PERCEPTIONS OF PROFESSIONAL HEALTHCARE MANAGERS ON HOW GOVERNANCE INFLUENCES SERVICE QUALITY IN A PUBLIC HOSPITAL IN THE FREE STATE

by

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Submitted in fulfilment of the requirements in respect of the Master's Degree in Governance and Political Transformation in the Department of Governance and Political Studies in the Faculty of the Humanities at the University of the Free State

Date of submission

2 July 2018

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DECLARATION

I declare that this mini-dissertation submitted for Master's degree Governance and Political Transformation at the University of the Free State is my personal work and has not been previously submitted for another academic qualification.

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KARABO D. LOGABANE

JULY 2018

ACKNOWLEDGEMENTS

To God be the Glory and Honor*. "Lord you have been wonderful for watching over me and guided me through".*

The successful completion of this study is due to:

- The unwavering support and inspiration of my supervisor Mrs. I. Seale, who provided her expert guidance.
- Dr. T. Coetzee whose support, guidance and motivation contributed greatly to my successful completion of the course.
- Ms. M. Darren for your diligent and dedicated support in editing and formatting my work.
- The Free State Department of Health for allowing me access to not only your facilities but also personnel who became participants of this study.
- My husband Gopolang for all your love, support and perseverance.
- My daughter Molemo for proof reading my script and transcribing notes, my son Otsile and daughter Dintle, you were the support I needed when the going gets tough.
- My supportive family, especially my parents, parents-in-law, grandma and my siblings for believing in me and your constant prayers.
- My home cell family, your constant prayers made it possible for me.
- My former managers Mr. A. Stofile and Mr. L. Tau for offering me support and encouragement. Their roles in my study were immense.
- My friends and colleagues, your friendship and honest advice is much appreciated.
- Dr. M. Jama, for your encouragement. You became my pillar of strength when I felt I had reached a point of despair. Your efforts are much appreciated.

Thank You.

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1.1 INTRODUCTION

Countries in sub-Saharan Africa are faced with the critical challenge in the health sector of putting policy into action (Oluwole 2008:n.p.). In South Africa policy-makers have been very productive since the change in 1994 (Hilliard & Msaseni 2000:67). However, does the performance and delivery of the public healthcare match the real and good intentions of the policy-maker? Despite the legislation and implementation of policies, service delivery has become a challenge for the Department of Health (DoH). A seminal report of the Presidential Review Commission on the Reform and Transformation of the Public Service in South Africa stated that South African state departments are in general strong on policy and weak on delivery (RSA 1998:16). Policy might be in place but the implementation and delivery of operational goods and services remain an enormous challenge. A substantial percentage of the South African population lack access to basic services and infrastructure as a result of the slow service delivery pace of government (Uregu Ile 2010: 51).

In South Africa, public and private healthcare are two separate industries. Public healthcare is for those who cannot afford to pay for access to quality care (those who do not belong to medical aid schemes) and private healthcare for those who can access private health facilities because of their medical aid or financial situation. Private hospitals consume a large portion of health resources for a small percentage of the population whilst public hospitals have to render services to a large population but with limited resources (McIntyre, Thomas & Cleary 2004:673). Thus the inequitable South African health system weakens the rights of the unemployed and low-income groups (Sekhejane 2013:2) where the underprivileged group often use healthcare less than the richer groups (McIntyre et al. 2004:200).

Prior to 1994 the healthcare system was built on apartheid ideology and was characterized by racial and geographic disparities (Hilliard & Msaseni 2000:67). Public hospitals in demographic black areas were generally known as hospitals that render

poor quality service. According to (Hilliard & Msaseni 2000:68), these hospitals exhibited a lack of competent personnel, lack of commitment, inefficiency and ineffectiveness, and a low skills base. Today we can still see the difference between public hospitals situated in the previously black geographical areas and public hospitals situated in the previously white geographical areas. They are both public hospitals but due to the geographic set-up and the racial segregation prior to 1994, service delivery still seems to differ. The Presidential Review Commission (1998), Public Service Commission (2004), Public Audit Act (2004) and the White Paper for Transformation of the Public Service (1995) disclose that prior to the South African democratization in 1994, the policy framework of the state and public administration was secretive, non-accountable and not responsible, thus both internal and external financial control measures were not implemented.

Since the inception of democracy in 1994, there are still inequities in the healthcare system where there is a differentiation between private and public hospitals. The South African healthcare system has moved towards the mandatory policy of national health insurance in order to improve service provision where everyone has appropriate, efficient and quality health services that give all citizens access to healthcare (RSA DoH 2011a:10). The South African government faces a huge financial burden as a result of a population without medical aid where most citizens are utilizing public healthcare facilities. The Minister of Health, Dr. Aaron Motsoaledi, said that the introduction and implementation of the National Health Insurance (NHI) policy would serve to reduce the gap between public and private healthcare and thus provide better healthcare for all (WHO 2010:803-804). According to the NHI policy, the South African health system is unequitable, with the privileged and less privileged having disprmy loving kids Molemo, Otsile and Dintle oportionate access to healthcare services (RSA DoH 2011a:11). The low- income class in South Africa cannot afford to access private healthcare but public healthcare is available to all citizens (McIntyre et al. 2004:220). The NHI policy envisages that all South African citizens and legal residents will benefit from healthcare on an equitable sustainable basis by reducing payment out of their own pocket for healthcare services. It is proposed to roll out on primary level first and then later move to secondary and tertiary levels and public hospitals (RSA DoH 2015:29).

Although the NHI policy is a model that is widely promoted by the World Health Organization (WHO) (RSA DoH 2011a:5), it poses financial challenges for the South African government in an era where the country is still battling to improve on governance and quality public health services. Its implementation in the midst of the current situation will be a challenge by itself (WHO 2010:803-804). Gray and Vawda (2017:20) recently stated in the 20th edition of the South African health review published by the Health Systems Trust that the legislative component of the NHI policy is still poorly developed and remains a challenge.

1.1.1 Governance in the South African healthcare system

In the new South African dispensation the financial aspects of public hospitals are governed by the rules and regulations of the Public Finance Management Act, 1999 (RSA 1999: 106) to ensure good governance. Governance in a hospital environment does not only consist of social and economic health aspects, but it includes a financial aspect to enable the effective running of service delivery. The purpose of governance related to the financial aspect is to assist the Department of Health to obtain its vision and mission.

The Constitution of the Republic of South Africa outlines the powers and functions of the three spheres of government, namely the national, provincial and local spheres that form the responsibilities within the national health system. According to the South African Year Book of the Department of Health (RSA DoH 2002:339), the Department of Health is responsible for the following tasks:

I. Formulating norms, standards and procedures for the health-care services;
II. Formulating health policy and legislation;
III. Ensuring appropriate utilization of health resources;
IV. Regulating public and private health sectors;
V. Ensuring access to cost effectiveness and appropriate health communities at all levels, i.e. regional, district and primary healthcare level.

According to the Health Act (RSA 2003:4), facilities are divided into categories or levels of public hospitals such as district, regional, tertiary, central and specialized hospitals.

The above responsibilities are disseminated to the provincial level and it is the responsibility of the provincial health department to plan, regulate, and provide health services to all. This is also an appeal to the local government to render primary health services (clinics) to the community. The provincial health department will then decentralize powers and functions to the respective hospitals. These hospitals will then carry out the mission and vision of the Department of Health working towards governance.

1.1.2 Quality health service delivery

Quality challenges in the healthcare system threaten the health and lives of patients and reduce productivity (RSA DoH 2017:3). The White Paper on the Transformation of the Public Service (RSA 1995a:20), as well as the White Paper on Transforming Public Service Delivery (RSA 1997:15), was introduced during a new era in the South African public service. The aim was to transform the South African public service entirely and improve service delivery. The improvement in the delivery of public services means redressing the imbalances of the past while maintaining continuity of service to all levels of society, focusing on meeting the needs of South Africans.

The government formulated a number of policies that emphasized the need for quality service delivery in all aspects of governance especially in public healthcare. The National Department of Health, as statutory body, formulated national frameworks to give guidance to the provincial, regional as well as the district departments in implementing their own initiatives in order to improve quality care. Furthermore, a number of policies are also aimed at improving the relations between healthcare workers and patients. The Batho Pele policy (1997) and Patient Right Charter (1997) serve as tools to address the issues raised by patients and their expectations of healthcare facilities.

The recent South African abbreviated National Policy on Quality in Healthcare aims to provide a way for quality care improvement in both the public and private sectors (RSA DoH 2017:2). It comes at a time when the public healthcare system is in absolute need to refocus its collective efforts towards mending the quality of care provided in public health facilities (RSA DoH 2017:1).

The next section will address the problem statement.

1.2 PROBLEM STATEMENT

Access to healthcare is regarded as a basic human right as stipulated in the Constitution of the Republic of South Africa (RSA 1996:27). However, the services in South African public healthcare institutions are poorly maintained and overcrowded (Brink & Berndt, 2003:76; WHO 2010:803-804). Although access has been increased in the public sector, the quality of healthcare has deteriorated and has remained poor (Brink & Berndt 2003:75). Among others, public healthcare experiences a shortage of health professionals and skilled health workers, a shortage of equipment and is faced with the deterioration of public infrastructure, especially public hospitals (Sekhejane 2013:2; WHO 2010:803-804). These factors have placed an additional strain on the health system, (Brink & Berndt 2003:72; WHO 2010:803-804).

It is a general assumption that service delivery and good quality in public hospitals are compromised and good governance practices are not adhered to. Channels of communication and related issues are considered to be nonfunctional. The involvement of employer with employee, of senior management with lower categories, is also a critical challenge. Decisions are taken by management without protocol being followed and the views of personnel are not being taken into consideration (Brink & Berndt 2003:73). These communication challenges on management level can hamper quality care delivered by healthcare institutions.

Public hospitals are entirely run on government funding. Furthermore, there are patients that are fully subsidized by the government like pensioners, children under the age of six, pregnant women as well as the disabled.

Most public hospitals cater for a large group of previously disadvantaged communities. Public hospitals have various divisions like centres of excellence, primary healthcare clinics and trauma units. Irrespective of all the service centres these hospitals are overburdened with various quality challenges.

1.2.1 Purpose and objectives of the study

The purpose of this study is to describe the perceptions of professional healthcare managers on how governance influences service quality and how governance and quality service delivery can be improved in a public hospital in South Africa. These managers are the persons with practical experience of governance-related issues. Therefore the research will take place in a specific context where professional healthcare managers work in the hospital used for this study.

The objectives of the study, based on the above purpose, are summarized as follows:

- To describe governance in the South African health context;
- To describe quality service delivery in the South African health context;
- To identify governance-related factors on public hospital level that have an influence on service delivery;
- To provide recommendations to improve governance and service delivery in public hospitals.

With the problem statement and purpose of the study in mind, the research question is:

> *What are the governance-related factors that have an influence on service delivery in public hospitals and how can public hospitals improve their governance and quality of service delivery?*

1.3 RESEARCH PARADIGM

Philosophies or metatheories of science are referred to as “schools of thought” or paradigms (Babbie & Mouton 2001:15, 20; Burns & Grove 2009:710). According to Babbie and Mouton (2001:13, 14), “meta-science” refers to reflections and critique that are proposed regarding scientific practice in order to make sense of science and contribute to better science. Metascience includes paradigms in the philosophy of science, paradigms in research methodologies and research ethics.

Within the phenomenology paradigm, human beings are engaged in the process of making sense of their worlds and experience their worlds differently (Babbie & Mouton 2001:28; Burns & Grove 2009:55). In this paradigm the aim is primarily directed towards understanding and the meanings which people ascribe to the practices in their societies (Babbie & Mouton 2001:33). The final result of the phenomenological study is an explanation of “the phenomena as seen through the eyes of people who experienced it firsthand” (De Vos, Strydom, Fouché & Delport 2011:305) or to capture the “lived experiences” (Burns & Grove 2009:54). Phenomenology has traditionally been associated with qualitative research (Babbie & Mouton 2001:33; De Vos et al. 2011:401).

The nature of this study is qualitative and descriptive within a phenomenological paradigm. The term “qualitative” refers to a collection of methods and techniques which share a certain set of principles or logic (Babbie & Mouton 2001:270). The qualitative researcher seeks a better understanding of complex situations and phenomena where human behaviour is described (De Vos et al. 2011:64, 65; Burns & Grove 2009:8). A “descriptive study” is when the researcher carefully and deliberately describes situations and what was observed (De Vos et al. 2011:96). As a result of the scientific process the researcher can make more accurate descriptions than general observance (Babbie & Mouton 2001:79; De Vos et al. 2011:96).

1.4 RESEARCH METHODOLOGY

The research methodology section focusses on the research process and the kind of tools and procedures to be used (Babbie & Mouton 2001:75). Botma, Greef, Mulaudzi and Wright (2010:199, 290) refer to research methods or techniques as the data gathering and analysis endeavors which involve a rigorous approach.

1.4.1 Research technique

The research techniques often used in qualitative research are classified into four groups, namely observation, interviewing, the use of documents and audio –visual material (Botma et al. 2010:290; Potter, Gordon & Hammer 2004:120). The preference for certain techniques is directed by the tradition of enquiry and phenomenological researchers will therefore most often make use of interviewing, either by the use of in-depth individual interviews or focus groups discussions (Creswell & Clark 2011:121-122). For this study the Nominal Group Technique (NGT) will be used. The NGT is a structured small-group discussion where the analysis can be quantitative and qualitative (Botma et al. 2010:251).

