

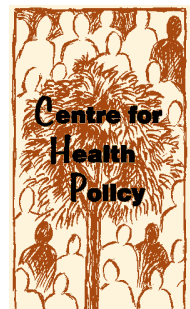
Investigating the role of power and institutions in hospital-level implementation of equity-oriented policies

Moremi Nkosi¹
Veloshnee Govender²
Ermin Erasmus¹
Lucy Gilson^{1,3}

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For more information about this paper please contact Ermin Erasmus.
Email: ermin.erasmus@nhls.ac.za

- 1) Centre for Health Policy, University of the Witwatersrand
- 2) Health Economics Unit, University of Cape Town
- 3) Health Economics and Financing Programme,
London School of Hygiene and Tropical Medicine



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For more information about CREHS please contact:

Consortium for Research on Equitable Health Systems (CREHS)
London School of Hygiene and Tropical Medicine,
Keppel Street,
London, UK
WC1E 7HT

Email: nicola.lord@lshtm.ac.uk

Website: www.crehs.lshtm.ac.uk

For more information about this research paper please contact: Ermin Erasmus

Email: ermin.erasmus@nhls.ac.za

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EXECUTIVE SUMMARY

This report tells the story of policy implementation in two South African district hospitals: Hospital A, located in North West Province, and Hospital B, a facility in the Western Cape. It focuses specifically on their implementation of the Uniform Patient Fee Schedule (UPFS) and Patients' Rights Charter (PRC) – two equity-oriented policies. These policies were selected because of their relevance to the achievement of equity in health services delivery. The exemptions built into the UPFS, coupled with the graduated fee levels, are important measures supporting financial access to hospitals. The PRC can, among other things, contribute to achieving equity through the empowerment of patients and by ensuring that all patients are treated with respect, courtesy and dignity (influencing the acceptability of care).

The research on which this report is based was conducted towards the end of 2006 and during the first four months of 2007 by the Centre for Health Policy, University of the Witwatersrand, and the Health Economics Unit, University of Cape Town. Its formal objectives were:

- To analyse how the power exercised in decision-making influences the implementation of (equity-oriented) policies, and their chances of success
- To determine the key institutional influences that drive decision-making around (equity-oriented) policies and assess their impact on policy implementation
- To identify any major additional influences over (equity-oriented) policy implementation
- To determine to what extent patients are aware of the policies of focus, their views on the way they are implemented, and benefits received.
- To derive recommendations about how to strengthen (equity-oriented) policy implementation

The report contains detailed case studies of Hospital A and Hospital B's implementation of the UPFS and PRC. Each case study contains the following key information:

- A detailed description of implementation practices relevant to the UPFS and PRC
- Views on the successes and challenges of implementation and the ways in which implementation practices help or hinder the achievement of equity goals. It includes specific consideration of the organisational culture of each hospital and the degree of trust that hospital staff have in the management of the respective hospitals.

The report ends with a chapter that synthesises and explains in greater depth the policy implementation experiences reported in the case studies, highlights common factors influencing the implementation of health policies, and draws out implications and conclusions relevant to policy implementation. Key findings and conclusions include:

Synthesis of and explanations for policy implementation experience (UPFS):

- The practice of UPFS implementation is to a large extent geared towards revenue generation rather than the granting of exemptions, with support for exemptions appearing to be more implicit than active in both hospitals. Few exemptions are given in either hospital and patients who cannot pay become debtors. Although the hospitals don't necessarily take strong steps to collect outstanding debts, there is nevertheless evidence that some patients do come to

pay off their debts, and so incur additional costs. In practice, there also appears to be only limited fee graduation for higher income patients and, at least in Hospital A, there are signs that some higher income patients may not pay at all as clerks give them preferential treatment. Dynamics such as these are obviously of concern from an equity perspective. More positively, no patient was turned away because of being unable to pay.

- This bias towards revenue generation is supported by factors such as the close link between the UPFS and a hospital-specific revenue target (encouraging a view of policy success as revenue generation, rather than financial protection); the potentially onerous procedures for proving exemption eligibility; limited patient understanding of exemption requirements; and the fact that clerks, although quite conscientious in their jobs, commonly exercise their discretionary power in various ways that support revenue generation. Further support for implementation appears to result from the fit between the “rational” and “hierarchical” elements of the hospitals’ organisational cultures. The “rational” element of the culture points, among other things, to competitiveness and an emphasis on achievement and the meeting of objectives. In contexts where these attributes are highly valued, a revenue goal seems like a natural target to aim at and to focus on. Arguably, the revenue target and the goal of revenue generation have additional significance because they originate with, and are clearly important to, higher authorities that are very significant in the lives of the hospitals. This draws on the “hierarchical” elements of both hospitals’ cultures and the accompanying emphasis on issues such as reporting relationships and adherence to rules and regulations.
- While there are many similarities in the hospitals’ implementation experience (as outlined above), they differ clearly in senior management style. Managers in Hospital A enjoy high-trust relationships with staff, which encourages clerks and other staff to support the revenue generation goal of the UPFS. In contrast, reactions against the more hierarchical management style in Hospital B are associated with problems such as staff members not checking patient information thoroughly. The management of Hospital A also appears to have directed more effort at engaging the Hospital Board and wider community about the policy.

Synthesis of and explanations for policy implementation experience (PRC):

- The staff of both hospitals clearly demonstrate respect and care for patients, but the ethic of care in Hospital B seems to be more weakly institutionalised and more reliant on individual staff members’ personal and professional norms. In terms of the explicit implementation of the PRC, the hospitals’ experiences are very different. In Hospital A it is explicitly implemented and enjoys fairly widespread (if sometimes somewhat grudging) acceptance among staff, while it is not explicitly implemented in Hospital B.
- In Hospital B, the lack of implementation is related to the features of the policy (broad goals, multiple dimensions, diffuse implementation activities etc.), the difficulties of achieving the ultimate outcomes of the PRC, the sense that the policy covers what providers already do, as well as the lack of clear support for PRC implementation activities from higher authorities. There also appears to be a sub-optimal fit between the organisational culture of Hospital B and the PRC. The facility has quite a strong preference for order, control and stability, but this can be very difficult to achieve as the PRC is perhaps not very precisely defined, can be interpreted in different ways and to a large extent relies on the discretion of frontline

implementers.

- In Hospital A, the PRC enjoys clear managerial support and its implementation is also furthered by other factors, including the parallel process of COHSASA accreditation the facility is involved in.
- Differences in managerial trust between the two hospitals also have relevance to PRC implementation. The relatively greater level of such trust in Hospital A is itself stated by health workers as a factor supporting their efforts to ensure good relationships with patients, in contrast to Hospital B.

Common influences over the implementation of health policies:

- The experiences of the case study hospitals show that co-production - the need for providers and patients to work together – is key to health care provision and policy implementation. Successful co-production can stimulate the morale and motivation of health workers, as well as positive attitudes and behaviours towards patients and, correspondingly, affirmation from patients for health workers. The need for co-production does, however, challenge implementation based on a top-down management approach. It requires local level policy adaptation, implying that providers and policy formulators cannot fully control policy implementation.
- Policy implementation is more difficult where the values embedded in policies (such as challenging provider power over patients) conflict with the values of the implementers. Top-down implementation approaches might, therefore, achieve some success where conflict is low and the policy is not ambiguous. However, much more active management is likely to be necessary to support the implementation of more contentious policies such as the PRC.
- The research has clearly shown that the exercise of discretionary power by implementers (hospital managers, nurses, clerks etc.) influences implementation practices and outcomes – sometimes for the better, but sometimes with the effect of limiting financial protection and acceptable access to services. A key challenge is to identify how to encourage the exercise of discretionary power in support of policy goals.
- Our understanding of, among other things, the managerial practices and organisational cultures of the case study hospitals suggests that all organisational models or forms are not equally appropriate for all types of tasks. Typical public sector organisations might cope well with fairly tightly specified policies such as the UPFS. However, policies such as the PRC, which are characterised by greater ambiguity and conflict with implementer norms, are likely to require greater adaptation and risk-taking, as well as innovative and enabling leadership.

Conclusions and implications:

- With regard to the UPFS, this research indicates that it is difficult to exempt as part of a fee policy because the over-riding concern is revenue generation and not equity or access. There is thus a case for considering other measures to ensure financial protection such as the

removal of fees and the introduction of financing mechanisms that enable income and risk cross-subsidies (e.g. mandatory insurance).

- With regard to the PRC, it is clear that this policy is likely to always be difficult to implement, given its goal and the difficulties of achieving that goal. However, due to the known access barriers facing patients (especially the most vulnerable and marginalized patients), there is clearly a need to continue to focus policy action around the issue of delivering acceptable services.

- With regard to policy implementation practice more generally, this research points to:
 - The influence of how policies are framed or the meanings attached to policies over the implementation trajectory. Is success, for example, defined as revenue generation or the correct granting of exemptions?
 - The importance of engaging deliberately with the “softer” and yet “harder to manage” elements of policy implementation, e.g. developing strategies to manage health workers’ fears and anxieties over the PRC;
 - The need to be aware of the potential influence of organisational culture over the practice of policy implementation; and
 - The potential importance of management styles and workplace trust to policy implementation – given that they can, among other things, help foster a sense of buy-in and reduce resistance to policy implementation.

SECTION A: INTRODUCTION

1) Brief overview of the report

This report presents the experiences of two case study hospitals, one in North West and the other in the Western Cape. It focuses on their implementation of two equity-oriented policies: the Uniform Patient Fee Schedule (UPFS) and Patients' Rights Charter (PRC).

Section A covers the research objectives, the policy focus of the work, research methodology and ethical issues. Sections B and C contain detailed descriptions of the two case study hospitals and their experiences with implementing the UPFS and the PRC. Finally, in Section D, we provide in-depth explanations of the policy implementation experiences in the hospitals and draw out lessons for future policy implementation.

2) Background experience and research objectives

There is widespread evidence to show that health system performance in low and middle-income countries is inequitable. The poor, for example, often use health care less than richer groups, despite their likely higher levels of health need (Gwatkin et al., 2004).

There is also some evidence that policies intended to promote equity, like other policies, may be resisted and may have unexpected, negative impacts. Such policies are often, for example, opposed as, in seeking to benefit powerless groups, they challenge the status quo and vested interests (e.g. Nelson, 1989; Reich, 1996; Williams and Satoto, 1983). Indeed, as health systems themselves reflect the wider patterns of inequality of any society (Mackintosh, 2001), equity-promoting policies often challenge the norms, traditions and hierarchies within health systems. In this way they also challenge existing professional practices, the practices that influence who gets access to health services as well as the treatment and nature of care offered to different groups (Freedman et al., 2005; Mackintosh and Gilson, 2002; Tibandebage and Mackintosh, 2005). Yet despite evidence of these problems there has been only limited international investigation of the factors explaining the poor achievements of new policies intended to promote equity.

This research seeks to use notions of power and institutions, highlighted above and identified from past experience as likely to be important influences, as starting points for the investigation of processes of policy change and implementation in relation to equity-oriented policies. This will help to take forward past thinking and provide a basis for new thinking about how policy and implementation managers might 'do things differently'.

The specific research objectives identified for this study are, therefore:

1. To analyse how the power exercised in decision-making influences the implementation of (equity-oriented) policies, and their chances of success
2. To determine the key institutional influences that drive decision-making around (equity-oriented) policies and assess their impact on policy implementation
3. To identify any major additional influences over (equity-oriented) policy implementation
4. To determine to what extent patients are aware of the policies of focus, their views on the way they are implemented, and benefits received.
5. To derive recommendations about how to strengthen (equity-oriented) policy implementation

3) The policy focus of the research

3.1) The Uniform Patient Fee Schedule (UPFS)

The UPFS was first published by the National Department of Health in April 2000. It was approved as the policy for the billing of services provided by public hospitals at the joint meeting of the Minister of Health and Members of Executive Councils (MECs) for Health in November 2000. Following this, the North West and Western Cape implemented the policy in all provincial and district hospitals in April 2001 and June 2002 respectively.

The UPFS aims to ensure that all patients treated in public hospitals are uniformly billed for the services received. The types of patients recognised in the UPFS, the criteria according to which they are classified and their levels of subsidisation are shown in **Table 1** below.

The classification structures in the UPFS policy document also indicate various health care services that patients are expected to receive free of charge, irrespective of their classification. These include services such as 'all primary health care services', 'termination of pregnancy', 'services for persons with mental disorders' and 'infectious, formidable and/or notifiable diseases'. This indicates that the UPFS policy has in-built mechanisms that are intended to ensure that those patients without any income and/or the indigent are not denied any access to needed care when they come to the hospital. The exemption criteria within the policy allow us to investigate whether these criteria are being uniformly applied to all patients and whether it is indeed the poor, unemployed and indigent patients that are being granted free access to the services they need.

Table 1: Summary of UPFS patient groups and levels of fee subsidisation

Patient Category	Classification Basis	Level of subsidisation
H0 (Patients qualifying for full subsidisation)	<ul style="list-style-type: none">• All individuals who are recipients of any of the following grants/pensions*:<ul style="list-style-type: none">○ Old age pension○ Child support grant○ Veteran's pension○ Maintenance grant○ Disability grant (e.g. pension for the blind)○ Single care grant (for patients with mental disorders)• Patients who are formally unemployed<ul style="list-style-type: none">○ Proof of unemployment is mandatory• Reclassified patients<ul style="list-style-type: none">○ These are patients who cannot afford to pay the fees on the basis of their initial classification and so they are placed into this category. This can only be done	Patients in this category are fully subsidised by the state. They receive all services free of charge (subject to documentary proof)

	by the head of the facility at which they seek care	
H1 (Subsidised patients)	<ul style="list-style-type: none"> Any individual with an annual income below R36,000 or a household with a combined income below R50,000 	Most of the services they utilise are heavily subsidised and/or free e.g. they pay only 20 % of the consultation fee and 5 % of emergency transport services (if they use the service)
H2 (Subsidised patients)	<ul style="list-style-type: none"> Any individual with an annual income below R72,000 or a household with a combined income below R100,000 	They pay higher rates (2 to 3 times more) than patients in the H1 category.
H3 (Full paying patients)	<ul style="list-style-type: none"> Any individual with an annual income greater than/equal to R72,000 or a household with a combined income greater than/equal to R100,000 Non-South African citizens Patients with medical aid or treated on account of foreign governments, local authorities and/or an employer Patients treated by a private practitioner at a public health care facility 	They pay the full UPFS price**

Source: DOH (2005)

* Any person who is a recipient of any of the mentioned grants, but belongs to a medical scheme is automatically re-categorised as a full paying patient, i.e. H3

**Full price here basically refers to the public sector rate as determined in the annually reviewed fee annexure, not the private sector rate. So the rates are still subsidised, but less so than for the other three categories.

3.2) The Patients' Rights Charter (PRC)

The PRC is intended to provide a clear description to patients and health workers of the common standards of service to expect in facilities. According to the NDOH, the policy's main objective is to *"help improve the quality of care received by patients in the National Health System"* (<http://www.doh.gov.za/search/index.html>, accessed 12 June 2007). In the policy document there is a balance between the rights of patients and their obligations towards their own health and well-being. Below is a summary of the twelve rights that the Charter accords to patients:

A healthy and safe environment	Participation in decision-making on matters of policy and matters affecting one's health
Access to health care (emergency; palliative; rehabilitation)	Knowledge of one's health insurance
Choose a particular health care service and/or provider for treatment	Be treated by a clearly identified health care provider
Confidentiality and privacy of one's health records and information	Informed consent
Refusal of treatment	Be referred for a second opinion on request to

	a provider of choice
Continuity of care	Complain about health services and to have such complaints suitably investigated and be informed of the outcome

The responsibilities of patients include the responsibility to comply with the treatment prescribed by providers, take care of their health, look after the health records in their possession, use the health system responsibly and not abuse it and also to provide health care providers with accurate information for diagnostic and treatment purposes and to respect the rights of other patients and health care providers.

In essence, the PRC is aimed at empowering previously disadvantaged and disempowered patients so that they can have access to the care they need when they need it and at ensuring that they are treated with respect, courtesy and dignity when they are in the health facilities. This intention of the policy then allows us to investigate whether all patients are actually treated like this when they come to the hospital or whether the providers treat patients of different socio-economic backgrounds differently.

4) Methodology: data collection

4.1) Site selection and access

In selecting the case study hospitals, the research team used a number of criteria. Firstly, it sought hospitals that were of the same level (i.e. district). Secondly, and for reasons to do with the equity-focus of the research, the idea was to work in hospitals located in largely rural areas with low socio-economic status. It was also intended to select relatively well-functioning hospitals, with the assumption that policy implementation experiences were more likely to be positive in such settings. A well-functioning hospital was understood to mean that there was evidence of a hospital leadership committed to building good relationships and teamwork, a problem solving orientation and staff capacity building, amongst other things. The above criteria were discussed with the provincial departments of health and other knowledgeable persons and so the case study sites were identified.

Before beginning the fieldwork, the study was introduced to the hospitals' management and key officials in the provincial and regional departments of health. At the hospital level, this process also included being introduced to staff in management positions and those involved directly in the implementation of the UPFS and PRC. This also included meetings with unit managers of the different wards and departments to introduce them to the study, as well as to identify ways in which they could facilitate the fieldwork.

4.2) Data collection tools and phases

This study used various data collection techniques and tools to elicit information from respondents. **Table 2** below provides a complete list of the tools used, the respondents targeted, the number of respondents who participated, the purposes of the different methods and the relevance of the data collection tools to the research objectives.

The data collection occurred in two phases. In Hospital A, phase 1 was undertaken between November-December 2006 and phase 2 between January-February 2007. In Hospital B, phase 1

was undertaken between November-December 2006 and phase 2 between February-April 2007. The activities were sequenced in this way for 3 reasons:

- The research team needed a point at which to stop and reflect to assess if the information being collected was addressing the research objectives;
- It was important for the research team to take a break because the information that the tools in the second phase were expected to elicit could only be appropriately collected after having carefully reflected on the information provided by the respondents during the first phase of work;
- The break was important so as not to overload the respondents with multiple tools and requests for information and interviews within a very limited time frame.

Phase 1 focused mostly on the initial narrative interviews, relationship mapping and observations, while phase 2 was oriented towards continuing observations and in-depth interviews with provincial and district officials, hospital staff and patients. The surveys on organisational trust and organisational culture were carried out across both phases.

The organisational culture survey drew on the competing values framework (Mannion *et al.* 2005 & Zammuto and Krakower 1991). This framework outlines four culture types, based on two axes. The horizontal axis reflects the focus of the organisation. Organisations on the far-left have an internal focus and are concerned about integration, while those on the far right have an external focus and are more concerned with competitiveness and differentiation from other organisations. On the vertical axis, organisations at the top are more likely to value spontaneity, flexibility and individuality, while those at the bottom are likely to emphasise order, control and stability.

The organisational culture types are: clan, developmental, hierarchical and rational (Mannion *et al.* 2005, Quinn and Rohrbaugh 1983, Shortell *et al.* 2000, Zammuto and Krakower 1991). The clan culture has a leader who is a mentor and the environment is cohesive and participative. There is an emphasis on morale and people in the organization are bonded by loyalty and tradition. The developmental culture is one where the leader is a risk-taker and innovator and he/she leads in an environment characterized by creativity and adaptability to circumstances. The priority of the developmental organisation is entrepreneurship with an emphasis for originality. The hierarchical culture is one where the leader is more of a bureaucrat with emphasis directed towards predictability, order, rules and uniformity. This culture type reflects the values and norms that are frequently associated with bureaucracy. The factor that bonds staff in such an organization emanates from the rules and policies that are in place. Lastly, the rational culture is dominant in organisations where the leader is goal-oriented and the priority emphases of the organization's activities are planning, efficiency, competitiveness and winning. Staff in such an organization bond on the basis of competition and are motivated by the belief that competent performance leading towards the achievement of the desired organisational goals will be rewarded.

Table 2: Methods employed in data collection

Method	Respondents	Number of respondents		Purpose of method	Objective(s) addressed
		Hospital A	Hospital B		
Initial narrative interview	<ul style="list-style-type: none"> Provincial health department Regional health department Providers (clinical¹ & non-clinical²) Hospital Managers Hospital management 	47	27	<ul style="list-style-type: none"> To better understand provincial and regional perspectives of the policies To get an initial insight into and description of policy implementation To determine provider and manager perspectives on the policies of focus To identify key role players in policy implementation To identify problems associated with the policies To inform the development of the other tools. 	1; 2; 3; 4
Relationship mapping interview	<ul style="list-style-type: none"> Providers (clinical & non-clinical) Hospital Managers 	13	7	<ul style="list-style-type: none"> To identify any networks at play in the implementation of policies To identify key role players in influencing policy implementation To determine the nature of relationships across spheres 	1; 2; 3
Organisational trust (survey)	<ul style="list-style-type: none"> Representative sample of all staff in the hospital 	185	92	<ul style="list-style-type: none"> To determine whether staff in the hospital trust those in the management with respect to decision making, information & negotiations 	2
Organisational culture (survey)	<ul style="list-style-type: none"> Representative sample of all hospital staff 	155	77	<ul style="list-style-type: none"> To determine the dominant culture within the hospital To understand the elements of organisational culture at play in the hospital 	2
In-depth interviews	<ul style="list-style-type: none"> Hospital Board Members Patients District & provincial officials 	25	28	<ul style="list-style-type: none"> To determine patient & community understandings of the policies To get a better understanding of patient-provider interactions 	1; 2; 4

¹ Clinical providers: doctors & nurses

² Non-clinical providers: dieticians, pharmacists, radiographers, dentists, cleaners, porters, security personnel & administrative clerks

Hospital staff in-depth interviews	<ul style="list-style-type: none"> • Providers (clinical & non-clinical) • Hospital Managers 	30	18	<ul style="list-style-type: none"> • To get a better understanding of patient-provider & provider-provider interactions • To explore further issues raised in the initial narratives • To determine the nature of relationships across various spheres of interactions in the system 	1; 2; 3
Observation	N/A	N/A	N/A	<ul style="list-style-type: none"> • To determine the nature of patient-provider interactions • To determine the nature of provider-provider interactions • To observe the general functioning of the hospital • To determine the implementation practices of the policies in the hospital • To supplement information from interviews 	1; 2; 3

Table 3: The Competing Values Framework

<p><u>Clan</u></p> <ul style="list-style-type: none"> • Cohesive, participative • Leader as mentor • Bonded by loyalty, tradition • Emphasis on morale 	<p><u>Developmental</u></p> <ul style="list-style-type: none"> • Creative, adaptive • Leader as risk-taker, innovator • Bonded by entrepreneurship • Emphasis on innovation
<p><u>Hierarchical</u></p> <ul style="list-style-type: none"> • Order, rules, uniformity • Leader as administrator • Bonded by rules, policies • Emphasis on predictability 	<p><u>Rational</u></p> <ul style="list-style-type: none"> • Competitiveness • Leader as goal-oriented • Bonded by competition • Emphasis on winning

Source: Mannion *et al.* (2005)

The cultures are not mutually exclusive and no culture is better than the other: they are just different in terms of how the organisation structures its operations. It is possible to find a combination of all four cultures in a particular organisation at any given time.

The organisational trust survey tool was based on the organisational trust inventory (Cummings and Bromiley 1996). It consists of 3 sets of questions (each made up of 4 questions) aimed at eliciting information along 3 dimensions: “keeping commitments”, “not taking excessive advantage” and “negotiating honestly”. We used this tool to ask staff members about their perceptions of the management of the case study hospitals.

