Performance management and public policy

The case of the health sector in South Africa

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ABSTRACT

The South African healthcare sector stands at the threshold of major restructuring in an attempt to address inadequacies as a result of fragmentation of health services in apartheid South Africa. The performance of health services, particularly in more remote areas, has decreased and has led to reduced quality and effectiveness of health services. For individuals residing in rural communities, access to health services can be arduous. Delivery of essential services has to meet the needs of marginalised people who live in remote areas. The department of health is faced with growing expectations from citizens to use resources efficiently and effectively so that healthcare can be afforded and accessed by all. National Health Insurance (NHI) aims to introduce reforms to improve the provision of healthcare.

The health sector is reputed to be good at formulating policies, discussing ideas, making recommendations and spending resources, but poor on implementing policies. The government insists that the policy framework is transparent and well-defined and that what is needed is effective implementation. Regrettably, the transition of policy into practice is more complex than the perceived judgement of government. The results of this study may be useful not only to the case study institution, but to all District Hospitals, especially the Department of Health and the public management sector and may assist in taking the NHI forward.

INTRODUCTION

Policy analysis, in its more conventional form, tends not to take into account the need for better performance from public sector organisations and its employees. It is as if the two concerns have no relationship to one another. This article is an attempt to show that the two are much more related than is normally assumed. In extreme form, this can give rise to the notion that performance issues are unrelated to policy.

It has been argued for many years that implementation failure is one of the main reasons why policies do not yield the anticipated results. In South Africa, good policies are drawn up but not implemented. Meyer and Cloete argue that 'bad implementation' has been a major obstacle in developing countries' (Meyer and Cloete 2007:301). One manifestation of this is the failure to fully utilise budgets intended for developmental purposes. Another is the delay in service delivery which can occur in this context.

Using South Africa's public health sector as a case study, this article aims to show that close linkages exist between policies and performance, and adoption of a policy without examining, and acting upon, issues related to performance can be a significant reason for the failure to implement. A recent publication, which reflects global experience, stresses that there are complex relationships between policy, implementation, performance, evaluation and monitoring (Patton 2010:47-49). This article is based on a similar recognition of the need to deal with this inter-connectedness and thus possibly reduce the incidence of 'policy fiascoes', a term referred to in one of the contributions to the same publication (Hamilton and Kusek 2010:74).

The policy context for this analysis is similar to that applicable to other sectors such as education: the need to combat racially driven inequities carried over from earlier regimes. The article also aims to increase the amount of research on health policy in Africa, a need stressed by Harrison some time ago (Harrison 1998). The perspective of this article is also derived from the need for more research on health policy in Africa, as argued earlier by Harrison.

This article is focussed on important changes, aimed at greater equality of provision, which are under way in South Africa's public health sector. It draws attention to how changes in the health policy have serious implications which need to be managed. One such change concerns the need to raise performance at various parts of the health system, namely: inclusive of government departments, clinics and hospitals in the face of passive resistance. This takes the form of a culture of formal, rather than substantive, compliance with directives from the top of the hierarchy. Another possible area of resistance, noted in the article, may come from the private sector which may be adversely affected by some proposed changes.

The article also has another sub-theme. It is argued that an investigation into what works well must be conducted, against what does not. Such a focus can often generate important lessons beyond those emerging from the diagnosis of failure as shown, for example, in an analysis of the Sri Lanka experience (Sivagnasothy and Anushyanthan 2010:373-374). A case in point in this article is a public hospital, which has been relatively successful, where in-depth research was done and is reported upon.

Current interest in performance management is, in part, due to an awareness that poor performance can render the implementation of policies and plans ineffective and devoid of impact. For example, in 2003, South Africa adopted a performance management system for its state-run schools in order to transform them to deal with the huge disparities inherited from apartheid (Ntombela, Mphele and Penceliah 2010:361–363). These continuing disparities were seen by some critics as a crisis of 'poor national performance' as a result of which South Africa ranked ninth in Africa in terms of literacy (Equal Education 2011:5–6).

There has been growing recognition on the part of government of the need to transform performance in the public sector as specified in the *Government Gazette* (Republic of South Africa 2012d). In public health, the emphasis is on the provision of efficient and effective services. Performance management is becoming increasingly important because it brings together employees and management, thereby strengthening their commitment to work towards achieving the goals of the organisation.