1.4.1.1 Nominal Group Technique

Through the NGT data can be gathered during a single meeting and the technique can generate resourceful information that accurately reveals the thoughts of the participants. (Potter et al. 2004:126, 127). It is a more controlled variant of brainstorming used in problem-solving sessions to encourage creative thinking, without group interaction at idea generation stage (Potter et al. 2004:128). The NGT is used to obtain information about a specific concern and is likely to generate information to accomplish the purpose of this phenomenological study within a limited period of time (Potter et al. 2004:127). This structured qualitative small-group technique (De Vos et al. 2011:503) is appropriate to the purpose of this study where the influence that governance has on service delivery and quality will be described.

The research questions that will be posed to the participants during the nominal group interviews will be formulated to achieve the purpose of the research. The initial questions will be piloted on participants who are not included in the study, after which the questions will be finalized for the actual nominal group.

1.4.2 Population and sampling

Greeff (2011:366) defines population as a comprehensive or totality of all objects, subjects or members that conform to specifications. Burns and Grove (2009:42) also state that population refers to all the elements, individuals, objects, or substances that meet the criteria for inclusion in a given universe. The population in this study will be individual persons working as professional healthcare managers in a public hospital in the Free State. (Babbie & Mouton 2001:84; Botma et al. 2010:51, 52, 123, 290).

Burns and Grove (2009:42) define sampling as a process for selecting a group of people, behaviours or other elements with which to conduct a study that meets the set specifications and inclusion criteria. Fox and Bayat (2007:55) describe sampling as a process whereby a representative part of the population is selected for the purpose of determining the characteristics of the whole population. In this study the sample will be done in a nonprobability and purposive manner (Botma et al. 2010:126; Burns & Grove 2009:42, 355). The sample will include all willing participants of the population.

1.4.3 Data collection

Data collection refers to the gathering of information in an established systematic way that enables one to answer stated questions, test hypothesis and evaluate outcomes (Burns & Grove 2009:542)**.** As already mentioned, the method to be used for data collection will be the NGT.

1.4.4 Preparation and conducting of the nominal group

The researcher will prepare a large room to accommodate at least five to ten participants at a time. The tables will be organized in a U- shape with a flip chart at the open end of the U. The researcher will give participants a warm welcome, explain the importance of the task, and the importance of each member's contribution. A skilled facilitator will conduct the nominal group.

1.4.5 Steps to conduct the nominal group

The following steps will be followed during the nominal group discussion:

Step 1, Generating Ideas: The facilitator will present the question or problem to the group in written form and will read it aloud to the group. The researcher will direct everyone to write ideas related to the given question down on a blank piece of paper and they have to work independently (Botma et al. 2010:251).

Step 2, Recording Ideas: Group members will engage in a round-robin feedback session to concisely record each idea (without debate at this point). The researcher will write an idea from a group member on a flip chart that is visible to the entire group, and proceed to ask for another idea from the next group member, and so on (Botma et al. 2010:251).

Step 3, Discussing Ideas: Each recorded idea will then be discussed to determine clarity and importance. For each idea, the researcher will ask, "Are there any questions or comments group members would like to make about the item?" This step provides an opportunity for members to express their understanding of the logic and the relative importance of the item. The creator of the idea need not feel obliged to clarify or explain the item; any member of the group can play that role (Botma et al. 2010:251, 252).

Step 4, Voting on Ideas: Individuals will vote privately to prioritize the ideas. The votes will be tallied to identify the ideas that are rated highest by the group as a whole. The

researcher will establish what criteria are used to prioritize the ideas (Botma et al. 2010:252).

1.5 METHODOLOGICAL INTEGRITY

The full application of the components of trustworthiness mentioned below will be discussed in Chapter three.

Credibility focusses on the reliability of the key findings during data collection; it establishes that the results of the research are believable (Polit & Beck 2008:580). It depends on the quality of information gathered rather than on the amount of data gathered. Babbie and Mouton (2001:270) assert that credibility is about the truth of the findings in the qualitative study. The researcher will make field notes during the nominal group to improve the credibility of the results.

Transferability refers to the degree to which the research can be applied in other contexts for the benefit of others in similar situations (Polit & Beck 2008:586). Babbie and Mouton (2001:272) define transferability as findings that can be transferred to other similar contexts. The specifics in this study are not necessarily comparable to other contexts, but may be useful for hospitals with a similar context.

Dependability refers to the consistency and quality of the data over time. (Botma et al. 2010:234, 292). If the study were to be repeated with similar respondents in the same environment or context the findings should be similar (Babbie & Mouton 2001:278). A step-by-step process will be followed and a co-coder will be used to confirm theme and category selection during the qualitative analysis.

Conformability refers to questions on how research findings are supported by the collected data as well as how accurate the data is. (Polit & Beck 2008:586). It also refers to the bias of the researcher during the research process (Babbie & Mouton 2001:278). The nominal group will be conducted by a skilled facilitator by means of a step-by-step process (Moon, Brewer, Januchowski-Hartley, Adams & Blackman 2016:

2). The researcher will take field notes during the data collection process to triangulate with the nominal data (Babbie & Mouton 2001:278).

1.6 DATA ANALYSIS

Data analysis is the process to reduce and organize the data, where a re-creation of the data takes place (Polit & Beck 2008:716; Burns & Grove 2009:44). The quantitative data analysis in this study will take place during the NGT session and will be done by the participants and the facilitator that conducted the group session (Botma et al. 2010:253). Qualitative analysis will be done by means of a thematic analysis where themes and categories based on the nominal data will be identified (Botma et al. 2010: 253; De Vos et al. 2011:91).

1.7 ETHICAL ISSUES

The ethical aspects are taken into consideration during the collection of data as stipulated by Burns and Grove (2009:188). Due to the nature of the research, which involves personal data, the qualitative method requires sensitivity to the feelings of the participants (Polit & Beck 2008:88). The professional healthcare managers in this research will not be influenced by the researcher and there will be no threats and intimidations. The participants can withdraw at any time during the process. The nominal groups will be conducted by an independent facilitator, with written consent from the participants.

1.8 VALUE OF THE STUDY

The data collected from the nominal groups might lead to a better understanding of the challenges in the specific context of the selected public hospital. The suggestions of the participants can make a positive contribution to governance and service delivery related

to challenges in the hospital used in this study and other public hospitals with a similar context.

1.9 STUDY OUTLINE

The rest of the study will address the following aspects:

- Chapter two will consist of a literature overview addressing good governance and quality service delivery.
- Chapter three will clarify the research design and methodology.
- Chapter four will focus on the discussion of the research findings.
- Chapter five will conclude with recommendations and limitations of the study.

1.10 CONCLUSION

In this chapter the background and problem statement of the study are discussed. A short overview of the research plan is included. In the next chapter a brief literature overview will be given.

CHAPTER 2: LITTERATURE OVERVIEW

2.1 INTRODUCTION

In Chapter one the researcher discussed the overview of the research study relating to the background, problem statement, research question, purpose and objectives, paradigmatic perspective and the research methodology. In this chapter a brief overview of the literature is elucidated since integration of control literature will be part of the discussion in Chapter four.

The aim of this chapter is to introduce the reader to what good governance entails and why it is important. The first section defines good governance and its characteristics. Global governance as well as the South African healthcare perspective will be addressed. In the second section quality service delivery in public healthcare will be explained. Improving performance and delivery, challenges that hamper service delivery and transformation on the White Paper on Transformation (Batho Pele) will also be addressed.

2.2. GOVERNANCE

In the context of health systems, governance refers to functions carried out by government to improve the health of the population while ensuring that policies are implemented in health service delivery, financing and resource generation. Governance is concerned about responding to health priorities, the roles of both public and private sectors and their relationship with each other on how to implement the national goals and objectives.

In the next section governance will be defined.

2.2.1 Definitions of governance

The concept governance, comprises (1) the functioning and capability of the public sector and (2) the rules and institutions that create the framework for the conduct of both private and public sector (Loffler 2009:216). Loffler (2009:216) proposes that control should be exercised when public officials execute the functions of government.

Kjaer (2004:12) defines governance as the institutional capacity of public organizations to provide the public with health care and other goods demanded by a country's citizens in an effective, transparent, impartial, and accountable manner, subject to resource constraints. Effective governance is conceptualized as the achievement by a democratic government to develop policy objectives to sustain its society (Thornhill 2012:132).

Governance refers to measures that involve setting the rules for the exercise of power and settling conflicts over such rules (Kjaer 2004:12). Governance is thus a stewardship of formal and informal political rules of the game.

Van de Walle and Cornelissen (2014:441) state that good governance refers to ensuring the rule of law by improving efficiency and accountability of the public sector and tackling corruption. Therefore governance may be understood as being "good" and "effective" only when the government of the day attains its ultimate goal of creating a satisfactory quality of life for each citizen.

Chhotray and Stoker (2009:16) refer to governance as the practice of collective decision-making based on the development of networks and changing of public-private margins that emerged in the core of development of public administration. The network of governance calls for the politician administrators to have an interaction between public officials and private actors in society.

The characteristics of good governance will follow below.

2.2.2 Characteristics of good governance

Good governance is characterized by the following characteristics: transparency, accountability, participation as well as efficiency and effectiveness (Grindle 2004:527).

2.2.2.1 Transparency

Grindle (2004:527) defines transparency as decisions taken according to rules and regulations and is reachable and available at all times. Transparency also means that information should be accessible to the community and they should be informed about the decisions taken by government (Thornhill, 2012:133).

Section 195(1) (g) of the Constitution of South Africa (RSA 1996) emphasizes the need of transparency in the delivery of public healthcare. The need for the implementation of transparency by public health-care managers is to free them from corruption and nepotism. Thornhill (2012:132) acknowledges that the purpose of access to information builds public trust which in turn safeguards them against corruption. Ladi (2008:29) acknowledges that effective sharing of information can take place through Information Technologies (IT) at all levels of public service and will promote the understanding of transparency and promote a better functioning of democracy. Citizens have the constitutional right to information on what the government does and what it cannot do.

Therefore openness and transparency are features of good governance. In a democratic system of government transparency will assist in improving service delivery as stipulated in Section 195(1) (g) of the Constitution of South Africa (RSA 1996). Transparency promotes accountability and will be discussed next.

2.2.2.2 Accountability

Gregory (2007:341) refers to accountability as related to responsibility. Accountability entails an obligation to fulfil a task rendered and gives an account in the way it is

intended to (Van Niekerk, Van der Waldt & Jonker 2002:3). Accountability can be described as answerability.

In the South African healthcare context, the national sphere of government assigns public healthcare professionals and the powers vested in the institutions to deliver service effectively (Adetula 2011:15). Furthermore, the responsibility of the government is to be accountable to the citizens and provide quality services (Du Toit, Knipe, Van Niekerk, Van der Waldt & Doyle (2013:103). The officials should carry out their work diligently and provide good service to the patients.

In terms of the Constitution of the Republic and other government legislation accountability determines the framework within which public servants exercise their authority in performing their functions (RSA 1996). It suggests that civil servants should be held answerable when they transgress over the restrictions of the assigned framework or task (De Wet, Malan, Mphaisha, Sokhela, Tshiyoyo, Reddy, Govender, Muller, Van der Waldt, Holtzhausen, Fourie, Dassah, Brynard, Sindane & Uys 2014:401).

Gregory (2007:340) categorizes accountability into three dimensions, namely financial, administrative, and political accountability. Financial accountability implies that the public healthcare official (who has been assigned those financial powers) has an obligation to report on the intended and actual use of the resources. Administrative accountability indicates that there should be internal control measures in place to prevent fraud and corruption in the healthcare sector. Political accountability implies that there should be checks and balances among the three tiers of government, i.e. the executive, legislative as well as the judiciary.

When governance is discussed with regard to improving the quality of service, accountability becomes dominant not only in terms of performance but also in fairness and equity (Kjaer 2004:200). Therefore public officials should be accountable for the task assigned to them to ensure good governance.

2.2.2.3 Participation

According to the English Oxford Dictionary (2018) participation is defined as the “action of taking part in something”. In the public health sector participation by both men and women in the community is a cornerstone of good governance (Grindle 2004:526). However, participation needs to be informed and organized. Therefore freedom of expression by clients in a healthcare institution will be exercised and then decisions will be taken. It ensures that corruption is minimized and the views of the minority are taken into consideration.

2.2.2.4 Effectiveness and efficiency

Effectiveness and efficiency mean that the processes in the public healthcare system should produce results that meet the needs of the citizens while making the best use of resources at its disposal (Grindle 2004:527). The Constitution of South Africa (Act 108 of 1996) entails that efficiency and effectiveness need to be pursued in the public healthcare system (RSA 1996). Van de Walle and Cornelissen (2014:443) allude that both effectiveness and efficiency in public healthcare are fundamental for good governance and service delivery.

Raga and Taylor (2005:25) propose three categories of normative criteria as a foundation for effectiveness and efficiency in service delivery. The first category or “value” criterion includes the following characteristics: integrity, transparency, equity, reliability, quality, professionalism and nondiscrimination. The second category or “attitude” criterion entails the following characteristics: responsibility, quality awareness, adaptability, clarity, listening ability, speed and involvement. The third category or “aptitude” criterion includes the following characteristics: knowledge, leadership qualities, communication skills, analytical capability, independence, goal orientation and the ability for further education and training.

The following section will address governance in relation to the health system.

2.2.3 Governance in the global health system

Healthcare is a complex phenomenon. The healthcare system's fundamental role is to improve the health of citizens, prevent and protect citizens against diseases and treating ill health (WHO 2005:16; McIntyre et al. 2007:23).