5) Methodology: data analysis

Data extraction templates were created for the interview tools and divided into themes related to the research objectives. The templates allowed the retrieval of key information from each interview using a thematic coding approach and linking the information to the objectives. The information from the respective interview tools was then used in a process of triangulation to verify findings emerging from the observations and also from other documents available to the researchers. This need to triangulate data from various information sources posed a challenge. To address this, members of the research team did most of the coding as teams and other team members were used to cross-check the information in the completed data extraction templates. There was a deliberate attempt to ensure a process of continuous reflexivity in the entire research process.

Data from the self-completed tools was analysed using Stata. Information was first captured in Excel and, once checked for correctness, was exported to Stata for computations. The data from the questionnaire on organisational trust was basically used to compute proportions based on each response category. The more complicated and demanding computations were for the questionnaire for assessing organisational culture. The results for the self-administered tools were weighted to take into account the professional categories from which we had sampled.

6) Ethics

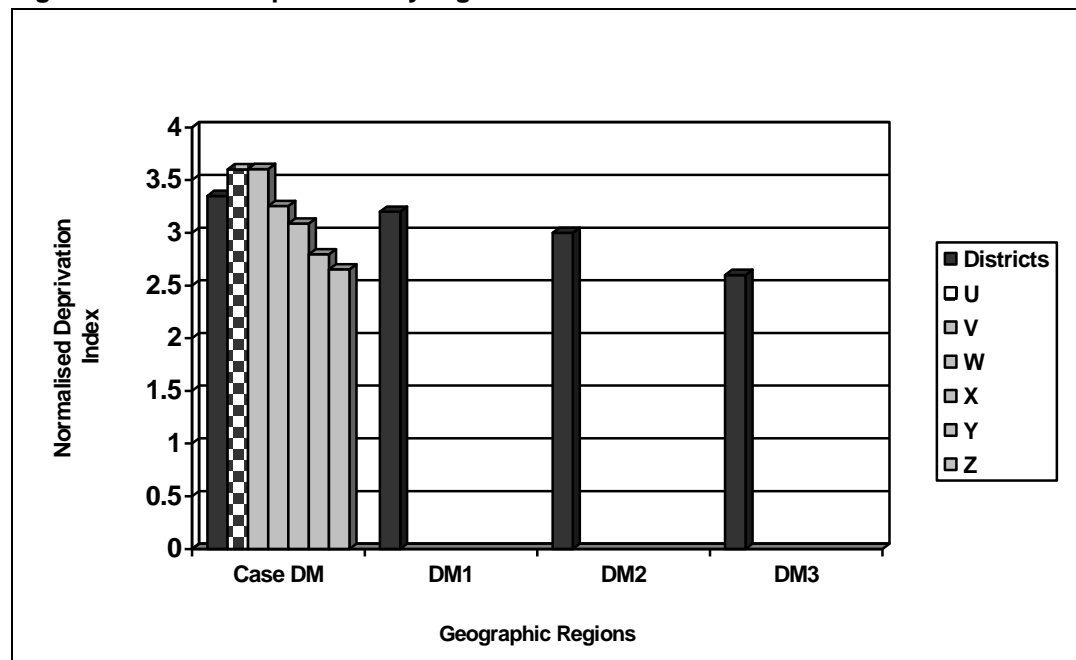
Approval was obtained from the University of Cape Town and University of the Witwatersrand, permission was sought from the relevant provincial departments of health and the researchers approached the management of the case study facilities before starting the fieldwork. Respondents were informed that they could refuse to participate in the study and that they will suffer no harm as a result such a refusal. Respondent and facility identities were kept confidential. All interviews were anonymised to ensure that the information could not be ascribed to any particular respondent. Only the core research team accessed the interview data.

SECTION B: CASE STUDY – HOSPITAL A (NORTH WEST)

1) Description of Hospital A and the local context

The town outside of which Hospital A is located is in a primarily rural area of the North West Province. The town is part of a district municipality, hereafter referred to as Case DM. Case DM is further broken down into six local municipalities and to retain the anonymity of the case study hospital we refer to them as U, V, W, X, Y and Z. **Figure 1** below shows that Case DM is the most deprived of the regions in the North West Province. Within Case DM, local municipality U (represented by the checked bar) is where Hospital A is located. Local municipality U is clearly one of the most deprived areas in Case DM and is also ranked as the third most deprived area in the entire province. The deprivation indices for local municipalities V, W, X, Y and Z are shown, in descending order, next to the index score for local municipality U.

Figure 1: Relative deprivation by region



Source: Barron et al. (2006)

At the outset, Hospital A was a missionary hospital, established by the Roman Catholic Church in the early 1930s as a facility intended to provide basic health services to the people from the surrounding villages. It remained a missionary hospital from the time of its initiation until 1974 when it was taken over by the Bophuthatswana “homeland” and turned into a public

hospital co-owned and managed by the Catholic missionaries. The case study hospital remained under the Bophuthatswana government until 1994 when South Africa held its first fully democratic elections. Today, the case study hospital is a district hospital under the North West Provincial Department of Health.

Hospital A has a bed capacity of 434 of which 290 (66%) are active. As at December 2006, it had 561 approved posts of which 481 (85%) were filled. It is supported by 3 health centres, 4 mobile clinics and 19 static clinics dotted over a large area. The hospital has 8 wards and offers a number of services to the general public ranging from surgical, paediatric, maternity, psychiatry and TB treatment services to an outpatient dental clinic, counselling services, X-Ray, physiotherapy, and theatre services. The hospital also has an Anti-Retroviral Therapy (ART) Clinic. This clinic caters for a large number of patients who come from the surrounding areas, including distant places like Schweizer-Reneke, Pampierstad and Reivilo. The main referral hospitals for the case study hospital are Klerksdorp and Tshepong Hospitals.

According to the hospital's 2005/06 annual report, it serves a population of about 190,000 people spread over a vast area comprising 96 villages and 3 townships. In the areas surrounding the hospital, people are mainly involved in farming as a subsistence and commercial activity. Of those employed, the majority work as seasonal labourers on commercial farms in the surrounding areas, while a small proportion is employed in government departments. The road and transport network is generally poor, especially that which services the far-off villages, which makes it particularly difficult for patients to reach the hospital or for the Emergency Medical Services (EMS) to reach patients promptly in times of emergency. It is argued that unemployment in the area is rife, with some of the study's respondents quoting estimates as high as 70% of people being unemployed.

Recently, the hospital was coupled to another facility about 60 km away. This hospital was initially owned by a company that had been operating a factory in the area. The facility mainly served the factory workers and their families. However, after the factory was relocated the facility was taken over by the government and it now serves the entire local population. Hospital A and this former factory health facility have been paired so that the latter can draw on the administrative and clinical expertise of the bigger and better resourced Hospital A. The two facilities had a combined budget of close to R62 m for the 2005/06 financial year, with Hospital A receiving 94% of the budget and the remainder going to the other facility. For the 2005/06 financial year, Hospital A was expected to raise a revenue target of R800, 000 from the billable services that it provides.

Figure 2 shows the results of the hospital's organisational trust survey. It indicates relatively high levels of trust in management, especially on issues around keeping to commitments and negotiating honestly. Responses around the theme of taking excessive advantage were more negative. This might be related to performance appraisals being conducted around the time the survey was administered.

Figure 2: Trust in management in Hospital A

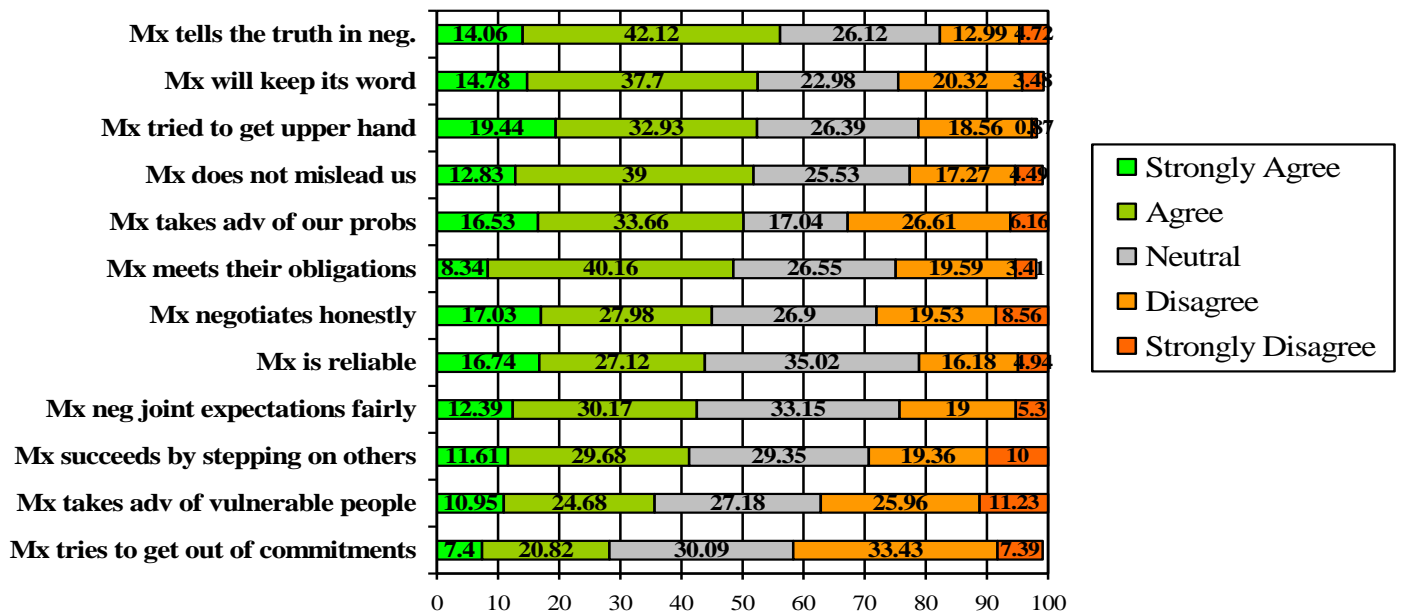


Table 4 captures the results of the organisational culture survey in Hospital A. It reflects a hospital with a strong competitive streak (Rational, 28%), a cultural element that is about performing well and achieving objectives. This is mixed with a bureaucratic outlook (Hierarchical, 30%) in terms of which it is important to do things in an orderly way, to act within rules, regulations and polices, and to respect reporting relationships. All these elements play out in a context where cohesion and people’s morale is important, and where being supportive of others is valued (Clan, 35%).

Table 4: Organisational culture in Hospital A

<u>Clan (35%)</u>	<u>Developmental (7%)</u>
<ul style="list-style-type: none"> • Cohesive, participative • Leader as mentor • Bonded by loyalty, tradition • Emphasis on morale 	<ul style="list-style-type: none"> • Creative, adaptive • Leader as risk-taker, innovator • Bonded by entrepreneurship • Emphasis on innovation
<u>Hierarchical (30%)</u>	<u>Rational (28%)</u>
<ul style="list-style-type: none"> • Order, rules, uniformity • Leader as administrator • Bonded by rules, policies • Emphasis on predictability 	<ul style="list-style-type: none"> • Competitiveness • Leader as goal-oriented • Bonded by competition • Emphasis on winning

2) Hospital A’s management structure

The core management group of Hospital A comprises the Chief Executive Officer (CEO), Hospital Superintendent (Chief Medical Officer) and Matron (Chief Nurse). The CEO is responsible for the overall day-to-day operations of the facility and is the ultimate decision maker concerning all key matters relating to the facility. In his duties, he is accountable to both the district and provincial offices on all matters concerning hospital personnel, finances

and procurement. The Hospital Superintendent is mainly responsible for the clinical care provided in the hospital. The Superintendent has oversight over the activities and responsibilities accorded to all the doctors in the hospital. He is responsible for the pharmacy, radiology laboratory, physiotherapy, social work, male and female medical units, and occupational therapy and works very closely with the Matron. On the other hand, the Matron is assisted by two assistant directors for nursing who work directly under her supervision and guidance. The two assistant directors are each responsible for a particular set of wards/units in the facility.

The core management group is further assisted by the “broader/middle-level management group”. This group comprises mainly the unit managers from all sections of the hospital: human resources, finance, information, auxiliary services, in-house security services, pharmacy, radiology, nutrition, ART clinic, and all the other wards in the hospital. Most of the matters pertaining to hospital operations and activities are discussed in the broader management group at a meeting that is held three times a week – Monday, Wednesday and Friday. It is at these meetings that matters relating to patient complaints, garbage/refuse collection, staff absenteeism, hospital security, and facility maintenance are discussed. It is also commonly used by the unit managers to communicate key concerns and problems that they are encountering in the wards to the broad management committee of the hospital.

When decisions are reached at this meeting, it is decided if it is adequate for the unit heads to have meetings with their staff to inform them of the decisions or whether a memorandum should be sent to all staff. Decisions made at these meetings are communicated through the unit heads to the staff in their respective units, usually at early morning meetings. At these meetings they discuss key information received from management (especially that which is related to ward/unit operational matters). In some instances, the CEO issues memoranda, which are posted on notice boards in the units for all to read. Memoranda usually communicate information meant for all hospital staff, irrespective of their level or cadre group, e.g. death of a hospital staff member, requests to staff to attend an event or revenue collection issues.

From having spent a relatively long period there, one clearly gets a sense of the close relations and interactions that exist among staff in the hospital, irrespective of their level or cadre group. This is probably partially due to the long periods of time that some staff members (particularly nurses) have spent at the hospital. This has impacted on the development of mutually beneficial relations across the hospital's various cadre groups. The senior management of the hospital is also easily accessible and it was a common occurrence to observe junior members of staff casually interacting and conversing with more senior staff members. Staff members apparently pride themselves on working in a facility that has won a number of awards, both at district and provincial levels, and this seems to translate into staff trying to ensure that the status quo continues and where possible improves. The regular meetings that senior members of staff hold and the ways in which they pass information on to the other staff also seem to foster good working relations in the hospital. This, in a way, translates into the better performance of the hospital. A number of people we interviewed were actually quick to note that the hospital was more of a “*family or home*” to them than just a working place.

The Hospital Board comprises about eleven members with various social and political backgrounds, and it is actively involved in matters pertaining to the operations and health service delivery of the hospital. The majority of the members are either current or former councillors, while a few are involved with local non-governmental organisations and the community radio station. According to the district officials interviewed, Hospital A has one of

the most active community governance and accountability structures of all the hospitals in the health district. The hospital board is very active in its interactions with the hospital's management and the community over issues of patient care and community awareness of the hospital's activities, including dissemination of information on policies being implemented at the facility. For instance, some of the board members have been involved in promoting community awareness of various policies and some members have actually been incorporated into the hospital's sub-committees (e.g. ethics committee, HR portfolio committee) so as to ensure transparency in the operations of the facility.

3) Description of policy implementation findings and equity implications

3.1) Hospital A and the Uniform Patient Fee Schedule experience

The responsibility of implementing the UPFS rests primarily with the clerks who work in the Records/Fees Office of the hospital. This office has three windows, which are usually manned by two clerks who deal directly with patients before they move on to the outpatients department for treatment. It is also the place where the patient files are stored for retrieval when patients come to the hospital.

When patients first come into the Records/Fees Office they must drop their appointment cards into a small box on the information counter marked "Insert Your Appointment Card Here" in both English and siTswana. After this, the patient must get back into the queue on the benches. Staff members from the Records Office then come to collect these cards and use them to retrieve the patient files. They then hand over the folder to the patient, who has to wait for his/her turn with the clerks. Opposite the clerks' windows is an information desk that is manned by an Information Officer who also acts as the 'queue manager' by ensuring that all patients have both their appointment cards and their files and that they are sitting in the correct queue before they go to see any of the clerks.

Patients without appointment cards or hospital files sit on the other side of the benches where they have to wait for the Information Officer to get their details and issue them with a card so that they can go and see the clerk responsible for patient information verification. Here, they are asked about employment status, residential and postal address, income, marital status, and other relevant information. Patients who already have hospital files are asked to pay a R20 consultation fee before going on to the Outpatient Department (OPD) and being attended to by the health workers there. Those who cannot pay the R20 are sent to the Accounts Office where they are issued with an account and receipt, which then allows them to access the services. Patients without files in the hospital have to pay R20 for the creation of the file and R20 for consultation and treatment. Only then can they join the queue leading to the room where the nurses take their basic health information. However, sometimes patients join the queue in the OPD without having been to the clerks' offices. These patients are turned back by the nurses and/or doctors in the OPD once they notice that the patients' files do not have a stamp with today's date or that the patients don't have receipts showing that they have paid the stipulated fee to the clerks.

According to the UPFS policy document (2005), H0 "is not the default classification for a patient attending a public hospital. Unless proof of status is produced a patient is classified as H1 to H3 depending on income [and] the default classification for a person without income is therefore H1". Most of the patients who come to the hospital are by default categorized as H1 and so they pay the minimum fee of R20. Apparently this is done not only to comply with the official policy document (most of the patients do not have the documents needed for full and correct classification), but also to make the process of patients accessing services easier because spending too much time asking the questions about their income or employment

status could unnecessarily delay them in accessing services. Additionally, during our entire time at the hospital we did not see or hear any of the clerks tell patients who said they could not afford to pay the fees about the possibility of getting an exemption and how they could go about this. On a few occasions we heard the clerks in the Accounts Office say to patients that if they were unemployed they should go to the police station to get an affidavit, but they did not then explain to the patients that this could allow them to get free hospital care. While it can be genuinely argued that most of the patients who come to the hospital do not pay anything, this is generally true for on-the-spot payments. We observed a relatively small number of patients who had been discharged on earlier days or who had been to the hospital for treatment but had no money returning to the hospital just to come and pay the owing amounts. It was not clear from the observation whether these patients should have been granted exemptions or whether it was correct for them to be charged fees.

Further, in some instances we saw some of the clerks talking to patients or those escorting them in a very condescending manner, especially if they were not forthcoming with the information that was required for the clerks to properly assist them. This was particularly true for patients who had outstanding accounts for some time and had returned to seek care even before they had cleared these balances. However, in all such cases the patient was finally granted another account (reflecting both the old and new owing amount), which allowed them to access care. We never noticed or encountered a patient who had been denied access to services because of an unpaid account or because of having no money to pay the requested fee.

The Fees Clerks rely on a wider group of people within and outside the hospital to implement the UPFS policy. The staff in the Accounts Office are relied on to grant exemptions and/or to allow patients to access care without making an upfront payment. Managers and other staff provide support by informing patients and community members about the policy and where they should go if they need information it. Additionally, the Hospital Board is actively involved in conducting community awareness campaigns aimed at ensuring that people are aware of the policy and of how it affects the accessing of services at the hospital.

Most of the respondents interviewed on the policy felt that the Provincial Department of Health and the Provincial Treasury are the ones who develop the policy and inform the hospital to implement it. These two institutions are involved in the implementation process through the purchase of equipment like computers and they also coordinate and conduct the various training workshops that the clerks have to attend to be able to implement the policy correctly. The Provincial Offices are also said to be the ones that issue the standard guidelines which those responsible for implementation in the hospital are expected to follow. Some of the more senior people in the hospital alluded to the revenue target of R800, 000 per year. They argued that this is arbitrarily set by the Provincial Treasury, without any consultation with the hospital management and with little consideration of the fact that the majority of the hospitals' patients are unemployed. Some of the hospital's senior managers pointed out that the hospital, with help from the District Office, had been trying to engage Provincial Treasury on how the revenue target is set and whether this is something that could be reviewed taking into consideration the high unemployment levels in the district.

The revenue target seems to create unexpected pressures for the clerks in the hospital. On the one hand, they are expected to reach the target and on the other they fear that if they reach the target it will be increased. Also, if they fail to raise sufficient revenue they will be considered as an under-performing section of the hospital. The combination of these factors seems to create pressure for the clerks to concentrate on collecting fees with little or no attention directed towards explaining to patients about the possibility of exemptions and how

they can access them. However, it must be noted here that most of the interviewed clerks emphasised that the target does not make them want to charge each patient, irrespective of whether they qualify for an exemption or not. Instead they argued that the revenue target has simply reinforced the need to ensure that patients with the ability to pay the fees are actually paying for the services they use in the hospital.

To a certain extent, the clerks also admitted to using their discretion in deciding if patients should access services for free or if they should be charged a fee. They admitted to using this discretion for people who had been to the hospital several times and said that they had no money or for people whom they judged to be unable to pay simply from their appearance. A clerk in the Accounts Office stated that

“Yes sometimes we don’t charge them but we know that it is wrong, but people can come for the sixth time not having any proof that they are not working or money. At the end of the day our outstanding is so high because of this person who is not working and they don’t have a proof”.

However, it is not clear if this kind of discretion was only applied to the patients the clerks felt deserved the free access or whether they even extended it to their close colleagues and relatives, even if they were aware that they could pay the fees. In a few instances, we observed that the staff in the fees office and also clinical staff would help their ‘relatives’ jump the queues in the OPD or get to be treated in a much more comfortable private ward even without them having any medical aid.

A senior member of the hospital’s management also has a hands-on approach to the way the policy is implemented in the hospital. He actually has his computer logged onto the Patients Administration and Billing system so that he can monitor implementation. There is also a letter issued by the Accounts Office requesting that all hospital staff with owing balances on their hospital records pay the outstanding amounts by a stated date. This letter further states that, failing this, the State Accountant will be asked to deduct this money from the payroll. This letter is signed by both the Chief Administrative Clerk and the CEO. In interviews with some of the clerks, they pointed out that this letter lead to many of the staff paying their accounts and that they raised more revenue than expected in that month. These kinds of actions point to rigorous policy implementation and the importance that the senior personnel in the hospital attach to the revenue collection section.

According to most of the hospital staff and the Hospital Board members, the Hospital Board, to support implementation, has been conducting a number of awareness campaigns in the community about the payment of hospital fees. The Board members also said that they had been called upon on several occasions by the hospital management to inform the community of changes to the policy, such as the change in the fee levels. Closely related to this, the CEO and the Chief Director of the Health District has, on more than one occasion, gone to the local radio station to discuss the UPFS and its implications for patients and the community.

The hospital management use the referral system to further policy implementation in that satellite clinics inform patients about the fees when they refer them to the hospital. While the clinics are not expected to formally play a role in UPFS implementation, the hospital has come up with a resourceful way of engaging with the clinics so that policy implementation in the facility benefits. There are some letters written by the hospital management and displayed in the Accounts Office requesting clinic heads to inform their staff that if they decide to refer patients to the hospital they should inform those patients about the fees that they will be expected to pay.

Most of the interviewed patients stated that they knew that they had to pay something when they come to the hospital. However, patient awareness about the UPFS policy specifically was virtually non-existent. They also added that in most cases they were not aware of what they were paying for and that the payment requests were based on the UPFS policy from national and provincial government. Many expressed ignorance about the fact that they could access exemptions if they could not afford the fees they were being asked to pay. Most of the patients were not even aware of the procedures they had to follow before they could be granted exemptions.

The patients could also not clearly state whether they knew anything about who qualifies for exemptions. When prompted on whether any of the clerks in the Records/Accounts Office had at any time told them about the possibility of getting exemptions if they could not afford to pay the fees or if they were unemployed, all the patients said no. Some hospital board members felt that while the policy was right in trying to ensure payment by those with the ability to pay, the policy was not working very well in the hospital for those who could not afford to pay because of certain factors, primarily high unemployment and poverty levels. For instance, asked if patients were aware of the payment of fees at the hospital and how well this policy was being implemented at the hospital, one board member responded that

“Yes actually the community is aware of payments but one of the issues is that we are living in the community which is very poor especially to enable them to pay the subscription fee because some of the patients do fail to pay and this makes some of them become in the other way round of becoming afraid may be to go back to the hospital when they are sick because they know that they still owe the hospital something. So it is a matter of concern that I think we all must try and address... Actually the system doesn't work well. As I have explained that it has actually challenges in terms of making sure that patients who are not able to pay are not being made to pay and also that the hospital is able to collect enough revenue from those that are expected to pay. It is difficult because some don't actually have that ability to pay and the strategy of how to address this issues is quite difficult but like I say we need to sit down and review how best to go forward in terms of making sure that this policy is taken forward. You know I can possibly maybe 80 % of the community cannot pay; you can see around the area it is so disadvantaged and the employment rate is so low”.