In 2007, the National Treasury published a framework document to better manage information related to programme performance which stressed the importance, throughout government, of measuring results, an important component of performance management, drawing on the work of early contributions to new approaches to public management (Republic of South Africa 2007:1). The framework sets out a number of requirements government is expected to follow. In terms of this framework, departments (including Health) have to:

- 'Identify baseline information informing policy;
- Set out desired effect of policy;
- Specify performance indicators;
- Set performance targets;
- Indicate available resources;
- Allocate responsibilities;
- Report progress with implementation of plans and budgets; and
- Report on performance against plans and budgets'. (Republic of South Africa 2007:5).

This approach indicates the need for reliable information. It echoes Rugumyamheto's comment on Tanzania's public sector reforms which include an emphasis on performance management:

> *'Performance management works only if there is information and only if under performance is visited with real and serious repercussions' (Rugumyamheto 2007:99).*

It is encouraging that South Africa's first ever development plan on a national scale (released in 2012) acknowledges the need for improved public sector management, in general, and health, in particular. However, reference to performance management is indirect rather than explicit in the draft document (Republic of South Africa 2012c).

In this article, following Minnaar (2010:49-50), performance management is ideally seen as an integrated way of planning for performance. It is about activating the organisation to achieve the 'level and extent of performance planned for', providing for monitoring mechanisms and for overall evaluation. It is also important that performance, strategy and policy mandates are aligned to one another (Minnaar 2010:109).

Whilst acknowledging and outlining some of the key problems, the article also suggests that it might be possible to learn from success. For this reason, a case study is included which presents an example of a relatively well performing hospital and suggests that lessons of value might be derived from such an approach. This is in line with what was recommended almost ten years ago with particular reference to primary healthcare (PHC). To improve implementation, there is a need to draw together the 'best of the PHC experience' in order to revitalise such initiatives (Sanders 2003:57).

HEALTHCARE IN SOUTH AFRICA: AN OVERVIEW

South Africa has advanced considerably in terms of resuscitating the public healthcare system despite a combination of challenges which have, at various points in time, led to frustration and controversy. Since 1994, it has established progressive public health legislation and policies, introduced free care for children under six, as well as for pregnant or breastfeeding mothers, and ensured the increase of immunisation coverage and erected a number of tertiary hospitals.

Despite these developments, South Africa's healthcare system is stretched and under-resourced. It is plagued by issues of poor access, equity and quality. Weaknesses in the areas of human resources, training, support, supervision, leadership and managerial capacity are cause for concern. Added to this is

the fact that the country has been experiencing one of the highest HIV rates of infection throughout the world. HIV creates more demand on healthcare as many more people fall ill. HIV also undermines the capacity of healthcare workers, many of whom themselves are living with HIV.

However, this over-burdened system is the only route for most of the population, especially those who reside in rural areas (Kegakilwe 2013:30). Health is a sector which reflects, in a magnified way, the extreme inequalities of the society as a whole. A struggling and often criticised public sector system stands alongside a private system which is excellent for those in a small minority who can afford it. For those with the ability to pay, the South African private health system is regarded as one of the best in the world (Yach and Kistnasamy 2006:4). The government is, therefore, confronted with great challenges in accomplishing its duty to ensure that all its citizens are able to access healthcare services.

As a result of these inequality driven shortcomings, the effectiveness of health services, especially in rural places, has actually declined, resulting in reduced quality and productivity, closing of wards, longer waiting times, reductions in the number of available beds for inpatients, disruption of emergency services and poor utilisation of personnel. An encouraging factor, however, is that one can access healthcare during times of need and, in most cases, services are free. The public health system still manages to deliver healthcare services, albeit plagued with incompetent and inadequate performance in some facilities.

In 2003, the Minister launched the Hospital Revitalisation Programme, with a budget of R1.9-billion, in an attempt to improve the system. Hospital infrastructure, procurement of necessary equipment and management skills all needed to be addressed. These were key objectives of this programme.