An association between governance and health system performance has grown in recent years (Marks, Cave & Hunter 2010:57). At the beginning of the century, the World Bank and International Monetary Fund published working papers indicating the negative association between governance and the quality of service delivery, especially in infant and child mortality (Rajakumar & Swaroop 2008:96). In their recommendations, they suggested that good governance might be improved by adhering to the characteristics of governance, which include participation, transparency, accountability as well as efficiency and effectiveness as discussed earlier in this chapter.

Rajakumar and Swaroop (2008:97) state that authorities have an impact on governance. Governance failures are the result of a lack of authority and inefficiency. Some of the studies have recognized governance failures related to accountability and responsiveness. The lack of accountability in hospital authorities needs to be addressed in the public healthcare sector (Marks et al. 2010:56). Marks et al. (2010:56) suggest that healthcare professional managers should be given clear tasks with explicit responsibilities. The decentralization of powers in a healthcare sector was also suggested to improve participation in decision-making, and allowing public officials to be more accountable in their prescribed functions.

The decentralization of powers in the health systems of many countries is taking place at a much faster speed and can possibly happen with fewer resources (Marks et al. 2010:56). Progressively health sector reforms, often with elements of decentralization, are being adapted to provide a more equitable and responsive health system. An increased emphasis on primary healthcare resulted in health reforms whereby the allocation of resources, public accountability as well as monitoring and evaluation were implemented (WHO 2005:16). Tarin, Green, Omar and Shaw (2009:309) propose that

the institutional management should ensure the importance of good governance practices in the planning and implementation of new strategies.

The South African perspective of governance in the healthcare sector will be addressed below.

2.2.4 Governance of the public healthcare sector: South African perspective

The Department of Health developed polices 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 (RSA 1997). The White Paper outlines the vision of the Department and the Ministry of Health. Some of the issues covered by the White Paper present what needs to be done to correct the ills of the Department of Health and how it intends 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 a District Health System model which is believed to be the most effective vehicle for the delivery of primary healthcare.

In the South African context, access to healthcare is regarded as a basic human right as stipulated in the Constitution of the Republic of South Africa (RSA 1996:27). Prior to 1994, the health needs of the majority of South Africans were ignored. Most resources benefited the minority group. The majority of people in rural areas have been disadvantaged with regard to healthcare access. Urban services were better funded than the rural areas (Horwitz 2009:2). The inequalities in healthcare delivery in South Africa have placed a burden of segregation in public hospitals prior 1994, before the democratic government. McIntyre et al. (2004:200) maintain that the disparities of apartheid South Africa are attributed to racial discrimination as well as economic and social policies that are regarded as unacceptable inequalities. Meyer and Cloete (2006:204) state that discrimination is a stigma that violates basic human rights. The marginalized community could not access the services provided by private healthcare, only those who could afford it would have access.

Dookie and Singh (2012:3) state that accountability in financial expenditure remained a challenge post 1994 which has to be addressed in the South African public healthcare sector. Proper control on expenditure by public healthcare officials was not adhered to (McLeod & Grobler 2010:30). This resulted in public hospitals becoming extremely overcrowded and without sufficient resources. Challenges such as human resources constraints, financial constraints and policy implementation as well as monitoring and evaluation systems to measure performance and evaluate outcomes had an impact on service delivery and good governance (Hassim, Heywood & Berger 2007:361). Mosadeghrad (2014:64) conducted a study to identify factors affecting the quality of healthcare services in Iran. Most of the challenges to ensuring good governance were purely that hospital management failed to take decisions. Accountability is linked with the ability of leadership to take a prompt decision to ensure quality healthcare.

The policy document on quality in health care for South Africa (RSA DoH 2007:20) applies to both public and private healthcare. The policy addresses important issues to promote quality healthcare. An overview of the main issues will be discussed in the following three paragraphs.

The **distribution of equality at all levels** had to be ensured. The public healthcare was transformed to redress historical inequities. Essential healthcare was aimed at the previously disadvantaged communities, especially those in rural areas. Infrastructure, such as clinics on primary healthcare level, was made available without any cost to the users (Blakely, Atkinson, Kvizhinadze, Nghiem, McLeod, & Wilson, 2014:14). Immunization campaigns were introduced with good results as a preventative measure to reduce disease risks. The National Health Amendment Act 12 of 2013 defines the distribution of equality at all healthcare levels whereby centralized powers were vested in the provincial sphere and local sphere (RSA 2013). This was done mainly for the purpose of preventive measures. Regardless of some successes, the public healthcare sector still experiences some constraints on meeting the National Department of Health objectives.

The Department of Health took various initiatives to ensure **adequate human resources** and address the issue of human resources related to financial challenges facing the Department. In 2007, government introduced an Occupation Specific Dispensation (OSD) for doctors and nurses with the intention of retaining those with scarce skills, especially in rural areas. However, this led to more expenditure without improving the healthcare system (Hassim, Heywood & Berger 2007:362). Despite all the efforts, the inadequate human resources and lack of accountability remained a challenge.

More emphasis was placed on **leadership and accountability**. Accountability is defined as demonstrating one's performance and is an important feature of good governance, not only in a sense of bureaucracy but also for democratic government (Druke 2007:61). Accountability is a cornerstone of democracy. Talpin (2011:101) highlights that accountability is a measure to ensure transparency by public health-care officials. It requires that public accounts are verified, policies are implemented when formulated and thus fighting corruption. Gildenhuys (2011:45) is of the view that integrity by leadership is basically the way to lead good governance. Leadership in the public health-care must be authentic, honest, and loyal to the community it serves.

Ten years after the implementation of the policy document on quality in healthcare for South Africa (RSA DoH 2007:20), some of these aspects still need attention.

2.2.5 Structure of the South African health sector

The South Africa Department of Health (DoH) is a structure at national level that is designed to assist in attaining quality healthcare required to improve the healthcare of citizens (RSA DoH 2007:20). It is a structure that coordinates all aspects of both private and public healthcare delivery. The national Department of Health is responsible for the national health policy. The policies from the national Department of Health are coordinated among local, district, provincial as well as national authorities. A single

governmental structure will coordinate all aspects of both public and private healthcare delivery and all existing departments will be coordinated among local, provincial, and national authorities (RSA DoH 2007:22). Authority over, responsibility for, and control over funds will be decentralized to the lowest level possible so that it is compatible with rational planning, administration and the maintenance of good quality (RSA DoH 2007:22).

The nine provincial Departments of Health are responsible for developing provincial policy within the framework of national policy and the public health service delivery. Each of nine provinces will have a Provincial Health Authority that is responsible for coordinating the health system at the provincial level. At the central level is the National Health Authority (NHA) which is a body that is responsible for policy formulation and strategy planning, as well as the overall health system in the country. It also allocates the national health budget.

Three tiers of hospitals, i.e. tertiary, regional and district exist in the health system. Furthermore, there is a primary healthcare system which is a mainly nurse- driven service in the clinics and includes the district hospital and community health centres. Local government is responsible for preventive and promotive services. The private health system consists of general practitioners and private hospitals. The level of care in private hospitals is mostly funded through the board of healthcare funders or medical schemes.

Lastly, the health service profession is established by statutory body services which include the following: the Health Profession Council of South Africa (HPCSA), the South African Nursing Council (SANC), the South African Dental Technician Council (SADTC), the South African Pharmacy Council (SAPC), the Allied Health Service Professions Council of South Africa (AHPCSA) and the Council for the Social Service Professions (SACSSP) (RSA GCIS 2018:339).

The Department of Health is committed to providing quality healthcare to all South Africans in order to achieve a cohesive National Health System and to implement

policies that reflect its mission, goals and objectives in the National Yearbook. (RSA GCIS 2018:339). The White Paper, also called the Batho Pele White Paper on health, deals with the transformation of the health service sector to reduce the large level of social inequality (RSA 1997). The paper's aim is to introduce a strong shift towards universal and free access to comprehensive health for all segments of the population.

2.2.6 Good governance and the implementation of NHI post 1994

Post 1994 after the democratic election in South Africa, the Department of Health has developed and implemented a number of policies that impact positively on service delivery. For many years poor service delivery in healthcare has been considered to be a critical issue (RSA DOH 2010a). The public healthcare system was fragmented to preserve discrimination. However, the government later published a plan for NHI (National Health Insurance) so that each citizen would be able to benefit from healthcare irrespective of geographical differences.

The Department of Health was tasked to address the challenges of unequal distribution of healthcare and in 2011 to review the health policies and legislation to ensure consistency (SAHR 2011:21). With the implementation of the NHI (National Health Insurance) policy the aim is to create fairness in sharing healthcare resources such as skilled healthcare professionals, finance and other resources (RSA DoH 2010a). However, it will be the role of the hospital management to ensure that the implementation of the NHI policy is effective.

The NHI aims at:

- Promoting and protecting the rights of citizens to basic healthcare services.
- Ensuring that no citizen is denied medical treatment or emergency services.
- Everyone to have access to healthcare services (RSA DoH 2010a).

The NHI is a healthcare financing system that ensures that every citizen has access to quality healthcare services as stipulated by the Constitution of South Africa, Act 108 1996 (RSA 1996). Government is faced with the challenge to look for a fair healthcare

financing system for all citizens, hence they approached this mechanism. The implementation of the NHI will create fairness in the sharing of healthcare resources such as skilled healthcare professionals, finance and other resources. NHI means that each citizen will receive free healthcare when required and lack of money will not be a barrier.

The current Minister of Health, Dr. Aaron Motsolaedi, suggested that for the NHI to succeed the government or the country should aim at “Improving quality service in the public hospitals and it must be a priority and pricing in the private sector must be tackled equally” (Media statement 2011).

As a policy approach of the NHI, good governance is aimed at increasing efficiency and patient satisfaction for all citizens of South Africa. The Department of Health aims at building a better understanding of what NHI is all about and why it should be implemented. However, with such a policy change, the healthcare sector is still likely to encounter implementation challenges. On 22 March 2012, Dr. Aaron Moatsolaedi announced the districts that were part of the pilot roll-out (SA News 2012).

2.2.7 Leadership as an element of governance

The World Health Organization (WHO 2007:23) states that leadership and governance in a health system are critical. It involves overseeing both private and public health- care sectors and protects the interests of the public (WHO 2007:23). However, governance remains a challenge in many countries and not only in South Africa. Without the integrity of leadership in the public healthcare sector, the institutions would not be able to carry out their functions effectively (Gildenhuys 2011:45). Leadership entities such as departmental ministers, portfolio committees, professional bodies and auditors need to ensure that good governance is practiced in the healthcare sector.

The World Health Organization (2007:23) listed the functions of leadership that will ensure good governance in the health sector as the following:

- Formulate policies on the priorities of service delivery;
- Ensure enforcement of the implementation;
- Ensure accountability through transparency.

It is the responsibility of leadership to enforce legislation and policy implementation such as the right afforded by the Constitution to the community to ensure that health services are equitable to all users as stipulated by The National Health Act, 61 of 2003 (RSA 2003). The major policy implementation was the introduction of the NHI policy, in which a Green Paper was released for comments in August 2011. The government decision was to fully implement the national health insurance by 2025 as indicated by Dr Aaron Motsolaedi (Media statement 2011).

Cloete and De Coning (2011:40) allude that good governance is based on the fundamentals of transparency and accountability by both public and private institutions. Therefore the responsibility and solidarity must be the cornerstone of ethics to ensure good governance in every community or society. Ethics is defined as “what is good for the individual and for society”, it establishes the nature of duties that people owe themselves and one another (Cloete & De Coning 2011:44). Ethics involves learning what is right and wrong, and then doing the right thing.

DeSimone and Werner (2012:9) refer to ethical conducts that lead to good governance and good leadership, namely: professional competency and confidentiality.

Professional competency should be maintained in public healthcare sectors, therefore lack of knowledge and incompetency should not be used as an excuse for not executing service delivery. The public officials should have a high level of competency and skills to meet the current and future demands of the occupation they perform (DeSimone & Werner 2012:9). In the public healthcare institution, the Human Resource Development (HRD) section has professionals that are responsible for facilitating the training of healthcare managers and supervisors to ensure that they have the knowledge and skills necessary to be effective in the positions they occupy (DeSimone & Werner 2012:11).

Public officials should maintain **confidentiality** at all cost. The information should not be disclosed unless there is consent to do so. Patients in public healthcare share their

information with professional healthcare officials, and this information should be kept protected. The patients share the information with the trust that it will be kept safe, and should the information leak, it might have a negative impact on their care.

In the next section, the quality service delivery framework will be discussed in detailed.

2.3 QUALITY SERVICE DELIVERY

Service delivery is a dominant function of the government sector (Brink & Berndt 2003:70). According to Brink and Berndt (2003:70), service quality is defined as the ability of an organization to determine customer expectations and to deliver the service at quality level that will at least equal those customer expectations. In a state where patients' expectations depend on healthcare facilities, quality care should meet their needs and be delivered timeously. Chowdhary and Prakash (2007:495) define service quality as the gap that exists between the expectations of the patients and their perceptions. The concept service delivery is a comprehensive concept. It is not only referring to an end-product or result, but refers to the results of objectives, decisions and accomplishment embarked on by institutions and people.