Some of the patients interviewed noted that when they tell the clerks that they cannot pay the fees because they don't have the money and/or are unemployed, the clerks would immediately ask them to go to the accounts office to see the senior administrative clerk so that they are issued with a 'credit' account which would then allow them to access services. A relatively small number of patients also expressed concern about the way some of the clerks talk down to them at the hospital. The common assertion among the patients who raised this issue was that the clerks address them in a rude manner and that they don't look at them nicely and so they become scared or they feel intimidated to ask the clerks questions. The patients also felt that in most cases when they don't have the money to pay the fees, the clerks do not want to understand and they don't help them. One patient stated that

“...the thing is the clerks don't know how to talk to us they are rude. Because they don't know how to talk to us even if you explain to a person that you don't have money they don't understand”

Some patients also expressed dissatisfaction with being asked to pay fees every time they came to the hospital because the government had earlier announced that services will be provided for free. One patient put this as follows

“Maybe people are getting confused because in the first place in 1994 they were saying that, the health department, it will be free for every one and then we get used to that and then as time goes on along the way they changed the system patients should pay so that makes patients confused and say we can’t pay you said the health will be for free suddenly they change the system...some patients don’t have money for, let me say this, some people are staying far from hospital”.

The feeling among some of the patients we interviewed is that most of the clerks are not helpful in terms of assisting them with accessing the services in the hospital when they don’t have the money to pay for the fees. They also seem to feel that the clerks do not address them with courtesy and respect and that in some instances the way they look at them makes them feel intimidated. Some hospital board members corroborated this information by stating that in most instances patients who are treated well and with respect are those who are employed.

Clearly, these factors have a bearing on whether deserving patients will access the exemptions if needed, on how patients are treated at the hospital and it impacts on how well the hospital implements the policy. The feeling that the clerks are uncooperative and rude, though expressed by small number of patients, and that the clerks are generally not forthcoming with information about exemptions has a bearing on whether this policy is well-implemented in the hospital and also influences how well other policies like the Patients’ Rights Charter are being implemented and whether the objectives behind these two policies are being realised.

3.2) Hospital A’s UPFS implementation achievements and equity challenges

In looking at the UPFS policy and drawing out the equity consequences of the implementation processes, the focus was on issues linked to whether patients are made to pay fees when they come to the hospital and, if they are, whether the fees reflect their varying abilities to pay. Importantly, particularly in relation to the purported high levels of deprivation in the area, we also tried to assess whether the hospital granted poor, unemployed and indigent patients exemptions to services. **Table 8** below summarises the key equity achievements and challenges surrounding the implementation of the UPFS policy in the hospital.

The basic and primary achievement of the hospital with regards to the UPFS policy is that it has actually managed to put the policy into practice and also that the majority of the patients who come to the hospital for treatment are aware, to varying degrees, that they are expected to pay something for the services rendered.

The UPFS implementation process is supported by a wider group of people than just those within the hospital who have a formal role to play in collecting revenue. The management team of the hospital has managed to rally support for the policy from staff of all backgrounds. This has been achieved by emphasising the various awards the hospital has won for its service delivery performance and how they fail to achieve the same in revenue collection. The hospital has over the years failed to raise sufficient revenue to meet the target and the staff in the fees office are uncomfortable with this. There seems to be a norm in the hospital of wanting to perform well in all activities and the fact that it is regarded as non-performing in relation to the revenue target means that most of the staff have been galvanised into thinking about the target and how best to achieve it. This is evident in the way that clinical staff will refuse to treat any patient if they notice that the patient’s file has no stamp from the Accounts Office. In most cases, such patients are sent back to the Records Office so that they can pay

the fee or at least be issued with an account for later payment. While this is a good thing, as all patients are made to follow the procedures, it could also have detrimental effects on the ease with which patients decide to come to the hospital to seek care. The mere knowledge that staff ask the patients to go back to the Accounts Office to get their files stamped before they can get treated could imply that some patients fear or at least delay seeking care until they have enough money to pay the fees. In equity terms, this is undesirable as some patients will be denied care due to the procedures and requirements and because of this “the right to access to health care” will not be a right some groups of patients will find easy to exercise.

Management has achieved a plus in putting into place a structure that streamlines the process through which patients have to go before they can access services, even if they cannot pay the stipulated fees. This is so that their access is not hampered. The creation of an information desk manned by an information officer who attends to patients’ queries and assists them in getting their files from the records is not only important to the implementation of the UPFS but also adds value to the way the hospital is implementing the Patients’ Rights Charter. While the idea of creating an information desk might not have been conceived with the UPFS and PRC policies in mind, the result is that the assistance provided to patients helps them to access services in the hospital in a much easier manner than would otherwise be the case.

Additionally, the hospital has put up a number of UPFS posters in the Records Office indicating the fees that patients are expected to pay. This adds to the activities that the facility is undertaking to give patients information about the policy. This is important in that it promotes a level of empowerment among community members. Not only do they have the knowledge about the fees they are expected to pay (implying they cannot be over-charged), but they also have the information about the possibility of accessing exemptions. Therefore, the deliberate efforts of the hospital’s management in promoting community awareness of the policy is likely to yield some positive equity outcomes, primarily through patients being provided with the right information on the hospital fee levels and the accessing of exemptions.

Furthermore, senior members of the hospital’s management have kept a hands-on approach to the way the policy is implemented and are reasonably proactive in trying to ensure that staff, not just patients, pay fees for the services they receive. Notably, these managers have been involved in ensuring that hospital staff are paying fees to the hospital for all the services they receive, irrespective of the cadre group to which they belong. This is desirable as it helps to promote financial equity among staff and non-staff in that every person who can pay the fees is expected to pay, regardless of whether they work in the hospital or not. It is important that the hospital staff pay the fees as they are earning an income, translating into the ability to pay. It would be inequitable for staff not to pay fees simply because they are employed in the hospital.

The hospital’s multi-pronged strategy of getting the buy-in of key actors (the Hospital Board, traditional leaders, satellite clinics and local radio station) is another positive thing that the hospital has adopted in trying to ensure community awareness and successful implementation. The efforts by the hospital to promote awareness of the policy is positive, not only because it helps to ensure that patients pay when they use the services at the facility, but also because it empowers them with the information they need to access and utilise the facility’s services. It is also particularly important if, through these awareness activities, patients are informed of the possibility of getting exemptions and the requirements for being granted exemptions. Clearly, patients in possession of such information will not fear coming to the hospital even if they do not have money to pay for fees because they are aware that there

are mechanisms and processes to help them access care freely if they furnish the implementers with the necessary information and qualify for exemptions.

As indicated in **Table 5**, some key factors have impacted on how well the policy has been implemented in the hospital and the equity achievements/problems that have resulted from this. One major and underlying factor is the revenue target set by the Provincial Treasury. This seems to have added pressure for the hospital to concentrate more on the collection of payments than on ensuring that all the patients who qualify for exemptions have access to them. Despite such an approach, the documentary evidence collected from the hospital indicates that for the 2005/6 financial year the hospital was only able to collect about R315, 000 (40%) of its R800, 000 revenue target. This target also seems to have a demoralising impact on the clerks in the Fees Office. For instance, one of the senior managers of the facility said that the revenue target affects the clerks in that they do not look forward to attending the monthly revenue meetings because they fail to collect sufficient revenue. This ends up demoralising them. He stated that

“...you know on a regular basis we have included revenue collection as part of our budget discussions on a monthly basis, when they [the clerks] collect less they feel very bad that they have collected less and whether they collected more or less depends on the type of patients that come in – if for that month a lot of patients that came were non-paying patients obviously you know we will collect less but the fact that they are unable at the end to come closer to the target because it is too high it can be a bit demoralising you know to people because we have set a target that we all know is not achievable”.

This kind of feeling might have negative consequences for the way certain parts of the policy are implemented. This is particularly so for the exemptions because the more exemptions the clerks grant, the less likely they are to reach the revenue target. They may, therefore, use their discretion to ration exemptions or, in the worst-case scenario, not to grant any exemptions or not to provide information about exemptions. The reasonably large number of patients passing through the hospital and the purportedly few clerks working in the hospital also make it almost impossible for the latter to spend enough time with the patients so as to verify their information and use this to decide if, and how much, the patients should pay. Moreover, most of the patients were marginally knowledgeable about the UPFS policy and the existence of exemptions and how they could access them. Even from the research team's observations in the Fees Office it was not evident that any of the clerks on duty were actively informing patients about exemptions when the patients said they did not have the money to pay the requested fees. This kind of behaviour is likely to disempower patients because if they are not aware of the exemptions then they cannot request it and so even patients who genuinely deserve free access to health care will end up paying fees. A number of the interviewed patients felt that the clerks in the Fees Office were not very helpful in providing information about the policy. They also pointed out that in some instances some of the clerks were rude to them. Clearly, the perception by some of the patients that some of the fees clerks are rude and unhelpful is prone to worsen this because even patients who are aware of exemptions will fear asking about them because they do not want to be treated rudely. They will just resign to paying the fees rather than trying to get the exemption, even if they deserve it. While it might seem acceptable to the policy implementers to do so, it is possible that the poor and the unemployed are forced to come back and pay the owing amount because of fear of the consequences if they do not do so.

The financial burden of such an action is potentially huge because poor people might have to borrow the money to pay the hospital, on top of having to find money to travel to and from the hospital. The equity consequence of this is that patients who deserve exemptions will not

access them and will part with the little money they have. In the long run this could have very negative consequences for their household's welfare.

Another factor that seems to have adversely impacted on the implementation of the UPFS policy is the attitude of some of the staff towards the payment of fees when they or their close associates get treated at the hospital. A senior staff member said

"...people are not very happy because what happens if you are working in a bank you expect little bit concession from the bank. If you are working railway you expect little bit better service from railway or if you are working in the South African Airways you will expect some little rebate when you're flying. Similarly my people also wish that when we are working in a hospital we should not be charged too much. Not at parallel with the people outside the system/hospital because we are from the same department. They want some favour, at least some they are not happy. But we cannot do anything because this is a public hospital. Because of this yah they learn the tactic of how to get the medication and consultation without paying the fees. So mostly even our hospital people are consulted but they don't I'm sure they are not paying because they are some techniques and ways that they use to get free care".

Table 5: Summary of the UPFS policy’s key equity achievements and problems in Hospital A

Evaluation criteria	Equity achievements	Equity problems
Are all patients made to pay fees when they come to the hospital?	<ul style="list-style-type: none"> All patients are allowed to access care whether they can pay the fees or not In most instances, if not all, people are not forced to pay if they cannot, but instead their owing amounts are allowed to become bad debts 	<ul style="list-style-type: none"> Majority of the patients are issued with accounts and exemptions are not actively granted to patients. Nor are patients actively informed about exemptions by fees clerks Most of the people are categorized as paying patients (irrespective of their employment status and/or income levels) There was some feeling among some patients and hospital board members that patients with better-off backgrounds are treated favourably – in two instances researchers observed some patients getting free care and/or jumping the queues when they actually should have been charged fees or followed queues
Which patients are granted exemptions when they come to the hospital?	<ul style="list-style-type: none"> Maybe given to patients with full information Some possibilities of ad hoc exemptions based on physical appearance, numerous visits to hospital 	<ul style="list-style-type: none"> Patients are rarely directly granted exemptions in the hospital – exemptions are accessed by default through written-off (bad debt) accounts People who know staff in the hospital are sometimes allowed free care hence they may access exemptions even if they don’t qualify for and/or deserve them More often than not people are issued with accounts indicating how much they owe the hospital and so feel forced to come back to pay so as to avoid having a debt and they end up incurring higher overall costs (associated to indirect costs of accessing care e.g. transport)
Are the fees that patients pay graduated according to ability to pay?	<ul style="list-style-type: none"> Highest income patients, e.g. those covered by Road Accident Fund or having medical aid coverage, mostly classified correctly as H3 	<ul style="list-style-type: none"> There is the potential that some of the higher income patients are given preferential treatment in that they do not pay fees and/or jump queues at the expense of the potentially more needy patients From the evidence we have, it is not clear that the fees are actually graduated and so patients with dissimilar incomes could be facing the same burdens, which is inequitable
Any additional issues identified (linked to acceptability)	<ul style="list-style-type: none"> Patients in the facility are generally treated very well Patients in the hospital are not turned away when they cannot pay fees and even if they have a high balance on their account they are still allowed to get access to health services Management has made several efforts to ensure the process of paying fees or being issued with accounts is properly streamlined so that patients are not unnecessarily delayed in accessing needed services 	<ul style="list-style-type: none"> The clerks are sometimes rude to some patients and this leads to some patients feeling disempowered by clerks (e.g. for fear of being reprimanded patients resign to paying fees because of the attitude and treatment by some clerks despite the fact that they cannot afford it) Staff focus on revenue collection and not on ensuring that those who cannot pay are not paying fees to the hospital Clerks do not have enough time to explain to patients about exemptions and this disempowers patients in that they cannot ask for exemptions if they don’t know about their existence

On several occasions, we saw relatives of hospital staff jumping the queues in the OPD and not getting accounts when they came to seek care. Also, some patients who could have faced difficulties in the Accounts Office because they did not have money to pay the high owing amounts on their accounts or the requested bypass and/or consultation fee would call upon a relative or friend working in the hospital to negotiate with the Accounts Office in order for them to get treatment. It was also not readily clear whether all paying patients were paying appropriately graduated fees based on their ability to pay. In some cases the relatives of the staff were easily and quickly attended to by the doctor on duty, while those who do not know anybody in the hospital waited in the queues. The equity implications here are that it is more likely for those with connections within the hospital not to pay the stipulated fee, while those who deserve exemptions might end up paying the fees because they don't have anybody within the system to help them. Also, these people will not be attended to as quickly as those with links to the system and may not be treated with the courtesy, dignity and respect that is accorded to those with associates in the system. And so, even if they get treated for their conditions, they still might leave feeling dejected by the experience.

The complicated requirements around patients providing supporting documentation before getting an exemption also add to the difficulty of effectively implementing the policy. This is particularly true when it comes to patients obtaining "unemployment affidavits" from their local police stations, most of which are far from the hospital. Patients' failure to provide all the relevant documentation also means that the hospital staff cannot grant them exemptions, even if they qualify. This is because the patients do not have any evidence to support the clerks' decision. Additionally, it was quite apparent from the patient interviews that very few of them knew about the policy and how they could benefit from it. As a result, most of the patients are disempowered by their lack of knowledge and the inactive nature of the fees clerks in giving patients information concerning exemptions worsens the situation.

The implication of all these factors combined is that the practice among the Fees Clerks is to categorize the majority of the patients as H1, namely the UPFS categorization where patients are expected to pay the minimum fees. This means that patients who should be paying more, i.e. those who fall into the higher categorizations, are potentially missed and so the revenue collection is lesser than would have been the case. More importantly, in terms of equity it implies that the safeguards that have been built into the policy to ensure that the unemployed, indigent and poor people get free care are lost by the practice of charging all patients or at least issuing them with accounts. In most instances the clerks indicated regret at issuing some patients with accounts even if they knew that the patient would not pay the fees. However, they stated that in most instances there was nothing they could do as patients did not provide them with evidence to support the granting of exemptions. Without such evidence it was policy that the patients should be asked to pay.

Patients without supporting information and money to pay the fees are issued with accounts and expected to honour those accounts when they have the money. When the patients do not return to pay their accounts the hospital issues them with reminders, but it then becomes difficult to trace the patients because most houses are not properly marked. Many of the patients do not return to honour those accounts and in some instances these balances are written off as bad debts. Conversely, if the patient has already come to the hospital it is virtually impossible for the clerks to ask them to go home and collect the appropriate documents because most of the patients come from far. So either way the additional policy requirements have in some cases reinforced each other and inadvertently made implementation difficult. The unfortunate

consequence of such difficulties is that the hospital has informally decided to treat all patients as fee paying patients and exemptions are primarily granted by default rather than as an actively pursued aspect of the policy. In most cases the better-off patients come to the hospital with the money and they pay the fees when asked to. Alternatively most of them have private medical aid and all the clerks have to do is to indicate the patient's medical aid number on the file and the patient then proceeds to access treatment.

Many of the clerks in the records office and also the patients and hospital board members that we interviewed noted there were a number of aspects of the local context that made the UPFS difficult to implement. These included high unemployment, the distance that patients have to travel to the hospital, the informal nature of many of the settlements from which the patients come, and the generally low levels of literacy among community members.

3.3) The Patients' Rights Charter (PRC) experience in Hospital A

Many of the staff interviewed on the PRC, particularly the nurses, indicated that the policy was introduced in the hospital in the early 2000s. In the early years of implementation, some of the more senior nursing staff were sent for training and it was expected that they will train their subordinates when they return. For the staff newly recruited into the hospital there is an orientation programme and one of the policies included in this is the PRC. In the more recent past, very little has been done to try and train staff in the implementation of the policy. However, recently there has been an increase in the number of PRC-related activities at the hospital, mainly as a result of the hospital's involvement in The Council for Health Service Accreditation of Southern Africa (COHSASA) accreditation process, which has some requirements that are very similar to the requirements of the PRC.

PRC implementation in the hospital involves various interrelated activities. These include community awareness campaigns through meetings organised by the Hospital Board with the support of the management, supervisory visits by senior district and provincial officials to assess the hospital's needs and performance, purchasing name tags for all hospital staff to ensure that they are easily identifiable, promoting patient awareness of the PRC in the hospital through widespread distribution of posters, the creation of an information desk and the queue management committee to help patients access hospital services in a timely fashion, and also the regular collection and use of information from patients through satisfaction surveys. All these activities are aimed at ensuring that patients have sufficient knowledge to make informed decisions about their well-being and that they are reasonably involved in activities impacting on their health status. The following section provides a discussion of the PRC implementation experience in the hospital and the relevance of each activity to the achievement of the PRC objectives.

Most of the activities undertaken by the hospital to promote awareness of the PRC have tended to involve stakeholders closely working within the hospital context. The more distant stakeholders like the Provincial and District Offices primarily play the role of designing the policy and informing the hospital management of the policy, providing initial promotional materials and also scheduling training workshops for the staff from all the facilities in the province to attend. Apart from these activities, most of the people interviewed in the hospital felt that the Provincial and District Offices play a tiny part in how the hospital implements the policy and who among its staff it involves in this process. However, it was evident from some of the interviews that in some instances officials from the Provincial and District offices would visit the hospital to familiarise themselves with its

operations. One respondent pointed that one such visit resulted in the hospital receiving a new operating table, which went a long way to ensuring that patients who needed minor surgical operations were treated within the hospital and not referred. However, it was not clear whether monitoring and evaluating PRC implementation was considered an explicit part of these visits by the officials.

Most of the hospital management committee members said that the CEO, with some of his more senior staff, has been to the local community radio station to discuss the PRC and other policies as part of awareness campaigns. One of the senior nurses noted that the hospital management group promoted the PRC in conjunction with other policies through a number of interrelated activities. She noted that

“We did this by going with management and the CEO to the communities, through the churches where we had health care professionals going to the churches and doing that. We were attending also the tribal meetings whereby in the tribal meetings we were making people know. And we have even taken this further whereby the governance structures that have been instituted in the NW province that is the Hospital Boards, district health committees, and there will also be clinic committees whereby these were also taught or were made aware of the Batho Pele principles and the PRC with the hope that they would cascade this down to the community areas...”

Some of the senior hospital managers said the Hospital Board had been tasked with going to the almost 100 villages and informing community members of the PRC and its impact on the nature and quality of the hospital's services. To supplement the activities of the Hospital Board, members of the management team have also been involved in organising public meetings to which officials from the local municipality and traditional leaders are invited so as to achieve the buy-in of as many stakeholders as possible.

Interviewees also indicated that a number of activities have been undertaken by the hospital to promote both awareness of the policy and to make sure that the policy is implemented effectively. A senior manager pointed out that

“... on introduction there were a lot of activities that were undertaken to educate people about the PRC. One of those elements is to make sure that the Patients' Rights are displayed all over the hospital so that they can be read by everybody – patients and staff. And that is being monitored on a regular basis... As the hospital we purchased the name tags for everybody from the grounds man to myself and it makes the issue about the handling of complaints very easy.”

As is indicated in the above quote, the hospital has bought all staff name tags so that they are easily identifiable to the patients. A senior manager in the hospital stated that this initiative was particularly undertaken to help meet the PRC requirement that *patients should be served by an identified and named provider*.

Despite receiving a limited number of PRC posters from the Provincial Office and not having a budget for printing more posters, the hospital management mobilised funds for printing and translating additional posters so that all the wards at least have a PRC poster both in English and the local language. This mobilisation of funds is not only an indication of the hospital's interest in and commitment to the policy, but also shows how keen they are to stretch themselves to further implementation. Since a large number of the people who come to the hospital are not very educated, the translation of the posters into siTswana makes it much easier for the patients to

read about the Charter and to ask providers what it means. The effort to ensure that there is sufficient and translated posters in all sections of the hospital is also good for equity because even if the staff in the hospital are not actively informing the patients of their rights, the patients who are literate enough to read the posters can get the information from the notice boards and so know their rights and when and how they can exercise these rights. Some of the clinical staff noted that one of the primary aims of the hospital was to make sure that all patients knew about the policy. A senior nurse we interviewed informed us that this is done mainly through posters and

“...around the Charter, the rights themselves they [the patients] are informed through the help desk, through the information the PRC is actually put in all corners of the hospital, all notice and bulletin boards exposed in both languages, English and Tswana for them to understand because our community is mainly Tswana speaking, so that they must understand what the PRC is all about and thus can ask any question to a health care provider in the hospital of the Charter if there is something that they don't understand what that means”.

The active stance taken by management is also evident in how most of the staff in the hospital are to a certain extent conversant with the PRC policy and its importance. This is clearly a gain for patients and equity, especially if the staff practices those rights, as all patients will be treated with dignity and respect irrespective of their background or social standing.

It was pointed out to us by some of the senior managers that the hospital had established an information desk, which is manned by an information officer who assists patients with getting their files from the hospital records room and directs them to the relevant sections of the hospital. Both the clinical and non-clinical staff in the hospital referred to the information desk as an initiative that assisted patients in accessing services. This is clearly an attempt by those managing the hospital to ensure that patients coming to the hospital are receiving timely access to care, which is a component of the PRC policy.

This information officer also attends to patient queries about the hospital's services and also acts as a queue manager by directing patients to different sections of the hospital. A number of nurses also stated that, where time allows, all the staff dealing with patients are expected to discuss some of the components of the PRC and the patients are then expected to sign a document indicating that they have been provided with information about the Charter and that they understand it. It is unclear if this happens as we did not observe it during the time we spent at the hospital.

To complement the activities of the information desk, the hospital management recently instituted a committee made up of both managerial and non-managerial hospital staff. A senior member of the hospital's management committee said that over the years the hospital has been concerned about the time patients spend in queues, particularly in the OPD. The aim of the committee, it seems, is to regularly collect information from patients, primarily in the OPD and casualty sections, on how long they have waited in the queues and whether they have been informed of the reason for the wait. If the information collected by this committee is actually used to ensure that patients face limited barriers to accessing services, then it is a gain for PRC implementation. This is because such an effort addresses patients' right to access health services in a timely manner. It appears that one of the positive outcomes of having such a committee has been the use of staff on duty in particular units as queue managers. This was also raised in interviews as a

clear way in which the hospital is trying to implement the PRC policy. A senior professional nurse in one of the busiest sections of the hospital stated that

“Sometimes, most of the times we try to have a queue manager who is explaining to the patients how our services works, to direct them where to get the file, where to start if it is for the first time you come to the hospital, if the patient is very ill on arrival what to do. We explain to them that if it is for the first time you start with the filing but if you see that the patient is very ill, cannot wait there just call one of the nurses to see the patient so that they can be taken to the casualty for first aid and take the patient straight to the doctor if the doctor is around. Also that queue manager is also expected to explain how are we doing our routine”.

