

A	There has been adequate human resources in the hospital	Yes	1	No	2
B	Staff turnover has been very high	Ye	1	No	2
		s			
C	More employees left the public service to private and abroad	Yes	1	No	2
D	More staff will be joining the hospital as Community service officers in January	Yes	1	No	2
E	Most employees have been working part time	Yes	1	No	2
F	Most employees are threatening to leave the public service	Yes	1	No	2
G	Service delivery is at its best and there is nothing hampering it currently	Yes	1	No	2
Other reasons. Specify -		Yes	1	No	2

2.4 According to your knowledge, what do you think are the reasons for the staff resignations?

A	Staff going abroad	Yes	1	No	2
B	Staff going for private practice	Yes	1	No	2
C	Staff going back to school	Yes	1	No	2
D	Staff going to other hospitals	Yes	1	No	2
E	Want to only serve the hospital on sessional basis	Yes	1	No	2
F	Staff don't want to work at rural areas	Yes	1	No	2
G	Unsure	Yes	1	No	2
Other reasons. Specify					

2.5 Regarding staff resignations, what were their comments during exit interviews?

A	Poor working conditions	Yes	1	No	2
B	Lack of incentives in the public sector	Yes	1	No	2
C	Low staff morale	Yes	1	No	2

D	No promotions in the public sector	Yes	1	No	2
E	Better salaries in the private sector	Yes	1	No	2
F	Competent packages abroad	Yes	1	No	2
G	Poor working conditions in the institution	Yes	1	No	2
Other		Yes	1	No	2

2.6 Do you hold staff meetings?

Never	Seldom	Sometimes	Often	Very often
1	2	3	4	5

2.7 What are the main complaints during staff meetings?

2.8 Do you have adequate accommodation for staff in your institution?

Not at all	Some accommodation	Inconsistent	Adequate	Unsure
1	2	3	4	5

2.9 If "Yes" how is the condition of the accommodation?

Good	Fairly good	Poor quality	No staff accommodation in hospital	Problem beyond the hospital control
1	2	3	4	5

2.10 Do you receive complaints from the community served by the hospital?

Never	Seldom	Sometimes	Often	Very often
1	2	3	4	5

2.11 If "Yes" how do you address them? Please explain

2.12 Do you have a Quality Assurance Team in the hospital?

No	Yes
1	2

2.13 Does your hospital do patient surveys and how often?

2.14 What percentage of each race is represented in your institution?

Coloured	Indian	Black	White	Other

2.15 How do manage cultural diversity in your institution?

2.16 In which way do you agree or disagree with the following statements regarding HIV/AIDS in your institution? (SD = Strongly Agree, D = Disagree, N = Neutral, A = Agree, SA = Strongly Agree)

		SD	D	N	A	SA
A	Institution looses young and talented officers in huge numbers	1	2	3	4	5

		SD	D	N	A	SA
B	Disease does not have any effect on staff performance	1	2	3	4	5
C	Only a small number of employees are affected and it does not make a difference	1	2	3	4	5
D	Management is aware of the problem and a contingent plan is in place	1	2	3	4	5

2.17 In spite of signed performance agreements, numerous health professionals are engaged in private practice meanwhile employed on full time basis. If this problem happens in your hospital, how would you solve the problem?

2.18 Which leadership/management style do you use in managing your institution?

A	Autocratic leadership	1
B	Democratic leadership	2
C	Free-reign style leadership	3
D	Combination of the above three	4
E	Non of the above	5
F	Unsure	6

2.19 Regarding performance management, what do you suggest the Department should do to improve the system and the seriousness to the health professionals?

2.20 In your view, what are the main issues that make health professionals leave their province and go and settle in other provinces and even abroad?

2.21 How would you describe the working relationship between yourself and other members of management?

Good	Fair	Bad
1	2	3

2.22 Is your hospital adequately resourced? If not, what is the reason?

2.23 What are the major challenges faced by your institution and how do you deal with them?

2.24 Is your institution using the Strategic plan developed to achieve the organizational objective?

Yes	No
1	2

If "Yes" are you achieving the institution's vision, mission and objectives?

If "No" what is guiding your institution to achieve its set objectives?

2.25 How would you rate your hospital in terms of service delivery?

Excellent	Good	Moderate	Fair	Poor
1	2	3	4	5