It can be debated that the basic principle of government in a true democracy is service delivery. Service delivery is concerned with the performance of work or duty by an official, with the aim of assisting the others and the power to control or make use of resources. Therefore government provides or facilitates access to social services like health, social development, education etc. However, if government fails to meet the needs of its community, then the ruling party of the day should accept the responsibility for its failure (Roos, 2008: 94). Roos (2008:94) also states that members of the public should demand a proper explanation as to how and why their demands are not met. To attain and meet the needs of the communities is a true reflection of democracy. It requires a sustainable public service.

According to the WHO (n.d.:3), the network of service delivery should have the following key characteristics, namely comprehensiveness, accessibility, coverage, continuity, quality, person-centredness, coordination as well as accountability and efficiency, which will be discussed below.

A **comprehensive** range of health services is provided appropriate to the needs of the target population, including preventative, curative, palliative and rehabilitative services and health promotion activities.

Services are directly and permanently **accessible** with no undue barriers of cost, language, culture, or geography. Health services should be closer to the people. Services may be provided in the home, the community, the workplace, or health facilities as appropriate.

Service delivery is designed so that all people in a defined target population are **covered** irrespectively, i.e. the sick and the healthy, all income groups and all social groups.

Service delivery is organized to provide an individual with **continuity** of care across the network of services, health conditions, levels of care, and over the life-cycle.

Health services are of high **quality**, i.e. they are effective, safe, centred on the patient's needs and given in a timely fashion.

Services are organized around the **person**, not the disease or the financing. Users perceive health services to be responsive and acceptable to them. There is participation from the target population in service delivery design and assessment. People are partners in their own healthcare.

Local area health service networks are actively **coordinated**, across types of provider, types of care, levels of service delivery, and for both routine and emergency preparedness. The patient's primary care provider facilitates the route through the needed services, and works in collaboration with other levels and types of provider.

Coordination also takes place with other sectors (e.g. social services) and partners (e.g. community organizations).

Health services are well managed so as to achieve the core elements described above with a minimum wastage of resources. Managers are allocated the necessary authority to achieve planned objectives and held **accountable** for overall performance and results.

2.3.1 Improving performance by improving delivery

Quality is important to public service to ensure that it meets the purpose and the needs of the society consistently (Boschoff & Gray 2004: 28, Plaks & Butler 2012:65). Quality service increases confidence and productivity in the organization whilst increasing client satisfaction. Quality should meet the expectation of the patients and the needs should be delivered on time. It is thus believed that when the clients are satisfied they are more likely to respond positively to treatment (Plaks & Butler 2012:69). Attention should be given to quality care.

Improving access to healthcare will improve quality service by increasing the number of healthcare professionals as well as the number of healthcare facilities (Van Rensburg 2012:49). Another priority that needs to be addressed is to enforce ethics in the care of clinical services so as to provide excellence in the service rendered. In the South Africa Health Review 2011, the Minister of Health highlighted that poor service delivery is caused by poor decision-making of leadership in the Department of Health (SAHR 2011). Healthcare professionals should improve their competencies (knowledge, attitude and skills) to deliver high quality service care. Health science departments at the universities play a role in providing education and skills development for all healthcare workforces. An economical, effective and efficient government should be able to provide service delivery that meets the needs of the citizens (SAHR 2011). Healthcare has the assignment to put more emphasis on health improvement and

poverty alleviation. The policies of South Africa have to be explicit in stipulating the trends in inequalities in healthcare (Labonte & Schreker 2011:28).

The National Health Act has shown a steadfast commitment to improving the quality of healthcare (RSA 2003). The strategic plan for 2010/11-2012/13 states that the vision of the department is to be "an accessible, caring and high quality health system" (RSA DoH 2010b:10). Its mission is "to improve the health status through the prevention of illnesses and the promotion of healthy lifestyles and to consistently improve the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability" (RSA DoH 2010b:10).

Furthermore, the National Department of Health (RSA DoH 2011b) envisages the implementation of quality improvement standards. The aim was to identify the gaps between performances by the healthcare professionals and the actual service delivery. This approach will assist the public hospitals to bring about changes within the sector by striving towards excellent service delivery. The quality improvement approach will also assist with compliance with the performance agreement of all managers to ensure that standards are met (RSA DoH 2011b).

The healthcare sector can create the mechanisms that bring effective health-improving technologies to the people. The need for improvement in the delivery of health services is determined by the availability of funds and the utilization of technology to achieve an effective outcome (Phaswana-Mafuya, Peltzer & Davids 2011:503). According to National Treasury PPP Practice Note Number 06 of 2004, government was struggling with the rising healthcare costs and increased demand for healthcare services in the face of ongoing budget constraints (RSA 2004). The Department of Health was tasked in 2011 to review the health policies and legislation to combat challenges faced with the rising healthcare costs (SAHR 2011:21).

The government introduced “private-public partnership” also in the healthcare sector to improve service delivery in public hospitals (RSA 2004). The government aimed at enhancing service delivery by improving quality infrastructure and related services so as to ensure a better life for all. The intention was also to improve the operation of public health services and facilities and to expand access to higher quality services (RSA 2004).

Private-public partnership is defined as a

> *contract between a public-sector institution and a private party, where the private party performs a function that is usually provided by the public-sector and/or uses state property in terms of the PPP agreement. Most of the project risk (technical, financial and operational) is transferred to the private party. The public sector pays for a full set of services, including new infrastructure, maintenance and facilities management, through monthly or annual payments (RSA 2017:159).*

Public managers should react quickly to the needs of patients and the community. Gi-Du Kang (2004:267) proposes that service quality may be evaluated based on dimensions as listed below.

Reliability, which is the ability of public officials to perform services accurately to the patients or community served. Therefore public managers should react quickly to the needs of patients and the community.

Responsiveness, which is the ability to be trustworthy, whereby patients and the community can rely on the quality of service rendered to them by officials. Public healthcare officials should show dedication to the service they render to the people. Public healthcare professionals should provide prompt service to the community they serve.

Assurance is the ability of public officials to have knowledge and to convey trust and confidence in the service they render. Public officials are expected to have skills and competency in their field.

Empathy, public officials must be caring and understanding, and pay attention to the needs of the patients or community they serve.

2.3.2 Challenges that hampered service delivery

Post 1994, the government has attempted to create policies which are conducive to the support of service delivery. However, government departments including the Department of Health are still facing many challenges. The health service inherited in 1994 was the reflection of a system which was not focusing on improving health or providing an efficient and effective health service (Gildenhuys 2011:45). Access to both financial and human resources was distributed along racial lines. There was a major focus on hospitals that were predominantly serving whites and which had more resources than hospitals serving the marginalized group (Gildenhuys 2011:45). The Department of Health was tasked to address the challenges of unequal distribution of healthcare and in 2011 to review the health policies and legislation to ensure consistency (SAHR 2011:21).

However, the following challenges still remained in the healthcare sector and transformation is required.

2.3.2.1 Resistance to change

Reaction to change varies from individual to individual. Studies have shown the following reasons for individual resistance to change (Swanepoel, Erasmus & Van Wyk 2000:738):

Fear of the unknown - staff may resist change because they worry about things proposed by the organization which may affect their work or their daily lives. When

change is initiated by someone else, they may feel dissatisfied about it and want to know the rationale behind the implementation.

Self-interest - some employees are not willing to give up their existing benefits. Change should actually benefit the organization as a whole but some employees feel that if change comes in terms of “loss of power” and salary changes, then it is a setback.

Habit - change requires a totally new way of doing things, new skills and developments. In most cases people rely on their old way of doing things and find change as complicated when new things are introduced.

2.3.3 Transformation of service delivery

Changes in the workplace become part of employment equity programmes which create a major drive and thus enable an organization to carry out change (Swanepoel et al. 2000:738). Public healthcare sectors often transform or change as a result of external or internal forces. Factors such as political, economic, social and technological issues addressed by the government of the day may have an influence on the institutions to regulate with new adventures.

These various forces may also have an impact on the institutions forcing them to make drastic improvements that will sometimes not be realistic and achievable for the institution (Swanepoel et al. 2000:738). However, transformation is needed to improve service delivery in the healthcare sector.

Savedoff and Hussmann (2006:3) state that measures taken by the government to combat corruption through the anti-corruption strategy accepted in 2002 played a role in transforming the public health sector. The aim was to promote good governance, reduce corruption and improve public sector service delivery (RSA DPSA 2002). It assisted in increasing accountability and the establishment of norms and standards of

public healthcare managers (RSA DPSA 2002). This strategy assisted with making work easier for employees and has a positive impact on productivity and service delivery (Savedoff and Hussmann 2006:3). Facilities were selected to undergo a quality check, for instance physician licensing was reviewed by the board. This process promoted greater accountability by requiring periodic licensing reviews of physicians' qualifications (Savedoff and Hussmann 2006:3).

The regular audits of medical equipment purchases were also a preventive measure used to eliminate discrepancies in the procurement section. Quality Improvement Councils, which do peer chart review, a form of "internal auditing", was assigned to ensure that the correct standards are adhered to (RSA DoH 2011b). Surveys on patient satisfaction were also used to assess the level of accountability of public officials. Patient satisfaction surveys include a quality and a corruption score (RSA DoH 2011b).

2.3.4 The White Paper on Transforming Public Service Delivery

It is the vision of government to promote integrated unified service delivery. The White Paper on Transforming Public Service Delivery (RSA 1997) called "Batho Pele", provides a policy framework and guidelines within which the public service is expected to operate. Service delivery is based on the Batho Pele principle stated in the White Paper on Transforming Public Service Delivery which was established to provide a policy framework for transformation of the public service.

The content of this White Paper deals with how public services are provided and how service delivery can be improved. The White Paper on the Transformation of the Public Service was established to serve as a guide for the introduction and implementation of new policies and legislation aimed at transforming the South African public service (RSA 1997). Section 195 (1) of the Constitution provides that the government of the day should have democratic values and principles which are upheld in the Constitution (RSA

1996). The values listed are human dignity, equality, the advancement of human rights and freedom, non-racialism as well as non-sexism.

The Batho Pele policy framework consists of eight service delivery principles which will be discussed in detail below.

Consultation signifies that “citizens should be consulted about the level and quality of public services they receive, and wherever possible, should be given a choice about the services that are offered” (RSA1997:15). In the public healthcare it is the right of patients to be given choices on the treatment and the service rendered to them. The Constitution of South Africa (Act 108, 1996) emphasizes that public sectors must ensure that there is communication with the people and that people should be consulted (RSA 1996). The mission and vision of the Department of Health is to ensure that general welfare is rendered to all patients without prejudice (RSA 2003).

Access signifies that “all citizens should have equal access to the services to which they are entitled” (RSA1997:15). Access to healthcare is fundamental. The Patient Right Charter (PRC) (1999) addressed the standards of achieving realization of the rights of patients to access health services (RSA DoH 1999). The PRC indicates the availability of resources, proper infrastructure to ensure that service delivery is not hampered. The National Department of Health also implemented the availability for and access by the previously disadvantaged people, especially those who are in rural areas. The building of clinics and primary healthcare facilities was implemented to curb overcrowding in hospitals.

Standards signify that “citizens should be told what level and quality of public services they will receive so that they are aware of what to expect” (RSA1997:15). National and provincial departments should publish standards for quality services they provide. In public hospitals, standards have to be displayed and be visible on the walls for patients to see. The National Department of Health emphasizes the visibility of quality standards in the healthcare policy (RSA DoH 2007:2). The display has to comprise the name of

the ward, the time for ward rounds, the schedule rooster of the nursing staff and other personnel, times for serving meals, and lastly the schedule for visiting times. Performance against standards must be measured regularly and if the standard target is not met, a new target date must be set (RSA DoH 2007:3). The standards should meet the expectation of both patients and the community.

Courtesy signifies that "citizens should be treated with courtesy and consideration". Healthcare professionals should treat patients with fairness, empathy, understanding as well as respect. Respect and courtesy are also addressed in the Bill of Rights, Constitution of South Africa (108, 1996) (RSA 1996). Courtesy is also associated with ethical behaviour. The Constitution of South Africa (1996) section, 195(1) clearly states that professionals should maintain a high standard of professional ethics.

Providing information signifies that "citizens should be given accurate information about the public services rendered to them and which they are entitled to receive". The right to information is important for patients in public healthcare to let patients understand the health service they are entitled to receive, being their illness, diagnosis or their treatment (RSA 1997:19). The policy on Quality Healthcare for South Africa states that patients who are treated with dignity and are well-informed respond positively to treatment rendered to them (RSA DoH 2007:13). Failure to provide information to patients may lead to complaints being lodged, very often to the media.

Openness and transparency signify that "citizens should be told on how national and provincial departments are run, how much they cost and who is in charge" (RSA 1997:15). Openness and transparency are the foundation of a democratic government and are fundamental to good governance and the improvement of service delivery. The Constitution of South Africa (1) (g) states that transparency is needed in public service delivery (RSA 1996:195). Transparency assists the public healthcare manager to refrain from corruption thus ensuring good governance.

Remedy signifies that “if the promised standard of service is not delivered, citizens should be offered an apology, an explanation and a speedy remedy, and when complaints are made, citizens should receive a sympathetic positive response” (RSA 1997:21). Government entities are bound to make mistakes, therefore patients are encouraged to lodge complaints so that service delivery can be improved. The Batho Pele White Paper directs customer satisfaction to be treated as a top priority (RSA 1997:19). Complaints should be dealt with without any delay and the hospital must give prompt feedback when complaints are lodged (RSA 1997: 22).

Value for money signifies that “public services should be provided economically and efficiently in order to give citizens the best possible value for money” (RSA 1997:15).