Clearly, there are links here to some of the PRC rights. For instance, the queue manager facilitates quick access to services for patients who need emergency care (the right to timely access to emergency care), while also providing patients with information about where they can get help (the right to information about services). A staff member of the ward is allocated this role on a daily basis and during the course of that shift has the responsibility to make sure that patients don't wait too long. If it happens that she is tied up with something else, we observed that in most cases another staff member takes over that role and continues to assist the patients. This was particularly true of the OPD.

Therefore, it is evident that these initiatives are aimed at ensuring that patients in the OPD are not unnecessarily delayed before being attended to and that they have the information to help them access the services that they need. These are good initiatives in that they assist the hospital in achieving some of goals of the PRC, particularly the right to information and also the right to access services in a timely manner. It also indicates the proactive nature of the hospital's management in ensuring that the problems patients associate with accessing care within the facility are being addressed.

Some of the nurses and auxiliary staff in the hospital also informed us that when patients are admitted, the nursing staff in the wards are expected to give them pamphlets with information on the main components of their care while in the hospital and one of the issues covered in these handouts is the PRC.

Each hospital section has a marked suggestion box into which patients can post their complaints, compliments or suggestions. In many cases, when asked about how the PRC was being implemented, the nurses pointed out that these suggestion boxes had been put up to allow patients to voice their concerns, as a way of addressing the PRC requirement that providers should give patients access to appropriate mechanisms and channels for voicing their complaints. However, most of the nursing staff we spoke to lamented that in most cases patients do not write down their complaints and rarely do they slot them into the suggestion boxes. They also informed us that the keys to the suggestion boxes are kept by a member of the Hospital Board and that it is the responsibility of this person to open the suggestion boxes quarterly. From the information we could gather, it was not possible to determine how well the complaints are addressed or whether anyone within the hospital is tasked with the responsibility of making sure that the complaints are properly attended to.

It is worth noting that the hospital has well-structured complaints handling procedures. Over the entire fieldwork period, staff from various cadre groups said that the hospital's management takes patient complaints very seriously and makes all efforts to ensure that complaints are appropriately

addressed. To this effect, patients who complain when in any of the wards are in most instances directed to the unit head's office where a formal complaint is lodged and written down where necessary. It is then the responsibility of the unit head to either deal with the complaint at that level or escalate it to senior managers, depending on the nature of the complaint. The complaints from the various sections of the hospital are then discussed at the broader management group meetings and appropriate measures are taken to address the complaints from that level. This shows an integrated and proactive approach to addressing patient complaints, adds to the effectiveness with which the PRC is implemented and helps to empower patients.

Additionally, we were told by some respondents and also saw that the hospital collects information from discharged patients about their satisfaction with services, so that it can collate this information from the various wards and perhaps use it to improve service delivery. Giving patients a chance to evaluate the services is a good thing, especially if the views of the patients are taken up by the appropriate managers in order to improve service delivery. It was pointed out by some of the key senior people in the hospital that this information was actually used to feed into programmes aimed at improving service delivery. However, it was not very clear how this information was actually compiled and utilised and the attempts we made to get hold of some of this information failed. We can therefore not make a judgement as to whether this information is actually used or not. Overall however, it is clear that a number of activities have been undertaken at the hospital to try and ensure that the policy's objectives are being achieved.

3.4) Hospital A's PRC Implementation achievements, problems and associated equity implications

One of the aims of the study was to understand if provider-patient interactions influence how patients access services and if these interactions are deemed beneficial and acceptable by patients. In this respect, we used a number of approaches to elicit information from patients about how they felt providers treated them. The majority of the patients we interviewed felt that generally the staff in the hospital had a neutral approach to treating patients in that they didn't favour anyone and that they were interested in helping them get better. Most of the patients reported that the hospital staff spoke to them in a 'nice' way and that they bypassed the clinic to come to the hospital because they were treated 'well' and that *'the hospital is a very nice place to come to'*.

Some patients also pointed out that the hospital staff are not rude and that it is mainly because of this that they keep coming back. Because of the treatment they get it is easy for them to encourage other patients to come to the hospital. Even in our observation, it was evident that most of the staff tried to help patients with whatever they needed assistance with. It is plausible to conclude here that when patients feel welcome, are treated humanely and respected in the facility, they are likely to find it easier to voice their complaints and seek redress, irrespective of their socio-economic status. This will have a positive influence on their right to accessing health care in that it will foster good patient-provider relations and thus create an environment that is more amenable to the implementation of the Charter and the realisation of its objectives.

The information in **Table 6** below provides a breakdown of the achievements of the hospital in implementing the PRC and the potential problems that could arise in relation to implementation, based on observations and information from interviewees.

The hospital has implemented the PRC and to a certain extent has ensured that most of its staff are aware of the importance of the PRC and its intended benefits to patients. Additionally, the hospital management acquired a name tag for each staff member. This makes it easy for patients to identify those treating them and addresses the PRC principle that *“each patient has the right to be treated by an identified/known provider”*.

When time allows and senior/trained staff are available, the hospital conducts training and orientation programmes on various policies (including the PRC) that are aimed at informing both old and new staff about the policies and their roles in implementation. While this is not done regularly, it still supports PRC implementation because staff are kept informed of the policies and are reminded of their importance. Through observation in the hospital, it was evident quite early on that staff had good relations among themselves (within and across cadre groups) and that this was positively impacting on service delivery to patients. On several occasions over an extended time period, staff were seen easily sharing tasks and interacting in a manner promoting team spirit. This was evident in the wards when staff were changing patients' beddings or wound dressings, in the OPD section when staff were retrieving patient files, and in the pharmacy when those on duty were dispensing prescriptions. The positive attitude of staff in interactions amongst themselves was also evident in the way they were willing to assist patients with getting to particular sections of the hospital (e.g. helping with pushing a patient's wheelchair to the ART clinic or taking patient samples to the laboratory). At no time during the data collection process did any member of the research team notice any staff member refusing to help a patient with anything or even shouting at a patient. This paints a clear picture of how good relations among providers themselves and between providers and patients can impact on policy implementation and patient care. Clearly, having such good relations between providers and patients is desirable because patients will respect providers and in return providers will respect patients, which will make realisation of the PRC's objectives easier.

Hospital staff from different professional and cadre groups interact easily and help each other with a variety of tasks. A number of nurses noted that this happens because the hospital is regarded as a *“family”* by many of them and that most of the staff have *“good working relationships with colleagues from all sections because they believe in working as a team”*. This kind of expression was common across interviewees and it was evident that this spirit of togetherness was impacting on PRC implementation. The existence of a caring culture was also seen in the interactions between providers and patients. Across the hospital, staff could easily be observed helping patients and sharing hospital equipment (e.g. microwave and fridge in the ART clinic) with no signs of ill-feeling. This kind of interaction goes a long way in fostering good interactions between providers and patients and hence helps with PRC implementation.

The staff's positive outlook towards the hospital, their work and patient care leads to a desire to provide good quality care to patients. The positive attitude amongst hospital staff towards sharing duties is also good in that it ensures that patients are attended to with minimum delay. The openness of staff and their common expression of empathy towards patients create an environment that fosters good relations between providers and patients and in the long run has positive impacts on general hospital functioning and more specifically on the implementation of the PRC. Where providers are friendly, open and easily approachable, patients are likely to be comfortable with complaining and providers are likely to be willing to address such complaints without holding grudges against patients. This kind of environment is thus likely to empower patients and to foster good PRC implementation. Consequently, providers will not find it a strenuous process to inform patients of their rights and they will also be comfortable with ensuring

that patients are aware of their rights and that they are respected. Providers will try to ensure patients are empowered with knowledge about their health conditions and available treatment options, and issues surrounding participation in decision-making, seeking second opinions and continuity of care will be unproblematic.

The hospital's management team has drawn on many stakeholders to try and ensure that the policy is operationalised. One strategy has been to draw on the influence, resources and networks of the Provincial and District offices in conducting training for key staff in the hospital. These key people have then been used to train staff on how to implement the policy. The hospital has also drawn on local church and traditional leaders and politicians to promote widespread community awareness of the Charter. Key hospital management personnel have been involved in community awareness campaigns with the existing governance structures, one of which is the Hospital Board. In addition, the hospital has asked the District Health Committee to assist the Hospital Board in accessing certain areas and also in promoting awareness of the PRC among the community members. The use of the local radio station by the CEO, supported by board members and senior district officials, to inform community members about various activities and policies at the hospital also adds to the better implementation of the policy. Furthermore, the enthusiastic involvement of the hospital in the COHSASA accreditation process has had significant spin-offs for the operations of the hospital and its ability to meet most of the PRC principles. The fact that the standards stipulated by COHSASA have patient well-being as a focus implies that the hospital's efforts towards achieving these standards have a bearing on how well patients are treated (clinically and interpersonally) in the hospital and helps to ensure that the services in the facility are people-centred. This is the driving principle of the PRC as well.

The efforts by the management, the Hospital Board and the health care providers to make patients aware of the policy and its implications for their access and use of services are important in equity terms because it may make patients aware of their rights. This has the potential to empower the patients and makes it possible for them to voice their concerns about issues in the facility. This type of dynamic is desirable in that patients are likely to find accessing and utilising the services easier as time goes by. Patients are empowered through knowing what they are entitled to and so they can exercise their rights when the need arises.

One of the apparently main problems that impacts on PRC implementation is the issue of staff shortages, particularly in relation to the clinical professions. It was consistently raised by doctors and nurses as a major hindrance. A common argument was that the shortage of staff meant that patients have to wait longer in the queues. Also, because there wasn't enough nurses the PRC requirement that "*staff should spend at least thirty minutes with each patient explaining about the PRC*" was practically impossible to adhere to. This requirement is not explicitly stated in the Charter and it is not clear where the staff got the '30 minutes rule' from.

Table 6: Summary of the PRC policy implementation’s key achievements and problems in the hospital

Question and rights of relevance	Achievements	Problems
<p>Do patients feel providers offer respectful care/treat all fairly? participation in matters of policy and affecting one’s health informed consent refusal of treatment referred for second opinion</p>	<ul style="list-style-type: none"> • Generally, most of the patients indicated that staff in the hospital are friendly, courteous and helpful • Most of the patients pointed out that there was generally no sense of discrimination in the hospital and/or that they had not experienced it personally 	<ul style="list-style-type: none"> • However, there were a number of patients who felt that in some instances patients who knew someone in the hospital and/or were related to hospital staff were accorded preferential treatment. Hospital Board members also stated that they have encountered community members complaining about this, particularly in relation to patients who are known and/or better-off • Though not commonly raised by many patients, some of them felt that staff in specific sections of the hospital (e.g. clerks in the fees office) are sometimes rude to them and this makes them scared to ask for information
<p>Do providers interact with patients (and all groups of patients) in ways that are largely respectful? participation in matters of policy and affecting one’s health informed consent refusal of treatment be referred for second opinion complaints procedure</p>	<ul style="list-style-type: none"> • Staff commonly express care and empathy for patients, saying how important it is that all patients are treated with dignity. A number said that most of their patients are cooperative and friendly, which makes it easy to inform them of their rights • The facility tries to empower patients with their rights and complaints channels are in place • Staff-staff relations are good and this translates into good provider-patient interactions. Staff are generally courteous and approachable, which supports PRC implementation and helps to foster good interactions • Hospital Board members noted that management was concerned about patient welfare and tried its best to ensure patient access to good quality care 	<ul style="list-style-type: none"> • Some of the staff in the hospital feel patients sometimes complain unnecessarily and that in most cases they are “abusive of their rights”. This is problematic and potentially detrimental for equity because if staff feel patients are trouble-makers, they will not want to tolerate and address the patients’ complaints. This could lead to undesirable provider–patient interactions, which in turn would negatively affect how the policy is implemented

<p>Do providers express respectful attitudes towards patients (and all groups of patients)?</p> <p><i>participation in matters of policy and affecting one's health</i></p>	<ul style="list-style-type: none"> • Staff express care and empathy for patients, saying how important it is that all patients are treated with dignity. • Observation showed staff were courteous to all patients There was no apparent patient ill-treatment and staff generally helped all patients as quickly as they could • Patients and Hospital Board members commonly said that staff are willing to assist patients and that management is supportive of patients when they complain and tries its best to address complaints 	<ul style="list-style-type: none"> • Some complained about the approach of fees clerks in dealing with patients who cannot pay fees. Patients who complained about this commonly noted that clerks are not understanding and sometimes rude • Nurses commonly said that patients are quick to claim their rights, but do little to take responsibility for their health. A common phrase was that "patients are abusive of their rights". The researchers saw no abuse by patients. Such an assertion could be used to justify neglect of patient entitlements, leading to poor PRC implementation
<p>Do hospital procedures support respectful treatment of patients?</p> <p><i>healthy and safe environment access to health care knowledge of health insurance be treated by clearly identifiable provider confidentiality and privacy complaints procedure</i></p>	<ul style="list-style-type: none"> • The hospital tries in various ways to inform patients of their rights: PRC posters are widely distributed and each section of the hospital has suggestion boxes. • New staff are oriented on the PRC and this reinforces the importance of the policy • Management has created a queue management committee to try and shorten waiting times • All staff have names tags, which allows for easy identification by patients • The hospital tries to empower patients with their rights and complaints channels are in place 	<ul style="list-style-type: none"> • In certain sections of the hospital (e.g. OPD) high patient loads and long queues can make it difficult to access services. Some staff felt that accessing services was particularly difficult for underprivileged and elderly patients. This problem was linked to some shortages of key clinical staff, mainly doctors and nurses (though other cadre posts were also similarly not fully filled) • Some of the staff we interviewed pointed out that patients who complain are just "difficult and trouble-makers". This kind of labelling of patients is likely to make it difficult for patients to exercise their rights because staff might not take them seriously

The attitude of staff towards the policy and patients also seemed relevant to implementation. Though most of the interviewed staff pointed out that they and their colleagues fully supported the policy, a few noted that it seemed to be a tool for checking up on them and so they didn't really like the idea of it. Some of the respondents also pointed out that in many cases the policy itself was not the problem, but that the problem was rather the failure of the patients to recognise that the PRC rights are accompanied by responsibilities and that they should try and uphold both. It was commonly said in the interviews that patients quickly demand things from providers without taking cognisance of what is expected of them in the Charter. One nurse put it as follows

"You know the patients rights are not that difficult to implement because you know, basically what we do is we make the staff aware that this is PRC and these are the rights of patients and this is how we are supposed to be treating patients. The challenge, I see the challenge mainly from the patients neh, they only look at their rights but they forget that these rights they go hand-in-hand with the responsibilities. The biggest challenge that we have is to maybe link the responsibilities to the rights because now every body knows his right".

This kind of feeling was regularly referred to by nurses as a factor that influences their implementation of the policy. Frustrations arising from patients' selective application of the policy, can lead to staff reluctance in implementation. In fact, it was not uncommon in the interviews with the clinical staff for the phrase *"patients abuse their rights"* to come up as a reason for PRC implementation being regarded as difficult. Some of the nursing staff went as far as saying that in most cases they impinge on their patients' rights not because they want to ignore the Charter, but because the patients are provocative and so the impingement is brought on by the patients themselves.

Patients abusing their rights (and this demotivating staff) was not evident during our stay at the hospital. However, the fact that many of the staff, especially the nurses, consistently pointed it out as a factor that affects how they implement the PRC could also have serious equity implications. It could lead to some of the staff justifying their failure to respect the tenets of the PRC on the basis of their discretionary judgements. Consequently, patients could end up feeling disrespected and dehumanised, leading to a situation where they do not want to use the services of the only hospital easily accessible to them. However, it must be emphasised that the notion of patient abuse of rights did not manifest in staff not listening to patient complaints, mistreating patients or not taking any action to address patient complaints. Staff were proactive in dealing with patient complaints and on some occasions patients could be seen being taken to the Matron's office to get their complaint attended to as quickly as possible. We also did not come across any staff member who abused any patient verbally or denied them care.

Closely related to the issue of staff numbers is the issue of the patient loads in certain units, particularly the ARV Clinic and OPD. The large numbers of patients in these sections makes it difficult for staff to spend sufficient time with each patient and is more likely to increase staff burnout. The high patient loads imply that patients may not be properly informed about the PRC and also that staff might sometimes be unable to spend sufficient time with them to determine their health conditions, leaving patients feeling neglected and mistreated. However, it is important to note that patients themselves felt that there were certain sections in the hospital, for example the ARV clinic and TB ward, where they felt particularly welcome and that they appreciated this. Nevertheless, the high patient loads and the staff burnout have the potential to increase the chances of providers not treating patients well, adversely impacting on the implementation of the policy.

The hospital has been facing some challenges in ensuring that staff are correctly implementing the policy and one of these relates to training opportunities. Many of the nurses we interviewed said that most of the training activities around the implementation of the PRC were undertaken only in the initial years. Since then, few nurses have gone for training and in most cases those that have experience/training in implementation either don't have sufficient time to train their colleagues or the workload is so heavy that staff (even newly recruited staff) cannot be sent on the training programme.

From observation conducted in different parts of the facility, it was evident that providers, particularly the clinical staff, were facing significant barriers to ensuring patient confidentiality and privacy. This was especially the case for the most crowded units in the hospital: the ART clinic and the OPD. The number of patients in these sections was high and the space within which they operated particularly limited. For instance, the OPD section has about 6 interconnected consultation rooms and it was quite common for one to observe a staff member entering one consultation room door and exiting from another. We also observed non-clinical staff opening doors to the consultation rooms when looking for colleagues with little regard for what was going on behind the doors. We also noted that the hospital has a limited number of privacy screens. In some cases, even where they were available, the clinical staff appeared reluctant to use them because of their cumbersome nature. However, the failure to do so is a violation of patients' right to privacy and confidentiality, particularly if they are being exposed in an open area where there are people waiting to see patients or even just in front of their fellow inpatients. Continuing to do so is surely likely to lead to patients feeling 'degraded' and finding the care they receive culturally unacceptable.

Further, we encountered patients who alluded to some of the patients in the queues being accorded preferential treatment, either because the staff knew them or because they were relatives. While we did notice such incidents in the OPD and male medical wards, they did not happen so regularly as to warrant huge concern. It is, however, still relevant to highlight them and their potential equity consequences. Some of the patients also pointed out that there were sections in the hospital where they got better treatment than in others, not because they knew anyone, but just because of the attitude of the staff. The sections in which they felt they got better treatment were the ARV clinic and the TB ward because the staff were friendly and did not shout at them or those escorting them. They felt it was quite common for staff in the Records Office and the OPD to help and/or treat the patients they knew better than those they didn't. A common complaint from the patients interviewed in the OPD was that the clerks in the Records/Accounts Office did not want to listen to their explanations for not having the money to pay fees.

Most of the patients who pointed this out also said it made them feel unhappy, but that there is nothing they can do about it because it was the nearest hospital they could come to and they could not afford the private doctors in town. One patient clarified that this kind of behaviour from the staff in the Records/Accounts Office

"...makes me feel bad and what can I say it makes me feel uncomfortable with myself. I think patients they don't have choice because around this area...it's a rural area and this hospital is the only hospital and then people from near by the rural area they all treated here for their problems, for their different kind of treatment maybe its either HIV or High Blood, Diabetic all kinds of disease all the people around this area around...they come here for treatment, sometimes they get bad treatment because the hospital gets so full of patients"

Patients being given preferential treatment and access to services has negative equity implications in that it means that those who know someone in the hospital will likely find it easier to access services and will likely be treated with more courtesy and respect by other hospital staff as well. These patients might be granted free access to services when they should be paying. Also, it might mean that the clinical staff's triage is not necessarily based on patient need. So, the patients with the least need might be able to access services first, with those with the most need stuck in the queues and unable to access the services in a timely manner because they do not know anyone. Such a 'personalisation' of public services leads to an avoidable skewness in access to services, and unfortunately it is the poor that might suffer most. This is a cultural acceptability issue in that it deals with how patients expect to be treated by providers and how these provider-patient interactions relate to patient perceptions of service quality and the responsiveness of the services to their needs and expectations.

The feeling that some of the patients receive preferential treatment could also lead to unbearable financial burdens for some of the patients who do not receive this kind of treatment. If patients are disgruntled with the treatment they are getting, they might decide to seek care elsewhere. This hospital is the only one located close to most of the community and so if they decide to seek care at another public hospital, the patients will incur huge additional expenditure, which they might not be able to absorb without affecting their well-being. The same is true if they decide to get treatment from the private doctors in town. It is clear that the issue of preferential treatment could over the long term translate into issues closely linked to financial access, which in this case is not about access to exemptions, but about the potential added financial burdens patients face if they decide to seek care from alternative sources due to unacceptable treatment.

The minority of patients who complained about the behaviour of the hospital staff complained mainly about staff not addressing them with courtesy. In most cases they noted that the staff, particularly the fees clerks, were rude to them and did not want to listen to their explanations concerning their inability to pay fees. The patients also noted that this made them scared of complaining and so in most cases they just accepted the bad treatment. This has two equity consequences. Firstly, it means that for fear of potential victimisation, the patients do not voice their dissatisfaction. Consequently, they face the potential of being ill-treated every time they come to the facility and this makes them feel dejected and unhappy. Secondly, it means that even if patients receive the appropriate medical care for their conditions, they still leave the hospital feeling 'uncomfortable' with themselves and unhappy with the way the staff interacted with them. So here, it is not that the patients are not being given the appropriate clinical care, but it is the psychological effect that the process of seeking the care is having on the patients' dignity and self-worth. The result is that some patients will dread going to the hospital and might actually opt to stay at home and self-treat rather than go to the hospital for treatment. The consequence of this is that their access to the facility is affected negatively by the hospital staff's attitude towards them and their health status might actually worsen because of this. These issues were aptly summarised by one respondent who said

"Some patients get bored to come here and you will find that a person is sick but when thinking of coming to the hospital and stay the whole day before you get help, they stay at home and sometimes you find that you don't have enough money to go to a private doctor so you just borrow"

There was also an almost unanimous denial of PRC awareness among interviewed patients. Most of them had not encountered anyone in the hospital telling patients about the PRC and had

no time to read the posters on the walls because they were busy trying to access services. This lack of awareness was quite surprising as it seemed contrary to the number of PRC awareness activities and campaigns reported by other informants. If this lack of patient awareness of the PRC is genuine, then many of the patients at the hospital are disempowered and consequently equity suffers. The patients can only exercise their rights if they are aware of them. Lack of knowledge exposes the patients to potential abuse by staff and makes it impossible for any equity gains to be achieved.

There was also a sense of futility among patients about complaining and whether the hospital management actually did anything to address complaints. A patient who claimed to have been coming to the hospital for some time noted that

“...people will complain outside because they feel there is no one they can come and complain to in here, they will say you know the doctors and nurses of this hospital are doing this and this and we are not happy about their services. They will also say that the hospital does not care for us because they don't do anything when we complain. They will say all this but I have never seen them complain here in the hospital, they just sit quiet and leave after being treated you know”.