A growing number of studies point to deficiencies in leadership and management of different aspects of the system. This is evident by the varying quality of care delivered within the public sector, such as ineffective management of health facilities, and an absence of oversight and accountability. According to Thomas (2007:129), an additional challenge for leaders in healthcare organisations around the world is stricter and new forms of accountability. With the acceptance of responsibility and authority comes the obligation to answer for performance.

LEGISLATION AND OTHER IMPERATIVES GOVERNING THE HEALTHCARE FRAMEWORK

According to the World Health Organisation (WHO), fact sheet No 232, the right to health can be summarised as the enjoyment of the highest attainable

standard of health without discrimination based on race, religion, political beliefs, and economic or social conditions (WHO 2007).

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

> *"Everyone has the right to a standard of living adequate for the health and well-being of himself/herself and of his/her family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (United Nations Article 25(1) 1948, Amnesty International 2009:433).*

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

All citizens have a vested interest in how the government provides essential services. The provision of healthcare costs the citizens of this country money. Citizens should, therefore, be aware of the services offered and how officials spend the funds which citizens provide. This means that there is a need for transparency so that the public knows how the state's money is being spent. Therefore, it is important for this country to know, at all times, what elected officials are doing with public monies. The *Constitution of the Republic of South Africa,* 1996 states that:

> *"Efficient, economic and effective use of resources must be promoted" according to section 195 (1b) of the Constitution of the Republic of South Africa, 1996.*

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

> *"A preventive health scheme shall be run by the state. Free medical care and hospitalisation shall be provided for all, with special care for mothers*

> *and young children. Slums shall be demolished, and new suburbs built where all have transport, roads, lighting, playing fields, crèches and social centres. The aged, the orphans, the disabled and the sick shall be cared for by the state" (The Freedom Charter 1955).*

The Preamble of the *Constitution of the Republic of South Africa,* 1996 states that one of its objectives is to enhance the quality of life of all citizens. In addition, the objective of The *National Health Act*, 2003 (Act No 61) , Section (2)(c)(i) is to protect, respect, promote and fulfil the rights of the people of South Africa which includes the constitutional right of access to healthcare and healthcare services.

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

Looking at health in general, it has been argued that 'A prerequisite for the realisation of Health for all is sufficient numbers and effective performance of health personnel in all phases of health systems development' (Sanders 2003:57).

NATIONAL HEALTH INSURANCE (NHI) IN SOUTH AFRICA

A Green Paper outlining broad policy proposals for National Health Insurance (NHI) was released by government in August 2011. It will have taken almost 35 years to reach the stage of implementation. The significant inequity in healthcare delivery to the South African population makes it essential that government arrives at a solution that is equitable and sustainable. Therefore, the green paper was seen by many as a welcome document. It forms part of a multi-faceted approach which includes infrastructure and improving human resources. The proposals have been reviewed and supported by the National Planning Commission (*Sunday Times* 2012:12). It was also supported in the 2012 Budget Speech, although the financial details remain open for additional consideration.

There is little doubt that the NHI will require funding 'over and above current budget allocations to public health', funding options are identified as payroll tax, surcharges on taxable income and increased Value Added Tax (Republic of South Africa 2012a:25). The longer term depends on further uncertainties, related to 'institutional reforms and health service delivery capacity', a statement implying better performance if not referring to it directly. There are also risks because of the amount of money entailed. Public health services now stand at about 4% of Gross Domestic Product and could reach 6% by 2025 (Republic of South Africa 2012b:81). Performance management will have to be effective to ensure that value for money is attained. An Office of Standards Compliance has been established in the Department of Health to 'improve monitoring and raise standards across all health facilities'; it will eventually become an independent public body (Republic of South Africa 2012b:84).

Lead by Dr Aaron Motsoaledi, the Minister of Health since 2009, the proposal is a plan to redirect the public health system. According to the Minister:

> *"The present system of financing healthcare in SA is skewed. There needs to be universal coverage for all South Africans, not just those who can afford private healthcare" (New Agenda 2012:14).*

Pointing out that only 16% of the population have private cover (medical aid), Dr Motsoaledi argues that a system is needed to provide better healthcare for all citizens (Department of Health 2012:14). These sentiments were echoed in the recently released National Development Plan which points to a 'crumbling health system and a rising disease burden' requiring major reform, including better management at institutional level (Republic of South Africa 2012c:51).