2.4 CONCLUSION

The White Paper emphasizes that the services should be cost-effective and delivered within the resource allocation (RSA 1997:22). Wasteful expenditure must be eliminated and it is important for healthcare managers to plan, organize and control the resources in a way that will be cost-effective for the patients. In the context of governance, public service delivery is the result of objectives, decisions and accomplishments embarked on by institutions and people. The government of the day should have policies in place that guide government institutions and officials to achieve objectives in order to improve the welfare of the people. For any government to remain in power, it has to strive to deliver efficient, effective and economical public services. The publication of the White Paper on Transforming Service Delivery, 1997, (Notice 1459 of 1997) in 1997 represented a step towards enhanced service delivery in the South African Public Service. From the discussion in this chapter, it is obvious that service delivery takes place within the boundaries of a legislative framework.

The next chapter will deal with the research design and methodology.

CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3. 1 INTRODUCTION

Chapter one briefly discussed the background, paradigmatic perspectives, purpose of the research, problem statement, research question, research objectives as well as the trustworthiness and ethical principles. Chapter two was aimed at introducing the reader to what good governance and service delivery entail and why they are important. In this third chapter, the researcher emphasized a plan to obtain answers to the research question. The research question aims to bring insight and knowledge through the perceptions of professional healthcare managers on how governance influences service delivery in a public hospital in the Free State and how quality service delivery can be improved.

This chapter outlines the research design and methodology for the study in more detail. The research methodology section focusses on the research process and the kind of tools and procedures to be used to organize and structure the study in a methodical or orderly manner (Babbie & Mouton 2001:75; Botma et al. 2010:41, 311; Polit & Beck 2008:732).

3.2 RESEARCH DESIGN

The nature of this study is qualitative, and a phenomenological approach was taken, whereby the researcher carefully and deliberately described the research process. The phenomenological approach focusses on the meaning of the lived experience of human beings and how they make sense of their worlds (Botma et al. 2010:185, 190; Babbie & Mouton 2001:28). The qualitative approach is a process of understanding that is based on methodological traditions of inquiry which explore a social or real human problem (Babbie & Mouton 2001:28, 76; Botma et al. 2010:59). Qualitative research is a systematic interactive subjective approach used by the researcher in order to understand and give meaning to participant perceptions in their everyday life (Burns & Grove 2009:53; Botma et al. 2010:182; De Vos et al. 2011:65).

Subsequently the research methodology section will be addressed where the following aspects will be discussed in detail: population and sampling, data collection strategy, data analysis, trustworthiness and ethical aspects.

3.3 RESEARCH METHODOLOGY

Research methodology is referred to as the research process and the procedures to be used (Babbie & Mouton 2001:72; Botma et al. 2010:199). It guides the researcher in planning and implementing the research in a way that is intended to achieve goals and maximizes control over factors that could interfere with the validity of findings. With this research, the environment within which data was collected was at a public hospital in the Free State province. The researcher gathered data from professional healthcare managers who worked in the hospital and were directly involved in governance and service delivery.

In the following section a detailed description of the population and sampling method will be discussed.

3.3.1 Population and sampling

Population is defined as a totality of all elements such as objects, substances or members that conform to a set of specifications or criteria in a given universe (Botma et al. 2010: 200; Greeff 2011:366). Burns and Grove (2009:42) explain that population refers to all the elements, individuals, objects, or substances that meet the criteria for inclusion in a given universe. In this study the population consisted of professional healthcare managers (supervisors, assistant managers and executive managers) from different cost centres (sub-directorates) in the hospital chosen for this study. This group had experience in managing the hospital setting and service delivery aspects. Based on their experience and knowledge they can contribute to what measures can be taken to ensure that quality service is delivered effectively and efficiently to the community. The inclusion criteria (Botma et al. 2010:200) used to identify the population are:

- Being currently employed at a management or supervisory level the hospital.
- Having relevant experience in the hospital setting (e.g. HR, Finance, Supply Chain, Revenue and Allied Health);

Botma et al. (2010:124) define sampling as a method to select a portion of the population which can represent the accessible population. Moore and McCabe (2005:30) describe sampling as a process that is used to obtain data or observation from a group which can be either from a population or universe. Fox and Bayat (2007:55) define sampling as a process or a technique whereby a representative part of the population is selected for the purpose of determining the characteristics of the whole population. In this study the sample was done purposively and included all willing persons of the population who were available for data collection (Burns & Grove, 2009:352; Botma et al. 2010:126). The participants were professional healthcare managers from different sub-directorates with relevant experience in the hospital setting.

3.3.2 Data collection

Data collection refers to the gathering of information in an established systematic way that enables one to answer stated questions, test hypotheses and evaluate outcomes (Burns & Grove 2009:542; Botma et al. 2010:131)**.**

In this study data was collected by means of the nominal group technique (NGT). A nominal group is defined as a more controlled variant of brainstorming used in problem-solving sessions to encourage creative thinking, without group interaction at idea generation stage with the purpose of reaching consensus (Botma et al. 2010:251; Potter et al. 2004:128). The NGT was used to obtain information in order to accomplish the purpose of this phenomenological study within a limited period of time. With this technique more ideas might be generated than with a formal group discussion as every member has a chance to contribute and prevent one person from dominating the process (Abdullah & Islam 2011:81). This structured technique also fits the purpose of

this study to explore and describe the influence that governance has on service delivery. One nominal group was conducted for this study since only nine participants met the inclusion criteria.

Before the nominal group commenced, there was approval of the study and access to participants was approved by the following authority structures:

- The Chief Executive Officer (CEO) of the hospital
- The Head of Finance and Supply Chain
- The Manager Finance

3.3.3 Preparation and conducting of the nominal group

On the day of the nominal group interview, the facilitator and the researcher arrived at the venue before the participants in order to organize the room and check all the equipment to be used. The research was conducted at the hospital.

The researcher prepared a large room to accommodate at least five to ten participants. The physical data collection environment is a setting where human interaction should not be constrained (Polit, Beck & Hungler 2001:266). The researcher and the facilitator ensured that the room was conducive to data collection. The tables were organized in a U- shape with a flip chart at the open end of the U, which the facilitator used to document the results.

When the participants arrived, the researcher gave them a warm welcome, explained the importance of the task, and the importance of each member's contribution. The researcher explained the process and purpose of the research study, and reassured the participants about the confidentiality and anonymity. The participants were given an information document regarding their participation in the research study. The information document included: the purpose of the research study, the potential benefits as well as the risks, the assurance of confidentiality and anonymity, the researcher's contact information, the participants' voluntary consent and they were allowed the right to withdraw from the study at any stage (Polit et al. 2001:238: Botma et al. 2010:14-16).

When the participants had fully understood what was expected, the researcher documented the informed consent process by having participants sign the consent form.

The researcher ensured that the participants who took part all gave written consent to participate in the research. The researcher and the participants also agreed that all cellphones would be switched off to avoid unwanted distraction during the process until the session was over. The nominal group interview commenced when the participants were all ready.

3.3.4 Steps to conduct nominal groups

After the consent process an independent skilled facilitator started the data collection process with a briefing session explaining the four steps of the NGT to the participants, where after the first step commenced (Potter et al. 2004:128).

Step 1, Generating Ideas: During step one the facilitator presented the first question to the group in a written form and read the question to the group (Botma et al. 2010: 252). Each question was addressed through its own cycle of four steps. The questions that were posed to the participants during the nominal group interview were formulated to achieve the purpose of the research. The initial questions were piloted by the CEO and the head of finance of the hospital used in this study. The final questions used were:

- *What are the governance-related factors that have an influence on service delivery in public hospitals?*
- *How can public hospitals improve their governance and quality of service delivery?*

The facilitator directed everyone to write ideas down to answer the question and they had to work independently.

Step 2, Recording Ideas: The group members engaged in a round-robin feedback session to concisely record each idea (without debate at this point) (Botma et al. 2010:252). The facilitator wrote an idea from a group member on a flip chart that was

visible to the entire group, and proceeded to ask for another idea from the next group member until all the ideas had been captured.

Step 3, Discussing Ideas: Each recorded idea was then discussed to determine clarity and importance (Botma et al. 2010:252). For each idea, the facilitator asked, “Are there any questions or comments group members would like to make about the idea?” This step provided an opportunity for members to express their understanding of the logic and the relative importance of the item. The creator of the idea did not need to feel obliged to clarify or explain the item; any member of the group could play that role. The facilitator steered the process whereas the researcher made field notes of the discussion during this step.

Step 4, Voting on Ideas: Individuals ranked the top five ideas privately to limit influencing each other (Botma et al. 2010:252). Table 3.1 is an example of how to go about when calculating the votes and prioritize ideas.

Table 3.1: Example of how to calculate votes and prioritize ideas

Idea number	Votes per person	Calculated vote number	Priority
1	5+5+5+3+1	19	1
2	4+3+3+1+1	12	4
3	5+2	7	5
4	3+2+5+3	13	3
5	5+4+1+2+2	15	2

The participants prioritized and scored their five ideas that they considered most important, in the following way: 5 = most; 4 = second most; 3 = third most; 2 = fourth most; and 1 = least. After they had prioritized their ideas accordingly, each individual displayed their score on the flip chart next to the appropriate idea. Finally, the votes per

idea were tallied by the facilitator as indicated under the “votes per person” (see Table 3.1). The “calculated vote number” in Table 3.1 is the total ranking score per idea. Each idea is then arranged from highest priority to lowest priority according to the “calculated vote number”.

3.3.5 Data analysis

Data analysis is a process to reduce and organize the data through synthesis so that it makes meaning (Polit & Beck 2008:498; Burns & Grove 2009:44). The quantitative or numeric data analysis in this study took place during the NGT sessions and was done by the participants and the facilitator that had conducted the nominal group session (Botma et al. 2010: 253). After voting for the five most important ideas, the ideas were arranged from highest to lowest priority.

The qualitative analysis was done after the nominal group by the researcher through thematic analysis where categories and themes were identified based on the ideas written down by the participants (Botma et al. 2010:253; De Vos et al. 2011:91). The nominal group facilitator co-coded the data to increase dependability (Botma et al. 2010:235).

Although the NGT uses quantitative and qualitative data the emphasis of this study will be mostly on the qualitative data collected.

3.4 TRUSTWORTHINESS

Botma et al. (2010:231-232) state that in qualitative research, validity is measured through accuracy and truthfulness of the findings, whereby trustworthiness is defined as a way in which qualitative researchers ensure the credibility, dependability, transferability and conformability of the study, which were evident in their research (Polit & Beck 2008: 511). The following components were addressed to ensure the trustworthiness and rigour of the study:

Credibility focusses on the reliability of the key findings during data collection, it establishes that the results of the research are credible and represent the actual meaning of the partakers (Polit & Beck 2008:580: Moon et al. 2016: 2). Babbie and Mouton (2001:270) assert that credibility is about the truth of the findings in the qualitative study. Botma et al. (2010:292) state that "the researcher reports the perspectives of the participants as clearly as possible".

During the nominal group interview, the facilitator engaged with the participants to judge the credibility of the results. All participants were involved in a supervisory level at the hospital chosen for this study and were therefore in a position to identify challenges and make suggestions on how the hospital can improve its governance and quality of service delivery. The researcher made field notes during the nominal group which was used to triangulate with the NGT data findings (Botma et al. 2010:292).

Transferability refers to the extent to which the research can be transferred to other contexts. The study should be sound and considered applicable to benefit others in similar situations (Polit & Beck 2008:586). Babbie and Mouton (2001:272) define transferability where findings can be transferred and applied to other contexts. If the specifics were comparable, the research would be more credible. The aim of this study was not to compare it to another context but to explore and describe the perceptions of professional healthcare managers on how governance in the hospital chosen for this study influences service quality. An investigator who is interested in using these findings may do so of own accord.

Dependability refers to the findings of the researcher being consistent and is a process to determine the quality of data (Botma et al. 2010:234, 292). In other words, dependability is an appraisal of the quality of the data collection and data analysis processes and the degree to which the research procedures were followed (Moon et al. 2016: 2). With this research the step-by-step process of the nominal group positively influenced the dependability. Furthermore, a co-coder was used to enhance dependability during qualitative analysis to identify themes and categories (Botma et al. 2010:292).

Confirmability refers to questions on how research findings are supported by the data collected; it refers to the neutrality and accuracy of data (Polit & Beck 2008:586). This process establishes whether the researcher has been biased during the study or not (Babbie & Mouton 2001:278). Data was collected and analyzed by all participants, the facilitator 'word for word' transcribed the data and accurately calculated the voting process on the flip charts. By providing a step-by-step description of the process followed by the facilitator, the researcher enables the reader to determine confirmability (Moon et al. 2016: 2). The researcher took field notes during step three to substantiate the nominal data (Babbie & Mouton 2001:278).

3.5 ETHICAL ISSUES

Ethical aspects such as beneficence, respect for people and justice were taken into consideration during the research process (Botma et al. 2010:277; Burns & Grove 2009:188, 735; Polit & Beck 2008:87). Approval to conduct the study was obtained from the relevant authorities (Botma et al. 2010:277). The researcher is not aware of any harm that the participants could have undergone (Botma et al. 2010:277). By taking part in the nominal group session the participants derived the benefit from sharing their experiences, which provided a platform to debrief.