The quarterly opening of the suggestion boxes is an impediment to adequately addressing patients' complaints. Patients who feel they could be victimised if they complained verbally are more likely to write down their complaints and use the boxes. Patients who felt more empowered, better-off and confident would more easily voice their concerns and might get them addressed more quickly. Therefore, it is important for the hospital to ensure that complaints, regardless of the channel, are given equal importance and dealt with in a reasonable time. To ensure an equitable process of addressing complaints the hospital and the Hospital Board must develop mechanisms to check the suggestion boxes more regularly. Otherwise the impression might be created that complaints from the most vulnerable patients are not addressed adequately. If this is the case, the PRC requirement that patients' complaints be fully investigated and that they be informed of the outcome of the investigations will not be effectively implemented.

Therefore, many patients were satisfied with how they were treated at the hospital, but some felt they were not treated well. This made them feel bad about themselves and the hospital and its staff. This has implications for how confidently patients can complain and to whom they can complain. If patients have to complain to a nurse who will be treating them at a later stage, they might fear victimisation and so not air their complaints. While it is impossible to avoid interpersonal dynamics in patient-provider interactions, it is important that both parties recognise the need for respect and dignity. This will not only play a role in the effective implementation of the PRC, but it will also foster beneficial provider-patients relations. Nonetheless, the kindness and understanding displayed by most staff implies that patients are, more of than not, treated with courtesy, respect and dignity and that, in the event of patient complaints, staff will try, within certain constraints, to ensure that these complaints are addressed.

SECTION C: CASE STUDY – HOSPITAL B (WESTERN CAPE)

1) Hospital B's local context

Hospital B is located in one of the 5 districts in the West Coast region of the Western Cape. The district population is estimated at 72113, of which approximately 72% are coloured, 17% black and 10% white (Statistics South Africa 2001).

The district is an important wheat producing area and agriculture is the dominant economic activity. Migration, predominantly from the Eastern Cape, is an important factor driving local population growth and is expected to put pressure on the district's essential services. Unemployment in the area is high and the area is characterized by seasonal employment due to the dependency on agriculture. Employment and income levels tend to be defined along racial lines, with whites (60%) and coloureds (40%) dominating managerial positions. Whites and coloureds also tend to occupy more of the clerical and skilled jobs and coloureds and blacks predominate in the unskilled categories. Approximately 8% of households in the district are dependent on social grants and transfers (e.g. state old age pensions, disability grants, child support grants etc.) (Municipality 2007). Although the road infrastructure is well maintained and well linked to the surrounding towns, public transport is poor, with heavy dependence on mini-buses for the lower socio-economic groups (Municipality 2007).

The West Coast region has 5 health districts. There are district hospitals (seven level-1 facilities) in the region, including Hospital B. The West Coast Health Directorate is tasked with the implementation, co-ordination and evaluation of district-based services.

2) Description of Hospital B

Hospital B was established in the early 1920s and extended in 1946. It is located in a middle-class white suburb approximately 1.5 km from the town's main road. Its target population consists of people from five smaller towns approximately 30-40 km away. People from these towns travel town by mini-bus and often walk from the town centre to the hospital. There are mini-buses that travel to the hospital, but patients feel this is expensive. Prior to 1994, the hospital served only the coloured and white communities. At the same time, services in the hospital were segregated by race, i.e. there were separate inpatient and OPD services for coloured and white patients.

Hospital B has a bed capacity of 85, all of which are active and spread across the surgical (12), medical (35), paediatrics (25) and maternity (13) wards. Three of the beds in the medical ward are classified as private. The hospital consists of an outpatients department (OPD), as well as a casualty, general, day, maternity and paediatrics ward. The day ward was a general men's ward, but was under-utilized and has been converted. The hospital has a bed occupancy rate of 70%. This is relatively low and is a result of under-utilised beds in the paediatric ward. Currently, the hospital OPD does not function fully as a paying facility, but operates as a free primary health care clinic. The main referral primary health care facility is not recognized as such due to vacant posts and insufficient capacity to provide a full range of services. It is being upgraded and in the interim all the primary care services provided in Hospital B's OPD ward are free. It is mainly for this reason that H1 patients, who normally pay a R20 fee, are exempted. For the 2005/06 financial year the hospital had an operating budget of R28 million.

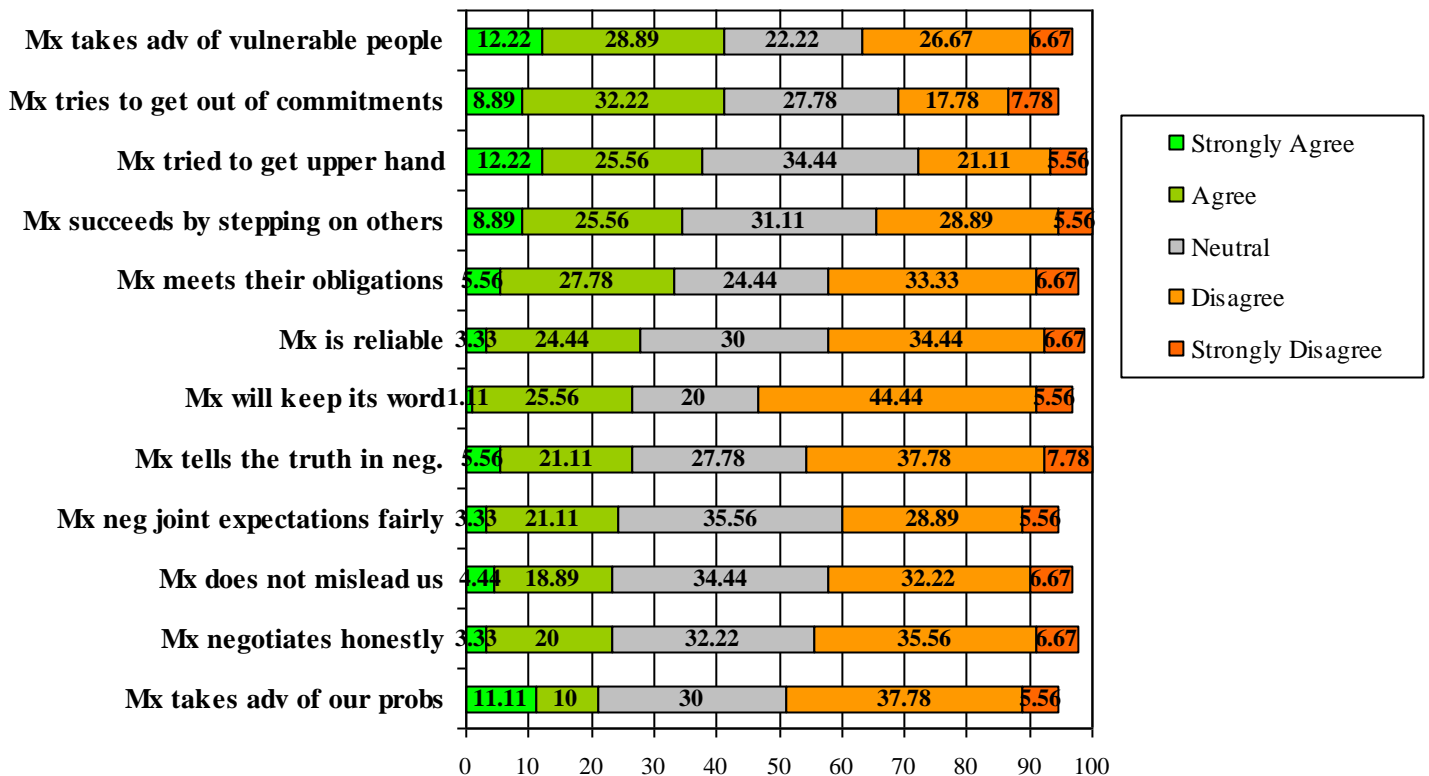
Hospital B is the main referral facility for the 12 fixed and 4 mobile clinics in the area. The main level-two referral facility is Paarl Hospital and Tygerberg is the primary tertiary referral facility. There are 222 posts (193 filled). In line with the province's "Health Care 2010" agenda, which calls for significant restructuring of all public health services, it is anticipated that only 12 of the 29 posts will be filled, with the remainder being frozen or abolished.

A core part of the study was to understand the hospital's culture and staff trust in management and how this influences facility functioning. The results of the questionnaires completed by staff are shown in **Table 7** and **Figure 3**. Table 12 shows the comparative strength of the rational cultural type, combined with fairly equal mixtures of the other three types. Figure 3 shows fairly modest levels of trust in management. On a number of questions, more respondents than not answered in a way that indicated a lack of trust.

Table 7: Distribution of organizational survey results for Hospital B

<p style="text-align: center;"><u>Clan (22%)</u></p> <ul style="list-style-type: none"> • Cohesive, participative • Leader as mentor • Bonded by loyalty, tradition • Emphasis on morale 	<p style="text-align: center;"><u>Developmental (15%)</u></p> <ul style="list-style-type: none"> • Creative, adaptive • Leader as risk-taker, innovator • Bonded by entrepreneurship • Emphasis on innovation
<p style="text-align: center;"><u>Hierarchical (20%)</u></p> <ul style="list-style-type: none"> • Order, rules, uniformity • Leader as administrator • Bonded by rules, policies • Emphasis on predictability 	<p style="text-align: center;"><u>Rational (43%)</u></p> <ul style="list-style-type: none"> • Competitiveness • Leader as goal-oriented • Bonded by competition • Emphasis on winning

Figure 3: Trust in management



3) Hospital B's management structure and communication strategies

The senior hospital management comprises the medical superintendent, the hospital secretary and the matron.

The superintendent's key functions include providing the link between the hospital and the regional and provincial departments of health, as well as planning, evaluating and monitoring overall hospital functioning. In addition to these responsibilities, he/she fulfils a clinical function and also works in theatre. The hospital secretary oversees the administrative section, is responsible for the budget and expenditure, labour relations, recruitment and selection and for overseeing certain departments (grounds, maintenance, laundry and workshop). In the absence of the medical superintendent, the hospital secretary is the acting head of the hospital. The matron's key function relates to the functioning of the wards and she has overall responsibility for the nursing personnel, including performance, personnel development, disciplinary actions etc. She is supported by two area managers. One is responsible for the OPD, casualty, inpatients and theatre wards and the other for infection control, house-keeping and the maternity and paediatric wards. The area managers meet with the matron daily to update her.

3.1) Communication

Communication in Hospital B occurs at several levels, described in greater detail below:

- Between the hospital and the community/regional/provincial office
 - Between senior management and departments/wards
 - Between departments and wards
 - Within departments and wards
 - Quarterly meeting with head office
-
- **Between the hospital and the regional and provincial offices:** The medical superintendent works closely with the hospital secretary to prepare quarterly reports for submission to the regional office. These reports give an account of expenditure for that quarter, the general performance of the hospital and hospital statistics and are discussed at the quarterly meetings with the regional director.
 - **Monthly finance meeting with provincial department:** Each month, the hospital secretary meets with the finance officer from the province, the regional director for health and the region's deputy director for finance to discuss monthly expenditure and projections for the following month.
 - **Hospital board:** The board meets every 2 months and comprises 4 community members, the matron, medical superintendent and hospital secretary. The meetings are well attended and if a member fails to attend 3 consecutive meetings, he/she is removed from the board. This has not happened recently. The board members also do ward rounds and speak to the staff and patients about various issues. Generally, this is followed by a report that is circulated to the board and discussed at the following meeting.
 - **Top management meeting:** This meeting occurs once a week and is for the medical superintendent, hospital secretary, matron, senior administrative officer and unit heads of infection control, supplies and stores, and the kitchen.

- **Quality assurance meeting:** The Quality Assurance Committee meets every 2 months and comprises a hospital board member chosen by the hospital, the case manager, matron, medical superintendent, senior radiographer, social worker and hospital secretary. Its standing agenda deals with hospital statistics, patient and staff satisfaction surveys, performance improvement and the regional quarterly reports.
- **Quarterly staff meetings:** These have been taking place since November 2006. It was considered important to introduce this meeting in the hospital because the staff had complained that they were left out of decisions affecting them. It is anticipated that the quarterly meetings will help improve communication between general hospital staff and the senior management.
- **Financial Control Committee:** This committee meets once every 2 months and was introduced by the hospital secretary. Every department (ward clerk and sister) prepares a spreadsheet of their expenses and this is compared with the hospital secretary's. All departments in the hospital are treated as cost-centres and this meeting is an opportunity to explain and project their expenditure. The hospital secretary admitted that the departments found it challenging in the beginning, but now they *"have ownership and on every cent that they spend and they query why they are being charged. They are more aware of what they do and their money and what things costs."*
- **Meetings between hospital secretary and departments:** The hospital secretary meets with various departments (laundry, workshop and different sections) once every 2 months. She is also required to meet with the finance and fees department, but this often does not happen since they work pretty well. Also, being located in the same building means that they speak to each other daily.
- **Nursing staff meetings:** The newly appointed matron has changed this meeting, which used to be attended by only sisters, to include all nursing staff. She refers to it as an *"information and open meeting"* where all nursing staff have the opportunity air their problems and concerns in an open environment.

4) Implementation of the UPFS policy in Hospital B

The UPFS was implemented in the Western Cape in 2002. In September 2006, tariff codes were revised to address the codes which were problematic for the medical schemes to process payments to the public hospitals. The September revision also addressed the issue of consistency across the 9 provinces in terms of tariff codes that appear on invoices. The Western Cape has updated the tariffs with effect from 1 April 2007, but only in respect of the maximum tariffs. Maximum tariffs are charged to those who exceed the means test and those who are members of medical schemes and other funded patients. Clearly, this has benefits for the patients qualifying for subsidisation.

4.1) Hospital B and the UPFS implementation process

Hospital expenditure in the financial year 2006/7 was approximately R28 million. Treasury set the hospital a revenue target of R1,641,000 and it received an income of R1,661,218.88 (an 'over recovery' of R 20 218.88). A senior manager attributed this to the "*good team work of the fees department*" in following up unpaid fees, particularly those arising from the Department of Correctional Services. There were also rumours from staff that failure to meet the budget can impact directly on the medical superintendent's performance appraisal and salary. There is confidence that, with the recent appointment of the case manager, the hospital's UPFS income will increase.

In 2006, there were 6,955 admissions of which 58% were H0 and 35% were H1-HF. Discussions with staff suggest that H1 patients are the "*main culprits*" in terms of bad debts. One staff member said 80% of bad debts are attributed to H1 patients. This clerk also claims that many of those categorised as H1 reside in an informal settlement on the outskirts of the town, which is home to migrants from mostly the Eastern Cape. The clerk also maintains that since postal delivery service to this area is poor and patients are often unable to provide postal addresses, follow-up on unpaid fees is difficult.

Patients start arriving at the OPD from 6:30 am. The clerks arrive by 6:30 and the first thing they do is to hand over the files for the booked patients to the nurses. Booked patients are those who have either made an appointment to see the doctor or are there for the specialist clinics, e.g. paediatrics and internal medicine. Their folders are retrieved the day before. The fee for an appointment is R20 and on each day between 8-10am one of the doctors is dedicated to seeing ten patients with appointments. Many of these patients are farm workers and the elderly from the old aged homes.

Before seeing clinical staff, the patients first meet the admissions clerks. The clerks are based in the OPD and work a 7am-7pm shift. They are relieved by night clerks based in casualty and working the 7pm-7am shift. The day clerks work in OPD from 7am-4pm and from 4-7pm in casualty. After 4pm, patients go directly to casualty. The OPD has 3 clerks: one is responsible for referral patients coming in for X-rays, follow-ups with the doctor and those with bookings; one deals with new patients; and the third retrieves patients' records. Outside the admissions office, is a reception room for 7-8 people. The admissions office has 2 reception windows that are staffed by 2 clerks. The clerk at the 1st window receives patients with appointments and referrals from GPs or clinics. The 2nd clerk receives patients who are there for dressings, X-rays, physiotherapy, dental care, casualty and any other queries. Outside each of the windows is a box in which patients drop their patient cards. This determines the order in which they are seen.

Once they have dropped off their cards, they wait in a waiting room that can accommodate up to 60 people. If patients did not bring their cards, they have to provide their name, surname and date of birth and the information is then recalled on the electronic system. The waiting room is often over-crowded with the result that many of the patients wait outside. This poses a problem since they sometimes miss hearing their names being called. The OPD now has a microphone to amplify the voices of the clerks.

There was no evidence of queue jumping or patients being given preferential treatment either by the admission clerks, nurses, doctors or the pharmacist. It would seem, however, that not all

patients are aware of or understand the appointment system and this could lead to a perception that certain patients are given preferential treatment.

The patient cards are then given to the clerk responsible for retrieving the patient folders. If he is very busy, another clerk will assist him. The folders are then handed over to the admissions clerk who recalls the patient for the verification of his/her information. Patients must show proof of income and identity, as well as their AllPay, pension or disability card or latest bank statement. If married, proof of the spouse's income must be shown. If patients are H3, the UPFS form is used for OPD. If they cannot produce proof of income, the clerks often use their discretion in deciding. As one of them said, they can sometimes judge by the patient's age whether he/she is a pensioner and if a patient is young and without proof of income, the patient will be placed into the H1 category. The criteria that the clerks use in making these judgements are elaborated below.

If patients have unsettled accounts, the clerks remind them of this and ask that they arrange for the account to be settled. Based on observations and patient interviews, the clerks are seldom rude, discourteous or aggressive when reminding patients about outstanding fees. Payments can be made to the clerks or the cashier. Since this verification happens on each visit, patients often complain that it is time consuming.

For outstanding debts, clerks give patients a statement and refer them to the fees clerks. Beyond reminding patients thereof, the admissions clerks are not especially insistent in enforcing that fees are settled. Based on observations, nurses and doctors did not remind patients to settle outstanding accounts. It does not appear as if the clerks' or the nurses' behaviour towards patients depends on the latter's income or account status.

Once the information has been verified, the folders are handed over to two chief professional nurses. They see all patients first before the patients consult with a doctor or the specialist. They take patients' blood pressure and weight and ask them general questions about their health. There are two consulting areas, screened off by curtains, which are referred to as "prep rooms". All patients are seen in the first consultation room and depending on the patient's history the nurses might carry out further procedures. In the second room, injections, pap smears and cleaning of wounds are done.

Once the consultation with the nurse is over, the nurse will decide if the patient needs to see a doctor, unless the patient has an appointment with either the doctor or specialist. If the patient is to be seen by a doctor, his/her folder is placed on a table outside the doctors' consulting rooms. There are benches outside the doctors' and specialist's waiting rooms where patients wait until called by the doctor. After this, if patients need medication, they are directed to the pharmacy. Their folders are handed over to the pharmacist and the patients wait on benches outside the pharmacy to be called.

If necessary, the OPD clerk sets up a referral to another hospital. The ward clerk is also responsible for setting up appointments for specialists and returning patients. If a patient needs to be admitted, she liaises with the ward clerks and a porter then accompanies the patient to the ward.

The OPD also provides medications for patients with chronic ailments and it is common to see these patients coming in throughout the day, despite being scheduled to come between 7:00-8:00. Unlike other patients, they go directly to the nurses. Although we often saw the nurses

interrupting their work to attend to them, the nurses did not complain. The nurses check their prescription before sending them to the pharmacy. The nurse also reminds them of their next visit and these patients consult a doctor every 6 months. Their folders are kept separately and they are referred to as the “Monthly Medications”. They do not pay for their medication.

The role of the case manager is critical in ensuring that paying patients are billed correctly. The role of this person, according to one of the respondents, is to ensure that *“Everything that is charted, all the medicines, prescriptions, procedures, otherwise we lose out”*. Paying patients include H3 patients and those covered by the Road Accident Fund and the other government departments (e.g. Department of Correctional Services and South African Police) who are billed for the full costs as per the UPFS guidelines. It is the responsibility of the admissions clerks to verify the income status of patients when being admitted. If they are categorised as H3, they receive a UPFS form which is attached to their patient folder. Every morning, the case manager calls the ward clerks to check if any UPFS patients have been admitted. If UPFS patients have been admitted, the case manager meets them and explains to them the billing system and if they are medical aid patients, she verifies their authorisation. Theoretically, it is the responsibility of each department to chart all procedures that the patient receives. In the wards, the sisters are responsible for charting all procedures. In practice, this often does not happen and it is the responsibility of the case manager to follow this up. Once the patient is discharged, the case manager reviews the form and ensures that all the information is recorded and correct before assigning an ICD10 code. The form is then processed by the billings clerk who prepares a statement of account. This is sent directly to the medical insurance, the government department or the patient.

When the fee system and private beds were first introduced, the emphasis was on making the wards more attractive and acceptable for private patients. For instance, a TV, new and different linen and curtains were introduced into the private rooms along with different cutlery and crockery. However, there is low utilization of the private beds, with the result that often when the wards are full, the private beds are used. Over the years, the staff appeared to have lost interest in ‘maintaining’ the private beds. The allocation of these beds to non-private patients is not based on any specific criteria and patients who are allocated to these beds do not receive preferential treatment.

4.2) UPFS and exemptions

As noted earlier, the hospital’s OPD operates as a free primary care facility. Therefore, all non-specialist services are free for subsidised patients. For specialist services, H1, H2 and H3 patients are required to pay according to their fee category and H0 patients are exempt. If H1, H2 and H3 patients present for non-specialist services at casualty after 4pm or are admitted for inpatient care, they are required to pay.

The OPD’s status as a free PHC affects how patients with insufficient proof of income are classified. According to the UPFS, H1 is the default category for such patients. However, the hospital practice is different and moreover dependent on whom we spoke to. According to admissions clerks, patients without proof of income can be classified as either H2 or H3. However, a fees clerk claimed that all patients without proof of income are classified as H3. This was justified on the basis of past experience of patients who provided fraudulent affidavits as

proof of their unemployment. However, since the onus for patient classification rests with the admissions clerks it would appear that the practice of classifying patients without proof of income as H3 is not followed.

The granting of exemptions depends on the discretion of the clerk and the clerk's perception of the financial and employment status of the patient. Therefore, even if an OPD patient appears to be a pensioner or a recipient of a disability grant, unless they provide the information the patient is classified as either H2 or H3. For patients claiming to be formally unemployed and without sufficient proof of income, an affidavit is no longer sufficient as support for those claims.

Unemployed patients with insufficient proof of unemployment status, the self-employed and those with outstanding debts are referred to the fees clerks. They have to complete an income and expenditure form (IEF) which in addition to requiring biographical information also requires the name of the employer (if there is one) and proof of accounts (e.g. electricity bills, clothing accounts etc). The IEF is intended for assisting indebted patients to structure their instalments in an affordable way. However, the hospital's use of IEF is outside of UPFS guidelines and it appears that it is being used as a tool for means testing. Although the clerks claim that this seldom happens, if patients are unable to provide proof of income and expenditure, the patient remains classified as H3. However, this can be revised depending on the discretion of the clerk. For instance, if the patient is *'familiar'* to the clerk as a *'local farm worker'*, the clerk will revise the patient's category accordingly. Based on the burdensome documentary proof and the discretionary power of the clerks, unless patients can prove otherwise, they remain classified as H3 and accumulate debt. This is clearly a barrier to access.

Based on observations, patients are never denied care but reminded that they have to provide proof of status on their next visit. Once they provide proof, the clerk revises the classification and informs the fees office to make the necessary revisions. We observed several patients disputing their accounts. The clerk told them that unless they produced their AllPay card and identity document, their accounts could not be reversed.

The clerks' perception is that patients often try to *"cheat the system"*. The clerks mentioned the example of a patient who was admitted and insisted that he was a state patient, although he had no documents as proof. His wife came later and told the clerk that her husband, although unemployed, was a dependent on her medical aid and told the clerk that he *'should not believe everything that patients say'*. This stereotyping is an exercise of power on the part of clerks and is another example of an access barrier.