The proposals entail a system of contributions for universal care to be paid in advance of an illness. The broad plan is for these contributions to be made by individuals (presumably families), employers and the state. There is no doubt that this effort represents a significant attempt to redistribute both the payment for, and the availability of, healthcare: 'An important consideration is that the revenue base should be as broad as possible in order to achieve the lowest contribution rates and still generate sufficient funds to supplement the general tax allocation to the NHI (Republic of South Africa 2011:35). A similar reform is currently being introduced in Kenya so that low income and unemployed Kenyans may have better access to healthcare (Adera 2012:10).

The Green Paper makes it clear that NHI is a long-term scheme that will be implemented over a 14 year period. The first five years will concentrate on building the health sector and preparing it for change. The paper states that the primary phases of NHI will focus on improving the services of the public healthcare system. The Green Paper introduces the start of a complete

transformation of the country's health system which would begin in a pilot phase in 11 districts.

On the 22nd March 2012, Dr Motsoaledi, announced the 11 districts where the NHI pilot programme will be rolled out. The 11 districts represent a district in each of the nine provinces, with three sites identified in KwaZulu-Natal. Motsoaledi mentioned that two districts were identified in KwaZulu-Natal because it has the second largest population in the country and it has the highest burden of disease. According to Motsoaledi, the programme will begin on the 1stApril 2012 because it coincides with the beginning of the financial year (South African Government Information 2012).

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

- Eastern Cape – OR Tambo;
- Mpumalanga – Gert Sibande;
- Limpopo – Vhembe;
- Northern Cape – Pixley ka Seme;
- KwaZulu-Natal – uMzinyathi ,uMgungundlovu and Amajuba;
- Western Cape – Eden;
- North West – Dr K Kaunda;
- Free State – Thabo Mofutsanyane; and
- Gauteng – Tshwane.

The pilot tests are the building blocks for the successful implementation of NHI. The programme will focus on the most susceptible sectors of the country and aims to strengthen the operation of the public health system. The National Development Plan takes the view that, for the pilot phase to work well, the following are needed: more personnel, new forms of managerial authority and stronger statutory structures for community representation (Republic of South Africa 2012c:52).

It is intended that doctors in private practice will be instrumental in strengthening the success of the government's proposed NHI. According to the Minister of Health, the Department of Health (DOH) will ensure the payment of private practitioners, who will work in public clinics in the pilot districts. However, the NHI has not been universally welcomed by those who benefit from the status quo. This is one of the reasons why the debate has become quite heated, as noted by a distinguished Australian health economist who observed much of the anger and resistance coming from the private medical schemes and healthcare providers (Mooney 2011:3).

Employing foreign doctors to work in remote areas may reduce staff shortages. However, the Health Professions Council of South Africa tends to be slow to register these doctors. Staff appointments take up to 5 months to be approved. The government has the prime responsibility of ensuring access to healthcare for all, especially for the most vulnerable groups. It is important for government to ensure that services are brought closer to the people and the communities be made aware of services being rendered pertaining to how, when and where. The government must ensure that hospitals and clinics have fully equipped offices with staff that display the necessary knowledge and skills.

WHO WILL PAY FOR THE NHI?

The NHI fund will receive finance from tax revenues and contributions by individuals who earn above a specific level. Payment towards NHI will be unavoidable for higher income earners and employers although it is not clear at this stage at what income threshold the tax would be incurred. It will be up to individuals to choose whether to continue to belong and contribute to a private medical aid, but there will be no tax subsidies for those who choose to do so. It is, therefore, possible that few people will continue with medical scheme contributions because of the expense incurred in paying both NHI contributions and medical scheme contributions. However, people with low incomes will not directly pay into the NHI fund. Employers will be expected to assist by ensuring that their workers' contributions are collected and submitted in a manner similar to unemployment fund contributions whilst paying a matching sum (Child 2011).