The professional healthcare managers in this research were not influenced by the researcher and there were no risks, threats or intimidations. The principle to respect people was adhered to (Burns & Grove 2009:735). It was explained to the participants during the invitation that they should feel free to participate in the nominal group interview. The voluntary aspect of participating in the research study was also explained to the group of professional healthcare managers and written informed consent was obtained from those who participated (Botma et al. 2010:277). Participants were able to withdraw at any time during the process. Participants were treated fairly (Burns & Grove 2009:189, 735) by communicating before the NGT to them that no remuneration will be given to them. The nominal group was conducted by an independent skilled facilitator.

The following ethical aspects were considered during the nominal group session to ensure that the rights of participants were not violated (Brink & Bernt 2003:31, 33; Botma et al. 2010:277):

- The purpose of the research was explained to the participants;
- Written consent was obtained;
- Participation was entirely voluntary;
- Participants were informed about their rights to withdraw should they wish to do so;
- Confidentiality of the data was maintained and the group was asked not to discuss the session with other people;
- The responses remained anonymous in the reporting of the research;
- A skilled independent facilitator conducted the nominal group.

3.6 SUMMARY

In this chapter the researcher described the research design and methodology in more detail. The next chapter will discuss the findings of the research with the integration of control literature.

CHAPTER FOUR: RESEARCH FINDINGS AND DISCUSSION

4.1 INTRODUCTION

The methodology and design were discussed in the previous chapter. This chapter presents and discusses the findings of the research based on the data that was captured from the nominal group. Tables are used to assist with the interpretation of the research results. The discussion focusses on the research results, namely the governance-related factors that have an influence on service delivery in a public hospital and how governance and service delivery can be improved.

The demographic data of the participants that took part in the nominal group will briefly be discussed below.

4.2 DEMOGRAPHIC PROFILE

The characteristics of the participants from whom data was collected are illustrated in Table 4.1. Race, gender and participant position at the hospital are included in the table.

Table 4.1 Demographic profile

Characteristics	**Participants**						
Race	African		White		Coloured		Total
Gender	Male	Female	Male	Female	Male	Female	
Supervisors	2	1	1	1	1	0	6
Assistant managers				1	1		2
Executive Managers	0	0		1			1
Total	2	1	1	3	2	0	9

A total of nine people participated in the nominal group of which five participants were male and four were female. The group included six supervisors, two managers and one executive manager. The data for this study was collected from the professional healthcare managers at a chosen hospital who met the inclusion criteria and were available on the day of the nominal group discussion.

A general overview of the research findings will be given in the next section.

4.3 GENERAL OVERVIEW OF THE RESEARCH FINDINGS

The two research questions each had its own nominal group cycle of (1) generating ideas, (2) recording ideas, (3) discussing the ideas and (4) voting to prioritise the ideas.

The first question was:

> *''What are the governance-related factors that have an influence on service delivery in public hospitals? ''*

In Table 4.2 the eighteen ideas that originated from the nominal group data of Question one are recorded. The ideas are displayed in the table according to the ranking priority which originated from the voting of the participants during step four of the nominal group. The ideas are ranked from one to eighteen. The calculated vote number that each idea scored is indicated in the table. If two ideas received the same vote number, the idea that most people voted for will have priority (see priority 5 & 6 in Table 4.2).

Table 4.2: Generated ideas of Question one

Priority/ranking	Ideas	Calculated vote number
1	Insufficient budget	31
2	Poor planning	13
3	Lack of resources	12
4	Shortage of skilled staff	11
5	Lack of quality assurance *(four people voted)*	10
6	Fund shifting *(three people voted)*	10
7	Lack of authorized officials for document approval	9
8	Lack of training	9
9	Poor risk management	8
10	Poor management of absenteeism	6
11	Lack of accountability due to unclear channels of communication	5
12	Crisis management of old infrastructure	4
13	Cumbersome supply chain processes	3
14	Lack of funds for daily activities	2
15	Training needs not addressed	2
16	Posts not advertised	0
17	High turnover of staff	0
18	Red tape with operational processes	0

The second question was:

> *"How can public hospitals improve their governance and quality of service delivery?"*

In Table 4.3 the ideas that originated from the nominal group data of Question two are recorded.

Table 4.3: Generated ideas of Question two

Priority/ranking	Ideas	Calculated vote number
1	Adequate budget allocation	26
2	Proper planning	16
3	Sufficient staff to be effective	11
4	Proper training *(4 people voted)*	9
	Accountability for actions (4 people voted)	9
5	Effective supply chain management (SCM) procedures *(3 people voted)*	9
6	Adherence to national core standards *(two people voted)*	9
7	Enforce Batho Pele principles	8
8	Timely maintenance	7
9	Enforce discipline (Labour relations matters)	7
10	Inclusive decision-making	6
11	Ensure enough equipment to render service	5
12	Align strategic plan with patient needs	5
13	Regular roadshows to community	3
14	Implement policies	2
15	Effective staff appointment	2
16	Appoint skilled staff	1

The ideas are displayed in the table according to the ranking priority from one to sixteen. The total calculated vote number that each idea scored is indicated in the table.

If two ideas received the same vote number, the idea that the most people voted for will have priority (see priority 6 and 7 in Table 4.3). Where the same number of people voted for an idea the ranking will be equally shared (see priority 4 in Table 4.3)

4.3.1 Categories and themes

Although the NGT uses quantitative and qualitative data the emphasis of this study will be mostly on the qualitative data collected. The prioritized nominal group ideas or responses emerged into themes for each question respectively which was posed during the nominal group session (see Table 4.4).

Table 4.4: Categories and themes of Questions one and two

Categories	Themes (Question one): Governance-related factors that influence service delivery	Themes (Question two): Factors to improve governance and service delivery
Budget	• Insufficient funds • Fund shifting	• Budget allocation
Planning	• Delayed recruitment • Training needs • Cumbersome supply chain	• Effective supply chain • Strategic planning • Proper training • Regular roadshows
Resources (Staff and equipment)	• Lack of skilled staff • Accountability • High turnover • Old infrastructure	• Skilled staff employment • Enough equipment • Timely maintenance
Quality assurance	• Risk management • Absenteeism • Operational red tape	• Accountability & discipline • Adhere to core standards • Policy implementation

The themes of both questions were then placed into general governance categories according to the themes. Four main categories were identified for both questions, namely: budget, planning, resources and quality assurance (see Table 4.4). The themes of Question one (governance-related factors that influence service delivery) are indicated in blue and the themes of Question two (factors to improve governance and service delivery) are indicated in green in the tables following in this chapter.

The next section comprises a discussion of the findings.

4.4 DISCUSSION OF FINDINGS

Governance-related factors which have an influence on service delivery and how public hospitals can improve their governance and quality of service delivery will be discussed simultaneously according to the categories of the analysis in Table 4.4. The governance-related factors which have an influence on service delivery (Question one) will be displayed in a blue table, and how public hospitals can improve their governance and quality of service delivery (Question two) will be displayed in a green table together with each main category.

In the discussion to follow the prioritized participant ideas (1) and the field note quotes of the participants (2) which were used and documented by the researcher during the nominal group and more specifically during step three of the nominal group were written down verbatim.

Firstly the budget category will be addressed.

4.4.1 Budget

A budget is a quantified, planned course of action over a definitive time period (Pauw, Woods, Van der Linde, Fourie & Visser 2002:134). It is an attempt to estimate inputs and the costs of inputs along with associated outputs and revenues from outputs (Pauw et al. 2002:134). Olander (2007:10) states that a budget for public service organizations

reflects all public resources available, is perceived as transparent and makes it possible to ensure that resources are utilized effectively and efficiently.

4.4.1.1 Budget-related factors that influence service delivery (Question one)

Budget-related factors that have an influence on service delivery will be discussed below with the focus on the two budget themes, namely insufficient funds and fund shifting (see Table 4.5).

Table 4.5: Budget-related factors that influence service delivery

Category	**Budget**
Themes	• Insufficient funds • Fund shifting

Despite a budget at the hospital, the issue of insufficient funds was by far the main priority idea for the first question as voted for by the participants and this priority will be discussed below.

- **Insufficient funds**

The following quote was made by a participant and was recorded as a field note during step three of the nominal group:

> *"Due to budgetary constraints the hospital is unable to hire support and medical personnel."*

Due to an insufficient budget of the previous financial year and not enough allocated funds, the hospital is unable to hire medical and support personnel in order to improve service delivery. There is a delay in the procurement of medical consumables as a

result of the shortage of personnel and this state of affairs results in service providers not gaining confidence to conduct business with the hospital. The United Nations in their Millennium Development Goals likewise identified healthcare human resources as a critical restriction to achieving service delivery goals (Lopes, Almeida & Almada-Lobo 2015:13).

Furthermore, a shortage of staff has a negative impact on resource planning and thus affects quality service (Lopes et al. 2015:13). Another participant made the following remark during step three related to the shortage of medical consumables:

"There is lack of medical consumables"

This lack of medical equipment forces managers to find alternative solutions to which fund shifting is a possibility.

- **Fund shifting**

According to the National Treasury fund shifting is the movement of funds that takes place between economic classifications within a main division of vote (RSA DoH 2000:4). According to section 19(1) of the Public Finance Management Act (PFMA), Act, No. 29 1999 (RSA 1999), the accounting officer is responsible for the effective, economical and transparent management of the resources of the department or institution. In the case of the hospital in this study, it is the responsibility of the Finance Manager to shift funds. According to a participant, fund shifting from one cost centre (different sections in the hospital) to another cost centre is frequently done in the institution.

The cost centres are faced with the problem of losing funds as a result of this fund shifting which also hampers service delivery. A "hands-on management approach", as implemented since 1999 in public institutions in South Africa should be enforced to manage and disseminate resources to promote effective service delivery (Hood & Margetts 2007:11).

It seems that insufficient control over financial management in the hospital causes an unavailability of resources, both human and medical consumables. This deficiency therefore hampers service delivery. It is thus the responsibility of operational managers to ensure that service delivery is not compromised due to budget constraints.

4.4.1.2 Budget-related factors for improving governance and service delivery (Question two)

Budget-related factors to improve governance and service delivery will be discussed below with reference to the budget allocation theme (see Table 4.6).

Table 4.6 Budget-related factors for improving governance and service delivery

Category	**Budget**
Theme	• Budget allocation

- **Adequate budget allocation**

Adequate budget allocation was listed as the main priority idea for Question two on how public hospitals can improve their governance and quality of service delivery.

The finance manager is responsible for compiling of the budget. After the approval of the budget, it should be executed through financial management systems and appropriate control measures should take place (RSA DoF 2000:3). During budget preparation the approved budget plan has to be communicated to the whole cost centre after which the managers should negotiate the allocated amount in relation to what they budgeted in the hospital. The budget must be communicated to the team in such a way that it is clear and easy to interpret. Budget execution requires the release of funds by the finance manager for procurement of medical consumables. Through accounting and monitoring there should be good practices in procedures, monitoring skills and

evaluation to ensure that service delivery is effectively and efficiently executed by means of the usage of resources (RSA 1999; RSA DoF 2000:3-9). Should there be overspending, the accounting officer has to take corrective measures. Underspending has an adverse effect because if a cost centre underspends it means that in the next financial year it will not receive more funds.

Therefore better budgeting in terms of the Public Finance Management Act (PFMA) results in accountability, effectiveness and the efficient achievement of priorities (RSA 1999). This accounting and monitoring process will result in a financial performance report. Reporting and auditing refers to the managers taking corrective and management decisions where financial information reveals possible deviations in using the funds (RSA 1999; (RSA DoF 2000:3-9).

It seems that not all managers are acquainted with the budget process since the following quote was made by a participant:

> *"There is a need to train and develop programs on financial management within the hospital"*.

It is the function of the operational managers to ensure that cost centres utilize their consumables economically, effectively and efficiently. The operational managers should adhere to timely procurement of medical consumables to avoid unnecessary delays.

According to the Economic Commission for Africa (2005:56) it is also a prerequisite for citizens to influence the state budget. The voice of the community (patients) is therefore supposed to be taken into consideration by the hospital management through surveys on how they wish service to be rendered.

Planning is the next category that will be discussed.

4.4.2 Planning

Health planning is described as the first step to achieve the things that are necessary to improve the health status of people (Scutchfield, Howard & Shapiro 2016:n.p.). In the public health service setting, planning is primarily concerned with "developing and supporting a health system that delivers high quality services to the community" (Queensland Health 2015:4).

4.4.2.1 Planning-related factors that influence service delivery (Question one)

Themes that clustered under planning, related to Question one, include delayed recruitment processes, lack of training and cumbersome supply chain (see Table 4.7).

Table 4.7: Planning-related factors that influence service delivery

Category	**Planning**
Themes	• Delayed recruitment process • Lack of training needs • Cumbersome supply chain processes

- **Delayed recruitment**

Recruitment processes after the retirement of personnel as well as the appointment of scarce skills posts take a long time in the hospital. The perception of participants was that the recruitment process of human resources in the hospital was extended or did not take place at all, and as a result critical cost centres were not adequately staffed. Failure to appoint personnel timeously resulted in the hospital utilizing personnel who were not trained for a particular specialty.

The following quote made by a participant was recorded as a field note during step three of the nominal group:

"Poor human resource planning, for instance for retiring personnel or scarce skills posts, affects service delivery negatively as recruitment processes take a long time".

According to (Van Dijk, 2003:41), public institutions have a division that deals mainly with human resource management based on legislation of the government of the day. These officials are the backbone of good governance and will enable the organization to attain its goals and objectives. At the Health Summit that took place in 2001, former Minister of Health, Dr. Manto Tshabalala-Msimang alluded to policy implementation issues with respect to slow service delivery, which are affected by leadership decision making (Tshabalala-Msimang 2001). The challenges faced by the hospital might be due to a lack of leadership, inexperienced leadership or insufficient training. The managers dealing with recruitment have to prioritize, strategize and coordinate the process.