During one of our visits, a patient and his spouse arrived at the OPD. He had no proof of income and told the clerk that both he and his spouse worked and that their joint monthly income was ± R5000, which would place him in the H2 category. However, the clerk classified him as H3 and promised to revise this to H2 once the patient provided the necessary supporting documents. It therefore appears that clerks, in the absence of proof of income, and depending on their judgment of patients' appearance (race, dress etc.) and information gleaned from them about their employment status, residential location and overall socio-economic status, will classify patients into a higher payment category. The onus then rests on the patient to rectify the situation.

4.3) Hospital B's achievements associated with implementing the UPFS policy

If the main objective of the UPFS is income generation against a revenue target, this has been met. There is clear direction and support for the policy from management, particularly the medical superintendent. This is demonstrated by the setting up of processes to ensure that the hospital meets its target and that fee generation is a core objective. The absence of a case manager was regarded as a key obstacle to ensuring that paying patients are appropriately billed. The recent appointment of the case manager is expected to resolve this problem and in some ways to relieve the duties of the ward sisters in ensuring that UPFS forms are correctly filled in and the task of the medical superintendent and billings clerks in assigning ICD10 codes.

The provincial department of health has supported the hospital with monitoring and evaluation and training sessions, although this has met with a mixed reaction from the hospital staff. While the fees clerks find it useful in terms of increasing the efficiency of their work, the admissions clerks have found it less useful. Their reasons are unclear.

4.4) Problems and challenges associated with implementing the UPFS policy

The policy faces a number of challenges. On the hospital side, senior management perceives the admissions clerks and nurses as not being cooperative and supportive enough. Similarly, interviews have revealed that clerks feel under-valued and the nurses view the UPFS-related tasks as not their primary responsibility. Patients are aware of the fee system, but there remains a large gap in understanding how it works in practice and, more importantly, its implications for them. More specifically, many patients are unaware of the categories of patients qualifying for exemptions and the differences between various categories. This is discussed in greater detail below.

4.4.1) Cooperation between the case manager and other staff

At the outset, it is important to note that senior managers in the hospital support the policy. One of these senior managers said the following:

"It is a policy that I have been interested in from the start. I went to the initial training and I am very much interested in this policy."

Despite such support, including the support provided by the medical superintendent, the implementation of the UPFS in the hospital has not been smooth. Some managers share the view that staff members are not motivated and do not realize the importance of the policy. One of the respondents had the following to say about the admissions clerks:

"...admission clerks working in OPD don't get the initial information right. We tried from the start to motivate them. Without them, and the initial info that they put in the system is so important, tried to impress upon them how important they are. Didn't make a difference, we still struggle with them."

In addition, the case manager in particular seems to be meeting with resistance. Some of the sisters regard her role as interference in ward affairs. One view is that the forms are relatively easy to complete and that steps have been taken to make the process easy for sisters. However,

a sister remarked that while the form is easy to understand, they are short staffed and the UPFS forms are kept in their offices and they can't always remember to fill in the form. She felt that they need more sessions where everybody comes together and the UPFS is explained. Another sister remarked that since the case manager was previously a theatre nurse, she does not have an understanding of the responsibilities of working in the wards and an appreciation of the constraints on their time. In addition, nurses are emphatic that their primary responsibility is patient care and that administration, while important, is not their priority. Interestingly, they responded similarly to the study questionnaires, further suggesting their wariness of documentation and that they do not see it as integral to their responsibilities. One strategy to offset this resistance is for the medical superintendent to accompany the case manager on ward rounds. This might boost the latter's credibility. In January 2007, the medical superintendent sent a memo to all wards informing them of the role of the case manager and requesting their cooperation. It is too early to say if this has been effective.

A common complaint from ward sisters and some of the more senior managers is that the admissions clerks do not always include the UPFS form and that paying patients are consequently not always identified. From their side, clerks complain of feeling under-valued and not being consulted in decisions that affect them.

4.4.2) Level of patient awareness of the fee system

A total of 18 patient interviews were done: 8 in OPD, 8 in Ward A (inpatient) and 2 in the maternity ward. All but one of the patients were aware of the fee system, although many did not seem to understand how it worked in practice. Below are some of the responses:

- *"I just heard that you must pay according to your illness."*
- *"All that I know is that they work it out according to your salary".*
- *"Well, its according to your wages, I think to how many children you have. And unemployment you pay differently. I don't know anything else."*
- *"I'm aware that if you are working then you have to pay. That I'm aware of but I can't pay, I really can't pay. I am classified as an old age pensioner and I have an All-pay card."*

One of the respondents appeared to have a more comprehensive understanding of the system and was aware of his payment category:

"I get a disability grant, I'm a H1 I think which means fees are very negligible. I don't know anything about if I was a private patient. I know nothing about how they would charge you then."

When queried about the exemption system, there was a broad range of responses spanning those who were ignorant of the categories to those who were able to list in some detail the groups who qualified for exemptions:

- *"I would say it is those who used up all their money. If you have used it all up with what are you going to pay?"*
- *"Its people who gets disabilities. People that don't work. I think so."*
- *"The old people who receive pension grant, they don't pay."*
- *Those are the people who have to sit those long hours. I think its people who's unemployed or just don't want to pay.*

- *“It is people with TB. Remember that people with TB must take treatment. I do see a person with TB here when they are talking.”*

When asked about the objectives of the system and the use of the money, several patients said that they did not know. Others felt that it is used to cover the hospital’s expenses, whilst others felt that it was collected by the government to pay for other services such as pensions.

This poor level of awareness of the UPFS system was also borne out by observations in the inpatient wards, where patients were unaware of how it affected them. For example, a pensioner with diabetes who has been to the hospital several times was unaware of the entitlement to free care. Also, a farm worker who was admitted and classified as an H1 patient was unaware that he was expected to pay R35 for his hospital stay. Although clerks have claimed that when admitting patients, they explain the fee and exemption system and if patients are H1, they issue them with a bill for R35 immediately, this does not appear to be well understood by patients. This is not helped by the fact that there is little information in terms of notices, posters or pamphlets around the hospital. That is, there is no information on the groups of people entitled to free services. Such examples suggest that either the clerks or more generally clinical staff do not explain the fee and exemption system to all patients or that the information needs to be communicated differently. The extent to which language congruency or lack thereof is a factor in the communication and information needs to be considered. Observations of the interactions between patients and clerks found that there is a significant exchange of information relating to the verification of the patient status (i.e. identity, income etc.), but this did not include an explanation of the different payment categories or the exemption system.

The poor awareness of the fee and exemption system and the burdensome process for proving income status need to be considered alongside the socio-economic profile of the population. The district is characterized by high levels of unemployment and when there is employment, it is mainly seasonal in nature due to the dependency on agriculture. In addition, there is a high level of dependency on social grants. Therefore, from an equity perspective, the administrative practices underlying the implementation of the fee and exemption system make them particularly difficult for lower-income patients to access.

4.4.3) Raising awareness of the UPFS/exemption system in Hospital B

Discussions with some of the staff involved in UPFS implementation suggest that the main ‘*culprits*’ in terms of bad debts are the H1 patients living in an informal settlement on the outskirts of the district. Residents of this settlement are recent migrants from the Eastern Cape. Given the poor postal delivery service to this area and the lack of postal addresses, follow-up on fees is difficult. The hospital management regards the appointment of the case manager as an important step in ensuring that private patients are correctly billed. However, this addresses only partially the challenges identified in the fee system and it is not clear how other challenges (e.g. lack of cooperation from staff and awareness raising around the UPFS) will be dealt with.

The hospital management has indicated that awareness of the UPFS in the community, particularly the black community, remains poor. This has been partly attributed to the absence of a Community Health Forum that can be a platform for raising awareness. The hospital’s last effort at awareness raising occurred more than 2 years ago. In the past year, two Xhosa-speaking admissions clerks have been appointed and this has been in response to the increasing number of Xhosa-speaking patients being seen at the hospital.

The hospital board also has an important role. However, interviews with board members point to a low level of awareness of the fee system, with responses ranging from ignorance to vague understanding. Hospital board members have also indicated that their interactions with patients during hospital visits have not touched on the fee system. The hospital board includes members of the coloured and white communities and they have a range of professional backgrounds (e.g. retired teacher, private doctor, accountant, CANSA co-ordinator). The absence of a black board member is worth noting. It is possible that this absence is an obstacle to reaching out to the black community, which is growing in significance in terms of the patient profile.

In 2004, during Hospital Open Day, an information session on the fee system was held. In the same year, the hospital wrote an article in a local Afrikaans newspaper about the fee system and how it is structured in the hospital. This article also described the amount outstanding in unpaid fees and the responsibility of patients in settling their accounts. If there is truth to the claim that a large proportion of unpaid fees arise from Xhosa-speaking residents living in the nearby informal settlement, they would arguably have poor access to an Afrikaans newspaper. It may then be necessary for the hospital to consider alternate and more accessible means of communication, including awareness campaigns, either through the radio or facilitated by local leaders.

5) Implementation of the PRC in Hospital B

Much of this section reflects expected practice in the province and region and does not reflect the actual practice of Hospital B.

At the provincial level, the implementation of the PRC falls under the directorate for quality assurance. During 2000/1, the Western Cape Department of Health promoted widely the PRC as a key component and indicator of Quality of Care (QoC) among health workers and patients. At the regional level, quality assurance officers are responsible for monitoring and evaluating QoC on a quarterly basis, as well as for undertaking information and training sessions at health facilities. Monitoring and evaluation would for instance include verifying that PRC posters are displayed in the hospital. Information and training sessions on QoC are generally included under orientation programmes for new staff and hence are not regular. During QoC month in October every year, awareness sessions are run and the PRC is integrated with other QoC components. Client satisfaction surveys incorporate questions on access, assurance, empathy, reliability, responsiveness and tangibles³, some of which directly relate to the PRC. For instance, questions on the hospital environment and facilities (comfort, cleanliness and catering) link to the PRC element of a 'healthy and safe environment'. The survey also deals with issues of patient care and treatment (communication, confidence and trust, dignity and trust, information and acknowledging patients), which speak to the PRC elements of access and participation in decision-making. Every district hospital is required to carry out these surveys annually. Although

³ Access refers to the cost and time for patients to use a service as well as hospital hours. Assurance refers to the ability of the service provider to be knowledgeable and to inspire confidence and trust. Empathy refers to the ability to care and display compassion towards patients. Reliability refers to the ability to accurately perform the services offered. Responsiveness refers to the willingness to assist patients and tangibles refers to the quality of equipment and the physical surroundings.

the PRC is regarded as important, it is viewed as one of several components of QoC and hence is integrated with other activities.

The provincial health department issued a circular (14/02/2007) entitled "Implementation and Monitoring of Generic Service Standards: Head Office". This included specific reference to the PRC, also mentioning that it must be "*prominently displayed at all departments and health facilities*". Other statements relating to the PRC include:

- "Signage reflecting available services and service delivery times will be prominently displayed in all 3 Western Cape official languages at all departments and health facilities
- Identification will be worn by employees at all times in all departments and health facilities
- All clients lodging complaints will be provided with a response reflecting the outcome within 30 working days
- All departments will be clean, tidy and conducive to a good work environment".

At the facility level, QoC implementation includes setting up hospital boards, quality assurance committees, a complaints system and annual client satisfaction surveys. While all of these include elements of PRC, they do not focus on the PRC exclusively. For instance, as noted above the client satisfaction survey incorporates questions that link to the PRC. One of the functions of the hospital board is to visit the facility and evaluate it in terms of cleanliness, as well as to speak to patients about the care that they receive. This also speaks to elements in the PRC. It appears that a specific indicator of the PRC implementation is the display of PRC posters in all 3 official languages (Afrikaans, English and Xhosa) at all entry and exit points.

The Health Facilities Boards Act (Western Cape Provincial Government 2001) sets out new governance structures for hospitals with the purpose of ensuring that health facilities respond adequately to community needs. The boards include community representatives from a range of organisations such as development forums, women's and youth organisations, civics, welfare and religious organisations and NGOs.

Based on observations and discussions with hospital management, the display of posters has not been implemented. However, a hospital board has been introduced, quality assurance meetings are held and a patient satisfaction survey was carried out in December 2005. Although patient satisfaction surveys are expected to be carried out annually, it was not carried out in 2006 and the next one was to be carried out in November 2007. A patient complaint system, intended as a feedback mechanism to management, has been implemented by the recently appointed matron (May 2007) and she and the case manager will oversee its implementation. Basically, this will entail responding to the complaints within a month and bringing them to the attention of the hospital board. In response to the early-2007 circular from the provincial department of health, the hospital management noted that all staff members are required to wear name tags as part of the PRC implementation. It was observed that barring a few staff members (nurses in the OPD, hospital matron etc.) most do not wear name tags.

Hospital-wide observations revealed that the PRC was not displayed anywhere. Batho Pele was only posted in the maternity ward. However, in early December, we found that the PRC (in English) had been posted in the OPD waiting room. The Afrikaans and Xhosa versions were absent. In mid-December it came up during a discussion with hospital management and staff that the PRC poster (Afrikaans, English, and Xhosa) will be displayed in the facility. This was

discussed at the last quality assurance meeting in December '06. In this meeting, a copy of the PRC was handed around.

Client surveys (different from annual patient/client satisfaction surveys carried out by the regional office) are intended to be carried out regularly by the hospital to obtain feedback on how to improve services. The client survey form is a single page and the one side is in English and Afrikaans and the overleaf is in Xhosa. The heading of the form contains the statement: *"Batho Pele- People First"*, but makes no mention of the PRC. The form deals with questions of 1) reception/admission, 2) attitude of personnel; 3) handling and nursing care in all departments and 4) neatness/hygiene in departments. The form makes provision for poor literacy by allowing for figurative responses.

Although client surveys were carried out regularly, particularly in the inpatient wards, over the past year this has become less frequent. The hospital management had spoken to staff about the importance of the surveys and have re-introduced it, but it is still not being carried out. A senior staff member said the underlying reasons are that staff already feel overloaded and also that the surveys should not be carried out by staff who have a direct interaction with the patients (i.e. it is not the responsibility of nurses and doctors). It is not clear who is responsible for carrying out the surveys.

In summary, the PRC has not been explicitly implemented in the hospital although elements of it (e.g. a healthy and safe environment; receiving timely emergency care at any health care facility that is open regardless of one's ability to pay; positive disposition displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance) are being addressed.

5.1) Hospital B's PRC policy implementation achievements

5.1.1) Providers' perspective

Despite the absence of formal PRC training and displays of the posters around the hospital, our overall impression is that the staff are professional and caring in their attitudes towards the patients. This speaks directly to the PRC element of a "positive disposition displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance". Most providers hold the view that treating patients with respect and dignity is part of their training, which suggests a positive ethic of care.

There were also several examples of positive staff attitudes across all cadres towards patients, particularly those who appreciated the care received at the hospital:

- *"Patients write beautiful letters to the hospital about how we treat them and about the cleanliness of the ward. It makes me feel proud. It does not happen a lot."*
- *"Patients thank us in local newspapers and bring cake and thank you cards."*

Hospital B is clean and neat and has received an award for this. The toilets in the inpatient wards are clean and all areas are swept and mopped. The wards are neat and patients commented that their sheets were clean and that they received good food. The notice board contains a letter,

dated 28 April 2005, from a patient thanking them for the care received at the hospital, the cleanliness of the facility, the professionalism and general care of the staff. This again links directly to the PRC element of a “healthy and safe environment”. The recognition of the hospital by the public and its public image is clearly valued and important to all staff. As one of them remarked:

“Some patients place good reports in district newspaper about good treatment and care of personnel. It happens on a regular basis, also about the cleanliness of the hospital. it gives a warm feeling to my heart. If the public hears negative things about the hospital, they won’t come here.”

5.1.2) Patients’ perspective

Based on interviews and informal discussions with patients, overall impressions of treatment received are mainly positive and complimentary. There were complaints about the waiting time, but when queried about staff, most patients were complimentary in their responses:

“I’ve got no problem with the staff. The people are nice here. The doctors would say “can I help you”. He will ask me what’s wrong with me today. And he’ll look through the file. Then I must talk to him what’s wrong with me.”

Generally, patients felt that everyone was treated equally, irrespective of race, as illustrated in the following quote:

“There is no racism here. I feel convinced of it. Even if it’s not a European doctor or a white man, or a black doctor or an Indian or whatever. All the doctors they treat you with respect and I think that’s what causes the public to also treat them with respect”
“They receive the same treatment, everyone, white or black”.

Some patients had the following comments about admissions clerks:

- *“Sometimes the clerks are very outspoken.”*
- *“They are very friendly and they will help you as soon as possible. They are the same with everyone. You must wait your turn. Look they do it as quickly as possible”*
- *“They alright because when I came here for the first time they explained and they ask you out about your salary and where you’re working.”*

Therefore, despite there being a lack of formal implementation of the PRC, elements of it, particularly those relating to patient-provider interaction, are intrinsic to general patterns of care in the hospital.

5.2) Hospital B’s PRC policy implementation problems and challenges

The poor implementation of the PRC in the hospital can be interpreted in several ways. At worst, it may be interpreted as a denial of that right. At best, it may be viewed as an attempt by the hospital management not to promise what cannot be delivered, based on what is perceived as an

unrealistic and unworkable policy. In this section, the implications of this lack of implementation are explored.

5.2.1) Lack of support and direction from hospital management

Possibly the single largest challenge to the policy's implementation is the lack of support from hospital management:

"Nice in theory, but doesn't work in practice. You will never see the PRC up in my hospital...there is an over-exposure to information...it is a difficult one, it is far too comprehensive, and even if we stick it on the wall people won't read the 1st 2 sentences and they won't know what it is about because it is complicated and convoluted and it is not something that we can adhere to. In 2003 we considered putting up the PRC and we didn't have a Xhosa version and after that I felt let's stick to Batho Pele (BP). And also casualty is so full of forms, "from anything to don't spit and don't bring your fire weapons, there is an overload of information and people, even my staff don't read the notice boards. We should display a few core messages like, where to get the contraceptive pill" which should be in bold language as simple as possible."

It is curious that the regional quality assurance officer who does quarterly monitoring and evaluation across facilities has not noticed the absence of posters, which is part of a check-list of points to look out for. It is not clear whether the absence of posters was raised with hospital management and they have ignored it or whether the quality assurance officer noticed the absence but did not bring it up with the regional office or hospital management. Another possible explanation is that the absence of posters was noticed, but that the regional office might also concur with the hospital management that the display of posters is unnecessary.

It can be argued then that the lack of implementation and institutionalisation of the PRC, which is intended to empower patients, can have the counter effect. The effect is likely to be more profound for those who already have a low awareness of general civil and political rights. In such instances, patients with low levels of awareness of their rights as citizens more generally, and patient's' rights more specifically, are unlikely to raise issues which might be of concern to them for reasons of fear or because they are not aware of their rights. Based on the interviews, there did not seem to be evidence of this, suggesting a need for further interviews that focus specifically on this issue.

A client satisfaction survey was done by the Regional Department of Health of patients attending the hospital in 2005. An important finding was that communication, particularly relating to language, was a barrier to access. The lack of isiXhosa-speaking providers and its implications for communication was also pointed out in the present study:

"The hospital must employ more Black nurses who understand the Black patients because the nurses call me to explain to Black patients especially those that are HIV positive, about their illness in the presence of other patients in the ward."

While the employment of Xhosa-speaking admissions clerks is important for reducing the barriers identified in the 2005 client satisfaction survey, and more specifically links directly to implementation of the PRC with regard to the right of access to health care, many of the hospital staff including the fees clerks and the doctors and nurses do not speak isiXhosa either as first or second language. However, one of the doctors expressed the intention to study Xhosa in order to

improve communication with clients. The fact that none of the fees clerks speak isiXhosa is an issue of concern, especially since they are dealing with patients with unpaid fees and/or insufficient proof of income and have to be able to explain to them the necessary process for obtaining exemptions and documents for proof of income. It can be argued then that isi-Xhosa-speaking patients will find it more difficult to understand and access the hospital system.

5.2.2) Provider awareness and support of the PRC

The hospital management said staff had received training on Batho Pele, but interviews with staff showed that many had low levels of awareness of both Batho Pele and the PRC. Most of them had heard of the PRC but were less familiar with its specifics, besides knowing that it dealt with the rights of patients. We encountered one senior ancillary staff member who had been at the hospital for almost 10 years, but had not heard of the PRC. Only 4 interviewees were familiar with the details of the PRC. These included a senior member of management, 2 principal medical officers and a CPN. Staff mentioned specifically issues of confidentiality, informed consent and continuity of care.

Despite these low levels of awareness, most of the interviewees had strong views of the PRC or at least what they understood it to encompass. They agreed that it is important for patients to know their rights, but shared the view that the PRC ignores the rights of providers. The impression was that although there was no formal display of the PRC, patients were very much aware of their rights, and often reminded providers of it.

There also seems to be tension between the perceived rights of the patient in relation to providers. Staff complained that their needs are neglected and that they are often verbally, and sometimes, physically abused by patients but that they have no recourse:

“Patients can abuse the staff but the staff can’t do anything. How much abuse can nurses take?”
and *“They [patients] sometimes feel that they have the right to abuse us, but sometimes we feel neglected. If people are empowered, it comes with responsibility and I don’t think that people always realize it.”*

In many of the interviews, providers mentioned that patients often do not take responsibility for their own health. In addition, providers felt that their rights also needed to be recognized.

During interviews, when asked who was overall responsible for the PRC, respondents were either unsure and unable to name specific people or responded that everybody was responsible. This is another indication of the absence of implementation, overall lack of interest in the policy and/or the nature of the PRC itself. The diffuse nature of the policy seems to make it difficult to know who exactly is responsible for implementation and monitoring because every person who deals with patients is responsible for implementation in one way or another. Those more familiar with the PRC felt that specific rights (e.g. continuity of care, confidentiality) are more difficult to carry out.

Perhaps tensions in the patient-provider relationship are inevitable and inherent. Moreover, when patients are perceived to be breaching the norms of acceptable behaviour, staff do not feel obliged to be polite and respectful. This speaks to an exercise of provider discretionary power:

- *“Patients who have been drinking don’t deserve respect.”*

- *“If patients are impatient, I tell them: if you want to sit here for five minutes then you must pay GP rates.”*

In addition, there seems to be indications of discrimination and labelling of patients based on their age, race and socio-economic status. Some providers pointed out that

- *“Patients with premature babies have no discipline at the maternity ward. I had to weigh the baby and take off its clothes and the Black mother did nothing. I told her that she must take off the child’s clothes when I’m going to weigh her because it is not my baby.”*
- *“When a patient is Black or Coloured the White Sister will address them rudely and treat the White patients better.”*
- *“Hospital personnel look down on people from the farms. The personnel will allow rich people to put chains around their necks just because they have money. Any person must be treated with respect.”*

In summary, although providers are not aware of all the details of the PRC, they view it with caution because they perceive that it does not protect them. Provider insecurity and uncertainties around the policy inevitably lead to labelling of patients in terms of acceptable behaviour (i.e. cooperative, appreciative, polite etc.) and provides a justification for providing poor quality care. This compromises PRC implementation.

5.2.3) Hospital Board role in PRC implementation

According to the Health Facilities Boards Act, a key role of the hospital board is to ensure that facilities respond adequately to community needs. In relation to the PRC, this would entail working with community members to disseminate the key messages and actively being the link between the hospital and the community. The role of the board seems significantly limited. Interviews with board members clearly point to their lack of involvement in the implementation. Interviews were held with 5 of them and they all said they were unaware of how the policy is being implemented in the hospital.