The South African Revenue Service will be responsible for collecting taxes for the scheme, whilst the Treasury will calculate the tax revenue to be paid by individuals. It is proposed that it functions on the same basis as a medical aid scheme. The users will be able to be treated by private medical practitioners and facilities that have an agreement with the NHI without having to pay. The service providers will be able to claim from the NHI. It is expected that medical schemes will probably provide new options, focusing less on total cover and more on supplementing the care offered by NHI. This may suit individuals who want to use the NHI frequently but require some services that they will not have access to NHI. The NHI package will not include:

- Cosmetic surgery that is not necessary or medically indicated but done as a matter of choice – for instance, botox, liposuction and face-lifts;
- Expensive dental procedures performed for aesthetic purposes;
- Expensive eye-care devices like trendy spectacle frames;

- Medicines not included in the National Essential Drug List except in circumstances where the complementary list has been approved by the Minister of Health; and
- Diagnostic procedures outside the approved guidelines and protocols as advised by expert groups (Department of Health 2012).

McIntyre (2012) identified some discrepancies of the proposed NHI, maintaining that while the NHI aimed at universal coverage, major stumbling blocks can be identified for example, how the NHI will be funded. In the media, there are a growing number of reports which reflect the concerns of taxpayers: 'Taxpayers will buckle under R80bn NHI pressure' (Maphumulo 2013). Moreover, there is little detail in the green paper concerning the funding model, which should have been released in April 2012, but, has yet to emerge. McIntyre argues that there are limited funding options. The first is to raise taxes of employers and employees and the second is to increase value added tax (VAT) which will have a major impact on the poor. McIntyre stated that the green paper referred to healthcare under the NHI being "free at the point of service", yet also maintains that users could be obliged to make co-payments.

The White Paper on National Health Insurance

It was anticipated that the long awaited White Paper on the proposed NHI be released before the end of December 2012, and a Draft Bill presented to Parliament within the first quarter of 2013. However, the process has been subject to delay. Public comment on the green paper closed on 31 December 2011 with well over 150 submissions received. The biggest challenge is the consultation process encompassing public comment and engagement, which involves various stakeholders, including doctors, other health workers, private medical aid companies as well as the public (SABC News October 2012).

Need for improved performance and the burden of disease

Improving performance of health workers remains one of the major challenges that South Africa faces. The most important asset of the health system is human resources. Yet, the health sector is still a long way from providing the population with proper health services. The country is plagued by four major health problems, namely:

- HIV/AIDS and TB;
- Maternal, infant and child mortality;
- Non-communicable diseases; and
- Injury and violence.

The major causes of performance often falling short appear to be staff shortages, failure among political leaders to sustain the system, inadequate infrastructure, inadequate financial management, poor planning for human resources and deficient equipment. The lack of efficiency, motivation problems and an absence of supervisory capabilities within the public health sector play a major role. The introduction of NHI should take into account the burden of disease the country is experiencing.

Management of performance is not an annual event. Performance has to be monitored closely and some employees need to be reviewed more often than others. This is the fundamental aspect of individual performance. If it is not closely monitored, performance at the organisational level may deteriorate as management depends on contributions collectively made by individual staff (Lockett 1992:37–39).

Measuring performance in the public health sector

According to Kearney and Berman (1999:3), measurement determines how well organisations and employees are performing. It is also used by managers to provide public accountability. Measurement is increasingly used to provide on-going information about public sector performance. Measurement in public organisations, however, continues to be imperfect because their goals are complex, multidimensional and long-term. Further improvements in measurement are needed.

A performance measurement system provides an organisation with sufficient information to plan monitor and evaluate both policy and management (Bouckaert and Van Dooren 2009:155).

CASE STUDY OF MONTEBELLO HOSPITAL

A recent study of Montebello Hospital was aimed at measuring and evaluating approaches and policies for improving healthcare delivery through evidence-based research. This is a state-run District Hospital in the iLembe Health District, which serves a population of ±180 000 citizens. It is situated on the road between Pietermaritzburg and Tongaat and located in a rural area which is serviced by the Ndwedwe Local Municipality in the iLembe District of KwaZulu-Natal. Montebello Mission hospital was originally known as Mater Misericordiae (Mother of Mercy). The hospital was founded as a Ministry of the Dominican Congregation of Montebello to uplift the standard of life and better the health status of the local community and the surrounding areas.