Management personnel are the backbone of good governance and will enable the organization to attain its goals and objectives. Olander (2007:77) stipulates that personnel management in terms of recruitment and retention of staff has a link with financial management. Therefore the recruitment of staff is also dependent on the budget.

- **Lack of training**

Participants expressed the views that service delivery was hampered by the hospital's failure to plan strategically by ensuring that each personnel member was trained properly in their specific line of work. Training is the process of gaining skills, competencies and knowledge to perform an activity effectively (Shafritz & Russell 2005:356). The Department of Health developed a set of audit tools (norms and standards) with performance indicators to evaluate the outputs, outcomes and impact of training (RSA DoH 2011b:5). There is thus a need for the hospital to adhere to prescripts related to the training of personnel in their line of delegated duties.

- **Cumbersome supply chain processes**

According to the National Treasury Guide for Accounting Officers it is the responsibility of the cost centre managers to plan and manage the physical execution of their functional entities (RSA DoF 2000:6). The participants voiced their concern that the cost centres did not prepare their needs analysis for medical consumables that were procured from external service providers in time to align with the needs of the patients. One participant stated that procurement processes were "*always not adhered to".* Due to improper planning and inadequate personnel, service delivery was hampered.

Participants expressed the views that the policies and prescripts regarding supply chain procedures were not adhered to. They further elaborated on the lack of policy prioritization, proper time frames as well as the lack of intervention implementation.

4.4.2.2 Planning-related factors for improving governance and service delivery (Question two)

Planning-related factors to improve governance and service delivery will be discussed below with reference to the following themes: effective supply chain, strategic planning, proper training, and regular roadshows (see Table 4.8).

Table 4.8: Planning-related factors for improving governance and service delivery

Category	**Planning**
Themes	• Effective supply chain • Strategic planning • Proper training • Regular roadshows

- **Effective supply chain**

The participants stated that effective supply chain procedures would improve the governance and service delivery in the hospital. The idea of effective supply chain management was ranked 6th by the participants with a total calculated vote of nine (see Table 4.3). It is the responsibility of management to properly plan before hospital needs can be procured.

- **Strategic planning**

The participants identified proper planning and the alignment of patient needs with strategic plans as ideas to improve governance and service delivery in public hospitals. It is the responsibility of managers to strategically plan and execute the planned activity. In order to plan adequately the management within the hospital needs to follow the existing policies in terms of human resources, physical resources as well as financial resources for economic, efficient and effective service delivery. An institution cannot function solely with financial resources without human resources, and service delivery cannot benefit the patients if the resources utilized are not properly planned and prioritized.

The participants furthermore asserted that for governance to be effective there should be team cohesion amongst the managers in the cost centres. Kalish, Russell and Lee (2013:214) state that an effective team promotes a great exchange of ideas, team cohesion as well as mutual respect and personal satisfaction. Team cohesion amongst managers can enhance strategic planning.

- **Proper training**

The proper training idea was in fourth position according to the calculated vote number (see Table 4.3). The participants felt that training should be continuous.

Training is a strong signal to employees regarding management's commitment towards service delivery and is considered to be an ongoing process (Naidoo, 2004:21). Training transfers skills, information and values to the employees. Therefore the organization that is committed to training increases the skills sets, motivation, high productivity, transfer of knowledge and skills, as well as job satisfaction of their employees. Naidoo (2004:21) believes that there is a connection between training and job satisfaction. Therefore if the training of employees does not take place in an organization, the staff productivity might be influenced negatively.

- **Regular roadshows**

Regular roadshows to the community were not a high priority but the participants nevertheless indicated roadshows as a planning factor that could improve governance and service delivery. Participants felt that community awareness, through "media" and "open days", would serve as a means to attract the public to the utilization of services rendered at public hospitals. These roadshows and open days should be part of the annual planning.

The third category, namely resources will be discussed below.

4.4.3 Resources

The hospital cannot function without resources. Resources in this section include human as well as physical resources.

4.4.3.1 Resource-related factors that influence service delivery (Question one)

Resource-related factors that have an influence on service delivery will be discussed below with the focus on a lack of skilled staff, accountability, high turnover, and old infrastructure (see Table 4.9).

Table 4.9: Resource-related factors that influence service delivery

Category	Resources
Themes	• Lack of skilled staff • Accountability • High turnover • Old infrastructure

- **Lack of skilled staff**

Skilled labour refers to labour that requires workers who have specialized training or a learned skill set to perform at work (Farazmand 2004:24). The perception of participants was that lack of skilled staffing hampered labour to ensure productivity in the organization. The following quote made by a participant was recorded as a field note during step three of the nominal group:

"Lack of skilled staff to approve documents".

Delegated officials with powers vested in them require qualified personnel to approve documents. It was furthermore mentioned by a participant that managers who were not qualified did not want to take responsibility for document approval in some of the cost centres.

Mateus, Allen-Ile and Iwu (2014:71) concluded that there are severe skills shortages and that there is a desperate need for critical skills. The South African Bureau of Statistics estimates that between 1million and 1.6 million people in skilled, professional, and managerial positions have emigrated since 1994, and for every emigrant, 10 unskilled people lose their jobs. Mateus et al. (2014:71) state that immigration is a contributing factor to the skills shortage in the country. The government's affirmative action policy, which aims to address the appointment of previously disadvantaged people, had a great influence on the emigration of skilled white South Africans (Farazmand 2004:24). For the effectiveness of service delivery the government should

rather appoint and retain skilled people for the required job and not drive affirmative action to the detriment of patient care.

The ability to attract and retain skilled staff to promote adequate service delivery is still a challenge for health institutions.

- **Accountability**

Accountability is defined as the obligation to render an account regarding actions and or decisions (Van Niekerk et al. 2002:3; Gregory 2007:341). Therefore accountability is answerability. Within the context of this research study, accountability includes financial accountability, developing policies and also implementing measures for the control and evaluation of performance on service delivery (Gregory 2007:340). Financial accountability deals with monitoring and control of resources as well. The promotion of service delivery is tested on the strength of accountability.

The participants felt that a lack of accountability could be due to unclear channels of communication. One participant stated that:

"There should be transparency in information provided by the management to show accountability".

In particular, the participants were of the opinion that there should be access to information and management should exercise transparency to show accountability. Grindle (2004:527) states that transparency means that the decisions taken are done in a manner that follows rules and regulations and is accessible and available at all times for those who need clarity. Ssonko (2010:5) states that "transparency implies openness, communication and accountability".

It is the responsibility of the managers in the hospital to ensure that communication reaches all the departments and information is disseminated at all levels to promote transparency and thus shows accountability.

- **High turnover of staff**

Staff turnover has a vital impact on patient satisfaction and affects staff (Casey & Clark, 2011:931). There are many factors and reasons why people leave healthcare jobs. According to (Kelly & Ahern 2009:915) most health professionals leave the clinical settings because of fatigue, emotional distress and an unfriendly workplace. The high rate of staff turnover is a major challenge in the healthcare sector (Casey & Clark, 2011:930).

Although the high turnover of staff received no votes, participants were of the view that due to the high staff turnover, service delivery was most compromised. They raised issues like the quality of care, which was not adequate, less time was devoted to patient care, which affected patient mortality. Therefore high turnover increases the workload of the team that is left if the position is not filled.

- **Old infrastructure**

The crisis management idea related to old infrastructures was ranked 12th and received four calculated votes. They felt that poor Information-technology (IT) infrastructure is a risk that affects the healthcare sector and in particular service delivery.

According to Shohet and Lavy (2004:210), public health infrastructure requires a capable workforce and an up-to-date information system. Most healthcare sectors depend entirely on technology. McKee and Healy (2002:5) indicate that healthcare technology uses medical laboratories, radiology images, other medical investigations such as sonars, scans (MR, CT), scopes (Broncho, Laparoscopy), etc. Recently most public healthcare sectors in South Africa have been making use of IT to capture patients' demographics as manual procedures have been phased out. So they rely entirely on IT.

Despite the fact that the healthcare sector relies heavily on IT, they often do not have a recovery plan during the IT "disaster" (Shohet & Lavy 2004:210). In the case of medical laboratories, there is often a huge delay in releasing blood results to allow medical

doctors to diagnose patients promptly. The laboratory data is transmitted to the medical record system that provides the medical doctor with a complete medical record (Shohet & Lavy 2004:211). The delay causes poor service and results in patients not being attended to timeously. The laboratory management needs to manage and control specimens to avoid a catastrophe.

On the admission side, where the demographic data is obtained, when the system is down there is always a delay in capturing data manually. As a result, patients' information cannot be retrieved timeously. When systems are down, employees must ensure the protection, safety and confidentiality of patient information.

Therefore policies should be developed and implemented to address IT related issues during downtime. Information technology should be prioritized during budget allocation.

4.4.3.2 Resource-related factors for improving governance and service delivery (Question two)

The suggested themes for the improvement of resource-related challenges are staff employment, equipment and maintenance (see Table 4.10).

Table 4.10: Resource-related factors for improving governance and service delivery

Category	Resources
Themes	• Skilled staff employment • Enough equipment • Timely maintenance

- **Skilled staff employment**

Although effective staff employment and the appointment of skilled staff received the lowest ranking by the participants as possible solutions for improved governance and service delivery, it has been described under a “lack of skilled staff” with a calculated vote number of 11 as a major problem and justifies finding possible solutions.

The Department of Public Administration and Management by former Minister Lindiwe Sisulu has introduced a new School of Governance (Mail & Guardian 2013) which will provide compulsory training for public servants. The new School of Governance in collaboration with the South African National Development Plan (RSA 2012) aims to deliver a better public service to the people by educating and training public officials to improve their skills. Mateus et al. (2014:71) endorse such an attempt to improve on skills shortages where employers can advertise for selected skilled occupations. Irrespective of the new School of Governance and reshuffling of public servants in power, skilled staff appointments are still a challenge.

- **Enough equipment**

The WHO estimates that in developing countries approximately 65% of medical equipment is not functioning and lacks regulatory control (WHO 2012:n.p.). Nonfunctioning medical devices can be a contributing factor to long patient stay.

Participants were of the view that due to the lack of sufficient equipment in the hospital, service delivery was mostly compromised. They expressed challenges around medical equipment that was not maintained, replaced or repaired timeously and hindered service delivery.

Medical equipment serves as an important component of a healthcare system and is used as a tool to prevent, diagnose, monitor and treat diseases (McQuoid-Mason 2016:681). It can be in any form like machinery, appliance, instruments that are

intended to improve patient care. The shortage of medical equipment, either due to unavailability or nonfunction, is a barrier to the ability of the hospital to deliver quality service (McQuoid-Mason 2016:682).

It is therefore recommended that it is the duty of the managers in the cost centres to ensure that equipment is maintained and available.

- **Timely maintenance**

The maintenance management of healthcare facilities is highly crucial. Shohet and Lavy (2004:211) defines maintenance as a combination of any actions carried out to retain an item, such as to restore it to an acceptable condition or standard.

Timely maintenance as a factor to improve governance was ranked 9t^{h} by the participants with a total calculated vote of seven. During the step three discussion participants raised their concerns that a lack of proper maintenance, especially biomedical equipment, might negatively affect service delivery. A participant mentioned that equipment needed to be serviced regularly to minimize downtime and measures to prevent breakages had to be in place.

According to McKee and Healy (2002:4), preventive maintenance is better than corrective maintenance (replacement). It reduces the maintenance cost of major damage and downtime can be minimized as well. Corrective maintenance can be extremely expensive and can at times result in not having an item at hand.

Kutucuoglu, Hamali, Irani and Sharp (2001:176) believe that there is a relationship between maintenance strategy and patient satisfaction. Failure to procure an item can be highly detrimental to service delivery and patient care. Therefore the hospital has to ensure that there is maintenance management for mechanical, electrical as well as biomedical equipment. The National Core Standards of Health in South Africa (RSA DoH, 2011b:6) require that medical equipment should be maintained according to manufacturers' requirements to keep the equipment reliable and safe when required for diagnostic and treatment purposes.

In order to bring about high satisfaction in patient care the management within the public health facilities needs to employ proper maintenance strategies, implement policies and derive plans to mitigate during disaster.

4.4.4 Quality assurance

The term quality assurance in healthcare means “maintaining a high quality of healthcare by constantly measuring the effectiveness of the organizations that provide it” (Brumley 2018:n.p). This further entails measures to be taken to improve health services. An efficient monitoring and evaluation system would assist quality assurance within the hospital. It is a system used by the management to assess progress in attaining goals. The Council for Health Service Accreditation of Southern Africa (COHSASA) is the only internationally accredited quality improvement and accreditation body for healthcare facilities based in Africa (COHSASA 2016:n.p.).

4.4.4.1 Quality-assurance-related factors that influence service delivery (Question one)

Themes that clustered under quality assurance, related to Question one, include management of risk, absenteeism as well as operational red tape (see Table 4.11).