5.2.4) Patient awareness of the PRC

Many patients felt the need for their rights to be acknowledged. However, when interviewed specifically about the PRC, awareness was generally poor or absent:

- *“Yes, I think patients have the right to ask doctors/nurses why they doing those things. Because they have the right to ask questions.”*
- *“I don’t know. I would like to know what are the rights that a person does have. ...I don’t even know what my rights are.”*

Despite low levels of awareness of the PRC, patients seemed to have an inherent understanding of what those rights should entail:

- *“Just respect me as a person. Communication and everything else will run smoothly.”*
- *“Nurses won’t be able to be rude to them and respect them also. So that is why I think patients must also have rights. So that the nurses can’t take advantage of the patients”.*

In summary, the majority of patients interviewed, irrespective of race, socio-economic background and patient category, report being satisfied with the hospital's services. Patients spoke specially of being treated compassionately and respectfully, although there were a few reports of unfair treatment, based on race and socio-economic status.

It seems that most patients, in a general way, understand that they have certain rights, even if they are unaware of the PRC and its specific rights and responsibilities. They complain if they are treated badly or spoken to disrespectfully and many of them spoke of the right to be treated with respect and dignity. There were, however, several patients who were not aware of even these basic rights and who were eager for information of what they entailed. However, the PRC goes beyond this and speaks to the rights of informed consent, refusing medical treatment and obtaining a second opinion from another doctor. Unfortunately, the interviews were not able to glean this detailed information and the depth of patient awareness is not known.

In conclusion, **Tables 8 and 9** below summarise the equity achievements and problems associated with the implementation of both the UPFS and the PRC.

Table 8: Equity achievements and problems of the UPFS		
Evaluation criteria	Equity achievements	Equity Problems
<i>Are all patients made to pay fees?</i>	<ul style="list-style-type: none"> Irrespective of whether patients can pay the fees or have outstanding accounts, access is not denied People not forced to pay over time, but instead allowed to become bad debts Hospital staff are polite to even those patients who have outstanding accounts 	<ul style="list-style-type: none"> Patients may be categorised as H2 or H3 paying patients (irrespective of income level or employment status) if they do not have the necessary documentation People may come back to pay so as to avoid having a debt and incur overall higher costs People, particularly those in the lower socio-economic groups, may be deterred from seeking care because of lack of documentation or outstanding accounts Lack of information (posters, pamphlets etc.) in all 3 languages on the fee system. Increased reliance on the hospital staff to provide necessary information
<i>Which patients are granted exemptions?</i>	<ul style="list-style-type: none"> Pregnant women Children Social grantees (social pensioners, disability grants, formally unemployed) OPD functions as a PHC service, therefore all PHC services are free/exempt. Fees are linked to specialist services and referrals from private GPs 	<ul style="list-style-type: none"> Exemptions are given but onerous responsibility upon the patients to prove that they qualify for exemptions Poor patient awareness of the exemption system contributes to patient disempowerment Staff do not explain to patients about the exemption system Lack of information (posters, pamphlets etc.) in all 3 languages on the exemption system People may be deterred from seeking care. More inequitable if 'deserving patients' (i.e. H0 patients) are discouraged from seeking care
<i>Are the fees graduated by ability to pay?</i>	<ul style="list-style-type: none"> Fees are graduated by ability to pay. This improves financial access Fees linked to patients providing the necessary supporting documentation (salary/wage statement, AllPay card, bank statement, UIF card) proving income/socio-economic status 	<ul style="list-style-type: none"> The standard categorisation of all patients -irrespective of socio-economic status- without proof of income as H2 or H3 is regressive. It places a higher debt burden on 'deserving' H0 or H1 patients compared to higher income patients Labelling of patients as 'cheats' discourages patients from seeking care
<i>Additional issues</i>	<ul style="list-style-type: none"> No evidence of queue jumping or 	<ul style="list-style-type: none"> Rudeness on the part of clerks towards patients discourages

<i>identified but note they are linked to acceptability</i>	preferential treatment for friends and family of hospital staff <ul style="list-style-type: none"> • Employment of Xhosa-speaking clerks has helped bridge the communication and information gap to patients, particularly for patients who are not conversant in English/Afrikaans 	patients from seeking care
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Table 9: Equity achievements and problems of the PRC		
Question and rights of relevance	Equity achievements	Equity problems
Do patients feel providers offer respectful care/treat all fairly? <u>Relevant rights</u> participation in matters of policy and affecting one's health <i>informed consent</i> <i>refusal of treatment</i> <i>be referred for second opinion</i>	<ul style="list-style-type: none"> • Generally, patients cite examples of caring and respectful attitude of providers • Also speak of equal treatment irrespective of race and socio-economic status 	<ul style="list-style-type: none"> • Some complaints of patients being given preferential treatment because of race and socio-economic status • Some instances of poor quality of care • Limited patient awareness of rights disempowers patients, particularly those of lower socio-economic status and patients not conversant in English and Afrikaans
Do providers interact with patients (and all groups of patients) in ways that are largely respectful? <u>Relevant rights</u> participation in matters of policy and affecting one's health <i>informed consent</i> <i>refusal of treatment</i> <i>be referred for second opinion</i>	<ul style="list-style-type: none"> • Generally, staff (nurses, doctors, admin and auxiliary) are respectful in their interactions with patients 	<ul style="list-style-type: none"> • Examples of staff mentioning instances of what they consider poor patient care and lack of respect for patients • No real attempt by the hospital to inform patients about their rights

<p>Do providers express respectful attitudes towards patients (and all groups of patients)?</p> <p><u>Relevant rights?</u> <i>participation in matters of policy and affecting one's health</i></p>	<ul style="list-style-type: none"> • Generally, staff (nurses, doctors, admin and auxiliary) are respectful in their interactions with patients 	<ul style="list-style-type: none"> • Labelling of patients in terms of acceptable behaviour (i.e. cooperative, compliant, appreciative, polite etc.)
<p>Do hospital procedures support respectful treatment of patients?</p> <p><i>health and safe environment access to health care be treated by clearly identifiable provider confidentiality and privacy complaints procedure</i></p>	<ul style="list-style-type: none"> • Hospital cleanliness good • Respect for privacy of patients in terms of consulting areas 	<ul style="list-style-type: none"> • Language barriers (staff racial composition vs. patients) • Lack of PRC related information & activities • Staff do not wear name tags • No display of PRC posters • Limited patient awareness of rights

SECTION D: EXPLANATIONS AND IMPLICATIONS

1) Introduction

Earlier sections have presented each hospital's experiences and have identified some key explanatory factors of direct relevance to the access/equity impacts of the policies examined. Building on these analyses, this section, first, considers the factors enabling and constraining each policy's implementation by comparing and contrasting experience between hospitals and identifying some underlying explanations of this experience⁴. Then, second, drawing on relevant policy analysis theory, it highlights key influences over policy implementation practice and access achievements.

2) Explaining the UPFS access impacts

The UPFS experiences are quite similar across hospitals, and give cause for concern about their equity consequences. Although no-one is turned away if unable to pay, few exemptions are given in either hospital (when considering the non-primary care services of Hospital B) and patients who cannot pay essentially become debtors. Although few efforts appear to be made to collect revenue from those with long-standing debts in Hospital B, there is some evidence that some indebted patients do come to pay off their debts, and so incur additional costs. Wider South African evidence also shows that poorer patients may be deterred from using care at all due to concern about its costs, including the common difficulties of accessing exemptions (Gilson and McIntyre, 2007). At the same time, there appears to be only limited fee graduation for higher income patients in either hospital and, at least in Hospital A, there are signs that some higher income patients may not pay at all as clerks give them preferential treatment.

The explanations of these experiences are, in many respects, also similar between the hospitals, although there are some important differences. In essence, the practice of UPFS implementation is geared towards revenue generation rather than exemptions, with probable negative consequences for financial access. Why is this so?

The UPFS policy is clearly specified and laid out in ways that support the revenue generation goal, with guidelines for implementors on how to categorise patients on the basis of income level, what information is needed to prove income level, and what level of fee should be charged by income level category (see Section A, sub-section 3.1, page 8). Moreover, in both provinces UPFS has been closely linked to a hospital-specific revenue target, established and closely monitored by provincial authorities. This strongly encourages the core UPFS implementors (clerks, senior managers) to understand policy success as being about revenue generation rather than ensuring financial protection. The case study of Hospital A provides a good example of how much time and effort go into interrogating the revenue target, measuring performance against the revenue target and reporting on progress against the target (see Section B, sub-section 3.1, page 19).

⁴ Appendix A contains a series of tables that set out the equity/access achievements for each policy in each hospital, offer direct, first-level explanations for this, and then dig deeper to identify underlying explanations.

In contrast, the procedures for determining exemption eligibility are complicated, requiring patients to gather information and seek additional supporting documentation (e.g. affidavits) from agencies such as the police before coming to the hospital. Without the relevant information, policy guidelines require clerks to categorise patients as fee-paying. However, few patients in either hospital were aware of or understood the exemption procedures and so most do not come with the relevant information.

Following the letter of the policy guidelines, the general tendency in both hospitals is, therefore, to categorise all patients as paying patients until or unless they can prove they should be exempted (in Hospital A, patients are categorised as H1 and in Hospital B, H2-H3 for non-primary care patients). Fee clerks in both hospitals are quite conscientious in their jobs, but commonly exercise their discretionary power in support of revenue generation. For example, in Hospital A, they do this by not taking adequate time with patients to determine if they should be eligible or, in Hospital B, not advising them adequately on the documentation required. In Hospital A, patients also sometimes complain that clerks are rude to them, perhaps discouraging patients from asking for exemptions. Here the exercise of power over poorer patients seems to be a way of coping with long patient queues and clerks' frustrations with patients failing to provide the information necessary to allow them to do their jobs easily, including offering exemptions correctly (see Section B, sub-section 3.1, page 18). In Hospital B, meanwhile, clerks' behaviour seems partly to be a reaction to their concern to stop patients cheating the system. The case study of Hospital B highlighted examples of such perceived cheating and of clerks' attempts to counter this (see Section C, sub-section 4.2, page 46). The goal of revenue generation is also supported quite widely in Hospital A, so nurses and doctors support fee clerks by checking patient information and, where patients have by-passed the clerks' desk, returning them for appropriate categorisation. In contrast, in Hospital B admission clerks and nurses often fail to check patient information thoroughly, both because they do not see this as part of their job (nurses) and in reaction to what they regard as the rather hierarchical managerial style within the hospital. The results of all these dynamics are likely to include failing to identify both poorer patients who should be exempt and richer patients who should pay higher fees. Some richer patients are also allowed to get away without paying in Hospital A as clerks sometimes allow friends/family and hospital staff to avoid paying, or to jump the queue. This seems to be underpinned by the notion that hospital staff (and their close relatives and/or friends) should be entitled to concessions as a perk of the job.

Managerial action has also, in both hospitals, reinforced the revenue target as the central policy goal and managers have been supportive of fee clerks. For example, senior managers meet regularly with clerks and administrators to discuss UPFS implementation and revenue generation. In Hospital A, management action was taken to remind all staff that they should pay for care and that they should honour all their outstanding accounts. In Hospital B, the additional managerial actions taken to support revenue generation include appointing a case manager and instituting new procedures for gathering income and expenditure information from patients.

The nature of the policy, clearly laid out with an explicit goal established by higher authorities and imposed on the hospitals, also seems to support implementation aimed at revenue generation because it fits well with key elements of the organisational cultures of the two hospitals. As was demonstrated in the case studies of Hospitals A and B, the rational cultural type is quite strongly present in both facilities. This points, among other things, to competitiveness and an emphasis on achievement and the meeting of objectives. In contexts where these attributes are highly valued,

a revenue goal seems like a natural target to aim at and to focus on. Arguably, the revenue target and the goal of revenue generation have additional significance because they originate with, and are clearly important to, higher authorities that are very significant in the lives of the hospitals. This draws on the hierarchical elements of both hospitals' cultures and the accompanying emphasis on issues such as reporting relationships and adherence to rules and regulations. The strong performance orientation, and wider ranging performance successes, of Hospital A also underpin the hospital-wide focus on performance as revenue generation. Indeed, although the hospital's senior management had attempted to get the provincial revenue target revised downwards in recognition of the general poverty of the hospital's catchment population, this action could perhaps be seen as partly reflecting a concern to secure performance success in terms of revenue generation and as measured against the revenue target.

However, a clear difference between the hospitals is in senior management style. Within Hospital A, there are clearly high-trust relationships between managers and staff and between colleagues, and these encourage both clerks and other staff to support the revenue generation goal of UPFS. These relationships seem to be related to the quite strong presence of the clan cultural type in the make up of Hospital A. Organisations of this type are participative, value cohesion and morale, and obtain compliance through mechanisms such as trust and organisational members' commitment to the system. This seems like fertile ground for cultivating buy-in into key organisational goals such as revenue generation across a wide range of staff members. The hospital management style has also encompassed, if ultimately unsuccessfully, working with the Hospital Board to communicate policy information widely. This lack of success is suggested by patients' fairly poor knowledge of the policy requirements (see Section B, sub-section 3.1, page 20).

In Hospital B, however, there has been little managerial effort to conduct information campaigns in the wider community, or to work with the Hospital Board in any way. Moreover, within the hospital managerial actions seem to have bred more distrust than trust among staff. However, this distrust may also be associated with the organisational culture of the hospital. Other work has shown, for example, that the rational culture type, the strongest cultural type in Hospital B, is negatively correlated with trust and leader credibility and positively correlated with conflict and top managers being scapegoats (Zammuto and Krakower 1991)

Finally, it is important to note that there are signs in both hospitals of efforts to ensure richer groups pay more and to enable financial access by poorer groups. Graduated fees are part of the UPFS guidelines and as the information needed to categorise higher income patients appropriately is likely to be readily available to them, it should be fairly easy to charge them appropriately (except where patients do not readily volunteer the information, in order, as feared by Hospital B's clerks, to cheat the system). Active support for financial access by poorer groups, in contrast, encompasses both fee clerks' actions – such as, perhaps, exercising their discretionary power to exempt patients without the necessary information (Hospital A) and providing patients with information about how to access exemptions (Hospital B) – and both hospitals' general approach of writing off bad debts. Support for patients has been strengthened in Hospital B with the recent appointment of Xhosa speaking clerks who can better communicate with Xhosa speaking patients. More generally, however, clerks' actions in both hospitals appear to be underpinned at a first level by their own ethic of care, as well as the general health care worker concern to secure patient appreciation. In Hospital A, however, this concern appears to be more institutionalised than in Hospital B, perhaps linked to the hospital's Catholic history, the role modelling by middle managers and the parallel efforts to implement the Patients' Rights Charter

and become accredited through COHSASA. In addition, it is possible that the relatively high levels of managerial trust (see Section B, sub-section 1, page 15), wider trusting workplace relationships and the relatively strong clan element of hospital culture (Mannion et al. 2006) encourage health worker concern for patient dignity and respect. Nonetheless, managerial support for exemptions appears to be more implicit than active in both hospitals.

3) Explaining the PRC access impacts

Staff in both hospitals do demonstrate respect and care for patients, as attested by patients themselves, and there are commonly positive relationships between health workers in general (Hospital A) or among groups of health workers (Hospital B). Where expressed, respectful provider attitudes towards patients in Hospital B seem to be mostly underpinned by personal and professional norms, including inter-personal trust among work teams and personal concern for patient appreciation and the hospital's reputation. In Hospital A, these elements are reinforced by a much stronger sense of a hospital ethic of care, in part rooted in its history and traditions. However, there are significant differences in hospital experience around the PRC: from its implementation within the hospital and fairly widespread (if sometimes somewhat grudging) acceptance among staff in Hospital A, to non-implementation in Hospital B. There are also quite clear indications of differences between hospitals in provider attitudes towards patients. Particularly in Hospital B there is a tendency for providers to label groups of patients and justify poor behaviour towards them on the grounds of 'unacceptable' and/or 'abusive' patient behaviour. Finally, Hospital B's procedures provide a much weaker basis for the respectful treatment of patients. Overall, therefore, although both hospitals clearly do demonstrate respect and care for patients, there would appear to be a more weakly institutionalised ethic of care in Hospital B than Hospital A.

What explains the two hospitals' different experiences around the PRC and provider-patient relationships, and the, perhaps inevitable, provider-patient tensions that exist in both?

The PRC is a much less clearly specified policy than the UPFS. The goals of the policy are broader, the policy has multiple dimensions and the activities linked to it are diffuse and subject to variation between facilities and provinces. An important constraint on effective implementation is, moreover, the real disjuncture between the activities of PRC implementation (e.g. posters, suggestion boxes, name tags etc.) and the outcome sought – a re-balancing of provider-patient relationships, by empowering patients, to support better provision of care. Currently low levels of patient literacy and empowerment, as well as poverty inevitably act as a barrier to achieving this outcome, particularly given a wider social context of inequality, and are not clearly or adequately addressed by the PRC implementation activities. In Hospital B the policy features, difficulties of achieving its outcomes, and the notion that it only covers what health providers already do, are justifications presented for not implementing it. The lack of clear support for PRC implementation from higher level authorities, in direct contrast to the UPFS, presumably also explains why this hospital has so far been allowed to avoid implementation.

PRC implementation is anyway likely to be difficult because the very essence of the policy is seen as a threat to providers, as it challenges their power over patients and so their status. As is also common more widely (London et al., 2006), providers' discourse around the PRC in both hospitals, thus, includes concern about how patients abuse their rights as well as the need for

providers' rights (see Section B, sub-section 3.4, page 35 and Section C, sub-section 5.2.2, page 55). This discourse is, in turn, sometimes reflected in providers' labelling of some patients as abusive and un-deserving of good care. In its essence the PRC, thus, challenges providers' view of themselves as being in control of patient care, emphasizing the awkward truth that the provision of care is an act of co-production between provider and patients: providers and patients need to co-operate to deliver effective health care.

The exercise of discretionary power over patients represented by labelling and poor attitudes can also be seen as the common response of street level bureaucrats (Lipsky 1980) to stressful workplace conditions, including the nature of health care as co-production. Despite their best efforts, providers cannot always deliver good care. They get frustrated by not being able to assist patients and they bear the brunt of patient criticism, quite often for problems that are outside their control. Fear of such events helps explain provider discomfort about and reaction to the PRC policy and itself breeds negative attitudes and sometimes negative behaviour towards patients. In addition, in Hospital A, concerns were raised about (perceived) staff shortages, and no additional resources seem to have been made available to support PRC implementation – so, patient privacy was, for example, not always easy to maintain. In contrast, in Hospital B, the main workplace stressors identified by providers were tensions between staff groups, both professional and racial groups, as well as the dominant hierarchical management style within the hospital and lack of management trust. There also appears to be a less than optimal fit between the organisational culture of Hospital B and the PRC, perhaps helping to explain the managerial dislike of the policy and the apparent lack of other action to institutionalise the patient care ethic. This lack of fit relates to the hospital's fairly strong characterisation in terms of organisational culture types that value order, control and stability (hierarchical and rational). Arguably, organisations such as this can have some difficulty in getting to grips with a policy such as the PRC. This is a policy that is not as clearly defined as the UPFS, that can be interpreted in different ways, and that to a large extent relies on the discretion of frontline implementers - a policy, in other words, that might easily frustrate one's desire for control, order and stability.

There is a clear difference between hospitals around managerial style. In contrast to Hospital B, managers in Hospital A are appreciated for being open, approachable and personally supportive of others, and staff also appreciate the managerial procedures (such as the thrice-weekly morning report meetings) that enable widespread communication. Not surprisingly, there is a higher overall level of management trust (see Section B, sub-section 1, page 15 and Section C, sub-section 2, page 40). Some providers also noted that, in line with theory (Gilson et al. 2005), trust in management itself generates positive provider-provider and provider-patient relationships.

In addition, although there is clear managerial support for the PRC, including engagement with the Hospital Board to promote policy awareness in the community, and particularly for the parallel process of COHSASA accreditation, it is not tied to specific activities or groups of people (as with the UPFS). There is, instead, a sense of diffused responsibility within Hospital A for sustaining good provider-patient relationships. This is reflected in the wide-ranging examples providers gave of mid-level managers who have taken innovative action to address patient concerns or who have gone beyond the call of duty in their own activities, which are nonetheless backed up by dedicated PRC-related activities (such as training, so, for example, complaints procedures are widely known by staff). These innovative actions can, moreover, be seen as positive examples of the provider exercise of discretionary power, used to enable and enhance positive provider-patient relationships. They are underpinned by the clearly close working relationships among colleagues within the hospital in general, which is, in turn, partly a function of the fact that many

staff come from the community in which they work. However, there is also an openness to outsiders. The mutually reinforcing relationships within the hospital are, finally, underpinned by the hospital's organizational culture and hospital history and traditions. Good patient care is also sustained both by the value providers place on patient appreciation and the hospital's good reputation as well as by the religious traditions of the hospital. At the same time, the clan element of organizational culture encourages team work, as well as trust and commitment among staff, and is backed up by the sense of family inherent in the hospital.

4) Common influences over policy implementation practice and access achievements

Despite differences between policies and hospitals, when considered through the lens of policy analysis and organisational management theories the experiences reported here highlight a number of common factors influencing implementation of health policies, and specifically those intended to promote access and equity.

First, the experiences examined here show that co-production (Gregory 1995, Joshi and Moore 2004) between provider and patient is often seen by health providers as being essential to health care provision, and it influences health policy implementation. But the need for co-production represents a clear challenge to top-down policy implementation. It implies that providers (and policy formulators) cannot fully control policy implementation where policies work through provider-patient interactions. Strong top-down approaches to policy design and implementation are, therefore, often simply inappropriate for health policy. Instead, implementor discretion is required to encourage patient co-operation, requiring policy adaptations to address patient and contextual influences.

The extent of success in co-production is also itself a stimulus for virtuous or vicious cycles of provider attitudes and behaviour. Successful co-production can generate mutual appreciation between providers and patients and so sustain provider morale and motivation, and strengthen positive provider attitudes and behaviours towards patients. Limited success, however, can prompt providers to adopt street level bureaucrat coping strategies, including labelling and rudeness, and so prompt a cycle of negative behaviours and attitudes.

As the acceptability dimension of access is fundamentally based on provider-patient relations, successful co-production is thus, particularly, important to achieving it. In contrast, exemptions implemented at the point of use are only one way of seeking to protect financial access – which, given the difficulties demonstrated here, might be better replaced by approaches that do not require co-production, such as tax-based financing mechanisms. Indeed, allowing provider discretion in relation to policies aiming at securing financial access is commonly seen as undermining equity by allowing different practices in different places.

Second, both policy experiences also show that implementation is more difficult where the embedded values of policies (such as not allowing staff to get preferential treatment or challenging provider power over patients) conflict with implementor norms. Matland (1995) argues that policy ambiguity and conflict are intrinsic features of any policy that cannot be designed away and that they, in turn, influence the appropriate form of implementation. Administrative approaches to implementation are only likely to be appropriate where conflict and ambiguity are both low. High conflict requires the exercise of political power to sustain

implementation, high ambiguity points to the relevance of a more experimental approach to implementation to take account of variation in contextual conditions and high levels of both mean that coalition strength is vital to any implementation.

As the experiences here show, top-down and bureaucratic approaches to implementation are, therefore, rarely likely to secure policy goals, and much more active management is necessary. This may be particularly true for equity-oriented policies, such as the PRC, that clearly challenge established practices of power.

Third, both policy experiences show that street level bureaucrat behaviour, or the exercise of discretionary power by implementors, whether hospital managers, nurses or clerks, is clearly an influence over the practice and consequences of implementation (Lipsky 1980). Moreover, attitudes and behaviours that impact negatively on access may themselves be provoked by the particular nature, and associated stresses, of implementing policies requiring co-production. However, across hospitals there are also examples of the positive exercise of discretionary power in support of financial access and acceptability. The challenge is, therefore, to identify how to stimulate the exercise of discretionary power in support of policy goals (Elmore 1979).