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

The research questions of the study were:

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

The research undertaken at Montebello Hospital aimed to create knowledge to potentially change policy to alleviate problems, collect and use data that would encourage communities and individuals to participate in policy formulation and identify future research and policy issues to help communities influence policy. The study did not cover all District Hospitals in KwaZulu-Natal, but was limited to Montebello Hospital in the iLembe District. In addition, a single hospital was studied because the researcher was able to get an in-depth understanding of service delivery that would not have otherwise been possible if more than one hospital was surveyed.

Sampling Design

The main data collecting instruments were questionnaires and interviews, which encompassed the qualitative and quantitative approach. A prepared questionnaire was used to collect data from patients and healthcare practitioners. The target population was doctors, nurses and patients at Montebello Hospital. The sample consisted of 100 male patients and 100 female patients from a population of approximately 3700 out-patients per month. At the time of conducting the questionnaire the population of nurses was 205. The sample consisted of 50 nurses. The number of doctors employed at the hospital is 13. The questionnaire was administered to all the doctors. In view hereof, the researcher applied quota sampling to select the respondents. Quota sampling appealed because it was convenient. Costs were reduced in terms of travelling and data was collected speedily.

In order to identify any misrepresentation of questions during the data collection phase, a pilot study was carried out to test the reliability and validity of the questionnaire. Following piloting, the research questionnaire was administered to the sample by a team made up of the researcher and

three research assistants who were recruited from the Bachelor of Technology (B.Tech) Public Management students from the Durban University of Technology (DUT).

Semi-structured questionnaires were used, comprising of open-ended questions and close-ended-questions. The questionnaire was designed to obtain information from patients concerning quality healthcare, turnaround times, staff attitudes, cleanliness and availability of medication, whilst information obtained from healthcare practitioners determined their perceptions on funding, equipment, staffing and remuneration. The questionnaire was designed as follows:

Patients

Section A: Biographical and background information of respondents
Section B: Patients views on service delivery at Montebello Hospital

Healthcare practitioners

Section A: Biographical and background information of respondents
Section B: Healthcare practitioners' views on service delivery at Montebello Hospital

Face-to-face interviews were chosen as the survey data collection technique. Prior to the interview, permission was sought from the respondents to record the interview with the use of a digital voice recorder. This ensured accuracy in the data capturing process.

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

Research Question 1

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

The study revealed that 86% of the patients interviewed were of the opinion that staff are reliable and respond readily when needed. They indicated that the physical appearance of the hospital – such as lavatories, equipment, wards and beds are clean and well-maintained. 13,0% of the respondents indicated

that doctors and nurses are not skilled and knowledgeable, while 5,5% of the patients maintained that medication was not always available.

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

Research question 2

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

54% of the patients indicated that the queues are short and they do not have to wait excessively long before being seen. 28,0% of the respondents revealed that there are lengthy queues and turnaround times were slow. The patients were in agreement that healthcare practitioners provide personal care, empathy, mental support and understanding of their problems. In addition, there was consensus among patients that doctors and nurses communicate with clarity and in a friendly way in respect of *inter alia* test results, diagnoses, prescriptions and health regimes.

Research question 3

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

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

Discussion of the research questions

Service delivery failures are reported frequently in the media. These failures can play a strong role in shaping negative attitudes and dissatisfaction. Concern over the quality of services has led to a loss of confidence in public hospitals. Yet, an assessment of Montebello Hospital's healthcare system has revealed a favourable response. This may represent a bias among patients. It may also be because of the hospital that was selected. It might even be because no better service is expected. However, the findings reveal that Montebello Hospital is performing quite well.

Contrary to the perceived perception that the public health sector is collapsing because of poor service delivery, this research revealed that the efforts of Montebello Hospital are moving in a positive direction. For example, research question 1 shows the availability of medical personnel as well as their positive behaviour and attitude are of major benefit to the institution. Particularly reassuring is the abundance of empathy of the healthcare practitioners, their sympathetic demeanour, their high levels of competence and their awareness for the suffering of patients. The skills and knowledge of the doctors and nurses provide a sense that they have concern for the patients' best interests and that the hospital has delivered services with integrity.