Table 4.11: Quality-assurance-related factors that influence service delivery

Category	Quality assurance
Themes	• Risk management • Absenteeism • Operational red tape

- **Risk management**

The perception of the participants was that internal control measures were not practised effectively in the hospital. The following quote made by a participant was recorded as a field note during step three of the nominal group:

"Financial accountability in the hospital is not practised"

Financial accountability is characterized by all the processes such as procedures, inputs and outputs, resources (material, human, financial and informational) (RSA DoH 2007:11). Through internal control management, health leadership within the hospital must identify the risks they face, and ensure that they adhere to policies and procedures related to accountability (IMSA 2010:6). All managers and supervisors within the hospital should be aware of the importance of risk management in achieving their objective and implement monitoring and control. Therefore in a healthcare sector, in order for resources to be managed effectively under the prescripts of laws and regulations, there should be accountability of officials who manage the resources to assist the organization in attaining its mission (Uregu Ile 2010:51). The policies and procedures should assist managers to carry out their directives adequately so as to assist the organization to meet its objectives. For instance, in sections like procurement of goods and services, proper steps such as approvals, authorizations, verifications, reconciliations, reviewing operating performances should be adhered to and thus accountability ensured (Visser & Erasmus 2002:307; RSA DoH 2007:11).

The healthcare sector should not only focus on money or financial risk, but rather on an entire holistic approach so that service delivery can be rendered effectively. In so doing risk management could assist in improving the lives of people through proper planning to reinforce the government's political mandate of improving service delivery (Visser & Erasmus, 2002:309; RSA DoH 2007:6).

It is clear that the department lacks risk management skills as there are poor basic managing skills, poor financial management skills as well as poor environmental control. These risks could have a negative impact on service delivery (Visser & Erasmus:

2002:308; Young 2016:18). To this end, the new democratic government committed itself to improving the quality of services, the accessibility, efficiency and accountability of public goods and services to all recipients. While there are pockets of excellence in government delivery, the challenge, twenty three years after the first democratic election in 1994, still remains.

- **Absenteeism**

Blad (2017:9) defines absenteeism as a habitual pattern of absence from duty or obligation without good reason. It is therefore an unplanned absence.

The participants believed that absenteeism was a thorny issue and "the highest strategic risk" in the institution. They raised the concern that some departments had higher rates of absenteeism than others. The institution often found itself battling on without employees who did not report for duty. As a result service delivery was hampered. Pillay (2009:1) observes that the reason why people are absent from work is based on conditions relating to the individual (personal factors) and organizational contexts. The personal factors like health, family responsibility, and stress can contribute to absenteeism at the workplace (Pillay 2009:2).

The participants also stated that it was the manager's role to have open communication with his/her employees on a regular basis. Open lines of communication would assist in reducing high volumes of not reporting for duty. Therefore it is important that managers are consistent in adhering to the standards and policies in managing and reducing high volumes of absenteeism in a workplace. Lack of managing absenteeism can lead to poor team functioning (Cleary & Freeman 2006:992).

- **Operational red tape**

The participants highlighted the rise of corruption in the healthcare sector, which hinders service delivery. Their view was that corruption was "ever rising and unstoppable". They expressed the opinion that officials who were involved in corruption "often blame others"

and they “think that they make money faster in a short space of time”. In other words, their perception was that some officials enriched themselves. The participants highlighted that poor service delivery in the hospital was influenced by corruption in the name of saving money during procurement of certain medical items. The participants said that even the medicine in the public hospital was of sub quality, which may also be part of the money-making scheme.

In the cabinet sitting during the National Council of Provinces, former president Jacob Zuma reiterated that improvement of service delivery remained government top priority (Mail & Guardian 2012). This was done in an effort to improve service delivery by implementing programmes of monitoring fraud and corruption. It is therefore mandatory for public healthcare professionals to adhere to standards and procedures that assist in improving service delivery. The National Department of Health in South Africa (RSA DoH 2011b:6) has implemented core standards that serve as a tool to monitor the best quality care in the health system in order to combat corruption.

4.4.4.2 Quality-assurance-related factors for improving governance and service delivery (Question two)

Factors for the improvement of governance and service delivery that have an influence on quality assurance, were clustered under the themes: accountability, discipline, national core standards and policy implementation (see Table 4.12).

Table 4.12: Quality-assurance-related factors for improving governance and service delivery

Category	Quality assurance
Themes	• Accountability & discipline • Adhere to core standards • Policy implementation

- **Accountability and discipline**

Accountability means that public healthcare should serve all stakeholders within a reasonable framework. Du Toit et al. (2013:103) elucidate that it is government's responsibility to be accountable to the community it serves and provide quality services. Public healthcare is accountable to those who will be affected by its decisions and actions. Accountability cannot be enforced without transparency and the rule of law (Grindle 2004:527). Public servants within the healthcare sector should be held answerable when they contravene the prescripts in performing their functions (De Wet et al. 2014:401).

The participants in this study felt that supervisors had to be held accountable for their actions. It is thus concluded that healthcare managers should adhere to accountable principles as well as the managerial ethical code of conduct to ensure effectiveness and efficiency in service delivery (WHO 2017:10). The ethical code of conduct will guide the healthcare officials on how to render service in fairness as well as to safeguard the officials against unfair demands by patients in the hospital.

Furthermore, the participants felt that discipline related to labour relations should be enforced. Disciplinary measures may vary and corrective measures and policies made by an employee may also vary. Many forms of disciplinary measures are common at the workplace (Moulton 2005:31). There is either positive or negative reinforcement. Positive discipline promotes appropriate behaviour and encourages employee participation. Negative discipline discourages wrong behaviour and consists of elements like punishment, demotion, wage loss, suspension and even a dismissal (Gopee 2008:401).

The National Core Standards (RSA DoH 2011b:13) have adopted a tool in all public health institutions that will assist management in adhering to good governance and best practices. One of the tool measurements is to instil discipline in all health areas especially on employees (Moulton, 2005:30). There are processes to be followed during disciplinary action to assist an employee to improve. The Labour Relations officer

appointed in the public health institution assists the employee regarding matters on how to handle disciplinary processes (RSA 1995b).

Proper labour relations policies should be followed when instilling discipline in public health institutions.

- **Adhere to core standards**

The National Department of Health in South Africa (RSA DoH, 2011b:6) states that one of the core standards is committed to the provision of the best quality care and health service delivery. It is focusing on improving health systems effectively by improving quality in health service delivery, information, human resources, finance and financing, infrastructure and technology. The primary goal of the core standards is to assist in improving quality of care in all health establishments.

The National Core Standards idea to improve governance was ranked sixth with a calculated vote number of nine. The participants were of the view that supervisors, managers and all staff should ensure that compliance with standards was practised, implemented and became a continuous tool for quality improvement.

- **Policy implementation**

Policy implementation received a low rank but was nonetheless mentioned. Anderson (2011:2l0) defines policy implementation as a conversion of mainly physical and financial resources into concrete service delivery outputs in the form of facilities and services, or into other concrete outputs aimed at achieving policy objectives.

It is the primary role of leadership to ensure that there is effectiveness of policy implementation within the institution (Kuye 2010:212). Failure might lead to financial wastefulness and poor service delivery. To implement policy is crucially important for quality service delivery. Management in public healthcare should therefore pay

attention to the implementation of policies and prioritize resources to ensure quality service delivery.

4.5 CONCLUSION

In this chapter the researcher discussed the research findings. Four categories identified from the data, namely budget, planning, resources and quality assurance were addressed. In the last chapter the conclusions, recommendations and shortcomings will be addressed.

CHAPTER 5: CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

Chapter one gave an overview of the actuality, motivation and background. In the second chapter a short overview of the literature related to this study was given. The methodology and design were described in the third chapter. In the fourth chapter the research findings were discussed. This last chapter provides a summary of the purpose of the study, the results, recommendations, the value of the study and a conclusion.

The purpose of this study was to describe the perceptions of professional healthcare managers on how governance influences service quality and how governance and the quality of service delivery can be improved in a public hospital in South Africa. The objectives were to describe governance and service delivery in the South African health context as well as to identify governance-related factors that have an influence on service delivery in public hospitals. The last objective was to provide recommendations to improve governance and service delivery in public hospitals.

The nature of this study is qualitative and descriptive within a phenomenological paradigm. The nominal group technique (NGT) was used to gather and analyze the data. An additional thematic analysis was done as well where themes and categories based on the nominal data were identified. Factors that influence service delivery as well factors that can improve service delivery were categorized under four main headings, namely budget, planning, resources and quality assurance.

5.2 SUMMARY OF THE RESULTS

A summary of the results will follow.

5.2.1 Budget

Budget processes have been the most crucial challenge for the participants in this study in instances where an insufficient budget hampers service delivery. The hospital is unable to hire medical and support personnel, there is a delay in procurement of medical consumables as a result of a shortage of personnel and this may lead to huge backlogs of resources in the hospital.

Fund shifting also hampers service delivery. It seems that insufficient control over financial management in the hospital causes unavailability of resources, both human and medical consumables. This deficiency therefore hampers service delivery. It is thus the responsibility of operational managers to ensure that service delivery is not compromised due to budget constraints. A “hands-on management approach” was advised to promote effective service delivery. The operational managers should ensure that cost centres utilize their consumables economically, effectively and efficiently. The operational managers should also adhere to timely procurement of medical consumables to avoid unnecessary delays.

Transparency is crucial in the allocation of a budget as well as an open line of communication throughout the cost centres. It is suggested that there should be sufficient control over financial management in the hospital. The operational managers should take responsibility for ensuring that service delivery is not compromised due to budget constraints.

5.2.2 Planning

Service delivery is hampered by the hospital’s failure to plan strategically by ensuring that there is no delay in the recruitment process, there is adequate training, as well as that supply chain processes are followed. Failure to appoint personnel timeously results in the hospital utilizing personnel who are not trained for a particular speciality. Insufficient funds also results in the delay of new staff appointments.

It is the responsibility of managers to strategically plan and execute the planned activity. In order to plan adequately the hospital management needs to follow the existing policies in terms of human resources, physical resources as well as financial resources for economic, efficient and effective service delivery. An institution cannot function solely with financial resources without human resources, and service delivery cannot benefit the patients if the resources utilized are not properly planned and prioritized.

Training needs likewise have to be attended to. Employees need to increase their skill sets and knowledge. Training also encourages team cohesion. It is thus concluded that for governance to be effective, and service delivery to be efficient, there should be team cohesion amongst the managers in the cost centres, leadership should plan strategically and development in the organization through skills training is needed.

5.2.3 Resources

Lack of qualified personnel who approve documents is a challenge. The ability to attract and retain skilled staff to promote adequate service delivery is still challenging for health institutions. Due to a lack of skilled staff, the hospital is faced with non-accountability. This also results in high staff turnover. Although there are many reasons why people leave the workplace, staff turnover has a vital impact on patient satisfaction and affects staff. It is the responsibility of the hospital managers to ensure the implementation of measures that will attract and retain staff.

The crisis management on old infrastructure affects service delivery. Most public healthcare sectors rely entirely on IT. Therefore public health infrastructure requires a capable workforce and an up-to-date information system. It was highlighted that despite the fact that the healthcare sector relies heavily on IT, there is often no recovery plan during downtime. Service delivery is hampered because medical doctors will not be able to diagnose patients promptly. Inaccurate information may mislead the treating doctor. It is thus concluded that it is the responsibility of managers to ensure that policies are developed. In order to bring about great satisfaction in patient care, management of

public health facilities has to investigate maintenance strategies, implement policies and develop mitigation plans during disaster.

5.2.4 Quality assurance

Maintaining high-quality healthcare in public health is fundamental. The primary role of quality assurance in the health department is to assist in improving the quality of care in all health establishments. Public healthcare cannot maintain quality care due to risk management. It is clear that the department lacks risk management skills, that there are poor basic managing skills, poor financial management skills as well as poor environmental control. These risks could have a negative impact on service delivery.

Absenteeism is rated as a risk in the public healthcare sector. The institution often finds itself at a serious disadvantage on account of employees who did not report for duty. As a result of this, service delivery is hampered. However, absenteeism needs to be managed. Policies on the management of absenteeism have to be in place. A lack of managing absenteeism will lead to poor team functioning.

Operational red tape is also highlighted as a risk. Corruption is a thorny issue in the healthcare sector. Corruption hinders service delivery. The healthcare managers have to ensure that procedures are followed correctly to minimize corruption.

Lastly it was highlighted that governance can be improved by accountability, the adherence to the core standards as well as the implementation of policies. Management in public healthcare should therefore pay attention to the implementation of policies and prioritize resources to ensure quality service delivery.

5.3 RECOMMENDATIONS

The following recommendations are made:

- The hospital should ensure that proper budget allocation is followed and that the prescripts of the Public Finance Management Act are adhered to.

- The recruitment of personnel is a priority; therefore the leadership of the hospital should plan strategically to attract and retain employees within the hospital.

- The needs for training and development to acquire more knowledge should be prioritized.

- Leadership should ensure that processes of the Labour Relations Act are followed correctly and issues such as absenteeism are attended to. More emphasis should be on both patient and employee satisfaction.

- Maintenance of equipment including disaster management planning should be established at the hospital.

- Quality assurance as a tool to ensure that norms and standards are followed in the hospital should assist the hospital management to follow correct procedures according to the core standards.

5.4 VALUE OF THE STUDY

The data collected from the nominal groups can lead to a better understanding of the challenges in the specific context of the selected public hospital. The suggestions of the participants can make a positive contribution to governance and service delivery in public hospitals within a similar context as in this study.

5.5 SHORTCOMINGS

Although the study achieved its purpose the research was conducted in only one public hospital and can therefore not be generalized.

5.6 CONCLUSION

This study confirmed what the literature indicated. The quality and governance issues post 1994 are still a challenge in the health system of South Africa, twenty-three years later. According to this study the service delivery and the quality of care in the hospital used for this study are compromised by poor governance implementation.

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