Fourth, the experiences suggest that different bureaucratic forms or organisational models are likely to be necessary for different types of tasks (Gregory 1995). Procedural/bureaucratic organisations, as is common in the public sector, can support policy implementation where, for example, policies have clear goals and can be tightly specified (e.g. revenue generation and UPFS). However, where policies require co-production or are ambiguous and conflict with implementor norms or have unobservable outcomes, as with the PRC, such processes are much less likely to be successful and instead may prompt street level bureaucrats to adopt resisting behaviours that, in turn, undermine co-production. For such policies, craft or coping organisational forms are more likely to be appropriate – where craft organisations draw on the knowledge power of key implementers, and coping organisations draw on the power of implementors to persuade people to, for example, change behaviour. Gregory (1995) also argues that such organisations require a greater capacity for learning and adaptation than procedural/bureaucratic organisations as well as risk-taking, innovative and enabling leadership.

Finally, the contrasting managerial approaches and organisational cultures of the two hospitals show the potential for innovative public sector management and its consequences for policy implementation. The experience of Hospital A specifically reflects Stoker's (1991) argument (in Hill and Hupe 2002) that effective policy implementation requires the adoption of empowering forms of management (exercising the power to act) that enable co-operation among those involved in policy implementation, an idea in turn quite closely linked to an emphasis on the importance of network management to effective implementation (Hudson and Lowe 2004). This hospital's experience is also affirmed by a wider body of theory that emphasises that the key dimensions and elements of such management include: agreement on goals, strong communication, effective conflict management, mutual trust between managers and implementers, institutionalised client and peer assessment (Cline 2000, Elmore 1979, Hill and Hupe 2002, Lane 1987, Rothstein 1998, Stoker 1991). Important inter-personal managerial competencies include being able to give feedback without creating defensiveness, being able to

give honest expression to feelings and being open to new ideas, which are underpinned by strong inter-personal and professional ties (networks) among implementors and a reliance on incentives that elicit commitment rather than enforce conformity (Argyris 1957, in Elmore 1979). Etzioni (1961), in Hill (1997), meanwhile argues that in effective organisations levels of coercion and alienation are low, whilst those of remuneration, calculation and normative and moral involvement are high, and trust theory, finally, suggests that trusting workplace relationships are built on these sorts of managerial approaches and may generate trusting provider-client relationships (Gilson et al., 2005). Overall, therefore, empowering and enabling management may, thus, be particularly important for policy implementation requiring co-production.

5) Implications and conclusions

This last section of the report draws out some of the implications and conclusions flowing from the case studies of Hospital A and Hospital B. It focuses first on the policies themselves, starting with the UPFS and moving to the PRC, and then considers implementation practice more generally.

With regard to the policies themselves, the experiences of the two case study hospitals, firstly, lend support to the idea that it is difficult to exempt as part of a fee policy. More often than not, and as was the case in this research, the driving imperative is revenue collection, not access (Gilson et al. 2001). International experience (McIntyre 2007) suggests that financial access is better protected through either separate equity funds, which have their own implementation difficulties and costs, or through removing fees and moving towards financing mechanisms that enable cross-subsidy. In South Africa there is wider evidence on the financial barrier imposed by hospital fees, and the consequences for household poverty (South African Costs and Coping Study, personal communication J. Goudge), as well as the limited revenue collected through these fees. There are therefore clear arguments in favour of removing fees and establishing different systems that ensure that those with higher incomes pay more and cross-subsidise those with lower incomes (e.g. mandatory insurance, progressive tax system).

A second policy-related conclusion is that the PRC is likely to always be difficult to implement, given its goal and the difficulties of achieving that goal (London et al. 2006). However, it is clearly important to continue to focus policy action around the issue of acceptability because of the known access barriers facing patients, especially the most marginalized patients (Gilson et al. 2007). It was interesting to note how, in Hospital A, the COHSASA process was enthusiastically accepted and apparently generated end points similar to those of the PRC. This raises the question of whether an active quality assurance process is more appropriate or feasible from a provider perspective than the PRC? However, even if this were the case, it would still need to be complemented by action to empower patients, particularly the poorest and most marginalized. Within hospitals this could encompass activities such as the establishment of help desks and the provision of information, but also even more active steps such as the appointment of staff members tasked with helping people navigate the system. Such staff don't need to be medically trained and could be drawn from the local community (Dixon and Le Grand 2006). Wider international evidence, nonetheless, points to the need for wider action to address acceptability problems and for social empowerment (Gilson 2007; Gilson et al. 2007). Participatory approaches in particular are important, both at an individual and collective level. This calls for community-level action and stronger roles for structures such as hospital boards.

Third, with regard to implementation practice more generally, the experiences portrayed here point to the importance of the framing of policies and the meanings given to them. For example, in both case study hospitals the framing or meaning of the UPFS was centred on revenue generation. This highlights financial metrics and the collection of money and pushes to the background concerns about access impacts. Arguably, a reframing of the policy is one of the actions that will be necessary to bring about more active consideration of access impacts and the improved implementation of exemptions. One option might be to begin to more explicitly define good performance, an outcome and judgement sought by both hospitals, in terms of the correct granting of exemptions and the more active consideration of access issues. This would be in contrast to the current situation, where the revenue target seems to be the main yardstick.

In addition, this research suggests that it is important to engage deliberately and explicitly with the “softer” elements of policy implementation, as opposed to focusing mostly on quite tangible and surface-level manifestations of implementation such as displaying posters or wearing name tags. It is clear, for example, that some providers in both hospitals perceive the PRC as a threatening policy. Full, committed implementation seems to require strategies to take account of and manage the fears and anxieties of health workers. Similarly, the “softer” elements of policy implementation can be addressed by nurturing the relationship between providers and patients and by taking steps to increase the likelihood of co-production. Co-production is indispensable to the implementation of both the UPFS and the PRC. Providers themselves recognise it as important to their morale and motivation and to offering good care. Although they might be more elusive and harder to address, “softer” elements of policy implementation can clearly have a major impact on the course of events.

The implementation of the UPFS and the PRC in the two case study hospitals highlights, fourthly, the need to be aware of the potential influence of organisational culture over the practice of policy implementation. With regard to Hospital A, we have sought to argue that its cultural mix has equipped it well to cope with the demands of the UPFS and the PRC, two very different policies. The organisational culture of Hospital B, on the other hand, seems better suited to the implementation of the UPFS than the PRC. The fit between the values and assumptions of the organisational culture and the nature of the policy and ways of working required by the policy is therefore something to be mindful of and to strategise around in implementation.

Fifth and last, this work speaks to the potential importance of management styles and workplace trust to policy implementation. It highlighted, among other things, examples of positive role-modelling by senior and mid-level staff, explained that staff recognise and value this, and tried to show how it might aid policy implementation by helping to foster a sense of buy-in and by cushioning frontline implementers against some of their daily stresses. The research also showed the different levels of trust, both between staff and between staff and management, in the two hospitals and argued that greater levels of trust help implementation in that they make the exercise of managerial authority more legitimate and hence lead to less resistance to change in policy implementation. Again, in workplace trust and management style we have “soft” factors that might not relate to particular policies *per se*, but that can have profound effects on the course

of individual policies in that problems with these factors might manifest, or play out, as problems in the implementation of particular policies.

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APPENDIX A

Explaining UPFS access achievements

	HOSPITAL A		HOSPITAL B	
	Access achievements	Direct explanations	Access achievements	Direct explanations
1) <i>Are all patients made to pay fees?</i>	<ul style="list-style-type: none"> No-one turned away because can't pay People not forced to pay over time, but instead allowed to become bad debts 	<ul style="list-style-type: none"> Exemptions clearly offered in policy Fee clerks' ethic of care Fee clerks recognise real economic situation of patients (know local community) Hospital exercises discretionary power in allowing bad debts Hospital ethic of care Difficult to collect debts from patients because they are hard to locate, given informal villages 	<ul style="list-style-type: none"> No-one turned away because can't pay People not forced to pay over time, but instead allowed to become bad debts 	<ul style="list-style-type: none"> Exemptions clearly offered in policy Fee clerks' ethic of care Hospital exercises discretionary power in allowing bad debts
2) <i>Which patients are granted exemptions?</i>	<ul style="list-style-type: none"> Maybe given to patients with full information Some possibilities of ad hoc exemptions based on physical appearance, numerous visits to hospital 	<ul style="list-style-type: none"> Policy defines information needed for exemption Fee clerks may exercise discretionary power by exempting patients without information Fee clerks recognise real situation of patients (know local community) Hospital ethic of care 	<ul style="list-style-type: none"> OPD functions as a primary care service, so all services are free. Fees are only charged for 'specialist' services (not to H0) and referrals from private GPs. 	<ul style="list-style-type: none"> Policy defines information needed for exemption Fee clerks may exercise discretionary power by exempting patients without information Employment of Xhosa-speaking clerks helps to bridge information/language gaps
3) <i>Are the fees graduated</i>	<ul style="list-style-type: none"> Highest income patients, e.g. those covered by Road Accident Fund or 	<ul style="list-style-type: none"> Policy clearly defines graduated fees and information needed for appropriate categorisation 	<ul style="list-style-type: none"> Highest income patients e.g. with insurance, classified appropriately 	<ul style="list-style-type: none"> Policy clearly defines graduated fees and information needed for

<i>by ability to pay?</i>	having medical aid coverage, mostly classified correctly as H3	<ul style="list-style-type: none"> • Patients have readily available information that allows appropriate classification • Patients sometimes keen to gain access to private wards for in-patient care 		<p>appropriate categorisation</p> <ul style="list-style-type: none"> • Patients who have readily available information can be appropriately classified • Role of clerks in explaining to patients the documents which are necessary for showing socio-economic status
	Underlying explanations of access achievements		Underlying explanations of access achievements	
	<p>Empirical explanations:</p> <ul style="list-style-type: none"> • General provider concern for patient appreciation, and pride in hospital reputation, encourages caring behaviour • Middle and senior staff provide role models of actively caring for patients • Managerial support for fee clerks' use of discretionary power to generate revenue • Managerial action to encourage payment by staff • Managerial action to disseminate information on fees and exemptions within community • Parallel implementation of PRC and COHSASA accreditation process encourages caring behaviour • Hospital history as Catholic hospital supports ethic of care <p>Theoretical explanations:</p> <ul style="list-style-type: none"> • Workplace trust (trusting relationships) encourages concern for patient dignity and respect • Clan culture encourages concern for patient dignity and respect 		<p>Empirical explanations:</p> <ul style="list-style-type: none"> • General provider concern for patient appreciation, and pride in hospital reputation, encourages caring behaviour • Managerial action of appointing case manager supports implementation of graduated fees & appointment of Xhosa speaking staff assists with exemptions 	

Explaining UPFS access problems

	HOSPITAL A		HOSPITAL B	
	Access problems	Direct explanations	Access problems	Direct explanations
1) <i>Are all patients made to pay fees?</i>	<ul style="list-style-type: none"> • Most people categorised as H1 paying patients (whatever their income level) • People may come back to pay, to avoid having a debt and so incur overall higher costs • People may be deterred from seeking care given costs 	<ul style="list-style-type: none"> • Policy message of revenue target • Fee clerks exercise discretionary power by not taking time with patients • Other hospital staff support clerks' by checking information and ensuring those who by-pass clerks return to them • Performance norm of hospital 	<ul style="list-style-type: none"> • For non primary care services, most people categorised as H2/H3 paying patients (whatever income level) • People may come back to pay to avoid having a debt and so incur overall higher costs • People may be deterred from seeking care 	<ul style="list-style-type: none"> • Policy message of revenue target • Fee clerks exercise discretionary power to prevent patients 'cheating' the system • Admissions clerks exercise discretionary power in failing to check patients fully for income levels, possibly missing patients who should be exempt, as form of resistance to management pressure
2) <i>Which patients are granted exemptions?</i>	<ul style="list-style-type: none"> • Exemptions rarely/never given 	<ul style="list-style-type: none"> • Policy message of revenue target • Policy sets out complicated procedures to prove eligibility • Fee clerks exercise discretionary power by not providing information on exemptions, by being rude in frustration at patient failure to provide relevant information and as way of coping with long queues 	<ul style="list-style-type: none"> • Other than free primary care, exemptions only sometimes given 	<ul style="list-style-type: none"> • Policy message of revenue target • Policy sets out complicated procedures to prove eligibility • Fee clerks exercise discretionary power to prevent patients 'cheating' the system • Admissions clerks exercise discretionary power in failing to check patients fully for income levels, possibly missing patients who should be exempt, as form of resistance to management pressure • Hospital exercise of discretionary power demonstrated in hospital's use of own

		<ul style="list-style-type: none"> • Performance norm of hospital • Patient lack of awareness of possibility for exemption and of information needed, and lack of power in relationship 		<p>income and expenditure form, adding barriers to obtaining exemptions</p> <ul style="list-style-type: none"> • Limited wider efforts, including involving hospital board, to raise awareness of fee and exemption system, so patients rely on the hospital staff to provide the information on obtaining exemptions • Patient lack of awareness of possibility for exemption and of information needed (and poverty etc)
3) <i>Are the fees graduated by ability to pay?</i>	<ul style="list-style-type: none"> • Some probable higher income patients allowed preferential treatment (not pay, queue jumping) • Some probable higher income patients being categorised as H1 because not providing information 	<ul style="list-style-type: none"> • Fee clerks exercise discretionary power by favouring family/friends and hospital staff, in response to sense that staff are entitled to free services as perk of the job • Patients 'play' the system 	<ul style="list-style-type: none"> • For non-primary care services, most patients classified as H2/H3 even those who could qualify for exemptions • Patients 'play' the system 	<ul style="list-style-type: none"> • Fee clerks exercise discretionary power to prevent patients 'cheating' the system • Admissions clerks exercise discretionary power in failing to check patients fully for income levels, possibly missing patients who should be exempt, as form of resistance to management pressure • Nurses don't check for income levels, perhaps missing higher income patients, as form of resistance to management

	Underlying explanations of access problems	Underlying explanations of access problems
	<p>Empirical explanations:</p> <ul style="list-style-type: none"> • Policy clearly defined and yet content weak/complicated in relation to exemptions, enabling levying of fees & making exempting difficult • Use of clerks' discretionary power in favour of staff a response to norms outside policy • Management style has supported implementation for revenue generation, even whilst seeking to get target redefined more appropriately to hospital context • Management style has encouraged fee clerks to work towards performance goals by being caring and supportive of staff, e.g. regular meetings, good communication • Management style encourages team work within hospital generally and in relation to UPFS by being transparent, open, caring • Past hospital successes supports 'performance' norm, and so, UPFS implementation • Patient poverty etc as explanation of lack of patient awareness despite awareness activities 	<p>Empirical explanations:</p> <ul style="list-style-type: none"> • Nurses resist policy because not about patient care • Active management has supported implementation for revenue generation • Management style (hierarchical) has generated resistance from some providers • Management style (hierarchical) encompasses failure to conduct awareness campaigns and work with hospital board • Patient poverty etc as explanation of lack of patient awareness despite awareness activities

	Underlying explanations of access problems	Underlying explanations of access problems
	<p>Theoretical explanations:</p> <ul style="list-style-type: none"> • Policy nature (revenue generation) fits organisational culture/management style • Top down approach to setting revenue target fits well with rational culture (planning, goal setting etc.) and hierarchical culture (administration, adhering to rules etc.), adding pressure to implement UPFS for revenue generation • Exercise of discretionary power and rudeness partly a reaction to failing to meet revenue targets (so need to cope) & frustration with patients, <u>but</u> softened by managerial style (concern for clerks) itself drawing on clan culture of hospital • Workplace trust (trusting relationships) encourages provider support for hospital goals • Rational culture of hospital supports focus on performance goals • Clan culture supports all staff getting involved and buying into policy and fosters organisational pride 	<p>Theoretical explanations:</p> <ul style="list-style-type: none"> • Policy nature (revenue generation) fits organisational culture/management style • Top down approach to setting revenue target fits well with rational culture (planning, goal setting etc.) and hierarchical culture (administration, adhering to rules etc.), adding pressure to implement UPFS for revenue generation • Staff resistance to policy a coping strategy and reaction to top down imposition of policy outside and within hospital • Rational/hierarchical culture of hospital supports focus on performance goals • Rational cultures are negatively correlated with trust, morale, equity of rewards and leader credibility and positively correlated with leaders as scapegoats, conflict and resistance to change

Explaining PRC access achievements

	HOSPITAL A		HOSPITAL B	
	Access achievements	Direct explanations	Access achievements	Direct explanations
1) Do patients feel providers offer respectful care/treat all fairly?	<ul style="list-style-type: none"> • Yes generally • Patients cite examples of positive care; no feeling of discrimination 	<ul style="list-style-type: none"> • Provider ethic of care • Teamwork among providers • Positive role models among mid- level and managerial staff • Active role of hospital management team, e.g. implementation of PRC and support for COHSASA accreditation processes • Hospital ethic of care • Patient appreciation valued by providers • Live in small town, so providers sensitive to patient views • Reputation of the hospital and its public image as caring institution is important for staff 	<ul style="list-style-type: none"> • Yes generally • Patients cite examples of positive care; no feelings of discrimination based on race or socio-economic status 	<ul style="list-style-type: none"> • Provider ethic of care • Teamwork among sub-groups of providers • Some managers act as role models • Patient appreciation valued • Live in small town, so sensitive to patient views • Reputation of the hospital and its public image as caring institution is important for staff.
2) Do providers demonstrate respect for all groups of patients	<ul style="list-style-type: none"> • Yes, generally • Common demonstrations/expressions of empathy and care towards patients across range of cadres, including e.g. cleaners 	As above	<ul style="list-style-type: none"> • Yes, generally and across cadres , including auxiliary staff 	As above
3) Do hospital procedures support	<ul style="list-style-type: none"> • Yes, for example information provided on patient rights, opportunities to complain through 	<ul style="list-style-type: none"> • As above, plus: • Active role of hospital board in community awareness 	<ul style="list-style-type: none"> • In limited way e.g. hospital cleanliness good 	As above

respectful treatment of patients?	suggestion boxes and other procedures, orientation of staff quite widespread, action taken to address long queues length etc	campaigns and other hospital activities (e.g. opening of suggestion boxes – though delays are apparent)		
	Underlying explanations of access achievements		Underlying explanations of access achievements	
	<p><i>Empirical explanations:</i></p> <ul style="list-style-type: none"> • Providers need patient co-operation to achieve patient care goals • Management style (open, communicative, encouraging innovation) supports work with Hospital Board in support of policy implementation • Management style (open, communicative, encouraging innovation) builds trust in managers and other staff, which breeds provider-patient trust • Hospital history and ethos supportive <p><i>Theoretical explanations:</i></p> <ul style="list-style-type: none"> • Policy nature fits with organisational culture/management style, enabling implementation and making it easier to maintain the ethic of care, team work etc. • Trust in management underpins the legitimate exercise of managerial power in support of policy implementation • Management style fits with organisational culture (both the performance orientation, with patient care seen as valid performance indicator, and the clan culture encouraging teamwork, compliance built through affiliation, trust and commitment) • Workplace trust breeds provider-patient trust 		<p><i>Empirical explanations:</i></p> <ul style="list-style-type: none"> • Providers need patient co-operation to achieve patient care goals • Professional ethics act as norm driving behaviour • Inter-personal trust within teams supports positive working practices in addressing workplace challenges 	

Explaining PRC access problems

	HOSPITAL A		HOSPITAL B	
	Access problems	Direct explanations	Access problems	Direct explanations
1) Do patients feel providers offer respectful care/treat all fairly?	<ul style="list-style-type: none"> • Some complaints of preferential treatment being given to patients known to providers & staff rudeness to patients • A few observations of staff brusqueness with patients • Fairly widespread patient complaints of clerks' rudeness 	<ul style="list-style-type: none"> • Providers exercise discretionary power by favouring family/friends and hospital staff, in response to sense that staff are entitled to services as perk of the job • Providers exercise provider discretionary power over patients, by being rude, as a coping strategy in a stressed workplace 	<ul style="list-style-type: none"> • Some complaints of some patients being given preferential treatment because of race (a few instances of patients demanding preferential treatment on the basis of race) • Some instances of poor quality of care 	<ul style="list-style-type: none"> • No implementation of PRC/wider quality assurance initiative by hospital management • Staff exercise of provider discretionary power over patients, as a coping strategy in a stressed workplace
2) Do providers demonstrate respect for all groups of patients	<ul style="list-style-type: none"> • Providers sometimes label patients as 'abusing their rights', providing possible basis for insensitivity and even hostility towards patients 	<ul style="list-style-type: none"> • Provider response to policy, which they feel threatens their status by empowering patients • Provider exercise of provider discretionary power over patients, as a coping strategy in a stressed workplace 	<ul style="list-style-type: none"> • Labelling of patients in terms of 'cheating' by clerks • Labelling of H1 patients and especially those with unpaid fees as being from the local black informal settlement • Labelling of patients in terms of 'unacceptable' behaviour, encourages providers to think that 	<ul style="list-style-type: none"> • No implementation of PRC/wider quality assurance initiative by hospital management • Staff response to wider health policies (including the PRC) & societal changes which providers feel threatens their status by empowering patients • Staff exercise of provider discretionary power over patients, as a reaction to hierarchical managerial style, other tensions among staff (e.g. tensions between

	HOSPITAL A		HOSPITAL B	
			badly behaved patients (rude, impatience, drunk, non-compliant) deserve poor care	doctors and nurses, racial tensions)
3) Do hospital procedures support respectful treatment of patients?	<ul style="list-style-type: none"> Some problems experienced in accessing services e.g. queues, in part felt by staff to be due to staff shortages 	<ul style="list-style-type: none"> Some resource constraints Limited support from higher level authorities for PRC implementation 	<ul style="list-style-type: none"> Clear problems, for example language barriers between staff and patients, lack of PRC related information available in all relevant languages, especially Xhosa 	<ul style="list-style-type: none"> No implementation of PRC/wider quality assurance initiative by hospital management Managerial failure to involve hospital board in community engagement around quality of care Limited support from higher level authorities for PRC implementation = both regional and provincial
	Underlying explanations		Underlying explanations	
	<p><i>Empirical explanations:</i></p> <ul style="list-style-type: none"> Provider behaviours/attitudes represent a reaction to the need for, but problems of patient co-operation, with potential for patient complaints when fail Wider contextual factors linked to providers e.g. workloads and staff shortages Wider contextual factors linked to patients (poverty, race, disempowerment) mean patients lack power to complain etc 		<p><i>Empirical explanations:</i></p> <ul style="list-style-type: none"> Managerial dislike of policy Provider behaviours/attitudes represent a reaction to the need for, but problems of patient co-operation, with potential for patient complaints when fail History of hospital as whites only, racial tensions within hospital/with patients Wider contextual factors linked to patients (poverty, race, disempowerment, small rural, predominantly white/coloured district) mean patients (particularly black) lack power to complain etc 	

	HOSPITAL A		HOSPITAL B	
	<p><i>Theoretical explanations:</i></p> <ul style="list-style-type: none"> • Nature of policy breeds resistance to it – conflict and ambiguity embedded within it, as a result of clash of values, top-down imposition • Provider behaviours/attitudes represent street level bureaucrat behaviour in responding to workplace pressures 		<p><i>Theoretical explanations:</i></p> <ul style="list-style-type: none"> • Nature of policy breeds managerial and staff resistance to it – conflict and ambiguity embedded within it, as a result of clash of values, top-down imposition • Policy nature does not fit with organisational culture/management style, generating more stress in the organisation and making it more difficult to maintain the ethic of care, team work etc. • Provider behaviours/attitudes represent street level bureaucrat behaviour in responding to workplace pressures, including hierarchical management style • Problems of staff relations between some groups may be exacerbated by lack of management trust • Managerial style not support networking e.g. with hospital board 	