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

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

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

This research was conducted at a time when South Africa stands at the threshold of revolutionising the entire healthcare sector. The evidence presented in this study indicates that the public service has a role to play and can do so if the basic requirements, as outlined in this summary of the research, are met. A move towards improved service delivery is necessary to promote participation, community involvement, greater commitment from the government, better governance, accountability, transparency and improved political purpose within the DoH.

It is intended that doctors in private practice will be instrumental in strengthening the success of the government's proposed NHI. They should be compensated with an adequate wage if they are to set aside three hours of their working day to look after patients in the public sector–as proposed in

the new draft policy. According to the Health Minister, the state will guarantee the payment of private general practitioners working in public clinics in the pilot districts.

Encouraging foreign doctors to work in rural areas could reduce staff shortages. However, the Health Professions Council of South Africa seems to take a long time to register the doctors and staff appointments can take up to five months to be approved. Consequently, the doctors resort to finding employment in the private sector or abroad. In order to deal with the shortage of doctors in South Africa, the Minister of Health declared that the number of matriculated school leavers sent to Cuba for training would increase radically–1 000 matriculants have left in September 2012. In 2012 it was reported that 304 doctors had been trained in Cuba, 406 are currently studying and 98 were to graduate in 2013. Only about 1 200 doctors qualify at South Africa's eight medical schools annually (Wild, Kahn, Gernetzky, Child and Beukes 2012).

The government has the prime responsibility of ensuring access to healthcare for all, especially for the most vulnerable groups. It is important for government to ensure that services are brought closer to the people and the communities be made aware of services being rendered pertaining to where, how and when services will be delivered. The Batho Pele White Paper of 1997 requires departments to set standards which should be published and communicated to the citizens. The government must ensure that hospitals and clinics have fully equipped offices and staff who display the necessary knowledge and skills.

Do Healthcare Organisations need Performance Management?

One of the prerequisites for a well-performing hospital is well-motivated staff to carry out their work according to the principles of the organisation (Dieleman**,** Cuong**,** Anh and Martineau 2003). According to Bach and Sisson (2000:243), performance management is a means to achieve a particular end, based on the belief that the performance of organisations is closely related to the performance achieved by individual staff.

Armstrong and Baron (1998) suggested that only a few health systems in developing countries used performance management systems. While even fewer used performance management as the integrated set of policies and practices that put together, make possible the monitoring and improvement of staff performance. In many countries, performance management is still a set of poorly linked policies and practices, largely unrelated to performance. In some organisations, staff rating dominates the system. As a result, performance

management becomes more of an afterthought or even a means of blaming staff for the incompetence of managers.

Martinez and Martineau (2001) maintain that many countries have proposed reforms to their national health systems, yet few have managed to effectively address the improvement of performance. This is the case in the public health sector of South Africa where the health personnel work with unclear job specifications and confused lines of accountability, individual and organisational performance are rarely measured, and staff are paid often low salaries that do not match the quality of their work. Given this perspective, the scope for reform is greatly reduced.

Benefits of effective performance management

According to Eckerson (2011:26) most people think that performance management is simply about improving performance. Eckerson argues that this is not the case. Performance management is about steering performance in the right direction. Eckerson goes on to mention that it is possible to work efficiently but not effectively. Groups and teams may work long hours with great enthusiasm. However, if they develop or refine the wrong processes, products or services, then all their effort will not help them achieve the organisation's strategic goals.

Performance management is designed to help organisations focus on the few things that really drive business value instead of many activities that do not contribute to the long-term goals of the organisation.

CONCLUSION

The performance of the health sector and its failures are mentioned frequently in the media. This has played a major part in shaping negative attitudes and dissatisfaction with the healthcare services. The concern over the quality of healthcare services has led to the loss of confidence in public health provision. However, this article argued that concerns over deficiencies should not blind researchers and practitioners to successful experiences, such as those of Montebello, which can guide policy. There is a clear need for more research on good performers in the public sector as part of the preparations for the implementation of the NHI.

South Africa stands at the threshold of revolutionising the entire healthcare sector. The way towards improved service delivery is through participation, community involvement, greater commitment from government, better governance, accountability, transparency, reliable information and improved

political purpose within the public sector. For this to happen, there is a need for stronger linkages between policies as they appear on paper and the implications for performance in the real contexts in which health services are provided to the public.

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